# STATE OF ILLINOIS

SOLICITATION DOCUMENT

INTEGRATED CARE PROGRAM / 2010-24-005

The Illinois Department of Healthcare and Family Services (Department) is requesting Proposals (Offers) from responsible Bidders to meet the State's needs. Below is a brief description of our needs with detailed requirements in subsequent sections of this solicitation. If you are interested and able to meet these requirements, please submit a Proposal. This procurement is a Purchase of Care, which is exempt from the Procurement Code (30 ILCS 500/1-10(b)(3)) and Standard Procurement Rules (44 Ill. Admin. Code 1.10(d)(3)). The State, however, has chosen to solicit contractors by means of the Request for Proposal process provided for in the Code (30 ILCS 500/20-15) and Rules (44 Ill. Admin. Code 1.2015). This procurement, therefore, need not strictly comply with the Code and Rules (44 Ill. Admin. Code 1.2005(q)). We will award to the two most responsible Bidders in accordance with Section 2, How We Will Evaluate Offers.

We are issuing this solicitation in the following form and you must take that into account when reading and responding:

- ☐ Invitation for Bids
- ☒ Request for Proposals
- ☐ Request for Proposals (Professional and Artistic Services)

Brief Description: The Department is seeking the services of two qualified, experienced and financially sound Health Maintenance Organizations (HMOs) to enter into risk-based contracts to provide the full spectrum of Medicaid covered services through an integrated care delivery system to Older Adults and Adults (aged 19 and over) with Disabilities who are eligible for Medicaid but are not eligible for Medicare, in the counties of Lake, Kane, DuPage, Will, Kankakee and suburban (areas with zip codes that do not begin with "606") Cook county. This delivery system is called the Integrated Care Program.

The solicitation package consists of two parts:

Part A INSTRUCTIONS FOR SUBMITTING AND EVALUATING PROPOSALS: Part A consists of the following sections:

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| SECTION 1 | INSTRUCTIONS, DATES, RESERVATIONS AND OTHER GENERAL INFORMATION |
| SECTION 2 | HOW WE WILL EVALUATE PROPOSALS |
| SECTION 3 | SPECIFICATIONS / QUALIFICATIONS / STATEMENT OF WORK |

These sections provide information necessary for submitting a Proposal, set forth the basic legal and policy requirements associated with this solicitation and tell how we will evaluate Proposals.

Part B PROPOSAL RESPONSE FORMS: Part B consists of the following sections:

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| SECTION 4 | PROPOSAL TO STATE OF ILLINOIS |
| SECTION 5 | RESPONSIBILITY FORMS |
| SECTION 6 | RESPONSIVENESS |
| SECTION 7 | PAYMENT TERMS AND CONDITION |
| SECTION 8 | MODEL CONTRACT |

Your response to Part B will constitute your Proposal to the State and will provide us with information about you, what you will provide, and your ability to perform. We will evaluate this information as well as compliance with the Instructions.

In this document the State of Illinois will be referred to as "State", "Agency", "we" or "us". The person submitting a Proposal will be referred to as "Bidder", or "You". "We" is used appropriate to the context.

Please read the entire solicitation package and submit your Proposal for evaluation in accordance with all instructions.

Public Act 95-971 contains new registration requirements regarding bids and proposals submitted by Bidders. You must read and comply with the requirements. See www.purchase.state.il.us for additional information.

*NON-DISCRIMINATION POLICY In compliance with the State and Federal Constitutions, the Illinois Human Rights Act, the U.S. Civil Rights Act, and Section 504 of the Federal Rehabilitation Act, the State of Illinois does not discriminate in employment, contracts, or any other activity.*

SECTION 1 - INSTRUCTIONS, DATES, RESERVATIONS AND OTHER GENERAL INFORMATION

1.0 PROJECT CONTACT: If you have a question or suspect an error, you must immediately notify the Project Contact identified in this section. Do not discuss the solicitation or your Proposal, directly or indirectly, with any State officer or employee other than the State Project Contact. Only written answers to questions shall be binding on the State.

Michelle Maher
HealthCare and Family Services
201 South Grand Avenue East
Springfield, IL 62763

Phone: 217-524-7478
Fax: 217-524-7535
TDD: 800-526-5812
E-mail: michelle.maher@illinois.gov

1.1 BIDDER CONFERENCE / SITE VISIT: ☒ Yes ☐ No
Date and Time:
February 17, 2010
10:30 a.m.

Mandatory Attendance: ☒ Yes ☐ No
Location:
Illinois Department of Agriculture Administration Bldg. Auditorium
Illinois State Fairgrounds
8th Street and Sangamon Avenue, Gate 11
Springfield, IL

Questions regarding the RFP may be submitted to the Project Contact prior to the Bidder's Conference, at the Bidder's Conference, or up until 5:00 p.m. on the day of the Bidder's Conference. We will provide written responses to these questions and only those written responses shall be binding. Written responses will be posted on the Procurement Bulletin. Questions submitted after 5:00 p.m. on the day of the Bidder's Conference may be answered at the discretion of the Department.

Attendance is mandatory and you will be disqualified if you do not attend or fail to sign the attendance sheet. The actual bidding entity must be clearly identified when signing the attendance sheet. You must allow adequate time to accommodate security screenings at the site. The Bidder's Conference will be recorded to ensure the accuracy of questions asked.

1.2 PROPOSAL DUE DATE, TIME AND SUBMISSION LOCATION: Due Date: April 15, 2010 Time: 1:00 p.m.

DELIVER PROPOSALS TO:
Illinois Department of Healthcare and Family Services
Attn: Michelle Maher
201 South Grand Avenue East
Springfield, IL 62762

LABEL OUTSIDE OF ENVELOPE / CONTAINER:
Integrated Care Program/ 2010-24-005
April 15, 2010, 1:00 p.m.
[Bidder Name & Address]

We will open Proposals at the Due Date, Time and Delivery Location. Prior to the due date, you may mail or hand-deliver Proposals, modifications, and withdrawals. We do not allow e-mail, fax, or other electronic submissions. We must physically receive submissions as specified; it is not sufficient to show you mailed or commenced delivery before the due date and time. We will not consider Proposals, modifications or withdrawals submitted after the due date and time. All times are State of Illinois local times.

1.3 NUMBER OF COPIES: You must submit signed original and fourteen (14) copies of the Proposal in a sealed container. In addition, you must submit two (2) copies of the Proposal on CD in the following format: Microsoft Word and/or Excel and two (2) copies of the file on CD requested in Section 3.2.2.12. If you are requesting confidential treatment, you must make that request in the form and manner specified elsewhere in this solicitation. If Minority, Female, and Person with Disability Subcontracting is marked "YES", you must also submit one (1) original, one (1) copy, and one (1) CD of your Utilization Plan in a separate sealed envelope within your Proposal container.

In accordance with Public Act 95-971, if you do not submit the State Board of Elections Registration Certificate as required, your Proposal will be disqualified.

1.4 OFFER FIRM TIME: Your Offer must remain firm for 180 days from opening.

1.5 SECURITY: Bid Bond $ NA Performance Bond $ NA . You must submit the Bid Bond with the o and the Performance Bond within 10 days after award. The bond must be from a surety licensed to do business in Illinois. An irrevocable letter of credit is an acceptable substitute. The form of security must be acceptable to us.

1.6 PROTEST REVIEW OFFICE:

Illinois Department of Healthcare and Family Services
Office of the State Purchasing Officer
Attn: Thomas J. Sestak
2200 Churchill Road, C-3
Springfield, IL 62702

Ph: 217-557-5777
Fax: 217-557-6745
TDD: 800-526-5812

You may submit a written protest of our actions to the PROTEST REVIEW OFFICE following the requirements of the Standard Procurement Rules (44 Ill. Adm. Code 1.5550). We must physically receive the protest by noon of the seventh calendar day after you knew or should have known of the facts giving rise to the protest.

1.7 SMALL BUSINESS SET-ASIDE: ☐ Yes ☒ No. If "Yes" is marked, you must be certified by the Small Business Set-Aside Program at the time Proposals are due in order for us to evaluate your Proposal. For complete requirements and to certify your business in the Small Business Set-Aside Program, visit http://www.sell2.illinois.gov/bep/Set_Aside.htm.

1.8 MINORITY, FEMALE AND PERSONS WITH DISABILITY SUBCONTRACTING: ☒ Yes ☐ No. If "Yes" is marked, this solicitation contains a goal to include businesses owned and controlled by minorities, females and persons with disabilities in the State's procurement and contracting processes. This solicitation includes a specific Business Enterprise Program (BEP) utilization goal of 20% of the Administrative portion of the Capitation payments based on the availability of certified vendors to perform the anticipated direct subcontracting opportunities of this contract. This goal is split between the three types of BEP certified vendors as follows: Minority owned businesses- 9%; Female owned businesses- 6%; and Persons with Disabilities owned businesses- 5%. In addition to the number of copies requested above, you must submit an original and 1 copy of the Utilization Plan and Letter of Intent, sealed separately within the Proposal container. Failure to submit a Utilization Plan as instructed later in this solicitation will render the offer non-responsive. All questions regarding the subcontracting goal must be directed to Susan Hartman at Susan.Hartman@illinois.gov or (312) 814-2200. Subcontracting vendors must be certified by DCMS as BEP vendors before the time of contract award. Go to http://www.sell2.illinois.gov/bep/Business_Enterprise.htm for complete requirements for BEP certification.

1.9 PUBLIC CONTRACTS NUMBER: (775 ILCS 5/2-105) If you do not have a Department of Human Rights' (DHR) Public Contracts Number or have not submitted a completed application to DHR for one before opening we may not be able to consider your Proposal. Please contact DHR at 312-814-2431 or visit http://www.state.il.us/dhr/index.htm for forms and details.

1.10 OUT OF STATE COMPANIES: Non-Illinois Bidders must contact the Illinois Secretary of State (217-782-1834) regarding a Certificate of Authority to Transact Business in Illinois (805 ILCS 5/13). Application Form BCA 13.15 may be downloaded from http://www.cyberdriveillinois.com/departments/business_services/publications_and_forms/bca.html.

1.11 ILLINOIS PROCUREMENT BULLETIN (Bulletin): We publish procurement information (including updates) in the electronic Bulletin (http://www.purchase.state.il.us). Procurement information may not be available in any other form or location. You are responsible for monitoring the Bulletin; we cannot be held responsible if you fail to receive the optional e-mail notices.

1.12 AWARD: We will post a notice to the Bulletin identifying the apparent awardees. The notice extends the Offer Firm Time until we sign a contract or determine not to sign a contract. We may accept or reject your Offer as submitted, or may require contract negotiations. If negotiations do not result in an acceptable agreement, we may reject your Offer and begin negotiations with another Bidder. Protested awards are not final and are subject to resolution of the protest.

1.13 PUBLIC RECORDS AND REQUESTS FOR CONFIDENTIAL TREATMENT: Offers become the property of the State and these and late submissions will not be returned. Your Offer will be open to the public under the Illinois Freedom of Information Act (FOIA) (5 ILCS 140) and other applicable laws and rules, unless you request in your Offer that we treat certain information as exempt. We will not honor requests to exempt entire Offers. You must show the specific grounds in FOIA or other law or rule that support exempt treatment. Regardless, we will disclose the successful Bidder's name, and the substance of the Offer. If you request exempt treatment, you must submit an additional copy of the Offer with exempt information deleted. This copy must tell the general nature of the material removed and shall retain as much of the Offer as possible. You will be responsible for any costs or damages associated with our defending your request for exempt treatment. You agree the State may copy the Offer to facilitate evaluation, or to respond to requests for public records. You warrant that such copying will not violate the rights of any third party.

1.14 RESERVATIONS: You must read and understand the solicitation and tailor your Offer and activities to ensure compliance. We reserve the right to amend the solicitation; reject any or all Offers; to award by item, group of items, or grand total; and to waive minor defects. We may request a clarification; inspect your premises; interview staff; request a presentation; or otherwise verify the contents of the Offer, including information about subcontractors and suppliers. We may request Best & Final Offers when appropriate. We will make all decisions on compliance, evaluation, terms and conditions, and shall make decisions solely in the best interests of the State. This competitive process requires that you provide additional information and otherwise cooperate with us. If you do not comply with requests for information and cooperate, we may reject your Offer. You have no right to an award by submitting an Offer, nor do you have the right to a contract based on our posting your name in a Bulletin notice. We are not responsible for and will not pay any costs associated with the preparation and submission of your Offer. If you are the awardee, you shall not

commence, and will not be paid for any billable work prior to the date all parties execute the contract, unless approved in writing in advance by the State Purchasing Officer or the Chief Procurement Officer (or the CPO's designee).

1.15 GOVERNING LAW AND FORUM: Illinois law and rule govern this solicitation and any resulting contract. You must bring any action relating to this solicitation or any resulting contract in the appropriate court in Illinois. We do not allow binding arbitration. This document contains statutory references designated with "ILCS". You may view the full text at http://www.ilga.gov/legislation/ilcs/ilcs.asp. The Illinois Procurement Code (30 ILCS 500) and the Standard Procurement Rules (44 Ill. Adm. Code 1) are applicable to this solicitation and may be viewed by users registered for the Illinois Procurement Bulletin at http://www.purchase.state.il.us.

1.16 EMPLOYMENT TAX CREDIT: Bidders who hire qualified veterans and certain ex-offenders may be eligible for tax credits. Please contact the Illinois Dept. of Revenue (312-814-3215) for information about tax credits. If you receive this tax credit you must report to the Dept. of Central Management Services the number of individuals hired for whom you received tax credits. You must submit this information by August 31 of each year covering the previous 12 months (July–June) (PA 94-1067; 30 ILCS 500/45-67 and 45-70).

1.17 DEFINITIONS. Whenever used in this RFP, Contract, or amendment, including schedules, appendices, exhibits, and attachments to this RFP or Contract, the following terms will have the meanings defined below. Any objections or questions regarding the definitions shall be raised with the Department during the RFP process.

1.17.1 820 Payment File: The HIPAA transaction that the Contractor electronically retrieves from the Department which identifies each Enrollee for whom payment was made.

1.17.2 834 Audit File: The electronic HIPAA transaction that the Contractor retrieves monthly from the Department that reflects the Enrollees for the following calendar month.

1.17.3 834 Daily File: The electronic HIPAA transaction that the Contractor retrieves from the Department each day that reflects changes in enrollment subsequent to the previous 834 Audit File.

1.17.4 837D File: The HIPAA transaction that the Contractor electronically transfers to the Department which identifies HealthCare Claims for dental claims/ and or encounters.

1.17.5 837I File: The HIPAA transaction that the Contractor electronically transfers to the Department which identifies HealthCare Claims for institutional claims/ and or encounters.

1.17.6 837P File: The HIPAA transaction that the Contractor electronically transfers to the Department which identifies HealthCare Claims for professional claims/and or encounters.

1.17.7 Abuse: (i) A manner of operation that results in excessive or unreasonable costs to the Federal or State health care programs; (ii) the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish (42 CFR Section 488.301).

1.17.8 Action: (i) The denial or limitation of authorization of a requested service; (ii) the reduction, suspension, or termination of a previously authorized service; (iii) the denial of payment for a service; (iv) the failure to provide services in a timely manner; (v) the failure to respond to an Appeal in a timely manner, or (vi) solely with respect to an HMO that is the only Contractor serving a rural area, the denial of an Enrollee's request to obtain services outside of the Contracting Area.

1.17.9 Administrative Expenses: The operating costs that are not allocated to payments for Covered Services.

1.17.10 Administrative Rules: The sections of the Illinois Administrative Code that govern the Medicaid Program.

1.17.11 Adults with Disabilities: An individual who is 19 years of age or older, who meets the definition of blind or disabled under Section 1614(a) of the Social security Act (42 U.S.C.1382), and who is eligible for Medicaid.

1.17.12 Advance Directive: An individual's written directive or instruction, such as a power of attorney for health care or a living will, for the provision of that individual's healthcare if the individual is unable to make his or her healthcare wishes known.

1.17.13 Advanced Practice Nurse (APN): A Provider of medical and preventive services, including Certified Nurse Midwives, Certified Family Nurse Practitioners and Certified Pediatric Nurse Practitioners, who is licensed as an APN, holds a valid license in Illinois, is legally authorized under statute or rule to provide services, and is enrolled with the Department and contracted with the HMO.

1.17.14 Affiliate: Any person, firm, corporation (including, without limitation, service corporation and professional corporation), partnership (including, without limitation, general partnership, limited partnership and limited liability partnership), limited liability company, joint venture, business trust, association or other vendor that now or in the future directly or indirectly controls, is controlled by, or is under common control with Bidder or Contractor.

1.17.15 Affiliated means associated with another party for the purpose of providing health care services under a Contractor's Plan pursuant to a written contract.

1.17.16 Anniversary Date: the annual anniversary date of an Enrollee's initial enrollment in the HMO. For example, if an Enrollee became effective in an HMO on October 1, 2010, their Anniversary Date with that HMO would be each October 1 thereafter.

1.17.17 Appeal: A request for review of a decision made by the Contractor with respect to an Action.

1.17.18 Authorized Person(s): The Illinois Department of Healthcare and Family Services Office of Inspector General, the Medicaid Fraud Control Unit of the Illinois State Police, the United States Department of Health and Human Services, the Illinois Auditor General and other State and federal agencies with monitoring authority related to Medicaid.

1.17.19 Bidder: The entity submitting a Proposal under this RFP.

1.17.20 Business Continuity: Contractor's uninterrupted operation of its telecommunication, data, and information systems.

1.17.21 Business Day: Monday through Friday, 8:00 a.m. to 5:00 p.m. Central Time and including State holidays except for New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day and Christmas Day.

1.17.22 CAHPS: Consumer Assessment of Health Plans Survey is a public-private initiative to develop standardized surveys of patient's experience with ambulatory and facility level care.

1.17.23 Capitation: The reimbursement arrangement in which a fixed rate of payment per Enrollee per month is made to the Contractor for the performance of all of the Contractor's duties and responsibilities pursuant to the Contract.

1.17.24 Care Coordinator: An employee of the Contractor, together with an Enrollee and Providers, establishes an Enrollee Care Plan for the Enrollee and, through interaction with network Providers, ensures the Enrollee receives necessary services.

1.17.25 CART (Computer Aided Real-time Translation): The instant translation of spoken work into text performed by a CART reporter using a stenotype machine, notebook computer and real-time software.

1.17.26 Case Management: Services that assist Enrollees in gaining access to needed services, including medical, social, educational and other services, regardless of the funding source for the services.

1.17.27 Centers for Medicare & Medicaid Services (Federal CMS): The agency within DHHS that is responsible for the administration of the Medicare program and, in partnership with the states, administers Medicaid, the State Children's Health Insurance Program (CHIP), and the Health Insurance Portability and Accountability Act (HIPAA).

1.17.28 Certified Local Health Department: An agency of local government authorized under 77 Ill.Adm. Code Part 600 to develop and administer programs and services that are aimed at maintaining a healthy community.

1.17.29 Change of Control: Any transaction or combination of transactions resulting in: (i) the change in ownership of a vendor; (ii) the sale or transfer of fifty percent (50%) or more of the beneficial ownership of a vendor; or (iii) the divestiture, in whole or in part, of the business unit or division of a party that is obligated to provide the products and services.

1.17.30 Chronic Health Condition: A health condition with an anticipated duration of at least 12 months.

1.17.31 Code: The Illinois Procurement Code, 30 ILCS 500/1-5 et seq. Unofficial versions of the Code and Standard Procurement Rules (44 Ill. Adm. Code 1), which are applicable to this procurement, may be viewed at http://www.purchase.state.il.us/.

1.17.32 Complaint: A phone call, letter or personal contact from a Participant, Enrollee, family member, Enrollee representative or any other interested person expressing a concern related to the health, safety or well-being of an Enrollee.

1.17.33 Confidential Information: Any material, data, or information disclosed by either Party to the other that, pursuant to agreement of the Parties or the State's grant of a proper request for confidentiality, is not generally known by or disclosed to the public or to Third Parties including, without limitation: (a) all materials, know-how, processes, trade secrets, manuals, confidential reports, services rendered by State, financial, technical and operational information, and other matters relating to the operation of a Party's business; (b) all information and materials relating to Third Party vendors of the State that have provided any part of the State's information or communications infrastructure to the State; (c) software; and (d) any other information that the Parties agree should be kept confidential. See also Section 1.13 of this RFP, "Public Records and Requests for Confidential Treatment."

1.17.34 Contract: The Contract entered into between the Department and the awardee to provide the services requested by this RFP.

1.17.35 Contracting Area: The area from which the Integrated Care Program will be operational, consisting of the following counties in Illinois: Lake, Kane, DuPage, Will, Kankakee and Cook County excluding areas whose zip code begins with 606.

1.17.36 Contractor: An HMO selected to provide Covered Services under the Integrated Care Program.

1.17.37 Covered Services: Those State Plan benefits and services described in Section 2.1.10 of the Model Contract herein.

1.17.38 DHS-DASA: The Division of Alcohol and Substance Abuse within DHS that operates treatment services for alcoholism & addiction through an extensive treatment provider network throughout the State of Illinois. http://www.dhs.state.il.us/page.aspx?item=29725

1.17.39 DCFS: The Illinois Department of Children and Family Services or any successor agency. http://www.state.il.us/dcfs/index.shtml.

1.17.40 DCMS: The Illinois Department of Central Management Services and any successor agency.

1.17.41 Determination of Need (DON): The tool used by the Department or the Department's authorized representative to determine eligibility (level of care) for nursing facility and home and community-based services (HCBS) waivers for persons with disabilities, HIV/AIDS, brain injury, supportive living and the elderly. This assessment includes scoring for a mini-mental state examination (MMSE), functional impairment and unmet need for care in 15 areas including activities of daily living (ADL) such as eating, bathing, grooming, dressing, transferring and continence; and instrumental activities of daily living (IADL) including managing money, meal preparation, telephoning, laundry, housework, being outside the home, routine health, special health and being alone. The final score is calculated by adding the results of the MMSE, the level of impairment and the unmet need for care scores. In order to be eligible for nursing facility or waiver services, an individual must receive at least 15 points on functional impairment section and a minimum total score of 29 points.

1.17.42 Developmental Disability(ies) (DD): A disability that is attributable to a diagnosis of mental retardation or related condition such as cerebral palsy or epilepsy, that manifests before the age of 22 and is likely to continue indefinitely, results in impairment of general intellectual functioning or adaptive behavior, and results in substantial functional limitations in three or more areas of major life activities, such as self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living.

1.17.43 DHS: The Illinois Department of Human Services, and any successor agency.

1.17.44 DHHS: The United States Department of Health and Human Services.

1.17.45 DHS-DDD: The Division of Developmental Disabilities within DHS that operates programs for persons with developmental disabilities.

1.17.46 DHS-DMH: The Division of Mental Health within DHS that is the state mental health authority.

1.17.47 DHS-DRS: The Division of Rehabilitation Services, and any successor agency, within DHS that operates the home services programs for persons with physical disabilities, brain injury and HIV/AIDS.

1.17.48 DHS-OIG: The Department of Human Service Office of Inspector General is the entity responsible to investigate allegations of Abuse and Neglect of people who receive mental health or developmental disability services in Illinois and to seek ways to prevent it. Annual reporting is conducted in response to the Department of Human Services Act (20 ILCS 1305/1-17) and the Adults with Disabilities Domestic Abuse Intervention Act (20 ILCS 2435). http://www.dhs.state.il.us/page.aspx?item=29972

1.17.49 Disaster: An outage or failure of the Department's or Contractor's data, electrical, telephone, technical support, or back-up system, whether such outage or failure is caused by an act of nature, equipment malfunction, human error, or other source.

1.17.50 Disease Management Program (DM): A program that employs a set of interventions designed to improve the health of individuals, especially those with chronic diseases. Disease Management Program services include: i) a population identification process; ii) use and promotion of evidence-based guidelines; iii) use of collaborative practice models to include Physician and support service Providers; iv) Enrollee self-management education (includes primary prevention, behavioral modification, and compliance surveillance); v) case management; vi) process and outcome measurement, evaluation and management; and vii) routine reporting/feedback loop (includes communication with the Enrollee, Physician, ancillary Providers and practice profiling).

1.17.51 Disenrollment: Removal of an Enrollee from the HMO.

1.17.52 DoA: The Illinois Department on Aging, and any successor agency.

1.17.53 DPH: The Illinois Department of Public Health, and any successor agency, the State Survey Agency responsible for promoting the health of the people of Illinois through the prevention and control of disease, injury, licensure, and certification of NF's and ICF/DD facilities.

1.17.54 DRG: Diagnostic Related Grouping. The methodology by which the Department reimburses a hospital based on the diagnoses and procedures performed during the hospital stay. The diagnoses associated with the hospital stay are placed into groups requiring a similar intensity of services. The DRG reimbursement, similar to the system used by the federal Medicare program, is based on the average cost of providing services for the specific diagnosis group, regardless of how long a specific client may have actually been in the hospital.

1.17.55 Dual Eligible: A Participant who is eligible to receive services through both the Medicare and the Medicaid Program.

1.17.56 Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to, severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

1.17.57 Emergency Services: Those inpatient and outpatient health care services that are Covered Services, including transportation, needed to evaluate or Stabilize an Emergency Medical Condition, which are furnished by a Provider qualified to furnish Emergency Services.

1.17.58 Encounter: An individual service or procedure provided to an Enrollee that would result in a claim if the service or procedure were to be reimbursed Fee-For-Service under the Medicaid Program.

1.17.59 Encounter Data: The compilation of data elements, as specified by the Department in written notice to the Contractor, identifying an Encounter that includes information similar to that required in a claim for Fee-For-Service payment under the Department's Medical Program.

1.17.60 Enrollee: A Participant who is enrolled in an HMO. "Enrollee" shall include the caretaker relative or guardian where the Enrollee is an adult for whom a guardian has been named; provided, however, that the Contractor is not obligated to cover services for any individual who is not enrolled as an Enrollee with the Contractor.

1.17.61 Enrollee Care Plan: An Enrollee-centered, goal-oriented, culturally relevant, and logical, written plan of care that assures that the Enrollee receives medical and medically-related necessary services in a supportive, effective, efficient, timely and cost-effective manner that emphasizes prevention and continuity of care.

1.17.62 Enrollment Period: The twelve (12) month period beginning the effective date of enrollment.

1.17.63 Execution: The point at which all the parties have signed the Contract between the Contractor and the State.

1.17.64 External Quality Review Organization (EQRO): An organization contracted with the Department that meets the competence and independence requirements set forth in 42 CFR Section 438.354, and performs external quality review (EQR) and EQR-related activities as set forth in 42 CFR Section 438.358.

1.17.65 Family Training: Training for unpaid family members, including instruction about treatment regimens, Cardiopulmonary Resuscitation (CPR), use of equipment or other services identified in the Enrollee Care Plan.

1.17.66 Federally Qualified HMO: A managed care plan that Federal CMS has determined to be a qualified HMO under Section 1310(d) of the Public Health Service Act.

1.17.67 Federally Qualified Health Center (FQHC): A health center that meets the requirements of 89 IL Admin Code 140.461(d).

1.17.68 Fee-For-Service: The method of charging which bills for each Encounter or service rendered.

1.17.69 Fraud: Knowing and willful deception, or a reckless disregard of the facts, with the intent to receive an unauthorized benefit.

1.17.70 Grievance: An expression of dissatisfaction by an Enrollee, including Complaints, about any matter other than a matter that is properly the subject of an Appeal.

1.17.71 Group Practice: A group of Primary Care Providers who share a practice or are affiliated and provide direct medical or other services to Enrollees of any Primary Care Provider within that practice.

1.17.72 Habilitation: An effort directed toward the alleviation of a disability or toward increasing a person's level of physical, mental, social or economic functioning. Habilitation may include, but is not limited to, diagnosis, evaluation, medical services, residential care, day care, special living arrangements, training, education, sheltered employment, protective services, counseling and other services.

1.17.73 Health Insurance Portability and Accountability Act (HIPAA): Also known as the Kennedy-Kassebaum Bill, the Kassebaum-Kennedy Bill, K2, or Public Law 104-191, the federal law that makes a number of changes that have the goal of allowing persons to qualify immediately for comparable health insurance coverage when they change their employment relationships. Title II, Subtitle F, of HIPAA provides DHHS with the authority to mandate the use of standards for electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, Providers, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information.

1.17.74 Health Maintenance Organization (HMO): A health maintenance organization as defined in the Health Maintenance Organization Act (215 ILCS 125/1-1 et seq.).

1.17.75 Health Plan Employer Data and Information Set (HEDIS®): The Healthcare Effectiveness Data and Information Set established by the National Committee for Quality Assurance (NCQA).

1.17.76 HFS: The Illinois Department of Healthcare and Family Services and any successor agency. In this RFP, HFS is also referred to as "Agency" or "Department".

1.17.77 Home and Community-Based Services (HCBS) Waivers: Waivers under Section 1915(c) of the Social Security Act that allow Illinois to cover home and community services and provide programs that are designed to meet the unique needs of individuals with disabilities who qualify for the level of care provided in an institution but who, with special services, may remain in their homes and communities.

1.17.78 Homemaker Service: General non-medical support by supervised and trained homemakers. Homemakers are trained to assist Participants with their activities of daily living, including personal care, as well as other tasks such as laundry, shopping, and cleaning.

1.17.79 Hospitalist: A physician, who is part of an organized system of care, meaning a coordinated group working together, whose entire professional focus is the general medical care of hospitalized Enrollees in an acute care facility and whose activities include Enrollee care, communication with families, significant others, PCPs, and leadership related to hospital medicine.

1.17.80 IBNP (Incurred But Not Paid): The claims that have been incurred but have not been paid.

1.17.81 ILCS: Illinois Compiled Statutes. An unofficial version of the ILCS can be viewed at http://www.ilga.gov/legislation/ilcs/ilcs.asp.

1.17.82 Illinois Client Enrollment Broker (ICEB): The entity contracted by the Department to conduct enrollment activities for Potential Enrollees, including providing impartial education on health care delivery choices, providing enrollment materials, assisting with the selection of an HMO and PCP, and processing requests to change HMOs.

1.17.83 Implementation Period: The four month time period beginning on the date of award.

1.17.84 Ineligible Person: A Person that: i) under either Section 1128 or Section 1128A of the Social Security Act, is or has been terminated, barred, suspended or otherwise excluded from participation in, or as the result of a settlement agreement has voluntarily withdrawn from participating in, any program under federal law including any program under Titles XVIII, XIX, XX or XXI of the Social Security Act; and ii) has not been reinstated in the Medicaid Program or federal health care programs after a period of exclusion, suspension, debarment, or ineligibility; or iii) has been convicted of a criminal offense related to the provision of health care items or services in the last ten (10) years.

1.17.85 Institutionalized: Residency in a nursing facility, ICF/DD or state operated facility, but not including admission in an acute care or rehabilitation hospital setting.

1.17.86 Integrated Care Program: The program under which the Department will contract with HMOs to provide the full spectrum of Medicaid Covered Services through an integrated care delivery system to Older Adults and Adults with Disabilities who are eligible for Medicaid but are not eligible for Medicare.

1.17.87 Intermediate Care Facility (ICF): A facility for residents who have long-term illnesses or disabilities who may have reached a relatively stable plateau, which provides basic nursing care and other restorative services under periodic medical direction, including services that may require skill in administration.

1.17.88 Intermediate Care Facility for the Developmentally Disabled (ICF/DD): A facility for residents who have physical, intellectual, social and emotional needs, that provides services primarily for ambulatory adults with developmental disabilities and addresses itself to the needs of persons with mental disabilities or those with related conditions. Also known as Intermediate Care Facility for the Mentally Retarded (ICF/MR).

1.17.89 Long-Term Care (LTC) Facility or Nursing Facility (NF): A facility that provides skilled nursing or intermediate long-term care services, whether public or private and whether organized for profit or not-for-profit, that is subject to licensure by the Illinois Department of Public Health under the Nursing Home Care Act, including a county nursing home directed and maintained under Section 5-1005 of the Counties Code; and a part of a hospital in which skilled or intermediate long-term care services within the meaning of Title XVIII or XIX of the Social Security Act are provided.

1.17.90 Mandated Reporting: Immediate reporting required from a Mandated Reporter of suspected maltreatment when they have reasonable cause to believe that an individual known to them in their professional or official capacity may be Abused or Neglected. RFP Attachment A outlines the Abuse, Neglect and exploitation reporting requirements for Illinois citizens.

1.17.91 Marketing: Any written or oral communication from a healthcare delivery system or its representative that can reasonably be interpreted as intended to influence a Participant to enroll, not enroll, or to disenroll from a health care delivery system.

1.17.92 Marketing Materials: Materials produced in any medium, by or on behalf of the Contractor that can reasonably be interpreted as intended to market to Potential Enrollees. Marketing Materials includes written materials and oral presentations.

1.17.93 Marketing Misconduct: Any activity by an employee of the Contractor that is in violation of any provisions related to Marketing.

1.17.94 Marketing Misrepresentation: A statement or act an employee or representative of the Contractor knows to be false or misleading or believes to be untrue and inaccurate, and that is made with the intent to deceive or be unfair to a Potential Enrollee, Prospective Enrollee, or Enrollee.

1.17.95 Medicaid Program: The program under Title XIX of the Social Security Act that provides medical benefits to groups of low-income people.

1.17.96 Medicaid Management Information Systems (MMIS): A computerized system used for the collecting, processing, analyzing and reporting of information needed to support the Medicaid Program.

1.17.97 Medically Necessary: A service, supply or medicine that is appropriate and meets the standards of good medical practice in the medical community, as determined by the Provider in accordance with the Contractor's guidelines, policies or procedures, for the diagnosis or treatment of a covered illness or injury, for the prevention of future disease, to assist in the Enrollee's ability to attain, maintain, or regain functional capacity, or to achieve age-appropriate growth.

1.17.98 Mental Illness (MI): A diagnosis of schizophrenia, delusional disorder, schizoaffective disorder, psychotic disorders not otherwise specified bipolar disorder, or recurrent major depression resulting in substantial functional limitations.

1.17.99 Minimum Data Set (MDS): A federally mandated standardized resident assessment, care planning, and quality monitoring system that drives care delivery and Medicare payments in nursing homes and home health.

1.17.100 National Provider Identification Number (NPI): The national standard identifier for healthcare providers for use in the healthcare industry.

1.17.101 National Committee for Quality Assurance (NCQA): A private 501(c) (3) not for profit organization dedicated to improving health care quality and has a process for providing accreditation, certification and recognition, e.g., health plan accreditation.

1.17.102 National Council for Prescription Drugs Program 1.1 (NCPDP1.1): The HIPAA transaction that the Contractor transfers to the Department which identifies health care claims for pharmacy services.

1.17.103 Neglect: A failure to notify the appropriate health care professional, to provide or arrange necessary services to avoid physical or psychological harm to a resident or to terminate the residency of a Participant whose needs can no longer by met, causing an avoidable decline in function. Neglect may be either passive (non-malicious) or willful.

1.17.104 Negotiated Risk: The process by which a Participant, or his or her representative, may formally negotiate with Providers what risks each are willing to assume in service provision and the resident's living environment, and by which the resident is informed of the risks of these decisions and of the potential consequences of assuming these risks.

1.17.105 Nurse Training: Training that provides Participant specific training for nurses in the use of new or unique prescribed equipment, or special care needs of the Participant.

1.17.106 Nursing Facility (NF): See Long-Term Care Facility.

1.17.107 Occupational Therapy: A medically prescribed service identified in the Enrollee Care Plan that is designed to increase independent functioning through adaptation of the tasks and environment. The service is provided by a licensed occupational therapist that meets Illinois licensure standards. http://www.idfpr.com/dpr/WHO/ot.asp.

1.17.108 Office of Inspector General (OIG): The Office of Inspector General for the Illinois Department of Healthcare and Family Services as set forth in 305 ILCS 5/12-13.1.

1.17.109 Offer Firm Time: The six-month period following the opening of Proposals during which the Proposal shall remain firm and unaltered. A Proposal may be accepted, subject to successful contract negotiations, at any time during the Offer Firm Time. See RFP Section 1.4.

1.17.110 Older Adult: An individual who is 65 years of age or older and who is eligible for Medicaid.

1.17.111 Open Enrollment: The specific period of time each year in which Enrollees shall have the opportunity to change from one HMO to another HMO.

1.17.112 Order: Any written request from DCMS or an Agency/Buyer for services, products, and equipment pursuant to the Contract.

1.17.113 Participant: Any individual determined to be eligible for the Medicaid Program.

1.17.114 Party/Parties: The State of Illinois and the HMOs awarded a Contract pursuant to the procurement process.

1.17.115 Person: Any individual, corporation, proprietorship, firm, partnership, trust, association, governmental authority, vendor, or other legal entity whatsoever, whether acting in an individual, fiduciary, or other capacity.

1.17.116 Performance Measure: A quantifiable measure to assess how well an organization carries out a specific function or process.

1.17.117 Person With an Ownership or Controlling Interest: A Person that: has a direct or indirect, singly or in combination, ownership interest equal to five percent (5%) or more in the Contractor; owns an interest of five percent (5%{) or more in any mortgage, deed of trust, note or other obligations secured by the Contractor if that interest equals at least five percent (5%) of the value of the property or assets of the Contractor; is an officer or director of a Contractor that is organized as a corporation, is a member of the Contractor that is organized as a limited liability company or is a partner in the Contractor that is organized as a partnership.

1.17.118 Personal Assistant: Individuals who provide Personal Care to a Participant when it has been determined by the case manager that the Participant has the ability to supervise the Personal Care Provider.

1.17.119 Personal Care: Assistance with meals, dressing, movement, bathing or other personal needs or maintenance, or general supervision and oversight of the physical and mental well‐being of a Participant.

1.17.120 Personal Emergency Response System (PERS): An electronic device that enables a Participant at high risk of institutionalization to secure help in an emergency.

1.17.121 Physical Therapy: A medically-prescribed service that is provided by a licensed physical therapist and identified in the Enrollee Care Plan that utilizes a variety of methods to enhance an Enrollee's physical strength, agility and physical capacity for activities of daily living.

1.17.122 Physician: A person licensed to practice medicine in all its branches under the Medical Practice Act of 1987.

1.17.123 Placement Maintenance Counseling: Short-term, issue-specific family or individual counseling for the purpose of maintaining the Participant in the home placement. This service is prescribed by a Physician based upon his or her judgment that it is necessary to maintain the child in the home placement.

1.17.124 Post-Stabilization Services: Medically Necessary Non-Emergency Services furnished to an Enrollee after the Enrollee is Stabilized following an Emergency Medical Condition, in order to maintain such Stabilization.

1.17.125 Potential Enrollee: A Participant who is subject to mandatory enrollment in the Integrated Care Program, but is not yet an Enrollee of an HMO.

1.17.126 Pre-Admission Screening (PAS): Universal preadmission screening of all individuals, regardless of payment source, who enter a nursing facility (Nursing Home Care Act 210 ILCS 45/2-201.5 and 89 Ill. Adm. Code 140.642) to determine if they meet a nursing facility level of care as defined by state assessment tools. Although the screening rule covers only nursing facility placements, preadmission screenings are also completed on individuals who wish to participate in the home and community-based waiver programs compared to nursing facilities as defined in the waivers.

1.17.127 Primary Care Provider (PCP): A Provider, including a WHCP, who within the Provider's scope of practice and in accordance with State certification requirements or State licensure requirements, is responsible for providing all preventive and primary care services to his or her assigned Enrollees in the HMO.

1.17.128 Prior Approval: Review and written approval by the Department of any Contractor materials or actions, as set forth in the Contract, including but not limited to, subcontracts, intended courses of conduct, or procedures or protocols, that Contractor must obtain before such materials are used, executed, implemented or followed.

1.17.129 Private Duty Nursing: A service provided by an individual that meets Illinois licensure standards for nursing services and provides shift-nursing services.

1.17.130 Proposal: A Bidder's response to the RFP, consisting of the technical Proposal and all required forms and certifications. All required forms and certifications must be completed, signed, and returned by the Bidder. The Proposal may also be referred to as the Offer.

1.17.131 Prospective Enrollee: A Potential Enrollee who has begun the process of enrollment with the Contractor but whose coverage under the Contractor has not yet begun.

1.17.132 Protected Health Information (PHI): Information created or received from or on behalf of a Covered Vendor as defined in 45 CFR Section 160.103, that relates to the provision of health care to an individual; the past, present or future physical or mental health or condition of an individual; or past, present or future payment for the provision of health care to an individual. PHI includes demographic information that identifies the individual or about which there is a reasonable basis to believe, can be used to identify the individual. PHI is the information transmitted or held in any form or medium.

1.17.133 Provider: A Person enrolled with the Department to provide Covered Services to a Participant. Contractor is not a Provider.

1.17.134 Quality Assurance (QA): A formal set of activities to review, monitor and improve the quality of services by a Provider or HMO, including quality assessment, ongoing quality improvement and corrective actions to remedy any deficiencies identified in the quality of direct Enrollee, administrative and support services.

1.17.135 Quality Assurance Plan (QAP): A written document developed by the HMO in consultation with its QAP committee and Medical Director that details the annual program goals and measurable objectives, utilization review activities, access and other performance measures that are to be monitored with ongoing Physician profiling and focus on quality improvement.

1.17.136 Quality Assurance Plan (QAP) Committee: A committee established by the HMO with the approval of the Department, that consists of a cross representation of all types of Providers, including PCPs, specialists, dentists and long term care representatives from the HMO's network and of the entire Contracting Area and that, at the request of the Department, shall include the Department staff in an advisory capacity.

1.17.137 Quality Assessment and Performance Improvement (QAPI): The program required by 42 CFR Section 438.240, in which HMOs are required to have an ongoing quality assessment and performance improvement program for the services furnished to Enrollees, that: 1) assess the quality of care and identify potential areas for improvement, ideally based on solid data and focused on high volume/high risk procedures or other services that promise to substantially improve quality of care, using current practice guidelines and professional practice standards when comparing to the care provided; and 2) correct or improve processes of care and clinic operations in a way that is expected to improve overall quality.

1.17.138 Quality Improvement Organization (QIO): An organization designated by Federal CMS as set forth in Section 1152 of the Social Security Act and 42 CFR Section 476, that provides for the Department, quality assurance, quality studies and inpatient utilization review in the Fee-For-Service program and quality assurance and quality studies in the HCBS setting.

1.17.139 Quality Improvement System for Managed Care (QISMC): A quality assessment and improvement strategy to strengthen an HMOs' efforts to protect and improve the health and satisfaction of Enrollees.

1.17.140 Quality Management Plan (QMP): The overarching quality assurance and improvement plan framework intended to improve the quality of services and supports provided through Medicaid Home and Community-Based Services (HCBS) waiver programs to older persons and person with disabilities.

1.17.141 Quality Program: The HMO's overarching mission, vision and values, which through its goals, objectives and processes committed in writing in the QAP, are demonstrated through continuous improvement and monitoring of medical care, Enrollee safety, behavioral health services, and the delivery of services to Enrollees, including ongoing assessment of program standards to determine the quality and appropriateness of care, case management and coordination. It is system-wide and implemented through the integration, coordination of services, and resource allocation throughout the organization, its partners, providers, other entities delegated to provide services to Enrollees, and extended community involved with Enrollees.

1.17.142 Referral: An authorization provided by a PCP to enable an Enrollee to seek medical care from another Provider.

1.17.143 Rehabilitation: The process of restoration of skills to a person who has had an illness or injury so as to regain maximum self-sufficiency and function in a normal or as near normal manner as possible in therapeutic, social, physical, behavioral and vocational areas.

1.17.144 Resident: An Enrollee living in a facility who is eligible for Medicaid payment for facility services.

1.17.145 Resident Review: a clinical reassessment of the resident's functional capabilities to determine if the existing level of skilled nursing care is the most appropriate to meet his/her needs or if the individual could maximize personal recovery in the least restrictive, community-based integrated living environment such as permanent supportive housing models with a full array of wrap around support services, such as assertive community treatment, crisis services, case management, psycho-social Rehabilitation, supportive employment or in therapeutic transitional supervised/supported residential settings with support services and skills development as an interim step toward permanent supportive housing.

1.17.146 Respite: Services that provide the needed level of care and supportive services to enable the Enrollee to remain in the community, or home-like environment, while periodically relieving the non-paid family member or other caretaker of care-giving responsibilities.

1.17.147 Risk Mitigation: Based on an assessment or inventory of risks in the areas of Caregiver (vulnerability of participant or vulnerability due to caregiver); Environment (safety and accessibility); Behavioral (danger to self, others or illegal behavior); Medical Complications (medication and treatment, activities of daily living, specific conditions); and Compliance, a care plan is developed including strategies to prevent or ameliorate the addressed risks. The plan is closely monitored to determine changes in approaches.

1.17.148 Rural Health Clinic (RHC): A Provider that has been designated by the Public Health Service, the U.S. Department of Health and Human Services, or the Governor of the State of Illinois, and approved by the Public Health Service, in accordance with the Rural Health Clinics Act (see Public Law 95-210) as a RHC.

1.17.149 Security: The Bidder may be required to provide security (e.g., bond, cashier's check, money order or irrevocable letter of credit) with the Proposal and performance security within ten (10) days after acceptance of the Proposal unless a different time is specified herein. Security shall be in the form of a bond unless otherwise agreed. In the event a bond is used, a surety licensed to do business in Illinois must issue the bond on a form acceptable to the Department. The security shall be forfeited if the selected Bidder withdraws its Proposal before the expiration of the Offer Firm Time or after the Department issues a Notice of Intent to Award, does not honor the terms in its Proposal, or does not negotiate contract terms in good faith. Security submitted by Bidders will be returned when the Proposals expire or are rejected, or when the Department enters into a contract with the successful Bidder, whichever is earliest.

1.17.150 Serious Mental Illness (SMI): Refers to "emotional or behavioral functioning" so impaired in adults ages 18 and older as to interfere with their capacity to remain in the community without supportive treatment. The mental impairment is severe and persistent and may result in a limitation of their capacities for primary activities of daily living, interpersonal relationships, homemaking, self-care, employment or recreation. The mental impairment may limit their ability to seek or receive local, state or federal assistance such as housing, medical and dental care, rehabilitation services, income assistance and food stamps, or protective services. The DMH provider manual can be viewed at: http://www.illinoismentalhealthcollaborative.com/provider/prv_manual.htm

1.17.151 Service Authorization Request: A request by an Enrollee or by a Provider on behalf of an Enrollee for the provision of a Covered Service.

1.17.152 Significant Change: A decline or improvement in a Participant's status that will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, where the decline or improvement impacts more than one area of the Participant's health status and requires revision of the Enrollee Care Plan.

1.17.153 Site: Any contracted Provider through which the HMO arranges the provision of primary care to Enrollees.

1.17.154 Skilled Nursing: Nursing services provided within the scope of the State's Nurse Practice Act by registered nurses, licensed practical nurses, or vocational nurses licensed to practice in the State.

1.17.155 Skilled Nursing Facility (SNF): A group care facility that provides skilled nursing care, continuous skilled nursing observations, restorative nursing and other services under professional direction with frequent medical supervision, during the post acute phase of illness or during reoccurrences of symptoms in long-term illness.

1.17.156 SNFist: A Physician or Advanced Practice Nurse licensed under the State's Nurse Practice Act who is part of an organized system of care, meaning a coordinated group working together, whose entire professional focus is the general medical care of nursing facility residents and whose activities include Enrollee care oversight, communication with families, significant others, PCPs, and nursing facility administration.

1.17.157 Speech Therapy: A medically prescribed speech or language based service that is provided by a licensed speech therapist and identified in the Enrollee Care Plan that is used to evaluate or improve an Enrollee's ability to communicate.

1.17.158 Spend-down: The policy that allows an individual to qualify for Medicaid by incurring medical expenses at least equal to the amount by which his or her income or assets exceed eligibility limits. It operates similarly to deductibles in private insurance as the spend-down amount represents medical expenses the individual is responsible to pay.

1.17.159 Stabilization or Stabilized: A determination with respect to an Emergency Medical Condition made by an attending emergency room Physician or other treating Provider that, within reasonable medical probability, no material deterioration of the condition is likely to result upon discharge or transfer to another facility.

1.17.160 State: The State of Illinois, as represented through any agency, department, board, or commission.

1.17.161 State Facility: Any facility, site or location owned, managed, controlled or operated by the State.

1.17.162 State Fiscal Year (SFY): The State of Illinois' fiscal year begins on the first day of July of each calendar year and ends on the last day of June of the following calendar year. For example, FY 2012 begins July 1, 2011 and ends June 30, 2012.

1.17.163 State Plan: The Illinois State Plan filed with the Centers for Medicare & Medicaid Services, in compliance with Title XIX of the Social Security Act.

1.17.164 Supportive Living Facility (SLF): A residential apartment-style (assisted living) setting in Illinois that is certified by the Department that provides or coordinates flexible Personal Care services, twenty-four (24) hour supervision and assistance (scheduled and unscheduled), activities, and health related services with a service program and physical environment designed to minimize the need for residents to move within or from the setting to accommodate changing needs and references; has an organizational mission, service programs and physical environment designed to maximize residents' dignity, autonomy, privacy and independence; and encourages family and community involvement.

1.17.165 Tertiary Care: Medical care requiring a setting outside of the routine, community standard, which care shall be provided within a regional medical center by highly specialized Providers (specialists and subspecialists) who require complex technological, diagnostic, treatment and support facilities to provide such care.

1.17.166 Third Party: Any Person other than the Department, Contractor, or any of Contractor's Affiliates.

1.17.167 Utilization Management (UM) Program: A comprehensive approach and planned activities for evaluating the appropriateness, need and efficiency of services, procedures and facilities according to established criteria or guidelines under the provisions of integrated care. Typically UM includes new activities or decisions based upon the analysis of a care, and describes proactive procedures, including discharge planning, concurrent planning, pre-certification and clinical case appeals. It also covers proactive processes, such as concurrent clinical reviews and peer reviews, as well as appeals introduced by the Provider, payer or Enrollee.

1.17.168 Voluntary Managed Care (VMC): The State's risk-based managed care program in which eligible Participants can voluntarily enroll.

1.17.169 Wellness Programs: Comprehensive services designed to promote and maintain the good health of an Enrollee.

1.17.170 Women's Health Care Provider (WHCP): A Physician specializing by certification or training in obstetrics, gynecology or family practice.

1.18 ACRONYMS. Whenever used in this RFP, Contract, or amendment, including schedules, appendices, exhibits, and attachments to this RFP or Contract, the following acronyms will have the meanings identified below.

1.18.1 AABD: Aid to the Aged, Blind and Disabled

1.18.2 AES: Advanced Encryption Standard

1.18.3 APN: Advanced Practice Nurse

1.18.4 ASAM: American Society of Addiction Medicine

1.18.5 BEP: Business Enterprise Program Act for Minorities, Females and Persons with Disabilities

1.18.6 BI: Brain Injury

1.18.7 CAHPS: Consumer Assessment of Health Plans Survey

1.18.8 CART: Computer Aided Real-time Translation

1.18.9 CCP: Community Care Program

1.18.10 CMU: Case Management Units

1.18.11 CCU: Case Coordination Units

1.18.12 CFR: Code of Federal Regulation

1.18.13 DCMS: The Illinois Department of Central Management Services

1.18.14 CSHCN: Children with Special Health Care Need

1.18.15 DD: Developmental disability

1.18.16 DCFS: The Illinois Department of Children and Family Services

1.18.17 DHHS: The United States Department of Health and Human Services

1.18.18 DHR: The Illinois Department of Human Rights

1.18.19 DHS: The Illinois Department of Human Services

1.18.20 DHS-DASA: The Division of Alcohol and Substance Abuse within DHS

1.18.21 DHS-DDD: The Division of Developmental Disabilities within DHS

1.18.22 DHS-DMH: The Division of Mental Health within DHS

1.18.23 DHS-DRS: The Division of Rehabilitation Services, and any successor agency, within DHS

1.18.24 DHS-OIG: The Department of Human Service Office of Inspector General

1.18.25 DM: Disease Management Program

1.18.26 DoA: The Illinois Department on Aging

1.18.27 DOC: The Illinois Department of Corrections

1.18.28 DON: Determination of Need

1.18.29 DPH: The Illinois Department of Public Health

1.18.30 DRG: Diagnostic Related Grouping

1.18.31 DSCC: Division of Specialized Care for Children

1.18.32 DSM-IV: Diagnostic and Statistical Manual of Mental Disorders, 4th Edition

1.18.33 EMR: Electronic Medical Record

1.18.34 EQRO: External Quality Review Organization

1.18.35 EPSDT: Early, Periodic Screening, Diagnosis, and Treatment

1.18.36 Federal CMS: Centers for Medicare & Medicaid Services

1.18.37 FOIA: Freedom of Information Act

1.18.38 FQHC: Federally Qualified Health Center

1.18.39 HCBS Waivers: Homes and Community-Based Services Waivers

1.18.40 HCP: Home Care Program

1.18.41 HCPCS: Healthcare Common Procedure Coding System

1.18.42 HEDIS: Health Plan Employer Data and Information Set

1.18.43 HFS: The Illinois Department of Healthcare and Family Services

1.18.44 HIPAA: Health Insurance Portability and Accountability Act

1.18.45 HIT: Health Information Technology

1.18.46 HMO: Health Maintenance Organization

1.18.47 HSP: Home Services Program

1.18.48 IBNP: Incurred But Not Paid

1.18.49 ICEB: Illinois Client Enrollment Broker

1.18.50 ICF: Intermediate Care Facility

1.18.51 ICF/DD: Intermediate Care Facility for the Developmentally Disabled

1.18.52 ICF/MR: Intermediate Care Facility for the Mentally Retarded

1.18.53 IHA: Illinois Hospital Association

1.18.54 ILCS: Illinois Compiled Statutes

1.18.55 IPHCA: Illinois Primary Health Care Association

1.18.56 IPSEC: Internet Protocol Security

1.18.57 ISMS: Illinois State Medical Society

1.18.58 ISP: Internet Service Provider

1.18.59 ISSA: Individual Service and Support Advocates

1.18.60 LEA: Local Education Agency

1.18.61 LOC: Level of Care

1.18.62 LTC: Long-term Care

1.18.63 MDS: Minimum Data Set

1.18.64 MI: Mental Illness

1.18.65 MIS: Management Information System

1.18.66 MFTD: Medically Fragile/Technology Dependent

1.18.67 MMIS: Medicaid Management Information Systems

1.18.68 NAT: Network Address Translation

1.18.69 NCPDP1.1: National Council for Prescription Drug Programs, version 1.1

1.18.70 NCQA: National Committee for Quality Assurance

1.18.71 NF: Nursing Facility

1.18.72 NPI: National Provider Identification

1.18.73 OIG: Office of Inspector General

1.18.74 PAS: Pre-Admission Screening

1.18.75 PCCM: Primary Care Case Management

1.18.76 PCP: Primary Care Provider

1.18.77 PERS: Personal Emergency Response System

1.18.78 PHI: Protected Health Information

1.18.79 PIP: Performance Improvement Project

1.18.80 PR: Peer Review

1.18.81 QA: Quality Assurance

1.18.82 QAP: Quality Assurance Plan

1.18.83 QAPI: Quality Assessment and Performance Improvement

1.18.84 QIO: Quality Improvement Organization

1.18.85 QISMC: Quality Improvement System for Managed Care

1.18.86 QMP: Quality Management Plan

1.18.87 RHC: Rural Health Clinic

1.18.88 SFY: State Fiscal Year

1.18.89 SLF: Supportive Living Facility

1.18.90 SMI: Serious Mental Illness

1.18.91 SNF: Skilled Nursing Facility

1.18.92 TCP/IP: Transmission Control Protocol/Internet Protocol

1.18.93 TDD: Teletypewriter

1.18.94 TPN: Third Party Network

1.18.95 TTY: Telecommunications Device for the Deaf

1.18.96 SODC: State Operated Developmental Center

1.18.97 UM: Utilization Management

1.18.98 UR: Utilization Review

1.18.99 VMC: Voluntary Managed Care

1.18.100 VPN: Virtual Private Network

1.18.101 WHCP: Women's Health Care Provider

SECTION 2 - HOW WE WILL EVALUATE OFFERS

2.0 OFFER RESPONSE FORMS: We will evaluate the information you provide in the Offer Response Forms. You will find these forms in later sections of this solicitation.

2.1 EVALUATION CATEGORIES: We evaluate three categories of information: Administrative Compliance, Responsibility and Responsiveness. We will consider the information you supply or don't supply, and the quality of that information when evaluating your Offer. If we find a failure or deficiency, we may have to reject the Offer or reflect that in the evaluation.

2.1.1 ADMINISTRATIVE COMPLIANCE: We will determine whether your Offer complied with the Instructions for submitting Offers. Except for late submissions, we may require that a Bidder correct deficiencies as a condition of further evaluation.

2.1.2 RESPONSIBILITY: We will determine whether you are a "Responsible" Bidder; a Bidder with whom we can or should do business. Factors that we may evaluate to determine Responsibility include, but are not limited to: certifications, conflict of interest, financial disclosures, taxpayer identification number, past performance, references (including those found outside the Offer,) compliance with applicable laws, financial stability and the perceived ability to perform completely as specified. You must at all times have financial resources sufficient, in the opinion of the State, to ensure performance of the contract and must provide proof upon request. We may require that a Bidder correct any deficiencies as a condition of further evaluation.

2.1.3 RESPONSIVENESS: We will determine whether the Offer meets the stated requirements. Minor differences or deviations that have negligible impact on the suitability of the supply or service to meet the State's needs may be accepted or corrections allowed. If no administratively compliant and responsible Bidder meets a particular requirement, we may waive that requirement.

2.2 AWARD: We will award to the two most responsible Bidders whose Proposals pass Administrative review, are Responsive, and who show the greatest ability to implement the Integrated Care Program.

We will determine how well Proposals meet the Responsiveness requirements. We will rank Proposals from best to least qualified using a point ranking system (unless otherwise specified) as an aid in conducting the evaluation.

