STATE OF ILLINOIS
CONTRACT

Illinois Department of Healthcare and Family Services
Dual-Eligible Special Needs Plan (D-SNP)
BidBuy #: 25-479HFS-DIREC-P-XXXX|**Agency Reference Number:** 2026-24-001

Contract includes BidBuy Purchase Order? (The Agency answers this question prior to contract filing.)

☐ Yes

☒ No

Contract uses Illinois Procurement Gateway Certifications and Disclosures?

☒ Yes (IPG Certifications and Disclosures including IPG Active Registered Vendor Disclosure (formerly named Forms B))

☐ No

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Illinois Department of Healthcare and Family Services
Dual-Eligible Special Needs Plan (D-SNP)
BidBuy #: 25-479HFS-DIREC-P-xxxxx |**Agency Reference Number:** 2026-24-001

VENDOR

Vendor Name:	Address (City/State/Zip):
Printed Name:	Phone:
Title:	Email: Click here to enter text.
Signature:	Date:

STATE OF ILLINOIS

Purchasing Agency: Healthcare and Family Services	Phone:
Street Address: 201 South Grand Avenue East	Email:
City, State ZIP: Springfield, IL	
Official Signature:	Date:
Printed Name: Elizabeth M. Whitehorn	
Official's Title: Director	

AGENCY USE ONLY **NOT PART OF CONTRACTUAL PROVISIONS**

- Agency Reference #: 2026-24-001
- Project Title: Dual-Eligible Special Needs Plan (D-SNP)
- Contract #:
- Procurement Method (IFB, RFP, Small Purchase, etc.): RFP
- BidBuy / Bulletin Reference #: 25-478HFS-DIREC-B-44525
- BidBuy / Bulletin Publication Date: 9/2/24
- Award Code:
- Subcontractor Utilization? ☒ Yes ☐ No Subcontractor Disclosure? ☒ Yes ☐ No
- Funding Source:
- Obligation #:
- Small Business Set-Aside? ☐ Yes ☐ No Percentage:
- Minority Owned Business? ☐ Yes ☐ No Percentage:
- Women Owned Business? ☐ Yes ☐ No Percentage:
- Persons with Disabilities Owned Business? ☐ Yes ☐ No Percentage:
- Veteran Owned Small Business? ☐ Yes ☐ No Percentage:
- Other Preferences?

1. DESCRIPTION OF SUPPLIES AND SERVICES

1.1 **Goal:** The Illinois Department of Healthcare and Family Services (Department or HFS) is transitioning its Medicare-Medicaid Alignment Initiative demonstration program to a Dual Eligible Special Needs Plan (D-SNP) Program. With this transition, the Contractor shall establish and maintain a Medicare Advantage contract that only includes a fully integrated D-SNP (FIDE-SNP) with a service area limited to the State of Illinois (state or State). The Department seeks to create a single Medicare and Medicaid D-SNP contract while minimizing the cost increase to the state as much as possible and maintaining a high level of care integration. It also seeks to ensure a strong capitated managed care model that limits the disruption in health care access for Enrollees while keeping as much of the whole person, fully integrated care approach as possible. The D-SNP will focus on advancing health equity, including a requirement that outcome data and reports be broken out by race, ethnicity, and geography. In the delivery of the D-SNP contract requirements, any use of artificial intelligence shall comply with all current State rules, policies, and/or guidelines for acceptable use of artificial intelligence. The D-SNP will maintain the quality of the Enrollee's experience with the goal of improving the quality of health outcomes. In 2027, the Department plans to incorporate the managed long-term services and supports (MLTSS) population into the D-SNP Contract. The MLTSS program is a 1915(b) waiver program approved by the Centers for Medicare and Medicaid Services. The MLTSS population are those Medicaid customers receiving long term services and supports and eligible for enrollment in the DSNP but elect not to enroll.

1.2 **Supplies and/or Services Required:** The terms of this Contract shall be interpreted to be of Illinois, Department of Healthcare and Family Services (HFS) for a Dual-Eligible Special Needs Plan Vendor. The RFP 2026-24-001/25-478HFS-DIREC-B-44525 under which this Contract was awarded, the subsequent Proposal dated October 18, 2024, submitted by xxxx. in response to the RFP and the Contract shall form the entire agreement between the parties.

1.2.1 *Determination of Eligibility*

A. Contractor must comply with the Department's determination of Medicaid eligibility for enrollments. The Department, consistent with all applicable federal laws and its State Plan, has the exclusive right to determine an individual's Medicaid eligibility. Such a determination shall be final and is not subject to review or appeal by Contractor. Nothing in this section prevents the Contractor from providing the Department with information, such as a change of address, move to another state, change in category of eligibility, or other relevant information. f. If the Contractor believes such information indicates that an Enrollee's eligibility was

incorrectly determined or has changed so that enrollment with Contractor is no longer appropriate or that the Capitation rate for that Enrollee should be adjusted. Such notice shall include:

a. Detailed information on Medicaid eligibility changes such as:

i. the number Enrollees per new category; and

ii. Capitation rates applicable to any new category of individuals.

B. Contractor shall only enroll individuals meeting the following criteria in the D-SNP: (1) receiving full Illinois Medicaid benefits, (2) age 21 and older at the time of enrollment; (3) entitled to Medicare Part A, enrolled in Part B, and eligible to enroll in a Part D plan (full-benefit dually eligible beneficiaries as of the effective date of coverage under the D-SNP.)

C. Contractor shall not enroll individuals in the D-SNP if: (1) they are under the age of 21; (2) they are receiving developmental disability institutional services; (3) they participate in the Home and Community-Based Services (HCBS) waiver for Adults with Developmental Disabilities; (4) they are within the Medicaid Spend-down population; (5) they are enrolled in the Illinois Medicaid Breast and Cervical Cancer program; (6) they are enrolled in partial benefit programs; (7) they have Comprehensive Third Party Insurance, or (8) they are enrolled in the PACE program.

1.2.2 *Verification of Medicaid Eligibility Status***.** Contractor shall comply with the Department's verification of Medicaid eligibility status of Enrollees through an automated verification process provided by the state or the state's enrollment broker and the provided Health Insurance Privacy and Portability Act (HIPAA) file *(as defined in Section 5.1 Definitions 1-7)* to (1) determine if an Enrollee has other health insurance except Medicaid, and (2) identify other health insurance that may be obtained by an Enrollee. All HIPAA compliant files are located and maintained on the secure File Transfer Protocol (FTP) HFS mainframe.

1.2.3 *Enrollment*

A. Contractor agrees to conduct enrollment of dually eligible Enrollees in accordance with this contract and maintain exclusively aligned enrollment, in which any Enrollee who enrolls into the Contractor's D-SNP for Medicare benefits must also agree to receive Medicaid benefits

from the D-SNP. The Enrollee's enrollment into Contractor's D-SNP will be voluntary.

B. Contractor will be required to submit enrollment transactions for all enrollments to the Department or its authorized representative daily in a HIPAA compliant file format prescribed by the Department and defined in Section 5.1 Definitions 1 -7.

C. Contractor will be required to exchange a monthly 834 audit file for reconciliation with the Department or its authorized representative in an electronic format prescribed by the Department. Within five (5) Business Days after receipt of the 834 Audit File, Contractor shall update all electronic systems maintained by Contractor to reflect the information contained in the 834 Audit File received from the Department.

D. Contractor shall use the 834 Audit File to verify Contractor's Enrollees for the subsequent calendar month. Contractor shall not wait for the 820 Payment File to update eligibility.

E. Contractor shall be responsible for providing Covered Services to Enrollees from the Effective Date of Enrollment in Contractor's D-SNP. Contractor shall not be responsible for medical expenses incurred prior to the effective date of such enrollment.

F. Contractor shall not discriminate against a Potential Enrollee, Prospective Enrollee, or Enrollee on the basis of health status or need for health services and shall abide by all federal and State laws, regulations, and orders that prohibit discrimination because of race, color, religion, sex, sexual orientation, gender identity, national origin, ancestry, age, or physical or mental disability, including the Federal Civil Rights Act of 1964, the Americans with Disabilities Act of 1990, the Federal Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, the Illinois Human Rights Act, Executive Orders 11246 and 11375, and 42 CFR 438.3(d)(4).

1.2.4 *Default Enrollment*

A. The Department approves the use of a default enrollment process. The default enrollment process will begin at the sole discretion of the Department upon issuance of a notice to the Contractor from the Department. If the Department implements default enrollment at any

time in this Contract, the Department will provide Contractor with the required information for their default enrollment application as it pertains to the file exchanges *(HIPAA compliant files – see Section 5.1 Definitions 1 – 7)* that will occur between the Department and Contractor.

B. Contractor shall be responsible for coordinating those necessary activities to renew any existing default enrollment process approval(s) with CMS, as per the requirements of 42 CFR 422.66(c)(2)(ii), so that any such subsequent CMS approval(s)/renewal(s) of an existing approved default enrollment process shall be effective prior to the expiration of the initial approval.

C. If the Department implements default enrollment at any time in this Contract, through implementation of the default enrollment process the Department shall provide Contractor with information necessary to identify those categorically eligible (dually eligible for Medicare and Medicaid) Potential Enrollees who are or will be in their Medicare Initial Coverage Election Period. The default enrollment process is where customer information on first time Medicare eligibility is sent to the Contractor via an electronic and automatic HIPAA compliant file exchange so that the Contractor can default enroll customers into the D-SNP.

D. If CMS rejects Contractor's Default Enrollment Process proposal, Contractor must notify the Department within three (3) days of receiving the initial or renewal rejection notification. Failure to obtain approval for default enrollment will not end Contractor's contract with the state. Contractor may reapply for default enrollment approval from CMS.

E. Contractor shall be responsible for coordination and continuity of care to ensure that, for each Enrollee enrolled in Contractor's D-SNP through the default enrollment process, Contractor shall be responsible for continuing to provide covered services authorized by the Enrollee's previous managed care organization. Contractor shall be responsible to provide services without regard to whether such services are being provided by participating or non-participating providers for at least ninety (90) days, which shall be extended as necessary to ensure continuity of care pending the provider contracting with Contractor or the Enrollee's transition to a participating provider and any needed actions to mitigate potential negative consequences related to transition of providers.

F. Upon approval from the Department and CMS, Contractor shall begin default enrollment. in accordance with 42 CFR 422.66 and 42 CFR 422.68, Contractor must provide an enrollment notice to the Potential or Prospective Enrollee that meets the requirements for being eligible for default enrollment.

G. Contractor shall be responsible for submitting default enrollment reports to the Department per *Section 1.3.4 Default Enrollment Report.*

1.2.5 *Eligibility Deeming Period*

A. Contractor's Eligibility Deeming Period shall be a minimum of 90 days.

B. In accordance with 42 CFR 422.52(d), a D-SNP shall use the eligibility deeming period to maintain continuous coverage when a member temporarily loses Medicaid eligibility.

1.2.6 *Covered Service Areas***.** Contractor shall provide covered services in all counties for which the Contractor receives network adequacy approval from CMS (for Medicare Network) and the Department (for Medicaid network). Contractor shall ensure statewide network adequacy. See *Attachment 1 State of Illinois County List*. **Effective Calendar Year 2027,** Contractor shall have a single Medicare service area within the state of Illinois and Contractor shall be limited to one plan benefit package (PBP) in the Medicare service area**.**

1.2.7 *Disenrollment*

A. Contractor shall notify the Department of any individual who is no longer eligible to remain enrolled in the D-SNP in accordance with the published CMS regulatory guidance, in order for the individual to be disenrolled.

B. Contractor shall terminate an Enrollee's enrollment upon any of the occurrences specified in accordance with the published federal CMS regulatory guidance and the eligibility deeming period including but not limited to the following:

a. When an Enrollee has other significant insurance coverage or is placed in Spend-down status. The Department shall notify Contractor of such disenrollment in the daily 834 file. This notification shall include the effective date of termination; and

b. When an Enrollee is incarcerated in any county jail, Illinois Department of Corrections facility, another state's correctional facility, or federal penal institution.

C. Contractor shall not interfere with the Enrollee's right to disenroll from its DSNP through threat, intimidation, pressure, or otherwise.

D. 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 or disruptive behavior resulting from such Enrollee's special needs (except to the extent such Enrollee's continued enrollment with Contractor seriously impairs Contractor's ability to furnish Covered Services to the Enrollee or other Enrollees as defined in *42 CFR 422.74* or take an Adverse Benefit Determination in connection with an Enrollee who attempts to exercise, or is exercising, their Appeal or Grievance rights. Any attempts to seek to terminate enrollment in violation of this Section will be considered a breach of the Contract. For Discretionary Involuntary Disenrollment, Contractor must comply with 42 CFR 422.74

E. If the Enrollee transfers to another D-SNP, with the Enrollee's written consent, and in accordance with applicable laws and regulations, Contractor must transfer current Determination of Need (DON), (or other assessment tool adopted by the Department) information to the new D-SNP. Contractor shall provide an Enrollee's Individual Plan of Care (IPoC) and DON within ten (10) Business Days after receiving a request for it from the D-SNP in which the individual is enrolled. Contractor must transfer other Enrollee record information within five (5) Business Days to the new D-SNP upon written request signed by the disenrolled Enrollee

F. Contractor must notify the Department if Contractor becomes aware that an Enrollee has comprehensive insurance other than Medicare or Medicaid.

G. The termination or expiration of the Contract terminates Medicaid coverage for all Enrollees with Contractor. Termination will take effect at 11:59 p.m. on the last day of the month in which this Model Contract terminates or expires, unless otherwise agreed to, in writing, by the Parties.

1.2.8 *Readiness Review and Compliance***.** Contractor must comply with Department conducted Readiness Review requirements pursuant to 42 CFR 438.66(d)(4) including:

A. Readiness Review

a. Contractor shall establish and maintain a Medicare Advantage contract that only includes a D-SNP with a service area limited to the State of Illinois.

b. Contractor must remedy all deficiencies identified by the Department or its designee prior to the start of enrollment Start Date.

c. Contractor shall submit its completed Cultural Competence plan to the Department at least two (2) weeks prior to the Department's Readiness Review.

B. Maintain during the term of the resulting Contract a valid Certificate of Authority as a Health Maintenance Organization under 215 ILCS 125/1-1, et seq. Contractor shall provide proof of Certificate of Authority upon request.

C. Comply with all applicable provisions of federal and State laws, regulations, guidance, waivers, and terms and conditions of D-SNP including the implementation of a compliance plan. Contractor must comply with 42 CFR Part 422, Part 423, as well as Medicaid managed care requirements at 42 CFR 438.

D. Comply with Other Laws. No obligation imposed herein on Contractor shall relieve Contractor of any other obligation imposed by court order, law or regulation, including, but not limited to, those imposed by 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 CMS. The Department and CMS shall report to the appropriate agency any information it receives that indicates a violation of a law or regulation. The Department or CMS will inform Contractor of any such report unless the appropriate agency to which the Department or CMS has reported requests that the Department or CMS not inform Contractor.

E. Comply with all applicable administrative bulletins issued by the Illinois Department of Healthcare and Family Services (HFS), Illinois Department of Human Services (DHS) and Illinois Department on Aging (IDoA).

1.2.9 *Program Integrity*

A. Fraud, Waste, and Abuse compliance. Contractor shall have administrative and management arrangements, policies, and procedures that comply with all federal and state regulations and statutes governing the detection and prevention of Fraud, Waste, and Abuse, including but not limited to 305 ILCS 5/8A-1 et. seq., 42 CFR 455, 42 CFR 438 Subpart H, and sections 1128, 1156 and 1902(a)(68) of the SSA.

B. Program Integrity provision. Contractor shall include in its Medicaid Network Provider agreements, a provision requiring as a condition of receiving payment that the Provider comply with 1.2.9 of this Contract.

C. **Compliance program.** Contractor and any Subcontractors delegated responsibility for coverage of services or payment of claims under this Contract, shall implement and maintain a compliance program, as described within 42 CFR 422.503(b)(4)(vi), 423.504(b)(4)(vi), and 438.608, that includes, at a minimum, the following:

a. Written policies, procedures, and standards of conduct that demonstrate compliance with all applicable requirements and standards under the Contract and all federal and state requirements related to program integrity.

b. A designated Compliance Officer who is responsible for developing and implementing policies and procedures designed to ensure compliance with program integrity requirements. The Compliance Officer shall report directly to Contractor's CEO and Board of Directors.

c. A Regulatory Compliance Committee, consisting of members of the Board of Directors and senior management, which is responsible for oversight of the Contractor's compliance program.

d. A system of training and education for the Compliance Officer, Board of Directors, senior managers, and employees regarding Contractor's obligation to comply with federal and state requirements.

e. Effective lines of communication between the Compliance Officer and Contractor's employees, Subcontractors, and Network Providers.

f. Effective lines of communication between Contractor's Compliance Officer, Contractor's employees and the Illinois Office of Inspector General (OIG).

g. Enforcement of regulatory standards and program integrity-related requirements through well-publicized disciplinary guidelines.

h. A system of established and implemented procedures that includes surveillance and utilization controls conducted by a designated Special Investigations Unit (SIU) of dedicated staff adequate in number for routine internal monitoring, auditing of program integrity compliance risks, prompt response to compliance issues, investigation of potential compliance problems identified in the course of self-evaluation and audits, correction of identified compliance problems through corrective action plans, and ongoing compliance with program integrity-related requirements.

i. Under the purview of the Compliance Officer, Contractor shall employ Fraud, Waste and Abuse Investigators at a minimum ratio of one (1) Investigator to every 100,000 Enrollees.

D. Overpayment. Contractor shall have a provision for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential Fraud, Waste, and Abuse to the OIG.

E. Change reporting. Contractor shall adhere to OIG's directive for prompt reporting of a change in a Network Provider's circumstances that may affect the Provider's eligibility to participate in the Medical Assistance Program, including termination of Contractor's Provider agreement.

F. Quarterly and Annual reporting.

a. Contractor shall submit a quarterly report listing its Medicaid Network Providers in an electronic format established by the Illinois OIG.

b. Contractor shall submit an annual overpayment report in accordance with 42 CFR 438.608(d)(3).

G. Recipient verification. Contractor shall maintain a recipient verification procedure as described in *Attachment 2 Required Deliverables Submission and Reporting.* Contractor shall submit its procedure for review and approval by OIG at the commencement of the Contract and annually thereafter. Contractor shall provide an annual summary of the results of this procedure to the OIG.

H. Fraud, Waste, and Abuse prevention policies and procedures. Contractor shall establish written policies and procedures for all employees, Subcontractors, Network Providers, and agents that provide detailed information about the False Claims Act and other federal and state laws described in section 1902(a)(68) of the SSA, including administrative, civil, and criminal remedies for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting Fraud, Waste, and Abuse in federal health care programs. Contractor shall include in any employee handbook a description of these laws, the rights of employees to be protected as whistleblowers, and Contractor's policies and procedures for detecting and preventing Fraud, Waste, and Abuse.

I. OIG reporting portal utilization. In accord with OIG's directives, Contractor shall utilize OIG's reporting portal to promptly inform the OIG of: its audits and investigations of Fraud, Waste, and Abuse related to Illinois' Medical Assistance Program; any findings of potential Fraud, Waste, and Abuse; and any sanctions or actions taken against its Network Providers as a result of Fraud, Waste or Abuse, including but not limited to overpayment recovery, placement on prepayment review, and termination from Network. At the direction of the OIG, Contractor shall promptly inform the Illinois Medicaid Fraud Control Unit of any potential criminal activity.

J. Recoveries of overpayments from Network Providers. Both Contractor and the OIG can identify and recover overpayments made to Network Providers as the result of Fraud, Waste or Abuse. In accord with the requirements below, if Contractor identifies the overpayment, it may recover and retain the overpayment. If OIG identifies the overpayment, it may recover the overpayment from Contractor and Contractor may, in turn, recover the overpayment from the Network Provider.

K. Recoveries by Contractor. Contractor and its Subcontractors shall have internal policies and procedures to identify and recover overpayments

due to Fraud, Waste, and Abuse within timeframes as determined by the OIG.

a. Contractor shall utilize OIG's reporting portal as directed to inform OIG of Network Providers and paid claims that are under review for possible overpayment as a result of Fraud, Waste, or Abuse.

b. Contractor shall promptly report to OIG any overpayments made to a Subcontractor or Network Provider as the result of Fraud, Waste, or Abuse.

c. Contractor shall request approval from OIG to recover any overpayment resulting from Fraud, Waste, or Abuse prior to initiating any recovery action. Contractor shall not take any action to recover such overpayments until OIG approves the request.

d. Suspension of Payments. In accordance with 42 CFR 438.608(a)(8) and 455.23, at the direction of the State, the plan will suspend payments to a network provider for which the Department determines there is a credible allegation of fraud.

e. Contractor shall have a policy allowing for the Network Provider to appeal or seek reconsideration of the established overpayment prior to Contractor's recovery.

f. Upon request from OIG, Contractor shall provide supporting documentation related to the overpayment or recovery, including but not limited to claim and service line level detail related to the overpayment.

g. Contractor shall process all recoveries and overpayments as a service line level or claim level void to the original Encounter Data with specific adjustment detail as defined by the OIG or the Department.

h. Contractor is prohibited from taking any actions to recover or withhold overpayments to a Network Provider, when the specific dates, issues, services, or claims upon which the recovery or withhold are based on, meet one or more of the following criteria:

i. when OIG is auditing or investigating the issues, services, or claims that are the basis of the recovery or withhold;

ii. the improperly paid funds have already been recovered by the State of Illinois, either by the Department or the OIG directly or as part of a resolution of a federal or state investigation or lawsuit, including but not limited to False Claims Act cases;

iii. OIG has issued a Stand-Down Order to Contractor regarding a Network Provider who is the subject of the recovery action; and/or

iv. as Contractor must receive OIG approval prior to an overpayment recovery related to Fraud, Waste, or Abuse, Contractor shall confer with OIG if there is any concern about whether recovery is appropriate under these terms.

L. Recoveries by OIG. OIG or its subcontractors or external auditors may audit or investigate claims paid by Contractor to one of its Network Providers for services in Illinois' Medical Assistance Program. If OIG establishes an overpayment related to Fraud, Waste or Abuse made to a Network Provider, OIG shall proceed with recovery in accord with the following provisions.

a. OIG shall notify Contractor of the overpayment to the Network Provider and provide documentation supporting the overpayment finding. Within fourteen days after receipt of this information Contractor shall inform OIG whether: 1) Contractor disagrees with the overpayment finding and requests a reconsideration, providing any argument and documentation of its disagreement; 2) Contractor agrees with the overpayment finding and intends to repay the amount without seeking recovery from the Network Provider; or 3) Contractor agrees with the overpayment finding and will seek recovery from the Network Provider.

b. If Contractor disagrees with OIG's overpayment finding, OIG shall respond to Contractor's reconsideration request within fourteen (14) days, either changing its finding or denying the request for reconsideration. If an overpayment remains after the

reconsideration, Contractor shall proceed with one of the two remaining options listed in *Section 1.2.9.L.a. Program Integrity.*

c. If Contractor agrees with the overpayment finding but does not intend to recover the overpayment from its Network Provider, then OIG will proceed with collecting the overpayment through an offset on future capitation payments to Contractor.

d. If Contractor agrees with the overpayment finding and intends to collect from its Network Provider, Contractor shall initiate its collection process, including allowing for the Network Provider's appeal or reconsideration of the overpayment finding. If after the appeal or reconsideration has been exhausted the amount of the overpayment was not reduced, OIG shall collect the overpayment through an offset on future capitation payments to Contractor. If after the appeal or reconsideration has been exhausted the amount of the overpayment was reduced, OIG shall collect either the amount of the reduced overpayment or 25% of the overpayment OIG established, whichever is greater, through an offset on future capitation payments to Contractor.

e. If Contractor chose to seek recovery from its Network Provider, Contractor can use any legally available methods to recover those funds from its Network Provider. However, OIG's recovery of the overpayment from Contractor is not contingent on Contractor's recovery from its Network Provider.

M. When overpayment recovery is prohibited. In the event Contractor recovers or otherwise obtains funds in cases where overpayment recovery is prohibited, under this section or as otherwise directed by the OIG, Contractor shall notify the OIG and take all action in accordance with written instructions from the OIG.

N. Forfeiture of funds. In the event Contractor fails to adhere to the prohibitions and requirements of this *Section 1.2.9, Program Integrity*, Contractor may be subject to forfeiture of the funds described in, *Section 1.2.38 Sanctions* to the Department and the imposition of civil monetary penalties.

O. Non-Contractual Recoveries from Network Providers. If OIG requires Contractor to recover established overpayments made to a Subcontractor or Network Provider by the Department for performance

or nonperformance of activities not governed by this Contract, or other monies owed to the Department, Contractor shall immediately notify the Department of any amount recovered, and, as agreed to by the Parties:

a. Contractor shall immediately provide the amount recovered to OIG; or

b. OIG shall withhold the amount recovered from a payment otherwise owed to Contractor.

P. Self-Disclosure. Contractor shall include in its Network Provider agreements the requirement that the Provider report to Contractor when it has received an overpayment from Contractor. The Provider shall return the identified overpayment to Contractor within sixty (60) days of identifying the overpayment and notify Contractor in writing the specific reason for the overpayment and how the overpayment was identified by the Provider.

Q. Reporting and investigating suspected Fraud, Waste, and Abuse

a. Contractor and its Subcontractors shall cooperate with all appropriate federal and state agencies, including OIG, in the detection and prevention of Fraud, Waste, and Abuse.

b. Contractor and its Subcontractors shall have methods for identification, investigation, and referral of suspected Fraud cases in accordance with 42 CFR 455.13, 455.14, and 455.21.

c. In accordance with OIG directives, Contractor shall report through OIG's reporting portal all internal and external complaints of Fraud, Waste, or Abuse by Network Providers. This includes billing anomalies, potential risk of harm to Enrollees, and suspicious prescribing of controlled substances. Contractor shall audit and investigate these complaints to determine whether the allegations are substantiated and shall provide timely updates to the OIG on its findings.

d. Contractor shall promptly refer to OIG through the reporting portal all suspected Fraud, Waste, and Abuse.

e. Contractor shall promptly perform an audit or investigation of all incidents of suspected Fraud, Waste, and Abuse. Where the conduct being audited or investigated is potentially criminal,

Contractor shall not take any of the following actions without prior approval from the OIG:

i. Contact the subject of the investigation about any matters related to the investigation;

ii. Enter into or attempt to negotiate any settlement or agreement regarding the incident; or,

iii. Accept monetary or other consideration, including overpayment recovery, offered by the subject of the investigation in connection with the incident.

f. Contractor shall promptly provide the results of its investigation to the OIG through the OIG's reporting portal.

g. Contractor and its Subcontractors shall cooperate fully in any further investigation or prosecution by any duly authorized government agency, whether administrative, civil, or criminal. Such cooperation shall include providing, upon request, information, access to records, and access to interview Contractor's or Subcontractor's employees and consultants, including but not limited to those with expertise in the administration of the Illinois Medical Assistance Program, in medical or pharmaceutical questions, or in any matter related to an investigation.

h. When issued a Stand-Down Order by OIG as the result of an investigation into a credible allegation of Fraud, Contractor shall refrain from engaging in certain activities specified in the Order and this Contract related to the identified Network Provider.

i. Contractor and its Subcontractors shall cooperate with all OIG investigations, including but not limited to providing administrative, financial, and medical records related to the delivery of services and access to the place of business during normal business hours, except under special circumstances when after-hour admission shall be allowed. Special circumstances shall be determined by the OIG and may include the Illinois State Police Medicaid Fraud Control Unit or other relevant law enforcement entities.

j. Contractor, its Subcontractors and Network Providers shall provide data to the OIG when requested to support audits, investigations, verification activities, substantiate data validation reviews, and to reconcile any differences or anomalies.

k. Contractor shall have policies and procedures to implement suspension of payments to a Network Provider for which the OIG determines there is a credible allegation of Fraud in accordance with 42 CFR 455.23 or pursuant to 305 ILCS 5/12-4.25 (F, F-5, K, and K-5).

l. Contractor shall terminate a Subcontractor or Network Provider when notified by the OIG pursuant to *Section 6.10 Termination Rights*.

R. Prohibited Relationships

a. Contractor shall not employ, subcontract with, or affiliate itself with or otherwise have a relationship with any excluded individual or entity, as defined in Section 1128 of the SSA. Contractor and its Subcontractors shall provide written disclosure to the Department of any prohibited affiliation under 42 CFR 438.610.

b. Contractor shall not knowingly have a relationship with a director, officer or partner of Contractor; a Subcontractor as governed by 42 CFR 438.230; a person with ownership of 5% or more of Contractor's equity; or a Network Provider or person with an employment, consulting or other arrangement with Contractor for the provision of items and services that are significant and material to Contractor's obligations under this Contract, when:

i. that individual or entity is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or

ii. an individual or entity who is an affiliate of a person described above in this section.

c. If the Department finds Contractor out of compliance, the Department shall notify the Secretary of the U.S. Department of Health and Human Services of the noncompliance; the Department may continue an existing agreement with Contractor unless the Secretary directs otherwise; and the Department shall not renew or extend the duration of an existing agreement with Contractor, unless the Secretary provides to the Department and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliations.

S. Identified Overpayments.

a. Contractor shall report to the Department within sixty (60) calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the contract.

b. Contractor shall include claim and service line level detail in the quarterly report. Recoveries by Contractor of overpayments to Providers. Consistent with 42 CFR 422.326 and 438.608(d), Contractor must adopt and implement policies for the treatment of recoveries of overpayments from Contractor to a Provider.

T. Contractor must submit an Enrollee Recipient Restriction report to the Illinois OIG on a form provided by the OIG.

1.2.10 *Organizational Structure*

A. Contractor shall establish and maintain the interdepartmental structures and processes to support the operation and management of its D-SNP line of business in a manner that fosters integration of physical health, behavioral health, and Long-Term Services and Supports (LTSS) service provisions. The provision of all services shall be based on prevailing clinical knowledge and the study of data on the efficacy of treatment when such data is available.

B. On an annual, and an ad hoc basis, when changes occur, or as directed by the Department, Contractor shall submit an overall organizational chart that includes senior and mid-level managers for the organization.

C. Within five (5) Business Days after receipt of the 834 Audit File, Contractor shall update all electronic systems maintained by Contractor to reflect the information contained in the 834 Audit File received from the Department.

D. Contractor shall use the 834 Audit File to verify Contractor's Enrollees for the subsequent calendar month. Contractor shall not wait for the 820 Payment File to update eligibility.

1.2.11 *Covered Services***.** Contractor must provide, authorize, arrange, integrate, and coordinate the provision of all Covered Services for its Enrollees. These Covered Services will be covered directly by the FIDE-SNP.

A. *Service Package I*. Contractor shall provide, or arrange for the provision of, all Covered Services for Service Package I, to Enrollees at all times during the term of this Contract, whenever Medically Necessary. Service Package I includes all federally approved Medicaid services, except those included in Service Package II (*see Attachment 3 HCBS Service Package II Covered Services)*. Additional services that are explicitly excluded (until MLTSS is incorporated into this Contract per Section 1.2) from Service Package I are listed in *Attachment 4 MLTSS Covered Services*.

B. *Service Package II*.

a. Contractor shall provide, or arrange for the provision of, all Covered Services for Service Package II, to Enrollees at all times during the term of this Contract. Service Package II includes all Covered Services identified in *Attachment 3 HCBS Service Package II Covered Services including Certified Community Behavioral Health Clinic Services*. Individual Provider (IP) services in Service Package II shall be considered Covered Services only if such services can be included in a manner consistent with any existing collective bargaining agreement, or pertinent side letter, between the Illinois Department of Central Management Services and Service Employees International Union (SEIU) Healthcare Illinois. Contractor must abide by the rules and policies provided in each HCBS Waiver.

b. Electronic Visit Verification (EVV).

i. In the Department's sole discretion, the Contractor must have a fully operational electronic visit verification (EVV) system for in-home personal care and home health services

that complies with the requirements of 42 U.S.C. 1396b(l). The EVV system must verify and record electronically (for example, through a telephone or computer-based system) at least the following: the type of service performed, the individual receiving the service, the individual providing the service, the date of the service, the location of the service, and the time the service begins and ends. In addition to capturing the elements outlined above, the Contractor may use any EVV vendor and/or proprietary EVV system; however, the EVV system shall offer inter-operability and compatibility among EVV platforms and be compatible with the Department's EVV system as prescribed by HFS.

ii. All encounter claims submitted for services subjected to EVV requirements must have corresponding visit data submitted to the Department's EVV vendor.

iii. The implementation of EVV must not negatively impact the provision of services. The Department's policies and procedures regarding the provision of services remain the same and service delivery should continue as it did before the implementation of these EVV requirements. EVV does not change the method and location for service delivery.

C. Medical Necessity. The Contractor shall provide services to Enrollees as follows:

a. Authorize, arrange, coordinate, and provide Enrollees all Medically Necessary Covered Services in accordance with the requirements of the Contract.

b. Provide all Covered Services that are Medically Necessary, including but not limited to, those Covered Services that:

i. Prevent, diagnose, or treat health impairments.

ii. Attain, maintain, or regain functional capacity.

c. Not arbitrarily deny or reduce the amount, duration, or scope of a required Covered Service solely because of diagnosis, type of illness, or condition of the Enrollee.

d. Not deny authorization for a Covered Service that the Enrollee or the Provider demonstrates is Medically Necessary.

e. The Contractor may place appropriate limits on a Covered Service on the basis of Medical Necessity, or for the purpose of Utilization Management, provided that the furnished services can reasonably be expected to achieve their purpose. The Contractor's Medical Necessity guidelines must, at a minimum, be:

i. Developed with input from practicing Physicians in the D-SNP's Service Area;

ii. Developed in accordance with standards adopted by national accreditation organizations;

iii. Updated at least annually or as new treatments, applications and technologies are adopted as generally accepted professional medical practice;

iv. Evidence-based, if practicable; and

v. Applied in a manner that considers the individual health care needs of the Enrollee.

f. The Contractor's Medical Necessity guidelines, program specifications and service components for behavioral health services must, at a minimum, be submitted to the Department annually for approval no later than thirty (30) days prior to the start of a new Contract Year, and no later than thirty (30) days prior to any change.

g. Offer and provide to all Enrollees any and all non-medical programs and services specific to Enrollees for which the Contractor has received the Department's approval.

D. The Contractor agrees to provide Enrollees access to the following Covered Services:

a. All services provided under State Plan services, including but not limited to primary care, acute care, home health services, behavioral health services, medical supplies, equipment, and appliances, and at least 180 days of nursing facility coverage

during the plan year but excluding ICF/IID facility services, and those services otherwise excluded or limited in Excluded Services F.a or G.a Limitations on Covered Services of *Section 1.2.11 Covered Services*.

b. All services offered through Home and Community Based Services (HCBS) Waivers for individuals enrolled in the following waivers (*See Attachment 3 HCBS Service Package II Covered Services*).

   i. Persons who are Elderly;

   ii. Persons with Disabilities

   iii. Persons with HIV/AIDS;

   iv. Persons with Brain Injury; and

   v. Supportive Living Program

   vi. Long term services and supports

c. Pharmacy products that are covered by Illinois and may not be covered under Medicare Part D as provided by the Department. Contractors are encouraged to offer a broader drug formulary than minimum requirements.

d. Any supplemental benefits offered by the Contractor through their Plan Benefit Package (PBP).

   i. The Contractor shall determine where its Medicare supplemental benefits overlap with benefits covered in the Illinois Medicaid program. In areas where service overlap occurs, the Contractor shall ensure it adjudicates those claims first for in-network services under Contractor's Medicare supplemental benefits before adjudicating the claims as a Medicaid covered service.

   ii. No later than September 30 of each calendar year, in a format specified by the Department, the Contractor shall notify the Department of its supplemental benefits, inclusive of all benefits listed in the final plan benefit package.

iii. The Contractor shall provide a written report and analysis of the overlap and interaction between Contractor's supplemental benefit offerings and comparable Illinois Medicaid benefits including the impact on coordination of benefits, third party liability, and access. The structure and format of this report shall be developed in consultation with and be approved by the Department no later than October 1, 2025.

iv. The Contractor must notify enrollees about its supplemental benefits as required by CMS.

v. For CY 2027 and subsequent contract years, the Department intends to be a more active partner with the Contractor in determining its supplemental benefit offerings and better capture the value of supplemental benefits to D-SNP enrollees. Beginning August 2025 and every August thereafter, the Contractor shall collaborate with the Department in planning and developing supplemental benefits that align with benefits covered by the Illinois Medicaid program. In developing supplemental benefits, the Contractor shall also consider their potential impact of on coordination of benefits, third-party liability, and access. The Department in its sole discretion may require the Contractor to cover Medicaid services as a Medicare supplemental benefits including but not limited to the following Medicaid benefits - dental, hearing, vision, over-the- counter medicine and items, and non-emergency medical transportation (NEMT).

vi. For CY 2027, the Department is considering the following specific Medicaid services as mandatory supplemental benefits:

(A) Dental: The Illinois Medicaid dental package under 89 IL. Admin. Code Section 140.420 and Section 140.421.

(B) Vision: The Illinois Medicaid vision package under 89 Ill. Admin. Code Section 140.416 and Section 140.417 and Medicaid covered cost sharing for vision benefits covered under Part B such as eye exams for diabetic retinopathy, glaucoma screenings for high-risk members,

and diagnostic tests and treatment for members with age-related macular degeneration.

(C) Hearing: The Illinois Medicaid hearing benefits under 89 Ill. Admin Code Section 140.497.

(D) OTC Drug: The Medicaid state plan OTC benefits.

(E) NEMT: The Medicaid state plan NEMT benefits.

vii. For CY 2028 and subsequent calendar years, the Department will issue a notice to the Contractor regarding the mandatory supplemental benefits that the Department is considering.

e. Institution for Mental Diseases in lieu of Covered Services. The Contractor may provide psychiatric, and substance use disorder inpatient services in an Institution for Mental Diseases (IMD) that are medically appropriate and cost effective in lieu of the Covered Services under the State Plan to Enrollees between the ages of twenty-one and sixty-four (21–64) who have inpatient stays in an IMD of no more than fifteen (15) days in a calendar month. The Contractor shall not require an Enrollee to use such in lieu of services. The Department represents that Capitation Rates paid hereunder for IMD in lieu of services are actuarially sound and based on Covered Services under the State Plan. Eligibility and length of stay will be determined by IMD admissions status on the first day of every calendar month.

f. Contractor shall submit to the Department a copy of the final bid submitted to CMS for the Medicare Advantage contract containing the plan benefit package, including supplemental benefits, covered by this Contract concurrent with Contractor's submission to CMS. Contractor shall submit any and all changes made by CMS to HFS concurrent with finalization of the plan benefit package between Contractor and CMS.

E. Cost sharing for Medicaid Services.

a. For Enrollees who are Residents of NFs, FIDE-SNPs may require the Enrollee to contribute to the cost of NF care that amount

listed for the Enrollee on the Department's patient credit file, which will be transmitted monthly to the FIDE-SNP.

b. Contractor shall complete retroactive adjustments for up to twenty-four (24) months to Nursing Facilities, Supportive Living Facilities, and Specialized Mental Health Rehabilitation Facilities to account for patient credit liability amount changes.

c. Contractor shall pay claims and retroactive adjustments beyond twenty-four (24) months to Nursing Facilities, Supportive Living Facilities, and Specialized Mental Health Rehabilitation Facilities in cases due to delays in the State's eligibility processing of long-term care admissions and income changes that prevented Contractor from processing a payment or adjustment.

F. Excluded Services. The following services are not Covered Services

a. Services that are provided in a State Facility operated as a psychiatric hospital as a result of a forensic commitment;

b. Services that are provided through a Local Education Agency (LEA);

c. Services that are experimental or investigational in nature;

d. Services that are provided by a non-Affiliated Provider and not authorized by Contractor, unless this Contract specifically requires that such services be Covered Services;

e. Services that are provided without a required Referral or prior authorization as set forth in the Provider Handbook;

f. Medical and surgical services that are provided solely for cosmetic purposes;

g. Services or items furnished for the purpose of causing, or for the purpose of assisting in causing, the death of an Enrollee, such as by assisted suicide, euthanasia, or mercy killing, except as otherwise permitted by P. L. 105-12, Section 3(b), which is incorporated by Section 1903(i)(16) of the SSA.

h. Services for which Contractor uses any portion of a Capitation payment to fund roads, bridges, stadiums or any other items or

services that are not Covered Services, except such items or services that are Emergency Services or included as additional Covered Services in *Attachment 3 HCBS Service Package II Covered Services* and *4 MLTSS Covered Services*.

i. Pursuant to 305 ILCS 5/5-30(b), non-emergency ground ambulance services not covered by Medicare.

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

a. Sterilization services may be provided only as allowed by State and federal law (see 42 CFR Part 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.

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

H. Covered Services must be available to all Enrollees twenty-four (24) hours a day, seven (7) days a week, as authorized by Contractor.

I. Covered Services will be managed and coordinated by Contractor through the Interdisciplinary Care Team (ICT).

J. Covered Services shall be provided in the amount, duration and scope as set forth in 89 Ill. Adm. Code, Part 140, and this Contract, and shall be sufficient to achieve the purposes for which such Covered Services are furnished. This duty shall commence at the time of initial coverage as to each Enrollee.

K. Contractor shall cover the appropriate level of service for all Emergency Services and non-Emergency Services in an appropriate setting.

L. Contractor shall not refer Enrollees to publicly supported health care entities to receive Covered Services for which Contractor receives payment from the Department unless such entities are Network Providers with Contractor. Such publicly supported health care entities include, but are not limited to, the Chicago Department of Public Health and its clinics, Cook County Bureau of Health Services, and Certified Local Health Departments.

M. Medicaid Cost Sharing and FIDE-SNP Premiums. Cost sharing from Enrollees is prohibited. Contractor shall not charge Enrollees premiums for FIDE-SNP.

N. Medicare Part A and B Cost Sharing. Contractor will only enroll individuals as stated in 1.2.1 (C). Additionally, the Department does not allow for any nominal Medicaid copayments to be charged to the population(s) eligible for enrollment in Contractor's D-SNP under its Medicaid state plan. Therefore, per Sections 1902(n)(3)(B) and section 1852(a)(7) of the SSA and 42 CFR 422.504(g)(1)(iii), Contractor may not charge any D-SNP enrollees any cost sharing for any Medicare A or B service rendered by one of Contractor's Medicaid network providers, except in the rare case of Medicare Part A or B services that are not covered under the Department's Medicaid state plan or a Medicaid waiver, wherein SLMB+ and other full benefit dual eligible enrollees (FBDE) in Contractor's D-SNP may be charged the full Medicare cost-sharing amount(s) specified within the D-SNP's plan benefit package.

a. Medicare Part D Co-Payments. With approval from CMS, the Department may incorporate into Contractor's capitated rate amount for Medicare Part D Low-Income Subsidy (LIS) co-payments for enrollees who owe such copayments. If the Department chooses to pay for these Medicare Part D LIS co-payments, the Department shall notify Contractor and make any necessary modifications to capitation rates and Contractor shall refrain from collecting cost sharing from enrollees for prescription drugs.

O. Tracking Maximum Out of Pocket (MOOP) Amounts. The Contractor must track each enrollee's accrued out-of-pocket spending and alert enrollees and providers when the maximum out-of-pocket (MOOP) amount is reached, in accordance with federal regulations at 42 CFR 422.100(f)(4) and (f)(5)(iii) and 42 CFR 422.101(d). The Contractor shall notify the Department using a state-specified mechanism to alert the state to D-SNP enrollees for whom the MOOP amount has been reached.

P. Contractor must comply with serving the MLTSS population and ensure provision of covered services in *Attachment 4 MLTSS Covered Services* at the time of implementation of the MLTSS population in 2027.

1.2.12 *Care Delivery Model*

A. Contractor's Medicare Advantage organization is responsible for the coordination of both Medicare and Medicaid integrated benefits within a single managed care organization. Contractor's Medicare Advantage organization is responsible for coordinating the delivery of all benefits and Covered Services by both Medicare and Illinois Medicaid, including when Illinois Medicaid benefits are delivered via fee-for-service and/or Contractor. Contractor's Medicare Advantage organization shall use Medicare Parts A, B and D data and health care and other data received from the Department to coordinate the enrollee's Medicare and Illinois Medicaid benefits, including, but not limited to discharge planning, disease management, Health Related Social Needs (HRSN) and Care Management.

B. Contractor shall operate an Interdisciplinary Care Team (ICT) for all enrollees, consisting of nurse practitioners, social workers, registered nurses and/or licensed practical nurses, and licensed behavioral health clinicians, and other applicable Medicaid Network providers who coordinate care across Enrollees' Medicare and Medicaid benefits, regardless of payer, as well as health-related social supports that may impact members' ability to live in the community. Contractor shall use community peers and health outreach outworkers to provide in-person assistance to members in order to improve coordination of physical and behavioral health, LTSS, and social support needs.

C. Contractor shall have a clear process for ensuring coordination with DHS and IDoA as well as other entities providing LTSS services for D-SNP Enrollees in a way that promotes the most integrated approach to care coordination, care planning, and addressing care transitions. This includes ensuring a referral for any D-SNP Enrollee who needs an assessment for LTSS services.

1.2.13 *Model of Care***.** Contractor shall implement an evidence-based Model of Care (MOC) consistent with the Special Needs Plan (SNP) MOC, approved by the National Committee for Quality Assurance (NCQA), according to the Standards set forth in 42 CFR 422.4(a)(1)(iv), 422.101(f), and 422.152(g). The MOC shall include Department Care Coordination requirements set forth in *Section 1.2.14 Care Coordination* of this Contract. Contractor shall submit its MOC to CMS for review and approval and notify the Department that the MOC has been submitted. Contractor shall notify the Department of any proposed changes to its approved MOC prior to submitting revisions to CMS.

1.2.14 *Care Coordination*

A. Contractor shall have in place the following technology to assist with Care Coordination and Provider/Enrollee communication:

a. Enrollee Profiles. Contractor shall use technology and processes that effectively integrate data from a variety of sources to measure and monitor Enrollee's health outcomes and social determinants of health needs. Contractor will use any available data including demographics, eligibility data, claims payment information, care opportunities, care gap alerts, needs identified by assessments, and Enrollee preferences to measure and monitor outcomes. Contractor must ensure it receives the Care Coordination Claims Data (CCCD) for each new Enrollee monthly from the Department. The Department may require Contractor to issue reports or develop dashboards pursuant to this subsection.

b. Care Management System. Contractor's Care Coordinators will use its Care Management system to review assessments, interventions, and management of Chronic Health Conditions to gather information to support IPoCs and identification of Enrollees' needs. Contractor shall have fully operational portals, which provide Enrollees and Providers access to relevant information from the Care Management system.

c. Admission, Discharge, and Transfer (ADT) System. HFS has an Admission, Discharge, Transfer (ADT) system. The platform sends real-time ADT notifications from the admitting, transferring, or discharging facility, including emergency room visits. Contractor must connect to the ADT system in accordance with *Section 1.2.36 Data Security and Connectivity, E Connectivity Specifications*, and incorporate the alerts into its care coordination functions, including discharge planning.

B. Contractor shall offer Care Management services to all Enrollees to ensure effective linkages and coordination between the medical home and other Providers and services and to coordinate the full range of medical and social supports, as needed. As soon as Contractor reaches the Enrollee, Contractor shall assign a Care Coordinator and begin offering Care Management services to the Enrollee.

a. Contractor shall provide Care Management to all Enrollees that accept or request it, through a Care Coordinator who participates in an ICT. Care Management includes assessment of the Enrollee's clinical risks and needs, medication management, and health education on complex clinical conditions, as appropriate to the individual needs and preferences of the Enrollee.

   i. If Contractor enters into any contract with any entity that also administers the DON or prescreening required under HCBS Waivers, Contractor shall provide the name of that Provider to the Department within 24 hours of contract execution.

   ii. Contractor shall coordinate services with the services the Enrollee receives from community and social support providers.

   iii. Contractor shall have the capacity to perform the full range of Care Management prior to implementation, and the State will monitor Contractor's performance throughout the term of the resulting Contract.

   iv. Contractor shall implement procedures to coordinate services provided between settings of care, including timely discharge planning for hospital and institutional stays. Contractor shall also provide Case Management assistance to hospitals in securing timely transfer of patients from non-Network hospitals to contracted facilities and transition to community.

   v. For Enrollees residing in a Nursing Facility, Contractor shall ensure that Care Management services required by this Contract are provided. Nursing Facility Care Coordinators may provide Care Management services that supplement Contractor's Care Management services.

b. Each Enrollee who receives Care Management will be assigned a Care Coordinator. Contractor must provide Enrollee information on how to contact the Enrollee's designated person or entity primarily responsible for coordinating services.

i. Qualifications. Care Coordinators who serve Enrollees within the IDoA Persons Who are Elderly HCBS Waiver, Division of Rehabilitation Services within DHS (DHS-DRS) Persons with a Brain Injury HCBS Waiver, DHS-DRS Persons with HIV/AIDS HCBS Waiver, or DHS-DRS Persons with Disabilities HCBS Waiver must meet the applicable qualifications set forth in *Attachment 5 Qualifications and Training Requirements of Care Coordinators for 1915c HCBS Waiver Services*. Care Coordinators for all other Enrollees must have the appropriate qualifications to address the needs of Enrollees.

ii. Training requirements. Care Coordinators who serve Enrollees within the IDoA Persons Who are Elderly HCBS Waiver, DHS-DRS Persons with a Brain Injury HCBS Waiver, DHS-DRS Persons with HIV/AIDS HCBS Waiver, DHS-DRS Persons with Disabilities HCBS Waiver, or HFS Supportive Living Program HCBS Waiver must meet the applicable training requirements set forth below in *Section 1.2.14 B.b.iii Care Coordination*. Care Coordinators for all other Enrollees must have the training, in accordance with *Section 1.2.35 Training*, to address the needs of Enrollees.

iii. Training Requirements of Certain Care Coordinators. Care Coordinators for HCBS Waiver Enrollees shall receive a minimum of twenty (20) hours in-service training initially and annually. For partial years of employment, training shall be prorated to equal one-and–a-half (1.5) hours for each full month of employment. Care Coordinators must be trained on topics specific to the type of HCBS Waiver Enrollee they are serving. Training must include the following:

(A) Persons Who are Elderly Waiver. Aging related subjects.

(B) Person with Brain Injury Waiver. Training relevant to the provision of services to persons with brain injuries.

(C) Person with HIV/AIDS Waiver. Training relevant to the provision of services to persons with AIDS (e.g., infectious disease control procedures, sensitivity training, and updates on information relating to treatment procedures).

(D) Supportive Living Program Waiver. Training on the following subjects: resident rights; prevention and notification of Abuse, Neglect, and exploitation; behavioral intervention, techniques for working with the elderly and persons with disabilities; and disability sensitivity and Communicable Disease/Infection training.

C. Contractor shall provide Assessment and Individualized Care Planning including:

a. Identifying Need for Care Management. Contractor's goals, benchmarks, and strategies for managing the care of Enrollees in its traditional Disease Management Programs shall be incorporated in, and included as part of, Contractor's Care Management program. Contractor shall use population- and individual-based tools and real-time Enrollee data to identify an Enrollee's risk level. These tools and data shall include the following:

b. Predictive modeling. Contractor shall utilize claims and Care Coordination Claims Data (CCCD) to risk stratify the population and to identify high-risk conditions requiring immediate Care Management.

c. Surveillance data. Contractor shall identify Enrollees through Referrals, transition information, service authorizations, alerts, Grievance system, memos, results of the DON, or other assessment tools adopted by the State, and from families, caregivers, Providers, community organizations, and Contractor personnel.

d. Stratification. Based upon an analysis of the information gathered through the process in this section, Contractor shall stratify all Enrollees to determine the appropriate level of

intervention by its Care Management program. Contractor shall systematically assign an initial risk level within the first fifteen (15) days after enrollment. Initial risk levels shall be evaluated and updated to reflect the results of a health-risk assessment, and other relevant tools and data. Ongoing stratification shall occur as described at *Section 1.2.14.P Care Coordination* of this Contract. Contractor shall risk stratify as high-risk residents of Specialized Mental Health Rehabilitation Facilities and Cook County Nursing Facilities following completion of the Transitional Assessment by the Department's vendor contracted to perform such assessments for Williams class members and Colbert class members. Such Enrollees who transition to the community shall remain stratified as high-risk no less than eighteen (18) months.

e. Risk Category. Enrollees shall be assigned to one (1) of three (3) levels:

Risk Stratification	
Risk category	**Description**
Level 1: Low	Includes low- or no-risk Enrollees to whom Contractor provides, at a minimum, prevention and wellness messaging and condition-specific education materials.
Level 2: Moderate	Includes moderate-risk Enrollees for whom Contractor provides problem-solving interventions.
Level 3: High	Includes high-risk Enrollees for whom Contractor provides intensive Care Management for reasons such as addressing acute and chronic health needs, behavioral health needs, or addressing lack of social support.

f. Stratification Level. Contractor shall stratify Enrollee groups using the minimum requirements provided below:

Population	**Level 2 and 3 (combined moderate- and high-risk)**	**Level 3 (high-risk)**
D-SNP Enrollees	20%	5%

D. Contractor must use a comprehensive Health Risk Assessment (HRA) (including HRSN) designated by the Department for all D-SNP Enrollees.

a. The HRA shall consider Enrollees' medical, psychosocial, social, functional, cognitive, and behavioral health (including substance abuse) needs including housing stability, food security, and access to transportation. Contractor shall use the HRA to advance person-centered care for its Enrollees.

b. Contractor shall comply with changes to the HRA made by the Department. Department reserves the right to update the HRA and require additional specific areas of focus at any time during the resulting Contract.

E. HRA Procedures. Contractor shall complete an HRA, by following the procedures outlined in this section, within ninety (90) days after the Effective Enrollment Date for all Enrollees as follows:

a. HFS expects the Contractor to make multiple, continuous efforts to reach enrollees until an HRA and IPoC are completed or refused. If an Enrollee refuses, then the refusal must be documented either by hand, voice recording or e-signature.

b. The HRA will be conducted, in-person or over the phone, and an IPoC will be developed within ninety (90) days after the Effective Enrollment Date.

c. Enrollees receiving HCBS Waiver services or residing in a Nursing Facility (NF) as of the Effective Enrollment Date with Contractor. The HRA must be in-person and completed within ninety (90) days after the Effective Enrollment Date.

d. For those Enrollees transitioning to NFs the HRA must be in-person and completed within ninety (90) days of Contractor's receipt of the 834 daily file that indicates an Enrollee has transitioned to a NF.

e. Enrollees deemed newly eligible for HCBS services, the HRA must be in-person and completed within fifteen (15) days after the D-SNP is notified that the Enrollee is determined eligible for HCBS services.

F. If an Enrollee declines an HRA the Contractor shall reach out annually to conduct an HRA for each subsequent year of the resulting Contract.

G. Contractor shall locate and engage all Enrollees using community-based organizations and other outreach entities and personnel to assist in locating and engaging such Enrollees.

H. Contractor shall provide Enrollee engagement and education and use a multifaceted approach to locate, engage, and educate Enrollees and shall capitalize on every Enrollee contact to obtain and update Enrollee information. Contractor shall solicit input from Enrollees and other stakeholders to help develop strategies to increase motivation for enhanced independent and healthy living.

I. Contractor will encourage Providers to support Enrollees in directing their own care and developing an IPoC.

J. Contractor shall support an Interdisciplinary Care Team (ICT) for all Enrollees.

a. The ICT will ensure the integration of the Enrollee's medical and Behavioral Health services, and, if appropriate, Service Package II services. Duties of the ICT are separate from utilization management duties.

b. Each ICT will be person-centered, built on each Enrollee's specific preferences and needs, and deliver services with transparency, individualization, respect, linguistic and Cultural Competence, and dignity. Each ICT shall consist of clinical and nonclinical staff whose skills and professional experience will complement and support one another in the oversight of each Enrollee's needs.

c. ICT functions shall include:

i. providing Care Management for Enrollees; assisting in the development, implementation, and monitoring of IPoCs, including HCBS service plans where applicable; and, assisting in assuring integration of services and coordination of care across the spectrum of the healthcare system.

ii. ensuring a primary Care Coordinator is responsible for coordination of all benefits and services the Enrollee may need (Care Coordinators will have prescribed caseload limits as set forth in *Section 1.2.14.Q Care Coordination*).

iii. assigning a Care Coordinator who has the experience most appropriate to support the Enrollee.

iv. using motivational interviewing techniques.

v. explaining alternative care options to the Enrollee; and

vi. maintaining frequent contact with the Enrollee through various methods including face-to-face visits, e-mail, and telephone, as appropriate to the Enrollee's needs and risk level or upon the Enrollee's request.

K. Contractor shall develop Individualized Plans of Care (IPoC) and Service Plans for all Enrollees within 90 days after completion of a HRA or 90 days after the effective date of enrollment, whichever is later.

a. Contractor shall develop a comprehensive, person-centered IPoC for all Enrollees. Contractor shall engage Enrollees in the development of the IPoC as much as possible. An IPoC may not be finalized until signature from the Enrollee or authorized representative has been received either by hand, e-signature, or voice recording. For an Enrollee receiving HCBS Waiver services, a written signature is required for the IPoC, in accordance with 42 CFR 441.301(c)(2)(ix). Enrollees must be provided with a copy of the IPoC upon completion and may request a copy at any time. The IPoC is considered an Enrollee-owned document. The IPoC must:

i. incorporate all of the Enrollee's care needs, including: medical, Behavioral Health, Service Package II care, Social Determinants of Health (SDoH), and functional needs.

ii. include identifiable short- and long-term treatment and service goals to address the Enrollee's needs and preferences and to facilitate monitoring of the Enrollee's progress and evolving service needs.

iii. include, in the development, implementation, and ongoing assessment of the IPoC, an opportunity for Enrollee participation and an opportunity for input from the Primary Care Provider (PCP), other Providers, a legal

or personal representative, and the family or caregiver if appropriate.

b. Contractor shall include in the IPoC, as appropriate, the following elements:

i. the Enrollee's personal or cultural preferences, such as types or amounts of services;

ii. the Enrollee's preference of Providers and any preferred characteristics, such as gender or language;

iii. the Enrollee's health-related social needs;

iv. Covered Services and non-Covered Services to address each identified need, provided that Contractor shall not be required to pay for non-Covered Services;

v. actions and interventions necessary to achieve the Enrollee's objectives;

vi. follow-up and evaluation;

vii. collaborative approaches to be used;

viii. desired outcome and goals, both clinical and nonclinical;

ix. barriers or obstacles;

x. responsible parties;

xi. standing Referrals;

xii. community resources;

xiii. informal supports;

xiv. timeframes for completing actions;

xv. status of the Enrollee's goals;

xvi. home visits as necessary and appropriate for Enrollees who are homebound (as defined in 42 U.S.C. 1395n(a)(2)), who have physical or Cognitive Disabilities,

or who may be at increased risk for Abuse, Neglect, or exploitation;

xvii. back-up plan arrangements for critical services;

xviii. Crisis Safety Plans for an Enrollee with Behavioral Health conditions; and

xix. Wellness Program plans.

c. Contractor shall include an HCBS Waiver person-centered service plan for Enrollees receiving HCBS Waiver services. Contractor shall ensure the person-centered service plan is developed in accordance with 42 CFR 441.301(c) and as follows:

i. Planning Process. Contractor shall ensure that the person-centered planning process is initiated, and the service plan is developed within fifteen (15) days after Contractor is notified that the Enrollee is determined eligible for HCBS Waiver services. Contractor shall not wait for the 834 eligibility files to indicate Enrollee is eligible and services should begin. The source of truth for HCBS Waiver services to begin is notification from the state agency responsible for establishing HCBS waiver eligibility. The planning process shall be led, when possible, by the Enrollee and include individuals chosen by the Enrollee. The time, date, and setting of the meeting are set and every accommodation possible is made to include all persons identified by the Enrollee. An Enrollee's HCBS Provider(s), or those who have an interest in or are employed by the HCBS Provider(s), shall not participate in the planning process, unless the provision at 42 CFR 441.301(c)(1)(vi) is met. Contractor is responsible for establishing and maintaining procedures to assist Enrollees in the planning process, including how to resolve conflicts and disagreements that includes conflict-of-interest guidelines. The Enrollee's Care Coordinator will assist the Enrollee in leading the HCBS Waiver person-centered service planning and will coordinate with the Interdisciplinary Care Team (ICT).

ii. Informed Client Choice. Contractor's person-centered planning process shall provide sufficient information and guidance to ensure the Enrollee is enabled to make informed choices regarding services, supports HRSN and Providers. The planning process must reflect cultural considerations of the Enrollee and is conducted using accessible information presented in readily understood language. Alternative home and community-based settings considered during the planning process must be documented in the service plan.

iii. Service Plan Contents. Each person-centered service plan must be written in a manner that is understandable to the Enrollee and include: (1) documentation that the setting in which the Enrollee resides is chosen by the Enrollee, is integrated into and supports access to the community, and meets, when applicable, the HCBS Settings rule requirements at 42 CFR 441.301(c)(4); (2) the Enrollee's strengths and preferences; (3) the clinical and support needs identified through the DON; (4) person-centered goals and desired outcomes; (5) paid and unpaid services and supports that will assist Enrollee to achieve identified goals, address HRSNs, the Providers of those services and supports, including those self-directed by the Enrollee; (6) identified risk factors and strategies, including back-up plans, to minimize potential undesirable outcomes associated with those risks; and (7) the individual or entity responsible for monitoring the service plan.

iv. Service Plan Finalization. Contractor shall ensure that the final person-centered service plan is finalized with the informed written consent of the Enrollee and is signed by and distributed to individuals and Providers responsible for the service plan's implementation, as applicable.

v. Service Plan Review and Revision. Contractor shall ensure that an Enrollee's person-centered service plan is reviewed and revised upon reassessment of functional need at least every twelve (12) months, when an

Enrollee's circumstances or needs change significantly, or at the Enrollee's request.

d. For an Enrollee who is receiving HCBS waiver services through fee-for-service Medicaid on the date that such services become Covered Services under managed care, Contractor will use the Enrollee's existing service plan, and that service plan will remain in effect for at least a ninety (90)–day transition period unless changed with the input and consent of the Enrollee and only after completion of an in-person health risk assessment. The service plan will be transmitted to Contractor prior to the Effective Enrollment Date. The service plan Care Coordinator will lead the process for changing or updating the HCBS Waiver service planning, as appropriate, through coordination with the Enrollee and the ICT.

e. For an Enrollee who is receiving HCBS Waiver services through Contractor and who ceases to be eligible for Contractor services but continues to be eligible for an HCBS Waiver or equivalent home care services, Contractor shall transmit the Enrollee's existing service plan to the applicable State agency within fifteen (15) days after new coverage information is reflected in MEDI.

f. For an Enrollee who is receiving HCBS Waiver services through Contractor and who ceases to be eligible for Contractor services, Contractor shall notify the Enrollee' existing HCBS Waiver Provider(s) in writing of Contractor's service authorization termination date no later than seven (7) days from such date. The notice shall clarify to which HCBS waiver agency the enrollee will be transitioning.