The point evaluation system is described below.

2.2.1 The chart below shows the elements of Responsiveness that we will evaluate, their relative weights in point format and any minimum point requirements. The total number of points for Responsiveness is 1,000.

| Responsiveness Elements | Maximum Points |
|---|---|
| Organization/ Operation | 140 |
| Provider Network and Services | 200 |
| Risk Stratification/ Assessment/ Care Plan Development | 170 |
| Care Transition | 60 |
| Care Integration | 170 |
| Outcomes/ Evaluation | 60 |
| Health Information Technology | 100 |
| References/ Other Contracts | 100 |
| Total | 1,000 |

SECTION 3 - SPECIFICATIONS / QUALIFICATIONS / STATEMENT OF WORK

3.1 DEPARTMENT'S NEED FOR SUPPLIES / SERVICES

3.1.1 Overview. The Department is seeking the services of two qualified, experienced and financially sound Health Maintenance Organizations (HMOs) to enter into risk-based contracts for the Integrated Care Program, to provide the full spectrum of Medicaid Covered Services through an integrated care delivery system to Older Adults and Adults with Disabilities who are eligible for Medicaid but are not eligible for Medicare. The Integrated Care Program will operate in DuPage, Kane, Kankakee, Lake, Will, and suburban (areas with zip codes that do not begin with "606") Cook counties; the HMOs are required to cover this entire Contracting Area. The initial term of the contracts will be five years, with options to renew the contract for a potential total term of 10 years.

3.1.1.1 An integrated care delivery system is built on a foundation of well-resourced medical homes with an emphasis on wellness, preventive care, effective evidence based management of Chronic Health Conditions, and coordination and continuity of care. The Integrated Care Program proposed by the Bidder must be a system that relies on a network of Primary Care Providers, clinics, hospitals, nursing facilities, Intermediate Care Facilities for the Developmentally Disabled, Community Integrated Living Arrangements (CILA) and other residential settings for individuals with developmental disabilities, pharmacies, specialty care Providers, dentists, oral surgeons, mental health professionals and many other service providers, including ancillary Providers, social workers, health educators, home health nurses, aides, self directed Personal Assistants, speech, occupational and physical therapists, nutritionists, etc. The Integrated Care Program will use an approach in which Providers collaborate as a team and care is organized around the needs of persons in order to achieve efficient and effective assessment, diagnosis, treatment planning, treatment implementation, support services and outcome evaluation. The integrated team uses multiple perspectives, including a rich appreciation of diversity issues, to develop a full picture of the various needs of the person and of treatment and support goals and strategies. Illinois believes that the Integrated Care Program being sought under this RFP will be an opportunity to design services that allow for community living and prevent unnecessary institutional care or shorten the time in institutions by increasing appropriate diversion, refining and increasing the utilization of limited stay admission approval with rapid community reintegration, and identifying longer stay residents for community transition. The integrated care delivery system must include electronic health information exchange since the sharing of information and the process of integrating all the information from multiple perspectives of the team is the essence of interdisciplinary, integrated care. The team provides assessment of need, evaluation of services received, risk mitigation where needed, monitors responses and assesses status. Individuals are periodically reassessed, and new decisions are made about whether to continue with the original plans or to incorporate new information to revise goals and intervention strategies.

3.1.1.2 The HMOs shall be responsible for all Covered Services currently funded by Medicaid through the State Plan or waivers. Covered Services, however, will be phased in as three Service Packages as follows:

3.1.1.2.1 Service Package I. The Bidder shall demonstrate that it will be capable of providing the Covered Services in Service Package I upon execution of the Contract. Service Package I includes all Covered Services set forth as Service Package I in Section 2.1.10.1, which includes all non-long term care services and mental health and alcohol and substance abuse services. Short term post-acute rehabilitative stays in Nursing Facilities are not considered long term care services in the Integrated Care Program and will be the responsibility of the Contractor. In Illinois, the rate for Nursing Facilities does not cover pharmacy, physicians, hospital or other acute care services. (For a more detailed description of what is covered by the Nursing Facility rate, see Section 3.1.3.9 below.) The HMO will be responsible for the medical care services of Nursing Facility Residents in Service Package I. The HMO will also be responsible for the provision of medical care services to Nursing Facility Residents and to all waiver Participants otherwise eligible for the Integrated Care Program.

3.1.1.2.1.1 The Department had intended to include pharmacy services in the Service Package I Covered Services under this RFP in anticipation of the ability to collect full Medicaid rebates based on changes to Section 1927 of the Social Security Act contained in the comprehensive health care reform legislation pending in Congress. However, due to the current uncertainty of passage of that legislation, pharmacy services have been carved out of Covered Services. Nevertheless, the Department requests Proposals for management of pharmacy services and methods for sharing savings between Contractor and the Department. Should federal law change with respect to the ability to collect Medicaid rebates on prescription drugs reimbursed through capitated Managed Care Organizations, the Department would consider making pharmacy services a Covered Service under the Contract. In the alternative, Bidders may agree to accept risk for prescription drugs at the Department's net cost after rebates. RFP Attachment I provides

some basic information on the Department's drug program. For Bidders interested in exploring risk, detailed drug claims for the Potential Enrollees will be provided.

3.1.1.2.2 Service Package II. Long-term care services will be divided into two Service Packages. Service Package II includes all Covered Services set forth as Service Package II in Section 2.1.10.2. Service Package II will include Nursing Facility services and the care provided through all of the HCBS waivers operated in Illinois with the exception of those waivers designed for individuals with Developmental Disabilities. (See below for a more detailed description of waiver services and a link to a complete list.)

3.1.1.2.3 Service Package III. Service Package II includes all Covered Services set forth as Service Package III in Section 2.1.10.3. Service package III will include the Developmental Disability waiver services and ICF/DD services. (See below for a more detailed description of waiver services and a link to a complete list.)

3.1.1.2.4 The Bidder shall demonstrate that it is capable of assuming responsibility for Service Package II and III within one year after implementation of the Service Package I.

3.1.2 Population

3.1.2.1 The populations included as Potential Enrollees in the Integrated Care Program are non-Medicare eligible Medicaid Older Adults and Adults with Disabilities. The charts below show the number of eligibles to be included the Integrated Care Program. The first shows the population by county according to their category of assistance, i.e., the characteristic that makes them eligible. The second chart breaks down the same population by the setting or delivery system in which they receive care.

3.1.2.1.1 Number of Potential Enrollees for the Integrated Care Program, by county and HFS category of assistance, as of 12/01/09 (unduplicated)

| HFS county code | County | Category of Assistance | | | |
|---|---|---|---|---|---|
| | | TOTAL | Aged (01,91) | Blind (02,92) | Disabled (03,93) |
| **TOTAL** | | **37,737** | **6,564** | **98** | **31,075** |
| 030 | DuPage | 4,104 | 1,285 | 13 | 2,806 |
| 053 | Kane | 2,987 | 739 | 5 | 2,243 |
| 054 | Kankakee | 1,385 | 34 | 5 | 1,346 |
| 057 | Lake | 3,330 | 547 | 5 | 2,778 |
| 107 | Will | 3,306 | 510 | 4 | 2,792 |
| 200 | Cook* | 22,625 | 3,449 | 66 | 19,110 |

* Limited to zip code areas that do NOT begin with 606.

3.1.2.1.2 Number of Potential Enrollees for the Integrated Care Program, by county and institutional or waiver program status, as of 12/01/09 (unduplicated)

| HFS county code | County | TOTAL | Community residents | Institutional residents | | HCBS waiver program participants | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Nursing facility | ICF/MR | Aging (Older Adults & Disabled) | Brain injury | HIV/AIDS | Develop-mental disability | Supportive (assisted) living | Technology dependent | Physical disability |
| **TOTAL** | | **37,737** | **28,659** | **3,546** | **734** | **1,074** | **335** | **72** | **1,840** | **1** | **4** | **1,472** |
| 030 | DuPage | 4,104 | 3,374 | 181 | 60 | 192 | 28 | 4 | 134 | 0 | 0 | 131 |
| 053 | Kane | 2,987 | 2,457 | 170 | 56 | 64 | 20 | 7 | 96 | 0 | 1 | 116 |
| 054 | Kankakee | 1,385 | 872 | 236 | 119 | 22 | 13 | 2 | 52 | 0 | 0 | 69 |
| 057 | Lake | 3,330 | 2,525 | 450 | 97 | 8 | 19 | 4 | 142 | 0 | 1 | 84 |
| 107 | Will | 3,306 | 2,427 | 238 | 29 | 65 | 37 | 7 | 299 | 0 | 0 | 204 |
| 200 | Cook* | 22,625 | 17,004 | 2,271 | 373 | 723 | 218 | 48 | 1,117 | 1 | 2 | 868 |

* Limited to zip code areas that do NOT begin with 606.

3.1.2.2 Excluded Populations. The populations included as Potential Enrollees in the Integrated Care Program are the aged, blind and disabled populations (Categories 01/91, 02/92, and 03/93 respectively). The following aged, blind and disabled populations are excluded from participation in the Integrated Care Program:

3.1.2.2.1 Children under 19 years of age;
3.1.2.2.2 Participants eligible for Medicare Part A or enrolled in Medicare Part B;
3.1.2.2.3 Participants that are American Indian/Alaskan Natives;
3.1.2.2.4 Participants with Spend-down;
3.1.2.2.5 All Presumptive Eligibility categories;
3.1.2.2.6 Participants in the Illinois Breast and Cervical Cancer program; and
3.1.2.2.7 Participants with Comprehensive Third Party Insurance.

3.1.3 Current Delivery System and Services. In this Section we describe how services are currently delivered to Potential Enrollees. Contractors are not required to use the entities or processes described herein in their delivery of services. Services described herein are required to be provided by Contractors.

3.1.3.1 Current Medicaid Program Structure for Target Population. The Participants to be enrolled pursuant to the contracts awarded under this Purchase of Care currently receive Covered Services through the Medicaid Fee-For-Service system. Most of these Participants are enrolled in the Department's Primary Care Case Management (PCCM) program, which is a statewide mandatory program. This program operates through a State Plan Amendment pursuant to 42 CFR Section 438. Nursing Facility Residents and Home and Community-Based Waiver Participants do not participate in the PCCM program, except for the HCBS Waiver for Persons who are Elderly and the HCBS Waivers for Persons with Disabilities, which began enrollment in the PCCM Program in December 2009. The Department's Disease Management Program provides support to Participants enrolled in the PCCM program, including Older Adults and Adults with Disabilities who are not Medicare eligible, and who have chronic illnesses. Both the Disease Management Program and PCCM programs were launched in July 2006. Together, the programs work to achieve more appropriate and efficient utilization of medical care for Participants, reduce costs and improve health outcomes.

3.1.3.1.1 Primary Care Case Management - Illinois Health Connect. The Illinois' PCCM Program is named Illinois Health Connect. Under Illinois Health Connect, most eligible Participants statewide have selected or been assigned to a medical home, or are in the process of selecting a medical home. As of January 2010 there were over 1.7 million Participants enrolled with a medical home in Illinois Health Connect. As new clients become eligible for Illinois Health Connect, they have approximately 60 days to select a medical home. Participants who do not choose a PCP within the 60-day choice period are assigned to one. Illinois Health Connect enables clients to choose their own PCP while receiving the advantages of care coordination and case management. Automated Health Systems administers the day-to-day operations of Illinois Health Connect under a contract with the Department. As the administrator of the program, Automated Health Systems is responsible for the on-going development and maintenance of the Provider network, ongoing Provider and Specialist education and recruitment, monitoring and tracking PCP Enrollee capacity, implementing a referral tracking system, operating a Provider hotline, operating an Enrollee hotline, conducting Enrollee education and enrollment activities, processing Enrollee PCP change requests, conducting auto-assignments of Enrollees that do not choose a PCP, outreaching to children who have not received recommended EPSDT services, and maintaining a program website for Providers and Enrollees. Illinois Health Connect also works collaboratively with the Disease Management Program, Your Healthcare Plus, to provide the major components of Illinois' healthcare initiatives. Providers in Illinois Health Connect are reimbursed through the traditional Fee-For-Service system, however, Primary Care Providers (PCPs) are eligible for enhanced rates for certain services and bonus payments for high performance. You may find more information about Illinois Health Connect at: http://www.hfs.illinois.gov/managedcare/ or http://www.illinoishealthconnect.com/.

3.1.3.1.2 Disease Management Program - Your Healthcare Plus. Your Healthcare Plus is the Department's voluntary statewide Disease Management Program implemented on July 1, 2006. McKesson Health Solutions administers Your Healthcare Plus under a contract with the Department. The focus of Your Healthcare Plus is to promote and sustain the client-physician relationship, to support and educate eligible members on the appropriate management of their condition(s), to improve the quality of care and life for members and to achieve cost savings. Members of Your Healthcare Plus that will transition to the Integrated Care Program are adults that have chronic or complex health issues such as persistent asthma, coronary artery disease, chronic obstructive pulmonary disease, diabetes, heart failure, depression and schizophrenia, hemophilia, human immunodeficiency virus, end stage renal disease, cancer, co-occurring conditions including substance abuse and chronic pain, and may frequently utilize the emergency room. Member participation in this program is voluntary and available at no cost. At the end of SFY 2009, Your Healthcare

Plus had just over 240,000 eligible members. Heavy focus has been placed on finding and engaging members for the program whose conditions are especially complex and at highest risk of disease exacerbation. The Your Healthcare Plus team utilizes a variety of methods to find eligible members, including telephonic and field based outreach, outbound member mailing campaigns, Quality Improvement Organization (QIO) hospital admission alerts, and a gift card offered upon completion of assessment and enrollment into the program. Approximately 40% of the Your Healthcare Plus population has a primary or secondary behavioral health diagnosis. In an effort to increase the effectiveness of the Your Healthcare Plus program for the members who are prescribed certain behavioral health pharmaceuticals, McKesson Health Solutions subcontracts to provide behavioral pharmacy management services. The subcontractor monitors monthly behavioral health pharmacy claims for the purpose of identifying members who are receiving pharmacological treatment or a combination of treatments that present concerns about the quality or appropriateness of care being given. Your Healthcare Plus has also entered into collaboration with the Division of Mental Health (DHS-DMH) and Division of Alcoholism and Substance Abuse (DHS-DASA) to address associated issues for Your Healthcare Plus members. This includes working with local mental health and substance abuse agencies to ensure appropriate referrals and care coordination for Your Healthcare Plus members between behavioral health and medical care support. You may find more information about Your Healthcare Plus at: http://www.hfs.illinois.gov/dm/fact.html or http://www.yhplus.com

3.1.3.2 Dental Services (Service Package I). The Department contracts with DentaQuest, formerly known as Doral Dental of Illinois, as the fiscal intermediary and administrator of the dental program. The services provided by DentaQuest include Participant and Provider services such as providing Participants access and referrals to dental care, Participant education, outreach to children under age 21 in need of preventive care, recruiting and retaining a dental network, developing and maintaining dental policies and procedures in the Dental Office Reference Manual, performing provider education, disseminating information and performing provider profiling and feedback. DentaQuest also provides the general administration of the dental program, including Participant eligibility checks, claims administration and payment processing for dental claims, operation of a referral system to assist Providers in locating needed dental resources, data management and reporting, website operations, prior authorization for certain dental services and operating a dental quality assurance program. A list of dental Covered Cervices can be found in RFP Attachment B. Additional information on the Department's dental program can be found at: http://www.hfs.illinois.gov/mch/dental_prov.html

3.1.3.3 Alcohol and Substance Abuse Services (Service Package I). DHS-DASA is the lead agency for all substance abuse issues for the State of Illinois, DHS-DASA is responsible for coordinating the efforts of all State programs dealing with problems related to substance abuse. Treatment services to Participants are delivered under contract by community-based agencies. This system enables clients to be assessed and treated as close to their home communities as possible, allows communities to take ownership of their programs and facilitates public information and other adjunct services. Treatment services are delivered through a continuum approach, with individual clients moving from one level of care to another based upon their assessed needs. Level I and Level II services are face-to-face clinical services in a non-residential setting while Level III services are in a 24-hour structured and supervised treatment environment. More information on services and resources provided in Illinois may be found at the DHS Alcoholism and Addiction website: http://www.dhs.state.il.us/page.aspx?item=29725

3.1.3.4 Community Mental Health Services (Service Package I). The primary mission of the DHS-DMH is to assure that recovery-oriented, evidence-based, culturally sensitive community-focused treatment and supports are accessible to children/adolescents and adults most in need of mental health services, in order that they may be empowered to recover, succeed in accomplishing their goals and live full and productive lives. Recovery is a person-centered, individualized process. Therefore, service planning and service delivery must be consumer-directed, and the evaluation of outcomes must include consumer-level indicators of recovery and resilience. A range of treatments and services, evidence-based practices and exemplary practices, are employed and advanced across Illinois to promote recovery. DHS-DMH also strongly supports that all of these services are individually strength-based, thereby designed to foster recovery and resiliency for all consumers. It is the vision of DHS-DMH that all persons who experience mental illness will recover and that effective treatment and supports essential for full participation in one's community will be accessible and available at all stages of a person's life.

3.1.3.4.1 The Medicaid Community Mental Health Services Program is for individuals who require mental health services as indicated by a diagnosis contained in the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) or the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV) (1994) or DSM-IV-TR (2000) (American Psychiatric Association). Services are designed to benefit Participants:

3.1.3.4.1.1 Who require an evaluation to determine the need for mental health treatment;

3.1.3.4.1.2 Who are assessed to require medically necessary mental health treatment to reduce the mental disability and to restore an individual to the maximum possible functioning level;

3.1.3.4.1.3 Who are experiencing a substantial change/deterioration in age appropriate or independent role functioning, acute symptomatology, and who require crisis intervention services to achieve stabilization; or

3.1.3.4.1.4 Who, because of substantial impairment in role functioning, require multiple coordinated mental health services delivered in a variety of systems.

3.1.3.4.2 A comprehensive list of mental health services from the Rule 132 Service Definition and Reimbursement Guide can be found at: http://www.hfs.illinois.gov/assets/070107_cmph_guide.pdf. This link provides information on community mental health services and reimbursement details, such as HCPCS codes and units of service. It also lists general requirements for eligibility and community mental health Providers, as well as minimum staff requirements for the individual services. More information on mental health services and resources in Illinois may be found at the DHS Mental Health website: http://www.dhs.state.il.us/page.aspx?item=29728.

3.1.3.4.3 Community hospitals are considered Mental Health facilities under 405 ILCS 5/1-114 and 59 Ill. Admin. Code Section 111.20. A link to the Administrative Code section may be found at: http://www.ilga.gov/commission/jcar/admincode/059/059001110000200R.html.

3.1.3.5 State Operated Hospitals (Service Package I)

3.1.3.5.1 State-operated hospitals (SOHs) with acute civil units provide inpatient treatment to individuals who are eighteen years of age or older. Individuals served include those persons with Serious Mental Illness who cannot be served in a less restrictive setting. In addition, many of the individuals served also have other complicating problems such as substance abuse and Developmental Disabilities. Individuals are screened and subsequently referred by the community mental health center serving the county or geographical region where the person resides. The community mental health center is involved with all referrals to each regional SOH to ensure continuity of care. Individuals are generally admitted to the unit that serves their geographical region. Lengths of stay average less than two weeks but can be much longer or shorter depending upon individual need. A full range of programs and services are offered in the areas of medical/psychiatric services, nursing, psychology, social work, educational/vocational rehabilitation services, activity therapy, and spiritual services. Assessment and treatment planning are multi-disciplinary activities involving the individual, family/significant others, the community mental health center, other support services and the hospital treatment team. The individual served and treatment team collaboratively develops a treatment plan which outlines recovery goals based on an assessment of the individual's needs. The following strategies may be incorporated into an individual's treatment plan:

3.1.3.5.1.1 Supportive counseling and psychotherapy;
3.1.3.5.1.2 Group and family therapy supplemented by skills training;
3.1.3.5.1.3 Vocational evaluation and counseling;
3.1.3.5.1.4 Psycho-social skills training groups;
3.1.3.5.1.5 Substance abuse counseling;
3.1.3.5.1.6 Illness and medication education;
3.1.3.5.1.7 Referral to specialized service programs;
3.1.3.5.1.8 Community groups;
3.1.3.5.1.9 Wellness Recovery Action Planning (WRAP); and
3.1.3.5.1.10 Aftercare Planning in concert with the Participants, family and the community mental health center.

3.1.3.5.2 Several SOHs have additional services provided by the forensic program that operate:

3.1.3.5.2.1 Within the framework of the criminal statutes, involves persons adjudicated as Unfit to Stand Trial in restoration of fitness to stand trial efforts.

3.1.3.5.2.2 Within the framework of the criminal statutes, for all persons adjudicated Not Guilty by Reason of Insanity evaluates, recommends, and provides appropriate treatment to begin the rehabilitation process which will allow the individual to progress towards greater freedom and eventual release and reintegration into the community.

3.1.3.5.2.3 Provides expert evaluations of the patient's condition and progress, makes recommendations for fitness, continued care, or release to the community criminal courts.

3.1.3.5.3 State operated services are regulated under the Mental Health and Developmental Disabilities Code 405 ILCS 5/CH. I) and the Illinois Administrative Code (59 Ill. Admin Code). A link to the statute may be found at: http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1496&ChapAct=405%26nbsp%3BILCS%26nbsp%3B5%2F&ChapterID=34&ChapterName=MENTAL+HEALTH&ActName=Mental+Health+and+Developmental+Disabilities+Code%2E. For more information, see also http://intranet.dhs/onenet/page.aspx?item=13122.

3.1.3.6 Participant Direction. Participant direction of services means that the Participant has the authority to exercise decision making authority over some or all of her/his services and accepts the responsibility for taking a direct role in managing them. Participant direction is an alternative to Provider management of services wherein a service Provider has the responsibility for managing all aspects of service delivery in accordance with the participant-centered Enrollee Care Plan. Participant direction promotes personal choice and control over the delivery of services, including who provides services and how they are delivered. For example, the Participant may be afforded the opportunity and be supported to recruit, hire, and supervise individuals who furnish daily supports. When a service is Provider-managed, a Provider selected by the Participant carries out these responsibilities.

3.1.3.7 Pre-Admission Screening (PAS) for Nursing Facility Level of Care. Pre-Admission Screening is conducted for all individuals, regardless of payment source, who enter a nursing facility to determine if they meet a nursing facility level of care as defined by state assessment tools. Although the screening rule covers only nursing facility placements, preadmission screenings are also completed on individuals who wish to participate in the home and community-based waiver programs compared to nursing facilities as defined in the waivers. This PAS process will continue as currently in place to determine whether Enrollees are entitled to these services through the Contractor. Beginning July 1, 1996, federal requirements for universal screening were put in place that any individual seeking admission to a Long-Term Care Facility be screened to determine their need for that level of service regardless of payment source. Illinois' preadmission screening rule, 89 Ill Admin Code 140.642, may be found at: http://www.hfs.illinois.gov/assets/140.pdf. In Illinois, there are designated entities that conduct level of care evaluations for the institutional and the waiver populations. The Department, as the Medicaid agency, oversees the performance of these entities, ensuring that applicable level of care criteria has been properly applied. When a person seeks admission to a Long-Term Care Facility, the local screening agency is contacted to conduct an assessment. The contracted screening vendor will conduct a full assessment to determine if the person meets eligibility criterion requiring 24 hour skilled nursing care. Screening agencies are contracted through either the Department on Aging for those 60 years of age or older or Department of Human Services for those with mental illness, developmental disabilities or physical disabilities under the age of 60 years. The Long-Term Care Facility should not admit a resident without a screen except under very limited circumstances. The screen determines if the potential resident is appropriate for the admitting facility. Medicaid payment begins on the date of admission, date of screen or date of eligibility, whichever is later, unless the resident is admitted due to loss of a caregiver, from a hospital emergency room or from out-of-state. If a screen indicates a suspicion of Mental Illness or Developmental Disability, DHS-DMH or DHS-DDD is contacted to perform the screen to determine if the resident has a diagnosis that would make them not appropriate for a nursing facility, and would be better served in another setting more appropriate to their needs. Persons identified for Resident Review are determined by the Medicaid authority, DHS-DMH, State policy and Federal policy. Resident Reviews will be conducted under two circumstances: an "Initial Review" following admission of a person to a licensed nursing facility and reviews based on a Significant Change in the resident's condition. (89 Ill Admin Code 140.642 f (link provided above)). The goal of Resident Review assessments are to determine if the mental health needs identified in the PAS assessment are integrated into the individual's facility care plan, to offer the consumer choice in his living arrangement and to determine if the Participant could begin the transition to a less institutional setting. If assessment of the Resident Review determined that the Participant is a good candidate for transition, then transition planning should occur with the responsible community service vendor.

3.1.3.8 Pre-Admission Screening of Waiver Participants. Federal law, 42 CFR Section 441.301(b)(1), requires that Home and Community-Based Services provided through Title XIX Medicaid waivers be provided only to individuals who would otherwise require services at a level of care in a Medicaid certified institution, specifically a hospital, nursing facility, or Intermediate Care Facility for the Developmentally Disabled (ICF/DD). This Federal regulation may be viewed at: 42 CFR 441.301(b)(1). In order to comply with the regulation, an assessment must be conducted and a determination must be made indicating that an individual would need services at an institutional level of care, whether it is a hospital, nursing facility, or ICF/DD; if the waiver was not otherwise available. This level of care assessment must be done prior to the initiation of services and at least annually to verify that the individual continues to require the specified institutional level of care. In some programs, the assessments are conducted more often.

3.1.3.8.1 The current Pre-Admission Screening agencies for HCBS waivers are located statewide and are listed below by agency and program:

| State Agency | Waiver Programs | Level of Care | Screening Agents | Tool |
|---|---|---|---|---|
| Division of Rehabilitation Services (DHS DRS) | -Persons with Disabilities<br>-Persons with HIV or AIDS<br>-Persons with Brain Injury | Nursing Facility | Care Coordination Units<br><br>DRS local offices | Determination of Need (DON) |
| Division of Developmental Disabilities (DHS-DDD) | -Adults with Developmental Disabilities<br>-Support Waiver for Children with DD<br>-Residential Waiver for Children with DD | ICF/DD | Independent Service Coordination Agencies | Assessment of meeting federal ICF/DD eligibility criteria |
| Department on Aging (DoA) | -Persons who are Older Adults | Nursing Facility | Care Coordination Units | Determination of Need (DON) |
| Healthcare and Family Services | -Supportive Living | Nursing Facility | Care Coordination Units<br><br>DRS Local Offices | Determination of Need (DON) |
| University of Illinois-Division of Specialized Care for Children (DSCC) | -Children who are Medically Fragile, Technology Dependent | Hospital or Nursing Facility | DSCC Care Coordinators with Final Approval from HFS | Level of Care Tool for Children who are Medically Fragile, Technology Dependent (HFS 3871) |
| Note: The DHS-DRS and DoA screening agents also conduct Nursing Facility Pre-Admission Screening. | | | | |

3.1.3.9 Nursing Facility (Service Package II) and ICF/DD (Service Package III) General Services – Medicaid Requirements. Long term care services covered by the Department for Medicaid-eligible residents, as found in 89 Ill. Adm. Code 140.511, include Skilled Nursing Facilities and Intermediate Care Facilities (SNF and ICF) and Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DD). The facility shall provide an ongoing program of activities to meet the interests and preferences and the physical, mental and psychosocial well-being of each resident (77 Ill. Adm. Code 300.1410, Activity Program). Facilities must provide the following services at no additional charge:

3.1.3.9.1 All staff, routine equipment and supplies including oxygen (if less than one tank has been furnished to the resident for the month in question);

3.1.3.9.2 Room and board, supervision and oversight, and all laundry services;

3.1.3.9.3 Food substitutes and nutritional supplements;

3.1.3.9.4 Medications which are regularly available without prescription at a commercial pharmacy and which may be stocked by the facility under Department of Public Health regulations;

3.1.3.9.5 Over-the-counter drugs or items ordered by a physician; and

3.1.3.9.6 All other services necessary for compliance with the requirements of the Department of Public Health as set forth in the Skilled Nursing and Intermediate Care Facilities Code (77 Ill. Adm. Code 300) and the Intermediate Care for the Developmentally Disabled Facilities Code (77 Ill. Adm. Code 350).

3.1.3.10 State Operated Developmental Centers (SODCs) (Service Package III) are ICF/DDs for persons with developmental disabilities who are unable to be served in a community setting due to intense behavioral and/or medical difficulties. Admission to one of the nine SODCs occurs only after a careful screening by the Pre-Admission Screening agency and review by a team that includes the individual, guardian, family, current and prospective service Providers, network staff from the Division of Developmental Disabilities and representatives from the SODC. Intensive services will be provided to the individual with the goal of restoring a community living situation for the person as quickly as possible. Essential to successful habilitation in an SODC is the participation in transitional services by the appropriate PAS agency and community service Providers. To be eligible for an SODC a Participant must have a

Developmental Disability and require intensive supports/supervision. Persons must be screened by a PAS agency, receive technical assistance through the DD Network Clinical and Administrative Review Team, and be approved for admission by an SODC representative. Participants in an SODC receive intensive services with the goal of restoring them to a living situation in the community as quickly as possible. Additional information may be found at the following websites:

3.1.3.10.1 Nursing Facility Administrative Code – http://www.hfs.illinois.gov/lawsrules/ Click on Ill. Adm. Code 140; Subpart E, for general nursing facility provisions and Ill. Adm. Code 147 for Minimum Data Set (MDS) provision

3.1.3.10.2 DPH Nursing Facility Administrative Code – http://www.ilga.gov/commission/jcar/admincode/077/07700300sections.html

3.1.3.10.3 HFS Long Term Care Provider Notices – http://www.hfs.illinois.gov/ltc/

3.1.3.11 Home and Community-Based Services (HCBS). The provision of Home and Community-Based Services (HCBS) waivers allow Participants to receive non-traditional services in the community or in their own homes, rather than being placed in an institutional setting. Each HCBS waiver is designed for individuals with similar needs and offers a different set of services. Illinois currently operates nine HCBS waivers. For a complete list of waiver services, service definitions, and service limits see Attachment C. More information on the Illinois HCBS waivers may be found at the following link: http://www.hfs.illinois.gov/hcbswaivers/

3.1.3.11.1 HCBS Waiver for Persons who are Elderly (Service Package II). The Department on Aging (DoA) is the operating agency for the HCBS waiver for persons who are elderly, which is part of the Community Care Program (CCP). The CCP offers services to persons age 60 and over who meet functional and financial eligibility criteria. Those who meet Medicaid eligibility criteria are HCBS waiver participants. There are three services in this program: Homemaker Services, Adult Day Care and Personal Emergency Response Systems. The need for services is determined by local community agencies, Case Coordination Units (CCU)/Case Management Units (CMU), which are under contract with DoA.

3.1.3.11.2 HCBS Waiver for Assisted Living, Supportive Living Program (Service Package II). The HFS Division of Medical Programs is the operating agency for the Supportive Living Program. The Supportive Living Program serves persons age 65 and older or persons age 22 to 64 who have physical disabilities. A Supportive Living Facility (SLF) is a department approved residential setting in Illinois that: provides or coordinates flexible Personal Care services, 24 hour supervision and assistance (scheduled and unscheduled), activities, and health-related services with a service program and physical environment designed to minimize the need for residents to move within or from the setting to accommodate changing needs and preferences; has an organizational mission, service programs and a physical environment designed to maximize residents' dignity, autonomy, privacy and independence; and encourages family and community involvement. More information relating to services and requirements under this program, as well as a list of operational programs, can be found at the HFS website: www.slfillinois.com.

3.1.3.11.3 HCBS Waivers for Persons with Disabilities; Persons with HIV or AIDS, and Persons with Brain Injury (Service Package II). The DHS Division of Rehabilitation Services (DHS-DRS) is the operating agency for three of the Illinois HCBS waivers: persons with disabilities, persons with HIV/AIDS, and persons with brain injury. These waivers are part of a larger program called the Home Services Program (HSP). HSP is a consumer-directed program where most Participants hire, supervise, and terminate their own Personal Assistants. The program was designed using an independent living model, under the philosophy that regardless of disabilities or abilities, all persons have the right and responsibility to determine the direction of their lives and to fully and meaningfully participate as members of society. Although there are many services offered in these programs, the most used service is Personal Assistant. The State of Illinois serves as a co-employer for payment, unemployment, workers compensation and tax purposes and pays the Personal Assistants through a payroll system that processes paychecks every two-weeks. Hourly pay of personal assistants is currently determined by a labor contract with Service Employees International Union. Below is a brief description of the population served in each program.

3.1.3.11.3.1 Persons with Disabilities Waiver: The waiver for persons with disabilities serves individuals between the ages of birth through 59 years, unless the individual was receiving services prior to the 60th birthday and chose to remain in the waiver. The person must have a medical determination of a diagnosed, severe disability, which is expected to last for at least 12 months or for the duration of life.

3.1.3.11.3.2 Persons with HIV/AIDS Waiver: The waiver for persons with HIV/AIDS serves individuals of any age who have a medical determination of HIV or AIDS with severe functional limitations, which are expected to last at least 12 months or for the duration of life.

3.1.3.11.3.3 Persons with Brain Injury Waiver: The waiver for persons with brain injury serves individuals of any age who have an acquired brain injury. In this circumstance, brain injury is defined as: traumatic brain injury, infection (encephalitis, meningitis), anoxia, stroke, aneurysm, electrical injury, malignant or benign neoplasm of the brain, or toxic encephalopathy. The definition does not include degenerative, congenital or neurological disorders related to aging.

3.1.3.11.4 HCBS Waiver for Children who are Medically Fragile, Technology Dependent (Service Package II). The waiver for medically fragile/technology dependent (MFTD) children is administered through HFS, the state Medicaid agency, with day-to-day operations and case management provided by the University of Illinois-Chicago, Division of Specialized Care for Children (DSCC). Under the HCBS waiver's Home Care Program (HCP), DSCC offers coordination and support for in-home medical care, including care needed to achieve and promote community integration. The MFTD waiver serves individuals under the age of 21 who are medically fragile and technology dependent and who meet the minimum score on the Illinois MFTD Level of Care (LOC) instrument, as defined in *89 IL Admin Code 120.530.* These individuals may live at home with their parents and attend high school or community college, although some attend college away from home and require support services. The most utilized service for this group is shift nursing, which is a State Plan Service under the Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) program, not under the waiver. The primary service under the waiver is case-management. Additional services available only under the waiver include Respite; Environmental Accessibility Adaptations including electrical and plumbing modifications, assistance with electrical bills for technology equipment, and exterminator services; Nurse Training; Family Training; Placement Maintenance Counseling; and special medical equipment and supplies not covered by the Medicaid program.

3.1.3.11.5 HCBS Waiver for Adults and Children with Developmental Disabilities (DD) (Service Package III). The DHS Division of Developmental Disabilities (DHS-DDD) is the operating agency for three of the Illinois HCBS waivers: adults with developmental disabilities, residential waiver for children and young adults with developmental disabilities, and support waiver for children and young adults with developmental disabilities:

3.1.3.11.5.1 Adults with Developmental Disabilities Waiver: The waiver for adults with DD provides services to individuals, who are 18 years of age or older and who have mental retardation or developmental disabilities. The waiver allows participants to choose between participant direction and a more traditional service delivery, or a combination of the two options. Participant-directed opportunities are available to all participants in the waiver who elect the home-based support services option and want to direct their own services, with or without assistance from family members. This waiver uses a fiscal intermediary for individuals who choose to self-direct.

3.1.3.11.5.2 Residential Waiver for Children and Young Adults with Developmental Disabilities: The children's residential waiver provides 24-hour residential supports to eligible children and young adults with developmental disabilities, ages three through 21. Contracted independent screening and service coordination agencies across the State serve as the local point of access for children and their families. All participants and families receive assistance in directing service delivery from Individual Service and Support Advocates (ISSA) at these agencies.

3.1.3.11.5.3 Support Waiver for Children and Young Adults with Developmental Disabilities: The children's support waiver provides support services to eligible children and young adults with developmental disabilities, ages three through 21, who live at home with their families. The services are not intended to meet all of the needs of the participants being served. In combination with school-based services, natural supports, other community resources, and Medicaid State Plan services, the waiver assists the family in meeting the participant's needs. Like the adult waiver, this waiver affords families the choice between participant direction and more traditional service delivery, or a combination of the two options. This choice is presented at the initiation of services and at least annually thereafter. Contracted independent screening and service coordination agencies across

the State serve as the local point of access for children and their families. This waiver uses a fiscal intermediary for individuals that choose to self-direct.

3.2 SUPPLIES AND/OR SERVICES REQUIRED. This section will serve as the opportunity for the Bidder to convey their vision and structure for the Integrated Care Program by responding to the questions below. In addition, Bidders will be asked for information or data concerning your existing health plan. If you currently operate one or more health care plans and are using one of those health care plans as an example in a response, provide the name of the health care plans for which you are providing the information or data in each instance. The Department has designed this RFP to allow potential Bidders to demonstrate your understanding of the Integrated Care Program and your ability to design, implement and operate such a system. The Department understands that there can be varied approaches to such a system. Therefore, the Department has not prescribed in this RFP how such a system should be designed or operated. Instead this Section of the RFP asks numerous questions of Bidders in order to elicit innovative strategies and to better enable the Department to evaluate the true understanding and abilities of Bidders. The following section requires complete responses from the Bidder that addresses each question and provides any experience you have had in said area.

3.2.1 Organization/ Operation

3.2.1.1 Discuss the history and ownership of your organization. Include your experience in providing managed care in general, and specifically your experience providing the integrated care services that are proposed for this or similar populations. Explain your qualifications to respond to this RFP. Include accreditations, certifications and recognitions achieved, e.g. NCQA Health Plan Accreditation.

3.2.1.2 Describe your experience with implementing Disease Management Programs, and detail your successes and challenges with improving outcomes. Describe each disease management program you operate, including an outline of specific goals and benchmarks, outreach strategies and sample materials.

3.2.1.3 Describe your plan for consumer input into the operations and management of this program, experience in other programs with consumer input and any examples of program changes that resulted from this input.

3.2.1.4 Describe your philosophy and approach to consumer direction, oversight and management of services that are consumer selected, including how you manage situations that are not achieving desired outcomes.

3.2.1.5 Describe your Quality Program, including your philosophy and resources invested toward your QAPI Program, including but not limited to:

3.2.1.5.1 Governing Body;
3.2.1.5.2 Committee for development, implementation, and overseeing the QAPI Program;
3.2.1.5.3 Resources, staffing and qualifications including data and analytical resource;
3.2.1.5.4 Provider participation through planning, design, implementation and review;
3.2.1.5.5 QAPI Program education to Providers and Enrollees; and
3.2.1.5.6 Draft Quality Assurance and Performance Improvement Plan.

3.2.1.6 Describe your ongoing monitoring and evaluation of your QAPI including:

3.2.1.6.1 Overall effectiveness and demonstrated improvement;
3.2.1.6.2 Ongoing analysis of key performance measures; and
3.2.1.6.3 Frequency of monitoring, evaluation and analysis.

3.2.1.7 Describe your experience performing quality improvement projects (PIPs). Give examples of actual PIPs, detailing the PIP's focus and reason for selection, barriers, interventions used, and improvement achieved, including sustained improvement.

3.2.1.8 Provide a narrative describing your Utilization Management (UM) Program Plan description as well as its functions and responsibilities, and how you exercise these responsibilities, including criteria used and any special issues in applying Utilization Management guidelines for behavioral health, waiver services and long term care services. Describe how your UM Program detects, monitors, and evaluates under-utilization, over-utilization, and inappropriate utilization of services as well as processes to address opportunities for improvement.

3.2.1.9 Specify the type of personnel responsible for each level of UM, including prior authorization and decision-making. Provide a narrative description of your prior authorization processes.

3.2.1.10 Describe your methods of assuring the appropriateness of inpatient care. Such methodologies shall be based on individualized determinations of medical necessity in accordance with UM policies and procedures, and at a minimum include:

- 3.2.1.10.1 preadmission certification process for non-emergent admission;
- 3.2.1.10.2 a concurrent review program to monitor and review continued inpatient hospitalization, length of stay or diagnostic ancillary services regarding medical necessity;
- 3.2.1.10.3 admission review for urgent and/or emergency admissions; and
- 3.2.1.10.4 reviews of same day surgery procedures.

3.2.1.11 Describe how you would propose to phase-in the enrollment of Potential Enrollees to ensure that you are able to assess, provide appropriate medical homes, and develop care plans for Enrollees in a timely manner. Provide a detailed draft implementation work plan, with an estimated timetable to begin enrollment no later than October 1, 2010. This timetable should serve as an actual work plan and include, but not be limited to:

- 3.2.1.11.1 Initial planning meetings;
- 3.2.1.11.2 Coordination with State staff;
- 3.2.1.11.3 Periodic update meetings;
- 3.2.1.11.4 Customer service training;
- 3.2.1.11.5 Communication development;
- 3.2.1.11.6 Approval and production;
- 3.2.1.11.7 Contract development and execution;
- 3.2.1.11.8 Network development/ Provider relations; and
- 3.2.1.11.9 Development of system capabilities.

3.2.1.12 Complete Encounter Data will be critical to calculating Medical Loss Ratios and will be used for future rate settings. Describe how you will assure that your Providers submit all encounter data to you, particularly if you sub-capitate any providers.

3.2.1.13 Describe your experience submitting Encounter Data provided to a Medicaid agency, Medicare agency or private payer. How successful were you in getting the data accepted by the payers' system? What percentage of encounter data were you able to get successfully accepted?

3.2.1.14 Provide a comprehensive statement of your proposed staffing plan demonstrating how you will provide adequate staffing to address all requirements found in the RFP or proposed by Bidder. Include:

- 3.2.1.14.1 comprehensive organizational charts;
- 3.2.1.14.2 job descriptions for all key staff described in Section 3.3.1; and
- 3.2.1.14.3 résumés of known key staff. Provide detail of the implementation team and how it will differ from the on-going staff.

3.2.1.15 Describe how you will approach Abuse and Neglect and unusual incidents in the community setting.

### 3.2.2 Provider Network and Services

3.2.2.1 Describe how you will establish medical homes and equip them to promote wellness and preventive care, manage Chronic Health Conditions and fully coordinate care. Describe how you will ensure that frail older adults or persons with Developmental Disabilities, physical disabilities, or Serious Mental Illness, have medical homes equipped to handle the special needs of these subpopulations and how you will ensure access to the Medical Home when needed by all Enrollees, including access beyond normal business hours. Describe your ratios of PCPs to Enrollees and any limits you may have on panel sizes and how you determine those limits.

3.2.2.2 Describe any hospitalist and SNFist program you propose to operate, including employment relationship and targeted caseloads of these providers.

3.2.2.3 Describe any home visit and telehealth programs you propose to operate.

3.2.2.4 Describe any palliative care program you propose to operate.

3.2.2.5 Describe the ability of your network laboratories to report electronic lab values for use in performance measures and Case Management.

3.2.2.6 Describe how you will assure access to dental services for all Enrollees, including those with special needs.

3.2.2.7 Describe the mental health continuum of services you will use for those with serious mental illness (SMI) and the continuum of services for those with mental health and behavioral health needs that may not meet SMI and your rationale for this continuum.

3.2.2.8 Describe the process and criteria you will use, both initially and ongoing, to identify substance abuse and mental health Providers who will be Providers within your network. Describe how you propose to evaluate the existing substance abuse and mental health Provider pool to provide Covered Services.

3.2.2.9 Describe your approach to ensuring quality nursing care to Residents of Nursing Facilities, ICF/DD facilities, and home and community-based services. Include experience and innovations in providing this service under other contracts.

3.2.2.10 Describe any services you will offer to Enrollees beyond those required to be provided in the three Service Packages described in this RFP.

3.2.2.11 Provide a CD listing your network of Affiliated hospitals, health centers, PCPs, behavioral health providers, pharmacies, dentists, including oral surgeons, and ancillary providers for providing Service Package I. If you subcontract for Case Management services, list other provider types you are contracting with. Indicate your level of commitment by describing your agreements, i.e. Letter of Intent, Pending Contract, Contract. The data should be submitted in a Microsoft Excel file format including the following fields:

3.2.2.11.1 Provider Last Name
3.2.2.11.2 Provider First Name
3.2.2.11.3 Provider Specialty
3.2.2.11.4 Provider Address
3.2.2.11.5 Provider County
3.2.2.11.6 NPI
3.2.2.11.7 Provider Tax ID
3.2.2.11.8 Agreement Description

3.2.2.12 Provide distinct maps indicating the distribution of Providers, including PCPs, specialist, hospitals, behavioral health Providers, dentists, oral surgeons and other Providers available in the Contracting Area. Describe how the Network assures adequate access to services throughout the Contracting Area.

3.2.2.13 Detail your criteria for medical home selection for Enrollees, including standards for maximum distance or travel times.

3.2.2.14 Describe how you will use safety net providers that have traditionally served Enrollees, such as FQHCs, Certified Local Health Departments and Community Mental Health Centers.

3.2.2.15 Detail your Provider credentialing and recredentialing process.

3.2.2.16 Describe how you will evaluate Provider sites to ensure that special needs populations have access to those sites and that sufficient sites are equipped to serve Enrollees with developmental or other disabilities.

3.2.2.17 Describe how you will assure cultural competency throughout your network. What training programs and support do you offer staff and Providers regarding cultural competency?

3.2.2.18 Describe how you will develop and ensure key oral contacts and written materials are compliant with federal requirements and how you will supply interpretive services for all key oral contacts, and ensure written materials can be easily understood by the various populations included in this Program. Describe the alternative methods of communication you will offer and how Enrollees will access these methods. Describe how you will ensure the accuracy of translated materials and provide examples of materials currently provided to members in your other plans, including actual client handbooks.

### 3.2.3 Risk Stratification/Assessment/Enrollee Care Plan Development

3.2.3.1 Describe how you will maintain a profile for each Enrollee that includes demographics, PCP, case management assignment, and results of the risk assessment. Describe the profile that you will provide and submit an example.

3.2.3.2 Describe your approach to risk stratification and how it relates to performance of assessments, Enrollee Care Plan development, and any special care or Disease Management programs you propose to operate.

3.2.3.3 A well-designed process for developing and implementing Enrollee Care Plans is a critical component for assuring that Enrollees' needs are being addressed. Describe your process through which each Participant's needs, goals and preferences are identified and strategies are developed to address those needs, goals and preferences, and who develops and completes the Enrollee Care Plan and the process for collaboration.

3.2.3.4 Describe the supports and information that are made available to the Enrollee (and/or family or legal representative, as appropriate) to direct and be actively engaged in the Enrollee's Care Plan development process and the Enrollee's input into who is included in the process.

3.2.3.5 The Potential Enrollees in the Integrated Care Program are very mobile, are often difficult to locate, many times may be homeless, and are difficult to engage. Describe the strategies that you will utilize to address this.

3.2.3.6 Describe how the Enrollee Care Plan is made available to Providers and Enrollees.

3.2.3.7 Describe strategies and programs to enhance Enrollee compliance with Enrollee Care Plans.

3.2.3.8 State your estimated time frame for completion of risk stratification and assessments and Enrollee Care Plan development at Contract implementation. After implementation, what is the timeframe for completion of these processes for new Enrollees? How often do you re-assess Enrollees?

3.2.3.9 Describe the screening process that will be used for the identification of substance abuse issues in this population. Describe the referral and follow up process, both with the Enrollee and the substance abuse Provider.

3.2.3.10 Describe how you will assess and re-assess all Enrollees for behavioral health challenges. Provide copies of all assessment, evaluation and acuity ranking tools or forms proposed for use.

3.2.3.11 Describe your process for identifying the need and arranging services for Enrollees with Habilitation and Rehabilitation needs and cognitive deficits, and how you will integrate care delivery for Enrollees with co-occurring Mental Illnesses and substance abuse.

3.2.3.12 Describe your process for emergency department utilization review and identification of Enrollees with high utilization. Explain your process for analyzing the data and determining if Enrollees need Case Management services, and the steps taken to get them into Case Management. What other strategies for high emergency department utilization will you implement?

3.2.3.13 Describe your Enrollee Care Plan development processes to address back up plan arrangements for services that enable Enrollees in HCBS waivers to remain in the community.

3.2.3.14 Describe your approach to Risk Mitigation and negotiation for Enrollees living in the community, but at risk of institutional care including caregiver, environment, medical, behavioral and compliance.

### 3.2.4 Care Transition

3.2.4.1 Describe your plans and policies for transition of care for Enrollees currently under treatment for acute and Chronic Health Conditions.

3.2.4.2 Many of the Participants to be enrolled in the Integrated Care Program will already have a care plan developed by the Department's current Disease Management Program contractor in conjunction with the Participant's Providers. Describe how you will incorporate these existing care plans in the delivery of care or the development of new Enrollee Care Plans.

3.2.4.3 Describe how you will coordinate Enrollee Care Plan development and implementation with care plans and case coordinators currently serving enrollees who are receiving services through HCBS waivers.

3.2.4.4 Describe how you will assess the needs of this population currently in mental health or substance abuse treatment and effectively manage their current treatment plans and possible transfer to a different Provider.

### 3.2.5 Care Integration

3.2.5.1 Describe how you will design the compensation structure (both initial reimbursement and incentives or pay-for-performance programs) of medical homes and other Providers in your network to promote the goals of medical homes and accountable, integrated care.

3.2.5.2 Describe the resources and processes you will have in place for Case Management. What enrollees are assigned a Care Coordinator other than their PCP? What are the caseloads of Care Coordinators and do they vary depending on the needs of the Enrollees they are assigned? What are the qualifications of Care Coordinators and do they vary depending on the Enrollees assigned? What HIT resources do you use for Case Management? What are the duties of your Care Coordinators? Describe your successes in improving health outcomes and quality of life through Case Management activities.

3.2.5.3 Describe how you will assure integration of care between medical homes and other levels of care, including:

- 3.2.5.3.1 Hospital admission and discharge;
- 3.2.5.3.2 Emergency room follow-up;
- 3.2.5.3.3 Specialty care;
- 3.2.5.3.4 Medically complex care;
- 3.2.5.3.5 Medication Management;
- 3.2.5.3.6 Nutrition;
- 3.2.5.3.7 Mental Health;
- 3.2.5.3.8 Substance and alcohol abuse;
- 3.2.5.3.9 Institutional care;
- 3.2.5.3.10 Transition from institution to community living arrangements;
- 3.2.5.3.11 Community care and in home support services;
- 3.2.5.3.12 Wellness; and
- 3.2.5.3.13 Dental services.

3.2.5.4 Describe your Enrollee health education programs and materials and submit samples.

3.2.5.5 Describe your approach to Provider education on best practice strategies and evidence based clinical guidelines.

3.2.5.6 Describe your philosophy and approach to facilitate Enrollees needing nursing home or ICF/DD level of care to live in the community.

3.2.5.7 Describe how you will assure that Enrollees are given appropriate and individualized treatment based on their assessed mental health or substance abuse challenges.

3.2.5.8 Describe how you will assist Enrollees in accessing services outside the Service Delivery Package(s), such as housing, social service agencies, senior centers, etc., and your process for coordinating with these entities.

3.2.5.9 Describe your process for coordinating care with out-of-network providers and process for determining approval for accessing out of network providers.

### 3.2.6 Outcomes/ Evaluation

3.2.6.1 Propose at least four quality measures not already included in Attachment E that would best demonstrate successful integration of care or better outcomes and quality of care.

3.2.6.2 Describe how you will involve your Provider network in outcome measurement monitoring and quality improvement activities that address integrating the delivery of services.

3.2.6.3 Describe how you will monitor the quality measures in Attachment E and provide ongoing feedback to providers of their performance on these quality measures.

3.2.6.4 Describe your process for determining satisfaction among your Enrollees. Submit examples of your Enrollee Satisfaction Surveys and the quality improvement plans for similar populations in other markets.

3.2.7 Health Information Technology

3.2.7.1 Give an overview of how you will use health information technology (HIT) to accomplish the goals of accountable, integrated care.

3.2.7.2 Describe the technology resources of your major network Providers at the time of your proposal submission, any projected improvements by the time of contract implementation, and at selected milestones during the term of the contract. For example, how many have fully functioning Electronic Medical Records (EMRs); how many are currently in the process of converting to EMRs; which groups of providers share the same EMRs; what percentage of prescriptions are dispensed using e-prescribing, etc.

3.2.7.3 Describe your ability to exchange health information between the Contractor and those providers with functioning EMRs and between the Contractor and those providers without functioning EMRs.

3.2.7.4 Describe how you will promote meaningful use of HIT by providers within your network.

3.2.7.5 Describe the functionalities of the HIT resources of your HMO at the plan level at the time of your Proposal, any projected improvements by the time of contract implementation, and at selected milestones during the term of the contract.

3.2.7.6 Describe any resources you plan to provide to network Providers in the area of HIT. In particular, describe any plans for HIT in the area of behavioral health, as these providers have often been left out of HIT advances and many systems are ill-suited for behavioral health needs.

3.3 CONTRACTOR AND STAFF REQUIREMENTS

3.3.1 List of Individuals in an Administrative Capacity. The Contractor shall provide the following minimum key positions (either through direct employment or subcontract):

3.3.1.1 Chief Operating Officer (COO) or Chief Executive Officer (CEO) – The COO or CEO shall be a full-time position, located in Illinois, with clear authority over general administration and implementation of requirements set forth in the Contract, including responsibility to oversee the budget and accounting system implemented by the Contractor. This position shall be responsible for the daily conduct and operations of the Contractor's plan.

3.3.1.2 Medical Director – The Medical Director shall be an Illinois licensed Physician and shall be actively involved in all major clinical program components of the Contractor's plan including review of medical care provided, medical professional aspects of Provider contracts, and other areas of responsibility as may be designated by the Contractor. The Medical Director shall devote sufficient time to the Contractor's plan to ensure timely medical decisions, including after hours consultation as needed. The Medical Director shall be responsible for managing the Contractor's Quality Assessment and Performance Improvement Program. The Medical Director shall attend all quarterly quality meetings.

3.3.1.3 Quality Management Coordinator – The Quality Management Coordinator shall be a full-time position located in Illinois, who is an Illinois licensed Physician, Illinois licensed registered nurse, or another licensed clinician as approved by the Department based on the Contractor's ability to demonstrate that the clinician possesses the training and education necessary to meet the requirements for quality improvement activities required in the Contract. The Quality Management Coordinator must, at a minimum, be responsible for directing the activities of the quality improvement staff in monitoring and auditing the Contractor's healthcare delivery system to meet the Department's goal of providing health care services that improve the health status and health outcomes of its Enrollees.

3.3.1.4 Utilization Management Coordinator – The Utilization Management Coordinator shall be a full time position. The Utilization Management Coordinator shall be a licensed physician, or licensed registered nurse, or other professional as approved by the Department based on the Contractor's ability to demonstrate that the professional possesses the training and education necessary to meet the requirements for utilization review activities required in the Contract. This position will manage the inpatient certification review staff for inpatient initial, concurrent and retrospective reviews. The review staff shall consist of registered nurses, physicians, physician's assistants or licensed practical nurses experienced in inpatient reviews and under the direct supervision of a registered nurse, Physician, or Physician' assistant.

3.3.1.5 Care Coordination/Disease Management Program Manager – The Care Coordination/Disease Management Program Manager shall be a full time position. The Care Coordination/Disease Management Program Manager shall be a licensed Physician, licensed registered nurse, or other professional as approved by the Department based on the Contractor's ability to demonstrate that the professional possesses the training and education necessary to meet the requirements for Case Management and Disease Management Program activities required in the contract. This manager will direct all activities pertaining to Case Management and care coordination and monitor utilization of Enrollees physical health and behavioral health treatment.

3.3.1.6 Community Liaison – The Community Liaison shall be a full time position responsible for coordinating the provision of services with the waiver programs, community resources, other State agencies, and any other community entity that traditionally provides services for Potential Enrollees.

3.3.1.7 Chief Financial Officer (CFO) – The Chief Financial Officer is responsible for overseeing the budget and accounting systems of the Contractor. The CFO shall, at a minimum, be responsible for ensuring that the Contractor meets the Department's requirements for financial performance and its reporting.

3.3.1.8 Member Services Director – The Member Services Director shall be a full-time position responsible for coordinating communications with Enrollees and other Enrollee services such as acting as an Enrollee advocate. This position shall devote sufficient time to the Illinois account. There shall be sufficient member service staff to enable Enrollees to receive prompt resolution of their problems or inquiries.

3.3.1.9 Provider Service Director – The Provider Service Director shall be a full time position responsible for coordinating communications between the Contractor and its subcontractors and other Providers.

3.3.1.10 Management Information System (MIS) Director – The MIS Director shall be a full-time position that oversees and maintains the data management system that is capable of valid data collection and processing, timely and accurate reporting, and correct claims payment.

3.3.1.11 Compliance Officer – The Compliance Officer shall oversee the Contractor's compliance plan, oversee the Complaint, Grievance and fair hearing process and ensure and verify that Fraud and Abuse is reported in accordance with the guidelines in 42 CFR Section 438.608.

3.3.1.12 Designated Liaisons – The Contractor shall designate a Management Information System (MIS) Liaison and a general management primary liaison to facilitate communications between the Department and the Contractor's executive leadership and staff. A liaison may also serve in a key position.

3.3.1.13 Other key personnel identified by the Contractor.

## 3.4 SUBCONTRACTING REQUIREMENTS

3.4.1 Subcontractor Disclosure. Will you be using any subcontractors? ☐ Yes ☐ No

3.4.2 Provider Agreements and Subcontracts. Contractor may provide or arrange to provide any Covered Services with Affiliated Providers or fulfill any other obligations under this Contract by means of subcontractual relationships. No Provider agreement or subcontract can terminate the legal responsibilities of Contractor to the Department to perform under the Contract. All Provider agreements or subcontracts entered into by Contractor must be in writing and must provide the following:

3.4.2.1 Affiliated Providers and subcontractors shall be bound by the terms and conditions of this Contract that are appropriate to the service or activity delegated under the subcontract, including, but not limited to, the record keeping and audit provisions of this Contract, such that the Department or Authorized Persons shall have the same rights to audit and inspect subcontractors as they have to audit and inspect Contractor.

3.4.2.2 That Contractor shall remain responsible for the performance of any of its responsibilities delegated to Affiliated Providers or subcontractors.

3.4.2.3 That Affiliated Providers providing Covered Services for Contractor under this Contract must be enrolled as Providers in the Medicaid Program, if they are a Provider type that is required to enroll in the Medicaid Program to bill services on a Fee-For-Service basis. Contractor shall not contract or subcontract with an Ineligible Person.

3.4.2.4 That Contractor will report to the Department all entities that are sub-capitated or assume risk.

3.4.2.5 That all Provider agreements and subcontracts must comply with the Lobbying Certification contained in Section 5.10 of this RFP.

3.4.2.6 That all subcontracts with Affiliated Providers must include information about the Contractor's Grievance and Appeal processes. Contractor shall amend the subcontract as soon as practicable after notification from the Department of any substantive change to such procedures.

3.4.2.7 That Contractor will monitor the performance of all Affiliated Providers and subcontractors on an ongoing basis, subject each Affiliated Provider and subcontractor to formal review on a triennial basis, and, to the extent deficiencies or areas for improvement are identified during an informal or formal review, require that the Affiliated Provider or subcontractor take appropriate corrective action.

3.4.2.8 That Contractor retains the right to terminate any Provider agreement or subcontract, or impose other sanctions, if the performance of the Affiliated Provider or subcontractor is inadequate.

3.4.2.9 That, except as permitted or required by the Department in 89 Ill. Adm. Code 125 or the Department's Medical Program co-payment policy in effect at the time services are provided, neither Contractor nor its sub-contractors,

Affiliated Providers, or non-Affiliated Providers may seek or obtain funding through fees or charges to any Enrollee receiving Covered Services pursuant to this Contract.

3.4.3 Any contract or subcontract between Contractor and a FQHC or a RHC shall be executed in accordance with 1902(a)(13)(C) and 1903(m)(2)(A)(ix) of the Social Security Act, as amended by the Balanced Budget Act of 1997 and shall provide payment that is not less than the level and amount of payment which Contractor would make for the Covered Services if the services were furnished by a Provider which is not an FQHC or a RHC.

3.4.4 Prior to entering into a Provider agreement or subcontract, Contractor shall submit a disclosure statement to the Department specifying any Provider agreement or subcontract and Providers or subcontractors in which any of the following have a five percent (5%) or more financial interest:

3.4.4.1 Any Person also having a five percent (5%) or more financial interest in Contractor or its Affiliates as defined by 42 CFR Section 455.101;

3.4.4.2 Any director, officer, trustee, partner or employee of Contractor or its Affiliates; or

3.4.4.3 Any member of the immediate family of any Person designated in (a) or (b) above.

3.4.4.4 Upon request by the Department, Contractor shall immediately submit copies of executed contracts and subcontracts.

## 3.5 REFERENCES

3.5.1 References: You must provide references from established private firms or government agencies, (four preferred; two of each type preferred) other than the procuring agency, that can attest to your experience and ability to perform the contract subject of this solicitation. You must provide the name, contact information and a description of the supplies or services provided. You must attach your references with the responsibility forms.

3.5.2 Other Contracts: Please list all contracts you have had in the last three years to provide risk based managed care services to any payer indicating the entity with which you have a contract. List all Medicaid contracts separately. You must provide the name, contact information and a description of the supplies or services provided. You must attach this information with the responsibility forms.

## 3.6 WHERE SERVICES ARE TO BE PERFORMED

3.6.1 Contractor shall maintain an administrative office in Illinois from which the majority of Illinois specific administrative functions are performed.

3.6.2 Work Location Disclosure: Bidder shall disclose the location where the services required shall be performed. If at multiple locations, the known or anticipated value of the services performed at each location shall be identified. This information and economic impact on Illinois and its residents may be considered in the evaluation. If any work identified for performance in the United States is moved to another country, such action may be deemed a breach of the Contract.

## 3.7 OTHER SPECIFICATIONS

3.7.1 Certificate of Authority. In order to enter into a contract with the Department, Contractor must have and maintain for the term of the Contract, including any Contract extension, a valid Certificate of Authority as a Health Maintenance Organization under 215 ILCS 125/1-1, et seq. If Bidder does not currently have a valid Certificate of Authority as an HMO, the Bidder must have made application for such in order to submit a Proposal. Proof of Contractor's current Certificate of Authority or application for a Certificate of Authority must be included in its Proposal.

3.7.2 Financial Statements. The Proposal must provide the information described below for the Bidder itself. If the information described below does not exist for the Bidder, provide for the parent company.

3.7.2.1 Audited financial statements for the two most recent fiscal years for which the statements are available, as submitted to the Department of Insurance. The statements must include a balance sheet, income statement and a statement of cash flows. Statements must be complete with opinions, notes and management letters. If no audited statements are available, explain why and submit unaudited financial statements.

3.7.2.2 Balance sheet as of the end of the month immediately preceding the month in which application is made.

3.7.2.3 Documentation of lines of credit that are available, including maximum credit amount and available amount.

3.7.2.4 Short-term and long-term debt ratings by at least one nationally recognized rating service, if applicable.

3.7.2.5 Medical loss ratios for the most current two years defined as total medical and hospital cost divided by total premium income.

End of Instructions

SECTION 4 - OFFER TO STATE OF ILLINOIS

Project Title / Reference # ____Integrated Care Program/ 2010-24-005

The undersigned authorized representative of the identified Bidder does hereby submit this Offer to perform in full compliance with the subject solicitation. By completing and signing this Form, we are making an Offer to the State of Illinois that the State may accept. We are also certifying to compliance with the various requirements of the solicitation and the documents contained in the solicitation.

We have marked each blank below as appropriate and have used N/A when a section is not applicable to this solicitation. We understand that failure to meet all requirements is cause for disqualification.

We have:

____ Reviewed the Offer Form, including all referenced documents as well as the solicitation Instructions, filled in all relevant blanks, provided any requested information, and

____ Signed on the space(s) provided.

Acknowledgment of Amendments

____ We acknowledge receipt of any and all amendments to the solicitation and have taken those into account in making this Offer.

Offer Response Forms. Accompanying and as part of this Offer you will find:

For all Offers

____ Designated number of copies
____ Electronic copies.
____ Completed Responsibility Forms packet
    Business and Directory Information
    Conflict of Interest Disclosures
    Completed and Signed Taxpayer Identification Number form
____ Completed Minority, Female and Person with Disability Status and Subcontracting form
____ References
____Other Contracts
____ Political Contributions - We have made the certification required by Public Act 95-971, and attached the State Board of Elections certificate of registration as required.
____ Certificate of Authority or proof of application for a Certificate of Authority (See Section 3.7.1)
____ Financial Statements (See Section 3.7.2)

For RFPs

____ Response to Statement of Work/Specifications/Qualifications sections completed and submitted in the Offer package.

Exceptions. In preparing the Offer we have taken (check one)

____ No Exceptions
____ Exceptions to the State's language or requirements in the following sections of the Offer:
    ____ Contract
    ____ Responsibility forms

Details of the exceptions are shown (check one)
    ____ in the text of each section of the Offer
    ____ on a separate labeled attachment

Domestic Products (check one)

____ We are not making a claim for preference under the Procurement of Domestic Products Act (30 ILCS 517).

____ We are making a claim for preference under the Procurement of Domestic Products Act (30 ILCS 517). After reading the Act we certify we are eligible and that the following product or products bid or proposed in response to this solicitation meet the requirements of the Act. Check and complete as applicable:

____ All products

____ The following individual products (show line item if applicable)

_____

_____

Request for Confidential Treatment (check one)

___ We are not requesting confidential treatment for this Offer.

___ We are seeking confidential treatment for portions of this Offer. We have supplied, as an attachment to this Offer, a listing of the provisions identified by section number for which we seek confidential treatment along with the statutory basis under Illinois law for exempting that information from public disclosure. We have supplied an additional copy of the Offer with confidential information deleted. In the event the designation of confidentiality of this information is challenged, the undersigned hereby agrees to provide legal counsel or other necessary assistance to defend the designation of confidentiality and agrees to hold the State harmless for any costs or damages arising out of the State agreeing to withhold the materials based on Bidder's request. We are including a detailed justification to support the statutory basis under Illinois law for exempting that information from public disclosure.

Protests and Negotiations

If we are selected for award, we understand that does not entitle us to a contract. We further understand the award is conditioned on favorable resolution of any protests and to successful negotiation of terms and conditions including, but not limited to price and any exceptions requested.

Bidder Contact Person: The contact person for purposes of responding to any questions the State may have is:

Printed Name _____ Title _____

Address _____

Phone _____ Fax _____

Email _____

_____

(Bidder name and DBA)

_____

(Signature of party authorized to bind the named Bidder)

_____ _____

Printed Name Title

_____

Address

Phone _____ Fax _____

E-mail _____

SECTION 5 - RESPONSIBILITY FORMS

We have identified various information we need in order to determine if you are eligible to contract with the State and can be considered a "Responsible" Bidder.

You will need to:

Review each of the Responsibility forms, fill in all relevant blanks and provide any requested information.

- Business and Directory Information
- Conflict of Interest Disclosures
- Minority, Female, Person with Disability Status and Subcontracting
- Political Contributions
- Convictions and Judgments

Complete and sign the:

- Taxpayer Identification Form

Attach Certificate of Authority or proof of application for Certificate of Authority (see Section 3.7.1)
Attach your Financial Statements (see Section 3.7.2)
Attach References and Other Contracts (see section 3.5).

You must include all of this as part of your Offer or risk disqualification.

Business and Directory Information

(a) Name of Business (Official Name and D/B/A)

(b) Business Headquarters (include Address, Telephone and Facsimile)

(c) If a Division or Subsidiary of another organization provide the name and address of the parent

(d) Billing Address

(e) Name of Chief Executive Officer

(f) Customer Contact (include Name, Title, Address, Telephone, Toll-Free Number, Facsimile and E-mail)

(g) Company Web Site

(h) Type of Organization (i.e., Sole Proprietor, Corporation, Partnership, etc. -- should be the same as on the Taxpayer ID form below)

(i) Length of Time in Business

(j) Annual Sales (for most recently completed Fiscal Year)

(k) Number of Full-Time Employees (average from most recent Fiscal Year)

(l) Type of and description of business

(m) State of incorporation, state of formation or state of organization

(n) Identify and specify the location(s) and telephone numbers of the major offices and other facilities that relate to the Bidder's performance under the terms of this solicitation.

(o) Department of Human Rights (DHR) Public Contract Number
If Bidder has employed fifteen (15) or more full-time employees at any time during the 365-day period immediately preceding the publication of this solicitation in the Illinois Procurement Bulletin (or issuance date if not published), then Bidder must have a current Public Contract Number or have proof of having submitted a completed application for one prior to the Solicitation opening date. (44 Ill. Adm. Code 750.210(a)) For application information call the DHR Public Contracts unit at (312) 814-2431.

Show # _____ or attach proof of application.

(p) Information Regarding Debarment, Litigation and Terminations

1. During the last five (5) years has any order, judgment or decree of any Federal or State authority been issued barring, suspending or otherwise limiting your right to contract with any governmental entity, including school districts, or to engage in any business practice or activity?
Yes____ No____

2. Is there any current, pending or threatened litigation, administrative or regulatory proceedings, or similar matters that could affect your ability to perform the required services.
Yes____ No____

3. During the last five (5) years has any customer terminated a contract for cause or accepted damages in lieu of for cause termination?
Yes____ No____

(q) Disclosure of Business Operations with Iran (30 ILCS 500/50-36)

Each bid, offer, or proposal submitted for a State contract, other than a small purchase defined in Section 20-20 [of the Illinois Procurement Code], shall include a disclosure of whether or not the bidder, offeror, or proposing entity, or any of its corporate parents or subsidiaries, within the 24 months before submission of the bid, offer, or proposal had business operations that involved contracts with or provision of supplies or services to the Government of Iran, companies in which the Government of Iran has any direct or indirect equity share, consortiums or projects commissioned by the Government of Iran and:

(1) more than 10% of the company's revenues produced in or assets located in Iran involve oil-related activities or mineral-extraction activities; less than 75% of the company's revenues produced in or assets located in Iran involve contracts with or provision of oil-related or mineral – extraction products or services to the Government of Iran or a project or consortium created exclusively by that Government; and the company has failed to take substantial action; or

(2) the company has, on or after August 5, 1996, made an investment of $20 million or more, or any combination of investments of at least $10 million each that in the aggregate equals or exceeds $20 million in any 12- month period that directly or significantly contributes to the enhancement of Iran's ability to develop petroleum resources of Iran.

A bid, offer, or proposal that does not include this disclosure shall not be considered responsive. We may consider this disclosure when evaluating the bid, offer, or proposal or awarding the contract.

You must check one of the following items and if item 2 is checked you must also make the necessary disclosure:

___ There are no business operations that must be disclosed to comply with the above cited law.

___ The following business operations are disclosed to comply with the above cited law:

_____

_____

_____

CONFLICT OF INTEREST DISCLOSURES

Instructions. Bidder shall disclose with the Offer financial interests, potential conflicts of interest and contract information identified in Sections 1, 2 and 3 below as a condition of receiving an award or contract (30 ILCS 500/50-13 and 50-35).

If the Bidder is a wholly owned subsidiary of a parent organization, separate disclosures must be made by the Bidder and the parent. For purposes of this form, a parent organization is any entity that owns 100% of the Bidder.

This disclosure information is submitted on behalf of (show official name of Bidder, and if applicable, D/B/A and parent):

Name of Bidder:_____

D/B/A (if used):_____

Name of any Parent Organization:_____

Section 1: Section 50-13 Conflicts of Interest
All Bidders must complete this section regardless of the dollar value of the contract or method of procurement. Even if you mark "No Conflict of Interests" you may still need to complete Section 2 and 3.

(a) Prohibition. It is unlawful for any person holding an elective office in this State, holding a seat in the General Assembly, or appointed to or employed in any of the offices or agencies of State government and who receives compensation for such employment in excess of 60% of the salary of the Governor of the State of Illinois [$106,447.20], or who is an officer or employee of the Capital Development Board or the Illinois Toll Highway Authority, or who is the spouse or minor child of any such person to have or acquire any contract, or any direct pecuniary interest in any contract therein, whether for stationery, printing, paper, or any services, materials, or supplies, that will be wholly or partially satisfied by the payment of funds appropriated by the General Assembly of the State of Illinois or in any contract of the Capital Development Board or the Illinois Toll Highway Authority.

(b) Interests. It is unlawful for any firm, partnership, association, or corporation, in which any person listed in subsection (a) is entitled to receive (i) more than 7 1/2% of the total distributable income or (ii) an amount in excess of the salary of the Governor ($177,412.00], to have or acquire any such contract or direct pecuniary interest therein.

(c) Combined interests. It is unlawful for any firm, partnership, association, or corporation, in which any person listed in subsection (a) together with his or her spouse or minor children is entitled to receive (i) more than 15%, in the aggregate, of the total distributable income or (ii) an amount in excess of 2 times the salary of the Governor [$354,824.00], to have or acquire any such contract or direct pecuniary interest therein.

Check One:

_____ No Conflicts Of Interest

_____ Potential Conflict of Interest (If checked, name each conflicted individual, the nature of the conflict, and the name of the State agency that is associated directly or indirectly with the conflicted individual.)

Section 2: Disclosure of Financial Interest in the Bidder.
This applies to all contracts with an annual value exceeding $10,000 that must be procured using one of the authorized competitive methods of source selection. Complete the appropriate subsections.

Bidders must complete subsection (a), (b) or (c) below as applicable if the annual value exceeds $10,000. Use (c) if you do not meet the requirements for (a) or (b). In addition, all Bidders must complete Section 3.

(a) Publicly traded corporations subject to SEC reporting requirements
(a-1) Bidder shall submit their 10K disclosure (include proxy if referenced in 10k) in satisfaction of the financial and conflict of interest disclosure requirements set forth in subsections 50-35 a and b of the Procurement Code. The SEC 20f or 40f, supplemented with the names of those owning in excess of 5% and up to the ownership percentages disclosed in those submissions, may be accepted as being substantially equivalent to 10K.
Check here if submitting a 10k _____, 20f _____, or 40f _____.

(a-2) Bidder shall identify each contract, pending contracts, bids, proposals and other ongoing procurement relationships it has with units of State of Illinois government by showing agency name and other descriptive information such as bid number, project title, purchase order number or contract reference number (Attach additional pages as necessary. Show "none" if appropriate).

(b) Privately held corporations with more than 400 shareholders
(b-1) These Bidders may submit the information identified in 17 CFR Section 229.401 and list the names of any person or entity holding any ownership share in excess of 5% in satisfaction of the financial and conflict of interest disclosure requirements set forth in subsections 50-35 a and b of the Procurement Code.

(b-2) Bidder shall identify each contract, pending contracts, bids, proposals and other ongoing procurement relationships it has with units of State of Illinois government by showing agency name and other descriptive information such as bid number, project title, purchase order number or contract reference number (Attach additional pages as necessary. Show "none" if appropriate).

(c) General disclosure. Individuals, sole proprietorships, partnerships and any others not qualified to use subsection (a) or (b) above must complete (c-1) and (c-2) as appropriate.
(c-1) For each individual having any of the following financial interests in the Bidder (or its parent), please mark each that apply and show the applicable name and address. Use separate forms for each individual.

| | | | | |
|---|---|---|---|---|
| Does Ownership exceed 5%? | Yes ☐ No ☐ | If Yes show percentage* | _____%. | |
| Does Ownership value exceed $106,447.20? | Yes ☐ No ☐ | If Yes show $ amount | $_____ | |
| Does Distributive Income Share exceed 5%? | Yes ☐ No ☐ | If Yes show percentage* | _____%. | |
| Does Distributive Income Share exceed $106,447.20? | Yes ☐ No ☐ | If Yes show $ amount | $_____ | |

How is this interest held?

Type of ownership/distributable income share:
Sole Proprietorship ☐ Stock ☐ Partnership ☐ Other (explain)_____

Name:_____
Address:_____
_____

*For partnerships with more than 50 partners, the percentage share of ownership of each individual identified above may be shown in the following ranges (Dollar value fields must also be completed when applicable):
0.5% or less_____>0.5 to 1.0% _____>1.0 to 2.0%_____ >2.0 to 3.0 %_____> 3.0 to 4.0%_____%
>4.0 to 5.0%_____and in additional 1% increments as appropriate _____%

(c-2) In relation to individuals identified in c-1 above, indicate whether any of the following potential conflict of interest relationships apply. If "Yes," please describe each situation (label with appropriate letter) using the space at end of this Section (attach additional pages as necessary). If no individual has been identified in c-1 above, mark not applicable (n/a) here _____.

| | |
|---|---|
| (a) State employment, currently or in the previous 3 years, including contractual employment of services directly with the individuals identified in Section 1 in their individual capacity unrelated to the Bidder's contract. | Yes ☐ No ☐ |
| (b) State employment of spouse, father, mother, son, or daughter, including contractual employment for services in the previous 2 years. | Yes ☐ No ☐ |
| (c) Elective status; the holding of elective office of the State of Illinois, the government of the United States, any unit of local government authorized by the Constitution of the State of Illinois or the statutes of the State of Illinois currently or in the previous 3 years. | Yes ☐ No ☐ |
| (d) Relationship to anyone holding elective office currently or in the previous 2 years; spouse, father, mother, son, or daughter. | Yes ☐ No ☐ |
| (e) Appointive office; the holding of any appointive government office of the State of Illinois, the United States of America, or any unit of local government authorized by the Constitution of the State of Illinois or the statutes of the State of Illinois, which office entitles the holder to compensation in excess of expenses incurred in the discharge of that office currently or in the previous 3 years. | Yes ☐ No ☐ |
| (f) Relationship to anyone holding appointive office currently or in the previous 2 years; spouse, father, mother, son, or daughter. | Yes ☐ No ☐ |
| (g) Employment, currently or in the previous 3 years, as or by any registered lobbyist of the State government. | Yes ☐ No ☐ |
| (h) Relationship to anyone who is or was a registered lobbyist in the previous 2 years; spouse, father, mother, son, or daughter. | Yes ☐ No ☐ |
| (i) Compensated employment, currently or in the previous 3 years, by any registered election or re-election committee registered with the Secretary of State or any county clerk in the State of Illinois, or any political action committee registered with either the Secretary of State or the Federal Board of Elections. | Yes ☐ No ☐ |
| (j) Relationship to anyone; spouse, father, mother, son, or daughter; who is or was a compensated employee in the last 2 years of any registered election or reelection committee registered with the Secretary of State or any county clerk in the State of Illinois, or any political action committee registered with either the Secretary of State or the Federal Board of Elections. | Yes ☐ No ☐ |

## Section 3: Current and Pending Contracts

Bidder shall identify each contract, pending contracts, bids, proposals and other ongoing procurement relationships it has with units of State of Illinois government by showing agency name and other descriptive information such as bid number, project title, purchase order number or contract reference number. (Attach additional pages as necessary. Show "none" if appropriate.)

Minority, Female, Persons with Disability Status and Subcontracting

The Business Enterprise Program Act for Minorities, Females and Persons with Disabilities (BEP) (30 ILCS 575) establishes a goal for contracting with businesses that have been certified as owned and controlled by persons who are minority, female or who have disabilities.

Contract Goal to be achieved by the Bidder: This contract includes a specific Business Enterprise Program (BEP) utilization goal of 20% of the Administrative portion of the Capitation payments based on the availability of certified vendors to perform the anticipated direct subcontracting opportunities of this contract. This goal is split between the three types of BEP certified vendors as follows: Minority owned businesses- 9%; Female owned businesses- 6%; and Persons with Disabilities owned businesses- 5%. BEP certified vendors may include direct service Providers. In addition to the other award criteria established for this contract, the Agency will award this contract to a Contractor that meets the goal or makes good faith efforts to meet the goal. This goal is also applicable to change orders and allowances within the scope of work provided by the certified vendor.

By February 19, 2010, each potential Bidder shall establish a designated contact for potential BEP certified vendors. This may be in the form of a toll-free telephone number, e-mail address or on-line form. The designated contact must be reported to the Department's Project Contact by February 19, 2010.

Following are guidelines for the Bidder's response in the Utilization Plan. A format for the utilization plan is included in this section. Bidder should include any additional information that will add clarity to the Bidder's proposed utilization of certified vendors to meet the targeted goal. The Utilization Plan must demonstrate that the Bidder has either met the contract goal or that it has made good faith efforts to do so.

At the time of proposal submission, the certified vendor may not yet be certified with DCMS Business Enterprise Program; however, the certified vendor must meet the eligibility requirements and be fully certified in the BEP Program before contract award. Visit http://www.sell2.illinois.gov/bep/Business_Enterprise.htm for complete requirements and to apply for certification in the Business Enterprise Program.

If applicable, the Plan should include an executed Joint Venture agreement specifying the terms and conditions of the relationship between the partners and their relationship and responsibilities to the contract. The joint venture agreement must clearly evidence that the certified vendor will be responsible for a clearly defined portion of the work and that its responsibilities, risks, profits and contributions of capital and personnel are proportionate to its ownership percentage. It must include specific details related to the parties' contributions of capital, personnel and equipment and share of the costs of insurance and other items; the scopes to be performed by the certified vendor's own forces and under its supervision; and the commitment of management, supervisory personnel and operative personnel employed by the certified vendor to be dedicated to the performance of the contract. Each joint venture partner must execute the proposal to the Agency.

An agreement between a Contractor and a certified vendor in which the certified vendor promises not to provide subcontracting quotations to other vendors is prohibited. The Agency may request additional information to demonstrate compliance. The Bidder agrees to cooperate promptly with the Agency in submitting to interviews, allowing entry to places of business, providing further documentation, or soliciting the cooperation of a proposed certified vendor. Failure to cooperate may render the proposal non-responsive. The contract will not be finally awarded until the Bidder's Utilization Plan is approved.

Certified Vendor Locator References: Bidders may consult DCMS' BEP Certified Vendor Directory at www.sell2.illinois.gov/bep/Small_and_Diverse_Businesses.htm, as well as the directories of other certifying agencies but subcontracting vendors must be certified by DCMS as BEP vendors before the time of contract award.

Contractor Assurance: The Contractor shall not discriminate on the basis of race, color, national origin, sexual orientation or sex in the performance of this contract. Failure by the Vendor to carry out these requirements is a material breach of this contract, which may result in the termination of this contract or such other remedy, as the Agency deems appropriate. This assurance must be included in each subcontract that the Vendor signs with a subcontractor or supplier.

Calculating Certified Vendor Participation: The Utilization Plan documents work anticipated to be performed by all certified vendors and paid for upon satisfactory completion. Only the value of payments made for the work actually performed by certified BEP vendors is counted toward the contract goal. Counting guidelines are summarized below:

1) The value of the work actually performed by the certified vendor's forces shall be counted towards the goal. The entire amount of that portion of the contract that is performed by the certified vendor's forces, including supplies purchased or equipment leased by the BEP vendor shall be counted, except supplies purchased and equipment rented from the Contractor.

2) A joint venture shall count the portion of the total dollar value of the contract equal to the distinct, clearly defined portion of the work of the contract that the certified vendor performs with its forces toward the goal. A joint venture shall also count the dollar value of work subcontracted to other certified vendors. Work performed by the forces of a non-certified joint venture partner shall not be counted toward the goal.

3) When a certified vendor subcontracts part of the work of its contract to another firm, the value of the subcontracted work shall be counted toward the contract goal only if the certified vendor's subcontractor is a certified vendor. Work that a certified vendor subcontracts to a non-certified vendor will not count towards the goal.

4) A Contractor shall count towards the goal 100% of its expenditures for materials and supplies required under the contract and obtained from a certified vendor manufacturer, regular dealer or supplier.

5) A Contractor shall count towards the goal the following expenditures to certified vendors that are not manufacturers, regular dealers or suppliers:

(a) The fees or commissions charged for providing a bona fide service, such as professional, technical, consultant or managerial services and assistance in the procurement of essential personnel, facilities, equipment, materials or supplies required for performance of the contract, provided that the fee or commission is determined by the Agency to be reasonable and not excessive as compared with fees customarily allowed for similar services.

(b) The fees charged for delivery of materials and supplies required by the contract (but not the cost of the materials and supplies themselves) when the hauler, trucker, or delivery service is not also the manufacturer of or a regular dealer in the materials and supplies, provided that the fee is determined by the Agency to be reasonable and not excessive as compared with fees customarily allowed for similar services. The certified vendor trucking firm must be responsible for the management and supervision of the entire trucking operation for which it is responsible on the contract, and must itself own and operate at least one fully licensed, insured and operational truck used on the contract.

(c) The fees or commissions charged for providing any bonds or insurance specifically required for the performance of the contract, provided that the fee or commission is determined by the Agency to be reasonable and not excessive as compared with fees customarily allowed for similar services.

6) A Contractor shall count towards the goal only expenditures to firms that perform a commercially useful function in the work of the contract.

(a) A firm is considered to perform a commercially useful function when it is responsible for execution of a distinct element of the work of a contract and carries out its responsibilities by actually performing, managing, and supervising the work involved. The certified vendor must also be responsible, with respect to materials or supplies used on the contract, for negotiating price, determining quality and quantity, ordering the materials or supplies, and installing the materials (where applicable) and paying for the material or supplies. To determine whether a firm is performing a commercially useful function, the Agency shall evaluate the amount of work subcontracted, whether the amount the firm is to be paid under the contract is commensurate with the work it is actually performing and the credit claimed for its performance of the work, industry practices, and other relevant factors.

(b) A certified vendor does not perform a commercially useful function if its role is limited to that of an extra participant in a transaction or contract through which funds are passed in order to obtain certified vendor participation. In determining whether a certified vendor is such an extra participant, the Agency shall examine similar transactions, particularly those in which certified vendors do not participate, and industry practices.

7) A Contractor shall not count towards the goal expenditures that are not direct, necessary and proximately related to the work of the contract. Only the amount of services or goods that are directly attributable to the performance of the contract shall be counted. Ineligible expenditures include general office overhead or other Contractor support activities.

Good Faith Effort Procedures: If the Contractor cannot meet the goal, the Contractor must document in the Utilization Plan its good faith efforts that could reasonably have been expected to meet the goal. The Agency will consider the quality, quantity, and intensity of the Contractor's efforts.

1) The following is a list of types of action that the Agency will consider as evidence of the Contractor's good faith efforts to meet the goal. Other factors or efforts brought to the attention of the Agency may be relevant in appropriate cases.

(a) Soliciting through all reasonable and available means (e.g., attendance at pre-bid meetings, advertising and/or written notices) the interest of all certified vendors that have the capability to perform the work of the contract. The Contractor must solicit this interest within sufficient time to allow the certified vendors to respond to the solicitation. The Contractor must determine with certainty if the certified vendors are interested by taking appropriate steps to follow up initial solicitations and encourage them to bid. The Contractor must provide interested certified vendors with adequate information about the plans, specifications, and requirements of the contract in a timely manner to assist them in responding promptly to the solicitation.

(b) Selecting portions of the work to be performed by certified vendors in order to increase the likelihood that the goal will be achieved. This includes, where appropriate, breaking out contract work items into economically feasible units to facilitate certified vendor participation, even when the Contractor might otherwise prefer to perform these work items with its own forces.

(c) Making a portion of the work available to certified vendors and selecting those portions of the work or material needs consistent with their availability, so as to facilitate certified vendor participation.

(d) Negotiating in good faith with interested certified vendors. Evidence of such negotiation includes the names, addresses, and telephone numbers of certified vendors that were considered; a description of the information provided regarding the plans and specifications for the work selected for subcontracting and evidence as to why additional agreements could not be reached for certified vendors to perform the work. A Contractor using good business judgment will consider a number of factors in negotiating with certified vendors and will take a firm's price and capabilities into consideration. The fact that there may be some additional costs involved in finding and using certified vendors is not in itself sufficient reason for a Contractor's failure to meet the goal, as long as such costs are reasonable. Contractors are not required to accept higher quotes from certified vendors if the price difference is excessive or unreasonable.

(e) Thoroughly investigating the capabilities of certified vendors and not rejecting them as unqualified without sound reasons. The certified vendor's memberships in specific groups, organizations, or associations and political or social affiliations are not legitimate causes for the rejection or non-solicitation of bids in the Contractor's efforts to meet the goal.

(f) Making efforts to assist interested certified vendors in obtaining lines of credit or insurance as required by the Agency, the Contractor or to perform the scope of work.

(g) Making efforts to assist interested certified vendors in obtaining necessary equipment, supplies, materials, or related assistance or services.

(h) Effectively using the services of available minority/women community organizations; minority/women vendors' groups; local, state, and federal minority/women business assistance offices; and other organizations that provide assistance in the recruitment and placement of certified vendors.

2) In evaluating the Contractor's good faith efforts, the good faith efforts of other vendors to meet the goal on this solicitation or similar contracts may be considered.

3) If the Agency determines that the Contractor has made good faith efforts to meet the goal, the Agency will award the contract provided that the Contractor is otherwise eligible for award. If the Agency determines that the Contractor has not made good faith efforts, the Agency will notify the Contractor of that preliminary determination. The preliminary determination shall include a statement of reasons why good faith efforts have not been found, and may include additional good faith efforts that the Contractor could take. The Contractor shall have 5 business days to make the suggested good faith efforts and any other additional good faith efforts to meet the goal. The Contractor shall submit an amended Utilization Plan if additional certified vendor commitments to meet the goal are secured. If additional certified vendor commitments sufficient to meet the goal are not secured, the Contractor shall report the final good faith efforts made in the time allotted. All additional efforts taken by the Contractor will be considered. If the Agency determines that good faith efforts have not been made, it will notify the Contractor in writing of the reasons for its determination within 5 business days after receipt of the final Utilization Plan.

Contract Compliance: Compliance with this section is an essential part of the contract. The following administrative procedures and remedies govern the Contractor's compliance with the contractual obligations established by the Utilization Plan. After approval of the Plan and award of the contract, the Utilization Plan becomes part of the contract. If the Contractor did not succeed in obtaining enough certified vendor participation to achieve the goal, and the Utilization Plan was approved and contract awarded based upon a determination of good faith, the total dollar value of certified vendor work calculated in the approved Utilization Plan as a percentage of the awarded contract value shall become the contract goal.

1) The Utilization Plan may not be amended without the Agency's prior written approval.

2) The Contractor may not make changes to its contractual BEP certified vendor commitments or substitute BEP certified vendors without the prior written approval of the Agency. Unauthorized changes or substitutions, including performing the work designated for a certified vendor with the Contractor's own forces, shall be a violation of the utilization plan and a breach of the contract, and shall be cause to terminate the contract, and/or seek other contract remedies or sanctions. The facts supporting the request for changes must not have been known nor reasonably should have been known by the parties prior to entering into the subcontract. The Contractor must negotiate with the certified vendor to resolve the problem. Where there has been a mistake or disagreement about the scope of work, the certified vendor can be substituted only where agreement cannot be reached for a reasonable price or schedule for the correct scope of work.

3) Substitutions of a certified vendor shall be permitted under the following circumstances:
   (a) Unavailability after receipt of reasonable notice to proceed;
   (b) Failure of performance;
   (c) Financial incapacity;
   (d) Refusal by the certified vendor to honor the bid or proposal price or scope;
   (e) Material mistake of fact or law about the elements of the scope of work of a solicitation where a reasonable price cannot be agreed;
   (f) Failure of the certified vendor to meet insurance, licensing or bonding requirements;
   (g) The certified vendor's withdrawal of its bid or proposal; or
   (h) Decertification of the certified vendor.

4) If it becomes necessary to substitute a certified vendor or otherwise change the Utilization Plan, the Contractor must notify the Agency in writing of the request to substitute a certified vendor or otherwise change the Utilization Plan. The request must state specific reasons for the substitution or change. The Agency will approve or deny a request for substitution or other change in the Utilization Plan within 5 business days after receipt of the request.

5) Where the Contractor has established the basis for the substitution to the Agency's satisfaction, it must make good faith efforts to meet the contract goal by substituting a certified vendor. Documentation of a replacement vendor, or of good faith efforts to replace the certified vendor, must meet the requirements of the initial Utilization Plan. If the goal cannot be reached and good faith efforts have been made, the Contractor may substitute with a non-certified vendor.

6) If a Contractor plans to hire a subcontractor for any scope of work that was not previously disclosed in the Utilization Plan, the Contractor must obtain the approval of the Agency to modify the Utilization Plan and must make good faith efforts to ensure that certified vendors have a fair opportunity to bid on the new scope of work.

7) A new subcontract must be executed and submitted to the Agency within 5 business days after the Contractor's receipt of the Agency's approval for the substitution or other change.

8) The Contractor shall maintain a record of all relevant data with respect to the utilization of certified vendors, including but without limitation, payroll records, invoices, canceled checks and books of account for a period of at least 5 years after the completion of the contract. Full access to these records shall be granted by the Contractor upon 48 hours written demand by the Agency to any duly authorized representative thereof, or to any municipal, state or federal authorities. The Agency shall have the right to obtain from the Contractor any additional data reasonably related or necessary to verify any representations by the Contractor. After the performance of the final item of work or delivery of material by a certified vendor and final payment to the certified vendor by the Contractor, but not later than 30 calendar days after such payment, the Contractor shall submit a statement confirming the final payment and the total payments made to the BEP vendor under the contract.

9) The Agency will periodically review the Contractor's compliance with these provisions and the terms of its contract. Without limitation, the Contractor's failure to comply with these provisions or its contractual commitments as contained in the Utilization Plan, failure to cooperate in providing information regarding its compliance with these provisions or its Utilization Plan, or provision of false or misleading information or statements concerning compliance, certification status or eligibility of certified vendors, good faith efforts or any other material fact or representation shall constitute a material breach of this contract and entitle the Agency to declare a default, terminate the contract, or exercise those remedies provided for in the contract or at law or in equity.

10) The Agency reserves the right to withhold payment to the Contractor to enforce these provisions and the Contractor's contractual commitments. Final payment shall not be made on the contract until the Contractor submits sufficient documentation demonstrating compliance with its Utilization Plan.

UTILIZATION PLAN

_____ (the Bidder) submits the following Utilization Plan as part of our proposal in accordance with the requirements of the Minority, Female, Persons with Disability Status and Subcontracting section of the solicitation for _____. We understand that compliance with this section is an essential part of this contract and that the Utilization Plan will become a part of the contract, if awarded.

_____ (the Bidder) makes the following assurance and agrees to include the assurance in each subcontract with a subcontractor or supplier utilized on this contract: We shall not discriminate on the basis of race, color, national origin, sexual orientation or sex in the performance of this contract. Failure to carry out these requirements is a material breach of this contract, which may result in the termination of this contract or such other remedy, as the Agency deems appropriate.

Bidder's person responsible for compliance:

Name: _____

Title: _____

Telephone: (__) _____ extension _____

Email: _____

We submit one (1) of the following statements:

☐ We are certified (or are eligible and have applied to be certified) with BEP and plan to fully meet the BEP utilization goal through self-performance.

☐ We attach Section I to demonstrate our Plan fully meets the BEP utilization goal of _____% through subcontracting.

☐ We attach Section I to detail that we do not fully meet the BEP utilization goal. We also attach Section II, Demonstration of Good Faith Efforts.

Section I
Utilization of Certified Vendors

*Please submit a separate Section I for <u>each</u> proposed certified vendor.*

To achieve the BEP utilization goal through subcontracting, the following is proposed:

1) The proposed certified vendor's company name, address and phone number:

_____
_____
_____
_____
_____

At the time of submission, the above certified vendor is:

☐ Certified with the DCMS Business Enterprise Program (BEP)

☐ Meets the criteria and has submitted an application for certification with BEP
(BEP certification must be completed before contract award)

☐ Certified as a disadvantaged, minority, or woman business enterprise with the following governmental agency or private organization:
(BEP certification must be completed before contract award)

_____
_____

2) A detailed description of the commercially useful work to be done by this certified vendor is as follows:

_____
_____
_____

3) The total estimated cost to the state for this contract is $_____. The portion of the contract which will be subcontracted to this certified vendor is $_____, or _____% of the total cost of the contract.

4) A notarized signed letter of intent between _____ (the Bidder) and _____ (the certified vendor) detailing the work to be performed by the certified vendor and the agreed upon rates or prices, conforming to the Utilization Plan is included.

5) A joint venture agreement is not required, as the arrangement between _____ and _____ is that of contractor/sub-contractor and not a joint venture.
or,
A joint venture agreement between _____ and _____ is included in lieu of the letter of intent.

6) The Bidder has not prohibited or otherwise limited _____ (certified vendor) from providing subcontractor quotes to other potential bidders/vendors.

We understand that the Agency may require additional information to verify our compliance and we agree to cooperate immediately in submitting to interviews, allowing entry to any of our office locations, providing further documentation, or soliciting the cooperation of our proposed certified vendor. We will maintain appropriate records relating to our utilization of the certified vendor including: invoices, cancelled checks, books of account, and time records.

Section II
Demonstration of Good Faith Efforts to Achieve BEP Subcontracting Goal

If the BEP subcontracting goal was not achieved, the Good Faith Efforts checklist (Section II A) and contacts log (Section II B) must be submitted with the solicitation response (or as otherwise specified by DCMS). **Failure to do so may render the Bidder's solicitation response non-responsive and cause it to be rejected, or render the Bidder ineligible for contract award, at DCMS' sole discretion.** The Bidder will promptly provide evidence in support of its Good Faith Efforts to DCMS upon request.

Section II A
Good Faith Efforts Checklist
Insert on each line below the initials of the authorized Bidder representative who is certifying on behalf of the Bidder that the Bidder has completed the activities described below. **If any of the items below were not completed, attach a detailed written explanation why each such item was not completed.** If any other efforts were made to obtain BEP participation in addition to the items listed below, attach a detailed written explanation.

_____ Identified portions of the project work capable of performance by available BEP vendors, including, where appropriate, breaking out contract work items into economically feasible units to facilitate BEP participation even when the Bidder could perform those scopes with its own forces.

_____ Solicited through reasonable and available means (e.g., written notices, advertisements) BEP vendors to perform the types of work that could be subcontracted on this project, within sufficient time to allow them to respond.

_____ Provided timely and adequate information about the plans, specifications and requirements of the contract. Followed up initial solicitations to answer questions and encourage BEP vendors to submit proposals or bids.

____ Negotiated in good faith with interested BEP vendors that submitted proposals or bids and thoroughly investigated their capabilities.

____ Made efforts to assist interested BEP vendors in obtaining bonding, lines of credit, or insurance as may be required for performance of the contract (if applicable).

____ Utilized resources available to identify available certified vendors, including but not limited to BEP assistance staff; local, state and federal minority or women business assistance offices; and other organizations that provide assistance in the recruitment and placement of diverse businesses.

Section II B
Good Faith Efforts Contacts Log for Soliciting
BEP Sub-consultant, Subcontractor or Supplier Participation

Use this form to document all contacts and responses (telephone, e-mail, fax, etc.) regarding the solicitation of BEP sub-consultants, subcontractors and suppliers. Duplicate as needed. (It is not necessary to show contacts with certified vendors with which the Bidder reached an agreement to participate on this project, as shown on Section I of this Plan.)

| Name of certified vendor firm | Date and method of contact | Scope of work solicited | Reason agreement was not reached |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Letter of Intent (LOI)
Between Prime Bidder and Certified Vendor

Instructions: The responsive Bidder is required to submit this signed and notarized Letter of Intent from each certified vendor identified on the Utilization Plan. LOIs must be submitted with the proposal and must be notarized by both parties. Submit a separate LOI for each proposed certified vendor. The amount and scope of work indicated on each LOI shall be the actual amount indicated on the Utilization Plan submitted with the proposal and approved by the Agency.

Changes to the Utilization Plan including substitution of certified vendors are permitted only after award of the contract and only with prior written approval of the Agency. A request for changes to the Utilization Plan must be submitted on the *Request for Change of Utilization Plan Form* for all levels of subcontracting. LOIs must be submitted for all additions of certified vendors to the Utilization Plan prior to the start of work.

Project Name _____ Project/Solicitation Number: _____

Name of Prime Bidder: _____
Address: _____
Street City State Zip Code
Telephone: (__)_____ Fax: (__)_____ Email: _____

Name of Certified Vendor:_____
Address: _____
Street City State Zip Code
Telephone: (__)_____ Fax: (__)_____ Email: _____

Type of agreement: ☐ Services ☐ Supplies ☐ Both Services/Supplies

Type of payment: ☐ Lump Sum _____ ☐ Hourly Rate_____ ☐ Unit Price_____

Period of Performance: _____ Proposed Subcontract Amount $_____ or Proposed % of Contract _____

Description of work to be performed by certified vendor:
_____
_____

List the governmental agency or private organization with whom the certified vendor is currently certified as a disadvantaged, minority, or woman business enterprise.
_____
_____

The prime vendor and the certified vendor above hereby agree that upon the execution of a contract for the above-named project between the prime vendor and the State of Illinois, the certified vendor will perform the scope of work for the price as indicated above.

Prime Vendor (Company Name and D/B/A):

_____

_____
Signature

_____
Printed Name

Title:_____ Date:_____

Subscribed and sworn before me this
_____ day of _____, 200___.

_____
Notary Public

My Commission expires:_____

Certified Vendor (Company Name and D/B/A):

_____

_____
Signature

_____
Printed Name

Title:_____ Date:_____

Subscribed and sworn before me this
_____ day of _____, 200___.

_____
Notary Public

My Commission expires:_____

## Political Contributions

Public Act 95-971 addresses political contributions by Bidders, including affiliated persons and entities. The Act contains registration requirements and provides that all bids submitted to the State after January 1, 2009 contain a certificate of registration from the Illinois State Board of Elections or a certification that the bidding entity is not required to register. Further information about the registration requirements can be found on the Board of Elections website, www.elections.il.gov. Failure to submit this information will result in disqualification.

By submission of an Offer, you acknowledge and certify that you have read, understand and will comply with Public Act 95-971, including but not limited to, all provisions relating to reporting and making contributions to state officeholders, declared candidates for State offices and covered political organizations that promote the candidacy of an officeholder or declared candidate for office. Bidder acknowledges that the State may declare any resultant contract void if this certification is false or if the Act is violated.

In compliance with Public Act 95-971, check the following certification that applies to you:

☐ Bidder is not required to register as a business entity with the State Board of Elections.

or

☐ Bidder has registered as a business entity with the State Board of Elections and acknowledges a continuing duty to update the registration as required by the Act. Note: a copy of the official certificate of registration as issued by the State Board of Elections must be submitted as part of your Offer.

TAXPAYER IDENTIFICATION NUMBER

I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and

2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and

3. I am a U.S. person (including a U.S. resident alien).

- *If you are an individual, enter your name and SSN as it appears on your Social Security Card.*
- *If you are a sole proprietor, enter the owner's name on the name line followed by the name of the business and the owner's SSN or EIN.*
- *If you are a single-member LLC that is disregarded as an entity separate from its owner, enter the owner's name on the name line and the d/b/a on the business name line and enter the owner's SSN or EIN.*
- *If the LLC is a corporation or partnership, enter the entity's business name and EIN and for corporations, attach IRS acceptance letter (CP261 or CP277).*
- *For all other entities, enter the name of the entity as used to apply for the entity's EIN and the EIN.*

Name: _____

Business Name: _____

Taxpayer Identification Number:

Social Security Number _____

or

Employer Identification Number _____

Legal Status (*check one*):

☐ Individual

☐ Sole Proprietor

☐ Partnership

☐ Legal Services Corporation

☐ Tax-exempt

☐ Corporation providing or billing medical and/or health care services

☐ Corporation NOT providing or billing medical and/or health care services

☐ Governmental

☐ Nonresident alien

☐ Estate or trust

☐ Pharmacy (Non-Corp.)

☐ Pharmacy/Funeral Home/Cemetery (Corp.)

☐ Limited Liability Company (select applicable tax classification)

- ☐ D = disregarded entity
- ☐ C = corporation
- ☐ P = partnership

Signature: _____ Date: _____

CONVICTIONS AND JUDGMENTS

If the Bidder, its parent, a subsidiary or an affiliated company has been convicted, plead guilty, or found liable in the last 10 years or currently is facing criminal or civil actions for False Claims Act violations, Medicaid Fraud, Medicare Fraud, consumer Fraud, healthcare Fraud, or similar actions in any jurisdiction, list the jurisdiction in which the action was heard or is pending, the case name and docket number, and the exact charges, findings or allegations. Convictions or findings of liability should be listed regardless of whether they are currently under appeal. You may provide any explanatory material you feel would be helpful in evaluating your company's fitness to be awarded a contract in light of the information disclosed. If there is nothing to disclose in response to this question, please so indicate.

SECTION 6 - RESPONSIVENESS

Proposals should be organized in the following order. To be considered responsive to this RFP, the Bidder must:

1. Respond to each question in Section 3.2 of the RFP by stating in detail what experience the Bidder has, if applicable, and what processes and procedures the Bidder proposes for the Integrated Care Program. A simple restatement of RFP language will not be considered an acceptable response and may cause the Response to be disqualified. For each stated requirement or question, or for each request for information or data, you must provide the number of the section or subsection of the RFP to which you are responding. Your numbered responses must be in sequential order, corresponding to the RFP.
2. Answer the Subcontractor Disclosures question and confirm agreement with Section 3.4.
3. Disclose the Work Location for each administrative function as required in Section 3.6.
4. Complete Section 4, OFFER TO STATE OF ILLINOIS.
5. Complete Section 5, RESPONSIBILITY FORMS.
6. Confirm agreement with Section 7, PAYMENT TERMS AND CONDITIONS, and with the rates and financial information posted on the Illinois Procurement Bulletin or note any exceptions taken with a full explanation.
7. Indicate if you are proposing to accept risk for prescription drugs as a Covered Service at the Department's net cost after rebates, pursuant to Section 3.1.1.2.1.1.
8. Confirm agreement with Section 8, MODEL CONTRACT, or note any exceptions taken with a full explanation.

SECTION 7 – PAYMENT TERMS AND CONDITIONS

7.1 RATES: Reimbursement to the Contractors will be by Per Member/Per Month (PMPM) capitation rates. The Department's actuary will periodically develop actuarially sound rates that will be used in the Contracts. The rates for the first year are expected to be completed by the end of February. These rates will be posted on the Procurement Bulletin. Summary utilization data developed by the actuaries will be made available to Bidders at the Bidder's conference in the format shown on Attachment D.

7.2 RISK ADJUSTMENT: The Department's actuary will apply the Chronic Illness and Disability Payment System (CDPS) to adjust the actuarially sound base capitation rates for the AABD population for each Contractor. The Department will use the CDPS+Rx 5.1 version of the grouper. CDPS+Rx 5.1 is the revised version of CDPS which includes updated diagnostic information as well as Medicaid Rx functionality. The Department will develop a monthly risk score for the first three months that Enrollees are enrolled with the Contractor. The CDPS+Rx risk adjustment will then be updated at six months and then each six month period thereafter.

7.3 INCENTIVE POOL PAYMENTS:

7.3.1 The Department will withhold a portion of the contractual capitation rate each month. The withheld amount will be 1% in the first measurement year, 1.5% in the second measurement year and 2% in the third measurement year. Subsequent withhold amounts will be negotiated. The withheld amount will be combined with a bonus amount equal to 5% of the capitation rate to form an Incentive Pool. Contractors may earn payments from the incentive pool by achieving certain pay-for performance (P4P) quality metrics set forth in Attachment F. A portion of the Incentive Pool will be allocated to each P4P metric. If the contractor reaches the target goal on that metric, the Contractor will earn the percentage of the Incentive Pool assigned to that P4P metric. The date of the first month of the withhold and P4P measurement will be negotiated between the Department and the Contractors. After the initial year, Contractor will not be eligible for any Incentive Pool payments if it fails to meet a minimum performance standard. The minimum performance standard will require the Contractor to score at or above the baseline on all P4P measures.

7.3.2 Attachment F shows the P4P metrics for each of the first three years, estimated baseline measures and the weight of each. Attachment G details the methodology for measuring them. Final baselines and methodology will be set in consultation with Contractors. P4P metrics for future years will be negotiated.

7.3.3 For the P4P measures #1 through #8 in Attachment F, the target goal will be set at a percent above the baseline equal to 10% of the difference between the baseline score and 100%. For example, if the baseline is 50%, 10% of the difference between 50% and 100% is 5%, so the goal will be set at 55%. In subsequent measurement years, the previous year's performance will be the baseline for that measurement year unless the previous year's performance was below the initial baseline, in which case the initial baseline remains the baseline. For the P4P measures #9 and #10, the baselines will be negotiated with the Awardees. For the measures added in year two, the baselines and goals will be set during year one. For measures added in year three, the baseline and goal will be set in year two.

7.4 MEDICAL LOSS RATIO GUARANTEE: The Contract shall include a Medical Loss Ratio Guarantee. A targeted Medical Loss Ratio will be provided with the rates. If the Medical loss ratio calculated as set forth below is less than the targeted Medical Loss Ratio, Contractor shall refund to the state an amount equal to the difference between the calculated Medical Loss Ratio and the Targeted Medical Loss Ratio (expressed as a percentage) multiplied times the Coverage Year Revenue. The State shall prepare a Medical Loss Ratio Calculation which shall summarize Contractor's Medical Loss Ratio for Enrollees under the Contract for each coverage year. The Medical Loss Ratio Calculation shall be determined as set forth below.

7.4.1 Revenue. The revenue used in the calculation will consist of the Capitation payments as adjusted pursuant to Section 7.2 due from the State for services provided during the Coverage year, including amounts withheld pursuant to Section 7.3.1.

7.4.2 Benefit Expense. The State shall determine the Benefit Expense using the following data:

7.4.2.1 Paid Claims. Paid Claims shall be included in Benefit Expense. Paid Claims will be limited to services covered under the Contract. The State shall use Encounter Data claims for all dates of service during the Coverage year and accepted by the Department within six months after the end of the Coverage year. Encounter claims covered by sub-capitation contracts shall be priced at the Contractor's fee-for-service rate for services covered by this Contract or at no more than 110% of the Medicaid rate.

7.4.2.2 IBNP. IBNP as determined by the Department's actuary based on encounter data and made available for review by the Contractor.

7.4.2.3 Other Benefit Expenses. Incentive payments to network Providers paid within six months of the end of the coverage year for performance measured during the Coverage year provided the payments are made pursuant to agreements in place at the start of the measurement period under which the benchmarks triggering payments and the methodology for determining payments amounts are clearly set forth shall be included in Benefit Expense. Litigation reserves and payments in settlement of claims disputes, excluding legal fees, shall be included in Benefit Expense. Such amounts shall be recorded by Contractor for the Coverage year.

7.4.3 Data Submission. Contractor shall submit to the State, in the form and manner prescribed by the State, the data described in Section 7.4.2.3.within seven months after the end of the Coverage year. Encounter data must be submitted as required under the Contract.

7.4.4 Medical Loss Ratio Calculation. Within 90 days following the claims run-out period (9 months from the end of the Coverage Year, the State shall calculate the Medical Loss Ratio by dividing the Benefit Expense by the Revenue. The Medical Loss Ratio shall be expressed as a percentage rounded to the second decimal point. The Contractor shall have sixty (60) days to review the State's Medical Loss Ratio Calculation. Each Party shall have the right to review all data and methodologies used to calculate all moneys due under this Risk Settlement methodology.

7.4.5 Coverage year. The Coverage year shall run from the first day of the first month of coverage for Enrollees under the Contract until the last day of the twelfth month of coverage of Enrollees under the Contract. ("Coverage year). Each subsequent twelve month period after the initial Coverage year will be separate Coverage years. The Medical Loss Ratio Calculation shall be prepared using all data available from the Coverage year including six months of run-out for Benefit Expense (excluding sub-capitation paid during the run-out months) and IBNP.

SECTION 8 – MODEL CONTRACT

The following are provisions that the Department intends to include as terms of the Contract, and with which Contractor will be required to comply. Bidders are not expected to respond to any of these provisions in their Proposals but shall confirm agreement to comply or note any exceptions taken (See Section6 Responsiveness). If you are unable to accept one or more of these provisions, you must identify any exception that you want the Department to consider. You may show these changes in your Proposal by striking over language you find problematic, and underlining alternate language or by listing the sections and showing the alternate language on a separate page. You must provide these exceptions requests and alternate language with your Proposal. Please note that most of these provisions are required by law or important policy and the Department has very limited ability to consider and accept changes. Any proposed changes may be considered in the evaluation of the Bidder's Proposal.

# MODEL CONTRACT



## 1.0 TERM AND TERMINATION

1.1 TERM OF THIS CONTRACT: The Contract shall take effect on _____ and shall continue for a period of five (5) years.

1.2 RENEWAL. If the Contract is renewed, the renewal shall be subject to the same terms and conditions as the original Contract unless otherwise stated. The Contract may not renew automatically, nor may the Contract renew solely at the Contractor's option. The State reserves the right to renew for a total of five (5) years in any of the following manners or combination thereof:

1.2.1 One renewal covering the entire renewal allowance,
1.2.2 Individual one-year renewals up to and including the entire renewal allowance, or
1.2.3 Any combination of full or partial-year renewals up to and including the entire renewal allowance.

1.3 TERMINATION FOR CAUSE:

1.3.1 The State may terminate this Contract, in whole or in part, immediately upon notice to the Contractor if it is determined that the actions, or failure to act, of the Contractor, its agents, employees or subcontractors have caused, or reasonably could cause jeopardy to health, safety, or property. The Contract may be terminated if the State determines that the Contractor lacks the financial resources to perform under the Contract. If Contractor fails to perform to the State's satisfaction any material requirement of this Contract or is in violation of a material provision of this Contract, the State shall provide written notice to the Contractor requesting that the breach or noncompliance be remedied within the period of time specified in the State's written notice. If the breach or noncompliance is not remedied by that date the State may either: (a) immediately terminate the Contract without additional written notice or, (b) enforce the terms and conditions of the Contract, and in either event seek any available legal or equitable remedies and damages.

1.3.1.1 SOCIAL SECURITY ACT. This Contract may be terminated by the Department with cause upon at least fifteen (15) days' written notice to Contractor for any reason set forth in Section 1932(e)(4)(A) of the Social Security Act. In the event such notice is given, Contractor may request in writing a hearing, in accordance with Section 1932 of the Social Security Act by the date specified in the notice. If such a request is made by the date specified, then a hearing under procedures determined by the Department will be provided prior to termination. The Department reserves the right to notify Enrollees of the hearing and its purpose and inform them that they may disenroll from Contractor, and to suspend further enrollment with Contractor during the pendency of the hearing and any related proceedings.

1.3.1.2 TEMPORARY MANAGEMENT. While one or more agencies within the State of Illinois have the authority and retain the power under 42 CFR Section 438.702 to impose temporary management upon Contractor for repeated violations of the Contract, the Department will exercise its option to terminate the Contract prior to imposing temporary management. This does not preclude other state agencies from exercising such power at their discretion.

1.4 TERMINATION FOR CONVENIENCE: Following thirty (30) days written notice, the State may terminate this Contract in whole or in part without the payment of any penalty or incurring any further obligation to the Contractor. Following any such termination for convenience, the Contractor shall be entitled to compensation upon submission of invoices and proof of claim for services provided under this Contract up to and including the date of termination.

1.5 OTHER TERMINATION RIGHTS: This Contract may be terminated immediately or upon notice by the Department in its sole discretion in the event of the following:

1.5.1 Failure of Contractor to maintain the representations, warranties and certifications set forth in this Contract.
1.5.2 Failure of Contractor to maintain general liability insurance coverage as required in this Contract.