L. Contractor shall identify and evaluate risks associated with the Enrollee's care. Factors considered include the potential for deterioration of the Enrollee's health status; the Enrollee's ability to comprehend risk; caregiver qualifications; appropriateness of the residence for the Enrollee, other SDOH and HRSN factors; and behavioral or other compliance risks. Contractor shall incorporate the results of the assessment of risks into the IPoC. IPoCs that include Negotiated Risks shall be submitted to Contractor's medical director for review. Negotiated Risks shall not allow or create risks for other Residents in a group setting.

M. For Enrollees transferring MCOs for whom an IPoC has been developed, Contractor will use the Enrollee's existing service plan, and that service plan will remain in effect for at least a ninety (90)–day transition period unless changed with the input and consent of the Enrollee and only after completion of a face-to-face health-risk assessment.

N. In the event the Enrollee refuses to sign the IPoC, Contractor shall document:

a. in detail the specific reason why the Enrollee refuses to sign the IPoC; and

b. actions taken by the Care Coordinator to address Enrollee's concerns.

O. Contractor shall ensure that the Enrollee's IPoC is communicated to all the Enrollee's ICT members and Providers, as appropriate.

P. Contractor shall provide ongoing risk level assessment and stratification. Contractor will, on a monthly basis, analyze predictive-modeling reports and other surveillance data of all Enrollees to identify risk-level changes. As risk levels change, assessments and reassessments will be completed as necessary and IPoCs will be created or updated. For Enrollees whose risk level is updated to Level 3 (high-risk) or Level 2 (moderate-risk), Contractor shall complete a health-risk assessment and IPoC within ninety (90) days of the risk level update in accordance with 42 CFR 438.208. Contractor shall review IPoCs of Level 3 (high-risk) Enrollees at least every thirty (30) days, and of Level 2 (moderate risk) Enrollees at least every ninety (90) days and conduct reassessments as necessary based upon such reviews. In addition, Contractor shall conduct an in-person health-risk reassessment for Enrollees receiving HCBS Waiver services or residing in NFs each time there is a significant change in the Enrollee's condition or an Enrollee requests reassessment. Contractor will provide updated IPoCs to Providers that are involved in providing Covered Services to Enrollee within no more than ten (10) Business Days.

Q. Contractor shall comply with the following caseload requirements:

a. Caseload Ratios Relative to Risk. Care Coordinators responsible for the Care Management of Enrollees with varying risk levels shall have their overall caseload weighted and a blended overall caseload limit set. The maximum weighted caseload for a Care

Coordinator is six hundred (600) with Level 1 (low-risk) weighted as one (1), Level 2 (moderate-risk) weighted as four (4), and Level 3 (high-risk) weighted as eight (8). The Department may review existing caseloads at any time and may require a change in methodology or an Enrollee's assignment to a caseload.

b. Caseload standards. Caseloads of Care Coordinators shall not exceed the standards outlined as follows:

c. Maximum caseloads for Care Coordinators for the stratified categories identified below. For Enrollees in the Persons with Brain Injury waiver or the Persons with HIV/AIDS waiver, the caseloads shall not exceed 1:30.

Care Coordinator Ratios	
Risk category	**Caseload maximum** **(cases per Care Coordinator)**
Level 1: Low	600:1
Level 2: Moderate	150:1
Level 3: High	75:1

R. Contractor shall comply with the following contact standards: Care Coordinators who provide Care Management shall maintain contact with Enrollees as frequently as appropriate. Care Coordinators who provide Care Management to Level 2 (moderate risk) or Level 3 (high-risk) Enrollees shall have contact with such Enrollees at least once every ninety (90) days. The Care Coordinator or a member of the Enrollee's ICT shall have an in-person contact at least once every six (6) months with each Level 3 (high-risk) Enrollee who is not receiving HCBS Waiver services. Care Coordinators providing Care Management to Enrollees receiving HCBS Waiver services shall maintain contact as follows:

a. Persons who are Elderly. The Care Coordinator shall have in-person contact with the Enrollee not less often than once every ninety (90) days to monitor service provision and address potential gaps in service delivery.

b. Persons with Brain Injury. The Care Coordinator shall have contact with the Enrollee not less often than one (1) time per month to monitor service provision and address potential gaps in service delivery.

c. Persons with HIV/AIDS. The Care Coordinator shall contact the Enrollee not less than one (1) time per month, and not less than one (1) in-person contact every two (2) months to monitor service provision and address potential gaps in service delivery.

d. Persons with Disabilities. The Care Coordinator shall have in-person contact with the Enrollee no less than once every ninety (90) days in the Enrollee's home to monitor service provision and address potential gaps in service delivery.

e. Persons living in a Supportive Living Facility. The Care Coordinator shall contact the Enrollee no less often than one (1) time per year to monitor service provision and address potential gaps in service delivery.

S. Contractor shall ensure appropriate Transition of Care for Enrollees.

a. Transition of Care process. Contractor will manage Transition of Care for Enrollees moving from an institutional setting to other institutional settings or a community setting. Contractor shall arrange care according to the Enrollee's stated preferences and in the least restrictive environment appropriate to their needs. Contractor's process for facilitating Transition of Care will include:

i. Identification of Enrollees needing transition of care.

ii. Communication with entities involved in Enrollees' transition.

iii. Making accommodations so that all community supports, including housing, are in place prior to the Enrollee's move and that Providers are fully

knowledgeable and prepared to support the Enrollee, including interface and coordination with and among social supports, clinical services and LTSS.

iv. Environmental adaptations and equipment and technology the Enrollee needs for a successful care setting transition.

v. Stabilization and provision of uninterrupted access to Covered Services for the Enrollee.

vi. Assessment of Enrollees' ongoing care needs.

vii. Monitoring of continuity and quality of care, and services provided.

viii. Addressing community resources to meet HRSN of Enrollees and provisions for sharing discharge planning materials with any behavioral health providers, ICT team, primary care, specialists actively involved in member's care, and other care/community entities as indicated.

ix. Communication before transition. Contractor shall ensure that before a transition occurs, meetings are held or other communication is made, as appropriate, with the Enrollee, caregiver(s)/family support, provider(s) to address at a minimum the following core elements to ensure successful transition:

x. Diagnosis & health status of Enrollee, treatment plan, and addressing of member care needs, including but not limited to, DME, nutrition or physical therapy needs, and medications review (how to get them, what they are for, side effects, dosage) and medication reconciliation.

xi. Caregiver supports, or need for home and community-based services (HCBS) or long-term-care services to support Enrollee health and recovery;

xii. Accessible transportation, (a) to follow-up appointments, and (b) to meet any needs for community living to ensure care plan can be followed successfully (transportation to get medications or groceries);

xiii. Detail on follow-up appointment(s)/visit with providers that is set before the change occurs;

xiv. Linkage to Care Coordination for any avoidable hospital admission or readmission and provision of name and contact numbers for care coordinator(s) assigned to the Enrollee.

xv. Information on red flags/warning signs for health deterioration and given specific contacts in case of questions or what action to take regarding decline as part of transition care.

xvi. Securing staff to ensure adequate care during relocation processes

b. Transition of Care plan. Contractor shall initially, and as revised, submit to the Department, for the Department's review and Prior Approval, the Transition-of-Care policies, procedures, and staffing model designed to achieve a seamless, efficient transition with minimal impact to an Enrollee's care.

c. Transition of Care team. Contractor shall have an interdisciplinary Transition-of-Care team to design and implement the Transition-of-Care plan, as part of the IPoC, and provide oversight and management of all Transition-of-Care processes. The team will consist of skilled personnel such as care coordinators who have met the qualifications in *Section 1.2.35 Training*.

d. Transition of Care for new Enrollees. Contractor will identify new Enrollees who require transition services by using a variety of sources, including:

i. prior claim history as provided by the Department;

ii. IPoC provided by the previous Contractor;

iii. health-risk screenings completed by new Enrollees;

iv. Providers requesting information and service authorizations for Enrollees (existing prior authorizations for new Enrollees shall be honored by Contractor);

v. communications from Enrollees; and

vi. communication with existing agencies or service Providers that are supporting Enrollees at the time of transition.

e. Money follows the Person (MFP). Contractor shall assume the lead role in supporting individuals transitioning from institutional settings to the community. Contractor will work in collaboration with the existing community agencies that provide MFP transition coordination services. Contractor shall comply with all Department-issued written policy and directives.

f. Community Transitions Initiative/Programs (CTI). Contractor shall coordinate with any CTI programs and implement initiatives specific to achieving transitions from institutional settings to the community for Enrollees who have continuously resided in a Nursing Facility or a Specialized Mental Health Rehabilitation Facility for a minimum of sixty (60) days or a shorter period of time as specified by the Department. Contractor shall prioritize community transitions for class members of the Williams v. Quinn and Colbert v. Quinn consent decrees(Williams Consent Decree - IDHS: Williams Consent Decree Implementation Plan (state.il.us) and Colbert Consent Decree - https://hfs.illinois.gov/medicalprograms/mfp/colbert.html

i. Contractor's efforts must comply with Department issued written policy and directives, including but not limited to the nature, frequency, timing, and substance of the following CTI activities: outreach, assessment, transition planning, assistance with location of appropriate housing for transition, subsidies to enable transition, transition support, and follow-up.

ii. Contractor shall report on CTI activities according to specifications issued by the Department and may be required to use a shared platform to satisfy consent decree requirements in accordance with Department written policy.

iii. Contractor shall serve as the fiscal agent for the State-funded transition assistance funds made available by the

Department to Colbert and Williams class members, consistent with Department-issued policy, https://hfs.illinois.gov/content/dam/soi/en/web/hfs/sitecollectiondocuments/mco055communitytransitionsinitiative.pdf

iv. Contractor must develop a post transition follow-up and monitoring plan for each Enrollee transitioning to the community to ensure Enrollee receives necessary services and supports to maximize successful community transition.

T. Contractor shall provide Continuity of Care.

a. Policies and Procedures. Contractor must develop policies and procedures to ensure Continuity of Care for all Enrollees upon initial enrollment, as follows:

i. Contractor must offer an initial ninety (90)–day transition period for Enrollees new to the D-SNP, in which Enrollees may maintain a current course of treatment with a Provider who is currently not a part of Contractor's Provider Network.

ii. Contractor must offer a ninety (90)–day transition period for Enrollees switching from another Health Plan to Contractor. The ninety (90)–day transition period is applicable to all Providers, including Behavioral Health Providers and Providers of LTSS.

iii. Contractor shall pay for Covered Services rendered by a non-Network Provider during the ninety (90)–day transition period at the same rate the Department would pay for such services under the Illinois Medicaid FFS methodology. Non-Network Providers and specialists providing an ongoing course of treatment will be offered agreements to continue to care for an individual Enrollee on a case-by-case basis beyond the transition period if the Provider remains outside the Network or until a qualified Network Provider is available.

b. Contractor may choose to transfer Enrollees to a Network Provider during the Continuity of Care period only if:

   i. the Enrollee is assigned to a PCP that is capable of serving the Enrollee's needs appropriately;

   ii. an HRA, if necessary, is complete;

   iii. Contractor consulted with the new PCP and determined that it can appropriately meet the Enrollee's needs;

   iv. a Transition-of-Care plan is in place (to be updated and agreed to with the new PCP, as necessary); and

   v. the Enrollee agrees to the transfer prior to the expiration of the Continuity Care period.

c. Managed Care Reform and Patient Rights Act. Contractor shall provide for the continuity of services in accordance with 215 ILCS 134/25, Managed Care Reform and Patient Rights Act.

d. Effective Enrollment Date for hospital admissions. If an Enrollee is receiving medical care or treatment as an inpatient in an acute-care hospital on the Effective Enrollment Date, Contractor shall assume responsibility for the management of such care and shall be liable for all claims for Covered Services from that date. For hospital stays that would otherwise be reimbursed under the HFS Medical Program on a per-diem basis, Contractor's liability shall begin on the Effective Enrollment Date. Notwithstanding the foregoing, for hospital stays that would otherwise be reimbursed under the HFS Medical Program on a DRG basis, Contractor will have no liability for the hospital stay.

e. Continuity of Care for hospital stays. 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, 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. Contractor must maintain

documentation of such transfer of responsibility of medical care or treatment. For hospital stays that would otherwise be reimbursed under the Department's medical program on a per-diem basis, Contractor shall be liable for payment for any medical care or treatment provided to an Enrollee until the effective disenrollment date. For hospital stays that would otherwise be reimbursed under the Department's medical program on a DRG basis, Contractor shall be liable for payment for any inpatient medical care or treatment provided to an Enrollee where the discharge date is after the effective disenrollment date.

f. Continuity of Care for Nursing Facility (NF) residents

i. When a resident in a NF first transition to Contractor from the fee-for-service Medicaid system or from another Contractor, Contractor shall honor the existing IPoC and any necessary changes to that IPoC until it has completed a comprehensive assessment and new IPoC, to the extent such services are covered benefits under the Contract, which shall be consistent with the requirements of the Resident Assessment Instrument (RAI) Manual.

ii. When an Enrollee is moving from a community setting to a NF, and Contractor is properly notified of the proposed admission by a network NF, and Contractor fails to participate in developing an IPoC within the time frames required by NF regulations and this Contract, Contractor must honor an IPoC developed by the NF until Contractor has completed a comprehensive assessment and a new IPoC to the extent such services are covered benefits under the contract, consistent with the requirements of the RAI Manual.

U. Contractor shall provide coordination of care assistance to Prospective Enrollees to access a PCP or Women's Health Care Provider (WHCP) or to continue a course of treatment before Contractor's coverage becomes effective, if requested to do so by Prospective Enrollees, or if Contractor has knowledge of the need for such assistance. The Care Coordinator assigned to the Prospective Enrollee shall attempt to contact the

Prospective Enrollee no later than two (2) Business Days after the Care Coordinator is notified of the request for coordination of care.

V. 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 provide for consistent application of review criteria for authorization decisions by a healthcare professional or professionals with expertise in addressing the Enrollee's medical, Behavioral Health, LTSS, or other waiver needs. Contractor shall consult with the Provider requesting such authorization when appropriate and provided that LTSS authorizations are based on the Enrollee's current needs assessment and Person-centered service plan. If 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 is less than that requested, Contractor shall notify the Provider orally or in writing and shall furnish the Enrollee with written notice of such decision. Such notice shall meet the requirements set forth in 42 CFR 438.404.

W. Contractor shall authorize or deny Covered Services that require prior authorization, including pharmacy services, as expeditiously as the Enrollee's health condition requires. Requests for authorizations shall be reviewed and decided on within five (5) days after receiving the request for authorization from a Provider, with a possible extension of up to five (5) additional days, if the Enrollee requests the extension or Contractor informs the Provider that there is a need for additional written justification demonstrating that the Covered Service is Medically Necessary and the Enrollee will not be harmed by the extension. If the Provider indicates, or Contractor determines, that following the review and decision time frame could seriously jeopardize the Enrollee's life or health, Contractor shall authorize or deny the Covered Service no later than forty-eight (48) hours after receipt of the request for authorization, unless Contractor has not received clinical information sufficient upon which to make the determination. Contractor shall authorize or deny a prior authorization request for pharmacy services no later than twenty-four (24) hours after receipt of the request for authorization.

a. Contractor shall authorize services supporting individuals with ongoing or chronic conditions, or who require LTSS, in a manner that reflects the Enrollee's ongoing need for such services.

b. For all covered outpatient drug authorization decisions, Contractor shall provide notice as described in Section 1927(d)(5)(A) of the SSA.

c. For authorizations for Enrollees residing in a NF, if a response to the authorization is not provided within twenty-four (24) hours of the request and the NF is required by regulation to provide a service because a Physician ordered it, Contractor must pay for the service if it is a Covered Service, provided that the request is consistent with the policies and procedures of Contractor.

X. Upon the Effective Enrollment Date, Contractor shall assume full responsibility for any Covered Services necessary to treat medical conditions that may have existed prior to an Enrollee's enrollment with Contractor. Contractor shall support the continuation of any existing treatment plan provided that the Enrollee's treatment plan is current, a Covered Service, and Medically Necessary. Contractor shall evaluate the appropriateness of integrated Care Management and education for each Enrollee who it determines to have a preexisting condition.

Y. Contractor shall provide Hospitalist services, either through direct employment as a Network Provider, or through a sub-contractual relationship.

Z. Contractor shall have the ability to accept and pass to the Department Z-Codes on standard billing transactions and use the information in Care Coordination and Risk Stratification.

AA. Contractor shall develop and implement a Social and Structural Determinants of Health (SSDOH) Work Plan. The purpose of the SSDOH work plan is to identify, evaluate, and reduce, to the extent practicable, health disparities based on factors such as age, race, ethnicity, gender, primary language, and disability status. Contractor shall submit the SSDOH work plan to the Department for Prior Approval and then in accordance with *Attachment 2 Required Deliverables, Submissions, and Reporting*. At a minimum, the SSDOH must include:

a. a strategy that adopts a whole person care approach through the provision of SSDOH resources at the Enrollee and community levels;

b. incorporate Contractor's Cultural Competence plan to effectively provide services to all Enrollees, with targeted efforts to address and mitigate disparities and cultural gaps;

c. utilize analytic methods to identify, monitor, and address unmet social needs, such as:

i. enhanced use of SSDOH data as inputs in predictive and actuarial models, hot-spotting, and other advanced analytic methods;

ii. increase awareness of and access to community-based SSDOH supports and resources;

iii. delivery of care and resources provided to Enrollees based on their SSDOH needs;

iv. develop targeted strategies to address the SSDOH needs of special populations disproportionately impacted by SSDOH and at high risk for adverse health outcomes; and

v. promote statewide collaboration with other MCOs, the Department, other State agencies, and community partners in implementing SSDOH strategies.

d. report performance measure data against a set of Department-specified stratification criteria that may include, but is not limited to: race, ethnicity, geography, eligibility category, age, and gender, where appropriate and feasible.

e. provide comparative data analysis of performance measures by geographic region, as defined by the Department, to identify disproportionately impacted areas, race, ethnicity, gender, and age.

1.2.15 *Behavioral Health*

A. Behavioral Health Provider Network Requirements

a. Contractor shall collaborate with the Department in the selection and implementation of Care Coordination and Support Organizations (CCSOs), including participating in credentialing, readiness review, and other related processes designed to

ensure the capacity and capability of CCSOs to provide to Enrollees

b. In collaboration with the Department or its designee, Contractor shall provide ongoing training, support, and technical assistance to CCSOs, community mental health centers (CMHCs), Behavioral Health Clinics (BHCs), hospitals, PCPs, and other Behavioral Health Providers.

c. Contractor shall recruit behavioral health providers into Contractor's Provider Network and shall monitor its Provider Network to ensure adequate access to Medically Necessary services for Enrollees consistent with *Section 1.2.19.G Enrollee Access to Services,* of this contract. Contractor shall negotiate in good faith and enter into a Network Agreement with any willing Providers enrolled with the Department to deliver behavioral health services.

d. Contractor shall negotiate in good faith and enter into a Network Agreement with all Providers enrolled for participation as a CCSO in the Medical Assistance Program and must ensure that all Enrollees have access to the mobile crisis response provided by CCSO in their home designated service area or other geographic area determined by the Department.

B. Contractor shall require that its CCSO Network Providers:

a. Deliver MCR services consistent with all service requirements established by the Department, including but not limited to those outlined in the applicable Department Handbook(s) which can be found at Chapter 200 | HFS (illinois.gov); and,

b. Provide Contractor with a minimum of ninety (90) days advance written notice in the event the Provider is no longer willing or capable of continuing to serve as a CCSO within parts or all the Provider's designated service area (DSA).

C. Behavioral Health Mobile Crisis Response System

a. Contractor shall establish a Mobile Crisis Response (MCR) system capable of responding immediately to Enrollees experiencing a Behavioral Health Crisis and providing short-term crisis

intervention and stabilization services to Enrollees post-crisis, consistent with the requirements of this section.

b. Contractor shall provide Enrollees and their families with information on how and when to engage Contractor's Mobile Crisis Response (MCR) system, including how to access the state's Behavioral Health Crisis line and MCR providers. This information shall be included in Contractor's Member Handbook and easily accessible on Contractor's website.

D. Behavioral Health Crisis Line

a. Contractor shall ensure that Enrollees, family members of Enrollees, or other concerned parties are provided with information regarding the state's Behavioral Health Crisis line, known as Crisis and Referral Entry Services (CARES) and education regarding utilizing CARES for any Enrollee requiring access to Behavioral Health Crisis services.

b. Contractor shall not establish a separate Behavioral Crisis Line but shall refer Enrollees and other concerned parties to CARES.

E. Behavioral Health Mobile Crisis Response Services

a. Contractor shall ensure that MCR services are available twenty-four (24) hours per day, every day of the year, to Enrollees experiencing a Behavioral Health Crisis, regardless of where in the State, or any of the counties contiguous to the State, the Enrollee presents. This includes establishing a sufficient network of designated MCR providers responsible for receiving and appropriately serving all MCR referrals from CARES on a no-decline basis.

b. Contractor shall ensure the availability of MCR services, by requiring all responding MCR Providers to complete an in-person Behavioral Health crisis screening of all Enrollees experiencing a Behavioral Health Crisis consistent with the following timelines:

i. Within ninety (90) minutes of notification of an emergency referral. An emergency referral involves an Enrollee who presents in Behavioral Health Crisis and who requires an immediate screening and assessment to

determine if they can be safely stabilized in the community.

ii. Within twenty-four (24) hours of notification of a non-emergency referral. A non-emergency referral is when the Enrollee is not at immediate risk of harm, but still requires an MCR screening (i.e., court-ordered screening, Enrollees admitted to a psychiatric hospital prior to an MCR screening).

c. Contractor shall require that its Network Providers of MCR services:

i. Deliver MCR services consistent with all service requirements established by the Department including, but not limited to, those outlined in the Department's Handbook for Providers of Community-Based Behavioral Services, which can be found at, Chapter 200 | HFS (illinois.gov) such as the usage of the state's approved crisis assessment tool, the Illinois Medicaid Crisis Assessment Tool, (IM-CAT) as the standardized MCR screening tool;

ii. Provide immediate and sufficient Crisis and Stabilization services to stabilize an Enrollee in the community when clinically appropriate for the Enrollee; and,

iii. Provide Enrollees and their family with contact information that may be used at any time, twenty-four (24) hours a day, to contact the Provider in moments of a Behavioral Health Crisis in lieu of utilizing the CARES line.

d. If an Enrollee is screened, due to necessity, by a Non-Network Provider of MCR services, Contractor shall pay for the MCR service at the Medicaid rate.

e. Contractor shall establish policies and procedures that outline a process for individuals to escalate access to MCR issues in instances where the Network Provider of MCR has not met the standards included in this section. The policy and process must include specific actions that Contractor will take to remedy each

identified access to MCR issue within 24 hours and include specific actions that Contractor will take to bring the Network Provider of MCR into compliance with the Standards included in this section. Contractor will report all escalated access to MCR instances and their remediation to HFS monthly.

F. Inpatient Institutional Treatment

a. Contractor shall require its Network Providers of MCR services to facilitate the Enrollee's admission to an appropriate inpatient treatment setting, including arranging for the necessary transportation, when the Enrollee in a Behavioral Health Crisis cannot be stabilized in the community.

b. Contractor shall require its Network Providers of MCR services to inform the Enrollee and their parents, guardians, or caregivers, as applicable, about all available inpatient Network Providers and any pertinent policies needed to allow the involved parties to select an appropriate inpatient institutional treatment setting.

c. Contractor shall establish policies that outline a process for Network Providers of MCR services and hospitals to escalate access to care issues to Contractor in instances when an Enrollee is experiencing a Behavioral Health Crisis. The policy and process must also include specific actions that Contractor will take to remedy each identified access to care issue within 48 hours. Contractor will report all escalated access to care instances and their remediation to HFS on a monthly basis. The policies shall minimally include a requirement and process for Network Providers of MCR services and hospitals to notify Contractor in the instance:

i. An Enrollee requiring psychiatric inpatient hospitalization remains in an Emergency Department for a period of 24 hours or greater due to the inability to locate a hospital willing or able to admit the Enrollee; and

ii. An Enrollee receiving psychiatric inpatient services is identified as at significant risk of remaining at the inpatient facility after the Enrollee has been medically cleared for discharge.

d. Contractor or, when applicable, its Care Coordination and Support Organization (CCSO) working with the Enrollee, shall convene an emergency ICT for any Enrollee identified with access to care issues that minimally includes the MCR Provider, the Enrollee's guardian, if appropriate, any community providers offering community-based services to the Enrollee, and representatives from any State Agencies offering services to the Enrollee within forty-eight (48) hours of notification of the Enrollee's status. Contractor will continue to convene the ICT for the Enrollee until appropriate treatment services are identified and the Enrollee is transitioned to those services.

e. Contractor shall require its inpatient psychiatric Network Providers to administer a physical examination, including screenings for auto-immune and other infectious, parasitic, or inflammatory disease processes, to the Enrollee within twenty-four (24) hours after admission when an Enrollee requires admission to an appropriate inpatient institutional treatment setting. Contractor will ensure that Enrollees with positive screening results receive appropriate treatment.

f. Contractor shall provide and have documented procedure requirements for Network Providers regarding discharge and transition planning, consistent with the following:

i. Discharge and Transition planning shall begin upon admission;

ii. The Network Provider of MCR services shall:

(A) Participate in and take lead in coordinating staffing, discharge, and transition processes with assistance from the Enrollee's Care Manager, including coordinating all necessary follow-up appointments and referrals for the Enrollee upon transition back into the community. Appointments shall be established prior to discharge to ensure continuity across care providers;

(B) Notify the Enrollee's family and caregiver of key dates and events related to the admission,

staffing, discharge, and transition of the Enrollee, and shall make every effort to involve the Enrollee and the Enrollee's family and caregiver in decisions related to these processes; and,

(C) Speak directly with the Enrollee at least once each week while the Enrollee is receiving inpatient services. The Enrollee's Care Manager and community-based Providers responsible for providing services upon the Enrollee's discharge shall participate in all inpatient staffing by phone, videoconference, or in person.

g. Contractor shall coordinate communication of admission, pharmaceutical, and discharge data, consistent with the consents and releases secured, to the necessary Network Providers to promote Continuity of Care.

h. Contractor shall include a provision in its contracts or other agreements with its hospitals and Network Providers to notify Contractor or the MCR provider, as appropriate, at least twenty-four (24) hours in advance of any discharge from inpatient hospital stays.

G. Crisis Safety Plans. Contractor shall require its Network Providers of MCR services to:

a. Create, or review and update, a Crisis Safety Plan for all Enrollees that present in Behavioral Health Crisis, in collaboration with the Enrollee and their family, consistent with the following timelines:

i. Prior to the completion of Behavioral Health crisis intervention and stabilization services necessary to stabilize an Enrollee in the community following an MCR screening;

ii. Prior to the Enrollee's discharge from an inpatient psychiatric hospital setting for any Enrollee admitted to such a facility. When applicable, the MCR provider shall coordinate the completion of the Crisis Safety Plan with the Enrollee's CCSO.

b. Provide Enrollees and their families with physical copies of the Crisis Safety Plan consistent with the timelines above in *Section 1.2.15.G.a. Behavioral Health.*

c. Educate and orient the Enrollee and their family to the components of the Crisis Safety Plan, ensure that the plan is reviewed with the family regularly, and explain to the Enrollee and their family how the plan is updated as necessary.

d. Share the Crisis Safety Plan with all necessary medical professionals, including Care Coordinators and the Enrollee's CCSO, consistent with the authorizations established by consent or release.

H. Follow-Up After a Behavioral Health Crisis Event

a. Contractor shall establish policies promoting access to and delivery of Behavioral Health crisis stabilization, follow-up services, including the completion of IM+CANS, that shall minimally include:

i. Referral and immediate linkage of Enrollees who have remained in the community following a Behavioral Health Crisis event with an urgent appointment with a mental health provider within one (1) Business Day after the Behavioral Health Crisis event, if deemed Medically Necessary. Contractor will connect the Enrollee with their existing mental health provider, if applicable, or with a mental health provider certified to complete the IM+CANS, if they do not have an existing mental health provider.

ii. A period post-Crisis, no less than thirty (30) days, during which Contractor shall not require prior authorization of outpatient mental health services.

iii. Requirements for Network Providers to educate Enrollees who may be eligible for the State-funded Family Support Program (FSP) pursuant to 89 Ill. Adm. Code 139 about FSP to help these Enrollees access community-based services.

iv. Contractor shall convene an ICT meeting for Enrollees within three (3) days after a Behavioral Health Crisis event if the Enrollee is community stabilized and within four (4) days after discharge, if the Enrollee is hospitalized.

b. Contractor shall ensure that the Enrollee has a scheduled appointment with a Behavioral Health Provider for follow-up within three (3) days after the Enrollee's discharge from hospitalization. Contractor will connect the Enrollee with their existing mental health provider, if applicable, or with a mental health provider certified to complete the IM+CANS, if they do not have an existing mental health provider.

c. Psychiatric Resource and Pharmacological Services

i. For all Enrollees referred for MCR services, Contractor shall establish procedures and facilitate priority access to a psychiatric resource to provide consultation and medication management services, as Medically Necessary, within the following timeframes:

(A) Fourteen (14) days after an Enrollee's discharge from an inpatient psychiatric hospital setting; or,

(B) Within three (3) days after the Behavioral Health Crisis event for an Enrollee who is community stabilized.

ii. Contractor shall have procedures for communicating to the Enrollee's PCP the pharmacological services performed as part of MCR service, consistent with all consents and releases.

iii. Contractor shall attempt to supplement the psychiatric resources available through its network with telepsychiatry services. Telepsychiatry services may include identifying available psychiatric resources and enhancing access outside the Coverage Area by connecting such resources to the Coverage area or utilizing resources within the Coverage Area more efficiently by making such resources available to more

rural Enrollees via electronic means. All telehealth services must be delivered consistent with any rules or requirements on telehealth established by HFS including but not limited to 89 Ill. Adm. Code 140.403.

d. Contractor shall make available the details of its MCR service model to the Department as required in Quality Assurance. As a component of the QA/UR/PR Annual Report. Contractor shall provide a report relating to the previous State Fiscal Year on its MCR service model to the Department, that includes but is not limited to a detailed report of utilization, outcomes, and hospitalization rates.

I. Discharge Planning and Transitional Supports. For Enrollees not receiving CCSO services, Contractor shall:

a. Provide Enrollees with access to discharge planning and transitional services when being discharged from a psychiatric institutional level of care (e.g., hospital, PRTF, residential, Behavioral Health Crisis respite), to lower levels or community-based services. Contractor shall work with the involved parties to facilitate appropriate follow-up services, including the scheduling of follow-up treatment appointments.

b. Require the Care Coordinator to retain accountability and responsibility for the Enrollee as the transition between levels of care occurs.

c. Provide oversight regarding admissions and discharge dates for Enrollees. This oversight shall include facilitating the link between the institutional-based care Providers and Contractor's Care Coordinators. Contractor shall initiate follow-up care within seven (7) days after discharge from institutional levels of care and provide oversight that appropriate levels of services are being provided.

d. Develop, implement, and follow a procedure to confirm that a medication management review has been completed prior to discharge from institutional levels of care; to confirm that PCPs are made aware of any medications that have been prescribed for Enrollees during treatment at an institutional setting; and to

confirm with the Enrollees that they have the ability to get prescribed medications.

e. Communicate directly with the Enrollee or Enrollee's family within forty-eight (48) hours after transition.

f. Assist the Enrollee in attending all post-discharge appointments for follow-up care. Contractor shall provide appropriate Care Management based on concurrent assessment for an appropriate period of time following discharge, involving other parties (e.g. CCSO, MCR provider, Department of Children and Family Services (DCFS) caseworker) in the Care Management as necessary.

1.2.16 *Health Promotion and Wellness Activities*

A. Enrollee Health Education. Contractor will offer an expansive set of health education programs, including such programs through Care Coordinators that use comprehensive outreach and communication methods to effectively educate Enrollees, and their families and other caregivers, about health and self-care and how to access plan benefits and supports.