1.5.3 Any case or proceeding is commenced by or against Contractor seeking a decree or order with respect to the other party under the United States Bankruptcy Code or any other applicable bankruptcy or other similar law, including, without limitation, laws governing liquidation and receivership, and such proceeding is not dismissed within ninety (90) days after its commencement.

1.5.4 Material misrepresentation or falsification of any information provided by Contractor in the course of dealings between the parties.

1.5.5 Contractor takes any action to dissolve, merge, or liquidate.

1.5.6 Failure of the parties to negotiate an amendment necessary for statutory or regulatory compliance as provided in this Contract.

1.6 AUTOMATIC TERMINATION: This Contract shall automatically terminate on a date set by the Department for any of the following reasons:

1.6.1 If Contractor breaches any of the representations, warranties or covenants set forth in this Contract.

1.6.2 Upon Contractor's refusal to sign an amendment necessary for statutory or regulatory compliance, as provided in this Contract.

1.6.3 Upon the conviction of a felony of Contractor, an owner, a five percent (5%) shareholder, or person with management responsibility for Contractor.

## 2 DESCRIPTION OF SUPPLIES AND SERVICES

### 2.1 REQUIRED PROVISIONS

#### 2.1.1 Enrollment, Coverage and Termination of Coverage

2.1.1.1 Determination of Eligibility. The State has the exclusive right to determine an individual's eligibility for the Medicaid Program and eligibility to become an Enrollee. Such determination shall be final and is not subject to review or appeal by the Contractor. Nothing in this Section prevents the Contractor from providing the Department with information Contractor believes indicates that an Enrollee's eligibility has changed.

2.1.1.2 Enrollment Generally. A Potential Enrollee who lives in the Contracting Area shall be required to become an Enrollee. The ICEB shall be responsible for the enrollment of Potential Enrollees, including provision of all health care plan choice education and enrollment by auto-assignment. Contractor shall continue to accept Potential Enrollees for enrollment until Contractor reaches the enrollment limit set forth in the Contract. Contractor shall accept each Potential Enrollee whose name appears on the 834 Audit File and 834 Daily File. Enrollment shall be without restriction and shall be in the order in which Potential Enrollees apply or are assigned. Contractor shall not facilitate any enrollment activities. Nothing in the Contract shall be deemed to be a guarantee of any Potential Enrollee's enrollment with the Contractor.

2.1.1.2.1 Non-Discrimination. Contractor shall not discriminate against Potential Enrollees, Prospective Enrollees or Enrollees on the basis of an individual's health status, need for health services, race, color, or national origin, and shall not use any policy or practice that has the effect of discriminating on the basis of an individual's health status, need for health services, race, color, or national origin.

2.1.1.2.2 Electronic File. No less often than weekly, Contractor shall submit to the ICEB an electronic file of the information contained in the PCP, Hospital, and Affiliated Provider File described in Section 2.1.29.9.1 of the Model Contract. The ICEB will use the electronic file provided by Contractor for all enrollment functions.

2.1.1.2.3 Enrollment Packets.

2.1.1.2.3.1 Development. The Department and the ICEB will develop an enrollment packet to be sent by the ICEB to Potential Enrollees. Contractor will have an opportunity to review and comment on the information to be included in the enrollment packet, and may be asked to provide material for the enrollment packet. The enrollment packet will include at least the following: a personalized cover letter; the Department-approved information; the ICEB's website address and toll-free telephone number; an explanation of the mandatory Integrated Care Program, including the auto-assignment policy; choices for a PCP or WHCP; any services that are excluded by a Contractor that is exercising its right of conscience as specified in Section 2.1.19; phone numbers and web addresses where Potential Enrollees may obtain information about enrollment; and a pre-populated enrollment form.

2.1.1.2.3.2 Mailing. On a schedule determined by the Department and the ICEB, the ICEB will mail an initial enrollment packet to each Potential Enrollee. The ICEB or the Department will provide the mailing schedule to Contractor upon Contractor's request.

2.1.1.2.3.3 Second Mailing. If the Potential Enrollee does not make a choice within the time period specified in the initial enrollment packet, the ICEB will mail a second enrollment packet containing a reference to the first enrollment, basic information about the program, the HMO to which the Potential Enrollee will be assigned if an HMO is not chosen, and information on how to contact the ICEB to obtain additional information.

2.1.1.3 Enrollment.

2.1.1.3.1 Voluntary Enrollment. Potential Enrollees may enroll with the Contractor by completing the pre-populated client enrollment form. The form will be included in the enrollment packet, and is available online through the ICEB website or by calling the ICEB Client Helpline. On a daily basis, the ICEB will inform Contractor of Prospective Enrollees who have voluntarily chosen Contractor and the PCP, WHCP and Site selected.

2.1.1.3.2 Enrollment by Auto-Assignment. Potential Enrollees who do not select an HMO will be auto-assigned to a HMO by the ICEB. On a daily basis, the ICEB will inform Contractor of Prospective Enrollees who have been enrolled with a PCP and Site by auto-assignment. The Department and the ICEB will design an algorithm for the auto-assignment that will result in each HMO receiving approximately 50% of total Enrollees by the end of the first 12-month period of the Contract. During the second and subsequent years of the Integrated Care Program, auto-assignment will occur systematically and randomly by algorithm, so that each HMO will each receive 50% of all new Enrollees. The Department reserves the right to re-evaluate and modify the auto-assignment algorithm anytime for any reason during the second and subsequent years of the Contract, including to provide that auto-assignment will be based on Contractor quality measures.

2.1.1.3.3 Effective Date of Enrollment. If the enrollment is entered by the ICEB and accepted by the Department's database prior to the applicable cut-off date, Coverage shall begin as designated by the Department on the first day of the following calendar month. If the ICEB enters the enrollment after the applicable cut-off date, coverage shall begin no later than the first day of the second month following the date the enrollment is accepted by the Department's database.

2.1.1.3.4 Update of Enrollment Information. Within three (3) Business Days following receipt of the 834 Daily File, Contractor shall update all electronic systems maintained by Contractor to reflect the information contained in the 834 Daily File received from the Department. The 834 Audit File should be used to verify the Contractor's Enrollees for the following calendar month. The Contractor shall not wait for the 820 Payment File to update eligibility.

2.1.1.3.5 Confirmation Packet. Within three (3) Business Days after receipt of the 834 Audit or Daily file from the Department confirming that an enrollment was accepted, Contractor shall send a confirmation letter to the Enrollee. The confirmation letter shall include at least the following information: the effective date of enrollment; Site, PCP or WHCP and contact information; how to get Referrals; the role of the Care Coordinator; the benefits of preventive health care; Contractor's identification card for the Enrollee; a copy of Contractor's Enrollee Handbook; and Contractor's Certificate or Document of Coverage.

2.1.1.4 Change of HMO.

2.1.1.4.1 Initial Change Period. During the initial ninety (90) calendar days after the effective date of enrollment, whether the Enrollee selected the HMO or was auto-assigned, the Enrollee shall have the opportunity to change the assigned HMO. If the Enrollee contacts Contractor to request a change of HMOs, Contractor shall refer the Enrollee to the ICEB for that change to be made. The new HMO that the Enrollee changes to is responsible for coordination of care and transition planning. Unless otherwise specified in Section 2.1.16, the HMO in which the Enrollee was first enrolled is responsible for payment for Covered Services through the disenrollment date and for cooperating with the coordination of care and transition planning.

2.1.1.4.2 Open Enrollment Period. Once each year, each Enrollee shall have a 60-day period in which to change the HMO in which the Enrollee is enrolled. The 60-day Open Enrollment period shall begin ninety (90) calendar days prior to the of the effective date of enrollment in the HMO (the Anniversary Date). No later than ninety-five (95) calendar days prior to the Anniversary Date, the ICEB shall send notice to each Enrollee of the opportunity to make a change in HMOs and the 60-day deadline for doing so. If the Enrollee selects a different HMO during the Open Enrollment period, enrollment in the new HMO will be effective on the Enrollee's Anniversary Date.

2.1.1.5 Re-Enrollment After Resumption of Eligibility. Potential Enrollees whose Medicaid Program coverage has been reinstated in the last two calendar months will be re-enrolled with the HMO with which they were previously enrolled as long as the Enrollee's eligibility status and county of residence is still valid for participation in that HMO.

2.1.1.6 Coordination of Care. The Contractor shall provide coordination of care assistance to Prospective Enrollees to access a PCP or WHCP, or to continue a course of treatment, before the Contractor's coverage becomes effective, if requested to do so by Prospective Enrollees or the Prospective Enrollee's representative, or if the Contractor has knowledge of the need for such assistance. The Care Coordinator assigned to the Prospective Enrollee shall contact the Prospective Enrollee no later than two (2) Business Days after Care Manager is notified of the request for coordination of care.

2.1.1.7 Change of Site and Primary Care Provider or Women's Health Care Provider. The Contractor shall process PCP or WHCP change requests within thirty (30) days after the receipt of an Enrollee's request. Within three (3) business days after the processing such change, the Contractor shall submit a Site transfer record to the Department via the 834 Daily File. Such record shall contain the following data fields: Case name and identification number; Enrollee name and identification number; current Site number on the Department's database; and new Site number. The Department shall make available an error file each day which the Contractor must review in order to know if the Site transfer was rejected by the Department. If the Site transfer was rejected by the Department, the Contractor must submit a corrected Site transfer transaction within two (2) Business Days. The Department will provide the Contractor with no less than one hundred twenty (120) days advance notification prior to imposing a requirement that the Contractor electronically communicate old and new PCP numbers and old and new WHCP numbers with this record.

2.1.1.8 Termination of Coverage.

2.1.1.8.1 The Department shall terminate an Enrollee's coverage upon the occurrence of any of the following conditions:

2.1.1.8.1.1 Upon the Enrollee's death. Termination of coverage shall take effect at 11:59 p.m. on the last day of the month in which the Enrollee dies. Such termination may be retroactive to this date.

2.1.1.8.1.2 When an Enrollee elects to change HMOs during Open Enrollment, termination of coverage with the previous HMO shall take effect at 11:59 p.m. on the last day of the coverage year.

2.1.1.8.1.3 When an Enrollee no longer resides in the Contracting Area, unless waiver of this subparagraph is approved in writing by the Department and assented to by the Contractor and Enrollee, except for Enrollees living in the Contracting Area who are admitted to a Nursing Facility outside the Contracting Area, where placement is not based on the family or social situation of the Enrollee. If an Enrollee is to be disenrolled at the request of Contractor under the provisions of this paragraph, the Contractor must first provide documentation satisfactory to the Department that the Enrollee no longer resides in the Contracting Area. Termination of coverage shall take effect at 11:59 p.m. on the last day of the month prior to the month in which the Department determines that the Enrollee no longer resides in the Contracting Area. This date may be retroactive if the Department can determine the month in which the Enrollee moved from the Contracting Area.

2.1.1.8.1.4 When the Department determines that an Enrollee has other significant insurance coverage or is placed in Spend-down status. The Department shall notify the Contractor of such disenrollment on the 834 Daily File.

2.1.1.8.1.5 When the Department is aware that an Enrollee is incarcerated in a county jail or Department of Corrections facility, the Department will disenroll the Enrollee for the entire month for any month or part of a month in which the Enrollee is incarcerated.

2.1.1.8.2 The termination of this Contract terminates coverage for all Participants who become Enrollees under it. Termination of coverage under this provision will take effect at 11:59 p.m. on the last day of the last month for which the Contractor receives payment, unless otherwise agreed to, in writing, by the Parties to this Contract.

2.1.1.8.3 Except as otherwise provided in this Section, termination of Enrollee coverage shall take effect no later than 11:59 p.m. on the last day of the month following the month the disenrollment is processed by the Department.

2.1.1.8.4 The Contractor shall not seek to terminate enrollment because of an adverse change in an Enrollee's health status or because of the Enrollee's utilization of Covered Services, diminished mental capacity, uncooperative/disruptive behavior resulting from such Enrollee's special needs (except to the extent such Enrollee's continued enrollment with the Contractor seriously impairs the Contractor's ability to furnish Covered Services to the Enrollee or other Enrollees), or an Enrollee's Action in connection with exercising his or her Appeal or Grievance rights. Such attempts to seek to terminate enrollment will be considered in violation of the terms of this Contract.

2.1.1.9 Enrollment Limit.

2.1.1.9.1 The Department will limit the number of Enrollees enrolled with the Contractor to a level that will not exceed the Contractors physical and professional capacity. In its determination of capacity, the Department will consult with the Contractor, but the final determination is at the sole discretion of the Department. When the capacity is reached, the Department will accept no further enrollments unless termination or disenrollment of Enrollees creates room for additions. The capacity limits for the Contractor will be specified in the Contract.

2.1.1.9.2 Review of Enrollment Limit. The Department in its sole discretion may perform a review of the enrollment limit under the following circumstances: if the Contractor requests a review and the Department agrees to such review; if the Department determines that the Contractor's operating or financial performance reasonably indicates a lack of Provider or administrative capacity; or if the Department determines that capacity must be increased. This review shall examine the Contractor's Provider and administrative capacity in the Contracting Area. The Department shall use its best efforts to complete the review before the Contractor reaches the enrollment limit. Such review may indicate that Contractor may increase enrollment or must limit enrollment. Should the Department determine that the Contractor does not have the necessary Provider and administrative capacity to service any additional enrollments, the Department may freeze enrollment until such time that the Contractor's Provider and administrative capacity have increased to the Department's satisfaction.

2.1.1.10 Identification Card. The Contractor shall send new Enrollees an identification card bearing the name of the Contractor; the effective date of coverage; the twenty-four hour telephone number to confirm eligibility for benefits and authorization for services and the name and phone number of the PCP and, if applicable, the WHCP. The Contractor shall make reasonable efforts to send the identification cards no later than five (5) Business Days following receipt of the 834 Audit File. Contractor shall send a draft of the identification card described herein to the Department for Prior Approval no less than five (5) Business Days prior to the Readiness Review and when the card is revised. The Contractor shall not be required to submit for Prior Approval format changes to the card, provided there is no change in the information conveyed.

2.1.1.10.1 If the Contractor requires a female Enrollee who wishes to use a WHCP to designate a specific WHCP and if a female Enrollee does so designate a WHCP, the name and phone number of that WHCP shall appear on the identification card.

2.1.2 Communications with Prospective Enrollees, Potential Enrollees, and Enrollees. The requirements outlined in this section apply to all key oral contacts and written materials. The Contractor must make oral interpretation services available free of charge in all languages to all Potential Enrollees, Prospective Enrollees or Enrollees who need assistance understanding key oral contacts or written materials. The Contractor must include in all key oral contacts and written materials notification that such oral interpretation services are available, and provide a telephone number that can be used to obtain such services. Contractor shall provide a TDD/TTY service for communicating with Potential Enrollees, Prospective Enrollees, and Enrollees who are deaf or hearing impaired. All Contractor communications with Potential Enrollees, Prospective Enrollees and Enrollees require Prior Approval.

2.1.2.1 Key Oral Contacts. The Contractor shall conduct key oral contacts with Potential Enrollees, Prospective Enrollees and Enrollees in a language the Potential Enrollees, Prospective Enrollees and Enrollees understand. "Key oral contacts" include, but are not limited to: contacts with Enrollee's Care Coordinator; contacts to explain benefits; initial choice or change of PCP and WHCP; telephone calls to the toll-free phone line(s); and Enrollees' face-to-face encounters with Providers rendering care. Where the Participant's language is other than English or Spanish, Contractor shall offer and, if accepted by the Participant, shall supply interpretive services. If a Participant requests interpretive services by a family member or acquaintance, Contractor shall not allow such services by anyone who is under the age of eighteen (18). Contractor shall accept the caller's verification of the age of the person providing interpretive services unless Contractor has a valid reason for requesting further verification.

2.1.2.2 Written Materials. All Contractor written communications with Potential Enrollees, Prospective Enrollees and Enrollees must be easily understood by individuals with a sixth grade reading level. It will not be sufficient to simply have written materials at a sixth grade reading level and be available in English and Spanish. The materials must be presented in a layout and manner that enhances Enrollees' understanding of the material. Materials regarding choice of HMOs, selecting a PCP or WHCP, Enrollee Handbooks, basic information, and any information or notices distributed by Contractor or required to be distributed to Potential Enrollees, Prospective Enrollees or Enrollees by the Department or regulations promulgated from time to time under 42 CFR Section 438 are collectively, "written materials". The Department may require that Contractor provide written materials in additional languages at any time with written notice to Contractor and without requiring additional payment from the Department or Contract amendment.

2.1.2.3 Alternative Methods of Communication. Contractor shall make key oral contacts and written materials available in alternative formats, such as Braille, sign language interpreters in accordance with the Interpreters for the Deaf Act (225 ILCS 442), CART reporters, Video Relay Interpretation or Video Relay Services and in a manner that takes into consideration the special needs of those who are visually impaired, hearing-impaired or have limited reading proficiency. Contractor shall inform Potential

Enrollees, Prospective Enrollees and Enrollees, as appropriate, that information is available in alternative formats and how to access those formats. The Contractor must provide TDD/TTY service upon request for communicating with Prospective Enrollees and Enrollees who are deaf or hearing impaired.

2.1.2.4 Translated Materials. Translated written materials and scripts for translated key oral contacts require Prior Approval and must be accompanied by Contractor's certification that the translation is accurate and complete, and that the translation is easily understood by individuals with a sixth grade reading level. Contractor's first submittal of the translated materials to the Department for Prior Approval must be accompanied by a copy of the Department's approval of the English version and the required translation certification. Contractor shall make all written materials distributed to English speaking Potential Enrollees, Prospective Enrollees and Enrollees, as appropriate, available in Spanish and other prevalent languages, as determined by the Department. Where there is a prevalent single-language minority within the low income households in the relevant Department of Human Services local office area (which for purposes of this Contract shall exist when five percent (5%) or more such families speak a language other than English, as determined by the Department according to published Census Bureau data), the Contractor's written materials provided to Potential Enrollees, Prospective Enrollees or Enrollees must be available in that language as well as in English.

2.1.3 Basic Information.

2.1.3.1 "Basic information" as used herein shall mean information regarding:

2.1.3.1.1 Types of benefits, and amount, duration and scope of such benefits available under the Contractor. There must be sufficient detail to ensure Enrollees understand the benefits that they are entitled to receive as Covered Services, including behavioral health services;

2.1.3.1.2 Procedures for obtaining Covered Services, including authorization and Referral requirements;

2.1.3.1.3 Information, as provided by the Department, regarding any benefits to which an Enrollee may be entitled under the Medicaid Program that are not provided under the Contractor's plan and specific instructions on where and how to obtain those benefits, including any restrictions on an Enrollee's freedom of choice among Affiliated Providers;

2.1.3.1.4 The extent to which after-hours coverage and Emergency Services are provided, including the following specific information: (a) definitions of "Emergency Medical Condition," "Emergency Services," and "Post-Stabilization Services" that reference the definitions set forth herein; (b) the fact that prior authorization is not required for Emergency Services; (c) the fact that, subject to the provisions of this Contract, an Enrollee has a right to use any hospital or other setting to receive Emergency Services; (d) the process and procedures for obtaining Emergency Services; and (e) the location of Emergency Services and/or Post-Stabilization Services Providers that are Affiliated Providers;

2.1.3.1.5 The procedures for obtaining Post-Stabilization Services in accordance with the terms set forth in Section 2.1.14;

2.1.3.1.6 Policy on Referrals for specialty care and for Covered Services not furnished by an Enrollee's PCP;

2.1.3.1.7 Cost sharing, if any;

2.1.3.1.8 The rights, protections, and responsibilities of an Enrollee as specified in 42 CFR Section 438.100, such as those pertaining to enrollment and disenrollment and those provided under State and Federal law;

2.1.3.1.9 Grievance and fair hearing procedures and timeframes, provided that such information must be pre-approved before distribution;

2.1.3.1.10 Appeal rights and procedures and timeframes, provided that such information must be pre-approved before distribution; and

2.1.3.1.11 Contractor's website location and all information contained on the website, including Certificate of Coverage or Document of Coverage, Provider directory and ability to request a hard copy of these through member services.

2.1.3.1.12 A copy of the Contractor's Certificate of Coverage or Document of Coverage.

2.1.3.1.13 Names, locations, telephone numbers, and non-English languages spoken by current Affiliated Providers, including identification of those who are not accepting new Enrollees.

2.1.3.2 The Contractor shall have written policies to provide basic information to the Enrollees, to notify such Enrollees that translated materials are available and how to obtain them, and at the times described below:

2.1.3.2.1 To each Prospective Enrollee or Enrollee within thirty (30) days after Contractor receives notice of the Enrollees enrollment and within thirty (30) days following a significant change;

2.1.3.2.2 To any Potential Enrollee who requests it; and

2.1.3.2.3 Once each year Contractor must notify Enrollees of their right to request and obtain the basic information.

2.1.4 Other Information. Upon request, Contractor shall provide the following additional information to any Enrollee, Prospective Enrollee, or Potential Enrollee:

2.1.4.1 HMO and health care facility licensure;

2.1.4.2 Practice guidelines maintained by the Contractor in accordance Section 2.1.22.3; and

2.1.4.3 Information about Affiliated Providers of health care services, including education, Board certification and recertification, if appropriate.

2.1.5 Enrollee Handbook. The Contractor shall submit the Enrollee handbook to the Department for Prior Approval initially and as revised. The Contractor shall not be required to submit for Prior Approval format changes, provided there is no change in the information conveyed. The Contractor shall mail an Enrollee Handbook to new Enrollees no later than five (5) Business Days following receipt of the Enrollee's initial enrollment record on the 834 Audit File. The Contractor shall ensure that the Enrollee Handbook is written at or below a sixth-grade reading level. It will not be sufficient to merely have text at a sixth-grade reading level. The format must enhance Enrollees' understanding of the material presented. At a minimum, the Enrollee Handbook must contain information about:

2.1.5.1 HMO's contact information;

2.1.5.2 The Enrollee's rights and responsibilities and the Enrollee's freedom to exercise of those rights without negative consequences. Enrollee rights include the right to:

2.1.5.2.1 Be treated with respect and with due consideration for his or her dignity and privacy;

2.1.5.2.2 Receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's condition and ability to understand;

2.1.5.2.3 Participate in decisions regarding his or her health care, including the right to refuse treatment;

2.1.5.2.4 Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;

2.1.5.2.5 Request and receive a copy of his or her medical records, and to request that they be amended or corrected; and

2.1.5.2.6 Exercise his or her rights, and that the exercise of those rights does not adversely affect the way the Enrollee is treated.

2.1.5.3 The PCP Network and the PCP's role in directing and managing Enrollee care;

2.1.5.4 An explanation of Open Enrollment and the Open Enrollment period.

2.1.5.5 How to select and change a PCP, change "for cause", whether the Contractor will impose a restriction on the number of times Enrollee can change PCPs during the Enrollment Period, and the circumstances under which an Enrollee may select a specialist as a PCP.

2.1.5.6 The amount, duration, and scope of benefits available in sufficient detail to ensure that the Enrollee understands the benefits to which the Enrollee is entitled.

2.1.5.7 How and the extent to which the Enrollee may obtain direct access services, including family planning services.

2.1.5.8 The policies and procedures for obtaining services, including self-referred services, services requiring prior authorization and services requiring a Referral.

2.1.5.9 How to access after-hours, non-emergency care:

2.1.5.9.1 The procedures for obtaining Emergency Care. The information shall: specify that emergency care does not require a Referral; provide information about the 911 telephone system; and refer Enrollees to the Provider Directory or the Call Center for a list of facilities providing Emergency Services and Post-Stabilization Services. The information shall clearly communicate that Enrollees have a right to use any hospital or other setting for Emergency Services.

2.1.5.9.2 How to identify what constitutes an Emergency Medical Condition, Emergency Medical Services or the need for Post-Stabilization Services, as defined by 42 CFR Section 438.114(a) of the Balanced Budget Act.

2.1.5.10 The Contractor's Grievance and Appeals process and HFS' Appeal and fair hearing process, including how to register a Complaint, Grievance or Appeal.

2.1.5.11 How to access and receive written and oral information in languages other than English and in alternate language formats, including TDD/TTY.

2.1.5.12 The preferred drug list and how to obtain prescription drugs

2.1.5.13 The Disease Management Program and the services offered and how to access these services

2.1.6 Marketing The Contractor must abide by the requirements in 42 CFR Section 438.104 regarding Marketing activities.

2.1.6.1 Marketing by mail, mass media advertising and community oriented Marketing directed at Potential Enrollees will be allowed subject to the Department's Prior Approval. The Contractor shall be responsible for all costs of mailing, including labor costs. The Department reserves the right to determine and set the sole process of, cost, and payment for Marketing by mail, using names and addresses of Potential Enrollees supplied by the Department, including the right to limit Marketing by mail to a vendor under contract to the Department and the terms and conditions set forth in that vendor contract.

2.1.6.2 Face to face Marketing by the Contractor directed at Participants or Potential Enrollees is strictly prohibited.

2.1.6.3 Inappropriate Marketing Activities. The Contractor shall not:

2.1.6.3.1 provide cash to Potential Enrollees, Prospective Enrollees or Enrollees, except for stipends, in an amount approved by the Department, and reimbursement of expenses provided to Enrollees for participation on committees or advisory groups;

2.1.6.3.2 provide gifts or incentives to Potential Enrollees or Prospective Enrollees unless such gifts or incentives: (1) are also provided to the general public; (2) do not exceed ten dollars ($10) per individual gift or incentive; and (3) have been pre-approved by the Department;

2.1.6.3.3 provide gifts or incentives to Enrollees unless such gifts or incentives (1) are provided conditionally based on the Enrollee receiving preventive care; (2) are not in the form of cash or an instrument that may be converted to cash; and (3) have been pre-approved by the Department;

2.1.6.3.4 seek to influence a Potential Enrollee's enrollment with the Contractor in conjunction with the sale of any other insurance;

2.1.6.3.5 induce Providers or employees of the Department or the Department of Human Services to reveal confidential information regarding Participants or otherwise use such confidential information in a fraudulent manner; or

2.1.6.3.6 threaten, coerce or make untruthful or misleading statements to Potential Enrollees, Prospective Enrollees or Enrollees regarding the merits of enrollment with the Contractor or any other plan.

2.1.7 Notice of Termination. The Contractor must make a good faith effort to give written notice of termination of a Provider, within fifteen (15) days following such termination, to each Enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated Provider.

2.1.8 Communications with the Department. Contractor and Department shall meet at least monthly, and more frequently as needed. Meetings may be conducted in person, by teleconference or by videoconference as directed by the Department.

2.1.9 Communications between Providers and Enrollees. In accordance with the Managed Care Reform and Patient Rights Act (215 ILCS 134), Contractor shall not prohibit or otherwise restrict a Provider from advising an Enrollee about the health status of the Enrollee or medical care or treatment for the Enrollee's condition or disease regardless of whether benefits for such care or treatment are provided under this Contract, if the Provider is acting within the lawful scope of practice, and shall not retaliate against a Provider for so advising an Enrollee.

2.1.10 Network.

2.1.10.1.1 In accordance with 42 CFR, Section 438.206, the Contractor shall establish, maintain and monitor a network of appropriate Providers that is supported by written contracts and is sufficient to provide adequate access to all services under this integrated care model taking into consideration:

2.1.10.1.2 The anticipated number of Enrollees;

2.1.10.1.3 The expected utilization of services, in light of the characteristics, health care needs, behavioral health needs, and overall well being of the Enrollees;

2.1.10.1.4 The number and types of Providers required to furnish Covered Services and any additional services offered by the Contractor;

2.1.10.1.5 The number of Affiliated Providers who are not accepting new Enrollees; and

2.1.10.1.6 The geographic location of Providers and Enrollees, taking into account distance, travel time, the means of transportation and whether the location provides physical access for Enrollees with disabilities.

2.1.10.2 Safety Net Providers. The Contractor is encouraged to contract with safety net Providers including FQHCs, Rural Health Centers, Community Mental Health Centers, other behavioral health safety net Providers, and Certified Local Health Departments to the extent possible and practical. Where these safety net Providers are not utilized, the Contractor shall demonstrate that both adequate capacity and an appropriate range of services for vulnerable populations exist to serve the expected enrollment in the Contracting Area without contracting with safety net Providers.

2.1.10.3 Provision of Covered Services through Affiliated Providers. Where the Contractor does not employ Physicians or other Providers to provide direct health care or other necessary services, every provision in this Contract by which the Contractor is obligated to provide Covered Services of any type to Enrollees, including but not limited to provisions stating that the Contractor will "provide Covered Services," "provide quality care," or provide a specific type of health care service, such as the enumerated Covered Services in Section 2.1.10 shall be interpreted to mean that the Contractor arranges for the provision of those Covered Services through its network of Affiliated Providers.

2.1.11 Covered Services. For information regarding covered services under the Medical Assistance Programs, please visit the following website: http://www.iga.gov/commission/jcar/admincode/089/089001400A00030R.html and http://www.hfs.illinois.gov/assets/100.pdf. At a minimum, the Contractor shall provide the following services for all Enrollees:

2.1.11.1 Service Package I

2.1.11.1.1 Hospital inpatient services;
2.1.11.1.2 Hospital ambulatory services;
2.1.11.1.3 Hospital emergency room visits.
2.1.11.1.4 Ambulatory Surgical Treatment Center services
2.1.11.1.5 FQHCs, RHCs and other Encounter rate clinic visits;
2.1.11.1.6 Physician services;
2.1.11.1.7 Home health agency visits;
2.1.11.1.8 Laboratory and x-ray services;
2.1.11.1.9 Family planning services and supplies;
2.1.11.1.10 Medical supplies, equipment, prostheses and orthoses, and respiratory equipment and supplies;
2.1.11.1.11 Transportation to secure Covered Services;
2.1.11.1.12 Dental services, including oral surgeons, see RFP Attachment B;
2.1.11.1.13 Chiropractic services;
2.1.11.1.14 Podiatric services;
2.1.11.1.15 Optical services and supplies;
2.1.11.1.16 Optometrist services;
2.1.11.1.17 Advanced Practice Nurse services;
2.1.11.1.18 Audiology services;

2.1.11.1.19 Physical, Occupational and Speech Therapy services;
2.1.11.1.20 Renal Dialysis services;
2.1.11.1.21 Respiratory Equipment and Supplies;
2.1.11.1.22 Hospice services;
2.1.11.1.23 EPSDT services for Enrollees under age 21 pursuant to 89 Ill. Admin Code Section 140.485; excluding shift nursing for Enrollees in the MFTD waiver,
2.1.11.1.24 Nursing care for Enrollees under age 21 not in the MFTD waiver, pursuant to 89 Ill. Admin Code Section 140.472;
2.1.11.1.25 Nursing care for the purpose of transitioning children from a hospital to home placement or other appropriate setting for Enrollees under age 21, pursuant to 89 Ill. Adm. Code 146, Subpart D;
2.1.11.1.26 Mental health services provided under the Medicaid Clinic Option or Medicaid Rehabilitation Option; and
2.1.11.1.27 Subacute alcoholism and substance abuse services pursuant to Sections 140.390 through 140.396. [Should be: 89 Ill. Admin Code Sections 148.340 through 148.390 and 77 Ill. Admin Code Part 2090.

2.1.11.2 Service Package II

2.1.11.2.1 Nursing Facility services; and
2.1.11.2.2 Services provided through the HCBS waivers approved under Section 1915(c) of the Social Security Act except the HCBS Waiver for Adults and Children with Developmental Disabilities referenced in Section 3.1.3.11.5. This includes State Plan (non-waiver) nursing services for Enrollees in the MFTD waiver.

2.1.11.3 Service Package III

2.1.11.3.1 ICF/DD Facility services; and
2.1.11.3.2 Services provided through the HCBS waivers for Adults and Children with Developmental Disabilities referenced in RFP Section 3.1.3.11.5.

2.1.12 Excluded Services: The following services are not Covered Services:

2.1.12.1 Pharmacy services;
2.1.12.2 Services provided in a State Operated psychiatric hospital as a result of a forensic commitment; and
2.1.12.3 Services provided through a Local Education Agency (LEA).

2.1.13 Limitations on Covered Services. The following services and benefits shall be limited as Covered Services:

2.1.13.1 Termination of pregnancy shall be provided only as allowed by applicable State and federal law (42 CFR Section 441, Subpart E). In any such case, the requirements of such laws must be fully complied with and Form HFS 2390 must be completed and filed in the Enrollee's medical record. (Termination of pregnancy shall not be provided to Enrollees eligible under the State Children's Health Insurance Program (215 ILCS 106).)

2.1.13.2 Sterilization services may be provided only as allowed by State and federal law (see 42 CFR Section 441, Subpart F). In any such case, the requirements of such laws must be fully complied with and a HFS Form 2189 must be completed and filed in the Enrollee's medical record.

2.1.13.3 If a hysterectomy is provided, a HFS Form 1977 must be completed and filed in the Enrollee's medical record.

2.1.14 Emergency Services. The Contractor shall cover Emergency Services for all Enrollees whether the Emergency Services are provided by an Affiliated or non-Affiliated Provider.

2.1.14.1 The Contractor shall not impose any requirements for Prior Approval of Emergency Services. If an Enrollee calls the Contractor to request Emergency Services, such call shall receive an immediate response.

2.1.14.2 The Contractor shall cover Emergency Services for Enrollees who are temporarily away from their residence and outside the Contracting Area for all Emergency Services to which they would be entitled within the Contracting Area.

2.1.14.3 The Contractor shall have no obligation to cover medical services provided on an emergency basis that are not Covered Services under this Contract.

2.1.14.4 Elective care or care required as a result of circumstances that could reasonably have been foreseen prior to the Enrollee's departure from the Contracting Area is not covered. Unexpected hospitalization due to complications of pregnancy shall be covered. Routine delivery at term outside the Contracting Area, however, shall not be covered if the Enrollee is outside the Contracting Area against medical advice unless the Enrollee is outside of the Contracting Area due to circumstances beyond her

control. The Contractor must educate the Enrollee of the medical and financial implications of leaving the Contracting Area and the importance of staying near the treating Provider throughout the last month of pregnancy. The Contractor shall document that education was provided to the Enrollee if Contractor denies such a claim. In this specific instance, a mass mailing or a topic in the Enrollee Handbook will not be sufficient, unless Contractor has documentation that the topic was specifically reviewed, for example, by the treating Provider or the Care Coordinator.

2.1.14.5 The Contractor shall provide ongoing education to Enrollees regarding the appropriate use of Emergency Services, including intervention by the Care Coordinator.

2.1.14.6 The Contractor shall not condition coverage for Emergency Services on the treating Provider notifying the Contractor of the Enrollee's screening and treatment within ten (10) calendar days after presentation for Emergency Services.

2.1.14.7 The determination by a Physician of whether an Enrollee is sufficiently Stabilized for discharge or transfer to another facility shall be binding on the Contractor.

2.1.15 Post-Stabilization Services. The Contractor shall cover Post-Stabilization Services provided by an Affiliated or non-Affiliated Provider in any of the following situations: (a) the Contractor authorized such services; (b) such services were administered to maintain the Enrollee's Stabilized condition within one (1) hour after a request to the Contractor for authorization of further Post-Stabilization Services; or (c) the Contractor does not respond to a request to authorize further Post-Stabilization Services within one (1) hour, the Contractor could not be contacted, or the Contractor and the treating Provider cannot reach an agreement concerning the Enrollee's care and an Affiliated Provider is unavailable for a consultation, in which case the treating Provider must be permitted to continue the care of the Enrollee until an Affiliated Provider is reached and either concurs with the treating Provider's plan of care or assumes responsibility for the Enrollee's care.

2.1.16 Pre-existing Conditions and Treatment: The Contractor shall assume, upon the effective date of enrollment, full responsibility for any conditions that may have been preexisting prior to enrollment in the HMO and for any existing treatment plans under which an Enrollee on the effective date of enrollment is receiving medical care provided that the Enrollee's HMO PCP determines that such treatment plan is medically necessary for the health and well-being of the Enrollee. Enrollees with preexisting conditions must be evaluated for the appropriateness of Case Management and Disease Management Program inclusion or education.

2.1.17 Continuity of Care. The Contractor must provide continuity of care in accordance with Section 25 of the Managed Care and Patients Rights Act (215 ILCS 134/25).

2.1.17.1 If an Enrollee is receiving medical care or treatment as an inpatient in an acute care hospital on the effective date of enrollment, the Contractor shall assume responsibility for the management of such care and shall be liable for all claims for Covered Services from the effective date of enrollment. For hospital stays that would otherwise be reimbursed under the Medicaid Program by DRGs, the Contractor's liability for the hospital stay is retroactive to the admission date. For hospital stays that would otherwise be reimbursed under the Medicaid Program on a per diem basis, the Contractor's liability shall begin on the effective date of enrollment.

2.1.17.2 If an Enrollee is receiving medical care or treatment as an inpatient in an acute care hospital at the time coverage under this Contract is terminated, the Contractor shall arrange for the continuity of care or treatment for the current episode of illness until such medical care or treatment has been fully transferred to a treating Provider who has agreed to assume responsibility for such medical care or treatment for the remainder of that hospital episode and subsequent follow up care. The Contractor must maintain documentation of such transfer of responsibility of medical care or treatment. For hospital stays that would otherwise be reimbursed under the Medicaid Program by DRGs, the Contractor shall not be liable for payment for any inpatient medical care or treatment provided to an Enrollee where discharge date is after the effective date of disenrollment. For hospital stays that would otherwise be reimbursed under the Medicaid Program on a per diem basis, the Contractor shall be liable for payment for any medical care or treatment provided to an Enrollee until the effective date of disenrollment.

2.1.17.3 If Contractor becomes insolvent or is subject to insolvency proceedings as set forth in 215 ILCS 125/1-1 et seq., the Contractor shall be liable for all claims for Covered Services for the duration of the period for which payment has been made to the Contractor by the Department and shall remain responsible for the management of care provided to all Enrollees until the Contract is terminated.

2.1.18 Coordination of Care for PCP Terminations or Unavailability. The Contractor shall notify Enrollees when their selected PCP is terminated from the Medicaid Program or becomes unavailable for reasons other than termination. The Contractor shall provide written notice to Enrollees within fifteen (15) calendar days from the date a termination notice is issued to the PCP, or from the date the Contractor receives notice from the PCP of non-participation in the HMO or determines PCP unavailability due to other reasons. The notice requires Department Prior Approval.

2.1.19 Authorization of Services. The Contractor shall have in place and follow written policies and procedures when processing requests for initial and continuing authorizations of Covered Services. Such policies and procedures shall ensure consistent application of review

criteria for authorization decisions by a health care professional or professionals with expertise in treating the Enrollee's condition or disease and provide that the Contractor shall consult with the Provider requesting such authorization when appropriate. Contractor must respond to PCP's request for authorization of service within two (2) Business Days after the request, one (1) Business Day for urgent requests. If the Contractor declines to authorize Covered Services that are requested by a Provider or authorizes one or more services in an amount, scope, or duration that are less than that requested, the Contractor shall notify the Provider orally or in writing and shall furnish the Enrollee and Care Coordinator with written notice of such decision. Enrollee's notice shall meet the requirements set forth in 42 CFR Section 438.404. The Contractor shall report to the Department on a monthly basis its timeliness for approval or denial of PCP's Service Authorization Request.

2.1.20 Right of Conscience. The parties acknowledge that pursuant to 745 ILCS 70/1 et seq., a Contractor may choose to exercise a right of conscience by not rendering certain Covered Services. Should the Contractor choose to exercise this right, the Contractor must promptly notify the Department in writing of its intent to exercise its right of conscience in writing. Such notification shall state the services that the Contractor is unable to render pursuant to the exercise of the right of conscience. The Parties agree that at that time the Department shall adjust the Capitation payment to the Contractor and amend the contract accordingly. Should the Contractor choose to exercise this right, the Contractor must notify Potential Enrollees, Prospective Enrollees and Enrollees that it has chosen to not render certain Covered Services. This notice to Potential Enrollees, Prospective Enrollees and Enrollees requires Department Prior Approval. The Contractor must provide notification as follows:

2.1.20.1 To Potential Enrollees, prior to enrollment;
2.1.20.2 To Prospective Enrollees, during enrollment; and
2.1.20.3 To Enrollees, within ninety (90) days after adopting a policy with respect to any particular service that previously was a Covered Service.

2.1.21 Advance Directives. Contractor shall comply with all rules concerning the maintenance of written policies and procedures with respect to Advance Directives as promulgated by Federal CMS as set forth in 42 CFR Section 422.128. Contractor shall provide Enrollees with oral and written information on Advance Directives policies, and include a description of applicable State law. Care Coordinators shall work with Enrollees to help them understand the advantages of Advance Directives. Such information shall reflect changes in State law as soon as practicable, but no later than ninety (90) days after the effective date of the change.

2.1.22 Enrollee Verification Procedure. The Contractor will have in place a method for verifying with Enrollees whether services billed by Providers were received, as required by 42 CFR Section 455.20. The Contractor will submit its plan to the Department for Prior Approval no later than sixty (60) days after the effective date of the Contract.

2.1.23 Quality Assurance. The Contractor shall provide for the delivery of quality care with the primary goal of improving the health status of Enrollees and, where the Enrollee's condition is not amenable to improvement, maintain the Enrollee's current health status by implementing measures to prevent any further decline in condition or deterioration of health status. The Contractor must work in collaboration with Providers to actively improve the quality of care provided to Enrollees, consistent with its Quality Program, its quality improvement goals, the State's Quality Strategy, and all other requirements of the Contract. The Contractor must provide mechanisms for Enrollees and Providers to offer input into the Contractor's quality improvement activities.

2.1.23.1 Quality Program: Quality Assessment and Performance Improvement (QAPI) Program Activities. The Contractor must develop, maintain and operate a Quality Program that focuses on on-going quality assessment and performance improvement activities consistent with the Contract, and meet the requirements of 42 CFR Section 438.240. The QAPI program shall:
2.1.23.1.1 be consistent with the utilization control requirements of 42 CFR Section 456;
2.1.23.1.2 provide for ongoing and comprehensive review by appropriate health professionals of the process followed in providing health services;
2.1.23.1.3 provide for systematic data collection of performance and Enrollee results;
2.1.23.1.4 provide for interpretation of this data to the Provider; and
2.1.23.1.5 provide for making needed changes.

2.1.23.2 Performance Improvement Projects (PIPs). The Contractor shall perform performance improvement projects (PIPs) following Federal CMS protocols, designed to achieve, through ongoing measurements and intervention, significant improvement of the quality of care rendered, sustained over time, and resulting in a favorable effect on health outcomes and Enrollee satisfaction. The Contractor shall ensure that the following are documented for each PIP activity:
2.1.23.2.1 rationale for selection of the PIP topic as a QI activity;
2.1.23.2.2 study questions and indicators;
2.1.23.2.3 specific population targeted, including sampling methodology;
2.1.23.2.4 data collection and metrics to determine meaningful improvement and baseline measurement;
2.1.23.2.5 barrier analysis and interventions;
2.1.23.2.6 relevant clinical practice guidelines;
2.1.23.2.7 re-measurement dates and meaningful sustained improvement; and
2.1.23.2.8 as needed revisions to interventions should meaningful improvement not occur.

2.1.23.3 Clinical Practice Guidelines. The Contractor must adopt evidence-based clinical practice guidelines. Such practice guidelines must be based on valid and reliable clinical evidence, consider the needs of the Enrollees, be adopted in consultation with contracting health care professionals, and be reviewed and updated periodically, as appropriate. The Contractor must develop practice guidelines based on the needs and opportunities for improvement identified as part of its QAPI Program.

2.1.23.4 Enrollee Satisfaction Survey. The Contractor shall annually conduct an Enrollee Satisfaction Survey specifically designed for the Participants served in the Integrated Care Program. The Department will determine the survey instrument with input from the Contract. Contractor must contract with an NCQA-Certified HEDIS Survey vendor to administer the survey and submit results according to the HEDIS survey specifications. The Contractor shall submit its findings and explain what actions it will take on its findings as part of the comprehensive Annual QA/UR/PR Report.

2.1.23.5 Quality Measures. The Contractor shall report on-going quality measures as defined by the Department (see Attachment E). These measures have been selected to improve patient outcomes through the ongoing development and implementation of quality improvement strategies.

2.1.23.6 Utilization Management. The Contractor shall develop and maintain a utilization management (UM) program. As part of this program, the Contractor shall have policies and procedures with defined structures and processes. The UM program shall assign responsibility to appropriate individuals including a designated senior Physician and shall involve a designated behavioral health care practitioner in the implementation of behavioral health aspects of the program. The UM program shall be supported by an associated work plan and shall be evaluated annually and updated as necessary. The UM program shall have criteria that:

2.1.23.6.1 are objective and based on medical and/or behavioral health evidence;
2.1.23.6.2 are applied based on individual needs;
2.1.23.6.3 are applied based on an assessment of the local delivery system;
2.1.23.6.4 involve appropriate Providers in developing, adopting and reviewing them; and
2.1.23.6.5 are annually reviewed and updated as appropriate.

2.1.23.7 External Quality Review (EQR). The Contractor shall fully cooperate with External Quality Review and Department oversight and monitoring. Such activities will include external evaluations and assessments of its performance as authorized by the Department and conducted by the Department's contracted External Quality Review Organization (EQRO) or other designee. Independent assessment will include, without limitation, any independent evaluation required or allowed by federal or state statute or regulation. Such activities include:

2.1.23.7.1 Annual Quality Assurance Desk Review, with a comprehensive on site External Quality Review every three years. Such review will include oversight of the Contractor's processes to ensure that level of care policies and procedures are appropriate, and are being carried out accordingly.
2.1.23.7.2 Quarterly face-to-face meetings with the EQRO and Department for ongoing monitoring and focus on quality improvement.
2.1.23.7.3 Quarterly monitoring review of the level of care determinations made by the Contractor based on a statistically valid sample.
2.1.23.7.4 Quarterly monitoring review of Enrollee Care Plans developed by the Contractor based on a statistically valid sample.
2.1.23.7.5 Monthly telephonic conferences with the EQRO and Department regarding carrying out its QM Management Program, quality improvement activities, PIPs, and performance measures.
2.1.23.7.6 Participation in requirements, as specified by the Department or EQRO, relative to validation of performance measures and PIPs.

2.1.23.8 Grievance Procedure and Appeal Procedure.

2.1.23.8.1 Grievance. The Contractor shall establish and maintain a procedure for reviewing Grievances registered by Enrollees. All Grievances shall be registered initially with the Contractor and may later be appealed to the Department. The Contractor's procedures must: (1) be submitted to the Department in writing and approved in writing by the Department; (2) provide for prompt resolution, and (3) assure the participation of individuals with authority to require corrective action. The Contractor must have a Grievance Committee for reviewing Grievances registered by its Enrollees, and Enrollees must be represented on the Grievance Committee. At a minimum, the following elements must be included in the Grievance process:

2.1.23.8.1.1 An informal system, available internally, to attempt to resolve all Grievances;

2.1.23.8.1.2 A formally structured Grievance system that is compliant with Section 45 of the Managed Care Reform and Patient Rights Act and 42 CFR Section 438 Subpart F to handle all Grievances subject

to the provisions of such sections of the Act and regulations (including, without limitation, procedures to ensure expedited decision making when an Enrollee's health so necessitates)

2.1.23.8.1.3 A formally structured Grievance Committee must be available for Enrollees whose Grievances cannot be handled informally and are not appropriate for the procedures set up under the Managed Care Reform and Patient Rights Act. All Enrollees must be informed that such a system exists. Grievances at this stage must be in writing and sent to the Grievance Committee for review;

2.1.23.8.1.4 The Grievance Committee must have at least one (1) Enrollee of Contractor's services under this Contract on the Committee. The Department may require that one (1) member of the Grievance Committee be a representative of the Department;

2.1.23.8.1.5 Final decisions under the Managed Care Reform and Patient Rights Act procedures and those of the Grievance Committee may be appealed by the Enrollee to the Department under its Fair Hearings system;

2.1.23.8.1.6 A summary of all Grievances heard by the Grievance Committee and by independent external reviewers and the responses and disposition of those matters must be submitted to the Department quarterly;

2.1.23.8.1.7 An Enrollee may appoint a guardian, caretaker relative, PCP, WHCP, or other Physician treating the Enrollee to represent him throughout the Grievance process.

2.1.23.8.2 Appeals. The Contractor shall establish and maintain a procedure for reviewing Appeals made by Enrollees or Providers on behalf of Enrollees. All Appeals shall be registered initially with the Contractor and may later be appealed to the Department. The Contractor's procedures must: (1) be submitted to the Department in writing and approved in writing by the Department; (2) provide for prompt resolution, and (3) assure the participation of individuals with authority to require corrective action. The Contractor must have a committee in place for reviewing Appeals made by its Enrollees. At a minimum, the following elements must be included in the Appeal process:

2.1.23.8.2.1 A system that allows an Enrollee or Provider to file an Appeal either orally or in writing, within a reasonable period of time following the date of the notice of Action that generates such Appeal, which reasonable period of time shall not be less than twenty (20) days nor more than ninety (90) days; provided that the Contractor may require an Enrollee or Provider to follow an oral Appeal with a written, signed Appeal unless the Enrollee or Provider has requested review on an expedited basis;

2.1.23.8.2.2 A formally structured Appeals system that is compliant with Section 45 of the Managed Care Reform and Patient Rights Act and Subpart F of Section 438 of the Code of Federal Regulations to handle all Appeals subject to the provisions of such sections of the Act and CFR (including, without limitation, procedures to ensure expedited decision making when an Enrollee's health so necessitates and procedures allowing for an external independent review of Appeals that are denied by the Contractor);

2.1.23.8.2.3 Final decisions of Appeals not resolved wholly in favor of the Enrollee may be appealed by the Enrollee to the Department under its Fair Hearings system;

2.1.23.8.2.4 A summary of all Appeals filed by Enrollees and the responses and disposition of those matters (including decisions made following an external independent review) must be submitted to the Department quarterly;

2.1.23.8.2.5 An Enrollee may appoint a guardian, caretaker relative, PCP, WHCP, or other Physician treating the Enrollee to represent him throughout the Appeal process.

2.1.23.8.2.6 The Contractor agrees to review its Grievance and Appeal procedures, at regular intervals, for the purpose of amending same when necessary. The Contractor shall amend the procedures only upon receiving the prior written consent of the Department. The Contractor further agrees to supply the Department and/or its designee with the information and reports prescribed in its approved procedure. This information shall be furnished to the Department upon its request.

2.1.23.8.2.7 The Contractor shall establish a Complaint and resolution system for Providers that includes a Provider dispute process.

2.1.24 Timely Payments to Providers. The Contractor shall make payments to Providers for Covered Services on a timely basis consistent with the Claims Payment Procedure described at 42 U.S.C. § 1396a(a)(37)(A) and Illinois Public Act 91-0605. Complaints or disputes concerning payments for the provision of services as described in this paragraph shall be subject to the Contractor's Provider Grievance resolution system. In particular, the Contractor must pay 90 percent (90%) of all "clean claims" from Providers within thirty (30) days following receipt. Further, the Contractor must pay 99 percent (99%) of all "clean claims" from Providers within ninety (90) days following receipt. A "clean claim" means one that can be processed without obtaining additional information from the Provider who provided the service or from a third party, except that it shall not mean a claim submitted by or on behalf of a Provider who is under investigation for Fraud or Abuse, or a claim that is under review for medical necessity.

2.1.24.1 The Contractor shall pay for all appropriate Emergency Services rendered by a non-Affiliated Provider within thirty (30) days after receipt of a complete and correct claim. If the Contractor determines it does not have sufficient information to make payment, the Contractor shall request all necessary information from the non-Affiliated Provider within thirty (30) days following receiving the claim, and shall pay the non-Affiliated Provider within thirty (30) days following receiving such information. Such payment shall be made at the same rate the Department would pay for such services according to the level of services provided. Determination of appropriate levels of service for payment shall be based upon the symptoms and condition of the Enrollee at the time the Enrollee is initially examined by the non-Affiliated Provider and not upon the final determination of the Enrollee's actual medical condition, unless the actual medical condition is more severe. Within the time limitation stated above, the Contractor may review the need for, and the intensity of, the services provided by non-Affiliated Providers.

2.1.24.1.1 The Contractor shall pay for all Post-Stabilization Services as a Covered Service in the situations described in Section 2.1.14 above.

2.1.24.1.2 The Contractor shall pay for all Emergency Services and Post-Stabilization Services rendered by a non-Affiliated Provider, for which the Contractor would pay if rendered by an Affiliated Provider, at the same rate the Department would pay for such services exclusive of disproportionate share payments and Medicaid percentage adjustments, unless a different rate was agreed upon by the Contractor and non-Affiliated Provider.

2.1.24.1.3 The Contractor shall accept claims from non-Affiliated Providers for at least one (1) year after the date the services are provided. The Contractor shall not be required to pay for claims initially submitted by such non-Affiliated Providers more than one (1) year after the date of service.

2.1.25 Fees to Enrollees Prohibited.

2.1.25.1 Neither Contractor nor its sub-contractors, Affiliated Providers, or non-Affiliated Providers shall seek or obtain funding through fees or charges to any Enrollee receiving Covered Services pursuant to this Contract, except as permitted or required by the Department in 89 Ill. Adm. Code 125 or the Department's Medical Program co-payment policy in effect at the time services are provided. Contractor acknowledges that imposing charges in excess of those permitted under this Contract is a violation of §1128B(d) of the Social Security Act and subjects Contractor to criminal penalties.

2.1.25.2 The Contractor may charge co-payments to Enrollees in a manner consistent with 89 Ill. Adm. Code, Part 125 or the Department's Fee-For-Service co-payment policy then in effect. If the Contractor desires to charge such co-payments, the Contractor must provide written notice to the Department before charging such co-payments. Such written notice to the Department shall include a copy of the policy the Contractor intends to give the Providers in its network. This policy must set forth the amount, manner, and circumstances in which co-payments may be charged. Such policy is subject to the prior written approval of the Department. In the event the Contractor wishes to impose a charge for co-payments after enrollment of a Participant, it must first provide at least sixty (60) days prior written notice to such Participant. The Contractor shall be responsible for promptly refunding to a Participant any co-payment that, in the sole discretion of the Department, has been inappropriately collected for Covered Services.

2.1.26 Physician Incentive Plan Regulations. Contractor shall comply with the provisions of 42 CFR Section 422.208 and 422.210. If, to conform to these regulations, the Contractor performs Enrollee satisfaction surveys, such surveys may be combined with those required by the Department pursuant to Section 2.1.22.4 of this Model Contract.

2.1.27 Computer System Requirements.

2.1.27.1 The Contractor must establish and maintain a computer system compatible with the Department's system, and, if required, execute an electronic communication agreement provided by the Department. All costs associated with the data exchange software shall be borne by the Contractor.

2.1.27.2 The Contractor shall establish and maintain a communication link with the Department. Specifications for data security are as follows:

2.1.27.2.1 Third Party Network (TPN) or Internet Connection. The line connection to the Illinois Department of Central Management Services (DCMS) data center must either be through the private State telecommunications network to the DCMS Third Party Network (TPN) or through a secure connection via the Internet. The secure connection over the Internet will be via Site-to-Site Virtual Private Network (VPN).

2.1.27.2.2 Private State Telecommunications Network Requirements. If the Contractor chooses to connect through the private State telecommunications network, the Department must submit the orders to DCMS for processing, design, installation and configuration of the connection for the Contractor. The Contractor must supply information concerning the circuit termination point, onsite contact, and other information required for the order to be submitted to DCMS for processing and installation by the appropriate DCMS contractor. The Contractor must provide authorized Department personnel access to the location and the phone demark for the location where the circuit is to be installed.

2.1.27.2.3 Internet Site-to-Site VPN Requirements. If the Contractor chooses to connect through secure connections via the Internet, the connection must be made using Site-to-Site VPN. In this type of connection, the Contractor will be responsible for the cost of the connection between the Contractor and its Internet Service Provider (ISP), troubleshooting and any redundancy requirements associated with the Contractor's connection to the Internet or for Disaster recovery. The Contractor will also be responsible to procure, install, and support, any VPN equipment required at the Contractor's location to support secure site-to-site VPN communications via the Internet with DCMS. The Department will coordinate with the Contractor to ensure that any authorization/certificate paperwork required for the establishment of the VPN connection is completed. DCMS currently utilizes a Cisco 7600 series router with IPSEC accelerators to provide VPN connections to the DCMS data center. For VPN authentication, DCMS uses "pre-shared keys". DCMS performs a Network Address Translation (NAT) of all external addresses to make the connection conform to its IP addressing structure. Only STATIC IP addresses, no subnet pool addresses, from the Contractor's network are allowed by DCMS.

2.1.27.3 Illinois Department of Central Management Services Supported Encryption Configurations: Phase 1 IKE Properties (ISAKMP Protection Suites):

2.1.27.3.1 Encryption Algorithm.
2.1.27.3.2 Triple-DES (3DES).
2.1.27.3.3 Advanced Encryption Standard (AES) preferred
2.1.27.3.4 Data Integrity.
2.1.27.3.5 Hashing Algorithm: SHA or MD5 supported (MD5 is preferred).
2.1.27.3.6 Diffie-Hellman Group: Group 5 supported only.
2.1.27.3.7 Security Association Lifetime: 86400 seconds.

2.1.27.4 Illinois Department of Central Management Services Supported Encryption Configurations: Phase 2 IPSEC Properties:

2.1.27.4.1 Encryption Algorithm.
2.1.27.4.2 Triple-DES (3DES).
2.1.27.4.3 Advanced Encryption Standard (AES) preferred
2.1.27.4.4 Data Integrity.
2.1.27.4.5 Hashing Algorithm: SHA or MD5 supported (MD5 is preferred).
2.1.27.4.6 Perfect Forward Secrecy: Disabled.

2.1.27.5 Exchanging Configuration Information. The Department will work with the Contractor to determine the configuration and define any connection parameters between the Contractor and the DCMS data center. This will include any security requirements DCMS requires for the specific connection type the Contractor is using. The Contractor is required to work with both the Department and DCMS in exchanging configuration information required to make the connection secure and functional for all parties.

2.1.27.6 Transmission Control Protocol/Internet Protocol (TCP/IP). The Contractor shall cooperate in the coordination of the interface with DCMS and the Department. TCP/IP (Transmission Control Protocol/Internet Protocol) must be used for all connections from the Contractor to the DCMS data center.

2.1.27.7 Firewall Devices. The Contractor shall be responsible for the installation, configuration, and troubleshooting of any firewall devices required on the Contractor's side of the data communication link.

2.1.27.8 The Contractor must provide staff with proficient knowledge in telecommunications to ensure communication connectivity is established and maintained. The Contractor shall be responsible for performing Network Address Translation ("NAT") to facilitate connectivity and security protecting the Contractor's network.

2.1.27.9 The Contractor shall work with the Department to implement changes in technology as they become available to the Department. Any costs associated with the Contractor's side of processing, connectivity and/or changes to the manner in which the Contractor processes data for the Department shall be borne solely by the Contractor. The Contractor will work with the Department to resolve any issues related to these changes.

2.1.27.10 The Contractor shall retrieve and process all HIPAA transactions made available by the Department, including the 997, 824 and TA1 functional acknowledgments and 820 and 834 and, when implemented, the 835 remittance advice. The Contractor shall retrieve and process any proprietary files made available by the Department.

2.1.28 Readiness Review. Approximately sixty (60) days after Contract Effective Date, the Department will conduct a Readiness Review for Service Package I, after which the Department may approve Contractor for Enrollment. Contractor must receive Prior Approval of all submission and demonstration requirements prior to initiating enrollment. The Department may conduct the Readiness Review or may conduct the Readiness Review jointly with its EQRO agent. The EQRO may conduct separate Readiness Review. This Readiness Review may be conducted at Contractor's location or remotely. The HFS Readiness Review will include, but not be limited to a review of the contractor's operations, information system demonstration and systems testing, and interviews with HMO staff and network Providers. At the Readiness Review, Contractor shall submit for Department Prior Approval its Provider Directory, Provider Handbook, Enrollee Handbook, Training Manuals, and Contractor's Operations, Policies and Procedures Manuals. These manuals may be in draft form; however, Contractor must notify the Department prior to the Readiness Review which materials will not be in final form. At the Readiness Review, Contractor must provide a firm date by which it will submit the material in its final form to the Department for Prior Approval. Failure to meet these submittal dates may result in Department sanction.

2.1.28.1 Prior to the Readiness Review, Contractor shall submit, at a minimum, the materials listed below for Department review and approval to ensure that each process or item fully and consistently meets the Department's contractual requirements.

2.1.28.1.1 Contractor's Business Continuity and Disaster Recovery Plan;
2.1.28.1.2 Contractor's final Complaint Resolution Process;
2.1.28.1.3 Contractor's plan for hiring and training Care Coordinators;
2.1.28.1.4 Contractor's plan for recruiting Providers;
2.1.28.1.5 Contractor's phone and data systems reporting capabilities; and
2.1.28.1.6 Contractor's quality assurance and monitoring processes.

2.1.28.2 As part of the Readiness Review, Contractor shall demonstrate to the Department:

2.1.28.2.1 Contractor's data system meets all requirements, including data collection and reporting capabilities.
2.1.28.2.2 Contractor has hired Care Coordinator supervisory and management staff.

2.1.28.3 Contractor shall have an opportunity to make corrections prior to Implementation Date and will be required, upon request of the Department, to submit documentation to the Department that corrections have been made.

2.1.28.4 If Contractor is not ready to accept enrollment at the end of the Implementation Period, Contractor's failure may result in Department sanction.

2.1.28.5 Once the Department determines that Contractor has successfully met the requirements of the Readiness Review, Contractor may begin accepting enrollments at the end of the Implementation Period. The Department's determination shall be in writing.

2.1.28.6 The same requirements for Readiness Review herein shall apply to the implementation of Service Package II and Service Package III. The Readiness Reviews for Service Package II and Service Package III will begin 90 days prior to the anticipated implementation date.

2.1.29 Stakeholder Input. During the implementation period, Contractor will be required to participate in stakeholder advisory committees in order to plan transition and implementation.

2.1.30 Regular Information Reporting Requirements. The Contractor shall submit to the Department, or its designee regular reports and additional information as set forth in this Section. The Contractor shall ensure that data received from Providers and included in reports are accurate and complete by (1) verifying the accuracy and timeliness of reported data; (2) screening the data for completeness, logic, and consistency; and (3) collecting service information in standardized formats to the extent feasible and appropriate. All data collected by the Contractor shall be available to the Department and Authorized Persons. Such reports and information shall be submitted in a format and medium designated by the Department. The following terms shall have the following meanings: "annual" shall be defined by the State

fiscal year beginning July first of each year and ending on but including June thirtieth of the following year; and "quarter" shall be defined as three consecutive calendar months of the State's fiscal year. Unless otherwise specified, the Contractor shall submit all reports to the Department or its designee within thirty (30) days after the last day of the reporting period. The Department shall advise the Contractor of the appropriate format for such reports and information submissions in a written communication.

2.1.30.1 Disclosure Statements. The Contractor shall submit disclosure statements to the Department initially, annually, on request and as changes occur.

2.1.30.2 Encounter Data.

2.1.30.2.1 Submission. The Contractor must report all services received by Enrollees including services reimbursed by Contractor through a Capitation arrangement. On a monthly basis, the Contractor shall provide the Department with HIPAA Compliant transactions, including the 837D, the 837P and the NCPDP1.1 in the format and medium designated by the Department, prepared with claims level detail as required herein for all non-institutional Provider services received by Enrollees during a given month. For institutional Provider services, the Contractor shall provide to the Department the 837I HIPAA Compliant transaction with only those services paid by or on behalf of the Contractor. This data must be accepted by the Department within one hundred twenty (120) days after the Contractor's payment or final rejection of the claim or, for services paid through a Capitation arrangement, within 150 days after the date of service. The Contractor shall work with the Department to develop the protocol and requirements for submission of detailed data for any non-covered or Covered Services provided by the Contract that cannot be submitted through standards transactions, so this data may be captured in the Department's data warehouse. Any claims processed by the Contractor for services provided in a given report month subsequent to submission of the monthly Encounter Data Report shall be reported on the next submission of the monthly Encounter Data Report.

2.1.30.2.2 Testing. Upon receipt of each submitted data file, the Department shall perform two distinct levels of review:

2.1.30.2.2.1 The first level of review and edits performed by the Department shall check the data file format. These edits shall include, but are not limited to the following: check the data file for completeness of records; correct sort order of records; proper field length and composition; and correct file length. To be accepted by the Department, the format of the file must be one hundred percent (100%) correct.

2.1.30.2.2.2 If the format is correct, the Department shall then perform the second level of review. This second review shall be for standard claims processing edits. These edits shall include, but are not limited to the following: correct Provider numbers; valid recipient identification numbers; valid procedure and diagnosis codes; cross checks to assure Provider and recipient numbers match their names; and the procedures performed are correct for the age and sex of the recipient. The acceptable error rate of claims processing edits of the encounter data provided by the Contractor shall be determined by the Department. Once an acceptable error rate has been achieved, as determined by the Department, the Contractor shall be instructed that the testing phase is complete and that data should be sent in production.

2.1.30.2.3 Production. Once the Contractor's testing of data specified in Section 2.1.29.2.2 above is completed, the Contractor will be certified for production. Once certified for production, the data shall continue to be submitted in accordance with this Section. The data will continue to be reviewed for correct format and quality. The Contractor shall submit as many files as possible in a time frame agreed upon by the Department and the Contractor, to ensure all data is current.

2.1.30.2.4 Records that fail the edits described above in testing or production will be returned to the Contractor for correction. Corrected data must be returned to the Department for re-processing.

2.1.30.3 Financial Reports. The Contractor shall provide the Department with copies of all financial reports the Contractor is required to file with the Illinois Department of Financial and Professional Regulation.

2.1.30.4 Report of Transactions with Parties of Interest. The Contractor shall report to the Department all "transactions" with a "party of interest" (as such terms are defined in Section 1903(m)(4)(A) of the Social Security Act and SMM 2087.6(A-B)), as required by Section 1903(m)(4)(A) of the Social Security Act.

2.1.30.5 Electronic Data Certification. In a format determined by the Department, the Contractor shall certify by the 5th day of each month that all electronic data submitted during the previous calendar month is accurate, complete and true.

2.1.30.6 Enrollee Materials. In addition to the submission requirements described below, the Contractor must maintain documentation verifying that the information conveyed in the following categories of Enrollee materials are reviewed on an ongoing basis for accuracy and updated as needed.

2.1.30.6.1 Certificate or Document of Coverage and Any Changes or Amendments. The Contractor shall submit these documents to the Department for Prior Approval initially and as revised.

2.1.30.6.2 Enrollee Handbook(s). The Contractor shall submit the handbook to the Department for Prior Approval initially and as revised. The Contractor shall not be required to submit for Prior Approval format changes, provided there is no change in the information conveyed.

2.1.30.6.3 Identification Card. The Contractor shall submit the identification card to the Department for Prior Approval initially and as revised. The Contractor shall not be required to submit for Prior Approval format changes, provided there is no change in the information conveyed.

2.1.30.6.4 Provider Directory. The Contractor shall submit the Provider Directory applicable to Enrollees to the Department for review initially, and annually thereafter.

2.1.30.7 Fraud and Abuse Report. The Contractor shall report all suspected Fraud and Abuse as required by the Contract.

2.1.30.8 Marketing Reports.

2.1.30.8.1 Marketing Gifts and Incentives. The Contractor shall submit all Marketing Materials to the Department for Prior Approval initially and as revised.

2.1.30.8.2 Marketing Materials. The Contractor shall submit all Marketing Materials to the Department for Prior Approval initially and as revised. The Contractor shall not be required to submit for Prior Approval format changes, provided there is no change in the information conveyed.

2.1.30.8.3 Marketing Plans and Procedures. The Contractor shall submit descriptions of proposed Marketing concepts, strategies, and procedures for approval initially and as revised.

2.1.30.9 Provider Network Reports.

2.1.30.9.1 PCP, hospital, and Affiliated Provider File. The Contractor shall submit to the Department or the ICEB, in a format and medium designated by the Department, a weekly electronic file of the Contractor's PCPs. Contractor shall electronically submit changes to the file as changes occur. The file shall include:

2.1.30.9.1.1 Provider name, Provider number, office address, and telephone number;
2.1.30.9.1.2 Type of specialty (e.g., family practitioner, internist, oncologist, etc.), subspecialty if applicable, and treatment age ranges;
2.1.30.9.1.3 Identification of group practice, if applicable;
2.1.30.9.1.4 Geographic service area;
2.1.30.9.1.5 Areas of board-certification, if applicable;
2.1.30.9.1.6 Language(s) spoken by Provider and/or office staff;
2.1.30.9.1.7 Office hours and days of operation;
2.1.30.9.1.8 Special services offered to the deaf or hearing impaired (i.e., sign language, TDD/TTY, etc.);
2.1.30.9.1.9 Wheelchair accessibility status (e.g., parking, ramps, elevators, automatic doors, personal transfer assistance, etc.);
2.1.30.9.1.10 PCP indicator;
2.1.30.9.1.11 PCP gender and panel status (open or closed); and
2.1.30.9.1.12 PCP hospital affiliations, including information about where the PCP has admitting privileges or admitting arrangements and delivery privileges (as appropriate).

2.1.30.9.2 Provider Affiliation with Sites Report. The Contractor shall submit to the Department a monthly Provider Affiliation with Sites report as set forth in the format given to the Contractor by the Department; monthly updating of all Providers who have either become a Provider in the Contractor's network or who have left the network since the last report.

2.1.30.9.3 Provider Network Submissions. The Contractor shall submit to the Department, in a format and medium designated by the Department, Provider network reports that shall include, without limitation, the following: new site Provider Affiliations as new sites are added; site terminations immediately as they occur; and Enrollee site

transfers as they occur. New site/PCP information shall be reported in a format and medium as required by the Department.

2.1.30.10 Quality Assurance Reports.

2.1.30.10.1 Grievance Procedures. The Contractor shall submit Grievance Procedures to the Department for Prior Approval initially and as revised. The Contractor shall not be required to submit for Prior Approval format changes, provided there is no change in the information conveyed.

2.1.30.10.2 Primary Care Provider Ratio Report. The Contractor shall submit a quarterly report that provides the number of Enrollees assigned to each PCP and WHCP (by Site) and the Affiliated and unaffiliated hospitals to which the PCP has admitting and/or delivery privileges in a format provided by the Department.

2.1.30.10.3 Quality Assurance, Utilization Review and Peer Review Annual Report (QA/UR/PR Annual Report). The Contractor shall submit a QA/UR/PR Annual Report on a yearly basis, no later than sixty (60) days following the close of the Contractor's reporting period. This report shall provide a summary review of the effectiveness of the Contractor's Quality Assurance Plan. The summary review shall contain the Contractor's processes for quality assurance, utilization review and peer review. Included with this report shall be a comprehensive description of the Contractor's Provider network and an annual work plan outlining the Contractor's intended activities relating to quality assurance, utilization review, peer review and health education.

2.1.30.10.4 QA/UR/PR Committee Meeting Minutes. The Contractor shall submit the minutes of these meetings to the Department on a quarterly basis.

2.1.30.10.5 QA/UR/ PR Health Education Plans. The Contractor shall submit such plans to the Department for Prior Approval initially and as revised. The Contractor shall not be required to submit for Prior Approval format changes, provided there is no change in the information conveyed.

2.1.30.10.6 Summary of Resolutions of Grievance or Appeals and External Independent Reviews. The Contractor shall submit a quarterly report, in a format provided by the Department that provides a summary of the Grievances or Appeals filed by Enrollees and the resolution of such Grievances or Appeals as well as a summary of all external independent reviews and the resolution of such reviews. The report shall include types of Grievances or Appeals and external independent reviews by category and totals, the number and levels at which the Grievances or Appeals were resolved, the types of resolutions and the number pending resolution by category.

2.1.30.10.7 Case Management/Disease Management Program Plan. The Contractor shall submit its Case Management/ Disease Management Program Plan to the Department for Prior Approval initially and as revised. The Contractor shall not be required to submit for Prior Approval format changes, provided there is no change in the information conveyed.

2.1.30.10.8 Case Management/Disease Management Program Summary Report. The Contractor shall submit a summary report of all Enrollees, including CSHCN Enrollees, who are in the Contractor's Disease Management Program and Case Management Plan. The Department shall provide the report's format and required content. This report shall include a detailed spreadsheet of all Enrollees, including CSHCN Enrollees, who are case managed by the Contractor on a monthly basis.

2.1.30.10.9 CSHCN Plan. The Contractor shall submit its CSHCN Plan to the Department for Prior Approval initially and as revised. The Contractor shall not be required to submit for Prior Approval format changes, provided there is no change in the information conveyed.

2.1.30.10.10 Recall Systems Plan. The Contractor shall submit for Department prior approval, initially and as revised, its plan for Enrollee recall systems for missed services including missed appointments for Chronic Health Conditions and behavioral health follow-up.

2.1.30.11 Subcontracts and Provider Agreement Reporting

2.1.30.11.1 Executed Subcontracts and Provider Agreements. The Contractor shall provide copies of any subcontract and Provider agreement to the Department upon request.

2.1.30.11.2 Model Subcontracts and Provider Agreements. The Contractor shall provide copies of model subcontracts and Provider agreements related to Covered Services, assignment of risk and data reporting functions, including

the form of all proposed schedules or exhibits, intended to be used therewith, and any substantial deviations from these model subcontracts and Provider agreements to the Department initially and as revised.

2.1.30.12 Additional Reports. The Department shall require additional reports when Service Package II and Service Package III are implemented, based on State and Federal institutional and HCBS waiver reporting requirements. The Department may require additional reports throughout the term of the Contract, and the Contractor shall submit additional reports or submissions at the frequency determined by the Department. The Department will provide adequate notice before requiring production of any new reports or information, and will consider concerns raised by the Contractor about potential burdens associated with producing the proposed additional reports. The Department will provide the reason for any such request.

2.1.31 Program Integrity.

2.1.31.1 Contractor must establish an effective prepayment and post payment review process including but not limited to data analysis, system editing, and auditing of network providers.

2.1.31.1.1 Contractor shall develop and execute an audit program for network providers who perform and are paid for services under this plan.

2.1.31.1.2 Contractor must submit an annual audit plan to the OIG of mutually agreed upon audits of Providers based on Contractor's data analysis and selection criteria.

2.1.31.1.3 Contractor shall be responsible for all activities under its audit plan, including but not limited to selection, notification, auditing, and preparation of required audit reports. The audit results are to be reported to the OIG as completed.

2.1.31.1.4 Contractor shall report audit activity and summary results on a monthly basis. Detailed audit reports will be submitted electronically within 10 business days of completion and will include the audit report and results files. Audit working papers shall be available for review by the OIG upon request.

2.1.31.1.5 Contractor is responsible for collecting overpayments identified in an audit. Recoupments will offset expenses reported to the Department and will be included in the calculation of future capitation rates.

2.1.31.1.6 At the request of the Department, Contractor shall testify for the Department in any administrative or judicial proceeding brought to resolve any disputed audit findings.

2.1.31.2 This section of the Contract does not in any way limit the right or ability of the Department or Authorized Persons from auditing, reviewing, or investigating any entity participating in Contractor's program, including reviews, audits, and investigations of Contractor itself.

2.1.31.2.1 Contractor shall cooperate, facilitate, and support any such reviews, audits, and investigations.

2.1.31.2.2 Contractor's contracts with any subcontractors or network members will in no way limit these rights.

2.1.31.3 OIG reserves the right to continue to perform audits and other reviews of network providers, and to initiate the resulting recoupment actions as it currently does. The Contractor's contract with network members or any subcontractor shall in no way limit the Department's rights to take these actions. Based upon the outcomes of these audits or reviews, the Department may initiate recovery actions directly against the network providers. The amount to be recovered will be based on the amount paid by the Contractor to the network provider for the service rendered. This paragraph will in no way limit the OIG from conducting audits in a different manner than is presently employed. The Department's standard process involves the following:

2.1.31.3.1 Selection of a random sample of claims from the universe of all paid claims for that provider;

2.1.31.3.2 Auditing of the sample records to determine the extent of overpayments;

2.1.31.3.3 Extrapolation of in-sample overpayment dollars to the universe of claims from which the sample was drawn;

2.1.31.3.4 Recoupment of extrapolated overpayments, usually by withholding against future payments; and

2.1.31.4 Contractor may be required to recoup specific provider overpayments established outside of this contract.

2.1.31.4.1 Contractor must develop a systematic means to recoup these overpayment amounts from network providers and to relay these monetary recoupments to the Department.

2.1.31.4.2 Contractor must develop a means to receive notifications of amounts owed the Department by providers on an ongoing basis for the duration of the contract and to recoup these amounts. These recoupments must be relayed to the Department within xx business days. The Department will provide the notifications of new recoupments needed. The specific process and information transfer shall be determined by the Department within xx days after contract execution, in consultation with the Contractor and the OIG.

2.1.31.5 Contractor may be required to suspend provider's participation in network and/or withhold provider's payments if under investigation by Authorized Persons.

2.1.32 Review, Audit and Inspection. Contractor shall cooperate with audits, investigations, inspections and reviews performed by the Department or Authorized Persons, including but not limited to:

2.1.32.1 Comply with all state and federal audit review requirements.

2.1.32.2 Allow, with or without advance notice, visits from Authorized Persons or Department staff to observe and inspect Contractor operation.

2.1.32.3 Provide at no cost and upon request with or without prior notice, access to all records, documents, papers and other necessary materials for audits, investigations, inspections and reviews.

2.1.32.4 Provide at no cost and upon request with or without prior notice, access to any and all staff, including network providers and subcontractors, at all levels of the operation for audits, investigations, inspections or reviews.

2.1.32.5 Provide at no cost and upon request access to telephones, analog lines, fax machine, photocopier and any computer system used by Contractor in the performance of this contract.

2.1.32.6 Respond to and address in a timely fashion issues raised during audits, investigations, inspections and reviews.

## 3 STANDARD TERMS AND CONDITIONS

3.1 AVAILABILITY OF APPROPRIATION (30 ILCS 500/20-60): State shall use its best efforts to secure sufficient appropriations to fund this Contract. However, the State, at its sole option, may terminate or suspend this contract, in whole or in part, without penalty or further payment being required, if the Illinois General Assembly or the federal funding source fails to make an appropriation sufficient to pay such obligation, or if funds needed are insufficient for any reason.

3.2 AUDIT/RETENTION OF RECORDS (30 ILCS 500/20-65): Contractor and its subcontractors shall maintain books and records relating to the performance of the Contract or subcontract and necessary to support amounts charged to the State under the Contract or subcontract. Books and records, including information stored in databases or other computer systems, shall be maintained by the Contractor for a period of six years from the later of the date of final payment under the Contract or completion of the Contract, and by the subcontractor for a period of six years from the later of final payment under the term or during the six year period thereafter. Books and records required to be maintained under this section shall be available for review or audit by representatives of the State, the Auditor General, the Executive Inspector General and other governmental entities with monitoring authority, upon reasonable notice and during normal business hours. Contractor and its subcontractors shall cooperate fully with any such audit and with any investigation conducted by any of these entities. Failure to maintain books and records required by this section shall establish a presumption in favor of the State for the recovery of any funds paid by the State under the Contract for which adequate books and records are not available to support the purported disbursement. The Contractor shall not impose a charge for audit or examination of the Contractor's books and records. If federal funds are used to pay contract costs, the Contractor must retain its records for five years. Contractor shall take reasonable steps to insure that any subcontractor is in compliance with the requirements of this section.

3.3 TIME IS OF THE ESSENCE: Time is of the essence with respect to Contractor's performance of this Contract. Except as specifically waived in writing, failure by either Party to exercise or enforce a right shall not affect any subsequent ability to exercise or enforce a right.

3.4 FORCE MAJEURE: Failure by either Party to perform its duties and obligations will be excused by unforeseeable circumstances beyond its reasonable control and not due to its negligence including acts of nature, acts of terrorism, riots, labor disputes, fire, flood, explosion, and governmental prohibition. The non-declaring party may cancel the Contract without penalty if performance does not resume within 30 days after the declaration.

3.5 CONFIDENTIAL INFORMATION: Each Party, including its agents and subcontractors, to this Contract may have or gain access to confidential data or information owned or maintained by the other Party in the course of carrying out its responsibilities under this Contract. The receiving Party shall presume all information received or to which it gains access pursuant to this Contract is confidential unless otherwise designated by the disclosing Party. No confidential data collected, maintained, or used in the course of performance of the

Contract shall be disseminated except as authorized by law and with the written consent of the disclosing Party, either during the period of the Contract or thereafter. The receiving Party must return any and all data collected, maintained, created or used in the course of the performance of the Contract, in whatever form it is maintained, promptly at the end of the Contract, or earlier at the request of the disclosing Party, or notify the disclosing Party in writing of its destruction. The foregoing obligations shall not apply to confidential data or information lawfully in the receiving Party's possession prior to its acquisition from the disclosing Party; received in good faith from a third-party not subject to any confidentiality obligation to the disclosing Party; now is or later becomes publicly known through no breach of confidentiality obligation by the receiving Party; or is independently developed by the receiving Party without the use or benefit of the disclosing Party's confidential information. There are unique laws pertaining to confidentiality requirements for mental health and substance abuse, which can be found at the following links:

1) Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110) at
http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=2043&ChapAct=740%26nbsp%3BILCS%26nbsp%3B110%2F&ChapterID=57&ChapterName=CIVIL+LIABILITIES&ActName=Mental+Health+and+Developmental+Disabilities+Confidentiality+Act%2E

2) Mental Health and Developmental Disabilities Code (405 ILCS 5) at
http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1496&ChapAct=405%26nbsp%3BILCS%26nbsp%3B5%2F&ChapterID=34&ChapterName=MENTAL+HEALTH&ActName=Mental+Health+and+Developmental+Disabilities+Code%2E

3) Community Services Act (405 ILCS 30) at
http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1501&ChapAct=405%26nbsp%3BILCS%26nbsp%3B30%2F&ChapterID=34&ChapterName=MENTAL+HEALTH&ActName=Community+Services+Act%2E

4) Alcoholism and Substance Abuse Treatment and Intervention Licenses. Section 2060.319 Confidentiality-Patient Information at
http://www.ilga.gov/commission/jcar/admincode/077/077020600C03190R.html

5) Alcoholism and Substance Abuse Treatment and Intervention Licenses. Section 2060.321 Confidentiality- HIV Antibody/AIDS Status at
http://www.ilga.gov/commission/jcar/admincode/077/077020600C03210R.html

3.6 USE AND OWNERSHIP: All work performed or supplies created by Contractor under this Contract, whether written documents or data, goods or deliverables of any kind, shall be deemed work-for-hire under copyright law and all intellectual property and other laws, and the State of Illinois is granted sole and exclusive ownership to all such work, unless otherwise agreed to herein. Contractor hereby assigns to the State all right, title, and interest in and to such work including any related intellectual property rights, and/or waives any and all claims that Contractor may have to such work including any so-called "moral rights" in connection with the work. Confidential data or information contained in such work shall be subject to Section 3.5 herein.

3.7 INDEMNIFICATION AND LIABILITY: The Contractor agrees to indemnify and hold harmless the State of Illinois, its agencies, officers, employees, agents and volunteers from any and all costs, demands, expenses, losses, claims, damages, liabilities, settlements and judgments, including in-house and contracted attorneys' fees and expenses, arising out of (a) any breach or violation by Contractor of any of its representations, warranties, covenants or agreements set forth herein, (b) any actual or alleged death or injury to any person, damage to any property or any other damage or loss by whomsoever suffered, claimed to result in whole or in part from Contractor's negligent performance hereunder, (c) any act, activity or omission of Contractor or any of its employees, representatives, subcontractors or agents. Neither party shall be liable for incidental, special, consequential or punitive damages.

3.8 INSURANCE: Contractor shall, at all times during the term and any renewals, maintain and provide a Certificate of Insurance naming the State as additional insured for all required bonds and insurance. Certificates may not be modified or canceled until at least 30 days notice has been provided to the State. Contractor shall provide: (a) General Commercial Liability-occurrence form in amount of $1,000,000 per occurrence (Combined Single Limit Bodily Injury and Property Damage) and $2,000,000 Annual Aggregate; (b) Auto Liability, including Hired Auto and Non-owned Auto, (Combined Single Limit Bodily Injury and Property Damage) in amount of $1,000,000 per occurrence; and (c) Worker's Compensation Insurance in amount required by law. Insurance shall not limit Contractor's obligation to indemnify, defend, or settle any claims.

3.9 INDEPENDENT CONTRACTOR: Contractor shall, in the performance of this Contract, be an independent contractor and not an agent or employee of, or joint venturer with the State. All payments by the State shall be made on that basis.

3.10 ASSIGNMENT AND SUBCONTRACTING: This Contract may not be assigned, transferred or subcontracted in whole or in part by the Contractor without the prior written consent of the State. Contractor shall describe, as a supplemental provision to this Contract, the names and addresses of all authorized subcontractors utilized by Contractor in the performance of this Contract, together with a description of the work to be performed by the subcontractor and the anticipated amount of money that each subcontractor is expected to receive pursuant to this Contract. For purposes of this section, subcontractors are those specifically hired to perform all or part of the work or to provide the supplies covered by the Contract.

3.11 SOLICITATION AND EMPLOYMENT: Contractor shall not employ any person employed by the State during the term of this Contract to perform any work under this Contract. Contractor shall give notice immediately to the Agency's director if Contractor solicits or intends to solicit State employees to perform any work under this Contract.

3.12 COMPLIANCE WITH THE LAW: The Contractor, its employees, agents, and subcontractors shall comply with all applicable federal, state, and local laws, rules, ordinances, regulations, orders, federal circulars and all license and permit requirements in the performance of this Contract., including, without limitation, the Managed Care Reform and Patient Rights Act (215 ILCS 134/1 et seq.), the federal Balanced Budget Act of 1997 (Public Law 105-33) and regulations promulgated by the Illinois Department of Financial and Professional Regulation, the Illinois Department of Public Health or DCMS. Contractor shall be in compliance with applicable tax requirements and shall be current in payment of such taxes.

3.13 BACKGROUND CHECK: Whenever the State deems it reasonably necessary for security reasons, the State may conduct, at its expense, criminal and driver history background checks of Contractor's officers, employees or agents. Contractor shall reassign immediately any such individual who does not pass the background checks.

3.14 APPLICABLE LAW: This Contract shall be construed in accordance with and is subject to the laws and rules of the State of Illinois. The Department of Human Rights' Equal Opportunity requirements (44 Ill. Adm. Code 750) are incorporated by reference. Any claim against the State arising out of this Contract must be filed exclusively with the Illinois Court of Claims (705 ILCS 505/1). The State shall not enter into binding arbitration to resolve any Contract dispute. The State of Illinois does not waive sovereign immunity by entering into this Contract. The official text of cited statutes is incorporated by reference (An unofficial version can be viewed at http://www.ilga.gov/legislation/ilcs/ilcs.asp. In compliance with the Illinois and federal Constitutions, the Illinois Human Rights Act, the U. S. Civil Rights Act, and Section 504 of the federal Rehabilitation Act and other applicable laws and rules the State does not unlawfully discriminate in employment, contracts, or any other activity.

3.15 ANTI-TRUST ASSIGNMENT: If Contractor does not pursue any claim and cause of action it has arising under federal or state antitrust laws relating to the subject matter of the Contract, then upon request Contractor shall assign to the State all right, title and interest in and to the claim or cause of action.

3.16 AUTHORIZATION: Each Party to this Contract represents and warrants to the other that: (a) it has the right, power and authority to enter into and perform its obligations under this Contract and (b) it has taken all requisite action (corporate, statutory or otherwise) to approve execution, delivery and performance of this Contract, and (c) this Contract constitutes a legal, valid and binding obligation upon itself in accordance with its terms.

3.17 CONTRACTUAL AUTHORITY: The Agency that signs for the State of Illinois shall be the only State entity responsible for performance and payment under the Contract. When the Department of Central Management Services (DCMS) signs in addition to an Agency, DCMS does so as approving officer and shall have no liability to Contractor. When DCMS signs a Master Contract on behalf of State agencies, only the Agency that places an order with the Contractor shall have any liability to Contractor.

3.18 NOTICES: Notices and other communications provided for herein shall be given in writing by registered or certified mail, return receipt requested, by receipted hand delivery, by courier (UPS, Federal Express or other similar and reliable carrier), by e-mail, or by fax showing the date and time of successful receipt. Notices shall be sent to the individuals who signed the Contract using the contact information following the signatures. Each such notice shall be deemed to have been provided at the time it is actually received. By giving notice, either Party may change the contact information.

## 4 CERTIFICATIONS AND CONFLICTS

Contractor certifies it is under no legal prohibition on contracting with the State of Illinois, has no known conflicts of interest and further specifically certifies that:

4.1 Contractor, its employees and subcontractors will comply with applicable provisions of the U.S. Civil Rights Act, Section 504 of the Federal Rehabilitation Act, the Americans with Disabilities Act (42 U.S.C. § 12101 et seq.) and applicable rules in performance under this Contract.

4.2 Contractor is not in default on an educational loan (5 ILCS 385/3).

4.3 Contractor (if an individual, sole proprietor, or partner) has informed the director of the Agency in writing if he/she was formerly employed by that agency and has received an early retirement incentive prior to 1993 under Section 14-108.3 or 16-133.3 of the Illinois Pension Code, 40 ILCS 5/14-108.3 and 40 ILCS 5/16-133.3, and acknowledges that contracts made without the appropriate filing with the Auditor General are not payable from the "contractual services" or other appropriation line items. Contractor has not received an early retirement incentive on or after 2002 under Section 14-108.3 or 16-133.3 of the Illinois Pension Code, 40 ILCS 5/14-108.3 and 40 ILCS 5/16-133.3, and acknowledges that contracts in violation of Section 15a of the State Finance Act are not payable from the "contractual services" or other appropriation line items (30 ILCS 105/15a).

4.4 Contractor certifies (i) that it will offer to assume the collective bargaining obligations of the prior employer, including any existing collective bargaining agreement with the bargaining representative of any existing collective bargaining unit or units performing substantially similar work to the services covered by the contract subject to its bid or offer, and (ii) that it shall offer employment to all employees currently employed in any existing bargaining unit performing substantially similar work that will be performed under this contract (30 ILCS 500/25-80).

4.5 Contractor has not been convicted of bribing or attempting to bribe an officer or employee of the State of Illinois or any other State, nor has Contractor made an admission of guilt of such conduct that is a matter of record (30 ILCS 500/50-5).

4.6 If Contractor has been convicted of a felony, at least five years have passed after the date of completion of the sentence for such felony, unless no person held responsible by a prosecutor's office for the facts upon which the conviction was based continues to have any involvement with the business (30 ILCS 500/50-10).

4.7 If Contractor, or any officer, director, partner, or other managerial agent of Contractor, has been convicted of a felony under the Sarbanes-Oxley Act of 2002, or a Class 3 or Class 2 felony under the Illinois Securities Law of 1953, at least five years have passed since the date of the conviction. Contractor further certifies that it is not barred from being awarded a contract and acknowledges that the State shall declare the Contract void if this certification is false (30 ILCS 500/50-10.5).

4.8 Contractor and its affiliates are not delinquent in the payment of any debt to the State (or if delinquent has entered into a deferred payment plan to pay the debt), and Contractor and its affiliates acknowledge the State may declare the Contract void if this certification is false (30 ILCS 500/50-11) or if Contractor or an affiliate later becomes delinquent and has not entered into a deferred payment plan to pay off the debt (30 ILCS 500/50-60).

4.9 Contractor and all affiliates shall collect and remit Illinois Use Tax on all sales of tangible personal property into the State of Illinois in accordance with provisions of the Illinois Use Tax Act (30 ILCS 500/50-12) and acknowledges that failure to comply can result in the Contract being declared void.

4.10 Contractor certifies that it has not committed a willful or knowing violation of the Environmental Protection Act (relating to Civil Penalties under the Environmental Protection Act) within the last five years, and is therefore not barred from being awarded a contract. If the State later determines that this certification was falsely made by the Contractor, the Contractor acknowledges that the State may declare the Contract void (30 ILCS 500/50-14).

4.11 Contractor has not paid any money or valuable thing to induce any person to refrain from bidding on a State contract, nor has Contractor accepted any money or other valuable thing, or acted upon the promise of same, for not bidding on a State contract (30 ILCS 500/50-25).

4.12 Contractor is not in violation of the "Revolving Door" section of the Illinois Procurement Code (30 ILCS 500/50-30).

4.13 Contractor will report to the Illinois Attorney General and the Chief Procurement Officer any suspected collusion or other anti-competitive practice among any bidders, offerors, contractors, proposers or employees of the State (30 ILCS 500/50-40, 50-45, 50-50).

4.14 In accordance with the Steel Products Procurement Act, steel products used or supplied in the performance of a contract for public works shall be manufactured or produced in the United States, unless the executive head of the procuring agency grants an exception (30 ILCS 565).

4.15 Contractor will, pursuant to the Drug Free Workplace Act, provide a drug free workplace and Contractor and its employees shall not engage in the unlawful manufacture, distribution, dispensation, possession or use of a controlled substance during the performance of the Contract. This certification applies to contracts of $5000 or more with individuals; and to entities with 25 or more employees (30 ILCS 580).

4.16 Neither Contractor nor any substantially owned affiliate is participating or shall participate in an international boycott in violation of the U.S. Export Administration Act of 1979 or the applicable regulations of the U.S. Department of Commerce. This certification applies to contracts that exceed $10,000 (30 ILCS 582).

4.17 Contractor has not been convicted of the offense of bid rigging or bid rotating or any similar offense of any state or of the United States (720 ILCS 5/33 E-3, E-4).

4.18 Contractor complies with the Illinois Department of Human Rights Act and rules applicable to public contracts, including equal employment opportunity, refraining from unlawful discrimination, and having written sexual harassment policies (775 ILCS 5/2-105).

4.19 Contractor does not pay dues to, or reimburse or subsidize payments by its employees for any dues or fees to any "discriminatory club" (775 ILCS 25/2).

4.20 Contractor complies with the State Prohibition of Goods from Forced Labor Act, and certifies that no foreign-made equipment, materials, or supplies furnished to the State under the Contract have been or will be produced in whole or in part by forced labor, or indentured labor under penal sanction (30 ILCS 583).

4.21 Contractor certifies that no foreign-made equipment, materials, or supplies furnished to the State under the Contract have been produced in whole or in part by the labor or any child under the age of 12 (30 ILCS 584).

4.22 Contractor certifies that it is not in violation of Section 50-14.5 of the Illinois Procurement Code (30 ILCS 500/50-14.5) that states: "Owners of residential buildings who have committed a willful or knowing violation of the Lead Poisoning Prevention Act (410 ILCS 45) are prohibited from doing business with the State until the violation is mitigated".

4.23 Contractor warrants and certifies that it and, to the best of its knowledge, its subcontractors have and will comply with Executive Order No. 1 (2007). The Order generally prohibits Contractors and subcontractors from hiring the then-serving Governor's family members to lobby procurement activities of the State, or any other unit of government in Illinois including local governments if that procurement may result in a contract valued at over $25,000. This prohibition also applies to hiring for that same purpose any former State employee who had procurement authority at any time during the one-year period preceding the procurement lobbying activity.

4.24 In accordance with Public Act 95-307, all information technology, including electronic information, software, systems and equipment, developed or provided under this contract must comply with the applicable requirements of the Illinois Information Technology Accessibility Act Standards as published at www.dhs.state.il.us/iitaa.

4.25 Contractor has disclosed if required, on forms provided by the State, and agrees it is under a continuing obligation to disclose to the State, financial or other interests (public or private, direct or indirect) that may be a potential conflict of interest or which would prohibit Contractor from having or continuing the Contract. This includes, but is not limited to conflicts under the "Infrastructure Task Force Fee Prohibition" section of the State Finance Act (30 ILCS 105/8.40), Article 50 of the Illinois Procurement Code (30 ILCS 500/50), or those which may conflict in any manner with the Contractor's obligation under this Contract. Contractor shall not employ any person with a conflict to perform under this Contract. If any elected or appointed State officer or employee, or the spouse or minor child of same has any ownership or financial interest in the Contractor or the Contract, Contractor certifies it has disclosed that information to the State if required, on forms provided by the State, and any waiver of the conflict has been issued in accordance with applicable law and rule. A waiver is required if:

a) the person intending to contract with the State, their spouse or child: (i) holds an elective office in Illinois; (ii) holds a seat in the Illinois General Assembly; (iii) is an officer or employee of the Capital Development Board or the Illinois Toll Highway Authority; or holds an appointed position or is employed in any of the offices or agencies of the State government and who receives compensation for such employment in excess of 60% of the salary of the Governor (currently $106,447.20). (The conflict of interest threshold of 60% of the Governor's salary set forth in Section 50-13 does not apply to elective office holders, legislators, and officers or employees of the Capital Development Board or the Illinois Toll Highway Authority.);

b) the contract is with a firm, partnership, association or corporation in which a person referenced in a) above receives more than 7.5% of the total distributable income or an amount in excess of the salary of the Governor (currently $177,412.00).

c) the contract is with a firm, partnership, association or corporation in which a person referenced in b) above, together with their spouse or minor child, receives more than 15% in the aggregate of the total distributable income or an amount in excess of 2 times the salary of the Governor (currently $354,824.00) from the firm, partnership, association or corporation.

4.26 Contractor, as defined in Public Act 95-971, certifies that it has read, understands, and is in compliance with the Act and will not make a contribution that will violate the Act. In general, Public Act 95-971 contains new registration and reporting requirements for certain Contractors, as well as limitations on political contributions by certain Contractors and their affiliates. These requirements shall be effective for the duration of the term of office of the incumbent Governor or for a period of 2 years after the end of the contract term, whichever is longer.

Contractor certifies, in accordance with Public Act 95-971, as applicable:

☐ Contractor is not required to register as a business entity with the State Board of Elections.

or

☐ Contractor has registered as a business entity with the State Board of Elections and acknowledges a continuing duty to update the registration as required by the Act. A copy of the official certificate of registration as issued by the State Board of Elections is attached.

Contractor acknowledges that the State may declare this Contract void without any additional compensation due to the Contractor if this foregoing certification is false or if the Contractor (or any of its Affiliated Persons or Entities) engages in conduct that violates Public Act 95-971.

5.0 SUPPLEMENTAL PROVISIONS

5.1 Entire Contract. This Contract, consisting of the signature page, sections one through six, and any attachments marked (X) below, constitutes the entire Contract between the Parties concerning the subject matter of the Contract, and supersedes all prior proposals, contracts and understandings between the Parties concerning the subject matter of the Contract. Amendments, modifications and waivers must be in writing and signed by authorized representatives of the Parties. Any provision of this Contract officially declared void, unenforceable, or against public policy, shall be ignored and the remaining provisions shall be interpreted, as far as possible, to give effect to the Parties' intent. All provisions that by their nature would be expected to survive, shall survive termination. In the event of a conflict between the State's and Contractor's terms, conditions and attachments, the State's terms, conditions and attachments shall prevail.

5.2 Confidentiality of Program Recipient Identification. Contractor shall ensure that all information, records, data, and data elements pertaining to applicants for and recipients of public assistance, or to providers, facilities, and associations, shall be protected from unauthorized disclosure by Contractor and Contractor's employees, by Contractor's corporate affiliates and their employees, and by Contractor's subcontractors and their employees, pursuant to 305 ILCS 5/11-9, 11-10, and 11-12; 42 USC 654(26); 42 CFR Section 431, Subpart F; and 45 CFR Section 160 and 45 CFR Section 164, Subparts A and E. To the extent that Contractor, in the course of performing the Contract, serves as a business associate of the Agency/Buyer, as "business associate" is defined in the HIPAA Privacy Rule (45 CFR Section 160.103), Contractor shall assist the Agency/Buyer in responding to the client as provided in the HIPAA Privacy Rule, and shall maintain for a period of six (6) years any records relevant to a client's eligibility for services under the Agency/Buyer's medical programs.

5.3 Nondiscrimination. Contractor and Contractor's principals, employees and subcontractors shall abide by Executive Orders 11246 and 11375. Contractor further agrees to take affirmative action to ensure that no unlawful discrimination is committed in any manner, including, but not limited to, in the delivery of services under this Contract.

5.4 Child Support. Contractor shall ensure that its employees who provide services to the Agency/Buyer under this Contract are in compliance with child support payments pursuant to a court or administrative order of this or any other State. Contractor will not be considered out of compliance with the requirements of this Section if, upon request by the Agency/Buyer, Contractor provides:

5.4.1 Proof of payment of past due amounts in full;
5.4.2 Proof that the alleged obligation of past due amounts is being contested through appropriate court or administrative proceedings and Contractor provides proof of the pendency of such proceedings; or
5.4.3 Proof of entry into payment arrangements acceptable to the appropriate State agency.

5.5 Exclusions.

5.5.1 Contractor shall screen all current and prospective employees, contractors and sub-contractors, and any parties directly or indirectly affiliated with this Contract, prior to engaging their services under this Contract and at least annually thereafter, by:

5.5.1.1 requiring that current or prospective employees, contractors or sub-contractors and any parties directly or indirectly affiliated with this Contract, to disclose whether they are Excluded Individuals/Entities; and

5.5.1.2 reviewing the list of sanctioned persons maintained by the Agency's Office of Inspector General (OIG) (available at http://www.state.il.us/agency/oig), and the List of Excluded Individuals/Entities maintained by the U.S. Department of Health and Human Services OIG (HHS/OIG) (available at http://www.dhhs.gov/oig).

5.5.1.3 For purposes of this section, "Excluded Individual/Entity" shall mean a person or entity which:

5.5.1.3.1 under Section 1128 of the Social Security Act, is or has been terminated, barred, suspended or otherwise excluded from participation in, or as the result of a settlement agreement has voluntarily withdrawn from participation in, any program under federal law, including any program under Titles XVIII, XIX, XX or XXI of the Social Security Act;

5.5.1.3.2 has not been reinstated in the program after a period of exclusion, suspension, debarment, or ineligibility; or

5.5.1.3.3 has been convicted of a criminal offense related to the provision of health care items or services in the last ten (10) years.

5.5.1.4 Contractor shall terminate its relations with any employee, contractor or sub-contractor immediately upon learning that such employee, contractor or sub-contractor meets the definition of an Excluded Individual/Entity, and shall notify the OIG of the termination.

5.6 Termination for Breach of HIPAA Compliance Obligations. Contractor shall comply with the terms of the HIPAA Compliance Obligations set forth in Attachment H. Upon the Agency/Buyer's learning of a material breach of the terms of the HIPAA Compliance Obligations set forth in Attachment H, the Agency/Buyer shall:

5.6.1 Provide Contractor with an opportunity to cure the breach or end the violation, and terminate this Contract if Contractor does not cure the breach or end the violation within the time specified by the Agency/Buyer; or

5.6.2 Immediately terminate this Contract if Contractor has breached a material term of the HIPAA Compliance Obligations and cure is not possible; or

5.6.3 Report the violation to the Secretary of the United States Department of Health and Human Services, if neither termination nor cure by Contractor is feasible.

5.7 HIPAA Compliance Obligations. Contractor and the Agency/Buyer shall comply with the terms of the HIPAA Compliance Obligations set forth in Attachment H. If Contractor materially breaches the terms of the HIPAA Compliance Obligations, the Agency/Buyer may require a cure or terminate this Contract, as provided herein.

5.8 Retention of HIPAA Records. Contractor shall maintain for a minimum of six (6) years documentation of the protected health information disclosed by Contractor, and all requests from individuals for access to records or amendment of records, pursuant to Attachment H of this Contract, in accordance with 45 CFR Section 164.530(j).

5.9 Clean Air Act and Clean Water Act. Contractor is in compliance with all applicable standards, orders or regulations issued pursuant to the federal Clean Air Act (42 U.S.C. 7401 et seq.) and the federal Water Pollution Control Act (33 U.S.C. 1251 et seq.). Violations shall be reported to the United States Department of Health and Human Services and the appropriate Regional Office of the United States Environmental Protection Agency.

5.10 Lobbying.

5.10.1 Contractor certifies to the best of Contractor's knowledge and belief, that no federally appropriated funds have been paid or will be paid by or on behalf of Contractor, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal loan or grant, or the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan or cooperative agreement.

5.10.2 If any funds other than federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this federal contract, grant, loan or cooperative agreement, Contractor shall complete and submit Standard Form LLL, "Disclosure Forms to Report Lobbying," in accordance with its instructions. Such Form is to be obtained at Contractor's request from the Agency/Buyer's Bureau of Fiscal Operations.

5.10.3 Contractor shall require that the language of this certification be included in the award document for subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

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

5.11 Notice of Change in Circumstances. In the event Contractor becomes a party to any litigation, investigation or transaction that may reasonably be considered to have a material impact on Contractor's ability to perform under this Contract, Contractor will immediately notify the Agency/Buyer in writing.

5.12 Inability to Perform. If it becomes impossible for named individuals to render the services set forth in this Contract because of death or any other occurrence beyond the control of Contractor, Contractor shall not be relieved of Contractor's obligations to complete performance hereunder, but the Agency/Buyer, at its own option, may accept a substitute or terminate the Contract.

5.12.1 If any failure of Contractor to meet any requirement of this Contract results in the withholding of federal funds from the State, the Agency/Buyer may withhold and retain an equivalent amount from payments to Contractor until such federal funds are released to the State, at which time the Agency/Buyer will release to Contractor the equivalent withheld funds.

5.13 Disputes Between Contractor and Other Parties. Any dispute between Contractor and any third party, including any subcontractor, shall be solely between such third party and Contractor, and the Agency/Buyer shall be held harmless by Contractor. Contractor agrees to assume all risk of loss and to indemnify and hold the Agency/Buyer and its officers, agents, and employees harmless from and against any

and all liabilities, demands, claims, suits, losses, damages, causes of action, fines or judgments, including costs, attorneys' and witnesses' fees, and expenses incident thereto, for Contractor's failure to pay any subcontractor, either timely or at all, regardless of the reason.

5.14 Fraud and Abuse. Contractor shall report in writing to the Agency's Office of Inspector General (OIG) any suspected Fraud, Abuse or misconduct associated with any service or function provided for under this contract by any parties directly or indirectly affiliated with this Agreement including but not limited to, Contractor staff, Contractor Subcontractor, Agency employee or Agency contractor. Contractor shall make this report within three days after first suspecting Fraud, Abuse or misconduct. Contractor shall not conduct any investigation of the suspected Fraud, Abuse or misconduct without the express concurrence of the OIG; the foregoing notwithstanding, Contractor may conduct and continue investigations necessary to determine whether reporting is required under this paragraph. Contractor must report to OIG as described in the first sentence above. Contractor shall cooperate with all investigations of suspected Fraud, Abuse or misconduct reported pursuant to this paragraph. Contractor shall require adherence with these requirements in any contracts it enters into with Subcontractors. Nothing in this paragraph precludes Contractor or its subcontractors from establishing measures to maintain quality of services and control costs that are consistent with their usual business practices, conducting themselves in accordance with their respective legal or contractual obligations or taking internal personnel-related actions.

5.15 Gifts. Contractor and Contractor's principals, employees and subcontractors are prohibited from giving gifts to Agency/Buyer employees, and from giving gifts to, or accepting gifts from, any person who has a contemporaneous contract with the Agency/Buyer involving duties or obligations related to this Contract.

5.16 Media Relations and Public Information. Subject to any disclosure obligations of Contractor under applicable law, rule, or regulation, news releases pertaining to this Contract or the services or project to which it relates shall only be made with prior approval by, and in coordination with, the Agency/Buyer. Contractor shall not disseminate any publication, presentation, technical paper, or other information related to Contractor's duties and obligations under this Contract unless such dissemination has been previously approved in writing by the Agency/Buyer.

5.17 Rules of Construction. Unless the context otherwise requires or unless otherwise specified, the following rules of construction apply to this Contract:

5.17.1 Provisions apply to successive events and transactions;
5.17.2 "Or" is not exclusive;
5.17.3 References to statutes and rules include subsequent amendments and successors thereto;
5.17.4 The various headings of this Contract are provided for convenience only and shall not affect the meaning or interpretation of this Contract or any provision hereof;
5.17.5 If any payment or delivery hereunder shall be due on any day that is not a business day, such payment or delivery shall be made on the next succeeding business day;
5.17.6 "Days" shall mean calendar days; "business day" shall mean a weekday (Monday through Friday), excepting State holidays, between the hours of 8:30 a.m. Central Time and 5:00 p.m. Central Time;
5.17.7 Use of the male gender (*e.g.*, "he", "him", "his") shall be construed to include the female gender (*e.g.*, "she", "her"), and vice versa;
5.17.8 Words in the plural which should be singular by context shall be so read, and vice versa; and
5.17.9 References to "Illinois Department of Healthcare and Family Services," "Department" or "Agency" shall include any successor agency or agencies thereto.

5.18 Sale or Transfer. Contractor shall provide the Agency/Buyer with the earliest possible advance notice of any sale or transfer of Contractor's business. The Agency/Buyer has the right to terminate this Contract without cause upon notification of such sale or transfer.

5.19 Contractor Certifications. By signing this Contract, Contractor makes certain certifications and warranties. This Contract may be terminated immediately or upon notice by the Agency/Buyer in its sole discretion upon Contractor's failure to maintain these certifications and warranties.

5.20 Development Work. Neither Contractor, nor Contractor's principals, employees and subcontractors, nor any person with whom Contractor has, or is negotiating, a contract for such person's future employment, has performed any work for which there was payment by the Agency/Buyer that directly relates to the development of this Contract.

5.21 Travel. No payment for travel expenses will be made by the Agency/Buyer under this Contract.

5.22 Non-waiver. Failure of either party to insist on performance of any term or condition of this Contract or to exercise any right or privilege hereunder shall not be construed as a continuing or future waiver of such term, condition, right or privilege.

5.23 Amendments Necessary for Statutory or Regulatory Compliance: Contractor shall, upon request by the Department and receipt of a proposed amendment to this Contract, negotiate in good faith with the Department to amend the Contract if and when required, in the opinion of the Department, to comply with federal or State laws or regulations. If the Contractor believes that it is impossible to comply with

a provision of this Contract because of a contradictory provision of applicable State or federal law, the Contractor shall immediately notify the Department. The Department then will make a determination of whether a contract amendment is necessary. If the parties are unable to agree upon an amendment within sixty (60) days, or such shorter time required by federal or State law or regulation, the Department may terminate this Contract. The fact that either the Contract or an applicable law imposes a more stringent standard than the other does not, in and of itself, render it impossible to comply with both.

5.24 DENIAL OF PAYMENT SANCTION BY FEDERAL CMS. The Department shall deny payments otherwise provided for under this Contract for new Enrollees when, and for so long as, payment for those Enrollees is denied by Federal CMS under 42 CFR Section 438.726.

5.25 HOLD HARMLESS. The Contractor shall indemnify and hold the Department harmless from any and all claims, complaints or causes of Action which arise as a result of the Contractor's failure to pay either any Provider for rendering Covered Services to Enrollees or any vendor, subcontractor, or the Department's mail vendor, either on a timely basis or at all, regardless of the reason or for any dispute arising between the Contractor and a vendor, mail vendor, Provider, or subcontractor; provided, however, that this provision will not nullify the Department's obligation under Section 2.1.11 of the Contract to cover services that are not Covered Services under this Contract, but that are eligible for payment by the Department. The Contractor warrants that Enrollees will not be liable for any of the Contractor's debts should the Contractor become insolvent or subject to insolvency proceedings as set forth in 215 ILCS 125/1-1 et seq.

5.26 REPORTING, STATUS AND MONITORING

5.26.1 At the State's option the Parties will work together to monitor performance during the contract and any warranty term. This may include use of a performance scorecard with conditions, milestones, requirements, or timetables that must be met before additional steps may be taken, or payment is due. The scorecard may also record matters related to price, service, quality and other factors deemed important

5.26.2 Contractor shall cooperate with the State in this monitoring activity, which may require that Contractor report progress and problems (with proposed resolutions), provide records of its performance, allow random inspections of its facilities, participate in scheduled meetings and provide management reports as requested by the State.

5.26.3 Contractor shall immediately notify the State of any event that may have a material impact on Contractor's ability to perform the Contract.

5.26.4 Upon request and on forms provided by the Department, Contractor shall report the number of qualified veterans and certain ex-offenders hired during Contractor's last completed fiscal year. Contractor may be entitled to employment tax credit for hiring individuals in those groups (PA 94-1067)

Mandated reporters are required to report suspected maltreatment immediately when they have reasonable cause to believe that an individual known to them in their professional or official capacity may be Abused or Neglected. Although anyone may make a report, mandated reporters are professionals who may work with children, elderly, or persons with disabilities. The following outlines the Abuse, Neglect and exploitation reporting requirements for Illinois citizens.

## Children (Under the age of 18)

As mandated by the Abused and Neglect Child Reporting Act (*325 ILCS 5/4*), persons required to report Abuse and Neglect of children and youth under the age of 18 includes:

1. Medical Personnel: Physicians, physician assistants, psychiatrists, surgeons, residents, interns, dentists, dentist hygienists, pathologists, osteopaths, coroners, medical examiners, Christian Science practitioners, respiratory care practitioners, chiropractors, podiatrists, acupuncturists, registered and licensed practical nurses, advanced practice nurses, emergency medical technicians, hospital administrators and other personnel involved in the examination, care or treatment of patients.
2. School and Child Care Personnel: Teachers, school personnel, educational advocates assigned to a child pursuant to the School Code, truant officers, directors and staff assistants of day care centers and nursery schools, and child care workers.
3. Law Enforcement: Truant officers, probation officers, law enforcement officers, and field personnel of the Department of Corrections.
4. State Agencies: Field personnel from the Departments of Children and Family Services, Healthcare and Family Services, Juvenile Justice, Public Health, Human Services (acting as successor to the Department of Mental Health and Developmental Disabilities, Rehabilitation Services, or Public Aid), Corrections, Human Rights, or Children and Family Services, supervisor and administrator of general assistance under the Illinois Public Aid Code, probation officers, animal control officers or Illinois Department of Agriculture Bureau of Animal Health and Welfare field investigators.
5. Others: Social workers, social service administrators, substance abuse treatment personnel, domestic violence program personnel, crisis line or hotline personnel, foster parents, homemakers, home health aides, funeral home director or employee, licensed professional counselors, licensed clinical professional counselors, genetic counselors, recreational program or facility personnel, registered psychologists and assistants working under the direct supervision of a psychologist, members of the clergy.

*A full version of the Abused and Neglected Child Reporting Act can be found on the Illinois General Assembly website at the following hyperlink:* 325 ILCS 5/

### Reporting Procedures

The types of critical incidents that must be reported include any specific incident of Abuse or Neglect or a specific set of circumstances involving suspected Abuse or Neglect, where there is demonstrated harm to the child or a substantial risk of physical or sexual injury to the child. Critical incidents must be reported if the alleged perpetrator is a parent, guardian, foster parent, relative caregiver, paramour, any individual residing in the same home, any person responsible for the child's welfare at the time of the alleged Abuse or Neglect, or any person who came to know the child through an official capacity or position of trust (for example: health care professionals, educational personnel, recreational supervisors, members of the clergy, volunteers or support personnel) in settings where children may be subject to Abuse and Neglect.

Mandated reporters are required to report suspected child maltreatment immediately when they have reasonable cause to believe that a child known to them in their professional or official capacity may be an Abused or Neglected child. This is done by calling the Department of Children and Family Services 24-hour Child Abuse Hotline 1-800-25-ABUSE or 1-800-358-5117 (TTY). Reports must be confirmed in writing to the local investigation unit within 48 hours after the hotline call.