B. Collaborative Education Development and Oversight. Contractor's Medical Management Department and Medical Director shall be responsible for development, maintenance, and oversight of Enrollee health education programs.

C. Health Education Outreach. Contractor will identify regional community health education opportunities, improve outreach and communication with Enrollees and community-based organization members, and actively promote healthy lifestyles such as disease prevention and health promotion.

D. Flu/RSV/COVID Prevention Program. Contractor shall make a flu prevention program available for all Enrollees and will provide targeted outreach to high-risk Enrollees. The program will educate Enrollees about preventing the transmission of the influenza, RSV and Covid viruses.

E. Education through Care Coordinators. Contractor's Care Coordinators will attempt to contact all Enrollees who frequently use or recently visited an emergency room to determine whether the Enrollees are experiencing

barriers to primary and preventative care, to help resolve those barriers, if any, and to educate Enrollees on the appropriate use of emergency room services and the Enrollees' medical homes.

F. Enrollee IPoC Reassessment. Contractor will analyze predictive modeling reports and other surveillance data of all Enrollees monthly to identify risk level changes. As risk levels change, assessments and reassessments will be completed as necessary and IPoCs and interventions created or updated. For Enrollees whose risk level is updated to high-risk or moderate-risk, Contractor shall make best effort to complete a health risk assessment and IPoC within ninety (90) days of the risk level update. Contractor will review Enrollee IPoCs and intervention of Enrollees at high-risk at least every thirty (30) days, and Enrollees at moderate-risk at least every ninety (90) days, and conduct reassessments as necessary based upon such reviews. At a minimum, Contractor shall conduct a reassessment annually for each Enrollee who has an IPoC. In addition, Contractor will conduct an in-person reassessment for Enrollees receiving HCBS Waiver services or residing in NFs each time there is a significant change in the Enrollee's condition or an Enrollee requests reassessment.

G. Enrollee Engagement and Education. Contractor shall use a multifaceted approach to locate, engage, and educate Enrollees and shall capitalize on every Enrollee contact to obtain and update Enrollee information. Contractor shall solicit input from Enrollees and other stakeholders to help develop strategies to increase motivation for enhanced independent and healthy living.

H. Self-directed Care. Contractor will support the Enrollee in actively participating in the development of the Enrollee IPoC. Contractor will also encourage Providers to support Enrollees in directing their own care and Enrollee IPoC development. This will include giving PCPs a copy of the Enrollee IPoC.

I. Williams Service Plans. Contractor shall implement any behavioral service plan developed by DHS contractors for an Enrollee who is a class member under the Williams consent decree unless the Enrollee and the Enrollee's Williams Provider consent to a modification of such plan. Contractor is responsible for payment of services under such plan only to the extent the services are Covered Services. The Department, or its designee, will provide Contractor with a timely copy of any such plan. To the extent that Covered Services in such plan would not have been paid by Contractor

due to Contractor's utilization controls, Contractor is not obligated to pay until Contractor has received a copy of the plan.

J. Colbert Service Plans. Contractor shall implement any service plan developed by the Department's contractors for an Enrollee who is a class member under the Colbert consent decree unless the Enrollee and the Enrollee's Colbert Contractor consent to a modification of such plan. Contractor is responsible for payment of services under such plan only to the extent the services are Covered Services. The Department, or its designee, will provide Contractor with a timely copy of any such plan. To the extent that Covered Services in such plan would not have been paid by Contractor due to Contractor's utilization controls, Contractor is not obligated to pay until Contractor has received a copy of the plan.

1.2.17 *Provider Network*

A. Contractor must demonstrate to the Department annually that it has an adequate Provider network, for Medicaid covered services and approved by the Department, to ensure adequate access to medical, behavioral health, pharmacy, community-based services, LTC, and LTSS Providers that are appropriate for and proficient in addressing the needs of the enrolled population, including physical, communication, and geographic access. Contractor must maintain a Provider Network sufficient to provide all Enrollees with access to the full range of Medicaid Covered Services, including behavioral health services, other specialty services, and all other services required in 42 CFR 438.206 and under this Contract (see Covered Services in *Attachment 3 HCBS Service Package II Covered Services*). Contractor must notify the Department of any significant Provider Network changes immediately, but no later than three (3) days after becoming aware or should become aware of an issue, including a change in Contractor's network of Network Providers that renders Contractor unable to provide one (1) or more Covered Services within the access to care standards set forth in *Section 1.2.18.G Network Management*, with the goal of providing notice to the Department at least sixty (60) days prior to the effective date of any such change.

B. Contractor must comply with Section 1.2.18 H and the requirements specified in 42 CFR 422.504, 423.505, 438.214, which include selection and retention of Providers, credentialing and re-credentialing requirements, and nondiscrimination against providers that serve high-risk populations or specialize in conditions that require costly treatment.

C. Contractor may not employ or contract with Providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the SSA, and implementing regulations at 42 CFR Part 1001 et seq. Federal financial participation (FFP) is not available for any amounts paid to Contractor if Contractor could be excluded from participation in Medicare or Medicaid under section 1128(b)(8)(B) of the SSA or for any of the reasons listed in 42 CFR 431.55(h).

D. Contractor shall contract with a culturally diverse network of Providers of both genders and prioritize recruitment of bilingual or multi-lingual Providers. Contractor's contracts with Providers shall require that Providers comply with Contractor's Cultural Competence plan (See *Section 1.2.34 Cultural Competence*.) Contractor shall confirm the languages used by Providers, including American Sign Language, and ensure physical access to Providers' office locations.

E. Contractor shall establish, maintain, and monitor a network that is sufficient to provide adequate access to all Medicaid Covered Services, taking into consideration:

a. The anticipated number of Enrollees;

b. The expected utilization of services, in light of the characteristics and health care needs of Contractor's Enrollees;

c. The number and types of Providers required to furnish the Covered Services;

d. The number of Network Providers who are not accepting new patients; and

e. 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.

f. Contractor must make reasonable efforts to contact out-of-network Providers, including Providers and prescribers that are providing services to Enrollees during the initial continuity of care period, and provide them with information on becoming Network Providers.

g. Contractor must contract with entities and programs designated by the Department including but not limited to Section 1115 waiver providers, other non-traditional Medicaid provider types. This may include formal subcontracting as required by the Department. For the Medicaid Preventive Care and Education Organization (MPCEO), Contractor shall comply with all Department-issued written policy and directives regarding entities awarded contracts pursuant to 305 ILCS 5/12-4.56. Coordination may include bi-directional file exchanges with the entity including data elements specified by the Department. Contractor shall coordinate with Healthcare Transformation Collaboratives and the Breast Cancer Quality Improvement Program through written agreements with the Department with respect to data sharing as specified by the Department.

h. Contractor shall ensure that its Network Providers are responsive to the linguistic, cultural, ethnic, racial, religious, age, gender and other unique needs of any minority, homeless person, disabled individuals, or other special population served by Contractor, including the capacity to communicate with Enrollees in languages other than English, when necessary, as well as those who are deaf, hard-of-hearing or blind.

i. Contractor shall educate Providers through a variety of means including, but not limited to, Provider Alerts or similar written issuances, about their legal obligations under State and Federal law to communicate with individuals with limited English proficiency, including the provision of interpreter services, and the resources available to help Providers comply with those obligations. All such written communications shall be subject to review at the Department's discretion.

j. Contractor shall ensure that multilingual Network Providers and, to the extent that such capacity exists within Contractor's Service Area, all Network Providers, understand and comply with their obligations under State or federal law to assist Enrollees with skilled medical interpreters and the resources that are available to assist Network Providers to meet these obligations.

k. Contractor shall ensure that Network Providers and interpreters or translators are available for those who are deaf or hearing-impaired within Contractor's Service Area.

l. Contractor shall not include in its Provider Contracts any provision that directly or indirectly prohibits, through incentives or other means, limits or discourages Network Providers from participating as Network or non-network Providers in any Provider network other than Contractor's Provider Network.

m. Contractor shall not establish selection policies and procedures for Providers that discriminate against Providers that serve high-risk populations or specialize in conditions that require costly treatment.

n. Contractor must demonstrate that it has a contract with the Indian Health Care Provider for Medicaid covered services in applicable counties or provide documentation that the Indian Health Care Provider refused.

o. Contractor shall ensure that its Network Providers have a strong understanding of disability culture and LTSS.

p. At the Enrollee's request, Contractor shall provide for a second opinion from a qualified health care professional within the Provider Network or arrange for the Enrollee to obtain one outside the Provider Network, at no cost to the Enrollee.

q. If Contractor declines to include individuals or groups of Providers in its Provider Network, Contractor must give the affected Providers written notice of the reason for its decision.

r. Contractor shall use best efforts to contact out-of-network Providers, including, within the first one-hundred eighty (180) days or ninety (90) days after the enrollment of an Enrollee in Contractor's plan, such Providers that are providing services to Enrollees during the initial continuity of care period, and provide them with information on becoming Network Providers. If the Provider does not become a Network Provider, or if the Enrollee does not select a new Network Provider by the end of the one hundred eighty (180) day or ninety (90) day period, Contractor shall choose a Network Provider for the Enrollee.

s. Contractor must also offer single-case out-of-network agreements to Providers to treat the Enrollee until a qualified Network Provider is available.

t. Contractor must permit any Indian Enrollee eligible to receive services from an Indian Health Care Provider to choose an Indian Health Care Provider as their PCP, if the Indian Health Care Provider Contractor has a PCP in its network that has capacity to provide such services regardless of whether the Indian Health Care Provider is in or out of network.

u. Contractor must permit an out-of-network Indian Health Care Provider to refer an Indian Enrollee to a network Provider without requiring an Indian Enrollee to obtain a Referral from an in-network Provider.

v. Contractor may not pay for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room or hospital):

i. Furnished under the Contract by any individual or entity during any period when the individual or entity is excluded from participation under Titles V, XVIII, XIX, or XX pursuant to section 1128, 1128A, 1156, or 1842(j)(2);

ii. Furnished at the medical direction or on the prescription of a Physician, during the period when such Physician is excluded from participation under title V, XVIII, XIX, or XX pursuant to section 1128, 1128A, 1156, or 1842(j)(2) and when the person furnishing such item or service knew, or had reason to know, of the exclusion;

iii. Furnished by an individual or entity to whom the Department has failed to suspend payments during any period when there is a pending investigation of a credible allegation of Fraud against the individual or entity, unless the Department determines there is good cause not to suspend such payments; or

iv. Contractor may not pay for an item or service with respect to any amount expended for which funds may

not be used under the Assisted Suicide Funding Restriction Act of 1997.

w. Contractor is required to offer contracts to all NFs and Supportive living Facilities (SLFs) in the Service Area that render such Covered Services so long as such Provider meets all applicable State and federal requirements for participation in the Medicaid Program and meets the qualifications of the applicable HCBS Waiver. For NF services covered under the traditional Medicaid benefit, the contract offered by Contractor to the NFs and SLF must provide for payment that equates to at least the Medicaid payment level in Illinois FFS Medicaid. Nothing in this provision shall preclude Contractor and NFs or SLF from agreeing to alternate payment arrangements.

x. Subsequent to CY 2026, the Department may develop requirements for an acceptable level of network congruency between Contractor's Medicare and Medicaid participating providers to ensure access and availability of supplemental services, such that a minimum percentage of providers in Contractor's participating provider network shall participate in both Medicare and Medicaid managed care. The Department's requirements shall include requiring the Contractor to provide a report to the Department demonstrating network congruency.

F. Provider Qualifications and Performance.

a. Contractor may establish quality standards for NFs and SLFs, and may contract with only those Providers that meet such standards, provided that all of the contracting Providers are informed of any such quality standards no later than ninety (90) days after the start of the D-SNP and that the Department has given Prior Approval of the quality standards. Any such quality standards that are not established within ninety (90) days after the start of the D-SNP must be in effect for twelve (12) months before Contractor may terminate a contract of a Provider based on a failure to meet such quality standards. The Department may grant exceptions to these contracting requirements for reasons other than failure to meet the quality standards. The Department reserves the right to establish quality standards that MCOs must

use including but not limited to facilities with a history of noncompliance or negative outcomes.

b. On a continuing basis, Contractor shall monitor Enrollee Complaints and Appeals, quality-of-care and quality-of-service events, and medical record review. Contractor shall document its process for selecting and retaining Providers.

c. Contractor shall ensure that only those Providers that are approved and authorized by the Department are providing Covered Services under HCBS Waivers, and that those Providers are providing to Enrollees only Covered Services for which they are approved and authorized. The Department will provide Contractor with a weekly electronic Department extract file containing the list of such approved and authorized Providers.

d. Contractor shall require each Medicaid Provider that provides Covered Services under a DHS HCBS Waiver, under the Medicaid clinic option, or under the Medicaid Rehabilitation option, or that provides subacute alcoholism and substance-abuse treatment services pursuant to 89 Ill. Admin. Code 148.340-148.390 and 77 Ill. Admin. Code Part 2090, to enter any data regarding Enrollees that are required under State rules, or a contract between the Medicaid Provider and DHS, into any subsystem maintained by DHS, including DHS's automated reporting and tracking system (DARTS).

e. All Medicaid-enrolled Physicians who are Network Providers shall have and maintain admitting privileges and, as appropriate, delivery privileges at a hospital that is a Network Provider; or in lieu of these admitting and delivery privileges, the Medicaid-enrolled Physician shall have a written Referral agreement with a Physician who is a Network Provider and who has such privileges at a hospital that is a Network Provider. The Provider Contract shall include hospital affiliation. The agreement must provide for the transfer of medical records and coordination of care between Physicians.

G. Prior to the Effective Date, Contractor shall establish and maintain a secure Provider web portal, which shall include population health, quality, utilization, eligibility verification, prior authorization, and claims

information for PCP Enrollee populations. The Department retains the right to define minimum content requirements for the Provider portal.

H. Medicaid Provider Subcontracting Requirements

a. Notwithstanding any relationship(s) that the Contractor may have with any Medicaid Provider, the Contractor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of the Contract. Contractor shall require each Medicaid Provider to meet all terms and requirements of this Contract that are applicable to such Medicaid Provider through a written subcontract with the Contractor. All Medicaid Provider subcontracts must comply with the requirements of 42 CFR 438.230. No subcontract between the Contractor and a Medicaid Provider will operate to relieve Contractor of its legal responsibilities under the Contract.

b. Contractor is responsible for the satisfactory performance and adequate oversight of its Medicaid Providers who are required to meet the same federal and State financial and program reporting requirements as Contractor.

c. Contractor must establish written Medicaid Provider subcontracts between Contractor and Medicaid Providers providing Covered Services not delivered directly by Contractor or its employees.

d. Contractor shall only enter into Medicaid Provider Subcontracts with qualified or licensed Medicaid Providers enrolled in the Department's IMPACT system who continually meet federal and State requirements.

e. Contractor shall ensure that all subcontracts with Medicaid Providers contain the following:

i. that such Medicaid Provider subcontracts are binding;

ii. that Contractor will promptly terminate all subcontracts with Medicaid Providers or impose other sanctions if the performance of the Medicaid Provider is inadequate, as determined by either the Department or Contractor;

iii. that Contractor will promptly terminate subcontracts with Medicaid Providers that are terminated, barred, or suspended, or have voluntarily withdrawn, as a result of a settlement agreement under Section 1902(kk)(8) of the SSA, from participating in any program under federal law including any program under Titles XVIII, XIX, XX, or XXI of the SSA or are otherwise excluded from participation in the Department's Medical Program;

iv. that all Medicaid laboratory service Providers testing sites must comply with the CLIA regulations found at 42 CFR Part493;

v. that Contractor will monitor the performance of all Medicaid Providers and on an ongoing basis, subject each Medicaid Provider 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 Medicaid Provider or to take appropriate corrective action;

vi. that Contractor will require each Medicaid Provider to certify it is a "covered entity" as defined at 45 CFR 160.103;

vii. Enrollee protections that include prohibiting Medicaid Providers from holding an Enrollee liable for payment of any fees that are the obligation of the Contractor;

viii. Language that any services or other activity performed by a Medicaid Provider is in accordance with the Contractor's contractual obligations to the Department, including the unified appeals and grievance procedures under 42 CFR 422.629 through 422.634, 438.210, 438.400 and 438.402. (422.107(e)(9)). ;

ix. Language that specifies the Medicaid Providers agree to safeguard Enrollee Privacy and confidentiality of Enrollee health records; and

x. The Contractor shall ensure that all contracts or arrangements with Medicaid Providers shall state that

the Contractor has the right to terminate the contract with cause upon sixty (60) days' notice, and without cause upon one hundred twenty (120) days' notice, and shall require the Medicaid Provider assist with transitioning Enrollees to new Medicaid Providers, including sharing the Enrollee's medical record and other relevant Enrollee information as directed by the Contractor or Enrollee. In a for cause termination, Contractor must have an internal Grievance procedure that allows the Provider to contest the grounds for the termination prior to the effective date of the termination.

xi. The Contractor shall ensure that all contracts or arrangements with Medicaid Providers shall state that the Contractor shall provide a written statement to a Medicaid Provider of the reason or reasons for termination with cause.

xii. Language that the Contractor is obligated to pay contracted Medicaid Providers under the terms of the contract between the Contractor and the Medicaid Provider. The contract must contain a prompt payment provision, the terms of which are developed and agreed to by both the Contractor and the Medicaid Provider;

xiii. Language that Medicaid Provider services are provided in a culturally competent manner to all Enrollees, including those with limited English proficiency or reading skills, and diverse culturally and ethnic backgrounds;

xiv. Language that Medicaid Providers abide by all federal and State laws and regulations regarding confidentiality, disclosure and release of medical records, medical information, or other health and enrollment information;

xv. Language that Medicaid Providers maintain Enrollee records and information in an accurate and timely manner;

xvi. Language that Medicaid Providers ensure timely access by Enrollees to the records and information that pertain to them;

xvii. Language that clearly state the Medicaid Providers EMTALA obligations and must not create any conflicts with hospital actions required to comply with EMTALA;

xviii. Language prohibiting Medicaid Providers from closing or otherwise limiting their acceptance of Enrollees as patients unless the same limitations apply to all commercially insured enrollees;

xix. Language that prohibits the Contractor from refusing to pay an otherwise eligible Medicaid Provider for the provision of Covered Services solely because such Provider has in good faith:

(A) Communicated with or advocated on behalf of one or more of their prospective, current or former patients regarding the provisions, terms or requirements of the Contractor's health benefit plans as they relate to the needs of such Medicaid Provider's patients; or

(B) Communicated with one or more of their prospective, current or former patients with respect to the method by which such Medicaid Provider is compensated by the Contractor for services provided to the patient;

xx. Language that states the Medicaid Provider is not required to indemnify the Contractor for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against the Contractor based on the Contractor's management decisions, utilization review provisions or other policies, guidelines or actions;

xxi. Language that states the Contractor shall require Providers to comply with the Contractor's requirements

for utilization review, quality management and improvement, credentialing and the delivery of preventive health services.

xxii. Language that states the Contractor shall notify Medicaid Provider in writing of modifications in payments, modifications in Covered Services or modifications in the Contractor's procedures, documents or requirements, including those associated with utilization review, quality management and improvement, credentialing and preventive health services, that have a substantial impact on the rights or responsibilities of the Medicaid Provider, and the effective date of the modifications. The notice shall be provided 30 days before the effective date of such modification unless such other date for notice is mutually agreed upon between the Contractor and the Medicaid Provider or unless such change is mandated by the Department without 30 days prior notice;

xxiii. Language that states all Medicaid Providers must comply with all applicable requirements governing Physician incentive plans, including but not limited to such requirements appearing at 42 CFR Parts 417, 422, 434, 438.3(i)3)-(4), and 438.608(e) Specifically, Contractor shall ensure that contracts or arrangements with Medicaid Providers do not include incentive plans that include a specific payment made directly or indirectly to a Medicaid Provider as an inducement to deny, reduce, delay, or limit specific, Medical Necessary Services furnished to an individual Enrollee.

xxiv. Language that states all Medicaid Providers comply with all Enrollee payment restrictions, including balance billing restrictions, and develop and implement a plan to identify and revoke or provide other specified remedies for any of the Contractor's Medicaid Providers that do not comply with such provisions.

xxv. Language that states that no payment shall be made by the Contractor to a Medicaid Provider for a Provider Preventable Condition;

xxvi. Language that states that as a condition of payment, the Medicaid Provider shall comply with the reporting requirements as set forth in 42 CFR 447.26(d) and as may be specified by the Contractor. The Medicaid Provider shall comply with such reporting requirements to the extent the Medicaid Provider directly furnishes services.

xxvii. Language that requires the Medicaid Providers to work with Enrollees and the Contractor to assist Enrollees in keeping their appointments and prohibits the Medicaid Provider from billing Enrollees for missed appointments or refusing to provide services to Enrollees who have missed appointments.

xxviii. Language that prohibits the Medicaid Provider from refusing to provide services to an Enrollee because the Enrollee has an outstanding debt with the Medicaid Provider from a time prior to the Enrollee becoming an Enrollee.

xxix. Language that states that the Medicaid Provider shall not profit from provision of Covered Services that are not Medically Necessary or medically appropriate.

xxx. Language that states that the Medicaid Provider shall not profit from denial or withholding of Covered Services that are Medically Necessary or medically appropriate.

xxxi. Language that states that nothing in the subcontract shall be construed to prohibit contracts that contain incentive plans that involve general payments such as Capitation payments or shared risk agreements that are made with respect to Medicaid Providers or Medicaid Provider groups or that are made with respect to groups of Enrollees if such agreements, which impose financial risk on such Medicaid Providers or Medicaid Provider groups for the costs of medical care, services and equipment provided or authorized by another Medicaid Provider.

xxxii. Language that prohibits the Contractor from imposing a financial risk on medical Providers for the costs of

medical care, services or equipment provided or authorized by another Medicaid Provider unless such contract includes specific provisions with respect to the following:

(A) Stop-loss protection;

(B) Minimum patient population size for the Medicaid Provider or Medicaid Provider group; and

(C) Identification of the health care services for which the Medicaid Provider or Medicaid Provider group is at risk.

xxxiii. Language that states that nothing in the subcontract shall be construed to restrict or limit the rights of the Contractor to include as Medicaid Providers religious non-medical Providers or to utilize medically based eligibility standards or criteria in deciding Provider status for religious non-medical Providers.

I. Non-Payment and Reporting of Provider Preventable Conditions

a. Contractor agrees to take such action as is necessary for the Department to comply with and implement all Federal and State laws, regulations, policy guidance, and Illinois policies and procedures relating to the identification, reporting, and non-payment of Provider preventable conditions, including 42 U.S.C. 1396b-1 and regulations promulgated thereunder.

b. As a condition of payment, Contractor shall develop and implement policies and procedures for the identification, reporting, and non-payment of Provider Preventable Conditions. Such policies and procedures shall be consistent with federal law and regulation, including but not limited to 42 CFR 434.6(a)(12), 438.3(g), 447.26, and guidance and be consistent with the Department's policies, procedures, and guidance on Provider Preventable Conditions. Contractor's payment policies and procedures shall also be consistent with the following:

i. Contractor shall not pay a Provider for a Provider Preventable Condition.

ii. Contractor shall require, as a condition of payment from Contractor, that all Providers comply with reporting requirements on Provider Preventable Conditions as described at 42 CFR 447.26(d) and as may be specified by Contractor and/or the Department.

iii. Contractor shall not impose any reduction in payment for a Provider-Preventable Condition when the condition defined as a Provider-Preventable Condition for a particular Enrollee existed prior to the Provider's initiation of treatment for that Enrollee.

iv. A Contractor may limit reductions in Provider payments to the extent that the following apply:

(A) The identified Provider-Preventable Condition would otherwise result in an increase in payment.

(B) Contractor can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the Provider-Preventable Condition.

v. Contractor shall ensure that its non-payment for Provider-Preventable Conditions does not prevent Enrollee access to services.

J. Provider Education and Training

a. Provider Education. Prior to any enrollment of Enrollees under this Contract and thereafter, Contractor shall conduct Provider education regarding Contractor's policies and procedures.

b. Contractor must cooperate with Medicaid Technical Assistance Center (MTAC) by providing all necessary information for MTAC to perform its duties and cooperate with MTAC in developing educational materials for Providers.

c. Contractor must inform its Provider Network about the procedures and timeframes for Enrollee Grievances and Enrollee Appeals, per 42 CFR 438.414.

d. Contractor shall conduct orientation sessions for Network Providers and their office staff participating in the D-SNP.

e. Contractor shall educate Network Providers about the medical home model, the importance of using it to integrate all aspects of each Enrollee's care, and how to become a medical home, including educating Network Providers about resources, support, and incentives, both financial and non-financial, available for becoming a medical home and receiving applicable recognition such as NCQA certification.

f. Contractor will provide the cultural competency requirements at orientation, training sessions, and updates as needed. This will also include Americans with Disabilities Act (ADA) compliance, accessibility, and accommodations as required in *Section 1.2.18.F. Network Management.*

g. The Provider Manual shall be a comprehensive online reference tool for the Provider and staff regarding, but not limited to, administrative, prior authorization, and Referral processes, claims and Encounter submission processes, and plan benefits. The Provider Manual shall also address topics such as clinical practice guidelines, availability and access standards, Care Management Programs and Enrollee rights pursuant to *Attachment 6 Enrollee Rights*, including Enrollees' rights not to be balanced billed. Contractor must include in the Provider Manual a provision explaining that the Plan may not limit a Provider's communication with Enrollees.

h. Contractor shall make its Provider and Pharmacy Directory available to Providers via Contractor's web-portal.

i. Contractor shall encourage PCPs to provide health education to Enrollees. Contractor shall ensure that Providers have the preventive care, disease-specific and plan services information necessary to support Enrollee education to promote compliance with treatment directives and to encourage self-directed care.

j. Health, Safety and Welfare Education. As part of its Provider education, Contractor shall include information related to identifying, preventing, and reporting Abuse, Neglect, exploitation, and critical incidents.

k. DHS HCBS Waiver Provider Education. Contractor shall distribute Provider packets, which the Department or its designee will provide, to Enrollees and educate each Enrollee regarding the Enrollee's responsibility to provide the Provider packets to all Individual Providers, including Personal Assistants, and all other individual Providers who provide Covered Services under the Persons with Disabilities HCBS Waiver, Persons with HIV/AIDS HCBS Waiver, or Persons with Brain Injury HCBS Waiver. Contractor shall further educate Enrollees that such Providers may not begin providing Covered Services until the fully and correctly completed packets have been returned to and accepted by the local DHS-DRS office.

l. Illinois Department on Aging (IDoA) HCBS Waiver Homecare Service Provider training. Contractor, upon request of a Homecare Service Provider, shall agree to allow Provider to certify compliance with Contractor's training requirements for Provider's personnel, when comparable training has been completed in accordance with requirements of 89 Ill. Adm. Code 240.1535. Contractor shall require Provider to utilize the Department's Attestation of Training Completion form and certify completion by individual employee.

K. Payments to Providers

a. General Payments

i. Contractor shall make payments to Providers (including the fiscal agent making payments to Individual Providers (Ips) under the HCBS Waivers (see *Attachment 3 HCBS Service Package II Covered Services*)) for Covered Services on a timely basis consistent with the claims payment procedure described at 42 U.S.C. 1396a(a)(37)(A) and 215 ILCS 5/368a.

ii. Complaints or disputes concerning payments for the provision of services as described in this section shall be

subject to Contractor's Provider complaint resolution system pursuant to *Section 1.2.17 K.h Provider Network.*

iii. Contractor must pay ninety percent (90%) of all clean claims from Providers for Covered Services within thirty (30) days following receipt. Contractor must pay ninety-nine percent (99%) of all clean claims from Providers for Covered Services within ninety (90) days following receipt. For purposes of this section, a "clean claim" means a claim from a Provider for Covered Services that can be processed without obtaining additional information from the Provider of 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 determining whether it was Medically Necessary. For purposes of an Enrollee's admission to an NF, a "clean claim" means that the admission is reflected on the patient credit file that Contractor receives from the Department.

iv. Contractor will not be considered to be in Breach of this section, and the Department will not impose a monetary sanction pursuant to *Section 1.2.38 Sanctions* for Contractor's failure to meet the requirements of this section if such purported breach or failure occurs at a time when the Department has not paid any of the required Capitation to Contractor for two (2) consecutive months.

v. Contractor shall make all expedited payments in accordance with the timeframes listed in the Expedited Provider Report, which will be provided monthly by the Department. The reports will be provided to the Contractor once the contract is executed and the program is implemented.

vi. In accordance with 89 IL Admin Code 140.74, Contractor shall make payment to a Provider for a Medically Necessary Covered Service when payment is initially denied due to an Enrollee's inaccurate or updated Medicaid enrollment

information documented by the Provider on the date of service.

b. Emergency Services

i. Contractor shall pay for all appropriate Emergency Services rendered by a non-Network Provider within thirty (30) days after receipt of a clean claim. If Contractor determines it does not have sufficient information to make payment, Contractor shall request all necessary information from the non-Network Provider within thirty (30) days after receiving the claim and shall pay the non-Network Provider within thirty (30) days after 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 and exclusive of disproportionate share payments.

ii. 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-Network 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, Contractor may review the need for, and the intensity of, the services provided by non-Network Providers.

c. Contractor shall pay for all Post-Stabilization Services as a Covered Service in any of the following situations:

i. Network Provider

ii. Contractor authorized such services;

iii. such services were administered to maintain the Enrollee's Stabilized condition within one (1) hour after a request to Contractor for authorization of further Post-Stabilization Services;

iv. Contractor did not respond to a request to authorize such services within one (1) hour; or

v. Contractor could not be contacted;

vi. Non-Network Provider

vii. If the treating Provider is a non-Network Provider, Contractor and the treating Provider could not reach an agreement concerning the Enrollee's care and a Network Provider was unavailable for a consultation, Contractor must pay for such services rendered by the treating non-Network Provider until a Network Provider was reached and either concurred with the treating non-Network Provider's plan of care or assumed responsibility for the Enrollee's care.

viii. Contractor shall pay for Post-Stabilization Services rendered by a non-Network Provider at the same rate the Department would pay for such services according to the level of services provided and exclusive of disproportionate share payments.

d. Contractor shall pay for Family-Planning services, subject to *Attachment 3 HCBS Service Package II Covered Services* hereof, rendered by a non-Network Provider, for which Contractor would pay if rendered by a Network Provider, at the same rate the Department would pay for such services exclusive of disproportionate share payments, unless a different rate was agreed upon by Contractor and the non-Network Provider.

e. Contractor shall accept claims from non-Network Providers for at least six (6) months after the date the services are provided. Contractor shall not be required to pay for claims initially submitted by such non-Network Providers more than six (6) months after the date of service.

f. Contractor shall pay all Providers of HCBS Waiver services at a rate no less than the rate in effect for the Department for such Covered Services.

i. Contractor shall pay Provider agencies that provide in-home services under the Persons Who are Elderly HCBS Waiver and that also offer health insurance to their in-home service workers, at a rate that includes the enhanced rate set forth at 89 Ill. Admin. Code 240.1970. If any other HCBS Waiver includes a similar enhanced rate, Contractor shall pay the affected Provider agencies at a rate that includes such enhanced rate.

ii. Contractor shall not discriminate against Providers of HCBS Waiver services that offer health insurance to their in-home services workers.

g. When Contractor contracts with Providers at the Department FFS rate, Contractor shall:

i. pay all add-on enhanced payments (e.g., renal dialysis add-on, psychiatry add-on) from when the inclusion of add-ons into the rates comes into effect; and

ii. pay all Minimum Data Set (MDS) rates retroactive to the effective date. A Minimum Data Set rate is comprised of the nursing component, capital component and support component of each Nursing Facility, and when applicable, an add-on component when a Nursing Facility qualifies for enhanced rates.

h. Contractor shall establish an internal complaint and resolution system for Network and non-Network Providers, including:

i. a claim dispute process that allows Providers to contest a payment decision after a claim has been adjudicated;

ii. a service authorization dispute process that allows Providers to contest an authorization denial or a reduction, suspension, or termination of a previously authorized service;

iii. a system that creates a standardized tracking number per complaint in a format designated by the Department that maintains the date the complaint was filed and the date of resolution if applicable. The Department in

consultation with Contractor may change parameters around the tracking number. The Department shall provide Contractor with ninety (90) days' written notice of any such change; and

iv. a resolution process that provides a substantive response intended to resolve the dispute within thirty (30) days after receipt of the dispute request.

i. Federally-Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) Reimbursements: Contractor shall ensure that its payments to FQHCs and RHCs for services to Enrollees are no less than the sum of the difference between eighty percent (80%) of the Medicare FFS rate for that FQHC or RHC and the Medicaid PPS amount for that FQHC or RHC, where the Medicaid PPS amount exceeds eighty percent (80%) of the Medicare rate.

j. Payment of a portion of a Medicare Covered Service by a Contractor does not constitute a Medicaid Covered Service for the purposes of this section.

k. Compensation. Provider-compensation models shall reimburse for Covered Services provided and may reimburse for performance. Contractor shall not permit any payment to a Network Provider for Covered Services other than the payment made by Contractor, except when specifically required by this Contract or applicable law as provided in 42 CFR 438.60.