## Persons Age 18 through 59

For participants aged 18 and older, mandated reporters under 59 Illinois Administrative Code 50 includes all Medicaid Agency and Operating Agency staff and all community agency employees (including payroll employees, contractual employees, volunteers, and subcontractors). More details on the Administrative Code may be found at the following hyperlink: *59 IL Adm. Code 50*

### Reporting Procedures

At the time when the DRS central office is made aware of an incident, an HSP Counselor is assigned to the case. HSP counselors assist with reporting and remain involved in the case to ensure the customer is safe from harm and that an adequate plan of care is in place. DRS also works with each case until there is satisfactory resolution.

The DHS Office of the Inspector General, which is a semi-independent entity that reports to both the Governor and the Secretary of DHS, investigates alleged Abuse, Neglect and exploitation of adults with mental, developmental, or physical disabilities in private homes and of adults with mental or developmental disabilities in DHS-funded community agencies. To make a report of Abuse, Neglect, or exploitation, please call the DHS OIG Hotline at 1-800-368-1463 (voice and TTY)

The DHS Office of Inspector General Adults with Disabilities Abuse Project has statutory authority to respond to allegations related to Adults with Disabilities between the ages of 18 and 59 who reside in domestic situations. DHS OIG has authority to investigate, take emergency action, work with local law enforcement authorities, obtain financial and medical records, and pursue guardianship. With the individual's consent, substantiated cases are referred to DHS for development of a service plan to meet identified needs.

Elderly (Age 60 and over)

Under the Elder Abuse and Neglect Act (*320 ILCS 202/f-5*), persons required as mandated reporters while carrying out their professional duties in working with the elderly population includes:

1. A professional or professional's delegate while engaged in:
    1.1. Social services
    1.2. Law enforcement
    1.3. Education
    1.4. The care of an eligible adult or eligible adults
    1.5. Any of the occupations required to be licensed under the Clinical Psychologist Licensing Act, the Clinical Social Work and Social Work Practice Act, the Illinois Dental Practice Act, the Dietetic and Nutrition Services Practice Act, the Marriage and Family Therapy Licensing Act, the Medical Practice Act of 1987, the Naprapathic Practice Act, the Nurse Practice Act, the Nursing Home Administrators Licensing and Disciplinary Act, the Illinois Occupational Therapy Practice Act, the Illinois Optometric Practice Act of 1987, the Pharmacy Practice Act, the Illinois Physical Therapy Act, the Physician Assistant Practice Act of 1987, the Podiatric Medical Practice Act of 1987, the Respiratory Care Practice Act, the Professional Counselor and Clinical Professional Counselor Licensing Act, the Illinois Speech-Language Pathology and Audiology Practice Act, the Veterinary Medicine and Surgery Practice Act of 2004, and the Illinois Public Accounting Act;
2. An employee of a vocational rehabilitation facility prescribed or supervised by the Department of Human Services;
3. An administrator, employee, or person providing services in or through an unlicensed community based facility;
4. Any religious practitioner who provides treatment by prayer or spiritual means alone in accordance with the tenets and practices of a recognized church or religious denomination, except as to information received in any confession or sacred communication enjoined by the discipline of the religious denomination to be held confidential;
5. Field personnel of the Department of Healthcare and Family Services, Department of Public Health, and Department of Human Services, and any county or municipal health department;
6. Personnel of the Department of Human Services, the Guardianship and Advocacy Commission, the State Fire Marshal, local fire departments, the Department on Aging and its subsidiary Area Agencies on Aging and provider agencies, and the Office of State Long Term Care Ombudsman;
7. Any employee of the State of Illinois not otherwise specified herein who is involved in providing services to eligible adults, including professionals providing medical or rehabilitation services and all other persons having direct contact with eligible adults;
8. A person who performs the duties of a coroner or medical examiner; or
9. A person who performs the duties of a paramedic or an emergency medical technician.

A full version of the Elder Abuse and Neglect Act can be found on the Illinois General Assembly website at the following hyperlink: *320 ILCS 20/*

Reporting Procedures

Persons can report suspected Abuse, Neglect or exploitation to DoA by utilizing the Elder Abuse Hotline number at 1-866-800-1409, available 24 hours a day, seven days a week. Reports may also be made directly to the local Elder Abuse Provider Agency in the service area.

DoA policy specifically states that if direct service workers witness or identify a case of possible Abuse or Neglect, they are mandated to personally report the allegations to the designated Elder Abuse Provider Agency or to DoA's Hotline numbers. DoA's Office of Elder Rights maintains a tracking system of ANE investigations and statistical reports are generated annually.

Persons with Developmental Disabilities in Residential Facilities

For participants under the age of 18

For participants under the age of 18, mandated reporters are those professionals identified in the Abused and Neglected Child Reporting Act (*325 ILCS 5/4*). Please see the section on Children (Under the age of 18) for requirements.

A full version of the Abused and Neglected Child Reporting Act can be found on the Illinois General Assembly website at the following hyperlink: *325 ILCS 5/*

For participants aged 18 and older

For participants aged 18 and older, mandated reporters under *59 Illinois Administrative Code 50* include all Medicaid Agency and Operating Agency staff and all community agency employees (including payroll employees, contractual employees, volunteers, and subcontractors).

More details on the Administrative Code may be found at the following hyperlink: *59 IL Adm. Code 50*

Reporting Procedures
The types of critical incidents that must be reported include any allegation of physical or mental Abuse, Neglect or financial exploitation committed by anyone against the Waiver participant. Unauthorized use of restraint, seclusion or restrictive interventions is considered Abuse and must be reported. Serious injuries that require treatment by a physician or a nurse where Abuse or Neglect is suspected and medication errors that have an adverse outcome must be reported. Serious injuries that require treatment by a physician or a nurse must be included in a quarterly quality assurance report to the Operating Agency.

Deaths must be reported if the death occurred while the individual was present in an agency program or if the death occurs within 14 days after discharge, transfer or deflection from the agency program. Deaths must be reported within 24 hours from the time the death was first discovered or the reporter was informed of the death (only four hours if Abuse or Neglect is suspected).

Anyone may make a report under either rule by calling the DHS Office of the Inspector General 24-hour hotline at 1-800-368-1463 (voice and TTY)

Mandated reporters must report the allegation within four hours after the time it was first discovered by the staff. Mandated reporters must report allegations if they are told about Abuse or Neglect, if they witness it, or if they suspect it.

Long Term Care Facility Residents
Persons required to make reports or cause reports to be made as defined by the Abused and Neglected Long Term Care Facility Residents Reporting Act (*210 ILCS 30*) include:

- Any long term care facility administrator, agent or employee
- Any physician, hospital, surgeon, registered nurse, dentist, osteopath, chiropractor, podiatrist, coroner, social worker, social services administrator, or law enforcement officer
- Any accredited religious practitioner who provides treatment by spiritual means alone through prayer in accordance with the tenets and practices of the accrediting church
- Field personnel of the Department of Healthcare and Family Services and the Illinois Department of Public Health and County or Municipal Health Departments
- Personnel of the Department of Human Services (acting as the successor to the Department of Mental Health and Developmental Disabilities or the Department of Healthcare and Family Services), the Guardianship and Advocacy Commission, the State Fire Marshal, local fire department inspectors or other personnel, the Illinois Department on Aging or its subsidiary Agencies on Aging, or employee of a facility licensed under the Assisted Living and Shared Housing Act
- All employees of the State of Illinois who are involved in providing services to residents, including professionals providing medical or rehabilitation services and all other persons having direct contact with residents
- All employees of community service agencies who provide services to a resident of a public or private long term care facility outside of that facility.

Any long term care surveyor of the Illinois Department of Public Health who has reasonable cause to believe in the course of a survey that a resident has been Abused or Neglected and initiates an investigation while on site at the facility shall be exempt from making a report under this Section but the results of any such investigation shall be forwarded to the central register in a manner and form described by the Department.

In addition to the above persons required to report suspected resident Abuse and Neglect, any other person may make a report to the Department, or to any law enforcement officer, if such person has reasonable cause to suspect a resident has been Abused or Neglected.

A full version of the Abused and Neglected Long Term Care Facility Residents Reporting Act can be found on the Illinois General Assembly website at the following hyperlink: *210 ILCS 30/*

*Reporting Procedures*

The types of critical incidents that must be reported include any allegation of physical or mental Abuse, Neglect or financial exploitation committed by anyone against the Waiver participant. Unauthorized use of restraint, seclusion or restrictive interventions is considered Abuse and must be reported. Serious injuries that require treatment by a physician or a nurse where Abuse or Neglect is suspected and medication

errors that have an adverse outcome must be reported. Serious injuries that require treatment by a physician or a nurse must be included in a quarterly quality assurance report to the Operating Agency.

Mandated reporters must report the allegation within four hours after the time it was first discovered by the staff. Mandated reporters must also report allegations if they are told about Abuse or Neglect, if they witness it, or if they suspect it. Reports are to be made to the Department of Public Health (DPH) Long Term Care/Nursing Home Hotline at 1-800-252-4343.

Deaths must be reported if the death occurred while the individual was present in an agency program or if the death occurs within 14 days after discharge, transfer or deflection from the agency program. Deaths must be reported within 24 hours from the time the death was first discovered or the reporter was informed of the death (only four hours if Abuse or Neglect is suspected).

RFP ATTACHMENT B

# Dental Covered Services Comparison for Children and Adults

| | Children (< age 21) | Adults (> age 20) | Requires Prior Approval |
|---|---|---|---|
| **DIAGNOSTIC SERVICES** | | | |
| Oral Exams (For children, limited to one every 6 months per dentist in an office setting, and one every 12 months in a school setting. For adults, limited to 1st visit per dentist.) | X | X | |
| X-rays | X | X | |
| **Preventive Services** | | | |
| Prophylaxis – Cleanings (Once every 6 months) | X | | |
| Topical Fluoride (Annual) | X | | |
| Sealants | X | | |
| Space Maintenance | X | | |
| **Restorative Services** | | | |
| Amalgams | X | X | |
| Resins | X | X | |
| Crowns (For adults, limited to facial front teeth only.) | X | X | Y |
| Sedative Fillings | X | X | |
| **Endodontic Services** | | | |
| Pulpotomy | X | | |
| Root Canals (For adults, limited to facial front teeth only.) | X | X | |
| **Periodontal Services** | | | |
| Gingivectomy | X | | Y |
| Scaling and Root planning | X | | Y |
| **Removable Prosthodontic Services** | | | |
| Complete Denture (upper and lower) | X | X | Y |
| Partial Denture (upper and lower) | X | | Y |
| Denture Relines | X | X | Y |
| Maxillofacial Prosthetics | X | X | Y |
| **Fixed Prosthetic Services** | | | |
| Bridge | X | | Y |
| **Oral and Maxillofacial Services** | | | |
| Extractions | X | X | |
| Surgical Extractions | X | X | Y |
| Alveoloplasty | X | | Y |
| **Orthodontic Services** | | | |
| Orthodontia (Coverage limited to children meeting or exceeding a score of 42 from the Modified Salzmann Index) | X | | Y |
| **Adjunctive General Services** | | | |
| General Anesthesia | X | X | Y |
| IV Sedation | X | X | Y |
| Nitrous Oxide | X | X | |
| Conscious Sedation | X | X | Y |
| Therapeutic Drug Injection | X | X | Y |

RFP ATTACHMENT C

Home and Community-Based Waiver Services Chart

| Service | DoA | DHS-DRS | | | DSCC | DHS-DDD | | | Definition | Standards | Service Limits |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Persons who are Elderly | Persons with Disabilities | Persons with HIV/AIDS | Persons with Brain Injury | Children who are Medically Fragile, Technology Dependent | Adults with DD | Children's Residential | Children's Support | | | |
| Adult Day Service | x | x | x | x | | x | | | Adult day service is the direct care and supervision of adults aged 60 and over in a community-based setting for the purpose of providing personal attention; and promoting social, physical and emotional well-being in a structured setting.<br><br>The DD version of adult day service also includes transportation. | **DOA:**<br>89 Il.Adm.Code 240.1505-1590<br>Contract with Department on Aging,<br>Contract requirements,<br>**DD:**<br>59 Il.Adm.Code 120.70<br>Contract with Department on Aging,<br>Contract requirements,<br>**DRS:**<br>89 Il.Adm.Code 686.100 | **DOA, DRS**<br>The amount, duration, and scope of services is based on the service plan and is included in the service cost maximum/monthly cost limit. This service will not be duplicative of other services in the Waiver.<br><br>**DD**<br>For participants who chose home-based supports, this service is included in the participant's monthly cost limit.<br>The annual rate is spread over a State fiscal year maximum of 1,100 hours for any combination of day programs. |
| Adult Day Service Transportation | x | x | x | x | | | | | | **DOA:**<br>89 Il.Adm.Code 240.1505-1590<br>**DRS:**<br>89 Il.Adm.Code 686.100 | No more than two units of transportation shall be provided per MFP participant in a 24 hour period, and shall not include trips to a physician, shopping, or other miscellaneous trips. |

| Service | DoA | DHS-DRS | | | DSCC | DHS-DDD | | | Definition | Standards | Service Limits |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Persons who are Elderly | Persons with Disabilities | Persons with HIV/AIDS | Persons with Brain Injury | Children who are Medically Fragile, Technology Dependent | Adults with DD | Children's Residential | Children's Support | | | |
| Case Management (Administrative Claim) | x | x | x | x | x | x | x | x | Case management includes services that assist participants in gaining access to needed MFP, waiver and State Plan services, as well as medical, social, educational and other services, regardless of the funding source for the services. Responsibilities include assessment, care plan development and ongoing monitoring and review. | **DOA:**<br>89 Il.Adm.Code 240.1430<br>89 Il.Adm.Code 220.605<br><br>**DD:**<br>Community-based agencies - Entity under contract with the Operating Agency that provides Individual Service and Support Advocacy. Services must be provided personally by a professional defined in federal regulations as a Qualified Mental Retardation Professional<br>59 Il.Adm.Code 120.70<br><br>**DRS:**<br>Required to have at least a GED or CNA as well as experience in working with individuals with disabilities, independent living services, and home care, and a background in the medical aspects of disabilities.<br><br>**DSCC:**<br>Registered nurses, social workers, or other health care professionals (audiologists and speech pathologists | |

| Service | DoA | DHS-DRS | | | DSCC | DHS-DDD | | | Definition | Standards | Service Limits |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Persons who are Elderly | Persons with Disabilities | Persons with HIV/AIDS | Persons with Brain Injury | Children who are Medically Fragile, Technology Dependent | Adults with DD | Children's Residential | Children's Support | | | |
| Service Facilitation | | | | | | x | | x | Service Facilitation includes services that assist participants in gaining access to needed Waiver and other State Plan services, as well as medical, social, educational and other services, regardless of the funding source for the services. Responsibilities include assisting the participant and/or guardian in convening a support planning team, choosing services and service providers to meet the participant's needs, and ensuring participant health and welfare through ongoing monitoring of the provision of services. | Entity under contract with the Operating Agency that does not also provide Individual Service and Support Advocacy. Services must be provided personally by a professional defined in federal regulations as a Qualified Mental Retardation Professional. 59 Il.Adm.Code 120.70 | This service will not be duplicative of other services in the Waiver. For example, case management/care coordination services are a component of residential services. This service is included in the participant's monthly cost limit. No specific service maximum. The support plan/Service Agreement must set aside at least two hours per month to allow for routine required administrative activities. |
| Community Transition Services | x | x | | | | | | | Community transition services are non-recurring set-up expenses for MFP participants who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses.<br><br>Allowable expenses are those necessary to establish a basic household but that do not constitute room and board. | Enrolled vendor approved by the Service Facilitator and the participant/guardian | One-time transition services are viewed mainly to be one-time costs. In the event that the MFP participant should need the services after the twelve (12) month period of Money Follows the Person eligibility, Flexible Senior Spending (FSS) funds are available for the MFP participant's needs.<br><br>No more than $4,000 maximum may be spent per participant on Community Transition Services without the prior approval of the Community Reintegration Program (CRP) Manager or designee. |

| Service | DoA | DHS-DRS | | | DSCC | DHS-DDD | | | Definition | Standards | Service Limits |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Persons who are Elderly | Persons with Disabilities | Persons with HIV/AIDS | Persons with Brain Injury | Children who are Medically Fragile, Technology Dependent | Adults with DD | Children's Residential | Children's Support | | | |
| Environmental Accessibility Adaptations-Home | x | x | x | x | x | x | | x | Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization.<br><br>Excluded are those adaptations or improvements to the home that are of general utility and are not of direct remedial benefit to the participant.<br><br>**DSCC**<br>Vehicle modifications (wheelchair lifts and tie downs) are also provided under environmental modifications. | **DOA and DRS:**<br>89 Il.Adm.Code 686.608<br>**DSCC:**<br>DSCC Home Care Manual, 53.20.30, (Rev.9/01) &53.43 (Rev.9/01)<br>**DD:**<br>59 Il.Adm.Code 120.70<br>Independent contractor - Enrolled vendor approved by the Service Facilitator and participant/ guardian<br>Construction companies-Enrolled vendor approved by the Service Facilitator and participant/ guardian. | **DOA**<br>Requests for Home Modifications in excess of the $3,000 limit will be considered on a case-by-case basis by IDOA. Requests for Assistive technology in excess of the $1,000 limit will be considered on a case-by-case basis by IDOA.<br><br>**DRS**<br>The cost of environmental modification, when amortized over a 12 month period and added to all other monthly service costs, may not exceed the service cost maximum.<br><br>**DSCC**<br>All environmental modifications will be limited in scope to the minimum necessary to meet the participant's medical needs.<br><br>**DD**<br>This service is subject to prior approval by the Operating Agency. |
| Environmental Accessibility Adaptations-Vehicle | | | | | | x | | x | Vehicle Modifications are adaptations or alterations to an automobile or van that is the participant's primary means of transportation in order to accommodate the special needs of the participant. Vehicle adaptations are specified by the support plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant. The vehicle that is adapted must be owned by the participant, a family member with whom the participant lives or has consistent and on-going contact, or a non-relative who | 59 Il.Adm.Code 120.70 | This service will not be duplicative of other services in the waiver. This service requires prior approval by the Operating Agency.The following are specifically excluded:1. Adaptations or improvements to the vehicle that are of general utility, and are not of direct remedial benefit to the participant;2. Purchase or lease of a vehicle; 3. Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications. |

| Service | DoA | DHS-DRS | | | DSCC | DHS-DDD | | | Definition | Standards | Service Limits |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Persons who are Elderly | Persons with Disabilities | Persons with HIV/AIDS | Persons with Brain Injury | Children who are Medically Fragile, Technology Dependent | Adults with DD | Children's Residential | Children's Support | | | |
| | | | | | | | | | provides primary long-term support to the participant and is not a paid provider of such services. | | |
| Supported Employment | | | | x | | x | | | Supported employment services consist of intensive, ongoing supports that enable participants, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need supports, to perform in a regular work setting. It may include assisting the participant to locate a job or develop a job on behalf of the participant, and is conducted in a variety of settings; including work sites where persons without disabilities are employed. | **DHS:** 89 Il.Adm.Code 530 **DD:** 59 Il.Adm.Code 120.70 | **BI** When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by participants receiving waiver services as a result of their disabilities and will not include payment for the supervisory activities rendered as a normal part of the business setting.<br><br>The amount, duration, and scope of services are based on the determination of need assessment conducted by the case manager and the service cost maximum determined by the DON score.<br><br>**DD** For participants who chose home-based supports, this service is included in the participant's monthly cost limit. Services are subject to prior approval. |
| Home Health Aide | | x | x | x | | | | | Service provided by an individual that meets Illinois licensure standards for a Certified Nursing Assistant (CNA) and provides services as defined in 42CFR 440.70, with the exception that limitations on the amount, duration, and scope of such services imposed by the State's approved Medicaid State Plan shall not be applicable. | **DRS:** Individual: 210 ILCS 45/3-206<br><br>Agency: 210 ILCS 55 | Services provided are in addition to any services provided through the State Plan. The amount, duration, and scope of services are based on the determination of need assessment conducted by the case manager and the service cost maximum determined by the DON. |

| Service | DoA | DHS-DRS | | | DSCC | DHS-DDD | | | Definition | Standards | Service Limits |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Persons who are Elderly | Persons with Disabilities | Persons with HIV/AIDS | Persons with Brain Injury | Children who are Medically Fragile, Technology Dependent | Adults with DD | Children's Residential | Children's Support | | | |
| | | | | | | | | | | | |
| Nursing, Intermittent | | x | x | x | | | | | Nursing services that are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or a licensed practical nurse, licensed to practice in the state.<br>Nursing through the waiver focuses on long term habilitative needs rather than short-term acute restorative needs.<br>Intermittent nursing waiver services are in addition to any Medicaid State Plan nursing services for which the participant may qualify. | **DRS:**<br>Home Health Agency:<br>210 ILCS 55<br>Licensed Practical Nurse:<br>225 ILCS 65<br>Registered Nurse:<br>225 ILCS 65 | The amount, duration, and scope of services are based on the determination of need assessment conducted by the case manager and the service cost maximum determined by the DON score.<br>All waiver clinical services require a prescription from a physician. The duration and/or frequency of these services are dependent on continued authorization of the physician, and relevance to the customer's service plan. |
| Nursing,Skilled (RN and LPN) | - | x | x | x | - | x | | | Service provided by an individual that meets Illinois licensure standards for nursing services and provides shift nursing services. | **DRS:**Home Health Agency:<br>210 ILCS 55<br>Licensed Practical Nurse:<br>225 ILCS 65<br>Registered Nurse:<br>225 ILCS 65<br>**DD:**<br>Registered Nurse or Licensed Practical Nurse, under supervision by a registered nurse:<br>225 ILCS 65<br>68 Il.Adm.Code 1300<br>59 Il.Adm.Code 120.70 | **DRS**The amount, duration, and scope of services is based on the service plan and is included in the service cost maximum/monthly cost limit. This service will not be duplicative of other services in the Waiver. **DD**There is a State fiscal year maximum of 365 hours of service by a registered nurse and 365 hours of service by a licensed practical nurse.For participants who chose home-based supports, this service is included in the participant's monthly cost limit. |

| Service | DoA | DHS-DRS | | | DSCC | DHS-DDD | | | Definition | Standards | Service Limits |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Persons who are Elderly | Persons with Disabilities | Persons with HIV/AIDS | Persons with Brain Injury | Children who are Medically Fragile, Technology Dependent | Adults with DD | Children's Residential | Children's Support | | | |
| Occupational Therapy | | x | x | x | | x | | | Service provided by a licensed occupational therapist that meets Illinois standards. Services are in addition to any Medicaid State Plan services for which the participant may qualify. Occupational therapy through the waiver focuses on long term habilitative needs rather than short-term acute restorative needs | **DRS:**<br>Occupational Therapist:<br>225 ILCS 75<br>Home Health Agency:<br>210 ILCS 55<br>**DD:**<br>Occupational Therapist may directly supervise a Certified Occupational Therapist Assistant<br>225 ILCS 75<br>68 Il.Adm.Code 1315<br>59 Il.Adm.Code 120.70 | **DRS**<br>All waiver clinical services require a prescription from a physician.<br>The duration and/or frequency of these services are dependent on continued authorization of the physician, and relevance to the customer's service plan. The amount, duration, and scope of services is based on the service plan and is included in the service cost maximum<br><br>**DD**<br>This service is included in the participant's monthly cost limit for home-based supports. Services are subject to prior approval by the Operating Agency. |
| Physical Therapy | | x | x | x | | x | | | Service provided by a licensed physical therapist that meets Illinois standards. Services are in addition to any Medicaid State Plan services for which the participant may qualify. Physical therapy through the waiver focuses on long term habilitative needs rather than short-term acute restorative needs. | **DRS:**<br>Physical Therapist<br>225 ILCS 90<br>Home Health Agency:<br>210 ILCS 55<br>**DD:**<br>Physical Therapist may directly supervise a certified physical therapist assistant.<br>225 ILCS 90<br>68 Il.Adm.Code 1340<br>59 Il.Adm.Code 120.70 | **DRS**<br>All waiver clinical services require a prescription from a physician.<br>The duration and/or frequency of these services are dependent on continued authorization of the physician, and relevance to the customer's service plan. The amount, duration, and scope of services is based on the service plan and is included in the service cost maximum<br><br>**DD**<br>This service is included in the participant's monthly cost limit for home-based supports. Services are subject to prior approval by the Operating Agency. |

| Service | DoA | DHS-DRS | | | DSCC | DHS-DDD | | | Definition | Standards | Service Limits |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Persons who are Elderly | Persons with Disabilities | Persons with HIV/AIDS | Persons with Brain Injury | Children who are Medically Fragile, Technology Dependent | Adults with DD | Children's Residential | Children's Support | | | |
| Speech Therapy | | x | x | x | | x | | | Service provided by a licensed speech therapist that meets Illinois standards. Services are in addition to any Medicaid State Plan services for which the participant may qualify. Speech therapy through the waiver focuses on long term habilitation needs rather than short-term acute restorative needs. | **DRS:** Speech Therapist<br>225 ILCS 110<br>Home Health Agency:<br>210 ILCS 55<br>**DD:**<br>Speech/Language Pathologist<br>225 ILCS 110<br>68 Il.Adm.Code 1465<br>59 Il.Adm.Code 120.70 | **DRS**All waiver clinical services require a prescription from a physician. The duration and/or frequency of these services are dependent on continued authorization of the physician, and relevance to the customer's service plan. The amount, duration, and scope of services is based on the service plan and is included in the service cost maximum**DD**This service is included in the participant's monthly cost limit for home-based supports. Services are subject to prior approval by the Operating Agency. |

| Service | DoA | DHS-DRS | | | DSCC | DHS-DDD | | | Definition | Standards | Service Limits |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Persons who are Elderly | Persons with Disabilities | Persons with HIV/AIDS | Persons with Brain Injury | Children who are Medically Fragile, Technology Dependent | Adults with DD | Children's Residential | Children's Support | | | |
| Habilitation - Residential | | | | | | x | | | Residential habilitation means individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community in the most integrated setting appropriate to the individual's needs. It includes case management, adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill development, personal support, protective oversight and supervision, and reduction of maladaptive behaviors through positive supports and other methods. It may also include necessary nursing assessment, direction and monitoring by a registered professional nurse (RN), and support services and assistance by an RN or a licensed practical nurse (LPN) to ensure the participant's health and welfare. These include monitoring of health status, medication monitoring, administration of injections or suctioning, administration and/or oversight of the administration of oral and topical medications as appropriate under Illinois law. | 59 Il.Adm.Code 115 (DD Comm. Integrated Living Arrangements CILA) 77 Adm. Code 370 (Community Living Facilities - CLF) 59 Il.Adm.Code 50 (DHS OIG) 59 Il.Adm.Code 120.70 (DD Waiver rule) 59 Il.Adm.Code 116 (Med. Administration)<br><br>Contract requirements | This service will not be duplicative of other services in the Waiver. Residential Habilitation services are available to participants who request this service, require this intensity of service and meet the priority population criteria for residential services. Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement, other than such costs for modification or adaptations to a facility required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code. Payment is not made, directly or indirectly, to members of the participant's immediate family. Nursing supports are part-time and limited; 24-hour nursing supports are not available to participants in the Waiver. |

| Service | DoA | DHS-DRS | | | DSCC | DHS-DDD | | | Definition | Standards | Service Limits |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Persons who are Elderly | Persons with Disabilities | Persons with HIV/AIDS | Persons with Brain Injury | Children who are Medically Fragile, Technology Dependent | Adults with DD | Children's Residential | Children's Support | | | |
| Child Group Home (Residential Habilitation) | | | | | | | x | | Residential habilitation means case management and individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, and social and leisure skill development that assist the participant to reside in the most integrated setting appropriate to his/her needs. Residential habilitation also includes personal care and protective oversight and supervision. | 59 Il.Adm.Code 120.70 Unusual Incidents<br>89 Il.Adm.Code 331 Behavior Treatment Contract Requirements<br>89 Il.Adm.Code 384 Child Welfare Agencies<br>89 Il.Adm.Code 401 Group Homes<br>89 Il.Adm.Code 403 | Services are available to participants who request this service and meet the priority population criteria for residential services.<br><br>Payment is not made for the cost of room and board. Payment is not made, directly or indirectly, to members of the participant's immediate family. |
| Prevocational Services | | | | x | | | | | Prevocational services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. This can include teaching concepts such as compliance, attendance, task completion, problem solving and safety. Prevocational Services are provided to persons expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs). | 89 Il.Adm.Code 530 | The amount, duration, and scope of services are based on the determination of need assessment conducted by the case manager and the service cost maximum determined by the DON score.All prevocational services will be reflected in the individual's plan of care as directed to habilitative, rather than explicit employment objectives. |

| Service | DoA | DHS-DRS | | | DSCC | DHS-DDD | | | Definition | Standards | Service Limits |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Persons who are Elderly | Persons with Disabilities | Persons with HIV/AIDS | Persons with Brain Injury | Children who are Medically Fragile, Technology Dependent | Adults with DD | Children's Residential | Children's Support | | | |
| Habilitation-Day | | | | x | | x | | | **BI**<br>Day habilitation assists with the acquisition, retention, or improvement in self-help, socialization, and adaptive skills which takes place in a non-residential setting, separate from the home or facility which the individual resides. The focus is to enable the individual to attain or maintain his or her maximum functional level. Day habilitation shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.<br><br>**DD**<br>Assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that takes place in a non-residential setting, separate from the participant's private residence or other residential living arrangement. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice.<br>Services are furnished four or more hours per day on a regularly scheduled basis for one or more days per week or as specified in the participant's support plan. | **BI**<br>59 Il.Adm.Code 119<br>**DD**<br>Community-Based Agencies:<br>59 Il.Adm.Code 119 (Developmental Training);<br>59 Il. Adm. Code 50 (DHS OIG)<br>59 Il.Adm.Code 120.70 (DD Waiver Rule)<br>Contract requirements<br>Special Recreation Associations<br>59 Il.Adm.Code 119<br>59 Il.Adm.Code 50<br>59 Il.Adm.Code 120<br>Contract requirements | **BI**<br>The amount, duration, and scope of services are based on the determination of need assessment conducted by the case manager and the service cost maximum determined by the DON score.<br><br>This service shall be furnished 4 or more hours per day on a regularly scheduled basis, for 1 or more days per week unless provided as an adjunct to other day activities included in the individual's plan of care.<br><br>**DD**<br>The annual rate is spread over a State fiscal year maximum of 1,100 hours for any combination of day programs. Monthly payment is limited to a maximum of 115 hours for any combination of day programs.<br>Meals provided as part of these services shall not constitute a "full nutritional regimen" (three meals per day).<br>Day Habilitation does not include special education and related services which otherwise are available to the participant through a local education agency or vocational rehabilitation services which otherwise are available to the participant through a program funded under Section 110 of the Rehabilitation Act of 1973. |

| Service | DoA | DHS-DRS | | | DSCC | DHS-DDD | | | Definition | Standards | Service Limits |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Persons who are Elderly | Persons with Disabilities | Persons with HIV/AIDS | Persons with Brain Injury | Children who are Medically Fragile, Technology Dependent | Adults with DD | Children's Residential | Children's Support | | | |
| Placement Maintenance Counseling | | | | | x | | | | This service provides short-term, issue-specific family or individual counseling for the purpose of maintaining the participant in the home placement. This service is prescribed by a physician based upon his or her judgment that it is necessary to maintain the child in the home placement. | Licensed Clinical Social Worker<br>225 ILCS 20<br>Medicaid Rehabilitation Option<br>59 Il.Adm.Code 132<br>Licensed Clinical Psychologist<br>225 ILCS 15 | Services will require prior approval by HFS and will be limited to a maximum of twelve sessions per calendar year. |
| Medically Supervised Day Care | | | | | x | | | | This service offers the necessary technological support and nursing care provided in a licensed medical day care setting as a developmentally appropriate adjunct to full time care in the home. Medically supervised day care serves to normalize the child's environment and provide an opportunity for interaction with other children who have similar medical needs. | Licensed Day Care Facility<br>89 Il.Adm.Code 407<br>Health Care Center<br>77 Il.Adm.Code 260 | This service cannot exceed more than 12 hours per day, five days per week. |
| Homemaker | x | x | x | x | | | | | Homemaker service is defined as general non-medical support by supervised and trained homemakers. Homemakers are trained to assist individuals with their activities of daily living, including personal care, as well as other tasks such as laundry, shopping, and cleaning. The purpose of providing homemaker service is to maintain, strengthen and safeguard the functioning of MFP participants in their own homes in accordance with the authorized plan of care. | **DOA:**<br>89 Il.Adm.Code 240<br>**DRS:**<br>89 Il. Adm. Code 686.200 | **DOA, DRS:**<br>The amount, duration, and scope of services are based on the determination of need assessment conducted by the case manager and the service cost maximum determined by the DON score. |
| Home Delivered Meals | | x | x | x | | | | | Prepared food brought to the client's residence that may consist of a heated luncheon meal and/or a dinner meal which can be refrigerated and eaten later. | 89 Il. Adm. Code 686.500 | The amount, duration, and scope of services is based on the determination of need assessment conducted by the case manager and the service cost maximum. |

| Service | DoA | DHS-DRS | | | DSCC | DHS-DDD | | | Definition | Standards | Service Limits |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Persons who are Elderly | Persons with Disabilities | Persons with HIV/AIDS | Persons with Brain Injury | Children who are Medically Fragile, Technology Dependent | Adults with DD | Children's Residential | Children's Support | | | |
| | | | | | | | | | This service is designed primarily for the client who cannot prepare his/her own meals but is able to feed him/herself. | | This service will be provided as described in the service plan and will not duplicate any other services. |
| Personal Assistant | | x | x | x | | | | | Personal Assistants provide assistance with eating, bathing, personal hygiene, and other activities of daily living in the home and at work (if applicable). When specified in the plan of care, this service may also include such housekeeping chores as bed making, dusting, vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the consumer, rather than the consumer's family. Personal care providers must meet state standards for this service. The personal assistant is the employee of the consumer. The state acts as fiscal agent for the consumer. | 89 Il. Adm. Code 686.10 | The amount, duration, and scope of services is based on the determination of need assessment conducted by the case manager and the service cost maximum as determined by the DON score.<br><br>These services may include assistance with preparation of meals, but does not include the cost of the meals themselves.<br><br>Personal care will only be provided when it has been determined by the case manager that the consumer has the ability to supervise the personal care provider and the service is not otherwise covered. |

| Service | DoA | DHS-DRS | | | DSCC | DHS-DDD | | | Definition | Standards | Service Limits |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Persons who are Elderly | Persons with Disabilities | Persons with HIV/AIDS | Persons with Brain Injury | Children who are Medically Fragile, Technology Dependent | Adults with DD | Children's Residential | Children's Support | | | |
| Personal Support | | | | | | x | | x | Personal Support includes: Teaching adaptive skills, personal assistance in activities of daily living (ADLs), and respite services provided on a short-term basis.Personal Support may be provided in the participant's home and may include supports necessary to participate in other community activities outside the home. The need for Personal Support and the scope of the needed services must be documented in the participant-centered support plan. The amount of Personal Support must be specified in the support plan/Service Agreement. | **Personal Support Worker:** 18+ and is deemed by the participant / guardian to be qualified and competent. If hired on or after July 1, 2007, must have passed criminal background and Health Care Worker Registry (HCWR) checks prior to employment.**Community-Based Agencies and Special Recreation Associations:** The Agency must be under contract with the Operating Agency. Employees must complete training, pass training assessments and be certified.All employees must have passed criminal background and HCWR checks prior to employment. 59 Il.Adm.Code 120.70 | Personal Support will not be duplicative of other services in the Waiver.For participants who chose home-based supports, this service is included in the participant's monthly cost limit. For participants still enrolled in school, no Personal Support services may be delivered during the typical school day relative to the age of the participant or during times when educational services are being provided. |
| Personal Emergency Response System (PERS) | x | x | x | x | | x | | | PERS is an electronic device that enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. Trained professionals staff the response center. | **DOA:** Standards for Emergency Home Response 89 Il.Adm.Code 240 **DD:** Vendor certified by the Department on Aging to provide this service or approved by the Department of Human Services with a current written rate agreement. **DRS:** 59 Il.Adm.Code 120.70 **DRS:** 89 Il. Adm. Code 686.300 | PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision. |

| Service | DoA | DHS-DRS | | | DSCC | DHS-DDD | | | Definition | Standards | Service Limits |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Persons who are Elderly | Persons with Disabilities | Persons with HIV/AIDS | Persons with Brain Injury | Children who are Medically Fragile, Technology Dependent | Adults with DD | Children's Residential | Children's Support | | | |
| Respite | | x | x | x | x | | | | **DRS**<br>Respite services provide relief for unpaid family or primary care givers, who are currently meeting all service needs of the customer.<br>Services are limited to personal assistant, homemaker, nurse, adult day care, and provided to a consumer to provide his or her activities of daily living during the periods of time it is necessary for the family or primary care giver to be absent.<br><br>**DSCC**<br>Respite care services allow for the needed level of care and supportive services to enable the participant to remain in the community, or home-like environment, while periodically relieving the family of care-giving responsibilities. These services will be provided in the participant's home or in a Children's Community-Based Health Care Center Model, licensed by the Illinois Department of Public Health. | Adult Day Care<br>89 Il. Adm.Code 686.100<br>Home Health Aide<br>210 ILCS 45/3-206<br>RN/LPN<br>225 ILCS 65<br>Home Health Agency:<br>210 ILCS 55<br>Homemaker<br>89 Il.Adm.Code 686.200<br>PA<br>89 Il.Adm.Code 686.10<br>**DSCC:**<br>Health Care Center<br>77 Il.Adm.Code 260<br>Nursing Agency:<br>Meet DSCC nursing agency requirements-DSCC Home Care Manual, 53.09 | **DRS**<br>The amount, duration, and scope of services is based on the determination of need assessment conducted by the case manager and the service cost maximum determined by the DON score<br><br>FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence. It may be provided in an individual's home or in an adult day care setting.<br><br>**DSCC**<br>Respite care services will be limited to a maximum of 14 days or 336 hour annual limit. Exceptions may be made on an individual basis based on extraordinary circumstances.<br><br>FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence. |
| Nurse Training | - | - | - | - | x | | | | This service provides child specific training for nurses, under an approved nursing agency, in the use of new or unique prescribed equipment, or special care needs of the child. | DSCC Nursing agency requirements-DSCC Home Care Manual, 53.09. | This service cannot exceed the maximum of four hours per nurse, per waiver year. |

| Service | DoA | DHS-DRS | | | DSCC | DHS-DDD | | | Definition | Standards | Service Limits |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Persons who are Elderly | Persons with Disabilities | Persons with HIV/AIDS | Persons with Brain Injury | Children who are Medically Fragile, Technology Dependent | Adults with DD | Children's Residential | Children's Support | | | |
| Family Training | - | - | - | - | x | - | - | - | Training for the families of participants served on this waiver. Training includes instruction about treatment regimens and use of equipment specified in the plan of care and shall include updates as necessary to safely maintain the participant at home. It may also include training such as Cardiopulmonary Resuscitation (CPR). | Nursing Agency:<br>Meet DSCC nursing agency requirements-DSCC Home Care Manual, 53.09<br>Service Agency:<br>Qualify to provide the service. | All family training must be included in the participant's written plan of care. |
| Specialized Medical Equipment and Supplies | | x | x | x | x | | | | Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. All items shall meet applicable standards of manufacture, design and installation. | **DRS:**<br>68 Il. Adm. Code 1253<br>Pharmacies<br>225.ILCS.85<br>Medical Supplies<br>225.ILCS.51<br>**DSCC:**<br>225.ILCS.51<br>If not licensed under 225 ILCS 51, must be accredited by the Joint Commission on Accreditation of Healthcare Organizations, or other accrediting organization.<br><br>Meet DSCC Home Medical Equipment requirements for the waiver<br><br>A Medicaid enrolled pharmacy or durable medical equipment provider that provides items not available from a DSCC approved home medical equipment (HME) provider,(such as special formula). | **DRS:**<br>Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State Plan and shall exclude those items, which are not of direct medical or remedial benefit to the individual.<br><br>**DSCC:**<br>Medical supplies, equipment and appliances are provided only on the prescription of the primary care physician as specified in the plan of care. |

| Service | DoA | DHS-DRS | | | DSCC | DHS-DDD | | | Definition | Standards | Service Limits |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Persons who are Elderly | Persons with Disabilities | Persons with HIV/AIDS | Persons with Brain Injury | Children who are Medically Fragile, Technology Dependent | Adults with DD | Children's Residential | Children's Support | | | |
| Assistive Technology | | | | | | x | x | x | Assistive technology device means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants. Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device.<br><br>All items shall meet applicable standards of manufacture, design and installation. All purchased items shall be the property of the participant or the participant's family. | Equipment vendor - Enrolled vendor approved by the Service Facilitator and participant/guardian 59 Il.Adm.Code 120.70 | Items reimbursed with Waiver funds do not include any assistive technology furnished by the Medicaid State Plan and exclude those items that are not of direct remedial benefit to the participant.<br><br>This service is subject to prior approval by the Operating Agency. |
| Adaptive Equipment | | | | | | x | x | x | Adaptive equipment, as specified in the plan of care, includes devices, controls, or appliances that enable participants to increase their ability to perform activities of daily living or perceive and interact with the environment in which they live.; It also includes such other durable equipment not available under the State Plan that is necessary to address participant functional limitations; and necessary initial training from the vendor to use the adaptive equipment. All items shall meet applicable standards of manufacture, design and installation. All purchased items shall be the property of the participant or the participant's family. | Equipment vendors - Enrolled vendor approved by the Service Facilitator and participant/guardian 59 Il.Adm.Code 120.70 | Items reimbursed with Waiver funds do not include any medical equipment and supplies furnished under the State Plan and exclude those items that are not of direct remedial benefit to the participant.This service is subject to prior approval by the Operating Agency. |
| Supportive Living Facilities | x | | | | | | | | An affordable assisted living model administered by the Department of Healthcare and Family Services that offers frail elderly (65 and older) or persons with disabilities (22 | 89 Il Admin Code 146.215 | Frail elderly between the ages of 60 and 64 would not be eligible for SLF residency due to the program's minimum age requirement of 65. |

| Service | DoA | DHS-DRS | | | DSCC | DHS-DDD | | | Definition | Standards | Service Limits |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Persons who are Elderly | Persons with Disabilities | Persons with HIV/AIDS | Persons with Brain Injury | Children who are Medically Fragile, Technology Dependent | Adults with DD | Children's Residential | Children's Support | | | |
| | | | | | | | | | and older) housing with services. | | |
| Transportation - Non-Medical | | | | | | x | | | Non-Medical Transportation is a service offered in order to enable waiver participants to gain access to waiver and other community services, activities and resources, as specified by the support plan. Transportation services under the Waiver are offered in accordance with the participant's support plan. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge are utilized. | Drivers must have appropriate state licenses and proof of insurance 59 Il.Adm.Code 120.70 | For participants who choose home-based supports, this service is included in the participant's monthly cost limit. This service will not be duplicative of other waiver services.<br><br>No more than $500 of the monthly cost limit may be used for non-medical transportation services.<br><br>Excluded is transportation to and from covered Medicaid State Plan services and transportation to and from day program services. |

| Service | DoA | DHS-DRS | | | DSCC | DHS-DDD | | | Definition | Standards | Service Limits |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Persons who are Elderly | Persons with Disabilities | Persons with HIV/AIDS | Persons with Brain Injury | Children who are Medically Fragile, Technology Dependent | Adults with DD | Children's Residential | Children's Support | | | |
| Behavior Intervention and Treatment | | | | | | x | x | x | Behavior intervention and treatment includes a variety of individualized, behaviorally based treatment models consistent with best practice and research on effectiveness that are directly related to the participant's therapeutic goals. These services are designed to assist participants to develop or enhance skills with social value, lessen behavioral excesses and improve communication skills.<br>The strategies are a component of the participant-centered support plan and must be approved by the planning team.<br>Services are provided by professionals working closely with the participant's direct support staff and unpaid informal caregivers in the participant's home and other natural environments. | 59 Il.Adm.Code 120.70<br>Behavior Consultant<br>225 ILCS 15/1 et seq<br>68 Ill. Adm. Code 1400<br>Clinical psychologist - Services are supervised by a professional. Services are typically provided by a team of professionals.<br>Masters level - professional who is certified as a Behavior Analyst by the Behavior Analyst Certification Board.<br>Bachelor's level - professional who is certified as an Associate Behavior Analyst.<br><br>Professional who is certified to provide Relationship Development Assessment.<br>Professional with a Bachelor's Degree and who has completed at least 1,500 hours or training or supervised experience in the application of behaviorally-based therapy models consistent with best practice and research on individuals with Autism Spectrum Disorder. | For participants who choose home-based supports, this service is included in the participant's monthly cost limit.<br><br>There is a State fiscal year maximum of 66 hours. |

| Service | DoA | DHS-DRS | | | DSCC | DHS-DDD | | | Definition | Standards | Service Limits |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Persons who are Elderly | Persons with Disabilities | Persons with HIV/AIDS | Persons with Brain Injury | Children who are Medically Fragile, Technology Dependent | Adults with DD | Children's Residential | Children's Support | | | |
| Behavior Services (Counseling and Therapy) | | | | | | x | | | Psychotherapy is a treatment approach that focuses on a goal of ameliorating or reducing the symptoms of emotional, cognitive or behavioral disorder and promoting positive emotional, cognitive and behavioral development. Counseling is a treatment approach that uses relationship skills to promote the participant's abilities to deal with daily living issues associated with their cognitive or behavioral problems using a variety of supportive and re-educative techniques. | 59 Il.Adm.Code 120.70<br>Licensed Psychotherapists -<br>225 ILCS 15/1 et seq<br>68 Ill. Adm. Code 1400<br>225 ILCS 20/1 et seq.<br>68 Ill. Adm. Code 1470<br>Clinical Social Work<br>225 ILCS 55/1 et seq.<br>68 Ill. Adm. Code 1283<br>Marriage & Family Therapy<br>225 ILCS 107/1 et seq.<br>Licensed Counselors - All licensure categories for psychotherapists, plus Clinical Social Worker and Counselor<br>225 ILCS 107/1 et seq.<br>68 Ill. Adm. Code 1375 | For participants who choose home-based supports, this service is included in the participant's monthly cost limit. There is a State fiscal year maximum of 60 hours for any combination of psychotherapy and counseling services. |
| Behavioral Services (M.A. and PH.D) | | | | x | | | | | Behavioral Services provide remedial therapies to decrease maladaptive behaviors and/or to enhance the cognitive functioning of the recipient. These services are designed to assist customers in managing their behavior and cognitive functioning and to enhance their capacity for independent living. | Speech Therapist<br>225 ILCS 110/<br>Social Worker<br>225 ILCS 20/<br>Clinical Psychologist<br>225 ILCS 15/<br>Licensed Counselor<br>225 ILCS 107/ | The amount, duration, and scope of services are based on the determination of need assessment conducted by the case manager and the service cost maximum determined by the DON score.<br><br>The services are based on a clinical recommendation and are not covered under the State Plan. |

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| Crisis Services | | | | | | x | | | Crisis Services are provided on an emergency temporary basis because of the absence or incapacity of the persons who normally provide unpaid care. Absence or incapacity of the primary caregiver(s) must be due to a temporary cause. The definition of Crisis Services includes the same activities, requirements and responsibilities as Personal Support. The participant, legal representative, the service provider and the support planning team may set mutually acceptable rates for Crisis Services. | Standards are the same as for Personal Support services. 59 Il.Adm.Code 120.70 | Crisis Services are not available for caregiver absences for vacations, educational or employment-related reasons, or other non-emergency reasons. The rates must be specified in the Service Agreements and are subject to review and approval by the Operating Agency on either a targeted or a random sample basis. The service is also subject to prior approval by the Operating Agency.<br><br>This service will not be duplicative of other services in the Waiver. Crisis Services may not exceed $2,000 in any single month and may not be authorized for more than two consecutive months or 60 consecutive days. No Crisis Services may be delivered during the typical school day relative to the age of the participant or during times when educational services are being provided. |

| Service | DoA | DHS-DRS | | | DSCC | DHS-DDD | | | Definition | Standards | Service Limits |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Persons who are Elderly | Persons with Disabilities | Persons with HIV/AIDS | Persons with Brain Injury | Children who are Medically Fragile, Technology Dependent | Adults with DD | Children's Residential | Children's Support | | | |
| Training and Counseling for Unpaid Caregivers | | | | | | x | | x | Training and counseling services for individuals who provide unpaid support, training, companionship or supervision to participants. All training for individuals who provide unpaid support to the participant must be included in the participant's support plan. Training furnished to individuals who provide uncompensated care and support to the participant must be directly related to their role in supporting the participant in areas specified in the support plan. Counseling similarly must be aimed at assisting unpaid individuals who support the participant to understand and address participant needs. | 59 Il.Adm.Code 120.70 Clinical Psychologist 225 ILCS 15/1 et seq 68 Il.Adm.Code 1400 Clinical Social Work 225 ILCS 20/1 et seq. 68 Il.Adm.Code 1470 Marriage & Family Therapy. 225 ILCS 55/1 et seq. 68 Il.Adm.Code 1283 Counselor 225 ILCS 107/1 et seq. 68 Il.Adm.Code 1375 Specialized Training providers - Training programs, workshops or events deemed qualified by the participant/guardian and approved by the Service Facilitator. Examples include CPR instruction, first aid, and programs on disability-specific topics such as epilepsy, autism, etc. | This service will not be duplicative of other services in the Waiver. For participants who choose home-based supports, this service is included in the participant's monthly cost limit. This service may not be provided in order to train paid caregivers or school personnel. Caregivers who are compensated for direct services under this Waiver may not receive services under this service title. |

RFP Attachment D

Utilization Data Summary Format

Cost Model: Total

| Age/Gender Population: | Member Months: | | Fiscal Year 2009 | | |
|---|---|---|---|---|---|
| Type of Service | Admits Per 1,000 | Average Length of Stay | Utilization Per 1,000 | Net Allowed Charge | PMPM |
| *Inpatient Hospital* | | | | | |
| Medical | | | | | |
| Surgical | | | | | |
| General | | | | | |
| Maternity Delivery | | | | | |
| Maternity Non-Delivery | | | | | |
| Psychiatric | | | | | |
| Substance Abuse | | | | | |
| Other | | | | | |
| Subtotal | | | | | |
| *Outpatient Hospital* | | | | | |
| Surgery | | | | | |
| General | | | | | |
| Emergency Room | | | | | |
| End-Stage Renal Disease | | | | | |
| Subtotal | | | | | |
| *Ancillaries* | | | | | |
| Prescription Drugs | | | | | |
| Transportation | | | | | |
| DME/Prosthetics/Orthotics | | | | | |
| Home Health/Hospice | | | | | |
| Subtotal | | | | | |
| *Physician* | | | | | |
| Inpatient Surgery | | | | | |
| Outpatient Surgery | | | | | |
| Other Surgery | | | | | |
| Anesthesia | | | | | |
| Hospital Inpatient Visits | | | | | |
| Office Visits/Consults | | | | | |

| Age/Gender Population:<br><br>Type of Service | Per 1,000 | Average Admits of Stay | Length Per 1,000 | Net Utilization Charge | Allowed PMPM |
|---|---|---|---|---|---|
| Clinic Visit/Services | | | | | |
| Radiology | | | | | |
| Pathology | | | | | |
| Outpatient Behavioral Health | | | | | |
| Maternity - Normal Deliveries | | | | | |
| Maternity - Cesarean Deliveries | | | | | |
| DMHDD Rehabilitation Option Services | | | | | |
| Dental | | | | | |
| Other Professional | | | | | |
| Subtotal | | | | | |
| | | | | | |
| *Total Phase 1 Claims/Benefit Cost* | | | | | |
| *Total Phase 2 Claims/Benefit Cost* | | | | | |
| *Total Phase 3 Claims/Benefit Cost* | | | | | |
| | | | | | |
| *Total Claims/Benefit Cost* | | | | | |

RFP Attachment E
Quality Measures

| | Quality Measure | P4P Year |
|---|---|---|
| 1 | **General Hospital Inpatient Admits per 1,000** | |
| 2 | **Psychiatric Hospital Inpatient Admits per 1,000** | |
| 3 | **Rehabilitation Hospital Inpatient Admits per 1,000** | |
| 4 | **Follow-up After Hospitalization for Mental Illness** | |
| 5 | **Follow-up with PCP within 14 days following emergency room visit** | |
| 6 | **Inpatient Hospital Readmission Rate - 30 day Readmission Rate** | |
| 7 | **Emergency Department Utilization Rate per 1,000, Excluding ED Visit that Results in Inpatient Admission** | |
| 8 | **Colorectal Cancer Screening** | |
| 9 | **Breast Cancer Screening** | |
| 10 | **Cervical Cancer Screening** | |
| 11 | **Adult BMI Assessment** | |
| 12 | **Urinary Tract Infection Admission Rate (LTC)** | |
| 13 | **Bacterial Pneumonia Admission Rate (LTC)** | |
| 14 | **Annual monitoring of patients on persistent medication** | |
| 15 | **Behavioral Health Assessment completed for Enrollees needing an assessment as indicated by risk stratification as negotiated using a tool approved by the Department** | Yrs 1 & 2 |
| 16 | **Appropriate Follow up with Provider Following First BH Diagnosis** | Yr 3 |
| 17 | **Psychopharmacy Review Monthly for All Enrollees** | |
| 18 | **Access to Emergency Mental Health Services** | |
| 19 | **Access to Substance Abuse Treatment** | |
| 20 | **PCP Visit - Once Annually** | Yrs 1, 2, 3 |
| 21 | **PCP Visit within 14 days of every inpatient discharge** | Yrs 1, 2, 3 |
| 22 | **Services for Population in DD Waiver and Clients with Diagnostic History** | Yrs 1, 2, 3 |
| | HbA1c testing 2x per year: | |
| | Emergency Department Utilization Rate per 1,000 | |
| | Psychopharmacy Review Monthly with Messaging to Prescriber of Record | |
| 23 | **Antidepressant Medication Management** | Yrs 1, 2, 3 |
| | At least 84 days continuous treatment with antidepressant medication during 114 day period following IPSD | |
| | At least 180 days continuous treatment with antidepressant medication during 231 day period following IPSD | |
| 24 | **Diabetes Care** | Yrs 1, 2, 3 |
| | HbA1c testing 1x per year: | |
| | Microalbuminuria testing 1 X per year: | |
| | Cholesterol testing 1X per year: | |
| | Statin Therapy 80% of the time | |

| | Quality Measure | P4P Year |
|---|---|---|
| | ACE/ARB 80% of the time | |
| **25** | **Congestive Heart Failure** | Yrs 1, 2, 3 |
| | ACE/ARB | |
| | Beta Blocker | |
| | Diuretic | |
| **26** | **Coronary Artery Disease** | Yrs 1, 2, 3 |
| | Cholesterol testing 1X per year: | |
| | Statin Therapy 80% of the time | |
| | ACE/ARB 80% of the time | |
| | Beta Blocker Post MI for 6 months following MI | |
| **27** | **Chronic Obstructive Pulmonary Disease** | Yrs 1, 2, 3 |
| | Corticosteroid with acute COPD Exacerbation | |
| | Bronchodilator medications with a history of hospitalizations for COPD | |
| | Spirometry testing (1 time in last three years) | |
| **28** | **Care Plan in place for enrollees determined to need a care plan based on risk stratification as negotiated; Consumer Direction as part of Care Plan** | Yrs 1 & 2 |
| **29** | **Maintain Baseline Percentage of Waiver Enrollees in non-DD Waivers Served in the Community at the beginning of the year who are also served in the community throughout the year.** | Yrs 2 & 3 |
| **30** | **Maintain at end of the year baseline percentage of individuals with DD diagnosis who are served in the community at the end of the year.** | Yrs 2 & 3 |
| **31** | **Prevalence of Pressure Ulcers; High Risk Patients and Low Risk Patients** | Yr 3 |

RFP Attachment F
Pay for Performance (P4P) Measures

| # | Year | P4P Measure | FY'09 Baseline Measurement | Year 1 % of Total P4P | Year 2 % of Total P4P | Year 3 % of Total P4P |
|---|---|---|---|---|---|---|
| **1** | **1,2,3** | **PCP Visit - Once Annually** | 74.37% | 10% | 9% | 9% |
| **2** | **1,2,3** | **PCP Visit within 14 days of every inpatient discharge** | 21.11% | 10% | 8% | 8% |
| **3** | **1,2,3** | **Antidepressant Medication Management[1]** | | 10% | 8% | 8% |
| | | At least 84 days continuous treatment with antidepressant medication during 114 day period following IPSD | 73.62% | | | |
| | | At least 180 days continuous treatment with antidepressant medication during 231 day period following IPSD | 58.91% | | | |
| **4** | **1,2,3** | **Services for Population in DD Waiver and Clients with Diagnostic History[2]** | | 10% | 8% | 8% |
| | | PCP Visit - Once Annually | 68.17% | | | |
| | | Emergency Department Utilization Rate per 1,000 | 1,280 | | | |
| | | Psychopharmacy Review Monthly with Messaging to Prescriber of Record | Negotiated | | | |
| **5** | **1,2,3** | **Diabetes Care[3]** | | 10% | 9% | 9% |
| | | HbA1c testing 1x per year: | 73.17% | | | |
| | | Microalbuminuria testing 1 X per year: | 62.50% | | | |
| | | Cholesterol testing 1X per year: | 73.38% | | | |
| | | Statin Therapy 80% of the time | 39.82% | | | |
| | | ACE/ARB 80% of the time | 42.22% | | | |
| **6** | **1,2,3** | **Congestive Heart Failure[4]** | | 10% | 8% | 8% |
| | | ACE/ARB 80% of the time | 36.01% | | | |
| | | Beta Blocker 80% of the time | 33.25% | | | |
| | | Diuretic 80% of the time | 36.40% | | | |
| **7** | **1,2,3** | **Coronary Artery Disease[5]** | | 10% | 8% | 8% |
| | | Cholesterol testing 1X per year: | 69.97% | | | |
| | | Statin Therapy 80% of the time | 41.10% | | | |
| | | ACE/ARB 80% of the time | 40.12% | | | |
| | | Beta Blocker Post MI 30 days post MI | 32.55% | | | |
| **8** | **1,2,3** | **Chronic Obstructive Pulmonary Disease[6]** | | 10% | 9% | 9% |
| | | Corticosteroid with acute COPD exacerbation | 62.64% | | | |

| # | Year | P4P Measure | FY'09 Baseline Measurement | Year 1 % of Total P4P | Year 2 % of Total P4P | Year 3 % of Total P4P |
|---|---|---|---|---|---|---|
| | | Bronchodilator medications with a history of hospitalizations for COPD | 87.15% | | | |
| | | Spirometry testing (1 time in last three years | 18.06% | | | |
| **9** | **1,2** | **Care Plan in place for enrollees determined to need a care plan based on risk stratification as negotiated; Consumer Direction as part of Care Plan** | N/A | 10% | 8% | 8% |
| **10** | **1,2** | **Behavioral Health Assessment Using a Tool Approved by the Department Completed for Enrollees Needing an Assessment as Indicated by Negotiated Risk Stratification.** | N/A | 10% | 8% | 8% |
| **11** | **2,3** | **Maintain Baseline Percentage of Waiver Enrollees in non-DD Waivers Served in the Community at the beginning of the year who are also served in the community throughout the year.** | | | 8% | 8% |
| **12** | **2,3** | **Maintain at end of the year baseline percentage of individuals with DD diagnosis who are served in the community at the end of the year.** | N/A | | 9% | 9% |
| **13** | **3** | **Appropriate Follow up with Provider Following First BH Diagnosis** | N/A | | | |
| **14** | **3** | **Prevalence of Pressure Ulcers; High Risk Patients and Low Risk Patients** | N/A | | | |

[1] Must meet both goals to earn this portion of the pool

[2] Must meet all three goals to earn this portion of pool

[3] Must meet 2 of first 3 goals and 1 of last 2 goals to earn this portion of the pool

[4] Must meet 2 of 3 goals to earn this portion of the pool

[5] Must meet 3 of 4 goals to earn this portion of the pool

[6] Must meet 2 of 3 goals to earn this portion of the pool

# RFP Attachment G
# Clinical P4P Metrics Methodology

Total Integrated Care Program Population Eligible in FY09 was calculated by counting the unique recipient ids of any client who was in an eligible waiver or on the AABD population (excluding those clients carved out, according to the business rules), who lived in suburban Cook, DuPage, Kane, Kendall, Lake or Will counties at any time in FY09.
*Note: all populations described below are limited to the "Total Integrated Care Program Population Eligible in FY09" described above.*

## PCP VISITS (measured against entire Integrated Care Program population)

Measure 1 – Clients with at least one PCP visit during the year

Time period: measurement year (FY09)

Claims to include:

Step 1: For clients NOT enrolled in a home and community-based services waiver (HCBS waiver) , pull all claims when provider was the PCP of record, or affiliated with the PCP of record, on the date of service.