L. Value-Based Payments (VBP) include a broad set of Provider payment strategies intended to improve health care quality, outcomes, and efficiency by linking financial incentives to performance. Measurement of performance is based on a set of defined outcome metrics of quality, cost, and patient-centered care. Contractor shall develop and maintain a VBP strategy that follows the Alternative Payment Model (APM) Framework (2017 White Paper) developed by the Health Care Payment Learning and Action Network (HCP-LAN, https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf with a special emphasis on APM models in categories three (3) and four (4). Contractor shall include:

a. A written VBP Plan for the adoption, evolution, and growth of APMs in its Provider Network. The VBP Plan shall include the

most recent APM experience, the current status of Contractor's VBP efforts, and strategies to enhance or further those efforts over the two subsequent calendar years. Contractor's initial VBP Plan shall be submitted to the Department for Prior Approval no later than May 1, 2026. Each annual VBP Plan thereafter shall at a minimum shall, at a minimum, include:

i. A detailed description of all APMs Contractor is currently using within its Provider Network, including a brief discussion of associated performance measures. Provider type and number of enrollees covered under each APM by the HCP-LAN APM Framework category/sub-category into which the APM best fits (e.g., 2a, 3b, or 4a);

ii. For the APMs identified above, the total Medicaid payments to Providers for services covered under APMs and the percentage of Contractor's total Medicaid medical expenses paid in the prior year and expected to be paid in the current year under each type of APM model. The numerator and denominator, as defined by the Department, should include all Medicaid related medical spending, including primary and acute, behavioral health, and drug spending;

iii. For the APMs identified above, the percentage of Contractor's total Medicaid medical expenses expected to be paid under each type of APM model. The numerator and denominator, as defined by the Department, should include all Medicaid related medical spending, including primary and acute, behavioral health, and drug spending;

iv. Assessment of Provider readiness for VBP within Contractor's Provider Network, specifically analyzing Provider readiness to participate in APM Framework categories 3 and 4;

v. Methods and frequency for collection and assessment of quality performance data from Providers;

vi. Communication and collaboration approach with Providers on reviewing performance and defining strategies for improvement;

vii. Effectiveness of Contractor's VBP strategies for services and populations under the Contract, including measurable results demonstrating how Contractor's current APMs affect Enrollee outcomes, experience, and associated medical spending;

viii. Relationship to Contractor's commercial and/or Medicare Advantage VBP strategy, as applicable, and discussion of how these VBP strategies align with VBP efforts under the Illinois D-SNP program; and

ix. Alignment with the program goals under the Department's Comprehensive Medical Programs Quality Strategy.

b. Contractor shall annually update and submit the VBP Plan by May 1 of each calendar year, using a template provided by the Department. After the initial annual VBP Plan, the submission shall reflect actual experience in the prior calendar year and anticipated experience in the current calendar year. Contractor's submission must include numerators and denominators, as defined by the Department, that account for all relevant spending of medical services. The Department will use measurement methodologies developed by the Healthcare Payment Learning and Action Network (HCP-LAN) to evaluate the adoption, evolution and growth of the VBP arrangement in Contractor's Provider Network. The Department reserves the right to request revisions to Contractor's annual VBP Plan to align with Department priority areas. These revisions may include alignment across patient populations and payer types to align with multi-payer initiatives in which Medicaid is a participant (i.e., multi-payer alignment of incentives across Medicare, Medicaid, and/or commercially insured populations in Illinois). Contractor shall also complete and submit the HCP-LAN APM data collection tool to HCP-LAN according to the process and deadlines established annually by HCP-LAN.

c. Contractor must realize annual improvement in the level of VBP penetration as a percentage of its relevant spending for medical services governed under VBP arrangements with Providers. The Department will take this figure from the Contractors' annual VBP Plan, which will include detailed specifications regarding the methodology for calculating this percentage. Upon sixty (60) days written notice to Contractor the Department reserves the right to add specific VBP penetration targets, including potential targets for the adoption of more advanced VBP (I.e., HCP-LAN categories, 3-4) in future calendar years. Any additions or revisions to specific VBP penetration targets shall be effective the calendar year immediately following the notice from the Department.

d. The Department reserves the right to mandate participation in a Value Based Payment Arrangement after consultation with the Contractor.

1.2.18 *Network Management*

A. Contractor shall develop and implement a strategy to manage the Provider Network with a focus on access to services for Enrollees, quality, consistent practice patterns, independent living philosophy, cultural competence, and the integration and cost effectiveness. The management strategy shall address all Providers. Such strategy shall include at a minimum:

a. Conducting on-site visits to Network Providers for quality management and quality improvement purposes, and for assessing meaningful compliance with ADA requirements; and

b. Ensuring that its Provider Network is adequate to assure access to all Covered Services, and that all Providers are appropriately credentialed, maintain current licenses, and have appropriate locations to provide the Covered Services.

c. Contractor shall perform Quality Assurance evaluations of Provider practices, which shall include monitoring of Enrollee accessibility to ensure linguistic and physical accessibility. Contractor shall support Providers in achieving accessibility.

B. Contractor shall assure that all Network Providers, including out-of-State Network Providers that provide Medicaid Covered Services are screened and enrolled in the Department Medical Program, in compliance with 42 CFR 438.602(b), and if such enrollment is required by the Department's rules or policy in order to submit claims for reimbursement or otherwise participate in the Department Medical Program.

C. Contractor shall confirm with Provider within three (3) Business Days of receipt of all required information from Provider entering or exiting Contractor's Provider Network.

D. Medicaid Provider Contract Termination.

a. Contractor must comply with Medicare provider termination requirements pursuant to 42 CFR 422.202(d). For Medicaid provider terminations, Contractor shall give written notice of termination of a Medicaid Provider irrespective of whether the termination was for cause or without cause. Contractor shall make a good faith effort to give notice of a for cause termination of a Medicaid Provider within the timeframes required. For all terminations, Contractor must meet the following timelines:

i. For contract terminations that involve a Medicaid behavioral health Provider, at least forty-five (45) calendar days before the termination effective date, provide written notice and make one attempt at telephonic notice to Enrollees (unless Enrollees have opted out of calls) who are currently assigned to that Medicaid behavioral health Provider within the past three (3) years

ii. For contract terminations that involve specialty types other than Medicaid behavioral health at least thirty (30) calendar days before the termination effective date, provide written notice to all Enrollees who are assigned to, currently receiving care from, or have received care within the past three (3) months from a Medicaid Provider or facility being terminated.

iii. For contract terminations due to a Medicaid Provider ceasing to provide services or otherwise terminating its Medicaid Provider contract, Contractor shall

contractually obligate Medicaid Providers to provide written notice to Contractor at least sixty (60) calendar days before the termination effective date.

iv. Once a Contractor is aware that a Medicaid Network Provider serving one hundred (100) or more active Enrollees will be terminated, Contractor must inform the Department of this termination in writing (e-mail or letter) within three (3) Business Days.

v. This written notification must include:

(A) the Provider name;

(B) the reason for termination;

(C) the expected termination date;

(D) the current number of Enrollees served by (that is, who received primary care from, or was seen on a regular basis by) the terminated Provider; and

vi. the plan of action for transferring Enrollees to another Provider.

vii. Contractor shall make a good-faith effort to give written notice of termination of a Provider as soon as practicable, but no later than in accordance with the time frames listed in this section, after issuance of a termination notice by Contractor to a Provider, or receipt or issuance of a termination notice from a Provider, to each Enrollee who was served by the terminated Provider shall receive notice that Provider was terminated. In this notification, Contractor will provide direction to the Enrollee regarding how the Enrollee may select a new Provider.

viii. Contractor shall give written notice in advance of its nonrenewal or termination effective date of a Provider to the Provider and to each Enrollee served by the Provider no later than in accordance with the time frames listed in this section. The notice shall include a

name and address to which the Provider or an Enrollee may direct comments and concerns regarding the nonrenewal or termination. In the notification to the Enrollee, Contractor will provide direction regarding how the Enrollee may select a new Provider. Contractor may provide immediate written notice when a Provider's license has been disciplined by a State licensing board.

b. The notice shall include a name and address to which the Provider or an Enrollee may direct comments and concerns regarding the nonrenewal or termination. In the notification to the Enrollee, Contractor will provide direction regarding how the Enrollee may select a new Provider.

c. Contractor must transition Enrollees, or have a plan to transition Enrollees, to new Providers prior to terminating the contracts.

E. Non-Network Providers. It is understood that in some instances Enrollees will require specialty care not available from a Network Provider and that Contractor will arrange that such services be provided by a non-Network Provider. In such event, Contractor will promptly negotiate an agreement ("Single Case Agreement") with a non-Network Provider to treat the Enrollee until a qualified Network Provider is available. Contractor shall make best efforts to have any non-Network Provider billing for services be enrolled in the Department's Medical Program, as appropriate and in the same manner as Network Providers under *Section 1.2.18.B Network Management*, prior to paying a claim.

F. Access to Provider Locations. Provider locations shall be accessible for Enrollees with disabilities. Contractor shall collect sufficient information from Providers to assess compliance with the ADA. As necessary to serve Enrollees, Provider locations where Enrollees receive services shall be ADA compliant. In addition, Contractor shall include within its network Provider locations that are able to accommodate the unique needs of Enrollees.

G. Proximity, Access, and Network Adequacy Standards. Contractor must demonstrate annually that its Provider Network meets the stricter of the following standards:

a. Contractor shall ensure that at least two (2) NFs are within a fifteen (15) mile or thirty (30) minute radius from the Enrollee's

ZIP code of residence within each county of the Service Area, provided that each NF meets all applicable State and federal requirements for participation in the Medicaid Program. Notwithstanding the foregoing, Contractor may offer an Enrollee only one NF with the Prior Approval of the Department.

b. Medicaid Behavioral Health Provider access. Contractor shall ensure an Enrollee has access to at least two (2) Behavioral Health service Providers within a thirty (30)–mile radius of or thirty (30)–minute drive from the Enrollee's residence. If an Enrollee lives in a Rural Area, the Enrollee shall have access to at least one (1) Behavioral Health service Provider within a sixty (60)–mile radius of or sixty (60)–minute drive from the Enrollee's residence.

c. LTSS Provider types in which Enrollee travels to Provider. Contractor shall ensure an Enrollee has access to at least two (2) LTSS Providers within a thirty (30)-mile radius of or thirty (30)-minute drive from the Enrollee's residence. If an Enrollee lives in a Rural Area, the Enrollee shall have access to at least two (2) LTSS Providers within a sixty (60)-mile radius of or sixty (60)-minute drive from the Enrollee's residence.

d. Waiver Providers. For Providers of each of the Covered Services listed below under a HCBS Waiver, within each county in the Service Area, Contractor must maintain a network with at least eighty percent 80% of HCBS Providers that rendered services for the prior year. For counties where there is more than one Provider of Covered Services, Contractor must maintain a network that includes at least two of such Providers, even if one served more than eighty percent (80%) of the current HCBS Waiver participants. HCBS services subject to this standard include:

    i. Adult Day Care;

    ii. Homemaker;

    iii. Day Habilitation (offered for participants in the Persons with a Brain Injury (BI) HCBS Waiver);

    iv. Supported Employment (BI waiver);

v. Home Delivered Meals;

vi. Home Health Aides;

vii. Nursing Services;

viii. Occupational Therapy;

ix. Speech Therapy; and

x. Physical Therapy.

e. The following requirements apply for the remaining HCBS Waiver services:

i. Environmental Modifications: Contractor will be monitored to ensure that necessary environmental modifications are made within ninety (90) days after Contractor becomes aware of the need or from when Contractor should have been aware, and Contractor shall ensure compliance with Ill. Adm. Code 686.640.

ii. Personal Assistants: The Department is not dictating a network adequacy requirement, as Personal Assistants are hired at the discretion and choice of the Enrollee. Contractor is required, however, to assist Enrollees in locating potential Personal Assistants as necessary.

iii. Personal Emergency Response System: Contractor shall enter contracts that meet the requirements of 89 Ill. Adm. Code 240.235 with at least one (1) Provider serving each county within the Service Area.

iv. Automated Medication Dispenser. Contractor shall enter contracts that meet the requirements of 89 Ill. Adm. Code 240.1543 and shall authorize the automated medication dispenser service in accordance with 89 Ill. Admin. Code 240.741.

f. Contractor shall enter a contract with any willing and qualified community mental health center (Medicaid Provider Type 36) in the Service Area so long as the Provider agrees to Contractor's rate and adheres to Contractor's Quality Assurance (QA)

requirements. Contractor may establish quality standards in addition to those State and federal requirements and, after the first year of contracting, contract with only those Community Mental Health Centers that meet such standards, provided that each the contracting Provider is informed of any such additional standards no later than ninety (90) days after the start of its contract and that the Department has given Prior Approval. Any such standards that are not established within ninety (90) days after the start of the contract with the Community Mental Health Center must be in effect for one (1) year before Contractor may terminate a contract of a Provider based on a failure to meet such standards.

g. Family Planning. Contractor shall cover Family Planning services for all Enrollees whether the Family Planning services are provided by a Network or non-Network Provider.

h. Safety Net Providers. Contractor will prioritize recruiting safety net Providers, such as FQHCs and CMHCs, as Network Providers. Contractor shall not refuse to contract with an FQHC, RHC or CMHC that is willing to accept Contractor's standard rates and contractual requirements and meets Contractor's quality standards.

i. Medical Homes. Contractor's Network Provider network shall include Providers that act as medical homes, with a focus on FQHCs, CMHCs and multi-specialty PCP-centered medical groups and private practice PCP offices. An Enrollee may choose from among the available medical homes. Medical homes shall be patient-centered medical homes that provide and coordinate high quality, planned, family-centered health promotion; Wellness Programs; acute illness care; and Chronic Health Condition management. Medical homes shall provide all PCP services and be supported by Integrated Care Teams and Health Information Technology. Contractor will support medical homes and the integration of behavioral and physical health care by providing embedded Care Coordinators, as appropriate, onsite at FQHCs, CMHCs and high-volume Providers that agree to this approach. Contractor is required to have a process in place to facilitate medical homes advancing towards NCQA certification

and are required to provide financial incentives to Providers that achieve NCQA medical home certification.

j. Appointments. Contractor shall require for primary care and behavioral health services that time specific appointments for routine, preventive care are available within 30 Business Days from the date of request for such care for services where Medicare is primary and within twenty-five (25) Business Days for services where Medicare is not primary from the date of request for such care. Enrollees with more serious problems not deemed Emergency Medical Conditions shall be triaged and, if necessary or appropriate, immediately referred for urgent Medically Necessary care or provided with an appointment within one (1) Business Day after the request. Enrollees with problems or Complaints that are not deemed serious, but the Enrollee requires medical attention shall be seen within seven (7) Business Days after the request. Enrollees with problems or Complaints that are not deemed serious shall be seen within three (3) weeks from the date of request for such care. Initial prenatal visits without expressed problems shall be made available within two (2) weeks after a request for an Enrollee in her first trimester, within one (1) week for an Enrollee in her second trimester, and within three (3) days for an Enrollee in her third trimester. Network Providers shall offer hours of operation that are no less than the hours of operation offered to individuals who are not Enrollees. Contractor shall ensure that an initial appointment for outpatient treatment for mental, emotional, nervous, or substance use disorders or conditions is available within ten (10) Business Days from the date of request for an Enrollee. Follow-up appointments for outpatient treatment for mental, emotional, nervous, or substance use disorders or conditions shall be available within twenty (20) Business Days from the date of request for an Enrollee. The Contractor will not be held responsible if the Enrollee or provider voluntarily chooses to schedule an appointment outside of these required time frames.

k. Contractor will have mechanisms in place to ensure compliance with the timely access requirements pursuant to 42 CFR 422.112 and 438.206 and *Section 1.2.18.G Network Management* of this Contract, including monitoring Providers regularly to ensure

compliance and taking corrective action if there has been a failure to comply.

l. Contractor shall ensure that each Network Provider furnishing Covered Services to an Enrollee maintains and shares, as appropriate, an Enrollee health record in accordance with professional standards.

m. PCP Selection and Assignment.

i. Choice of Primary Care Provider. Contractor shall afford to each Enrollee a choice of PCP, which may be, where appropriate, a WHCP.

ii. Specialists as PCPs. Contractor shall offer pregnant Enrollees and Enrollees with Chronic Health Conditions, disabilities, or special health care needs the option of choosing a specialist to be their PCP or medical home. Such Enrollees or their Providers may request a specialist as a PCP at any time. Contractor shall contact the Enrollee promptly after the request to determine whether the Enrollee needs a specialist as a PCP. Contractor's Medical Director will approve or deny requests after determining whether the Enrollee meets criteria and whether the specialist is willing to fulfill the role and all the obligations of PCP or medical home.

iii. Homebound. If an Enrollee is homebound or has significant mobility limitations, Contractor shall provide access to primary care through home visits by the PCP to support the Enrollee's ability to live as independently as possible in the community.

n. Reasonably accommodate Enrollees and ensure that the programs and services are as accessible (including physical and geographic access) to an individual with disabilities as they are to an individual without disabilities. Contractor and its Network Providers must comply with the ADA (28 CFR 35.130) and 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794) and maintain capacity to deliver services in a manner that accommodates the needs of its Enrollees. Contractor shall have written policies and procedures to assure compliance, including ensuring that

physical, communication, and programmatic barriers do not inhibit individuals with disabilities from obtaining all Covered Services from Contractor by:

i. Providing flexibility in scheduling to accommodate the needs of the Enrollees;

ii. Providing interpreters or translators for Enrollees who are Deaf or hard of hearing, visually impaired, and those who do not speak English;

iii. Ensuring that individuals with disabilities are provided with reasonable accommodations to ensure effective communication, including auxiliary aids and services. Reasonable accommodations will depend on the particular needs of the individual and include but are not limited to:

(A) Providing large print (at least 16-point font) versions of all Written Materials to individuals with visual impairments;

(B) Ensuring that all Written Materials are available in formats compatible with optical recognition software;

(C) Reading notices and other Written Materials to individuals upon request;

(D) Assisting individuals in filling out forms over the telephone;

(E) Ensuring effective communication to and from individuals with disabilities through email, telephone, and other electronic means;

(F) Making available services such as teletypewriters (TTY), computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified interpreters for the deaf and hard of hearing;

(G) Individualized assistance;

(H) Ensuring safe and appropriate physical access to buildings, services and equipment;

(I) Demonstrating compliance with the ADA by surveying Providers or site review of facilities for both physical and programmatic accessibility, documenting any deficiencies in compliance and monitoring correction of deficiencies; and

(J) Identifying to CMS and the Department the individual, and the job title, in its organization who is responsible for ADA compliance related to this D-SNP. The D-SNP must also establish and execute a work plan to achieve and maintain ADA compliance.

H. Provider Credentialing, Recredentialing, and Board Certification

a. Credentialing and Re-credentialing. Contractor shall credential Providers, except as provided in this section, in accordance with NCQA credentialing standards as well as applicable HFS, DHS, IDoA, Illinois Department of Insurance and federal requirements, including requirements set forth at 42 CFR 422.204. Re-credentialing shall occur every three (3) years. At re-credentialing and on a continuing basis, Contractor shall verify minimum credentialing requirements and monitor Enrollee Complaints and Appeals, quality of care and quality of service events, and medical record review.

b. Medicaid Uniform Provider Credentialing and Re-credentialing. In accordance with 42 CFR 438.214, enrollment in the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system constitutes Illinois' Medicaid managed care uniform credentialing and re-credentialing process. Contractor must verify that network Providers who render services for which Medicaid is the primary payer are enrolled in IMPACT.

i. Delegated Credentialing. Consistent with 42 CFR 422.504(i)(4)(iv), the Contractor may subcontract or delegate all or part of its credentialing functions when an

entity, such as a Provider organization, maintains a formal credentialing program in compliance with Contractor, NCQA, the Department and applicable regulatory standards.

ii. Contractor shall remain responsible for delegated Provider credentialing and re-credentialing, except where Providers are enrolled in the IMPACT system.

c. Contractor shall accept Department electronic data file containing Medicaid participating providers on a weekly basis. Once Department provides an electronic data file list of enrolled Medicaid providers, Contractor will, within thirty (30) calendar days, identify in its provider directory those providers that accept both Medicare and Medicaid and are also within Contractor's network.

d. Contractor is prohibited from requiring Providers who only offer Medicaid-covered services under this Contract to undergo additional credentialing processes that are not a part of this Contract.

1.2.19 *Enrollee Access to Services***.** Contractor must provide services to Enrollees as follows:

A. Authorize, arrange, coordinate, and ensure the provision of all Medically Necessary Covered Services to Enrollees in accordance with the requirements of the Contract, including:

a. Meeting State standards for timely access to care and services, taking into account the requirements of *Section 1.2.18.G Network Management* and 42 CFR 438.206(c);

b. Offering hours of operation that are no less than the hours of operation offered to commercial beneficiaries or comparable to Medicaid Fee-For-Service, if the Provider serves only Medicaid beneficiaries;

c. Making services available twenty- four (24) hours a day, seven (7) days a week, when medically necessary; and

d. Establishing mechanisms to ensure compliance by Providers.

B. Offer adequate choice and availability of primary, specialty, acute care, behavioral health and LTSS Providers that meet the Department standards as provided in *Section 1.2.18.G Network Management*;

C. At all times, cover the appropriate level of service for all Emergency Services and non-Emergency Services in an appropriate setting.

D. Provide a mechanism for an Enrollee to obtain a second opinion from a qualified Provider, whether Network or non-Network, at no cost to the Enrollee. Contractor will assist in coordinating obtaining any second opinion from a non-Network Provider.

E. Offer adequate choice and availability of Providers.

F. PCP to Enrollee Ratio. Contractor's maximum PCP panel size shall be six hundred (600) Enrollees. If Contractor does not satisfy the PCP requirements set forth above, Contractor may demonstrate compliance with these requirements by demonstrating that (i) Contractor's full time equivalent PCP ratios exceed ninety percent (90%) of the requirements set forth above, and (ii) that Covered Services are being provided in the Service Area in a manner that is timely and otherwise satisfactory. Contractor shall comply with 1932(b)(97) of the SSA.

G. If Contractor's network is unable to provide necessary medical services covered under the Contract to a particular Enrollee, Contractor must adequately and timely cover these services out of network for the Enrollee, for as long as Contractor is unable to provide them. Contractor must ensure that cost to the Enrollee is no greater than it would be if the services were furnished within the network;

H. When any Medicaid medical, or LTSS Provider is terminated from Contractor's plan or leaves the network for any reason, Contractor must make a good faith effort to give written notification of termination of such Provider to the Department, by the later of thirty (30) calendar days prior to the effective date of the termination notice, or fifteen (15) days after receipt or issuance of the termination notice, to each Enrollee who received their care from, or was seen on a regular basis by, the terminated medical, or LTSS Provider. For Enrollees who are receiving treatment for a chronic or ongoing medical condition or LTSS, Contractor shall ensure that there is no disruption in services provided to the Enrollee; and

a. For contract terminations that involve a Medicaid behavioral health Provider, at least forty-five (45) calendar days before the termination effective date, provide written notice and make one attempt at telephonic notice to Enrollees (unless Enrollees have opted out of calls) who are currently assigned to that Medicaid behavioral health Provider within the past three (3) years

b. For contract terminations that involve specialty types other than Medicaid behavioral health at least thirty (30) calendar days before the termination effective date, provide written notice to all Enrollees who are assigned to, currently receiving care from, or have received care within the past three (3) months from a Provider or facility being terminated.

c. For contract terminations due to a Provider ceasing to provide services or otherwise terminating its Provider contract, Contractor shall contractually obligate Providers to provide written notice to Contractor at least sixty (60) calendar days before the termination effective date.

I. Availability of Services: After Hours. Medicaid specialty Provider contracts shall provide coverage for their respective practices twenty-four (24) hours a day, seven (7) days a week and have a published after-hours telephone number; voicemail alone after hours is not acceptable.

J. Services Not Subject to Prior Approval: Contractor will ensure coverage of Emergency Medical Conditions and Urgent Care services. Contractor must not require Prior Approval for the following services:

a. Any services for Emergency Medical Conditions as defined in 42 CFR 422.113(b)(1)(i) and 438.114(a), which includes emergency behavioral health care;

b. Urgent Care sought outside of the Service Area;

c. Urgent Care under unusual or extraordinary circumstances provided in the Service Area when the contracted Provider is unavailable or inaccessible;

d. Family planning services; and

e. Out-of-area renal dialysis services.

K. Authorization of Services. Contractor shall authorize services in accordance with 42 CFR 438.210, as follows:

a. For the processing of requests for initial and continuing authorizations of Covered Services, Contractor shall:

i. Have in place and follow written policies and procedures;

ii. Have in place procedures to allow Enrollees to initiate requests for provisions of services;

iii. Have in effect mechanisms to ensure the consistent application of review criteria for authorization decisions; and

iv. Consult with the requesting Provider when appropriate.

b. Contractor shall ensure that a Physician and a behavioral health Provider are available twenty-four (24) hours a day seven (7) days a week, three-hundred sixty-five (365) days a year for timely authorization of Medically Necessary services, including NF services, and to coordinate transfer of Stabilized Enrollees in the emergency department, if necessary. Contractor's Medical Necessity guidelines must, at a minimum, be no more restrictive than Medicare standards for acute services and prescription drugs and Medicaid standards for LTSS.

c. Any decision to deny a Service Authorization Request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a health care professional who has appropriate clinical expertise in treating the Enrollee's medical condition, performing the procedure, or providing the treatment. Behavioral health services denials must be rendered by board-certified or board-eligible psychiatrists or by a clinician licensed with the same or similar specialty as the behavioral health services being denied, except in cases of denials of service for psychological testing, which shall be rendered by a qualified psychologist.

d. Contractor shall ensure that all behavioral health authorization and Utilization Management activities are in compliance with 42

U.S.C. 1396u-2(b)(8). Contractor must comply with the requirements for demonstrating parity for both cost sharing (co-payments) and treatment limitations between mental health and substance use disorder and medical/surgical inpatient, outpatient, and pharmacy benefits. The department reserves the right to require changes in Contractor's utilization management policies with respect to behavioral health services.

e. Contractor must notify the requesting Provider, either orally or in writing, and give the Enrollee written notice of any decision by Contractor to deny a Service Authorization Request, or to authorize a service in an amount, duration, or scope that is less than requested.

   i. Be produced in a manner, format, and language that can be easily understood;

   ii. Be made available in Prevalent Languages, upon request; and

   iii. Include information, in the most commonly used languages about how to request language assistance services and Alternate Formats. Alternate Formats shall include materials which can be understood by persons with limited English proficiency.

f. Contractor must make authorization decisions in the following timeframes and provide notice that meet the timing requirements set forth in 42 CFR 438.210 and 305 ILCS 5/5F-32:

   i. Unless limited by *Section 1.2.19.K.f.v Enrollee Access to Services*, for standard authorization decisions, provide notice as expeditiously as the Enrollee's health condition requires and no later than) four (4) calendar days from the date of receipt of all Necessary Information for benefits, with a possible extension not to exceed four additional calendar days.

   ii. An extension under the preceding section shall only be allowed if the Enrollee or the Provider requests an extension, or

iii. Contractor can justify (to the satisfaction of the Department upon request) that the extension is in the Enrollee's interest; and there is a need for additional information where:

(A) There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received;

(B) Such outstanding information is reasonably expected to be received within fourteen (14) calendar days; and

(C) Contractor provides the Enrollee with notice of the reason for the extension and informs the Enrollee of the right to file an Expedited Grievance if the Enrollee disagrees with the decision to extend the Service Authorization Notice timeframe.

iv. Unless limited by *Section 1.2.19.K.f.v Enrollee Access to Services*, for expedited service authorization decisions, where the Provider indicates or Contractor determines that following the standard timeframe in *Section 1.2.19.K.f.i Enrollee Access to Services* could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, Contractor must make a decision and provide notice as expeditiously as the Enrollee's health condition requires and no later than forty-eight (48) hours after receipt of all Necessary Information for benefits for which Medicaid is the primary payor, not to exceed four (4) additional calendar days. Such extension shall only be allowed if:

(A) The extension is in the Enrollee's interest;

(B) And there is a need for additional information where there is a reasonable likelihood that receipt of such information would lead to approval of the request, if received;

(C) And such outstanding information is reasonably expected to be received within fourteen (14) calendar days.

v. For authorizations for Enrollees residing in a NF, if a response to the authorization is not provided within twenty-four (24) hours of the request and the NF is required by regulation to provide a service because a Physician ordered it, Contractor must pay for the service if it is a Covered Service, provided that the request is consistent with the policies and procedures of Contractor.

vi. For authorization decisions the criteria used shall be readily accessible on the website. Contractor shall make any current prior authorization requirements and restrictions, including the written clinical review criteria, readily accessible and conspicuously posted on its website to enrollees, health care professionals, and health care providers, in compliance with 215 ILCS 200/20.

vii. In accordance with 42 CFR 438.3(i) compensation to individuals or entities that conduct Utilization Management activities for the D-SNP must not be structured to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Enrollee.

1.2.20 *Critical Incidents and Other HCBS Required Reporting*

A. Contractor shall comply with critical incident reporting requirements of the DHS-DRS, IDoA, and HFS HCBS Waivers. Such reportable incidents include, but are not limited to, the incidents identified in *Attachment 5 Qualification and Training Requirements of Care Coordinators for 1915c HCBS Waiver Services, Attachment 7 Illinois Department of Human Services, Division of Rehabilitation Services Critical Incident Definitions, Attachment 8 Illinois Department of Aging Adult Protective Services Definitions and Attachment 9 Illinois Department of Healthcare and Family Services Incident Reporting for Supportive Living* for the appropriate HCBS Waivers.

B. Contractor shall comply with HCBS Waiver reporting requirements to assure compliance with Federal Waiver Assurances for Health Safety, and Welfare, and other Federal requirements as set forth in the approved HCBS Waivers. Contractor, on an ongoing basis, shall identify, address, and seek to prevent the occurrence of Abuse, Neglect and exploitation. Performance Measures regarding health, safety, welfare and critical incident reporting are included for all HCBS programs.

C. Contractor shall train all of Contractor's employees, Network Providers, and Affiliates, who have interaction with Enrollees or Enrollee's IPoC to recognize potential concerns related to Abuse, Neglect and exploitation, and on their responsibility to report suspected or alleged Abuse, Neglect or exploitation. Contractor's employees who, in good faith, report suspicious or alleged Abuse, Neglect or exploitation to the appropriate authorities shall not be subjected to any Adverse Benefit Determination from Contractor, its Network Providers, or Affiliates.

D. Contractor shall train Providers, Enrollees and Enrollees' family members about the signs of Abuse, Neglect, and exploitation, what to do if they suspect Abuse, Neglect or exploitation, and Contractor's responsibilities. Training sessions will be customized to the target audience. Training will include general indicators of Abuse, Neglect and exploitation and the timeframe requirements for reporting suspected Abuse, Neglect, and exploitation.

E. Reports regarding Enrollees who are disabled adults age eighteen (18) through fifty-nine (59), who are residing in the community, are to be made to the Illinois Adult Protective Services Unit of IDoA at 1-866-800-1409 (voice) and 1-888-206-1327 (TTY).

F. Reports regarding Enrollees who are age sixty (60) or older, who reside in the community, are to be made to the Illinois Adult Protective Services Unit of IDoA at 1-866-800-1409 (voice) and 1-888-206-1327 (TTY).

G. Reports regarding Enrollees in NFs must be made to the Illinois Department of Public Health's (DPH's) Nursing Home Complaint Hotline: 1-800-252-4343.

H. Reports regarding Enrollees in SLFs must be made to the Department's SLF Complaint Hotline: 1-800-226-0768.

I. Contractor shall provide the Department, upon request, with its protocols for reporting suspected Abuse, Neglect and exploitation and other critical incidents that are reportable.

J. Contractor shall provide the Department, upon request, with its protocols for assuring the health and safety of the Enrollee after an allegation of Abuse, Neglect or exploitation, or a critical incident, is reported.

K. Critical Incident Reporting

a. Contractor shall have processes and procedures in place to receive reports of critical incidents. Critical events and incidents must be reported and issues that are identified must be routed to the appropriate department within Contractor and, when required or otherwise appropriate, to the investigating authority.

b. Contractor shall maintain an internal reporting system for tracking the reporting and responding to critical incidents, and for analyzing the event to determine whether individual or systemic changes are needed.

c. Contractor shall have systems in place to report, monitor, track, and resolve critical incidents concerning restraints and restrictive interventions.

i. Contractor shall make reasonable efforts to detect unauthorized use of restraint or seclusion. Contractor shall require that events involving the use of restraint or seclusion are reported to Contractor as a reportable incident, and reported to the investigating authority as indicated if it rises to the level of suspected Abuse, Neglect, or exploitation.

ii. Contractor shall make reasonable efforts to detect unauthorized use of restrictive interventions. Contractor shall require that events involving the use of restrictive interventions are reported to Contractor as a reportable incident, and reported to the investigating authority if it rises to the level of Abuse, Neglect or exploitation.

L. Health, Safety and Welfare Monitoring

a. Contractor shall comply with all health, safety and welfare monitoring and reporting required by State or federal statute or regulation, or that is otherwise a condition for a HCBS Waiver, including, but not limited to, the following: critical incident reporting regarding Abuse, Neglect, and exploitation; critical incident reporting regarding any incident that has the potential to place an Enrollee, or an Enrollee's services, at risk, but which does not rise to the level of Abuse, Neglect, or exploitation; and Performance Measures relating to the areas of health, safety and welfare and required for operating and maintaining a HCBS Waiver.

b. Contractor shall comply with the Department of Human Services Act (20 ILCS 1305/1-1 et seq.), the Abuse of Adults with Disabilities Intervention Act (20 ILCS 2435/1 et seq.), the Elder Abuse and Neglect Act (320 ILCS 20/1 et seq.), the Abused and Neglected Child Reporting Act (325 ILCS 5/1 et seq.) and any other similar or related applicable federal and State laws.

M. Emergency, Out-of-Service Area Elective Care, Post-Stabilization Care Coverage, and State Operated Hospitals.

a. Emergency Services

i. Contractor's Provider network must ensure access to twenty-four (24) hour Emergency Services for all Enrollees, whether they reside in institutions or in the community. Contractor must cover and pay for any services obtained for Emergency Medical Conditions in accordance with 42 CFR 422.113 and 438.114.

ii. Contractor shall cover and pay for Emergency Services regardless of whether the Provider that furnishes the services has a contract with Contractor. Out-of-network payment policies are described at *Section 1.2.17.K Provider Network.* Contractor shall ensure that the Enrollee is not billed for the difference, if any, between such rate and the non-Network Provider's charges

iii. Contractor shall cover Emergency Services provided to Enrollees who are temporarily away from their residence and outside the Service Area to the extent that the Enrollees would be entitled to the Emergency Services if they still were within the Service Area.

iv. Contractor shall not deny payment for treatment for an Emergency Medical Condition or cases in which prudent layperson, who possesses an average knowledge of health and medicine, reasonably thought that the absence of immediate medical attention would result in the following: (1) 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; (2) Serious impairment to bodily functions; or (3) Serious dysfunction of any bodily organ or part; when the absence of immediate medical attention would not have resulted in placing the individual in serious jeopardy, pursuant to 42 CFR 438.11

v. Contractor shall not deny payment for Emergency Services in cases in which Contractor's representative instructed the Enrollee to seek Emergency Services.

vi. Contractor shall not limit what constitutes an Emergency Medical Condition based on lists of diagnoses or symptom. Contractor shall require Providers to notify the Enrollee's PCP of an Enrollee's screening and treatment but may not refuse to cover Emergency Services based on their failure to do so.

vii. An Enrollee who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. The attending emergency Physician, or the Provider treating the Enrollee, is responsible for determining when the Enrollee is Stabilized for transfer or discharge, and that determination is binding on Contractor if:

(A) Such transfer or discharge order is consistent with generally accepted principles of professional medical practice; and

(B) Is a Covered Service under this Contract.

viii. Contractor shall provide ongoing education to Enrollees regarding the appropriate use of Emergency Services. Contractor shall use a range of management techniques, policies and Enrollee or Provider initiatives to avoid unnecessary utilization of Emergency Services and to promote Care Management through an Enrollee's PCP or medical home.

ix. Contractor shall not impose any requirements for Prior Approval of Emergency Services.

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

b. Elective Care: Elective care or care required because of circumstances that could reasonably have been foreseen prior to the Enrollee's departure from the Service Area is not covered. Unexpected hospitalization due to complications of pregnancy shall be covered. Routine delivery at term outside the Service Area, however, shall not be covered if the Enrollee is outside the Service Area against medical advice unless the Enrollee is outside of the Service Area due to circumstances beyond her control. Contractor must educate the Enrollee regarding the medical and financial implications of leaving the Service Area and the importance of staying near the treating Provider throughout the last month of pregnancy.

c. Post-Stabilization Services: Contractor shall cover and pay for Post-Stabilization Care Services in accordance with 42 CFR 438.114(e) and CFR 422.113(c). Contractor shall cover Post-Stabilization Services provided by an Network or non-Network Provider in any of the following situations: (i) Contractor authorized such services; (ii) such services were administered to maintain the Enrollee's Stabilized condition within one (1) hour after a request to Contractor for authorization of further Post-

Stabilization Services; or (iii) Contractor does not respond to a request to authorize further Post-Stabilization Services within one (1) hour, Contractor could not be contacted, or Contractor and the treating Provider cannot reach an agreement concerning the Enrollee's care and an Network Provider is unavailable for a consultation, in which case the treating Provider must be permitted to continue the care of the Enrollee until an Network Provider is reached and either concurs with the treating Provider's plan of care or assumes responsibility for the Enrollee's care.

d. State Operated Hospitals (SOH): When covered by Medicaid, Contractor shall provide inpatient psychiatric care at a SOH for an Enrollee admitted under civil status, at Medicaid established rates, whether that SOH is a Network or non-Network Provider. Payment shall be made for all days utilized as determined by DHS-DMH and is not subject to the utilization review determinations or admission authorization standards of Contractor.

N. Emergency Medical Treatment and Labor Act (EMTALA). Contractor and Providers shall comply with EMTALA, which, in part, requires:

a. Qualified hospital medical personnel to provide appropriate medical screening examinations to any individual who "comes to the emergency department," as defined in 42 CFR 489.24(b); and,

b. As applicable, to provide individuals stabilizing treatment or, if the hospital lacks the capability or capacity to provide stabilizing treatment, appropriate transfers.

c. Contractor's contracts with its Providers must clearly state the Provider's EMTALA obligations and must not create any conflicts with hospital actions required to comply with EMTALA.

1.2.21 *Enrollee Services*

A. Enrollee Service Representatives (ESRs). Contractor must employ ESRs trained to answer inquiries and concerns from Enrollees and Potential Enrollees, in compliance with the following requirements:

a. Be trained to answer Enrollee inquiries and concerns from Enrollees and Prospective Enrollees;

b. Be trained in the use of those services required pursuant to *Section 1.2.18.G.d and e Network Management;*

c. Be capable of speaking directly with, or arranging for an interpreter to speak with, Enrollees in their primary language, including American Sign Language, or through an alternative language device or telephone translation service;

d. Inform callers that interpreter services are free;

e. Be knowledgeable about the Illinois Medicaid program, Medicare, and the terms of the Contract, including the Covered Services listed in *Attachment 3 HCBS Service Package II Covered Services;*

f. Be available to Enrollees to discuss and provide assistance with resolving Enrollee Complaints;

g. Have access to Contractor's Enrollee database, Contractor's Enrollee handbook, and an electronic Provider and Pharmacy directory;

h. Maintain the availability of services, such as TTY services, computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified interpreters and other services for Deaf and hard of hearing Enrollees;

i. Demonstrate sensitivity to culture, including disability culture and the independent living philosophy;

j. Provide assistance to Enrollees with cognitive impairments; for example, provide Written Materials in simple, clear language at a reading level of 6.0 and below, and individualized guidance from ESRs to ensure materials are understood;

k. Provide reasonable accommodations needed to assure effective communication and provide Enrollees with a means to identify their disability to the D-SNP;

l. Maintain employment standards and requirements (e.g., education, training, and experience) for Enrollee services staff to meet defined performance objectives; and

m. Ensure that ESRs make available to Enrollees and Potential Enrollees, upon request, information concerning the following:

i. The identity, locations, qualifications, and availability of Providers;

ii. Enrollees' rights and responsibilities;

iii. The procedures available to an Enrollee and Provider(s) to challenge or Appeal the failure of the D-SNP to provide a Covered Service and to Appeal any Adverse Benefit Determinations (denials);

iv. How to access oral interpretation services and Written Materials in Prevalent Languages and Alternate Formats;

v. Information on all Covered Services and other available services or resources (e.g., State agency services) either directly or through Referral or authorization;

vi. The procedures for an Enrollee to change plans or to opt out of the D-SNP; and

vii. Additional information that may be required by Enrollees and Potential Enrollees to understand the requirements and benefits of the D-SNP.

B. Enrollee Service Telephone Responsiveness. Contractor must operate a call center in accordance with the requirements of 42 CFR 422.111(h) and 423.128(d)(1).

C. Coverage Determinations and Appeals Call Center Requirements. Contractor must operate a toll-free call center with live Enrollee service representatives available to respond to Providers or Enrollees for information related to requests for coverage under Medicare or Medicaid, and Medicare and Medicaid Appeals (including requests for Medicare exceptions and prior authorizations). Contractor shall provide immediate access to requests for Medicare and Medicaid covered benefits and services, including Medicare coverage determinations and

redeterminations, via its toll-free call centers. The call centers must operate the call center in accordance with the requirements of 42 CFR 422.111(h)(1) and 423.128(d)(1).

D. Provider Accessibility and Nurse Support Line.

a. Contractor shall require PCPs and specialty Provider contracts to provide coverage for their respective practices twenty-four (24) hours a day, seven (7) days a week and have a published after-hours telephone number; voicemail alone after hours is not acceptable.

b. Contractor shall establish a toll-free advice line, available twenty-four (24) hours a day, seven (7) days a week, through which Enrollees may obtain medical guidance and support from a nurse. Contractor shall ensure that the nurses staffing the nurse advice line will be able to obtain Physician support and advice by contacting Contractor's Medical Director if needed.

E. Member Relationship Management System. Contractor shall have a system dedicated to the management of information about Enrollees, specifically designed to collect Enrollee-related data and processing workflow needs in health care administration. The system shall have, at a minimum, three (3) core integrated components:

a. Member demographics tracking and information;

b. Means to automate, manage, track and report on Contractor's workflows for outbound and outreach Enrollee campaigns as well as targeted outbound interventions (such as engaging high-risk Enrollees in-care or Disease Management Programs); and

c. Technology for use for inbound Enrollee contact and query management.

F. Enrollee Portal. Contractor shall have and maintain a secure Enrollee website that shall include, at a minimum, the following functions or capabilities:

a. Information about Contractor;

b. "Contact Us" information:

c. Local health events and news;

d. Provider search of the Provider directory

e. Access to the Enrollee's IPoC;

f. Access to the Enrollee's care gaps; and

g. Access to health education materials.

1.2.22 *Enrollee Grievance*

A. Contractor shall establish an Integrated Grievance process in compliance with 42 CFR 422.629-630. For purposes of this section, references to "grievance" shall mean "integrated grievance".

B. Grievance Filing

a. Internal Grievance Filing. An Enrollee, or an authorized representative, may file an Internal Enrollee Grievance at any time with Contractor or its Providers by calling or writing to Contractor or Provider. If the internal Enrollee Grievance is filed with a Provider, Contractor must require the Provider to forward it to Contractor. The Enrollee may file the Grievance at any time as allowed in 42 CFR 422.630(b).

b. External Grievance Filing. Contractor shall inform Enrollees that they may file an external Grievance in the Complaint Tracking Module (CTM) through 1-800 Medicare. Contractor must display a link to the electronic Grievance form on the Medicare.gov Internet Web site on Contractor's main Web page. Contractor must inform Enrollees of the email address, postal address or toll-free telephone number where an Enrollee Grievance may be filed.

1.2.23 *Internal Grievance Administration Process***.** Contractor must have a formally structured Grievance system, consistent with 215 ILCS 134/35, 42 CFR 422 Subpart M, 42 CFR 431 Subpart E and 42 CFR 438 Subpart F, in place for addressing Enrollee Grievances, including Grievances regarding reasonable accommodations and access to services under the ADA.

A. Contractor must maintain written records of all Grievance activities, which shall be accessible to the Department upon request, and notify the

Department of all Enrollee Grievances. Contractor must also submit to the Department, in the format required by the Department, a quarterly report summarizing all Grievances heard by the Grievance Committee and the responses to and disposition of those Grievances. Contractor must submit its Grievance procedures to the Department for Prior Approval. The system must meet the following standards:

a. Timely acknowledgement to the Enrollee of receipt of each Enrollee Grievance. Contractor must send the acknowledgement letter within five (5) business days after the receipt of the grievance;

b. Timely review of each Enrollee Grievance;

c. Establishing a Grievance and Appeals Committee, that meets, at minimum, on a quarterly basis;

d. Informal attempt by Contractor to resolve all Grievances;

e. Providing the Enrollee with a form and instructions on how the Enrollee may appoint an authorized representative to represent the Enrollee throughout the Grievance process;

f. Response, electronically, orally or in writing, as required by 42 CFR 422.630(e)(1) to each Enrollee Grievance within a reasonable time, but no later than thirty (30) days after Contractor receives the Grievance;

g. Expedited response, orally or in writing, within twenty-four (24) hours after Contractor receives the Grievance to each Enrollee Grievance whenever Contractor extends the Appeals timeframe (see 42 CFR 422.630(d) and *Section 1.2.19.k.f Enrollee Access to Services*) or Contractor refuses to grant a request for an expedited Appeal; and

h. Availability to Enrollees of information about Enrollee Grievances and Appeals, including reasonable assistance in completing any forms or other procedural steps, which shall include interpreter services and toll-free numbers with TTY and interpreter capability.

i. Ensure that decision makers on Grievances were not involved in previous levels of review or decision-making and are health care

professionals with clinical expertise in treating the enrollee's condition or disease if any of the following apply:

i. A Grievance regarding denial of expedited resolutions of an Appeal.

ii. Any Grievance involving clinical issues.

1.2.24 *Integrated/Unified Non-Part D Organization Determinations and Appeals*

A. Notice of Adverse Benefit Determination – In accordance with 42 CFR 422.631 and 438.404, Contractor must give the Enrollee written notice of any Adverse Benefit Determination by issuing a Coverage Decision Letter, using the template provided by CMS. Such notice shall be provided at least ten (10) days in advance of the date that the action will take effect in cases where previously approved items or services are being reduced, terminated, or suspended, in accordance with 42 CFR 422.631 and 438.404. Enrollees will be notified of all applicable Appeal rights through a single notice. An Enrollee, or a Provider or other authorized representative acting on behalf of an Enrollee and with the Enrollee's written consent, may Appeal Contractor's decision to deny, terminate, suspend, or reduce services. In accordance with 42 CFR 422.629(l) and 438.402, an Enrollee, authorized representative, or Provider acting on behalf of an Enrollee and with the Enrollee's consent may also Appeal Contractor's delay in providing or arranging for a Covered Service.

B. If Contractor denies payment for a service the Enrollee has received, the terms of the plan-provider agreement or, for Medicaid services, the provider dispute process under Illinois Public Act 101-0209 shall apply, along with the federal requirements at 42 CFR 422.629-634.

C. Level 1 Appeals

a. Process: All initial Appeal requests will be filed with Contractor in accordance with applicable laws and regulations (Level One Appeal).

b. An Enrollee may file an oral or written Appeal with Contractor within sixty-five (65) calendar days after receipt of the notice of Adverse Benefit Determination that generates such Appeal.

c. Contractor shall acknowledge receipt within five (5) business days of each Enrollee Appeal.

d. For Level One Appeals filed orally with Contractor, if the Enrollee does not request an expedited Appeal pursuant to 42 CFR 422.633(e), Contractor must send the Enrollee a written confirmation of the Enrollee's request to confirm the facts and basis of the Appeal. Contractor must send the confirmation of the Enrollee's oral request within five (5) business days after the receipt of the Appeal request.

e. An Enrollee may appoint any authorized representative including, but not limited to, a guardian, caregiver, relative, or Provider, to represent the Enrollee throughout the Appeal process. Contractor shall provide a form and instructions on how an Enrollee may appoint a representative.

f. Contractor shall consider the Enrollee, the Enrollee's authorized representative, or the representative of the Enrollee's estate as parties to the Appeal pursuant to 42 CFR 422.629(l). Contractor shall provide such parties a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. Contractor shall provide such parties, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination sufficiently in advance of the resolution timeframes.

D. Timeframes for Level 1 Appeal Resolution

a. Unless an Enrollee requests an expedited Appeal, for Level One Appeals other than for Part B drugs, Contractor shall render its decision on the Appeal within fourteen (14) Days from the date of receipt of the request of the Appeal and shall provide the Enrollee with written notice of the resolution pursuant to 42 CFR 422.633(f). Standard Appeals regarding Medicare Part B drugs will be resolved according to timeframes in 42 CFR 422.584(d)(1) and 422.590(c) and (e)(2)).For Level One Appeals other than for Part B drugs Contractor may extend this timeframe for up to fourteen (14) calendar days if the Enrollee or provider requests an extension or if Contractor is able to establish that the delay is in the interest of the Enrollee and Contractor desires additional information and/or documents and receipt of such information would lead to approval of the request, if received.

b. If Contractor extends this time frame not at the request of the Enrollee, Contractor must make reasonable efforts to give the Enrollee prompt oral notice of delay, and give the Enrollee written notice of the reason(s) for the extension as expeditiously as possible but no later than two (2) calendar days of making the decision to extend the timeframe and inform the Enrollee of the right to file an expedited integrated Grievance if the Enrollee disagrees with the delay and resolve the Appeal expeditiously, but no later than expiration date of extension.

c. Contractor shall comply with the timeline for standard Appeals regarding Medicare Part B drugs: Contractor shall render its decision on a standard Appeal regarding Medicare Part B drugs no later than seven (7) calendar days after submission of the Appeal according to 42 CFR 422.590(c). This timeline may not be extended.

d. If an Enrollee requests an expedited Appeal request, Contractor shall render a decision on an expedited Appeal request within twenty-four (24) hours after receipt of the expedited Appeal request information, unless there is an extension, in accordance with 42 CFR 422.633(f)(3). For expedited resolutions, Contractor shall provide written notice of an approved Appeal request. If the decision is a denial then Contractor shall provide written notice using the Appeal Decision Letter model notice provided by CMS., and shall make reasonable efforts to provide oral notice.

e. Contractor shall comply with the timeline for expedited Appeals regarding Medicare Part B drugs. Contractor shall render its decision on an Appeal regarding Medicare Part B drugs no later than twenty- four (24) hours after submission of the Appeal according to 42 CFR 422.590(e)(2). This timeline may not be extended.

f. Contractor shall also inform the Enrollee of the limited time available for the Enrollee to present evidence, and allegations of fact or law, in person as well as in writing.

E. If Contractor denies the Enrollee's request for an Expedited Appeal, it shall:

a. Transfer the Appeal to the appropriate timeframe for standard resolution of an Appeal and make the Appeal determination within fourteen (14) days of the expedited Appeal request;

b. Give the Enrollee prompt oral notice and deliver within two (2) calendar days written notice that:

i. Explains that the Appeal will be decided within the timeframe for a standard Appeal;

ii. Informs the Enrollee of the right to file an expedited integrated Grievance if the Enrollee disagrees with the decision not to grant an expedited Appeal;

iii. Informs the Enrollee of the right to resubmit a request for an expedited Appeal with any Physician's support; and

iv. Provides instructions about the Grievance process and its timeframes.

F. In a non-emergency situation, notwithstanding any provisions in State law to the contrary, in the event a NF Resident's Physician orders a service, treatment, or test that is not approved by Contractor, the Enrollee, or the Physician or other Provider acting on behalf of the Enrollee, may utilize a Level One expedited Appeal to Contractor, as defined in 42 CFR 422.633(f)(2).

G. Non-emergency situations not meeting the criteria for expedited Appeals set forth in 42 CFR 422.629 shall proceed as standard Appeals beyond Level One.

H. Contractor shall provide written notice to the Enrollee of the final decision of the Appeal, which shall comply with 42 CFR 422.633(f)(4) and include:

a. The determination of the Appeal;

b. Date of the Appeal determination;

c. Reasons for the determination;

d. Right to request and how to request a State Fair Hearing, if appropriate;

e. Right to continued benefits pending a State Fair Hearing, and how to request continued benefits, if appropriate; and

f. Notice that the Enrollee may be liable for the cost of any continued benefits if Contractor's action is upheld at the State Fair hearing.

g. If the appeal decision is a denial then Contractor shall provide written notice using the Appeal Decision Letter model notice provided by CMS.

I. If Contractor does not decide fully in the Enrollee's favor within the relevant timeframe or fails to meet the notice requirements Contractor shall automatically forward the case file regarding Medicare services to the IRE for a new and impartial review, per 42 CFR 422.634(a)(2).

J. Level 2 Appeals

a. If a Level One Appeal regarding Medicare services or Medicare/Medicaid overlap services is not decided fully in favor of the Enrollee, Contractor must auto-forward the standard Appeal to the IRE no later than 30 calendar days from when it received the appeal request and for expedited Appeals within 24 hours of its decision.

b. If the resolution of the IRE is not wholly in favor of the Enrollee, the Enrollee or authorized representative may then request further levels of Appeal, including for Medicaid benefits a State Fair Hearing, or for Medicare benefits Administrative Law Judge, a review by the Medicare Appeals Council, and judicial review.

c. Contractor must send a notice to the Enrollee informing them of their rights to file an Appeal with either: (i) the State Fair Hearing system; (ii) or Administrative Law Judge: (iii) or both in the case of Medicare/Medicaid overlap benefits, at the choice of the Enrollee.

d. Contractor must send the notice within three (3) Business Days after it receives the IRE's decision in all cases.

e. Contractor must comply with any requests for information or participation from such further Appeal entities.

f. Appeals involving Medicaid benefits not resolved wholly in favor of the Enrollee at Level 1 may be Appealed by the Enrollee to the State under its Fair Hearings system within one hundred twenty (120) calendar days after the date of Contractor's decision notice.

g. If an Appeal is filed with the State Fair Hearing system, Contractor will participate in the pre-hearing process, including scheduling coordination and submission of documentary evidence at least three (3) business days prior to the hearing, and shall participate in the hearing, including providing a witness to offer testimony supporting the decision of Contractor.

h. If an Appeal is filed with the State Fair Hearing system, the Department will take final administrative action for Standard Appeals within ninety (90) calendar days after the Enrollee filed the Appeal with Contractor, not including the number of days the Enrollee took to file for a State Fair Hearing, and final administrative action for Expedited Appeals must be taken within three (3) business days after the filing of an Appeal with the State Fair Hearing Agency. Contractor will participate in the pre-hearing process, including scheduling coordination and submission of documentary evidence at least three (3) business days prior to the hearing, and shall participate in the hearing, including providing a witness to offer testimony supporting the decision of Contractor.

i. Appeals involving Medicare/Medicaid overlap benefits not resolved wholly in favor of the Enrollee by the IRE may be Appealed by the Enrollee to the State under its Fair Hearings system within one hundred twenty (120) calendar days after the date of the IRE's decision notice.

j. For all Appeals except expedited Appeals regarding Medicare Part B drugs, if the IRE or State Fair Hearing decides in the Enrollee's favor and reverses Contractor's decision, Contractor must authorize the service under dispute as expeditiously as the Enrollee's health condition requires, but no later than seventy-two (72) hours from the date Contractor receives the notice reversing the decision. Generally, Contractor must provide the

services under dispute as expeditiously as the Enrollee's health condition requires, but no later than fourteen (14) calendar days from the date it receives notice that the IRE reversed the determination.

K. Subsequent Appeal Levels

a. If the Enrollee seeks review of the Administrative Law Judge's decision, the review of appeals related to Medicare benefits is the responsibility of the Medicare Appeals Council, followed by federal court, and the review of appeals related to Medicaid, pursuant to the State Administrative Review Law (735 ILCS 5/3-101 et seq.), is the responsibility of the State circuit court.

b. Any review of the final administrative action taken by the Department is the responsibility of State circuit court pursuant to the State Administrative Review Law (735 ILCS 5/3-101 et seq.).

c. Contractor must comply with any requests for information or participation from such further Appeal entities.

d. Any determination in favor of the Enrollee will require payment by Contractor for the service or item in question.

L. General Appeal Requirements

a. Contractor's Appeal procedures must: (i) be submitted to the Department in writing for Prior Approval by the Department; (ii) provide for resolution with the timeframes specified herein; and (iii) assure the participation of individuals with authority to require corrective action. Appeals procedures must be consistent with 42 CFR 422.629-634, 42 CFR 422.560 et seq., 42 CFR 431.200 et seq., and 42 CFR 438.400 et seq. Contractor must have a committee in place for reviewing Appeals made by Enrollees; and (iv) provide for only one level of Appeal by Enrollee

b. In compliance with 42 CFR 422.629(k) and 438.406(b), assure that the individuals who make decisions on Appeals were neither involved with a previous level of review nor were subordinates of any such individuals of review, and have appropriate clinical expertise to require corrective action for:

i. A denial of an Appeal based on a lack of medical necessity; or

ii. Any Appeal involving clinical issues.

c. Contractor shall not discriminate or take punitive action against a Provider who either requests an expedited resolution of Appeal or supports an Enrollee's Appeal pursuant to 42 CFR 438.410(b).

d. Except for a denial of HCBS Waiver services, which may not be reviewed by an external independent entity, Contractor shall have procedures allowing an Enrollee to request an external independent review, at no cost to the Enrollee, on both standard and expedited time frames, of Appeals for Medicaid covered items and services that are denied by Contractor, within thirty (30) calendar days after the date of Contractor's decision notice.

M. Continuation of Benefits Pending an Appeal

a. Consistent with the requirements of this section, Contractor must provide continuing benefits for all previously approved non-Part D benefits that are being terminated or modified pending Contractor's internal Appeal process. This means that such benefits will continue to be provided by Providers to Enrollees and that Contractors must continue to pay Providers for providing such services or benefits pending an internal Appeal.

b. Consistent with 42 CFR 422.632(c)(3), if an Enrollee files for continuation of benefits on or before the latter of ten (10) calendar days after Contractor sending the Adverse Benefit Determination, or the intended effective date of the proposed Adverse Benefit Determination, Contractor must continue the Enrollee's benefits during the Appeal process.

c. For Medicare-only benefits, continuation of benefits is available only for internal (level 1) Appeals and not at the IRE or subsequent levels of Appeal.

d. Pursuant to 42 CFR 422.632(d), if the final resolution of the Appeal is adverse to the Enrollee, Contractor may recover the cost of the continuation of benefits during the state fair hearing

stage if the enrollee requests continuation of benefits after the plan has issued its integrated reconsideration decision. If Contractor or the State Fair Hearing Officer reverses a decision to deny, limit or delay Covered Services, and those services were not furnished while the Appeal was pending, Contractor must authorize or provide the disputed services as expeditiously as the Enrollee's health condition requires. If Contractor or the State Hearing Officer reverses a decision to deny authorization of Covered Services, and the Enrollee received the disputed services while the Appeal was pending, Contractor must pay for those services in accordance with State rules and policy.

N. Effectuation of decisions.

a. If Contractor or the State Fair Hearing Officer reverses a decision to deny, limit or delay Covered Services, and those services were not furnished while the Appeal was pending, Contractor must authorize or provide the disputed services as expeditiously as the Enrollee's health condition requires, but no later than seventy-two (72) hours from the date Contractor receives notice reversing the decision.

b. If Contractor or the State Hearing Officer reverses a decision to deny authorization of Covered Services, and the Enrollee received the disputed services while the Appeal was pending, Contractor must pay for those services in accordance with State policy and regulations.

O. Part D Appeals.

a. Contractor shall utilize and all Enrollees may access the existing Part D Appeals Process described at 42 CFR 423, subpart M. Consistent with existing rules, Part D Appeals will be automatically forwarded to the Independent Review Entity (IRE) if Contractor misses the applicable adjudication timeframe. The IRE is contracted by CMS.

b. Contractor must maintain written records of all Appeal activities and notify CMS and the Department of all internal Appeals.

1.2.25 ***Hospital Discharge Appeals***. Contractor must comply with the hospital discharge Appeal requirements at 42 CFR 422.620 and 422.622.

1.2.26 *Other Medicare Quality Improvement Organization (QIO) Appeals*. Contractor must comply with the termination of services Appeal requirements for individuals receiving services from a comprehensive outpatient rehabilitation facility, SNF, or home health agency at 42 CFR 422.624 and 422.626.

1.2.27 *Quality Assurance Program*

A. Contractor shall meet accreditation requirements, pursuant to 305 ILCS 5/5-30 (a) and (h), any MCO serving at least five thousand (5,000) seniors, or people with disabilities, or fifteen thousand (15,000) individuals in other populations covered by the Accreditation Requirements. Pursuant to 305 ILCS 5/5-30 (a) and (h), any MCO serving at least five thousand (5,000) seniors, or, people with disabilities, or, fifteen thousand (15,000) individuals in other populations covered by the Medical Assistance Program that have been receiving full-risk Capitation for at least one (1) year are considered eligible for accreditation and shall be accredited by the NCQA within two (2) years after the date it was eligible for accreditation. Contractor's failure to achieve accreditation may result in the termination of the Contract.

a. Upon completion of each annual accreditation survey, Contractor must immediately authorize the NCQA to submit directly to the Department a copy of the final accreditation survey. Thereafter and on an annual basis between accreditation surveys, Contractor must submit a copy of the accreditation summary report issued as a result of the annual HEDIS® update, including status, survey type and level; any recommendation for actions or improvements; any corrective action plans; summaries of findings; and the expiration date of the accreditation, to the Department no later than ten (10) days after receipt from NCQA. Upon the Department's request, Contractor must provide all documents related to achieving accreditation. The Department will thereafter annually review Contractor's accreditation status as of September 15 of each year.

b. Medical Assistance Program that have been receiving full-risk Capitation for at least one (1) year are considered eligible for accreditation and shall be accredited by the NCQA within two (2) years after the date it was eligible for accreditation. Contractor's failure to achieve accreditation may result in the termination of the Contract.