Step 2: For clients enrolled in a HCBS waiver, pull all claims when provider was enrolled to participate as a PCP in the Illinois Health Connect (IHC) program on the date of service (HCBS waiver clients were not enrolled in IHC during the measurement year).

Metric: Count unique recipient ids of clients who had a claim that met the criteria in step 1 or step 2 above.

Measure: Numerator = unique clients who had a claim that met the criteria in step 1 or step 2 above. Denominator: entire Integrated Care Program population.

Measure 2 – Follow up with PCP within 14 days of discharge from an inpatient hospitalization.

Step 1 – Identify hospital discharges.

Look-back period: measurement year (FY09)

Claims to include: any claim for an inpatient hospitalization, as identified below:

| Category of Service | Description |
|---|---|
| 020 | Inpatient Hospital Services (General) |
| 021 | Inpatient Hospital Services (Psychiatric) |
| 022 | Inpatient Hospital Services (Physical Rehabilitation) |

Claims to remove: any claim where the patient status indicates the patient died during the hospitalization, as identified below:

| Patient Status Code | Description |
|---|---|
| 20 | Expired. |
| 21 | Expired-Not covered by Medicaid on date of death |
| 22 | Expired to be defined at state level |
| 23 | Expired to be defined at state level |
| 24 | Expired to be defined at state level |
| 25 | Expired to be defined at state level |
| 26 | Expired to be defined at state level |
| 27 | Expired to be defined at state level |
| 28 | Expired to be defined at state level |
| 29 | Expired to be defined at state level |
| 40 | Expired at home. |
| 41 | Expired in a medical facility (e.g. hospital, SNF, ICF, or free standing hospice). |
| 42 | Expired - place unknown. |

Metric: Unique recipient id/discharge date combination (total inpatient discharges) from claims identified in step 1, above.

Step 2 - Identify follow-up PCP visits

Time period: 14 days following inpatient discharge (beginning day after discharge date)

Claims to include:

Step 2a: For clients NOT enrolled in a home and community-based services waiver (HCBS waiver) , pull all claims when provider was the PCP of record, or affiliated with the PCP of record, on the date of service, for dates of service in the 14 days following inpatient discharge.

Step 2b: For clients enrolled in a HCBS waiver, pull all claims when provider was enrolled to participate as a PCP in the Illinois Health Connect (IHC) program on the date of service, for dates of service in the 14 days following inpatient discharge.

Metric: Unique recipient id/date of service combination for each PCP follow up visit identified above.

Measure: Numerator: Unique follow-up visits identified in step 2 above. Denominator: Unique hospital discharges identified in step 1 above.

## ANTIDEPRESSANT MEDICATION MANAGEMENT

Population: Clients with major depression, being treated with antidepressants

Step 1 – Identify clients with major depression

Look-back period: measurement year (FY09) and prior year (FY08)

Claims to include: First date of service for

1) a claim with a primary diagnosis of major depression, or
2) an inpatient claim with a non-primary diagnosis of major depression, or
3) first of two or more claims with a non-primary diagnosis of major depression (using diagnosis codes as listed in the table below)

| Code type | Code | Description |
|---|---|---|
| ICD-9 diagnosis | 296.20 – 296.25 | Major depressive disorder, single episode |
| ICD-9 diagnosis | 296.30 – 296.35 | Major depressive disorder, recurrent episode |
| ICD-9 diagnosis | 298.0x | Depressive type psychosis |
| ICD-9 diagnosis | 300.4x | Dysthymic disorder |
| ICD-9 diagnosis | 309.1x | Prolonged depressive reaction |
| ICD-9 diagnosis | 311.xx | Depressive disorder, nec |

Step 2 – Identify clients being treated with antidepressants

Time period: 30 days before through 14 days after date of service identified above

Claims to include: claims for antidepressant medications, identified using generic code numbers listed below

| Drug Specific Therapeutic Class Code | Description |
|---|---|
| H2H | MONOAMINE OXIDASE(MAO) INHIBITORS |
| H2S | SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS) |
| H2U | TRICYCLIC ANTIDEPRESSANTS & REL. NON-SEL. RU-INHIB |
| H2W | TRICYCLIC ANTIDEPRESSANT/PHENOTHIAZINE COMBINATNS |
| H2X | TRICYCLIC ANTIDEPRESSANT/BENZODIAZEPINE COMBINATNS |
| H7B | ALPHA-2 RECEPTOR ANTAGONIST ANTIDEPRESSANTS |
| H7C | SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS) |
| H7D | NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIS) |
| H7E | SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIS) |
| H7J | MAOIS - NON-SELECTIVE & IRREVERSIBLE |

Metric: For each recipient id, identify earliest script date for antidepressant medication, from scripts identified in step 2 above (IPSD)

Antidepressant Medication Management Measure 1 - Acute Phase Treatment: at least 84 days (12 weeks) continuous treatment with antidepressant medication during 114 day period following IPDS

Time period: 114 days from IPSD identified above.

Claims to include: all pharmacy claims for antidepressants as identified in table above.

Metric: Total days supply for all scripts in the included claims set.

Measure: Numerator: unique count of recipient ids for clients with at least 84 days supply of antidepressant medications. Denominator: unique count of recipient ids for all clients with a diagnosis of major depression and treated with antidepressant medication.

Antidepressant Medication Management Measure 2 - **Continuation Phase Treatment: at least 180 days (6 months) continuous treatment with antidepressant medication during 231 day period following IPSD**

Time period: 231 days from IPSD identified above.
Claims to include: all pharmacy claims for antidepressants as identified in table above.
Metric: Total days supply for all scripts in the included claims set.
Measure: Numerator: unique count of recipient ids for clients with at least 180 days supply of antidepressant medications. Denominator: unique count of recipient ids for all clients with a diagnosis of major depression and treated with antidepressant medication.

## INTEGRATED CARE PROGRAM POPULATION WITH DEVELOPMENTAL DISABILITIES ELIGIBLE IN FY09

*Note: all populations described below are limited to the "Integrated Care Program Population with Developmental Disabilities Eligible in FY09" described above.*

Population: A subset of the Integrated Care Program population who have been identified as having Developmental Disabilities:

Time Period: measurement year (FY09)
Clients to include:

1) Clients in the developmental disabilities HCBS waiver (Special Eligibility codes D0, D1 or D2)
   OR
2) Clients with a claim for service in an ICFDD facility (identified as any claim with the following provider type and category of service combinations)

| Provider Type Code | Description | Category of Service Code | Description |
|---|---|---|---|
| 029 | Mentally Retarded Facilities | 038 | Exceptional Care |
| 029 | Mentally Retarded Facilities | 073 | LTC - Intermediate MR |
| 029 | Mentally Retarded Facilities | 074 | LTC - MR Skilled Pediatric |
| 029 | Mentally Retarded Facilities | 076 | LTC - Specialized Living Center - Intermediate MR |
| 037 | DMHDD Day Training | 082 | LTC - Mental Health Brokered Day Training Level I |

3) Clients with a claim with a primary diagnosis described below:

| Code type | Code | Description |
|---|---|---|
| ICD-9 diagnosis | 29900 | AUTISTIC DISORDER, CURRENT OR ACTIVE STATE |
| ICD-9 diagnosis | 29980 | OTH SPEC PERVASIVE DEV DISORDERS, CURRENT, ACTIVE |
| ICD-9 diagnosis | 317 | MILD MENTAL RETARDATION |
| ICD-9 diagnosis | 318 | OTHER MENTAL RETARDATION |
| ICD-9 diagnosis | 3180 | MOD MENTAL RETARDATION |
| ICD-9 diagnosis | 3181 | SEVERE MENTAL RETARDAT |
| ICD-9 diagnosis | 3182 | PROFOUND MENTAL RETARDAT |
| ICD-9 diagnosis | 319 | MENTAL RETARDATION NOS |
| ICD-9 diagnosis | 3430 | CONGENITAL DIPLEGIA |
| ICD-9 diagnosis | 3431 | CONGENITAL HEMIPLEGIA |
| ICD-9 diagnosis | 3432 | CONGENITAL QUADRIPLEGIA |
| ICD-9 diagnosis | 3433 | CONGENITAL MONOPLEGIA |
| ICD-9 diagnosis | 3434 | INFANTILE HEMIPLEGIA |
| ICD-9 diagnosis | 3438 | CEREBRAL PALSY NEC |
| ICD-9 diagnosis | 3439 | CEREBRAL PALSY NOS |
| ICD-9 diagnosis | 3450 | GEN NONCONVULS EPILEPSY |
| ICD-9 diagnosis | 3451 | GEN CONVULSIVE EPILEPSY |
| ICD-9 diagnosis | 3452 | PETIT MAL STATUS |
| ICD-9 diagnosis | 3453 | GRAND MAL STATUS |
| ICD-9 diagnosis | 3454 | PSYCHOMOTOR EPILEPSY |
| ICD-9 diagnosis | 3455 | PARTIAL EPILEPSY NEC |
| ICD-9 diagnosis | 3456 | INFANTILE SPASMS |

| Code type | Code | Description |
|---|---|---|
| ICD-9 diagnosis | 3457 | EPILEPS PARTIAL CONTINUA |
| ICD-9 diagnosis | 3458 | EPILEPSY NEC |
| ICD-9 diagnosis | 3459 | EPILEPSY NOS |
| ICD-9 diagnosis | 7580 | DOWNS SYNDROME |

Metric: Unique recipient ids of clients identified above.

Measure 1 – Clients with at least one PCP visit during the year (clients with developmental disabilities only)

Time period: measurement year (FY09)

Claims to include:

Step 1: For clients NOT enrolled in a home and community-based services waiver (HCBS waiver), pull all claims when provider was the PCP of record, or affiliated with the PCP of record, on the date of service.

Step 2: For clients enrolled in a HCBS waiver, pull all claims when provider was enrolled to participate as a PCP in the Illinois Health Connect (IHC) program on the date of service (HCBS waiver clients were not enrolled in IHC during the measurement year).

Metric: Count unique recipient ids of clients who had a claim that met the criteria in step 1 or step 2 above.

Measure: Numerator = unique clients who had a claim that met the criteria in step 1 or step 2 above. Denominator: Integrated Care Program population with developmental disabilities.

EMERGENCY ROOM VISITS (clients with developmental disabilities only)

Time period: measurement year (FY09)

Claims to include:

1) Outpatient emergency room claims that did not result in an inpatient admission. Use category of service 024 (hospital outpatient) only, and the following revenue codes:

| Revenue Code | Description |
|---|---|
| 0450 | EMERGENCY ROOM (78) |
| 0451 | ER/EMTALA (88) |
| 0452 | ER BEYOND EMTALA SCREENING |
| 0453 | NOT ASSIGNED |
| 0454 | NOT ASSIGNED |
| 0455 | NOT ASSIGNED |
| 0456 | EMERGENCY ROOM/URGENT CARE (85) |
| 0457 | NOT ASSIGNED |
| 0458 | NOT ASSIGNED |
| 0459 | OTHER EMERGENCY ROOM |
| 0981 | PROFESSIONAL FEES / EMERGENCY ROOM |

2) All claims with the following procedure codes:

| Code type | Code | Description |
|---|---|---|
| CPT-IV | 99217 | OBSER CARE DISCHG DAY MANAGE |
| CPT-IV | 99218 | INIT OBSERV PER DAY E/M |
| CPT-IV | 99219 | INITIAL OBSERV PER DAY E/M |
| CPT-IV | 99220 | INITIAL OBSERV PER DAY E/M |
| CPT-IV | 99234 | OBSERVATION OR INPAT. HOSP CARE, EVAL/MANAGE COMP. EXAM |
| CPT-IV | 99235 | OBSERVATION OR INPAT. HOSP. EVAL/MANAGE COMP. EVAL. |
| CPT-IV | 99236 | OBSERVATION OR INPAT. HOSP. CARE EVAL MANAGEMENT EXAM |
| CPT-IV | 99281 | ER VISIT FOR E/M OF PATIENT |
| CPT-IV | 99282 | ER VISIT FOR E/M OF PATIENT |
| CPT-IV | 99283 | ER VISIT FOR E/M OF PATIENT |
| CPT-IV | 99284 | ER VISIT FOR E/M OF PATIENT |
| CPT-IV | 99285 | ER VISIT FOR E/M OF PATIENT |
| CPT-IV | 99286 | PHYS DIRECT EMS/ALS |

| Code type | Code | Description |
|---|---|---|
| CPT-IV | 99297 | SUBSEQ NICU CARE |
| CPT-IV | 99288 | OBS CARE BY FACILITY PT W/ CHK C.P. ASTHMA 8 TO 48* |
| HCPCS | G0244 | OBSER CARE DISCHG DAY MANAGE |

3) Any non-institutional claim with a Place of Service code of 'E' (emergency department)

Metric: An ER visit is a unique occurrence of the recipient id and date of service from the included claims.
Measure: Numerator = Total ER visits (as defined above). Denominator = unique recipient ids for clients in Integrated Care Program population with developmental disabilities during measurement year. (Multiply result by 1,000 to calculate rate per 1,000)

## DIABETES

Population: Integrated Care Program population with diabetes
Look-back period: measurement year (FY09) and prior year (FY08)
Claims to include: any claim with a diagnosis (primary or secondary) listed below

| Code type | Code | Description |
|---|---|---|
| ICD-9 diagnosis | 250.xx | Diabetes mellitus |
| ICD-9 diagnosis | 357.2 | Polyneuropathy in diabetes |
| ICD-9 diagnosis | 362.01 | Background diabetic retinopathy |
| ICD-9 diagnosis | 362.02 | Proliferative diabetic retinopathy |
| ICD-9 diagnosis | 362.03 | Nonproliferative diabetic retinopathy |
| ICD-9 diagnosis | 362.04 | Mild nonproliferative diabetic retinopathy |
| ICD-9 diagnosis | 362.05 | Moderate nonproliferative diabetic retinopathy |
| ICD-9 diagnosis | 362.06 | Severe nonproliferative diabetic retinopathy |
| ICD-9 diagnosis | 362.07 | Diabetic macular edema |
| ICD-9 diagnosis | 366.41 | Diabetic cataract |

Limited by: include clients with two or more claims in any twelve month period.
Metric: Count unique recipient ids.

### Diabetes Measure 1 – HbA1c testing

Look-back period: measurement year (FY09)
Claims to include: any claims for hemoglobin A1c (HbA1c) testing (see table of procedure codes below to identify HbA1c tests)

| Code type | Code | Description |
|---|---|---|
| CPT_IV procedure | 83036 | glycosylated (A1C) |
| CPT_IV procedure | 83037 | glycosylated (A1C) by device cleared for home use |

Limited by: include clients with at least one claim in the look-back period.
Metric: Count unique recipient ids.
Measure: Numerator = Unique count of recipient ids for clients with diabetes who have a claim for HbA1c testing during the measurement year. Denominator = Unique count of recipient ids for clients with diabetes.

### Diabetes Measure 2 – Microalbuminuria testing

Look-back period: measurement year (FY09)
Claims to include: any claims for microalbuminuria testing (see table of procedure codes below to identify microalbuminuria tests)

| Code type | Code | Description |
|---|---|---|
| CPT_IV procedure | 81000 | Urinalysis by dip stick for …protein… |
| CPT_IV procedure | 81001 | …automated |
| CPT_IV procedure | 81002 | …non-automated |
| CPT_IV procedure | 81003 | Urinalysis; quatitative or semi-quantitative except immunoassays |
| CPT_IV procedure | 82042 | Albumin, urine or other source, quantitative |
| CPT_IV procedure | 82043 | urine, microalbumin, quantitative |
| CPT_IV procedure | 82044 | urine, microalbumin, semi-quantitative (eg, reagent strip assay) |

| Code type | Code | Description |
|---|---|---|
| CPT_IV procedure | 84156 | Protein, total - urine |

Limited by: include clients with at least one claim in the look-back period.
Metric: Count unique recipient ids.
Measure: Numerator = Unique count of recipient ids for clients with diabetes who have a claim for microalbuminuria testing during the measurement year. Denominator = Unique count of recipient ids for clients with diabetes.

Diabetes Measure 3 – Cholesterol testing

Look-back period: measurement year (FY09)
Claims to include: any claims for cholesterol testing (see table of procedure codes below to identify cholesterol tests)

| Code type | Code | Description |
|---|---|---|
| CPT_IV procedure | 80061 | Lipid panel, including cholesterol total, lipoprotein direct measurement, high density cholesterol, triglycerides, |
| CPT_IV procedure | 83700 | Lipoprotein, blood; electrophoretic separation and quantitation |
| CPT_IV procedure | 83701 | …high resolutioni factionation… |
| CPT_IV procedure | 83704 | …quantitation of lipoprotein particles numbers… |
| CPT_IV procedure | 83718 | Lipoprotein, direct measurement, high density cholesterol |
| CPT_IV procedure | 83719 | VLDL cholesterol |
| CPT_IV procedure | 83721 | LDL cholesterol |

Limited by: include clients with at least one claim in the look-back period.
Metric: Count unique recipient ids.
Measure: Numerator = Unique count of recipient ids for clients with diabetes who have a claim for cholesterol testing during the measurement year. Denominator = Unique count of recipient ids for clients with diabetes.

Diabetes Measure 4 – Statin therapy 80% of the time

Look-back period: measurement year (FY09)
Claims to include: any scripts for statin drugs (see table of generic drug codes below to identify statin drugs)

| Generic Codes | Generic Name | Strength Description |
|---|---|---|
| 09840 | CHOLESTYRAMINE / ASPARTAME | Drug Code Manual does not give the strength description to this form of the drug (powder) |
| 09850 | CHOLESTYRAMINE / ASPARTAME | 4G |
| 09920 | CHOLESTYRAMINE / SUCROSE | 4G |
| 14295 | CHOLESTYRAMINE / SUCROSE | 4G |
| 16300 | COLESEVELAM HCL | 625MG |
| 25440 | COLESTIPOL HCL | 5G |
| 25441 | COLESTIPOL HCL | 7.5G |
| 25442 | COLESTIPOL HCL | 1G |
| 25450 | COLESTIPOL HCL | Drug Code Manual does not give the strength description to this form of the drug (powder) |
| 19983 | ASPIRIN / CALCIUM CARB/MAG/PRAVA | 81MG - 80MG |
| 12595 | FENOFIBRATE | 160MG |
| 24639 | FENOFIBRATE | 50MG |
| 13906 | FENOFIBRATE, MICRONIZED | 160MG |
| 13907 | FENOFIBRATE, MICRONIZED | 54MG |
| 23759 | FENOFIBRATE, MICRONIZED | 48MG |
| 23763 | FENOFIBRATE, MICRONIZED | 145MG |
| 23922 | FENOFIBRATE, MICRONIZED | 43MG |
| 23923 | FENOFIBRATE, MICRONIZED | 130MG |
| 92504 | FENOFIBRATE, MICRONIZED | 134MG |
| 93437 | FENOFIBRATE, MICRONIZED | 200MG |
| 93446 | FENOFIBRATE, MICRONIZED | 67MG |
| 25540 | GEMFIBROZIL | 600MG |
| 17650 | LOVASTATIN | 10MG |
| 17651 | LOVASTATIN | 20MG |
| 17652 | LOVASTATIN | 40MG |

| Generic Codes | Generic Name | Strength Description |
|---|---|---|
| 17654 | LOVASTATIN | 60MG |
| 47040 | LOVASTATIN | 20MG |
| 47041 | LOVASTATIN | 40MG |
| 47042 | LOVASTATIN | 10MG |
| 42331 | NIACIN (NIASPAN) | 500MG |
| 42332 | NIACIN (NIASPAN) | 750MG |
| 42333 | NIACIN (NIASPAN) | 1000MG |
| 42334 | NIACIN (NIASPAN STARTER PACK) | 50MG |
| 61810 | NIACIN (NIACOR) | 500MG |
| 15165 | NIACIN / LOVASTATIN | 500 - 20MG |
| 15166 | NIACIN / LOVASTATIN | 750 - 20MG |
| 15167 | NIACIN / LOVASTATIN | 1000 - 20MG |
| 27266 | NIACIN / LOVASTATIN | 1000 - 40MG |
| 23929 | OMEGA-3 ACID ETHYL ESTERS | 1G |
| 15412 | PRAVASTATIN SODIUM | 80MG |
| 48671 | PRAVASTATIN SODIUM | 10MG |
| 48672 | PRAVASTATIN SODIUM | 20MG |
| 48673 | PRAVASTATIN SODIUM | 40MG |
| 26531 | SIMVASTATIN | 5MG |
| 26532 | SIMVASTATIN | 10MG |
| 26533 | SIMVASTATIN | 20MG |
| 26534 | SIMVASTATIN | 40MG |
| 26535 | SIMVASTATIN | 80MG |
| 43720 | ATROVASTATIN CALCIUM | 10MG |
| 43721 | ATROVASTATIN CALCIUM | 20MG |
| 43722 | ATROVASTATIN CALCIUM | 40MG |
| 43723 | ATROVASTATIN CALCIUM | 80MG |
| 18387 | EZETIMIBE | 10MG |
| 23121 | EZETIMIBE / SIMVASTATIN | 10 - 10MG |
| 23125 | EZETIMIBE / SIMVASTATIN | 10 - 20MG |
| 23126 | EZETIMIBE / SIMVASTATIN | 10MG - 80MG |
| 23127 | EZETIMIBE / SIMVASTATIN | 10MG - 40MG |
| 00030 | FLUVASTATIN SODIUM | 20MG |
| 00031 | FLUVASTATIN SODIUM | 40MG |
| 89424 | FLUVASTATIN SODIUM | 80MG |
| 19153 | ROSUVASTATIN CALCIUM | 10MG |
| 19154 | ROSUVASTATIN CALCIUM | 20MG |
| 19155 | ROSUVASTATIN CALCIUM | 40MG |
| 20229 | ROSUVASTATIN CALCIUM | 5MG |
| 21391 | AMLODIPPINE / ATROVAST CAL | 5 - 10MG |
| 21392 | AMLODIPPINE / ATROVAST CAL | 5 - 20MG |
| 21393 | AMLODIPPINE / ATROVAST CAL | 5MG - 40MG |
| 21394 | AMLODIPPINE / ATROVAST CAL | 5MG - 80MG |
| 21395 | AMLODIPPINE / ATROVAST CAL | 10 - 10MG |
| 21396 | AMLODIPPINE / ATROVAST CAL | 10 - 20MG |
| 21397 | AMLODIPPINE / ATROVAST CAL | 10MG - 40MG |
| 21398 | AMLODIPPINE / ATROVAST CAL | 10MG - 80MG |
| 23866 | AMLODIPPINE / ATROVAST CAL | 2.5MG - 10MG |
| 23867 | AMLODIPPINE / ATROVAST CAL | 2.5MG - 20MG |
| 23868 | AMLODIPPINE / ATROVAST CAL | 2.5MG - 40MG |
| 94881 | NIACIN (NIACOR) | 500MG |
| 94891 | NIACIN (SLO-NIACIN) | 500MG |

Limited by: include all scripts in the look-back period.
Metric: Sum total days supply for all statins.

Metric (done for each unique recipient, expressed as a percent): Numerator = Total days supply for all statins in the look-back period. Denominator = Total days client was enrolled during the look-back period.
Measure: Numerator = Unique count of recipient ids for clients whose metric (above) was 80% or higher. Denominator = Unique count of recipient ids for clients with diabetes.

Diabetes Measure 5 – ACE/ARB 80% of the time

Look-back period: measurement year (FY09)

Claims to include: any scripts for ACE inhibitors or angiotensin receptor blockers (see table of generic drug codes below to identify ACE/ARBs)

| Generic Codes | Generic Name | Strength Description |
|---|---|---|
| 48611 | BENAZEPRIL HCL | 5MG |
| 48612 | BENAZEPRIL HCL | 10MG |
| 48613 | BENAZEPRIL HCL | 20MG |
| 48614 | BENAZEPRIL HCL | 40MG |
| 01480 | CAPTOPRIL | 100MG |
| 01481 | CAPTOPRIL | 25MG |
| 01482 | CAPTOPRIL | 50MG |
| 01483 | CAPTOPRIL | 12.5MG |
| 00960 | ENLAPRIL MALEATE | 5MG |
| 00961 | ENLAPRIL MALEATE | 10MG |
| 00962 | ENLAPRIL MALEATE | 20MG |
| 00963 | ENLAPRIL MALEATE | 2.5MG |
| 48580 | FOSINOPRIL SODIUM | 40MG |
| 48581 | FOSINOPRIL SODIUM | 10MG |
| 48582 | FOSINOPRIL SODIUM | 20MG |
| 47260 | LISINOPRIL | 5MG |
| 47261 | LISINOPRIL | 10MG |
| 47262 | LISINOPRIL | 20MG |
| 47263 | LISINOPRIL | 40MG |
| 47264 | LISINOPRIL | 2.5MG |
| 47265 | LISINOPRIL | 30MG |
| 48561 | MOEXIPRIL HCL | 7.5MG |
| 48562 | MOEXIPRIL HCL | 15MG |
| 13758 | PERINDOPRIL ERBUMINE | 2MG |
| 13759 | PERINDOPRIL ERBUMINE | 4MG |
| 93207 | PERINDOPRIL ERBUMINE | 8MG |
| 27570 | QUNIAPRIL HCL | 10MG |
| 27571 | QUNIAPRIL HCL | 20MG |
| 27572 | QUNIAPRIL HCL | 5MG |
| 27573 | QUNIAPRIL HCL | 40MG |
| 48541 | RAMIPRIL | 1.25MG |
| 48542 | RAMIPRIL | 2.5MG |
| 48543 | RAMIPRIL | 5MG |
| 48544 | RAMIPRIL | 10MG |
| 32191 | TRANDOLAPRIL | 1MG |
| 32192 | TRANDOLAPRIL | 2MG |
| 32193 | TRANDOLAPRIL | 4MG |
| 17604 | AMLODIPINE BESYLATE / BENAZEPRIL | 10MG-20MG |
| 26949 | AMLODIPINE BESYLATE / BENAZEPRIL | 5MG-40MG |
| 26950 | AMLODIPINE BESYLATE / BENAZEPRIL | 10MG-40MG |
| 33090 | AMLODIPINE BESYLATE / BENAZEPRIL | 5MG-20MG |
| 33092 | AMLODIPINE BESYLATE / BENAZEPRIL | 5MG-10MG |
| 33093 | AMLODIPINE BESYLATE / BENAZEPRIL | 2.5MG-10MG |
| 54501 | ENALAPRIL MALEATE / FELODIPINE | 5MG-5MG |
| 54502 | ENALAPRIL MALEATE / FELODIPINE | 5MG-2.5MG |
| 32111 | TRANDOLAPRIL / VERAPAMIL HCL | 2MG-180MG |
| 32112 | TRANDOLAPRIL / VERAPAMIL HCL | 1MG-24MG |

| Generic Codes | Generic Name | Strength Description |
|---|---|---|
| 32113 | TRANDOLAPRIL / VERAPAMIL HCL | 2MG-24MG |
| 32114 | TRANDOLAPRIL / VERAPAMIL HCL | 4MG-24MG |
| 73542 | CANDESARTAN CILEXETIL | 4MG |
| 73543 | CANDESARTAN CILEXETIL | 8MG |
| 73544 | CANDESARTAN CILEXETIL | 16MG |
| 73545 | CANDESARTAN CILEXETIL | 32MG |
| 47612 | EPROSARTAN MESYLATE | 400MG |
| 93456 | EPROSARTAN MESYLATE | 600MG |
| 04749 | IRBESARTAN | 150MG |
| 04750 | IRBESARTAN | 300MG |
| 04752 | IRBESARTAN | 75MG |
| 14850 | LOSARTAN POTASSIUM | 25MG |
| 14851 | LOSARTAN POTASSIUM | 50MG |
| 14853 | LOSARTAN POTASSIUM | 100MG |
| 17284 | OLMESARTAN MEDOXOMIL | 5MG |
| 17285 | OLMESARTAN MEDOXOMIL | 20MG |
| 17286 | OLMESARTAN MEDOXOMIL | 40MG |
| 23831 | TELMISARTAN | 40MG |
| 23832 | TELMISARTAN | 80MG |
| 23833 | TELMISARTAN | 20MG |
| 13838 | VALSARTAN | 320MG |
| 13844 | VALSARTAN | 160MG |
| 13846 | VALSARTAN | 80MG |
| 15902 | VALSARTAN | 80MG |
| 15903 | VALSARTAN | 160MG |
| 18092 | VALSARTAN | 40MG |
| 33191 | BENAZEPRIL / HYDROCHLORTHIAZIDE | 5MG - 6.25MG |
| 33192 | BENAZEPRIL / HYDROCHLORTHIAZIDE | 10MG - 12.5 MG |
| 33193 | BENAZEPRIL / HYDROCHLORTHIAZIDE | 20MG - 12.5 MG |
| 33194 | BENAZEPRIL / HYDROCHLORTHIAZIDE | 20MG - 25 MG |
| 54940 | CAPTOPRIL / HYDROCHLORTHIAZIDE | 25MG - 15 MG |
| 54941 | CAPTOPRIL / HYDROCHLORTHIAZIDE | 25MG - 25 MG |
| 54942 | CAPTOPRIL / HYDROCHLORTHIAZIDE | 50MG - 15 MG |
| 54943 | CAPTOPRIL / HYDROCHLORTHIAZIDE | 50MG - 25MG |
| 54860 | ENALAPRIL / HYDROCHLORTHIAZIDE | 10MG - 25MG |
| 54862 | ENALAPRIL / HYDROCHLORTHIAZIDE | 5MG - 12.5 MG |
| 10455 | FOSINOPRIL / HYDROCHLORTHIAZIDE | 20MG - 12.5 MG |
| 15621 | FOSINOPRIL / HYDROCHLORTHIAZIDE | 10MG - 12.5 MG |
| 88000 | LISINOPRIL / HYDROCHLORTHIAZIDE | 20MG - 12.5 MG |
| 88001 | LISINOPRIL / HYDROCHLORTHIAZIDE | 20MG - 25 MG |
| 88002 | LISINOPRIL / HYDROCHLORTHIAZIDE | 10MG - 12.5 MG |
| 15777 | MOEXIPRIL / HYDROCHLORTHIAZIDE | 15MG - 12.5MG |
| 67721 | MOEXIPRIL / HYDROCHLORTHIAZIDE | 15MG - 25MG |
| 67722 | MOEXIPRIL / HYDROCHLORTHIAZIDE | 7.5MG - 12.5MG |
| 54160 | QUINAPRIL / HYDROCHLORTHIAZIDE | 10MG - 12.5MG |
| 54161 | QUINAPRIL / HYDROCHLORTHIAZIDE | 20MG - 12.5MG |
| 94490 | QUINAPRIL / HYDROCHLORTHIAZIDE | 20MG - 25 MG |
| 21559 | CANDESARTAN / HYDROCHLORTHIAZIDE | 16MG - 12.5MG |
| 21569 | CANDESARTAN / HYDROCHLORTHIAZIDE | 32MG - 12.5MG |
| 18883 | EPROSARTAN / HYDROCHLORTHIAZIDE | 600MG - 12.5MG |
| 18884 | EPROSARTAN / HYDROCHLORTHIAZIDE | 600MG - 25MG |
| 11042 | IRBESARTAN / HYDROCHLORTHIAZIDE | 150MG - 12.5MG |
| 11295 | IRBESARTAN / HYDROCHLORTHIAZIDE | 300MG - 12.5MG |
| 24622 | IRBESARTAN / HYDROCHLORTHIAZIDE | 300MG - 25MG |
| 14852 | LOSARTAN / HYDROCHLORTHIAZIDE | 50MG - 12.5MG |
| 14854 | LOSARTAN / HYDROCHLORTHIAZIDE | 100MG - 25MG |

| Generic Codes | Generic Name | Strength Description |
|---|---|---|
| 25851 | LOSARTAN / HYDROCHLORTHIAZIDE | 100MG - 12.5MG |
| 20074 | OLMESARTAN / HYDROCHLORTHIAZIDE | 20MG - 12.5MG |
| 20075 | OLMESARTAN / HYDROCHLORTHIAZIDE | 40MG - 12.5 MG |
| 20076 | OLMESARTAN / HYDROCHLORTHIAZIDE | 40MG - 25MG |
| 12257 | TELMISARTAN / HYDROCHLORTHIAZIDE | 40MG - 12.5 MG |
| 12259 | TELMISARTAN / HYDROCHLORTHIAZIDE | 80MG - 12.5MG |
| 22866 | TELMISARTAN / HYDROCHLORTHIAZIDE | 80MG - 25MG |
| 07833 | VALSARTAN / HYDROCHLORTHIAZIDE | 80MG - 12.5MG |
| 09760 | VALSARTAN / HYDROCHLORTHIAZIDE | 160MG - 12.5MG |
| 17245 | VALSARTAN / HYDROCHLORTHIAZIDE | 160MG - 25MG |
| 27014 | VALSARTAN / HYDROCHLORTHIAZIDE | 320MG - 25MG |
| 27015 | VALSARTAN / HYDROCHLORTHIAZIDE | 320MG -12.5MG |

Limited by: include all scripts in the look-back period.
Metric: Sum total days supply for all ACE/ARBs.
Metric (done for each unique recipient, expressed as a percent): Numerator = Total days supply for all ACE/ARBs in the look-back period. Denominator = Total days client was enrolled during the look-back period.
Measure: Numerator = Unique count of recipient ids for clients whose ACE/ARB metric (above) was 80% or higher. Denominator = Unique count of recipient ids for clients with diabetes.

## CONGESTIVE HEART FAILURE (CHF)

Population: Integrated Care Program population with congestive heart failure
Look-back period: measurement year (FY09) and prior year (FY08)
Claims to include: any claim with a diagnosis or procedure from table below

| Code type | Code | Description |
|---|---|---|
| ICD-9 diagnosis | 428.xx | Heart failure |
| ICD-9 diagnosis | 402.01 | Hypertensive heart disease, malignant, with heart failure |
| ICD-9 diagnosis | 402.11 | Hypertensive heart disease, benign, with heart failure |
| ICD-9 diagnosis | 402.91 | Hypertensive heart disease, unspecified, with heart failure |
| ICD-9 diagnosis | 404.01 | Hypertensive heart & kidney disease, malignant, with heart failure |
| ICD-9 diagnosis | 404.03 | Hypertensive heart & kidney disease, malignant, with heart failure & chronic kidney disease |
| ICD-9 diagnosis | 404.11 | Hypertensive heart & kidney disease, benign, with heart failure |
| ICD-9 diagnosis | 404.13 | Hypertensive heart & kidney disease, benign, with heart failure & chronic kidney disease |
| ICD-9 diagnosis | 404.91 | Hypertensive heart & kidney disease, unspecified, with heart failure |
| ICD-9 diagnosis | 404.93 | Hypertensive heart & kidney disease, unspecified, with heart failure & chronic kidney disease |

Metric: Count unique recipient ids.

CHF Measure 1 – ACE/ARB 80% of the time
Look-back period: measurement year (FY09)
Claims to include: any scripts for ACE inhibitors or angiotensin receptor blockers (see table of generic drug codes below to identify ACE/ARBs)

| Generic Codes | Generic Name | Strength Description |
|---|---|---|
| 48611 | BENAZEPRIL HCL | 5MG |
| 48612 | BENAZEPRIL HCL | 10MG |
| 48613 | BENAZEPRIL HCL | 20MG |
| 48614 | BENAZEPRIL HCL | 40MG |
| 01480 | CAPTOPRIL | 100MG |
| 01481 | CAPTOPRIL | 25MG |
| 01482 | CAPTOPRIL | 50MG |
| 01483 | CAPTOPRIL | 12.5MG |
| 00960 | ENLAPRIL MALEATE | 5MG |
| 00961 | ENLAPRIL MALEATE | 10MG |
| 00962 | ENLAPRIL MALEATE | 20MG |
| 00963 | ENLAPRIL MALEATE | 2.5MG |

| Generic Codes | Generic Name | Strength Description |
|---|---|---|
| 48580 | FOSINOPRIL SODIUM | 40MG |
| 48581 | FOSINOPRIL SODIUM | 10MG |
| 48582 | FOSINOPRIL SODIUM | 20MG |
| 47260 | LISINOPRIL | 5MG |
| 47261 | LISINOPRIL | 10MG |
| 47262 | LISINOPRIL | 20MG |
| 47263 | LISINOPRIL | 40MG |
| 47264 | LISINOPRIL | 2.5MG |
| 47265 | LISINOPRIL | 30MG |
| 48561 | MOEXIPRIL HCL | 7.5MG |
| 48562 | MOEXIPRIL HCL | 15MG |
| 13758 | PERINDOPRIL ERBUMINE | 2MG |
| 13759 | PERINDOPRIL ERBUMINE | 4MG |
| 93207 | PERINDOPRIL ERBUMINE | 8MG |
| 27570 | QUNIAPRIL HCL | 10MG |
| 27571 | QUNIAPRIL HCL | 20MG |
| 27572 | QUNIAPRIL HCL | 5MG |
| 27573 | QUNIAPRIL HCL | 40MG |
| 48541 | RAMIPRIL | 1.25MG |
| 48542 | RAMIPRIL | 2.5MG |
| 48543 | RAMIPRIL | 5MG |
| 48544 | RAMIPRIL | 10MG |
| 32191 | TRANDOLAPRIL | 1MG |
| 32192 | TRANDOLAPRIL | 2MG |
| 32193 | TRANDOLAPRIL | 4MG |
| 17604 | AMLODIPINE BESYLATE / BENAZEPRIL | 10MG-20MG |
| 26949 | AMLODIPINE BESYLATE / BENAZEPRIL | 5MG-40MG |
| 26950 | AMLODIPINE BESYLATE / BENAZEPRIL | 10MG-40MG |
| 33090 | AMLODIPINE BESYLATE / BENAZEPRIL | 5MG-20MG |
| 33092 | AMLODIPINE BESYLATE / BENAZEPRIL | 5MG-10MG |
| 33093 | AMLODIPINE BESYLATE / BENAZEPRIL | 2.5MG-10MG |
| 54501 | ENALAPRIL MALEATE / FELODIPINE | 5MG-5MG |
| 54502 | ENALAPRIL MALEATE / FELODIPINE | 5MG-2.5MG |
| 32111 | TRANDOLAPRIL / VERAPAMIL HCL | 2MG-180MG |
| 32112 | TRANDOLAPRIL / VERAPAMIL HCL | 1MG-24MG |
| 32113 | TRANDOLAPRIL / VERAPAMIL HCL | 2MG-24MG |
| 32114 | TRANDOLAPRIL / VERAPAMIL HCL | 4MG-24MG |
| 73542 | CANDESARTAN CILEXETIL | 4MG |
| 73543 | CANDESARTAN CILEXETIL | 8MG |
| 73544 | CANDESARTAN CILEXETIL | 16MG |
| 73545 | CANDESARTAN CILEXETIL | 32MG |
| 47612 | EPROSARTAN MESYLATE | 400MG |
| 93456 | EPROSARTAN MESYLATE | 600MG |
| 04749 | IRBESARTAN | 150MG |
| 04750 | IRBESARTAN | 300MG |
| 04752 | IRBESARTAN | 75MG |
| 14850 | LOSARTAN POTASSIUM | 25MG |
| 14851 | LOSARTAN POTASSIUM | 50MG |
| 14853 | LOSARTAN POTASSIUM | 100MG |
| 17284 | OLMESARTAN MEDOXOMIL | 5MG |
| 17285 | OLMESARTAN MEDOXOMIL | 20MG |
| 17286 | OLMESARTAN MEDOXOMIL | 40MG |
| 23831 | TELMISARTAN | 40MG |
| 23832 | TELMISARTAN | 80MG |
| 23833 | TELMISARTAN | 20MG |
| 13838 | VALSARTAN | 320MG |

| Generic Codes | Generic Name | Strength Description |
|---|---|---|
| 13844 | VALSARTAN | 160MG |
| 13846 | VALSARTAN | 80MG |
| 15902 | VALSARTAN | 80MG |
| 15903 | VALSARTAN | 160MG |
| 18092 | VALSARTAN | 40MG |
| 33191 | BENAZEPRIL / HYDROCHLORTHIAZIDE | 5MG - 6.25MG |
| 33192 | BENAZEPRIL / HYDROCHLORTHIAZIDE | 10MG - 12.5 MG |
| 33193 | BENAZEPRIL / HYDROCHLORTHIAZIDE | 20MG - 12.5 MG |
| 33194 | BENAZEPRIL / HYDROCHLORTHIAZIDE | 20MG - 25 MG |
| 54940 | CAPTOPRIL / HYDROCHLORTHIAZIDE | 25MG - 15 MG |
| 54941 | CAPTOPRIL / HYDROCHLORTHIAZIDE | 25MG - 25 MG |
| 54942 | CAPTOPRIL / HYDROCHLORTHIAZIDE | 50MG - 15 MG |
| 54943 | CAPTOPRIL / HYDROCHLORTHIAZIDE | 50MG - 25MG |
| 54860 | ENALAPRIL / HYDROCHLORTHIAZIDE | 10MG - 25MG |
| 54862 | ENALAPRIL / HYDROCHLORTHIAZIDE | 5MG - 12.5 MG |
| 10455 | FOSINOPRIL / HYDROCHLORTHIAZIDE | 20MG - 12.5 MG |
| 15621 | FOSINOPRIL / HYDROCHLORTHIAZIDE | 10MG - 12.5 MG |
| 88000 | LISINOPRIL / HYDROCHLORTHIAZIDE | 20MG - 12.5 MG |
| 88001 | LISINOPRIL / HYDROCHLORTHIAZIDE | 20MG - 25 MG |
| 88002 | LISINOPRIL / HYDROCHLORTHIAZIDE | 10MG - 12.5 MG |
| 15777 | MOEXIPRIL / HYDROCHLORTHIAZIDE | 15MG - 12.5MG |
| 67721 | MOEXIPRIL / HYDROCHLORTHIAZIDE | 15MG - 25MG |
| 67722 | MOEXIPRIL / HYDROCHLORTHIAZIDE | 7.5MG - 12.5MG |
| 54160 | QUINAPRIL / HYDROCHLORTHIAZIDE | 10MG - 12.5MG |
| 54161 | QUINAPRIL / HYDROCHLORTHIAZIDE | 20MG - 12.5MG |
| 94490 | QUINAPRIL / HYDROCHLORTHIAZIDE | 20MG - 25 MG |
| 21559 | CANDESARTAN / HYDROCHLORTHIAZIDE | 16MG - 12.5MG |
| 21569 | CANDESARTAN / HYDROCHLORTHIAZIDE | 32MG - 12.5MG |
| 18883 | EPROSARTAN / HYDROCHLORTHIAZIDE | 600MG - 12.5MG |
| 18884 | EPROSARTAN / HYDROCHLORTHIAZIDE | 600MG - 25MG |
| 11042 | IRBESARTAN / HYDROCHLORTHIAZIDE | 150MG - 12.5MG |
| 11295 | IRBESARTAN / HYDROCHLORTHIAZIDE | 300MG - 12.5MG |
| 24622 | IRBESARTAN / HYDROCHLORTHIAZIDE | 300MG - 25MG |
| 14852 | LOSARTAN / HYDROCHLORTHIAZIDE | 50MG - 12.5MG |
| 14854 | LOSARTAN / HYDROCHLORTHIAZIDE | 100MG - 25MG |
| 25851 | LOSARTAN / HYDROCHLORTHIAZIDE | 100MG - 12.5MG |
| 20074 | OLMESARTAN / HYDROCHLORTHIAZIDE | 20MG - 12.5MG |
| 20075 | OLMESARTAN / HYDROCHLORTHIAZIDE | 40MG - 12.5 MG |
| 20076 | OLMESARTAN / HYDROCHLORTHIAZIDE | 40MG - 25MG |
| 12257 | TELMISARTAN / HYDROCHLORTHIAZIDE | 40MG - 12.5 MG |
| 12259 | TELMISARTAN / HYDROCHLORTHIAZIDE | 80MG - 12.5MG |
| 22866 | TELMISARTAN / HYDROCHLORTHIAZIDE | 80MG - 25MG |
| 07833 | VALSARTAN / HYDROCHLORTHIAZIDE | 80MG - 12.5MG |
| 09760 | VALSARTAN / HYDROCHLORTHIAZIDE | 160MG - 12.5MG |
| 17245 | VALSARTAN / HYDROCHLORTHIAZIDE | 160MG - 25MG |
| 27014 | VALSARTAN / HYDROCHLORTHIAZIDE | 320MG - 25MG |
| 27015 | VALSARTAN / HYDROCHLORTHIAZIDE | 320MG -12.5MG |

Limited by: include all scripts in the look-back period.
Metric: Sum total days supply for all ACE/ARBs.
Metric (done for each unique recipient, expressed as a percent): Numerator = Total days supply for all ACE/ARBs in the look-back period. Denominator = Total days client was enrolled during the look-back period.
Measure: Numerator = Unique count of recipient ids for clients whose ACE/ARB metric (above) was 80% or higher. Denominator = Unique count of recipient ids for clients with CHF.

CHF Measure 2 – Beta blocker 80% of the time

Look-back period: measurement year (FY09)

Claims to include: any scripts for beta blockers (see table of generic drug codes below to identify beta blockers)

| Generic Code | Generic Name | Strength Description |
|---|---|---|
| 01551 | CARVEDILOL | 25MG |
| 01552 | CARVEDILOL | 12.5MG |
| 01553 | CARVEDILOL | 3.125MG |
| 01554 | CARVEDILOL | 6.25MG |
| 10340 | LABETLOL HCL | 300MG |
| 10341 | LABETLOL HCL | 200MG |
| 10342 | LABETLOL HCL | 100MG |
| 26460 | ACEBUTOLOL HCL | 200MG |
| 26461 | ACEBUTOLOL HCL | 400MG |
| 20660 | ATENOLOL | 100MG |
| 20661 | ATENOLOL | 50MG |
| 20662 | ATENOLOL | 25MG |
| 12791 | BETAXOLOL HCL | 10MG |
| 12792 | BETAXOLOL HCL | 20MG |
| 63820 | BISOPROLOL FUMARATE | 10MG |
| 63821 | BISOPROLOL FUMARATE | 5MG |
| 12947 | METOPROLOL SUCCINATE | 25MG |
| 20741 | METOPROLOL SUCCINATE | 50MG |
| 20742 | METOPROLOL SUCCINATE | 100MG |
| 20743 | METOPROLOL SUCCINATE | 200MG |
| 17734 | METOPROLOL TARTRATE | 25MG |
| 20641 | METOPROLOL TARTRATE | 100MG |
| 20642 | METOPROLOL TARTRATE | 50MG |
| 20650 | NADOLOL | 120MG |
| 20651 | NADOLOL | 160MG |
| 20652 | NADOLOL | 40MG |
| 20653 | NADOLOL | 80MG |
| 20654 | NADOLOL | 20MG |
| 39350 | PENBUTOLOL SULFATE | 20MG |
| 20680 | PINDOLOL | 10MG |
| 20681 | PINDOLOL | 5MG |
| 03230 | PROPRANOLOL HCL | 80MG |
| 03231 | PROPRANOLOL HCL | 120MG |
| 03232 | PROPRANOLOL HCL | 160MG |
| 03233 | PROPRANOLOL HCL | 60MG |
| 19359 | PROPRANOLOL HCL | 120MG |
| 20621 | PROPRANOLOL HCL | 80MG |
| 20630 | PROPRANOLOL HCL | 10MG |
| 20631 | PROPRANOLOL HCL | 20MG |
| 20632 | PROPRANOLOL HCL | 40MG |
| 20633 | PROPRANOLOL HCL | 60MG |
| 20634 | PROPRANOLOL HCL | 80MG |
| 20635 | PROPRANOLOL HCL | 90MG |
| 39511 | SOTALOL HCL | 160MG |
| 39512 | SOTALOL HCL | 80MG |
| 39513 | SOTALOL HCL | 240MG |
| 39516 | SOTALOL HCL | 120MG |
| 20670 | TIMOLOL MALEATE | 10MG |
| 20671 | TIMOLOL MALEATE | 20MG |
| 20672 | TIMOLOL MALEATE | 5MG |
| 39340 | CARTEOLOL HCL | 2.5MG |
| 39341 | CARTEOLOL HCL | 5MG |
| 66990 | ATENOLOL / CHLORTHALIDONE | 50MG-25MG |

| Generic Code | Generic Name | Strength Description |
|---|---|---|
| 66991 | ATENOLOL / CHLORTHALIDONE | 100 - 25MG |
| 45061 | BISOPROLOL / HYDROCHOLRTHIAZIDE | 2.5 - 6.25MG |
| 45062 | BISOPROLOL / HYDROCHOLRTHIAZIDE | 5 - 6.25MG |
| 45063 | BISOPROLOL / HYDROCHOLRTHIAZIDE | 10 - 6.25MG |
| 51550 | METOPROLOL / HYDROCHOLRTHIAZIDE | 50MG-25MG |
| 51551 | METOPROLOL / HYDROCHOLRTHIAZIDE | 100MG-25MG |
| 51552 | METOPROLOL / HYDROCHOLRTHIAZIDE | 100MG-50MG |
| 52060 | NADOLOL / BENDROFLUMETHIAZIDE | 40 - 5MG |
| 52061 | NADOLOL / BENDROFLUMETHIAZIDE | 80 - 5MG |
| 52030 | PROPRANOLOL HCL / HCTZ | 40 - 25MG |
| 52031 | PROPRANOLOL HCL / HCTZ | 80 - 25MG |
| 52030 | PROPRANOLOL / HYDROCHLORTHIAZIDE | 40 - 25MG |
| 52031 | PROPRANOLOL / HYDROCHLORTHIAZIDE | 80 - 25MG |
| 52050 | TIMOLOL / HYDROCHLORTHIAZIDE | 10 - 25MG |

Limited by: include all scripts in the look-back period.
Metric: Sum total days supply for all beta blockers.
Metric (done for each unique recipient, expressed as a percent): Numerator = Total days supply for all beta blockers in the look-back period. Denominator = Total days client was enrolled during the look-back period.
Measure: Numerator = Unique count of recipient ids for clients whose beta blocker metric (above) was 80% or higher. Denominator = Unique count of recipient ids for clients with CHF.