B. Contractor shall maintain a well-defined QA organizational and program structure that supports the application of the principles of Continuous Quality Improvement (CQI) to all aspects of Contractor's service delivery system.

C. Contractor shall ensure the QA program is communicated in a manner that is accessible and understandable to internal and external individuals and entities, as appropriate.

D. Contractor's QA organizational and program structure shall comply with all applicable provisions of 42 CFR 438, including Subpart E, Quality Assessment and Performance Improvement, 42 CFR 422, Subpart D Quality Improvement, and shall meet the quality management and improvement criteria described in the most current NCQA Health Plan Accreditation Requirements.

E. Contractor shall establish procedures such that Contractor shall be able to demonstrate that it meets the requirements of the HMO Federal qualification regulations (42 CFR 417.106), the Medicare HMO/CMP regulations (42 CFR 417.418(c)), and the regulations promulgated pursuant to the Balanced Budget Act of 1997 (42 CFR 438.200 et seq.). These regulations require that Contractor have an ongoing fully implemented Quality Assurance Program for health services that:

a. Incorporates widely accepted practice guidelines that meet nationally recognized standards and the criteria referenced above, and are distributed to Network Providers, as appropriate, and to Enrollees and Potential Enrollees, upon request, and:

i. Are based on valid and reliable clinical evidence;

ii. Consider the needs of Enrollees, including assessing the quality and appropriateness of care furnished to Enrollees with special needs;

iii. Consider the comprehensive medical and social needs of Enrollees;

iv. Are adopted in consultation with Network Providers; and

v. Are reviewed and updated periodically as appropriate.

b. Monitors the health care services Contractor provides, including assessing the appropriateness and quality of care;

c. Stresses health outcomes and preventative care and monitors Enrollee risks status and improvement in health outcomes;

d. Provides a comprehensive program of care coordination, Care Management, and Disease Management, with needed outreach to assure appropriate care utilization and community referrals;

e. Describes its use of Care Coordination Claims Data (CCCD) files for risk stratification, risk management, Care Coordination, and Case Management of Enrollees or other uses;

f. Provides review by Physicians and other health professionals of the process followed in the provision of health services;

g. Includes fraud control provisions;

h. Establishes and monitors access standards;

i. In accordance with 42 CFR 422.1.5.2., incorporates one or more activities that reduces disparities in health and health care. These activities must be broadly accessible irrespective of race, ethnicity, national origin, religion, sex, or gender. These activities may be based upon health status and health needs, geography, or factors not listed in the previous sentence only as appropriate to address the relevant disparities in health and health care.

j. Uses systematic data collection of performance and Enrollee results, provides interpretation of these data to its Network Providers- (including, without limitation, Enrollee-specific and aggregate data provided by the Department) which may include HEDIS®, core set(s), and state defined measure and institutes needed changes based on data;

k. Includes a health information system to collect, analyze, and report quality performance data as described in 42 CFR422.516(a), 423.514, and 438.242(a) and (b).

l. Includes written procedures for taking appropriate remedial action and developing corrective action and quality improvement whenever, as determined under the Quality Assurance Program,

inappropriate or substandard services have been furnished or there was a delay in providing, or a failure to provide, Covered Services that should have been provided;

m. Describes its implementation process for reducing unnecessary emergency room utilization, inpatient services, including thirty (30)-day readmissions;

n. Describes its process for obtaining clinical results, findings, including emergency room and inpatient care, pharmacy information, lab results, feedback from other care Providers, etc., to provide such data and information to the PCP, specialist, Care Coordinator, or others, as determined appropriate, on a real-time basis;

o. Describes its process to assure follow up services after inpatient care for behavioral health, with a behavioral health Provider, follow up after inpatient medical care, including delivery care,

p. Describe its process to assure women have access to contraception and postpartum care, with a PCP or specialist, or follow up following an emergency room visit.

q. Details its processes for establishing patient-centered medical homes and the coordination between the PCP and behavioral health Provider, specialists and PCP, or specialists and behavioral health Providers;

r. Details its processes for determining and facilitating Enrollees needing nursing home, SLF or ICF level of care, or to live in the community with HCBS supports;

s. Describes its processes for addressing Abuse and Neglect and Critical incidents in the community setting;

t. Details its compensation structure, incentives, pay-for-performance programs, value purchasing strategies, and other mechanisms utilized to promote the goals of medical homes and accountable, integrated care;

u. Describes its health education procedures and materials for Enrollees; processes for training, monitoring, and holding Providers accountable for health education; and oversight of

Provider requirements to coordinate care and provide health education topics (e.g., perinatal care, obesity, heart smart activities, mental health, and substance abuse resources) and outreach documents (e.g., about chronic conditions) using evidence-based guidelines and best practice strategies;

v. Provides for systematic activities to monitor and evaluate the dental services rendered.

w. Applies the principles of CQI to all aspects of Contractor's service delivery system through ongoing analysis, evaluation and systematic enhancements based on:

i. Quantitative and qualitative data collection, data analysis and data-driven decision-making;

ii. Up-to-date evidence-based practice guidelines and explicit criteria developed by recognized sources or appropriately certified professionals or, where evidence-based practice guidelines do not exist, consensus of professionals in the field;

iii. Feedback provided by Enrollees and Providers in the design, planning, and implementation of its CQI activities; and

iv. Issues identified by Contractor, the Department; and

v. Ensure that the quality improvement (QI) requirements of this Contract are applied to the delivery of primary and specialty health care services, behavioral health Services and LTSS.

F. Contractor shall provide the Department a written description of its **Quality Assurance Plan (**QAP) for the provision of clinical services (e.g., medical, medically related services, care coordination, Care Management, Disease Management, and behavioral health services). This written description must meet federal and State requirements as outlined below:

a. Goals and objectives — The written description shall contain a detailed set of QA objectives that are developed annually and include a workplan and timetable for implementation and

accomplishment. The annual workplan shall include the following components or other components as directed by the Department:

i. Planned clinical and non-clinical initiatives;

ii. The objectives for planned clinical and non-clinical initiatives using specific, measurable, achievable, realistic and time-limited (SMART) taxonomy;

iii. The short and long term time frames within which each clinical and non-clinical initiative's objectives are to be achieved;

iv. The individual(s) responsible for each clinical and non-clinical initiative;

v. Any issues identified by Contractor, the Department, , Enrollees, or Providers, and how those issues are tracked and resolved over time;

vi. Program review process for formal evaluations that address the impact and effectiveness of clinical and non-clinical initiatives at least annually; and

vii. Process for correcting deficiencies.

b. The scope of the QAP shall be comprehensive, addressing both the quality of clinical care and the quality of non-clinical aspects of service, such as and including availability, accessibility, coordination, and continuity of care. The scope of the QAP should include activities for primary, specialty, and behavioral health services, and LTSS that reflect utilization across the network and include all the activities in this section and, in addition, the following elements:

i. A process to utilize HEDIS®, Consumer Assessment of Healthcare Providers and Services (CAHPS), Illinois specific measures as applicable, and other measurement results in designing QI activities;

ii. A medical record review process for monitoring Provider Network compliance with policies and procedures,

specifications, and appropriateness of care. Such process shall include the sampling method used which shall be proportionate to utilization by service type. Contractor shall submit its process for medical record reviews and the results of its medical record reviews to the Department;

iii. A process to measure Network Providers and Enrollees, at least annually, regarding their satisfaction with Contractor's Plan. Contractor shall submit a survey plan to the Department for Prior Approval and shall submit the results of the survey to the Department;

iv. A process to measure clinical reviewer consistency in applying Clinical Criteria to Utilization Management activities, using inter-rater reliability measures;

v. A process for including Enrollees and their families in Quality Management activities, as evidenced by participation in consumer advisory boards; and

vi. A process to assess the quality and appropriateness of care furnished to Enrollees using LTSS, including an assessment of care between settings and a comparison of services and supports received with those in the Enrollee's treatment/service plan.

vii. The QAP methodology shall provide for review of the entire range of care provided, by assuring that all demographic groups, care settings, (e.g., inpatient, ambulatory, and home care), and types of services (e.g., preventive, primary, specialty care, behavioral health, dental and ancillary services) are included in the scope of the review. Documentation of the monitoring and evaluation plan shall be provided to the Department.

viii. The written description shall specify quality of care studies and other activities to be undertaken over a prescribed time period, and methodologies and organizational arrangements to be used to accomplish them. Individuals responsible for the studies and other activities shall be clearly identified in the written work

plan and shall be appropriately skilled or trained to undertake such tasks. The written description shall provide for continuous performance measurement of the activities, including tracking of issues over time.

ix. The written description shall document how Physicians and other health professionals will be involved in reviewing quality of care and the provision of health services and how feedback to health professionals and Contractor staff regarding performance and Enrollee results will be provided.

x. The QAP methodology shall address health outcomes; a complete description of the methodology shall be fully documented and provided to the Department.

xi. The QAP shall objectively and systematically monitor and evaluate the quality, appropriateness of, and timely access to, care and service to Enrollees, and pursue opportunities for improvement on an ongoing basis. Documentation of the monitoring activities and evaluation plan shall be provided to the Department.

xii. The QAP shall detail its operational and management plan for including Enrollee and advocate input into its QAP processes.

G. Contractor shall provide the Department with the QAP written guidelines which delineate the QA process, specifying the following areas to be monitored:

a. The monitoring and evaluation of clinical care shall reflect the population served by Contractor in terms of age groups, race, ethnicity, disease categories, special risk status, and geographic region, and shall include quality improvement initiatives, as determined appropriate by Contractor or as required by the Department.

b. The QAP process shall, at a minimum, monitor and evaluate care and services in certain priority clinical areas of interest specified by the Department, based on the needs of Enrollees.

c. At its discretion or as required and the Department, Contractor's QAP process must monitor and evaluate other important aspects of care and service, including coordination with community resources.

d. At a minimum, the QAP process shall monitor for all populations the following areas:

i. Emergency room utilization.

ii. Inpatient hospitalization.

iii. Thirty (30)-day re-admission rate.

iv. Assistance to Enrollees accessing services outside the Covered Services, such as housing, social service agencies, senior center.

v. Health education provided.

vi. Coordination of primary and specialty care.

vii. Coordination of care, Care Management, Disease Management, and other activities.

viii. Individualized Enrollee IPoC.

ix. Access to dental benefits.

x. Preventive health care for adults (e.g., annual health history and physical exam; mammography; Papanicolaou test ("Pap test"), immunizations).

xi. Utilization of Family Planning services.

xii. PCP or behavioral health follow-up after emergency room or inpatient hospitalization.

xiii. Utilization of behavioral health benefits.

xiv. For Chronic Health Conditions (such conditions specifically including, without limitation, diabetes, asthma, congestive heart failure (CHF), coronary artery disease (CAD), chronic obstructive pulmonary disease

(COPD), behavioral health, including those with one or more co-morbidities) and appropriate treatment, follow-up care, and coordination of care, Care Management and Disease Management for all Enrollees.

xv. Identification of Enrollees with special health care needs and processes in place to assure adequate, ongoing risk assessments, treatment plans developed with the Enrollee's participation in consultation with any specialists caring for the Enrollee, to the extent possible, the appropriateness and quality of care, and if approval is required, such approval occurs in a timely manner.

xvi. Implementation of Care coordination, Care Management, Disease Management action plans.

e. The QAP process shall develop and monitor the implementation of Chronic Health Conditions improvement program. Criteria for the program must include:

i. Methods for identifying Enrollees with multiple or sufficiently severe chronic conditions that would benefit from participating in a chronic care improvement program.

ii. Mechanisms for monitoring Enrollees that are participating in the chronic improvement program and evaluating participant outcomes such as changes in health status.

iii. Performance assessments that use quality indicators that are objective, clearly and unambiguously defined, and based on current clinical knowledge or research.

iv. Systematic and ongoing follow-up on the effect of the program.

f. Additionally, the QAP process shall monitor at a minimum, for behavioral health the following areas:

i. Behavioral health network adequate to serve the behavioral health care needs of Enrollees, including mental health and substance abuse services sufficient to

provide care within the community in which the Enrollee resides.

ii. Assistance sufficient to access behavioral health services, including transportation and escort services.

iii. Enrollee access to timely behavioral health services.

iv. An Enrollee IPoC or treatment and provision of appropriate level of care.

v. Coordination of care between Providers of medical and behavioral health services to assure follow-up and continuity of care.

vi. Involvement of the PCP in aftercare.

vii. Enrollee satisfaction with access to and quality of behavioral health services.

viii. Mental health outpatient and inpatient utilization and follow up.

ix. Chemical dependency outpatient and inpatient utilization and follow up.

g. Additionally, the QAP process shall monitor at a minimum for pregnant women the following areas:

i. Assistance sufficient to access prenatal care services, including transportation services.

ii. Timeliness and frequency of prenatal visits.

iii. Provision of the Illinois Prenatal Care Quality Tool developed by the Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Act, and Referral and consultation recommendations for high-risk women based on the American Congress of Obstetricians and Gynecologists (ACOG) and the Illinois Perinatal Code.

iv. Development of reproductive life plans.

v. Birth outcomes and birth intervals

vi. Referral to the Perinatal Centers, as appropriate.

vii. Length of hospitalization for the mother.

viii. Length of newborn hospital stay for the infant.

ix. Assist the Enrollee in finding an appropriate PCP for the infant.

x. Recommended prenatal screening tests.

h. Additionally, the QAP process shall monitor at a minimum, for Enrollees in NFs and Enrollees receiving HCBS Waiver services the following areas:

i. Maintenance in, or movement to, community living.

ii. Number of hospitalizations and length of hospital stay.

iii. Falls resulting in hospitalizations.

iv. Behavior resulting in injury to self or others.

v. Enrollee non-compliance of services.

vi. Medical errors resulting in hospitalizations.

vii. Occurrences of pressure ulcers, weight loss, and infections.

H. Contractor shall utilize Quality Indicators (QI) as provided in this Contract, as well as other quality measures identified by Contractor, that are objective, measurable, and based on current knowledge and clinical experience.

I. Contractor shall document that methods and frequency of data collected are appropriate and sufficient to detect the need for a program change.

J. Contractor shall monitor priority clinical areas specified by the Department and evaluate quality of care through studies which address, but are not limited to, the quality indicators also specified by the Department.

K. Contractor shall ensure performance Improvement Projects (PIPs)/Quality Improvement Projects (QIPs). PIPs/QIPs (42 CFR 438.330) shall be 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 outcome and Enrollee satisfaction. Performance measurements and interventions shall be submitted to the Department annually as part of the QA/UR/PR Annual Report and at other times throughout the year upon request by the Department. If Contractor implements a PIP/QIP that spans more than one (1) year, Contractor shall report annually the status of such project and the results thus far. The PIPs/QIPs topics and methodology shall be submitted to the Department for Prior Approval.

L. Contractor shall ensure appropriate clinicians shall monitor and evaluate quality through review of individual cases (including behavioral health, Long-Term Care and HCBS Waiver services) where there are questions about care, and through studies analyzing patterns of clinical care and related service. This shall include:

a. Use of Multi-disciplinary teams where indicated, to analyze and address delivery systems issues.

b. Identification and documentation of clinical and related service areas requiring improvement and a corrective action plan shall be developed and monitored.

M. Contractor shall ensure implementation of remedial or corrective actions. The QAP shall include written procedures for taking appropriate remedial action whenever, as determined under the QAP, inappropriate or substandard services are furnished, including in behavioral health, or services that should have been furnished were not. QA actions that result in remedial or corrective actions shall be forwarded by Contractor to the Department on a timely basis. Written remedial or corrective action procedures shall include:

a. Specification of the types of problems requiring remedial or corrective action;

b. Specification of the person(s) or entity responsible for making the final determinations regarding quality problems;

c. Specific actions to be taken;

d. A provision for feedback to appropriate health professionals, Providers and staff;

e. The schedule and accountability for implementing corrective actions;

f. The approach to modifying the corrective action if improvements do not occur; and

g. Procedures for notifying a PCP group that a particular Physician is no longer eligible to provide services to Enrollees.

N. Contractor shall monitor and evaluate corrective actions taken to assure that appropriate changes have been made. Contractor shall ensure follow-up on identified issues to ensure that actions for improvement have been effective and provide documentation of the same.

O. Contractor shall evaluate Effectiveness of the QAP, including:

a. Evaluation of Continuity and effectiveness of the QAP. At least annually, Contractor shall conduct a regular examination of the scope and content of the QAP (42 CFR 438.330 (c)(i), (ii), and (iii)) to ensure that it covers all types of services, including behavioral health services, in all settings, through an Executive Summary and Overview of the Quality Improvement Program, including QA, Utilization Review (UR) and Peer Review (PR).

b. QAP Report. At the end of each year, a written report on the QAP shall be prepared by Contractor and submitted to the Department as a component part of the QA/UR/PR Annual Report. The report shall include an Executive Summary that provides a high-level discussion/analysis of each area of the Annual Report of findings, accomplishments, barriers and continued need for quality improvement. The report shall, at a minimum, provide detailed analysis of each of the following:

i. QA/UR/PR Plan with overview of goal areas;

ii. Major Initiatives to comply with the Department's Quality Assessment and Performance Improvement Strategy;

iii. Quality Improvement and work plan monitoring;

iv. Provider Network Access and Availability and Service Improvements, including access, utilization of dental services, and Provider satisfaction;

v. Cultural Competency;

vi. Equity and reducing disparities

vii. Fraud and Abuse Monitoring;

viii. Population Profile;

ix. Improvements in Care Management and Clinical Services/Programs;

x. Findings on Initiatives and Quality Reviews;

xi. Effectiveness of Quality Program Structure;

xii. Comprehensive Quality Improvement Work Plans;

xiii. Chronic Conditions;

xiv. Behavioral health (includes mental health and substance abuse services);

xv. Discussion of Health Education Program;

xvi. Member Satisfaction;

xvii. Enrollee Safety;

xviii. Fraud, Waste and Abuse and Privacy and Security;

xix. Delegation; and

xx. ADA Compliance/Monitoring.

P. Contractor shall have a QAP Committee. Contractor shall have a governing body to which the QA Committee shall be held accountable ("Governing Body"). The Governing Body of Contractor shall be the Board of Directors or, where the Board's participation with quality improvement issues is not direct, a designated committee of the senior management of Contractor. This Board of Directors or Governing Body

shall be ultimately responsible for the execution of the QAP. However, changes to the medical Quality Assurance Program shall be made by the chair of the QA Committee. Responsibilities of the Governing Body include:

a. Oversight of QAP. Contractor shall document through meeting minutes that the Governing Body has approved the overall Quality Assurance Program and an annual QAP.

b. Oversight entity. The Governing Body shall document that it has formally designated an accountable entity or entities within the organization to provide oversight of QA or has formally decided to provide such oversight as a committee of the whole.

c. QAP progress reports. The Governing Body shall routinely receive written reports from the QAP Committee describing actions taken, progress in meeting QA objectives, and improvements made.

d. Annual QAP review. The Governing Body shall formally review on a periodic basis (but no less frequently than annually) a written report on the QAP which includes studies undertaken, results, subsequent actions, and aggregate data on utilization and quantity of services rendered, to assess the QAP's continuity, effectiveness, and current acceptability. Behavioral health shall be included in the Annual QAP Review.

e. Program modification. Upon receipt of regular written reports from the QAP Committee delineating actions taken and improvements made, the Governing Body shall act when appropriate and direct that the operational QAP be modified on an ongoing basis to accommodate review findings and issues of concern within Contractor. This activity shall be documented in the minutes of the meetings of the Governing Board in sufficient detail to demonstrate that it has directed and followed up on necessary actions pertaining to QA.

Q. Contractor shall ensure the QAP delineates an identifiable structure responsible for performing QA functions. Contractor shall describe its committees' structure in its QAP and shall be submitted to the Department for approval. This committee or committees (Consumer

Advisory Committee and Community Stakeholder Committee) and other structure(s) shall have:

a. Regular Meetings. The QAP Committee shall meet on a regular basis with specified frequency to oversee QAP activities. This frequency shall be sufficient to demonstrate that the structure/committee is following up on all findings and required actions, but in no case shall such meetings be held less frequently than quarterly. A copy of the minutes shall be submitted to the Department as needed, and within ten (10) business days after the Department's request.

b. The role, structure, and function of the QAP Committee specified.

c. Documentation. Minutes kept documenting the QAP Committee's activities, findings, recommendations, and actions.

d. The QAP committee shall be accountable to the Governing Body and report to it on a scheduled basis on activities, findings, recommendations, and actions.

e. Membership. Meaningful participation in the QAP Committee by the Medical Director, practicing Physicians, senior leadership, and other appropriate personnel.

f. Enrollee advisory and community stakeholder committee. Feedback provided to the QAP by the Consumer Advisory Committee and Community Stakeholder Committee on the Plan's performance from Enrollee and community perspectives that meet at least quarterly throughout the D-SNP. These committees shall recommend program enhancements based on Enrollee and community needs; review Provider and Enrollee satisfaction survey results; evaluate performance levels and telephone response timelines; evaluate access and Provider feedback on issues requested by the QAP Committee; identify key program issues; such as racial or ethnic disparities, that may impact community groups; and offer guidance on reviewing Enrollee materials and effective approaches for reaching enrollees. The Consumer Advisory Committee will be comprised of randomly selected Enrollees, family members and other caregivers that reflect the diversity of the D-SNP population. The Community Stakeholder Committee will be comprised of local

representatives from key community stakeholders such as churches, advocacy groups, and other community-based organizations. Contractor will educate Enrollees and community stakeholders about these committees through materials such as handbooks, newsletters, websites, and communication events.

R. Contractor's Medical Director shall have substantial involvement in QA activities.

S. Contractor shall ensure the QAP has sufficient QA material resources, and staff with the necessary education, experience, and training, to effectively carry out its specified activities.

T. Provider Participation in the QAP:

a. Network Physicians and other Network Providers shall be kept informed about the written QAP.

b. Contractor shall include in all agreements with Network Provider and Subcontractors a requirement securing cooperation with the QAP.

c. Contracts shall specify that Network Providers and Subcontractors will allow access to the medical records of its Enrollees to Contractor and the Department.

U. Contractor shall remain accountable for all QAP functions, even if certain functions are delegated to other entities. If Contractor delegates any QA activities to subcontractors:

a. There shall be a written description of the following: the delegated activities; the subcontractor's accountability for these activities; and the frequency of reporting to Contractor.

b. Contractor shall have written procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the actual quality of care being provided.

c. Contractor shall be held accountable for subcontractor's performance and must assure that all activities conform to this Contract's requirements.

d. There shall be evidence of continuous and ongoing evaluation and oversight of delegated activities, including approval of quality improvement plans and regular specified reports, as well as a formal review of such activities. Oversight of delegated activities shall include:

i. No less than an annual audit.

ii. Analyses of required reports and Encounter Data.

iii. A review of Enrollee Complaints, Grievances

iv. Provider Complaints and Appeals, and quality of care concerns raised through Encounter Data, monitoring activities, or other venues.

v. Outcomes of the annual audit shall be submitted to and the Department as part of the Quality Assurance (QA), Utilization Review (UR), and Peer Review (PR)Annual Report.

e. Contractor shall be responsible for, directly or through monitoring of delegated activities, credentialing, and re-credentialing, and shall review such credentialing files performed by the delegated entity no less than annually, as part of the annual audit.

f. If Contractor identifies, or is informed of, areas requiring improvement, Contractor, shall take corrective action and implement a quality improvement initiative. If one or more deficiencies are identified, the Contractor must develop and implement a corrective action plan, with protections put in place by Contractor to prevent such deficiencies from reoccurring. Evidence of ongoing monitoring of the delegated activities sufficient to assure corrective action shall be provided to the Department through quarterly or annual reporting.

V. Contractor shall comply with Network Provider Credentialing. The QAP shall contain provisions to assure that Network Physicians and other Network Providers, are qualified to perform their services and are credentialed by Contractor. Recredentialing shall occur at least once

every three (3) years. Contractor's written policies shall include procedures for selection and retention of Physicians and other Providers.

W. Contractor shall comply with service compliance with Department policy and community standards. All services provided by or arranged to be provided by Contractor shall be in accordance with Department policies and clinical practice guidelines based on established evidence-based best practice standards of care, promulgated by leading academic and national clinical organizations, or as otherwise required by the Department, and shall be adopted by Contractor's QAP Committee with sources referenced and guidelines documented in Contractor's QAP.

X. Contractor's QAP shall be updated no less than annually and when new significant findings or major advancements in evidence-based best practices and standards of care are established.

Y. Contractor shall provide ongoing education to Network Providers on required clinical guideline application and provide ongoing monitoring to assure that its Network Providers are utilizing them. At a minimum, clinical practice guidelines and best practice standards of care shall be included by Contractor for the following conditions and services:

a. Asthma;

b. Congestive Heart Failure (CHF);

c. Coronary Artery Disease (CAD);

d. Chronic Obstructive Pulmonary Disease (COPD);

e. Diabetes;

f. Adult Preventive Care;

g. Prenatal, Postpartum reproductive healthcare.

h. Smoking Cessation;

i. Behavioral health (mental health and substance abuse) screening, assessment, and treatment, including medication management and PCP follow-up;

j. Psychotropic medication management;

k. Clinical Pharmacy Medication Review and pharmacy services;

l. Coordination of community support and services for Enrollees in HCBS Waivers;

m. Community reintegration and support; and

n. Long-term Care (LTC) residential coordination of services.

o. Other conditions and services as deemed by Contractor and/or the Department.

Z. Contractor shall have a process to promote continuity of Care Management. Contractor shall provide documentation on:

a. Monitoring the quality of care across all services and all treatment modalities and transitions of care; and

b. Studies, reports, protocols, standards, worksheets, minutes, or such other documentation as may be appropriate, concerning its QA activities and corrective actions and make such documentation available to the Department upon request.

AA. Contractor shall comply with QA Activity Documentation. The findings, conclusions, recommendations, actions taken, and results of the actions taken because of QA activity, shall be documented, and reported to appropriate individuals within the organization and through the established QA channels. Contractor shall document coordination of QA activities and other management activities including:

a. QA information shall be used in recredentialing, re-contracting, and annual performance evaluations.

b. QA activities shall be coordinated with other performance monitoring activities, including utilization management, risk management, and resolution and monitoring of Enrollee Complaints and Grievances.

c. There shall be documented evidence that management decisions of Contractor are reflective of QA activities and findings in the following areas:

i. Network changes;

ii. Benefits redesign;

iii. Medical management systems (e.g., pre-certification);

iv. Practice feedback to and from Physicians;

v. Other services, such as dental, vision, etc.;

vi. Member services;

vii. Care Management and Disease Management; and

viii. Enrollee education.

d. In the aggregate, without reference to individual Physicians or Enrollee identifying information, all QA findings, conclusions, recommendations, actions taken, results or other documentation relative to QA shall be reported to the Department on a quarterly basis or as requested by the Department. The Department shall be notified of any Medicaid Provider who ceases to be a Medicaid Network Provider for a quality-of-care issue.

BB. Contractor shall, at the direction of the Department, cooperate with the external, independent quality review process conducted at least annually by the External Quality Review Organization (EQRO). Such review process shall include, at a minimum, reviews of the quality outcomes, timeliness of, and access to, Covered Services. Contractor shall address the findings of the external review through its QA Program by developing and implementing performance improvement goals, objectives, and activities, which shall be documented in the next quarterly report submitted by Contractor following the EQRO's findings.

CC. Contractor's QA Program shall systematically and routinely collect data to be reviewed for quality oversight, monitoring of performance, and Enrollee care outcomes. The QA Program shall include provision for the interpretation and dissemination of such data to Contractor's Network Providers.

DD. The QA Program shall be designed to perform quantitative and qualitative analytical activities to assess opportunities to improve efficiency, effectiveness, appropriate health care utilization, and Enrollee health status, per 42 CFR 438.242 (b)(2).

EE. Contractor shall ensure that data received from Providers and included in reports are accurate and complete by:

a. verifying the accuracy and timeliness of reported data;

b. screening the data for completeness, logic, and consistency; and

c. collecting service information in standardized formats to the extent feasible and appropriate.

FF. Contractor shall have in effect a program consistent with the utilization control requirements of 42 CFR Part 456. This program will include, when required by the regulations, written plans of care and certifications of need of care.

GG. Performance Measures.

a. Contractor shall perform and report the quality and utilization measures required by the Department as described in this Contract and shall include, but are not limited to:

i. All HEDIS® and CAHPS data as articulated in the annual Reporting Requirements for HEDIS® and CAHPS data;

ii. All HCBS Waiver Performance Measures required by the Department, in accordance with the guidance provided by the Department.

b. Contractor shall perform and report the HCBS Waiver Performance Measures as required by the Department. Contractor shall not modify the reporting specifications methodology prescribed the Department without first obtaining the Department's written approval.

c. Contractor shall not modify the reporting specifications methodology prescribed by the Department without first obtaining the Department's written approval. Contractor must obtain an independent validation of its findings by a recognized entity, e.g., NCQA-certified auditor, as approved by the Department. The Department's External Quality Review Organization will perform an independent validation of at least a sample of Contractor's findings.

d. Contractor shall monitor other performance measures not specifically stated in this Contract that are required by CMS.

e. Contractor shall collect data and contribute to all D-SNP QI-related processes, as directed by the Department, as follows:

i. Collect and submit to the Department, at the specified frequency, data for the quality measures as required by this contract;

ii. Contribute to all applicable Department and data QA processes, which shall include, but not be limited to, responding, in a timely manner, to data quality inadequacies identified by the Department and rectifying those inadequacies, as directed by the Department;

iii. Contribute to the Department data regarding the individual and aggregate performance of Illinois Medicaid contracted plans with respect to the noted measures; and

iv. Contribute to the Department processes culminating in the publication of any additional technical or other reports by the Department related to the noted measures.

f. Contractor shall demonstrate how it will utilize results of the measures referenced in this section in designing QI initiatives.

HH. Contractor shall conduct Enrollee experience survey activities, as directed by the Department, disclose the survey results to the Department, and disclose the survey results to Enrollees upon request, as follows:

a. Conduct, as directed by the Department an annual CAHPS survey, including the Persons with Mobility Impairment Supplemental Questions, using an approved CAHPS vendor;

b. Conduct, as directed by the Department, a questionnaire at each annual reassessment to determine the Enrollee's perception of their quality of life using a format of Contractor's choice unless instructed differently by the Department for Enrollees in the Elderly Waiver (Community Care Program (CCP))

HCBS Waiver. This shall require that individuals conducting such survey are trained, on the population being surveyed including cultural competence applicable to the population. Contractor shall administer questions at each annual reassessment to determine the Enrollee's perception of their quality of life using a questionnaire format of Contractor's choice. In the event an Enrollee reports a negative perception of their quality of life, Contractor's Care Coordinator shall document steps taken and interventions implemented to assist the Enrollee in attaining an improved perception of quality of life;

c. Contribute, as directed by the Department, to data QA processes, including responding, in a timely manner, to data quality inadequacies identified by the Department and rectifying those inadequacies, as directed by the Department;

d. Administer the DHS-DRS Personal Assistant Evaluation to each DHS-DRS HCBS Waiver Enrollee (Persons with Disabilities HCBS Waiver, Persons with Brain Injury HCBS Waiver, and Persons with HIV/AIDS HCBS Waiver) at each annual reassessment to determine each Enrollee's satisfaction and evaluation of their Individual Provider. Contractor's Care Coordinators must follow-up on non-favorable evaluations with Enrollees to identify areas of improvement; and

e. Utilize member experience survey results in designing QI initiatives.