CHF Measure 3 – Diuretic 80% of the time

Look-back period: measurement year (FY09)
Claims to include: any scripts for diuretics (see table of generic drug codes below to identify diuretics)

| Generic Codes | Generic Name | Strength Description |
|---|---|---|
| 34802 | CHLORTHIAZIDE | 250MG |
| 34803 | CHLORTHIAZIDE | 500MG |
| 34981 | CHLORTHALIDONE | 100MG |
| 34982 | CHLORTHALIDONE | 25MG |
| 34984 | CHLORTHALIDONE | 50MG |
| 34985 | CHLORTHALIDONE | 15MG |
| 34820 | HYDROCHLORTHIAZIDE | 12.5MG |
| 34824 | HYDROCHLORTHIAZIDE | 25MG |
| 34825 | HYDROCHLORTHIAZIDE | 50MG |
| 07310 | INDAPAMIDE | 2.5MG |
| 07311 | INDAPAMIDE | 1.25MG |
| 34871 | METHYCLOTHIAZIDE | 5MG |
| 34990 | METOLAZONE | 10MG |
| 34991 | METOLAZONE | 2.5MG |
| 34992 | METOLAZONE | 5MG |
| 27700 | AMILORIDE HCL | 5MG |
| 91883 | EPLERENONE | 25MG |
| 91884 | EPLERENONE | 50MG |
| 27690 | SPIRONOLACTONE | 100MG |
| 27691 | SPIRONOLACTONE | 25MG |
| 27692 | SPIRONOLACTONE | 50MG |
| 82341 | AMILORIDE HCL / HCTZ | 5-50MG |
| 82330 | SPIRONOLACT / HYDROCHLORTHIAZID | 25MG - 25MG |
| 82331 | SPIRONOLACT / HYDROCHLORTHIAZID | 50 - 50MG |
| 88730 | TRIAMTERENE / HCTZ | 50 - 25MG |
| 88740 | TRIAMTERENE / HCTZ | 75 - 50MG |
| 88730 | TRIAMTERENE / HYDROCHLORTHIAZIDE | 50MG - 25MG |
| 88731 | TRIAMTERENE / HYDROCHLORTHIAZIDE | 37.5 - 25MG |
| 88740 | TRIAMTERENE / HYDROCHLORTHIAZIDE | 75 - 50MG |
| 88741 | TRIAMTERENE / HYDROCHLORTHIAZIDE | 37.5 - 25MG |

| Generic Codes | Generic Name | Strength Description |
|---|---|---|
| 35020 | BUMETANIDE | 0.5MG |
| 35021 | BUMETANIDE | 1MG |
| 35022 | BUMETANIDE | 2MG |
| 34910 | ETHACRYNIC ACID | 25MG |
| 34961 | FUROSEMIDE | 20MG |
| 34962 | FUROSEMIDE | 40MG |
| 34963 | FUROSEMIDE | 80MG |
| 21130 | TORSEMIDE | 5MG |
| 21131 | TORSEMIDE | 10MG |
| 21132 | TORSEMIDE | 20MG |
| 21133 | TORSEMIDE | 100MG |
| 33191 | BENAZEPRIL / HYDROCHLORTHIAZIDE | 5MG - 6.25MG |
| 33192 | BENAZEPRIL / HYDROCHLORTHIAZIDE | 10MG - 12.5 MG |
| 33193 | BENAZEPRIL / HYDROCHLORTHIAZIDE | 20MG - 12.5 MG |
| 33194 | BENAZEPRIL / HYDROCHLORTHIAZIDE | 20MG - 25 MG |
| 54940 | CAPTOPRIL / HYDROCHLORTHIAZIDE | 25MG - 15 MG |
| 54941 | CAPTOPRIL / HYDROCHLORTHIAZIDE | 25MG - 25 MG |
| 54942 | CAPTOPRIL / HYDROCHLORTHIAZIDE | 50MG - 15 MG |
| 54943 | CAPTOPRIL / HYDROCHLORTHIAZIDE | 50MG - 25MG |
| 54860 | ENALAPRIL / HYDROCHLORTHIAZIDE | 10MG - 25MG |
| 54862 | ENALAPRIL / HYDROCHLORTHIAZIDE | 5MG - 12.5 MG |
| 10455 | FOSINOPRIL / HYDROCHLORTHIAZIDE | 20MG - 12.5 MG |
| 15621 | FOSINOPRIL / HYDROCHLORTHIAZIDE | 10MG - 12.5 MG |
| 88000 | LISINOPRIL / HYDROCHLORTHIAZIDE | 20MG - 12.5 MG |
| 88001 | LISINOPRIL / HYDROCHLORTHIAZIDE | 20MG - 25 MG |
| 88002 | LISINOPRIL / HYDROCHLORTHIAZIDE | 10MG - 12.5 MG |
| 15777 | MOEXIPRIL / HYDROCHLORTHIAZIDE | 15MG - 12.5MG |
| 67721 | MOEXIPRIL / HYDROCHLORTHIAZIDE | 15MG - 25MG |
| 67722 | MOEXIPRIL / HYDROCHLORTHIAZIDE | 7.5MG - 12.5MG |
| 54160 | QUINAPRIL / HYDROCHLORTHIAZIDE | 10MG - 12.5MG |
| 54161 | QUINAPRIL / HYDROCHLORTHIAZIDE | 20MG - 12.5MG |
| 94490 | QUINAPRIL / HYDROCHLORTHIAZIDE | 20MG - 25 MG |
| 21559 | CANDESARTAN / HYDROCHLORTHIAZIDE | 16MG - 12.5MG |
| 21569 | CANDESARTAN / HYDROCHLORTHIAZIDE | 32MG - 12.5MG |
| 18883 | EPROSARTAN / HYDROCHLORTHIAZIDE | 600MG - 12.5MG |
| 18884 | EPROSARTAN / HYDROCHLORTHIAZIDE | 600MG - 25MG |
| 11042 | IRBESARTAN / HYDROCHLORTHIAZIDE | 150MG - 12.5MG |
| 11295 | IRBESARTAN / HYDROCHLORTHIAZIDE | 300MG - 12.5MG |
| 24622 | IRBESARTAN / HYDROCHLORTHIAZIDE | 300MG - 25MG |
| 14852 | LOSARTAN / HYDROCHLORTHIAZIDE | 50MG - 12.5MG |
| 14854 | LOSARTAN / HYDROCHLORTHIAZIDE | 100MG - 25MG |
| 25851 | LOSARTAN / HYDROCHLORTHIAZIDE | 100MG - 12.5MG |
| 20074 | OLMESARTAN / HYDROCHLORTHIAZIDE | 20MG - 12.5MG |
| 20075 | OLMESARTAN / HYDROCHLORTHIAZIDE | 40MG - 12.5 MG |
| 20076 | OLMESARTAN / HYDROCHLORTHIAZIDE | 40MG - 25MG |
| 12257 | TELMISARTAN / HYDROCHLORTHIAZIDE | 40MG - 12.5 MG |
| 12259 | TELMISARTAN / HYDROCHLORTHIAZIDE | 80MG - 12.5MG |
| 22866 | TELMISARTAN / HYDROCHLORTHIAZIDE | 80MG - 25MG |
| 07833 | VALSARTAN / HYDROCHLORTHIAZIDE | 80MG - 12.5MG |
| 09760 | VALSARTAN / HYDROCHLORTHIAZIDE | 160MG - 12.5MG |
| 17245 | VALSARTAN / HYDROCHLORTHIAZIDE | 160MG - 25MG |
| 27014 | VALSARTAN / HYDROCHLORTHIAZIDE | 320MG - 25MG |
| 27015 | VALSARTAN / HYDROCHLORTHIAZIDE | 320MG -12.5MG |
| 66990 | ATENOLOL / CHLORTHALIDONE | 50MG-25MG |
| 66991 | ATENOLOL / CHLORTHALIDONE | 100 - 25MG |
| 45061 | BISOPROLOL / HYDROCHOLRTHIAZIDE | 2.5 - 6.25MG |

| Generic Codes | Generic Name | Strength Description |
|---|---|---|
| 45062 | BISOPROLOL / HYDROCHOLRTHIAZIDE | 5 - 6.25MG |
| 45063 | BISOPROLOL / HYDROCHOLRTHIAZIDE | 10 - 6.25MG |
| 51550 | METOPROLOL / HYDROCHOLRTHIAZIDE | 50MG-25MG |
| 51551 | METOPROLOL / HYDROCHOLRTHIAZIDE | 100MG-25MG |
| 51552 | METOPROLOL / HYDROCHOLRTHIAZIDE | 100MG-50MG |
| 52060 | NADOLOL / BENDROFLUMETHIAZIDE | 40 - 5MG |
| 52061 | NADOLOL / BENDROFLUMETHIAZIDE | 80 - 5MG |
| 52030 | PROPRANOLOL HCL / HCTZ | 40 - 25MG |
| 52031 | PROPRANOLOL HCL / HCTZ | 80 - 25MG |
| 52030 | PROPRANOLOL / HYDROCHLORTHIAZIDE | 40 - 25MG |
| 52031 | PROPRANOLOL / HYDROCHLORTHIAZIDE | 80 - 25MG |
| 52050 | TIMOLOL / HYDROCHLORTHIAZIDE | 10 - 25MG |
| 51940 | CLONIDINE HCL / CHLORTHALIDONE | 0.1 - 15MG |
| 51941 | CLONIDINE HCL / CHLORTHALIDONE | 0.2 - 15MG |
| 51942 | CLONIDINE HCL / CHLORTHALIDONE | 0.3 - 15MG |
| 51960 | METHYLDOPA / HYDROCHLORTHIAZIDE | 250 - 15MG |
| 51961 | METHYLDOPA / HYDROCHLORTHIAZIDE | 250 - 25MG |
| 51963 | METHYLDOPA / HYDROCHLORTHIAZIDE | 500MG - 50MG |
| 85501 | PRAZOCIN HCL / POLYTHIAZIDE | 1 - 0.5MG |
| 85502 | PRAZOCIN HCL / POLYTHIAZIDE | 2MG - 0.5MG |
| 85503 | PRAZOCIN HCL / POLYTHIAZIDE | 5 - 0.5MG |

Limited by: include all scripts in the look-back period.
Metric: Sum total days supply for all diuretics.
Metric (done for each unique recipient, expressed as a percent): Numerator = Total days supply for all diuretics in the look-back period. Denominator = Total days client was enrolled during the look-back period.
Measure: Numerator = Unique count of recipient ids for clients whose diuretic metric (above) was 80% or higher. Denominator = Unique count of recipient ids for clients with CHF.

## CORONARY ARTERY DISEASE (CAD)

Population: Integrated Care Program population with coronary artery disease
Look-back period: measurement year (FY09) and prior year (FY08)
Claims to include: any claim with a diagnosis or procedure from table below

| Code type | Code | Description |
|---|---|---|
| ICD-9 diagnosis | 410.xx | Acute myocardial infarction |
| ICD-9 diagnosis | 411.xx | Other acute and subacute forms of ischemic heart disease |
| ICD-9 diagnosis | 412.xx | Old myocardial infarction |
| ICD-9 diagnosis | 413.xx | Angina pectoris |
| ICD-9 diagnosis | 414.01 | Coronary atherosclerosis of native coronary artery |
| ICD-9 diagnosis | 414.07 | Coronary atherosclerosis of bypass graft (artery) (vein) of transplanted heart |
| ICD-9 diagnosis | 414.8x | Other specified forms of chronic ischemic heart disease |
| ICD-9 diagnosis | 414.9x | Chronic ischemic heart disease, unspecified |
| CPT-IV procedure | 33510 | coronary artery bypass, vein only, single graph |
| CPT-IV procedure | 33511 | two coronary venous graphs |
| CPT-IV procedure | 33512 | Three coronary venous graphs |
| CPT-IV procedure | 33513 | Four coronary venous graphs |
| CPT-IV procedure | 33514 | Five coronary venous graphs |
| CPT-IV procedure | 33516 | Six or more coronary venous grafts |
| CPT-IV procedure | 33517 | coronary artery bypass, venous and arterial grafts, single vein graph |
| CPT-IV procedure | 33518 | two venous grafts |
| CPT-IV procedure | 33519 | three venous graphs |
| CPT-IV procedure | 33521 | four venous graphs |
| CPT-IV procedure | 33522 | five venous grafts |
| CPT-IV procedure | 33523 | six or more venous grafts |
| CPT-IV procedure | 33510 | coronary artery bypass, vein only, single graph |

| Code type | Code | Description |
|---|---|---|
| CPT-IV procedure | 33511 | two coronary venous graphs |
| CPT-IV procedure | 33530 | Reoperation, coronary artery bypass procedure or valve procedure, more than one month after original operation |
| CPT-IV procedure | 33533 | Coronary artery bypass, using arterial grafts, single |
| CPT-IV procedure | 33534 | two coronary arterial grafts |
| CPT-IV procedure | 33535 | three coronary arterial grafts |
| CPT-IV procedure | 33536 | four or more coronary arterial grafts |
| CPT-IV procedure | 33572 | coronary endarterectomy |
| CPT-IV procedure | 92980 | Transcatheter placement of an intracoronary stent |
| CPT-IV procedure | 92981 | each additional vessel |
| CPT-IV procedure | 92982 | Percutaneous transluminal coronary balloon agioplasty single vessel |
| CPT-IV procedure | 92984 | each additional vessel |
| CPT-IV procedure | 92995 | Percutaneous transluminal coronary atherectomy single vessel |
| CPT-IV procedure | 92996 | each additional vessel |
| CPT-IV procedure | 92975 | Thrombolysis, coronary, by intracoronary infusion |
| CPT-IV procedure | 92977 | Thrombolysis, coronary, by intravenous infusion |
| CPT-IV procedure | 92973 | Coronary; thrombectomy; percutaneous |
| ICD-9 procedure | 0.66 | Percutaneous Transluminal Coronary Angioplasty (PTCA) or Coronary Arthrectomy |
| ICD-9 procedure | 36.0x | Removal of Coronary Artery Obstruction and Insertion of Stent/s |
| ICD-9 procedure | 36.1x | Bypass Anastomosis for Heart Revascularization |
| ICD-9 procedure | 36.2 | Heart Revascularization by Arterial Implant |
| ICD-9 procedure | 36.3x | Other Heart Revascularization |
| ICD-9 procedure | 36.9x | Other operations on vessels of Heart |

Limited by: include clients with at least one claim in the look-back period.
Metric: Count unique recipient ids.

CAD Measure 1 – Cholesterol testing

Look-back period: measurement year (FY09)
Claims to include: any claims for cholesterol testing (see table of procedure codes below to identify cholesterol tests)

| Code type | Code | Description |
|---|---|---|
| CPT_IV procedure | 80061 | Lipid panel, including cholesterol total, lipoprotein direct measurement, high density cholesterol, triglycerides, |
| CPT_IV procedure | 83700 | Lipoprotein, blood; electrophoretic separation and quantitation |
| CPT_IV procedure | 83701 | …high resolutioni factionation… |
| CPT_IV procedure | 83704 | …quantitation of lipoprotein particles numbers… |
| CPT_IV procedure | 83718 | Lipoprotein, direct measurement, high density cholesterol |
| CPT_IV procedure | 83719 | VLDL cholesterol |
| CPT_IV procedure | 83721 | LDL cholesterol |

Limited by: include clients with at least one claim in the look-back period.
Metric: Count unique recipient ids.
Measure: Numerator = Unique count of recipient ids for clients with CAD who have a claim for cholesterol testing during the measurement year. Denominator = Unique count of recipient ids for clients with CAD.

CAD Measure 2 – Statin therapy 80% of the time

Look-back period: measurement year (FY09)
Claims to include: any scripts for statin drugs (see table of generic drug codes below to identify statin drugs)

| Generic Codes | Generic Name | Strength Description |
|---|---|---|
| 09840 | CHOLESTYRAMINE / ASPARTAME | Drug Code Manual does not give the strength description to this form of the drug (powder) |
| 09850 | CHOLESTYRAMINE / ASPARTAME | 4G |
| 09920 | CHOLESTYRAMINE / SUCROSE | 4G |
| 14295 | CHOLESTYRAMINE / SUCROSE | 4G |
| 16300 | COLESEVELAM HCL | 625MG |
| 25440 | COLESTIPOL HCL | 5G |

| Generic Codes | Generic Name | Strength Description |
|---|---|---|
| 25441 | COLESTIPOL HCL | 7.5G |
| 25442 | COLESTIPOL HCL | 1G |
| 25450 | COLESTIPOL HCL | Drug Code Manual does not give the strength description to this form of the drug (powder) |
| 19983 | ASPIRIN / CALCIUM CARB/MAG/PRAVA | 81MG - 80MG |
| 12595 | FENOFIBRATE | 160MG |
| 24639 | FENOFIBRATE | 50MG |
| 13906 | FENOFIBRATE, MICRONIZED | 160MG |
| 13907 | FENOFIBRATE, MICRONIZED | 54MG |
| 23759 | FENOFIBRATE, MICRONIZED | 48MG |
| 23763 | FENOFIBRATE, MICRONIZED | 145MG |
| 23922 | FENOFIBRATE, MICRONIZED | 43MG |
| 23923 | FENOFIBRATE, MICRONIZED | 130MG |
| 92504 | FENOFIBRATE, MICRONIZED | 134MG |
| 93437 | FENOFIBRATE, MICRONIZED | 200MG |
| 93446 | FENOFIBRATE, MICRONIZED | 67MG |
| 25540 | GEMFIBROZIL | 600MG |
| 17650 | LOVASTATIN | 10MG |
| 17651 | LOVASTATIN | 20MG |
| 17652 | LOVASTATIN | 40MG |
| 17654 | LOVASTATIN | 60MG |
| 47040 | LOVASTATIN | 20MG |
| 47041 | LOVASTATIN | 40MG |
| 47042 | LOVASTATIN | 10MG |
| 42331 | NIACIN (NIASPAN) | 500MG |
| 42332 | NIACIN (NIASPAN) | 750MG |
| 42333 | NIACIN (NIASPAN) | 1000MG |
| 42334 | NIACIN (NIASPAN STARTER PACK) | 50MG |
| 61810 | NIACIN (NIACOR) | 500MG |
| 15165 | NIACIN / LOVASTATIN | 500 - 20MG |
| 15166 | NIACIN / LOVASTATIN | 750 - 20MG |
| 15167 | NIACIN / LOVASTATIN | 1000 - 20MG |
| 27266 | NIACIN / LOVASTATIN | 1000 - 40MG |
| 23929 | OMEGA-3 ACID ETHYL ESTERS | 1G |
| 15412 | PRAVASTATIN SODIUM | 80MG |
| 48671 | PRAVASTATIN SODIUM | 10MG |
| 48672 | PRAVASTATIN SODIUM | 20MG |
| 48673 | PRAVASTATIN SODIUM | 40MG |
| 26531 | SIMVASTATIN | 5MG |
| 26532 | SIMVASTATIN | 10MG |
| 26533 | SIMVASTATIN | 20MG |
| 26534 | SIMVASTATIN | 40MG |
| 26535 | SIMVASTATIN | 80MG |
| 43720 | ATROVASTATIN CALCIUM | 10MG |
| 43721 | ATROVASTATIN CALCIUM | 20MG |
| 43722 | ATROVASTATIN CALCIUM | 40MG |
| 43723 | ATROVASTATIN CALCIUM | 80MG |
| 18387 | EZETIMIBE | 10MG |
| 23121 | EZETIMIBE / SIMVASTATIN | 10 - 10MG |
| 23125 | EZETIMIBE / SIMVASTATIN | 10 - 20MG |
| 23126 | EZETIMIBE / SIMVASTATIN | 10MG - 80MG |
| 23127 | EZETIMIBE / SIMVASTATIN | 10MG - 40MG |
| 00030 | FLUVASTATIN SODIUM | 20MG |
| 00031 | FLUVASTATIN SODIUM | 40MG |
| 89424 | FLUVASTATIN SODIUM | 80MG |
| 19153 | ROSUVASTATIN CALCIUM | 10MG |

| Generic Codes | Generic Name | Strength Description |
|---|---|---|
| 19154 | ROSUVASTATIN CALCIUM | 20MG |
| 19155 | ROSUVASTATIN CALCIUM | 40MG |
| 20229 | ROSUVASTATIN CALCIUM | 5MG |
| 21391 | AMLODIPPINE / ATROVAST CAL | 5 - 10MG |
| 21392 | AMLODIPPINE / ATROVAST CAL | 5 - 20MG |
| 21393 | AMLODIPPINE / ATROVAST CAL | 5MG - 40MG |
| 21394 | AMLODIPPINE / ATROVAST CAL | 5MG - 80MG |
| 21395 | AMLODIPPINE / ATROVAST CAL | 10 - 10MG |
| 21396 | AMLODIPPINE / ATROVAST CAL | 10 - 20MG |
| 21397 | AMLODIPPINE / ATROVAST CAL | 10MG - 40MG |
| 21398 | AMLODIPPINE / ATROVAST CAL | 10MG - 80MG |
| 23866 | AMLODIPPINE / ATROVAST CAL | 2.5MG - 10MG |
| 23867 | AMLODIPPINE / ATROVAST CAL | 2.5MG - 20MG |
| 23868 | AMLODIPPINE / ATROVAST CAL | 2.5MG - 40MG |
| 94881 | NIACIN (NIACOR) | 500MG |
| 94891 | NIACIN (SLO-NIACIN) | 500MG |

Limited by: include all scripts in the look-back period.
Metric: Sum total days supply for all statins.
Metric (done for each unique recipient, expressed as a percent): Numerator = Total days supply for all statins in the look-back period. Denominator = Total days client was enrolled during the look-back period.
Measure: Numerator = Unique count of recipient ids for clients whose metric (above) was 80% or higher. Denominator = Unique count of recipient ids for clients with CAD.

CAD Measure 3 – ACE/ARB 80% of the time

Look-back period: measurement year (FY09)
Claims to include: any scripts for ACE inhibitors or angiotensin receptor blockers (see table of generic drug codes below to identify ACE/ARBs)

| Generic Codes | Generic Name | Strength Description |
|---|---|---|
| 48611 | BENAZEPRIL HCL | 5MG |
| 48612 | BENAZEPRIL HCL | 10MG |
| 48613 | BENAZEPRIL HCL | 20MG |
| 48614 | BENAZEPRIL HCL | 40MG |
| 01480 | CAPTOPRIL | 100MG |
| 01481 | CAPTOPRIL | 25MG |
| 01482 | CAPTOPRIL | 50MG |
| 01483 | CAPTOPRIL | 12.5MG |
| 00960 | ENLAPRIL MALEATE | 5MG |
| 00961 | ENLAPRIL MALEATE | 10MG |
| 00962 | ENLAPRIL MALEATE | 20MG |
| 00963 | ENLAPRIL MALEATE | 2.5MG |
| 48580 | FOSINOPRIL SODIUM | 40MG |
| 48581 | FOSINOPRIL SODIUM | 10MG |
| 48582 | FOSINOPRIL SODIUM | 20MG |
| 47260 | LISINOPRIL | 5MG |
| 47261 | LISINOPRIL | 10MG |
| 47262 | LISINOPRIL | 20MG |
| 47263 | LISINOPRIL | 40MG |
| 47264 | LISINOPRIL | 2.5MG |
| 47265 | LISINOPRIL | 30MG |
| 48561 | MOEXIPRIL HCL | 7.5MG |
| 48562 | MOEXIPRIL HCL | 15MG |
| 13758 | PERINDOPRIL ERBUMINE | 2MG |
| 13759 | PERINDOPRIL ERBUMINE | 4MG |
| 93207 | PERINDOPRIL ERBUMINE | 8MG |
| 27570 | QUNIAPRIL HCL | 10MG |

| Generic Codes | Generic Name | Strength Description |
|---|---|---|
| 27571 | QUNIAPRIL HCL | 20MG |
| 27572 | QUNIAPRIL HCL | 5MG |
| 27573 | QUNIAPRIL HCL | 40MG |
| 48541 | RAMIPRIL | 1.25MG |
| 48542 | RAMIPRIL | 2.5MG |
| 48543 | RAMIPRIL | 5MG |
| 48544 | RAMIPRIL | 10MG |
| 32191 | TRANDOLAPRIL | 1MG |
| 32192 | TRANDOLAPRIL | 2MG |
| 32193 | TRANDOLAPRIL | 4MG |
| 17604 | AMLODIPINE BESYLATE / BENAZEPRIL | 10MG-20MG |
| 26949 | AMLODIPINE BESYLATE / BENAZEPRIL | 5MG-40MG |
| 26950 | AMLODIPINE BESYLATE / BENAZEPRIL | 10MG-40MG |
| 33090 | AMLODIPINE BESYLATE / BENAZEPRIL | 5MG-20MG |
| 33092 | AMLODIPINE BESYLATE / BENAZEPRIL | 5MG-10MG |
| 33093 | AMLODIPINE BESYLATE / BENAZEPRIL | 2.5MG-10MG |
| 54501 | ENALAPRIL MALEATE / FELODIPINE | 5MG-5MG |
| 54502 | ENALAPRIL MALEATE / FELODIPINE | 5MG-2.5MG |
| 32111 | TRANDOLAPRIL / VERAPAMIL HCL | 2MG-180MG |
| 32112 | TRANDOLAPRIL / VERAPAMIL HCL | 1MG-24MG |
| 32113 | TRANDOLAPRIL / VERAPAMIL HCL | 2MG-24MG |
| 32114 | TRANDOLAPRIL / VERAPAMIL HCL | 4MG-24MG |
| 73542 | CANDESARTAN CILEXETIL | 4MG |
| 73543 | CANDESARTAN CILEXETIL | 8MG |
| 73544 | CANDESARTAN CILEXETIL | 16MG |
| 73545 | CANDESARTAN CILEXETIL | 32MG |
| 47612 | EPROSARTAN MESYLATE | 400MG |
| 93456 | EPROSARTAN MESYLATE | 600MG |
| 04749 | IRBESARTAN | 150MG |
| 04750 | IRBESARTAN | 300MG |
| 04752 | IRBESARTAN | 75MG |
| 14850 | LOSARTAN POTASSIUM | 25MG |
| 14851 | LOSARTAN POTASSIUM | 50MG |
| 14853 | LOSARTAN POTASSIUM | 100MG |
| 17284 | OLMESARTAN MEDOXOMIL | 5MG |
| 17285 | OLMESARTAN MEDOXOMIL | 20MG |
| 17286 | OLMESARTAN MEDOXOMIL | 40MG |
| 23831 | TELMISARTAN | 40MG |
| 23832 | TELMISARTAN | 80MG |
| 23833 | TELMISARTAN | 20MG |
| 13838 | VALSARTAN | 320MG |
| 13844 | VALSARTAN | 160MG |
| 13846 | VALSARTAN | 80MG |
| 15902 | VALSARTAN | 80MG |
| 15903 | VALSARTAN | 160MG |
| 18092 | VALSARTAN | 40MG |
| 33191 | BENAZEPRIL / HYDROCHLORTHIAZIDE | 5MG - 6.25MG |
| 33192 | BENAZEPRIL / HYDROCHLORTHIAZIDE | 10MG - 12.5 MG |
| 33193 | BENAZEPRIL / HYDROCHLORTHIAZIDE | 20MG - 12.5 MG |
| 33194 | BENAZEPRIL / HYDROCHLORTHIAZIDE | 20MG - 25 MG |
| 54940 | CAPTOPRIL / HYDROCHLORTHIAZIDE | 25MG - 15 MG |
| 54941 | CAPTOPRIL / HYDROCHLORTHIAZIDE | 25MG - 25 MG |
| 54942 | CAPTOPRIL / HYDROCHLORTHIAZIDE | 50MG - 15 MG |
| 54943 | CAPTOPRIL / HYDROCHLORTHIAZIDE | 50MG - 25MG |
| 54860 | ENALAPRIL / HYDROCHLORTHIAZIDE | 10MG - 25MG |
| 54862 | ENALAPRIL / HYDROCHLORTHIAZIDE | 5MG - 12.5 MG |

| Generic Codes | Generic Name | Strength Description |
|---|---|---|
| 10455 | FOSINOPRIL / HYDROCHLORTHIAZIDE | 20MG - 12.5 MG |
| 15621 | FOSINOPRIL / HYDROCHLORTHIAZIDE | 10MG - 12.5 MG |
| 88000 | LISINOPRIL / HYDROCHLORTHIAZIDE | 20MG - 12.5 MG |
| 88001 | LISINOPRIL / HYDROCHLORTHIAZIDE | 20MG - 25 MG |
| 88002 | LISINOPRIL / HYDROCHLORTHIAZIDE | 10MG - 12.5 MG |
| 15777 | MOEXIPRIL / HYDROCHLORTHIAZIDE | 15MG - 12.5MG |
| 67721 | MOEXIPRIL / HYDROCHLORTHIAZIDE | 15MG - 25MG |
| 67722 | MOEXIPRIL / HYDROCHLORTHIAZIDE | 7.5MG - 12.5MG |
| 54160 | QUINAPRIL / HYDROCHLORTHIAZIDE | 10MG - 12.5MG |
| 54161 | QUINAPRIL / HYDROCHLORTHIAZIDE | 20MG - 12.5MG |
| 94490 | QUINAPRIL / HYDROCHLORTHIAZIDE | 20MG - 25 MG |
| 21559 | CANDESARTAN / HYDROCHLORTHIAZIDE | 16MG - 12.5MG |
| 21569 | CANDESARTAN / HYDROCHLORTHIAZIDE | 32MG - 12.5MG |
| 18883 | EPROSARTAN / HYDROCHLORTHIAZIDE | 600MG - 12.5MG |
| 18884 | EPROSARTAN / HYDROCHLORTHIAZIDE | 600MG - 25MG |
| 11042 | IRBESARTAN / HYDROCHLORTHIAZIDE | 150MG - 12.5MG |
| 11295 | IRBESARTAN / HYDROCHLORTHIAZIDE | 300MG - 12.5MG |
| 24622 | IRBESARTAN / HYDROCHLORTHIAZIDE | 300MG - 25MG |
| 14852 | LOSARTAN / HYDROCHLORTHIAZIDE | 50MG - 12.5MG |
| 14854 | LOSARTAN / HYDROCHLORTHIAZIDE | 100MG - 25MG |
| 25851 | LOSARTAN / HYDROCHLORTHIAZIDE | 100MG - 12.5MG |
| 20074 | OLMESARTAN / HYDROCHLORTHIAZIDE | 20MG - 12.5MG |
| 20075 | OLMESARTAN / HYDROCHLORTHIAZIDE | 40MG - 12.5 MG |
| 20076 | OLMESARTAN / HYDROCHLORTHIAZIDE | 40MG - 25MG |
| 12257 | TELMISARTAN / HYDROCHLORTHIAZIDE | 40MG - 12.5 MG |
| 12259 | TELMISARTAN / HYDROCHLORTHIAZIDE | 80MG - 12.5MG |
| 22866 | TELMISARTAN / HYDROCHLORTHIAZIDE | 80MG - 25MG |
| 07833 | VALSARTAN / HYDROCHLORTHIAZIDE | 80MG - 12.5MG |
| 09760 | VALSARTAN / HYDROCHLORTHIAZIDE | 160MG - 12.5MG |
| 17245 | VALSARTAN / HYDROCHLORTHIAZIDE | 160MG - 25MG |
| 27014 | VALSARTAN / HYDROCHLORTHIAZIDE | 320MG - 25MG |
| 27015 | VALSARTAN / HYDROCHLORTHIAZIDE | 320MG -12.5MG |

Limited by: include all scripts in the look-back period.
Metric: Sum total days supply for all ACE/ARBs.
Metric (done for each unique recipient, expressed as a percent): Numerator = Total days supply for all ACE/ARBs in the look-back period. Denominator = Total days client was enrolled during the look-back period.
Measure: Numerator = Unique count of recipient ids for clients whose ACE/ARB metric (above) was 80% or higher. Denominator = Unique count of recipient ids for clients with CAD.

CAD Measure 4 – Beta blocker post-MI (for clients not contraindicated for beta blocker)
Step 1 – Identify acute MI episodes
Look-back period: measurement year (FY09) and prior year (FY08)
Claims to include: any claim with a diagnosis (primary or secondary) of 410.xx (Acute myocardial infarction)
Step 2 – Remove clients for whom a beta-blocker in contraindicated
Look-back period: measurement year (FY09) and prior year (FY08)
Claims to include: any claim with a diagnosis (primary or secondary) in the table below:

| Code type | Code | Description |
|---|---|---|
| ICD-9 diagnosis | 493.xx | asthma |
| ICD-9 diagnosis | 458.xx | hypotension |
| ICD-9 diagnosis | 426.0 | Heart block >1 degree |
| ICD-9 diagnosis | 427.81 | Sinus bradycardia |
| ICD-9 diagnosis | 491.2 | Obstructive chronic bronchitis (COPD) |
| ICD-9 diagnosis | 496.xx | Chronic airway obstruction, NEC (COPD) |
| ICD-9 diagnosis | 506.4 | Chronic respiratory conditions due to fumes & vapors (COPD) |

Measure: Unique recipient ids who had an acute MI (step 1 above), and do not meet the contraindication criteria (step 2 above)

Step 3: Check for beta blocker script within 30 days of acute MI

Time period: 30 days from acute MI event identified above

Claims to include: pharmacy claims for beta blockers (see table of generic drug codes below to identify beta blockers)

| Generic Code | Generic Name | Strength Description |
|---|---|---|
| 01551 | CARVEDILOL | 25MG |
| 01552 | CARVEDILOL | 12.5MG |
| 01553 | CARVEDILOL | 3.125MG |
| 01554 | CARVEDILOL | 6.25MG |
| 10340 | LABETLOL HCL | 300MG |
| 10341 | LABETLOL HCL | 200MG |
| 10342 | LABETLOL HCL | 100MG |
| 26460 | ACEBUTOLOL HCL | 200MG |
| 26461 | ACEBUTOLOL HCL | 400MG |
| 20660 | ATENOLOL | 100MG |
| 20661 | ATENOLOL | 50MG |
| 20662 | ATENOLOL | 25MG |
| 12791 | BETAXOLOL HCL | 10MG |
| 12792 | BETAXOLOL HCL | 20MG |
| 63820 | BISOPROLOL FUMARATE | 10MG |
| 63821 | BISOPROLOL FUMARATE | 5MG |
| 12947 | METOPROLOL SUCCINATE | 25MG |
| 20741 | METOPROLOL SUCCINATE | 50MG |
| 20742 | METOPROLOL SUCCINATE | 100MG |
| 20743 | METOPROLOL SUCCINATE | 200MG |
| 17734 | METOPROLOL TARTRATE | 25MG |
| 20641 | METOPROLOL TARTRATE | 100MG |
| 20642 | METOPROLOL TARTRATE | 50MG |
| 20650 | NADOLOL | 120MG |
| 20651 | NADOLOL | 160MG |
| 20652 | NADOLOL | 40MG |
| 20653 | NADOLOL | 80MG |
| 20654 | NADOLOL | 20MG |
| 39350 | PENBUTOLOL SULFATE | 20MG |
| 20680 | PINDOLOL | 10MG |
| 20681 | PINDOLOL | 5MG |
| 03230 | PROPRANOLOL HCL | 80MG |
| 03231 | PROPRANOLOL HCL | 120MG |
| 03232 | PROPRANOLOL HCL | 160MG |
| 03233 | PROPRANOLOL HCL | 60MG |
| 19359 | PROPRANOLOL HCL | 120MG |
| 20621 | PROPRANOLOL HCL | 80MG |
| 20630 | PROPRANOLOL HCL | 10MG |
| 20631 | PROPRANOLOL HCL | 20MG |
| 20632 | PROPRANOLOL HCL | 40MG |
| 20633 | PROPRANOLOL HCL | 60MG |
| 20634 | PROPRANOLOL HCL | 80MG |
| 20635 | PROPRANOLOL HCL | 90MG |
| 39511 | SOTALOL HCL | 160MG |
| 39512 | SOTALOL HCL | 80MG |
| 39513 | SOTALOL HCL | 240MG |
| 39516 | SOTALOL HCL | 120MG |
| 20670 | TIMOLOL MALEATE | 10MG |
| 20671 | TIMOLOL MALEATE | 20MG |
| 20672 | TIMOLOL MALEATE | 5MG |
| 39340 | CARTEOLOL HCL | 2.5MG |

| Generic Code | Generic Name | Strength Description |
|---|---|---|
| 39341 | CARTEOLOL HCL | 5MG |
| 66990 | ATENOLOL / CHLORTHALIDONE | 50MG-25MG |
| 66991 | ATENOLOL / CHLORTHALIDONE | 100 - 25MG |
| 45061 | BISOPROLOL / HYDROCHOLRTHIAZIDE | 2.5 - 6.25MG |
| 45062 | BISOPROLOL / HYDROCHOLRTHIAZIDE | 5 - 6.25MG |
| 45063 | BISOPROLOL / HYDROCHOLRTHIAZIDE | 10 - 6.25MG |
| 51550 | METOPROLOL / HYDROCHOLRTHIAZIDE | 50MG-25MG |
| 51551 | METOPROLOL / HYDROCHOLRTHIAZIDE | 100MG-25MG |
| 51552 | METOPROLOL / HYDROCHOLRTHIAZIDE | 100MG-50MG |
| 52060 | NADOLOL / BENDROFLUMETHIAZIDE | 40 - 5MG |
| 52061 | NADOLOL / BENDROFLUMETHIAZIDE | 80 - 5MG |
| 52030 | PROPRANOLOL HCL / HCTZ | 40 - 25MG |
| 52031 | PROPRANOLOL HCL / HCTZ | 80 - 25MG |
| 52030 | PROPRANOLOL / HYDROCHLORTHIAZIDE | 40 - 25MG |
| 52031 | PROPRANOLOL / HYDROCHLORTHIAZIDE | 80 - 25MG |
| 52050 | TIMOLOL / HYDROCHLORTHIAZIDE | 10 - 25MG |

Metric: Count unique recipient ids of clients with a beta blocker script within 30 days of acute MI.
Measure: Numerator = Unique count of recipient ids for clients with acute MI, not contraindicated for beta blockers, with a script for a beta blocker within 30 days of an acute MI. Denominator = Unique count of recipient ids for clients with acute MI, not contraindicated for beta blockers.

## CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

Population: Integrated Care Population with COPD

Look-back period: measurement year (FY09) and prior year (FY08)

Claims to include: any claim with a diagnosis or procedure from table below

| Code type | Code | Description |
|---|---|---|
| ICD-9 diagnosis | 491.xx | Chronic bronchitis |
| ICD-9 diagnosis | 492.xx | Emphysema |
| ICD-9 diagnosis | 493.2x | Chronic obstructive asthma |
| ICD-9 diagnosis | 496.xx | Chronic airway obstruction, nec |
| ICD-9 diagnosis | 518.83 | Chronic respiratory failure |
| ICD-9 diagnosis | 518.84 | Acute & chronic respiratory failure |
| CPT-IV procedure | 32491 | Lung volume reduction |
| ICD-9 procedure | 32.22 | Lung volume reduction |

Metric: Count unique recipient ids.

COPD Measure 1 – Acute COPD exacerbation, treated with corticosteroids.

Step 1 – identify acute COPD exacerbation

Look-back period: measurement year (FY09)

Claims to include: Any claim with a diagnosis of 491.21 (Acute exacerbation of COPD)

Metric: Count unique recipient ids of clients with acute COPD exacerbation

Step 2 – Check for corticosteroid script for clients with acute exacerbation

Time period: measurement year (FY09)

Claims to include: pharmacy claims for corticosteroids (see table of generic drug codes below to identify corticosteroids)

| Generic Code | Generic Name | Strength Description |
|---|---|---|
| 26482 | CORTISONE ACETATE | 25MG |
| 26781 | HYDROCORTISONE | 10MG |
| 26782 | HYDROCORTISONE | 20MG |
| 26783 | HYDROCORTISONE | 5MG |
| 27051 | METHYLPREDNIOSOLONE | 16MG |
| 27052 | METHYLPREDNIOSOLONE | 2MG |
| 27055 | METHYLPREDNIOSOLONE | 32MG |

| Generic Code | Generic Name | Strength Description |
|---|---|---|
| 27056 | METHYLPREDNIOSOLONE | 4MG |
| 27058 | METHYLPREDNIOSOLONE | 8MG |
| 37499 | METHYLPREDNIOSOLONE | 4MG |
| 26800 | PREDNISOLONE | 15MG/5ML |
| 26892 | PREDNISOLONE | 5MG/5ML |
| 26963 | PREDNISOLONE | 5MG |
| 09115 | PREDNISOLONE SOD PHOSPHATE | 6.7MG/5ML |
| 33806 | PREDNISOLONE SOD PHOSPHATE | 15MG/5ML |
| 27160 | PREDNISONE | 5MG/5ML |
| 27161 | PREDNISONE | 5MG/ML |
| 27171 | PREDNISONE | 1MG |
| 27172 | PREDNISONE | 10MG |
| 27173 | PREDNISONE | 2.5MG |
| 27174 | PREDNISONE | 20MG |
| 27176 | PREDNISONE | 5MG |
| 27177 | PREDNISONE | 50MG |
| 38363 | PREDNISONE | 5MG |
| 38364 | PREDNISONE | 10MG |
| 00950 | BECLOMETHASONE DIPROPIONATE | 42MCG |
| 15793 | BECLOMETHASONE DIPROPIONATE | 84MCG |
| 80128 | BECLOMETHASONE DIPROPIONATE | 40MCG |
| 80131 | BECLOMETHASONE DIPROPIONATE | 80MCG |
| 82300 | BETAMET ACET / BETAMET NA PH | 6MG/ML |
| 27250 | BETAMETHASONE | 0.6MG/5ML |
| 27220 | BETAMETHASONE SODIUM PHOSPHATE | 3MG/ML |
| 17957 | BUDESONIDE | 0.25MG/2ML |
| 17958 | BUDESONIDE | 0.5MG/2ML |
| 27740 | BUDESONIDE | 200MCG |
| 27428 | DEXAMETHASONE | 4MG |
| 00840 | FLUNISOLIDE | 250MCG |
| 52861 | FLUNISOLIDE / MENTHOL | 250MCG |
| 53636 | FLUTICASONE PROPIONATE | 110MCG |
| 53638 | FLUTICASONE PROPIONATE | 44MCG |
| 53639 | FLUTICASONE PROPIONATE | 220MCG |
| 18987 | MOMETASONE FUROATE | 220MCG 120 |
| 24927 | MOMETASONE FUROATE | 220MCG (14) |
| 24928 | MOMETASONE FUROATE | 220MCG (30) |
| 24929 | MOMETASONE FUROATE | 220MCG (60) |
| 27614 | TRIAMCINOLONE | 4MG |
| 01210 | TRIAMCINOLONE ACETONIDE | 100MCG |
| 27450 | TRIAMCINOLONE ACETONIDE | 10MG/ML |
| 27452 | TRIAMCINOLONE ACETONIDE | 40MG/ML |
| 27542 | TRIAMCINALONE DIACETATE | 40MG/ML |
| 27560 | TRIAMCINALONE HEXAACETONIDE | 20MG/ML |
| 98680 | TRIAMCINOLONE ACETONIDE | 75MCG |
| 50584 | FLUTICASONE / SALMETEROL | 100 - 50MCG |
| 50594 | FLUTICASONE / SALMETEROL | 250 - 50MCG |
| 50604 | FLUTICASONE / SALMETEROL | 500 - 50MCG |
| 97135 | FLUTICASONE / SALMETEROL | 45 - 21MCG |
| 97136 | FLUTICASONE / SALMETEROL | 115 - 21MCG |
| 97137 | FLUTICASONE / SALMETEROL | 231 - 121MCG |
| 98499 | BUDESONIDE/FORMOTEROL FUMARATE | 80/4.5MCG INHALER |
| 98500 | BUDESONIDE/FORMOTEROL FUMARATE | 160/4.5MCG INHALER |
| 26482 | CORTISONE ACETATE | 25MG |

Metric: Count unique recipient ids of clients with a corticosteroid script during the measurement year
Measure: Numerator = Unique count of recipient ids for clients with acute COPD exacerbation with a script for a corticosteroid during the measurement year. Denominator = Unique count of recipient ids for clients with acute COPD exacerbation.

COPD Measure 2 – Bronchiodilator medications for clients with a history of hospitalization for COPD

Step 1 – identify clients with history of hospitalization for COPD

Look-back period: measurement year (FY09) and prior year (FY08)
Claims to include: Any inpatient hospital claim with a primary diagnosis listed below:

| Code type | Code | Description |
|---|---|---|
| ICD-9 diagnosis | 491.xx | Chronic bronchitis |
| ICD-9 diagnosis | 492.xx | Emphysema |
| ICD-9 diagnosis | 496.xx | Chronic airway obstruction, nec |
| CPT-IV procedure | 32491 | Lung volume reduction |
| ICD-9 procedure | 32.22 | Lung volume reduction |

Metric: Count unique recipient ids of clients with acute COPD exacerbation

Step 2 – Check for bronchiodialtor script for clients with history of hospitalization for COPD

Time period: measurement year (FY09)

Claims to include: pharmacy claims for bronchiodilator (see table of generic drug codes below to identify bronchiodilator)

| Generic Codes | Generic Name | Strength Description |
|---|---|---|
| 14255 | GUAIFENESIN / DYPHYLLINE | 100-100/15 |
| 51292 | GUAIFENESIN / DYPHYLLINE | 50-100/5ML |
| 51300 | GUAIFENESIN / DYPHYLLINE | 200-200MG |
| 51020 | GUAIFENESIN / THEOPHYLLINE | 90-150MG |
| 24621 | IPRATROPIUM BROMIDE | 17MCG |
| 42230 | IPRATROPIUM BROMIDE | 18MCG |
| 42235 | IPRATROPIUM BROMIDE | 0.2MG/2ML |
| 17853 | TIOTROPIUM BROMIDE | 18MCG |
| 20110 | ALBUTEROL | 90MCG |
| 14633 | ALBUTEROL SULFATE | 0.21MG/ML |
| 14634 | ALBUTEROL SULFATE | 0.42MG/ML |
| 20100 | ALBUTEROL SULFATE | 2MG |
| 20101 | ALBUTEROL SULFATE | 4MG |
| 22697 | ALBUTEROL SULFATE | 2.5MG/0.5 |
| 22780 | ALBUTEROL SULFATE | 2MG/ML |
| 22913 | ALBUTEROL SULFATE | 90MCG |
| 24858 | ALBUTEROL SULFATE | 4MG |
| 24859 | ALBUTEROL SULFATE | 8MG |
| 26987 | ALBUTEROL SULFATE | 4MG |
| 41680 | ALBUTEROL SULFATE | 5MG/ML |
| 41681 | ALBUTEROL SULFATE | 0.83MG/ML |
| 45730 | ALBUTEROL SULFATE | 4MG |
| 45731 | ALBUTEROL SULFATE | 4MG |
| 45732 | ALBUTEROL SULFATE | 8MG |
| 13456 | ALBUTEROL SULFATE / IPRATROPIUM | 2.5-0.5/3 |
| 72951 | ALBUTEROL SULFATE / IPRATROPIUM | 103-18MCG |
| 36801 | FORMOTEROL FUMERATE | 12MCG |
| 15665 | LEVALBUTEROL HCL | 0.31MG/3ML |
| 23146 | LEVALBUTEROL HCL | 1.25MG/0.5 |
| 24540 | LEVALBUTEROL HCL | 0.63MG/3ML |
| 24541 | LEVALBUTEROL HCL | 1.25MG/3ML |
| 24422 | LEVALBUTEROL TARTARATE | 45MCG |
| 19701 | METAPROTERENOL SULFATE | 650MCG |
| 19711 | METAPROTERENOL SULFATE | 6MG/ML |
| 19712 | METAPROTERENOL SULFATE | 4MG/ML |
| 19720 | METAPROTERENOL SULFATE | 10MG/5ML |
| 19730 | METAPROTERENOL SULFATE | 10MG |
| 19731 | METAPROTERENOL SULFATE | 20MG |
| 48021 | PIRBUTEROL ACETATE | 0.2MG |
| 64012 | SALMETEROL XINAFOATE | 50MCG |
| 64026 | SALMETEROL XINAFOATE | 21MCG |
| 20071 | TERBUTALINE SULFATE | 5MG |
| 20072 | TERBUTALINE SULFATE | 2.5MG |
| 00561 | AMINOPHYLLINE | 100MG |

| Generic Codes | Generic Name | Strength Description |
|---|---|---|
| 00564 | AMINOPHYLLINE | 200MG |
| 00622 | DIPHYLLINE | 100MG / 15ML |
| 00642 | DIPHYLLINE | 400MG |
| 00310 | THEOPHYLLINE ANHYDROUS | 300MG |
| 00312 | THEOPHYLLINE ANHYDROUS | 200MG |
| 00313 | THEOPHYLLINE ANHYDROUS | 125MG |
| 00323 | THEOPHYLLINE ANHYDROUS | 400MG |
| 00324 | THEOPHYLLINE ANHYDROUS | 100MG |
| 00325 | THEOPHYLLINE ANHYDROUS | 200MG |
| 00326 | THEOPHYLLINE ANHYDROUS | 300MG |
| 00352 | THEOPHYLLINE ANHYDROUS | 80MG / 15ML |
| 00410 | THEOPHYLLINE ANHYDROUS | 100MG |
| 00411 | THEOPHYLLINE ANHYDROUS | 200MG |
| 00413 | THEOPHYLLINE ANHYDROUS | 300MG |
| 00416 | THEOPHYLLINE ANHYDROUS | 450MG |
| 00421 | THEOPHYLLINE ANHYDROUS | 400MG |
| 00422 | THEOPHYLLINE ANHYDROUS | 600MG |
| 50584 | FLUTICASONE / SALMETEROL | 100 - 50MCG |
| 50594 | FLUTICASONE / SALMETEROL | 250 - 50MCG |
| 50604 | FLUTICASONE / SALMETEROL | 500 - 50MCG |
| 97135 | FLUTICASONE / SALMETEROL | 45 - 21MCG |
| 97136 | FLUTICASONE / SALMETEROL | 115 - 21MCG |
| 97137 | FLUTICASONE / SALMETEROL | 231 - 121MCG |

COPD Measure 3 – Spirometry testing

Look-back period: measurement year (FY09) and two prior years (FY07-08)

Claims to include: any claims for spirometry testing (see table of procedure codes below to identify spirometry tests)

| Code type | Code | Description |
|---|---|---|
| CPT_IV procedure | 94010 | Spirometry |
| CPT_IV procedure | 94014 | patient initiated spirometric recording |
| CPT_IV procedure | 94015 | patient initiated spirometric recording (includes hook-up, reinforced education, data transmission, data capture, trend analysis, and periodic recalibration |
| CPT_IV procedure | 94016 | patient initiated spirometric recording Physician review and interpretation only |
| CPT_IV procedure | 94060 | Bronchodilation responsiveness, spirometry as in 94010, pre and post bronchodilator administration |
| CPT_IV procedure | 94070 | Bronchospasm provocation evaluation, multiple spirometric determinations as in 94010 with administered agents |
| CPT_IV procedure | 94620 | Pulmonary stress testing; simple…with pre-post spirometry |

Limited by: include clients with at least one claim in the look-back period.

Metric: Count unique recipient ids.

Measure: Numerator = Unique count of recipient ids for clients with COPD who have a claim for spirometry testing during the look-back period. Denominator = Unique count of recipient ids for clients with CAD.

Attachment H
HIPAA Compliance Obligations

A. Definitions.

1. "Designated Record Set" shall have the same meaning as the term "designated record set" in 45 CFR section 164.501.
2. "Individual" shall have the same meaning as the term "individual" in 45 CFR Section 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 CFR Section 164.502(g).
3. "PHI" means Protected Health Information, which shall have the same meaning as the term "protected health information" in 45 CFR section 164.501, limited to the information created or received by Contractor from or on behalf of the Agency/Buyer.
4. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and 45 CFR Part 164 subparts A and E.
5. "Required by law" shall have the same meaning as the term "required by law" in 45 CFR section 164.501.

B. Contractor's Permitted Uses and Disclosures.

1. Except as otherwise limited by this Contract, Contractor may use or disclose PHI to perform functions, activities, or services for, or on behalf of, the Agency/Buyer as specified in this Contract, provided that such use or disclosure would not violate the Privacy Rule if done by the Agency/Buyer.
2. Except as otherwise limited by this Contract, Contractor may use PHI for the proper management and administration of Contractor or to carry out the legal responsibilities of Contractor.
3. Except as otherwise limited by this Contract, Contractor may disclose PHI for the proper management and administration of Contractor, provided that the disclosures are required by law, or Contractor obtains reasonable assurances from the person to whom the PHI is disclosed that the PHI will remain confidential and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person. Contractor shall require the person to whom the PHI was disclosed to notify Contractor of any instances of which the person is aware in which the confidentiality of the PHI has been breached.
4. Except as otherwise limited by this Contract, Contractor may use PHI to provide data aggregation services to the Agency/Buyer as permitted by 45 CFR section 164.504(e)(2)(i)(B).
5. Contractor may use PHI to report violations of law to appropriate federal and state authorities, consistent with 45 CFR section 164.502(j)(1).

C. Limitations on Contractor's Uses and Disclosures. Contractor shall:

1. Not use or further disclose PHI other than as permitted or required by the Contract or as required by law;
2. Use appropriate safeguards to prevent use or disclosure of PHI other than as provided for by this Contract;
3. Mitigate, to the extent practicable, any harmful effect that is known to Contractor of a use or disclosure of PHI by Contractor in violation of the requirements of this Contract;
4. Report to the Agency/Buyer any use or disclosure of PHI not provided for by this Contract of which Contractor becomes aware;
5. Ensure that any agents, including a subContractor, to whom Contractor provides PHI received from the Agency/Buyer or created or received by Contractor on behalf of the Agency/Buyer, agree to the same restrictions and conditions that apply through this Contract to Contractor with respect to such information;
6. Provide access to PHI in a Designated Record Set to the Agency/Buyer or to another individual whom the Agency/Buyer names, in order to meet the requirements of 45 CFR section 164.524, at the Agency/Buyer's request, and in the time and manner specified by the Agency/Buyer;
7. Make available PHI in a Designated Record Set for amendment and to incorporate any amendments to PHI in a Designated Record Set that the Agency/Buyer directs or that Contractor agrees to pursuant to 45 CFR section 164.526 at the request of the Agency/Buyer or an individual, and in a time and manner specified by the Agency/Buyer;
8. Make Contractor's internal practices, books, and records, including policies and procedures and PHI, relating to the use and disclosure of PHI received from the Agency/Buyer or created or received by Contractor on behalf of the Agency/Buyer available to the Agency/Buyer and to the Secretary of Health and Human Services for purposes of determining the Agency/Buyer's compliance with the Privacy Rule;
9. Document disclosures of PHI and information related to disclosures of PHI as would be required for the Agency/Buyer to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR section 164.528;

10. Provide to the Agency/Buyer or to an individual, in a time and manner specified by the Agency/Buyer, information collected in accordance with the terms of this Contract to permit the Agency/Buyer to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR section 164.528;
11. Return or destroy all PHI received from the Agency/Buyer or created or received by Contractor on behalf of the Agency/Buyer that Contractor still maintains in any form, and to retain no copies of such PHI, upon termination of this Contract for any reason. If such return or destruction is not feasible, Contractor shall provide the Agency/Buyer with notice of such purposes that make return or destruction infeasible, and upon the parties' written agreement that return or destruction is infeasible, Contractor shall extend the protections of the Contract to the PHI and limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible. This provision shall apply equally to PHI that is in the possession of Contractor and to PHI that is in the possession of subContractors or agents of Contractor.

D. Agency/Buyer Obligations. The Agency/Buyer shall:
1. Provide Contractor with the Agency/Buyer's Notice of Privacy Practices and notify Contractor of any changes to said Notice;
2. Notify Contractor of any changes in or revocation of permission by an individual to use or disclose PHI, to the extent that such changes may affect Contractor's permitted or required uses and disclosures of PHI;
3. Notify Contractor of any restriction to the use or disclosure of PHI that the Agency/Buyer had agreed to in accordance with 45 CFR section 164.522, to the extent that such restriction may affect Contractor's use or disclosure of PHI;
4. Not request that Contractor use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by the Agency/Buyer.

E. Breach Requirements.
1. Sections 164.308, 164.310, 164.312 and 164.316 of title 45, Code of Federal Regulations, apply to the Contractor in the same manner that such sections apply to the Agency. The Contractor's obligations include but are not limited to the following:
   a. Implementing administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic Protected Health Information that the Contractor creates, receives, maintains, or transmits on behalf of the covered entity as required by HIPAA;
   b. Ensuring that any agent, including a subContractor, to whom the Contractor provides such information agrees to implement reasonable and appropriate safeguards to protect the data; and
   c. Reporting to the Agency any security incident of which it becomes aware.

2. Privacy Obligations. To comply with the privacy obligations imposed by HIPAA, Contractor agrees to:
   a. Abide by any Individual's request to restrict the disclosure of Protected Health Information consistent with the requirements of Section 13405(a) of the HITECH Act;
   b. Use appropriate safeguards to prevent use or disclosure of the information other than as provided for by the Underlying Agreement and this Addendum;
   c. Report to the Agency any use or disclosure of the information not provided for by the Underlying Agreement of which the Contractors becomes aware;
   d. Ensure that any agents, including a subContractor, to whom the Contractor provides Protected Health Information received from the Agency or created or received by the Contractor on behalf of the Agency agrees to the same restrictions and conditions that apply to the Contractor with respect to such information;
   e. Make available to the Agency within ten (10) calendar days Protected Health Information to comply with an Individual's right of access to their Protected Health Information in compliance with 45 C.F.R. § 164.524 and Section 13405(f) of the HITECH Act;
   f. Make available to the Agency within fifteen (15) calendar days Protected Health Information for amendment and incorporate any amendments to. Protected Health Information in accordance with 45 C.F.R. § 164.526;
   g. Make available to the Agency within fifteen (15) calendar days the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528 and Section 13405(c) of the HITECH Act;
   h. To the extent practicable, mitigate any harmful effects that are known to the Contractor of a use or disclosure of Protected Health Information or a Breach of Unsecured Protected Health Information in violation of this Addendum;

i. Use and disclose an Individual's Protected Health Information only if such use or disclosure is in compliance with each and every applicable requirement of 45 C.F.R. § 164.504(e);
j. Refrain from exchanging any Protected Health Information with any entity of which the Contractor knows of a pattern of activity or practice that constitutes a material breach or violation of HIPAA;
k. To comply with Section 13405(b) of the HITECH Act when using, disclosing, or requesting Protected Health Information in relation to this Addendum by limiting disclosures as required by HIPAA.

3. Breach Notification. In the event that the Contractor discovers a Breach of Unsecured Protected Health Information, the Contractor agrees to take the following measures within 10 calendar days after the Contractor first becomes aware of the incident:
   a. To notify the Agency of any incident involving the acquisition, access, use or disclosure of Unsecured Protected Health Information in a manner not permitted under 45 C.F.R. part E. Such notice by the Contractor shall be provided without unreasonable delay, except where a law enforcement official determines that a notification would impede a criminal investigation or cause damage to national security. For purposes of clarity for this provision, Contractor must notify the Agency of any such incident within the above timeframe even if Contractor has not conclusively determined within that time that the incident constitutes a Breach as defined by HIPAA. The Contractor is deemed to have become aware of the Breach as of the first day on which such Breach is known or reasonably should have been known to such entity or associate of the Contractor, including any person other than the individual committing the Breach, that is an employee, officer or other agent of the Contractor or an associate of the Contractor;
   b. To include the names of the Individuals whose Unsecured Protected Health Information has been, or is reasonably believed to have been, the subject of a Breach;
   c. To complete and submit the Breach Notice form to the Agency (see Exhibit A); and
   d. To include a sample copy of the notice for the Agency.

4. Notification Duty. It is Contractors duty to provide the Breach notification to the affected individuals unless Agency agrees to provide the Breach notification.

5. Costs. Contractor assumes all costs for providing Breach notification unless Agency agrees to assume any costs.

6. Indemnification for Breach Notification. Contractor shall indemnify the Agency for costs associated with any incident involving the acquisition, access, use or disclosure of Unsecured Protected Health Information in a manner not permitted under 45 C.F.R. part E.

F. Interpretation. Any ambiguity in this Contract shall be resolved in favor of a meaning that permits the Agency/Buyer to comply with the Privacy Rule.

EXHIBIT A
NOTIFICATION TO THE AGENCY OF BREACH OF
UNSECURED PROTECTED HEALTH INFORMATION

NOTE: The Contractor must use this form to notify HFS of any Breach of Unsecured Protected Health Information. Contractor must immediately or within 10 calendar days of the breach being discovered provide a copy of this completed form to:
(1) the Contract Administrator (insert name) _____, in compliance with the Notice Requirements of the Underlying Agreement, and (2) the HFS Privacy Officer at:

Illinois Department of Healthcare and Family Services
Attn: Privacy Officer
201 South Grand Avenue East
Springfield, Illinois 62763

Information to be Supplied:
Contract Information
Contract Number
Contract Title
Contact Person for this Incident:
Contact Person's Title:
Contact's Address:
Contact's E-mail:
Contact's Telephone No.:

NOTICE:
Contractor hereby notifies the Agency that there has been a Breach of Unsecured (unencrypted) Protected Health Information that Contractor has used or has had access to under the terms of the Contractor Agreement, as described in detail below:

Date of Breach Date of Discovery of Breach:
Detailed Description of the Breach:

Types of Unsecured Protected Health Information involved in the Breach (such as full name, SSN, Date of Birth, Address, Account Number, Disability Code, etc – List All).

What steps are being taken to investigate the breach, mitigate losses, and protect against any further breaches?

Number of Individuals Impacted If over 500, do individuals live in multiple states?

Submitted by:
Signature: _____ Date: _____

Printed Name and Title: _____

# RFP Attachment I
# Pharmacy Program Overview

Pharmacy rates: Brand name drugs—AWP minus 12% plus $3.40 dispensing fee

Generic drugs—Lesser of AWP minus 25%, Federal Upper Limit or state MAC plus $4.60 dispensing fee

Link to MAC prices: http://www.ilsmac.com/

Link to FUL: http://www.cms.hhs.gov/reimbursement/05_federalupperlimits.asp

Link to PDL: http://www.hfs.illinois.gov/assets/pdl.pdf

Generic ratio: 3/1 (based on data for the entire Medicaid Program)

Scripts per person: 4.06 (based on data for Potential Enrollees)

Percentage of spending returned in rebates: 39.5% (based on data for the entire Medicaid Program)

All drugs have quantity limits and/or daily dose limits