II. Contractor shall implement and adhere to all processes relating to the Quality Improvement Project (QIP) Requirements, as directed by the Department, as follows:

a. In accordance with 42 CFR 438.330(d), measure data using objective quality indicators; and collect information and data in accordance with QIP requirement specifications for its Enrollees; using the format and submission guidelines specified by the Department in annual guidance provided for the upcoming contract year;

b. Implement the QIP requirements, including consideration of cultural competence needs, to achieve objectives of this section;

c. Evaluate the effectiveness of quality improvement interventions;

d. Plan and initiate processes to sustain achievements and continue improvements;

e. Submit to the Department, comprehensive written reports, using the format, submission guidelines and frequency specified by the Department. Such reports shall include information regarding progress on QIP goals and objectives, barriers encountered, and new knowledge gained. Contractor shall present this information to the Department at the end of the QIP project cycle or as directed.

f. In accordance with 42 CFR 422.152 (c), develop a chronic care improvement program (CCIP) and establish criteria for participation in the program. The CCIP must be relevant to and target Contractor's plan population. Although Contractor has the flexibility to choose the design of their CCIPs, the Department may require them to address specific topics.

g. Participate in efforts by the State to prevent, detect, and remediate critical incidents (consistent with assuring beneficiary health and welfare pursuant to 42 CFR 441.302 and 441.730(a)) that are based, at a minimum, on the requirements on the State for HCBS Waiver programs under 42 CFR 441.302(h).

JJ. Contractor shall assess the risks from external and internal sources to identify and analyze the relevant risks to the achievement of objectives. A mechanism shall be employed to identify and evaluate key exposures or vulnerabilities and establish plans for mitigating overall risks to the Enrollee, the Department, and Contractor.

KK. Contractor is responsible for conducting (at least annually) a risk assessment of events that occur or could occur that impact the vulnerability of the Enrollee, the Department, and Contractor. The impact of the risk shall be measurable or definable. Definable terms are measurable common measurement units (e.g., dollars, ratios in areas of health and safety).

a. The risk assessment shall include input from staff throughout Contractor's organization seeking input given the objectives about processes, resources, and solutions.

b. Contractor's Quality Assurance Program shall list how the impact can best be measured and a description of the controls in place to manage risk and the effectiveness of those controls.

c. Contractor's Quality Assurance Program shall perform and report the risk assessment outcomes and improvement in the committee minutes.

LL. Contractor shall comply with External Quality Review (EQR) activities and take all steps necessary to support the EQRO contracted by the Department and the QIO to conduct EQR Activities, in accordance with 42 CFR 438.358 and 42 CFR 422.153. EQR Activities shall include, but are not limited to:

a. Annual validation of Performance Measures reported to the Department, as directed by Department, or calculated by Department.

b. Annual validation of performance improvement projects required by Department and

c. At least once every three years, review of compliance with standards mandated by 42 CFR Part 438, Subpart E, and at the direction of Department, regarding access, structure and operations, and quality of care and services furnished to Enrollees.

d. Supporting the EQRO and QIO in conducting EQR activities including, but not limited to:

i. Designating a qualified individual to serve as Project Director for each EQR activity who shall, at a minimum:

(A) Oversee and be accountable for compliance with all aspects of the EQR activity;

(B) Coordinate with staff responsible for aspects of the EQR activity and ensure that staff respond to

requests by the EQRO, QIO, Department staff in a timely manner;

(C) Serve as the liaison to the EQRO, QIO and the Department to answer questions or coordinate responses to questions from the EQRO, QIO, and Department in a timely manner; and

(D) Ensure timely access to information systems, data, and other resources, as necessary for the EQRO and/or QIO to perform the EQR Activity and as requested by the EQRO, QIO, or Department.

ii. Maintaining data and other documentation necessary for completion of EQR Activities specified above. Contractor shall maintain such documentation for a minimum of seven years;

iii. Reviewing the EQRO's draft EQR report and offering comments and documentation to support the correction of any factual errors or omissions, in a timely manner, to the EQRO or Department;

iv. Implementing actions, as directed by Department to address recommendations for quality improvement made by the EQRO or QIO, and sharing outcomes and results of such activities with the EQRO or QIO and the Department in subsequent years; and

v. Participating in any other activities deemed necessary by the EQRO and/or QIO and approved by Department, including but not limited to the existing QIO responsibilities for when an Enrollee Appeals a Contractor's termination of pre-authorized coverage of an inpatient hospital admission or SNF, Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) services.

1.2.28 *Utilization Review and Peer Review*

A. All services provided or arranged to be provided by Contractor shall be in accordance with prevailing community standards. This program will include, when so required by the regulations, written plans of care and certifications of need of care.

B. Contractor shall ensure Network labs are capable of reporting lab values to Contractor directly. Contractor shall use the electronic lab values to calculate HEDIS® Performance Measures.

C. Contractor shall adopt practice guidelines that meet, at a minimum, the following criteria:

a. The clinical guidelines shall rely on credible scientific evidence published in peer reviewed medical literature generally recognized by the medical community. To the extent applicable, the guidelines shall take into account Physician specialty society recommendations and the views of Physicians practicing in relevant clinical areas and other relevant factors;

b. Consider the needs of the Enrollees;

c. Are adopted in consultation with Network Providers;

d. Are reviewed and updated periodically, as appropriate; and

e. Are available to all affected Network Providers, non-Network Providers, Enrollees and Potential Enrollees.

D. Contractor shall establish and maintain a peer review program approved by the Department to review the quality of care being offered by Contractor and its employees, and Medicaid Network Providers.

E. Contractor shall not compensate individuals or entities that conduct utilization review activities on its behalf in a manner that is structured to provide incentives for the individuals or entities to deny, limit, or discontinue Covered Services that are Medically Necessary for any Enrollee.

F. Contractor shall ensure that decisions governed by its practice guidelines are made consistently with those practice guidelines.

G. Contractor shall have a utilization review and peer review committee(s) whose purpose will be to review data gathered and the appropriateness

and quality of care for Covered Services. The committee(s) shall review and make recommendations for changes when problem areas are identified, and report suspected Fraud and Abuse in the HFS Medical Program to the Department's Office of Inspector General. The committees shall keep minutes of all meetings, the results of each review and any appropriate action taken. A copy of the minutes shall be submitted to the Department as needed, and within ten (10) business days after the Department's request. At a minimum, these programs must meet all applicable federal and State requirements for utilization review. Contractor and the Department may further define these programs.

H. Contractor shall implement a Utilization Review Plan, including medical and dental peer review as required. Contractor shall provide the Department with documentation of its utilization review process. The process shall include:

a. A written Utilization Management Program description which includes, at a minimum, procedures to evaluate medical necessity criteria used and the process used to review and approve the provision of Covered Services.

b. Practice guidelines that have been adopted, pursuant to *Sections 1.2.27 Quality Assurance Program and 1.2.28 Utilization Review and Peer Review* of this Contract.

c. Review of decisions supervised by qualified medical professionals and any decision to deny a Service Authorization Request or to authorize a service in an amount, duration or scope that is less than requested must be made by a health care professional who has appropriate clinical expertise in treating the Enrollee's condition or disease.

d. Written well-publicized and readily available Appeal mechanisms for both Providers and Enrollees.

e. Decisions and Appeals made in a timely manner as required by the circumstances and shall be made in accordance with the timeframes specified in this Contract for standard and expedited authorizations.

f. Mechanisms to evaluate the effects of the program using data on Enrollee satisfaction, Provider satisfaction or other appropriate measures. If Contractor delegates responsibility for Utilization Management, it shall have mechanisms to ensure that these standards are met by the subcontractor.

g. Review of the utilization procedures, at regular intervals, but no less frequently than annually, for the purpose of amending same, as necessary in order to improve said procedures. All updates must receive Department Prior Approval. Contractor agrees to supply the Department and its designee with the utilization information and data, and reports prescribed in its approved utilization review system or the status of such system. This information shall be furnished in accordance with *Sections 1.2.27 Quality Assurance Program and 1.2.28 Utilization Review and Peer Review* of this Contract or upon request by the Department.

I. Contractor shall establish and maintain a peer review program, subject to Department Prior Approval, to review the quality of care being offered by Contractor, employees and subcontractors. This program shall provide, at a minimum, the following:

a. A peer review committee comprised of Physicians and dentists, formed to organize and proceed with the required reviews for both the health professionals of Contractor's staff and any Network Providers which include:

b. A regular schedule for review;

c. A system to evaluate the process and methods by which care is given; and

d. A medical record review process.

J. Contractor shall maintain records of the actions taken by the peer review committee with respect to Providers and those records shall be available to the Department upon request.

K. A system of internal medical review, including behavioral health services, waiver and long-term care services, medical evaluation studies, peer review, a system for evaluating the processes and outcomes of care,

health education, systems for correcting deficiencies, and utilization review.

L. At least two (2) medical evaluation studies must be completed annually that analyze pressing problems identified by Contractor, the results of such studies and appropriate action taken. One of the studies may address an administrative problem noted by Contractor and one may address a clinical problem or diagnostic category. Contractor's medical evaluation studies' topic and design must receive Prior Approval.

M. Contractor shall participate in the annual collaborative PIPs/QIPs, as mutually agreed upon and directed by the Department.

N. Contractor further agrees to review the peer review procedures, at regular intervals, but no less frequently than annually, for the purpose of amending the peer review procedures in order to improve said procedures. All amendments must be approved by the Department. Contractor shall supply the Department and its designee with the information and reports related to its peer review program upon request.

O. The Department may request that peer review be initiated on specific Providers.

P. The Department may conduct its own peer reviews at its discretion. If Contractor's Utilization Management Program uses an algorithmic automated process in the course of review for medical necessity, Contractor shall comply with this Section.

a. Definitions. For purposes of this Section,

i. Clinical Peer means a health care professional who is in the same profession and the same or similar specialty as the health care provider who typically manages the medical condition, procedures, or treatment under review.

ii. Adverse Determination means as defined in 215 ILCS 180/10.

b. Contractor shall ensure that only a Clinical Peer makes any Adverse Determination based on medical necessity.

c. Any subsequent appeal shall be processed in accordance with this Contract and in compliance with 215 ILCS 134/45 including the restriction that only a Clinical Peer may review an appeal.

d. Utilization Management Programs that use automated processes shall have the accreditation and policies and procedures required by 215 ILCS 134/85 (b)(10).

e. Nothing in this subsection prohibits an accredited algorithmic automated process from being used to refer a case to a Clinical Peer for a potential Adverse Determination.

f. Nothing in this subsection prohibits either a Clinical Peer or an accredited algorithmic automated process, or both in combination, to certify the medical necessity of a health service in accordance with accreditation standards.

g. Contractor's Utilization Review Plan shall conform to this subsection.

1.2.29 *Marketing, Outreach, and Enrollee Communications Standards*

A. Contractor shall submit the communication and marketing materials for joint CMS and state review within the CMS Health Plan Management System (HPMS): The Department will provide the list of required communication and marketing materials upon joint approval from CMS and the Department. The materials shall include Contractor's Medicare Advantage contract ID number. The multi-plan submission process in HPMS is not applicable. In addition, when a third party, such as a pharmacy benefit manager (PBM), creates and distributes enrollee-specific materials on behalf of multiple organizations, it is not acceptable to use the material ID for another organization or a Y number for materials the third-party provides to D-SNP enrollees in D-SNP-only contracts. The material must be submitted in HPMS using a separate material ID number for the D-SNP contract.

B. Contractor shall obtain approval from CMS (if CMS review and approval is required under 42 CFR 422.2261 and the Medicare Communications and Marketing Guidelines (MCMG)) and the State before making the mentioned materials available to enrollees or prospective enrollees. The State will review and provide approval or disapproval of the materials within 10 or 45 days, depending on the material review parameters in HPMS, after Contractor submits the materials in HPMS.

C. Contractor shall comply with all Medicare and Medicaid statutes, regulations, and requirements including the MCMG, related to marketing of Contractor's services, including submission to CMS for approval.

D. Contractor shall not hold a marketing or educational event with our prior approval from the Department. Contractor must make available to the Department current schedules of all educational events conducted by Contractor to provide information to Enrollees or Potential Enrollees;

E. Contractor must convene all educational and marketing events at sites within Contractor's Service Area that are physically accessible to all Enrollees or Potential Enrollees, including persons with disabilities and persons using public transportation.

F. Contractor may not offer financial or other incentives, including private insurance, to induce Potential Enrollees to enroll with Contractor; and Contractor may not offer financial or other incentives, including private insurance, to induce Enrollees or Potential Enrollees to refer a friend, neighbor, or other person to enroll with Contractor;

G. Contractor may not directly or indirectly conduct cold call marketing door-to-door, telephone, or other unsolicited contacts per 42 CFR 438.104; and

H. Contractor may not use any Marketing, Outreach, or Enrollee Communications materials that contain any assertion or statement (whether written or oral) that:

   a. The Enrollee or Potential Enrollee must enroll with Contractor in order to obtain benefits or in order not to lose benefits;

   b. Contractor is endorsed by CMS, the Department, Medicare, Medicaid, the Federal government, Illinois, or similar entity.

I. Contractor's Marketing, Outreach, and Enrollee Communications materials must be provided at no cost to the Enrollee including:

   a. In a manner, format and language that may be easily understood by persons with limited English proficiency, or for those with Developmental Disabilities or cognitive impairments;

   b. As applicable, provided with a notice of availability of language assistance services and auxiliary aids and services per 42 CFR

422.2267(e)(31) and the MCMG. Prevalent Illinois Languages include:

Illinois	
1	Spanish
2	Polish
3	Chinese
4	Korean
5	Tagalog
6	Arabic
7	Russian
8	Gujarati
9	Urdu
10	Vietnamese
11	Italian
12	Hindi
13	French
14	Greek
15	German

c. As applicable, mailed with a non-discrimination notice or statement consistent with the requirements of 45 CFR Part 92.

J. Contractor must comply with submission, review and approval of Marketing, Outreach and Enrollee Communications materials and receive Prior Approval from CMS (where applicable) and the Department of marketing and Enrollee Communications materials in accordance with 42 CFR 422 Subpart V and the Medicare Communications and Marketing Guidelines (MCMG) (cms.gov), and as described in HPMS. Including:

a. CMS and the Department may conduct additional types of review of Contractor's Marketing, Outreach, and Enrollee Communications activities, including, but not limited to:

i. Review of on-site marketing facilities, products, and activities during regularly scheduled Contract compliance monitoring visits.

ii. Random review of actual Marketing, Outreach, and Enrollee Communications pieces as they are used in the marketplace.

iii. "For cause" review of materials and activities when Complaints are made by any source, and CMS or the Department determines it is appropriate to investigate.

iv. "Secret shopper" activities where CMS or the Department request Contractor's Written Materials.

b. Contractor may not begin Marketing, Outreach, and Enrollee Communications activities to new Potential Enrollees or Enrollees more than 90 days prior to the effective date of enrollment for the following Contract year.

c. Contractor materials may be designated as eligible for the File & Use process, as described in 42 CFR 422 Subpart V and 423, Subpart V, and the Medicare Communications and Marketing Guidelines and, therefore, will be exempt from prospective review and approval by both CMS and the Department.

d. CMS and the Department may agree to defer to one or the other Party for review of certain types of marketing and Enrollee Communications, as agreed in advance by both parties.

e. Consistent with the timelines specified in 42 CFR 422.2267(e), Contractor must provide new Enrollees with integrated Enrollee materials, which must also be provided annually thereafter including:

i. Annual Notice of Change. This shall include the procedures for an Enrollee to change D-SNP or to opt out of the D-SNP.

ii. A comprehensive, integrated formulary that includes prescription drugs and over-the-counter products required to be covered by Medicare Part D and the Department's outpatient prescription drug benefit and that uses the model document developed by CMS and the Department, or a distinct and separate notice on how to access this information online and how to request a hard copy, as specified in the Medicare Communication and Marketing Guidance.

iv. iii. A combined Provider and Pharmacy Directory that is consistent with the requirements or a distinct and separate notice on how to access this information online and how to request a hard copy, as specified in Chapter 4 of the Medicare Managed Care Manual for Medicaid Providers, https://hfs.illinois.gov/content/dam/soi/en/web/hfs/sitecollectiondocuments/mcomanual.pdf and the Medicare Communication and Marketing Guidelines. A single Member ID card for accessing all Covered Services under the D-SNP that uses the model document developed by CMS and the Department. All ID cards must include information regarding calling 988 in the event of a mental health crisis.

v. A Summary of Benefits (SB) that contains a concise description of the important aspects of enrolling in Contractor's plan, as well as the benefits offered under Contractor's plan, including any cost sharing, applicable conditions and limitations, and any other conditions associated with receipt or use of benefits, and uses the model document developed by CMS and the Department. The SB must provide sufficient detail to ensure that Enrollees understand the benefits to which they are entitled. For new enrollees, the SB is required when the enrollment form is provided per the MCMG.

vi. An Evidence of Coverage (EOC)/Member Handbook document, or a distinct and separate notice on how to access this information online and how to request a hard copy, that is consistent with the requirements in the MCMG; that includes information about all Covered Services

(A) Processes for Grievances and Internal and External Appeals, including:

- How to file;
- Grievance, Appeal and Fair Hearing procedures and timeframes;
- Toll-free numbers that the Enrollee can use to file a Grievance or an Appeal by phone; and

- A statement that when requested by the Enrollee, benefits will continue at the plan level for all benefits and, if the Enrollee files an Appeal or a request for State fair hearing within the timeframes specified for filing, the Enrollee may be required to pay to Contractor the cost of services furnished while the Appeal is pending if the final decision is adverse to the Enrollee; and

- How the Enrollee can identify who the Enrollee wants to receive written notices of denials, terminations, and reductions;

- How to obtain assistance with the Appeals processes through the ESR and other assistance mechanisms as the Department or CMS may identify, including an Ombudsperson;

(B) The extent to which, and how, Enrollees may obtain benefits, including Family Planning services, from out-of-network Providers;

(C) How and where to access any benefits that are available under the State Plan or HCBS Waivers, but that are not covered under the Contract, including any cost sharing, and how transportation is provided;

(D) How to change Providers;

(E) The procedures for an Enrollee to change D-SNP or to opt out of the D-SNP

(F) How to disenroll voluntarily;

(G) An explanation of the process by which care coordinators ensure that clinical information, including diagnostic and medication information, may be available to key caregivers;

(H) How to request and obtain a copy of the Enrollee's medical records, and to request that they be amended or corrected;

(I) How to obtain access to specialty, behavioral health, pharmacy and LTSS Providers;

(J) How to obtain services and prescription drugs for Emergency Medical Conditions and Urgent Care in and out of the Provider Network and in and out of the Service Area; including:

(K) What constitutes Emergency Medical Condition, Emergency Services, and Post-Stabilization Services, with reference to the definitions in 42 CFR 422.113 and 438.114(a);

(L) The fact that prior authorization is not required for Emergency Services;

(M) The process and procedures for obtaining Emergency Services, including the use of the 911 telephone system or its local equivalent;

(N) The locations of any emergency settings and other locations at which Providers and hospitals furnish Emergency Services and Post-Stabilization Services covered under the Contract;

(O) That the Enrollee has a right to use any hospital or other setting for emergency care; and

(P) The Post-Stabilization Care Services rules at 42 CFR 422.113(c).

f. Information about Advance Directives (at a minimum those required in 42 CFR 489.102, 422.128, and 438.3(j)), including Enrollee rights under the law of the Illinois, which information shall be updated to reflect any changes in State law as soon as possible, but no later than ninety (90) days after the effective date of changes;

g. Contractor's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of Advance Directives as a matter of conscience; that Complaints concerning noncompliance with the Advance Directive requirements may be filed with Contractor; designating a health care proxy, and other mechanisms for ensuring that future medical decisions are made according to the desire of the Enrollee;

h. How to obtain assistance from ESRs;

i. Enrollee rights as specified in *Attachment 6 Enrollee Rights*.

j. Information regarding Quality Improvement Programs.

K. Contractor will conduct Welcome Calls to each new Enrollee within thirty (30) days after the effective date of enrollment. For those new Enrollees who Contractor successfully contacts, Contractor will provide health education and respond to questions about Covered Services and how to access them and conduct a Health Risk Assessment to identify an Enrollee's potential need for services and Care Management.

L. Marketing, Outreach and Education Plan. On an annual basis, Contractor must submit to the Department for Prior Approval a Marketing, Outreach and Education Plan no later than November 15th that covers the following calendar year. The Marketing, Outreach and Education Plan must reflect a focused approach and strategy that aligns with the program goals under the Department's Comprehensive Medical Programs Quality Strategy. Contractor's Marketing, Outreach and Education Plan must include the following:

a. an overview of how Contractor's marketing, outreach, and education strategy will contribute to improved quality of care, access to care, and performance outcomes for Enrollees;

b. equity-based strategies on:

i. increasing Enrollee self-care management including promoting Primary Care Provider selection to encourage preventive care, and appropriate health screenings;

ii. education and outreach initiatives that are focused and designed to improve chronic disease management and

Behavioral Health through health literacy and lifestyle programs focused on adults;

iii. education and outreach initiatives on Behavioral Health, including reducing barriers to diagnosis and ongoing care for all populations;

iv. support Enrollee redetermination process for hard to reach populations;

c. a community-centric outreach and community engagement strategy for increasing awareness and educating Enrollees and Potential Enrollees;

d. sample marketing materials that follow the Department's marketing and outreach guidelines, including at a minimum marketing and promotional social media, radio, print, and other collateral materials that promote the State of Illinois Medicaid Program must be co-branded with the Department's logo that has equal visual positioning;

e. policy on prohibition against cold-calling, door-to-door marketing, and other prohibited activities and locations;

f. guidelines on gifts and incentives;

g. guidelines and goals, both quantitative and qualitative, for marketing activities and outreach events;

h. procedures for addressing marketing complaints; and

i. guidelines for securing Enrollee consent.

M. Contractor must provide Enrollees the following materials on an ongoing basis:

a. An Annual Notice Of Change (ANOC) that summarizes all major changes to Contractor's covered benefits from one Contract year to the next, and that uses the model ANOC document developed by CMS and the Department. Contractor must include a state-specific cover letter provided by the Department with the ANOC introducing enrollees to these changes;

b. As needed to replace old versions or upon an Enrollee's request, a single ID card for accessing all Covered Services provided by Contractor.

c. Contractor must provide all required notices for creditable coverage and late enrollment penalty notices required under Chapter 4 of the Prescription Drug Benefit Manual and the Low-Income subsidy (LIS) Rider required under Chapter 13 of the Prescription Drug Benefit Manual.

d. Consistent with the requirement at 42 CFR 423.120(b)(5) and 423.120(f), Contractor must provide Enrollees with at least thirty (30) days advance notice regarding changes to the comprehensive, integrated formulary.

e. Contractor must provide Enrollees with notice of any change that the State defines as significant in the information specified in 42 CFR 438.10(g) at least thirty (30) days before the intended effective date of the change.

f. Contractor must ensure that all information provided to Enrollees and Potential Enrollees (and families or caregivers when appropriate) is provided in a manner and format that is easily understood and that is:

   i. Written with cultural sensitivity and at an average sixth grade reading level; and

   ii. Available in alternative formats, according to the needs of Enrollees and Potential Enrollees, including braille, oral interpretation services in non-English languages, audio; American Sign Language video clips, and other alternative media, as requested.

g. Contractor will provide information to Beneficiaries on Physician Incentive Plans upon the Beneficiary's request, pursuant to 42 CFR 438.10(f)(3).

1.2.30 *Provider and Pharmacy Network Directory*

A. Maintenance and Distributions. Contractor must:

a. Maintain a combined Medicare and Medicaid Provider and Pharmacy Directory;

b. Provide either a copy or a distinct and separate notice on how to access this information online and how to request a hard copy, as specified in Chapter 4 of the Medicare Managed Care Manual and the Medicare Communication and Marketing Guidance, to all new Enrollees at the time of enrollment and annually thereafter to continuing Enrollees;

c. Provide an email address and toll-free phone/TTY numbers for enrollees to report any mistakes found in the Provider and Pharmacy Directory;

d. When there is a significant change to the network, Contractor must provide notice to Enrollees, as specified in Chapter 4 of the Medicare Managed Care Manual and the Medicare Communication and Marketing Guidelines;

e. Contractor must ensure an up-to-date copy is available on Contractor's website, consistent with the requirements at 42 CFR 422 and 423, Subpart C, and the Medicare Communication and Marketing Guidelines. The directory must be available online in a searchable and machine-readable file and format, and the directory must be publicly accessible without the necessity of providing a password, a username, or personally identifiable information;

f. Include written and oral offers of such Provider and Pharmacy Directory in its outreach and orientation sessions for new Enrollees.

B. Contractor must provide in the Provider and Pharmacy Directory, at a minimum, the following information for all Providers in Contractor's Provider Network:

a. The names, addresses, and telephone numbers of all current network Providers, and the total number of each type of Provider;

b. As applicable, Network Providers with training in and experience treating, including Providers with expertise in treating the D-SNP population;

c. For behavioral health Providers, training in and experience treating trauma, child welfare, and substance use;

d. For Network Providers, that are health care professionals or non-facility based and for facilities and facility-based Network Providers, days and hours of operation;

e. As applicable, whether the health care professional or non-facility based Network Provider has completed cultural competence training;

f. Whether the Network Provider has specific accommodations for people with physical disabilities, such as wide entry, wheelchair access, accessible exam rooms and tables, lifts, scales, bathrooms and stalls, grab bars, or other accessible equipment;

g. Whether the Provider offers covered services via telehealth.

h. Whether the Provider is accepting new patients as of the date of publication of the directory;

i. Whether the Network Provider is on a public transportation route;

j. Any non-English languages, including American Sign Language (ASL), spoken by Network Providers or offered by skilled medical interpreters at the Provider's Site;

k. As applicable, whether the network Provider has access to language line interpreters;

l. A description of the roles of the PCP and ICT and the process by which Enrollees select and change PCPs; and

m. The directory must include, at a minimum, the following information for all pharmacies in Contractor's pharmacy network:

i. The names, addresses, days and hours of operation, and telephone numbers of all current Network Providers and pharmacies;

ii. Whether the pharmacy provides an extended day supply of medications; and

iii. Instructions for the Enrollee to contact the Enrollee's toll-free Enrollee Services telephone line for assistance in finding a convenient pharmacy.

1.2.31 ***LTSS Financial Requirements***. Contractor shall be in compliance with all financial requirements of the Health Maintenance Organization Act (215 ILCS 125/1 et seq.), all rules promulgated thereunder, and 42 CFR 438.116. Other Financial Requirements shall include:

A. Contractor shall pay for DHS-DRS HCBS Waiver services provided by Individual Providers, including Personal Assistants, by making payment to the Department. DHS-DRS and the Enrollee shall remain the co-employers of the Individual Provider. DHS-DRS, as the co-employer, shall be responsible for making payment, and for the performance of related payroll and employment functions, for the Individual Provider. After the first one hundred eighty (180) days of an Enrollee's enrollment, Contractor shall be responsible to provide DHS-DRS with data, in a mutually agreed upon format, necessary to pay these bills prior to the date the bills are due to be submitted. The Department will provide invoices to Contractor, in a mutually agreed upon format, within sixty (60) days after DHS-DRS has paid such invoices for Individual Providers' hours paid to Individual Providers. The Department is a party to a collective bargaining agreement with SEIU covering Individual Providers, including Personal Assistants, in certain HCBS Waivers. Services provided by Individual Providers are included as a Covered Service. Wages agreed to pursuant to the collective bargaining agreement constitute the Medicaid rate for Individual Provider services, which Contractor is obligated to pay. Contractor shall have no obligation to become party to such agreement, or have any liability under such agreement, because of entering into this Contract. If the parties to the SEIU agreement negotiate terms that Contractor reasonably demonstrates materially increase Contractor's cost of providing, or arranging for the provision of, Covered Services or otherwise meeting its obligations under this Contract and to the extent such increased costs would exist absent the D-SNP, the Department will

address adjustments of the Capitation Rates as set forth in *Section 2.4.1 Capitation Payments*. The Department shall not negotiate contract rates with SEIU that are applicable only to the D-SNP. Nothing in this Contract shall impair or diminish DHS-DRS' status as co-employer of the Individual Providers working under the Home Services Program under Section 3 of the Disabled Persons Rehabilitation Act (5 ILCS 315). Nothing in this Contract shall diminish the effect of the collective bargaining agreement covering Individual Providers' employment.

B. Contractor shall pay all Providers of HCBS Waiver services at a rate no less than the State Medicaid rate for such Covered Services.

C. Contractor shall pay Provider agencies that provide in-home services under the Persons who are Elderly HCBS Waiver, and that also offer health insurance to their in-home service workers, at a rate that includes the enhanced rate set forth at 89 Ill. Admin. Code 240.1970. In the event that any other HCBS Waiver becomes subject to a duly promulgated State rule that includes a similar enhanced rate, Contractor shall pay the affected Provider agencies at a rate that includes such enhanced rate.

D. Contractor shall not discriminate against Providers of HCBS Waiver services that offer health insurance to their in-home services workers.

E. Contractor shall pay all Providers that are NFs owned by a county that has an intergovernmental agreement with the Department at a rate no less than the Department pays such a NF according to the approved State Plan. Contractor shall not discriminate against such NFs based upon the rate required by this section.

F. Contractor shall comply with the Department's instructions in disbursing payments pursuant to the CMS-approved State-directed payment for the Nursing Facility Star Rating program authorized under 42 CFR 438.6(c). Directed payments must be made directly to an account of the Provider and cannot be made to an intermediary. The Department will transmit to Contractor detailed instructions on the distribution of funds at the time such funds are paid to Contractor. On a monthly basis, the instructions will indicate the amounts to be paid to each eligible Provider and the timeframe for making the payments. These State-directed payments are supplemental value-based quality bonus payments to those Nursing Facilities that meet specified quality metrics, calculated by the Department based on CMS' Nursing Facility Star Ratings, and are separate payments outside of the MCO capitation payment.

G. Contractor shall reimburse eligible Nursing Facilities that adopt the Department-specified pay scale and promotional path for certified nursing assistants (CNAs) an enhanced daily rate following the methodology in the Medicaid State Plan. The Department will provide Contractor the data necessary to reimburse Nursing Facilities according to that methodology on a quarterly basis. These State-directed payments are supplemental value-based quality bonus payments to those Nursing Facilities that meet specified metrics and are separate payments outside of the MCO capitation payment.

1.2.32 *Information Management and Information Systems***.** The Contractor shall:

A. Maintain Information Systems (Systems) that will enable Contractor to meet all of the Department's requirements as outlined in this Contract. Contractor's health information systems shall provide information on areas that include, but are not limited to utilization, claims, Grievances and Appeals, and disenrollment for reasons other than Medicaid eligibility.

B. Support current Department requirements, and any future IT architecture or program changes. Such requirements include, but are not limited to, the following State standards:

a. The Illinois Unified Process Methodology User Guide;

b. The User Experience and Style Guide Version 2.0;

c. Information Technology Architecture Version 2.0; and

d. Enterprise Web Accessibility Standards 2.0.

C. Ensure a secure, HIPAA-compliant exchange of Enrollee information between Contractor and the Department and any other entity deemed appropriate by the Department. Such files shall be transmitted to the Department through secure file transfer protocol (FTP), high throughput screening (HTS), or a similar secure data exchange as determined by the Department.

D. Have a system and process in place to access and review electronic health records collected from providers. Contractor in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts.

E. Develop and maintain a website that is accurate and up-to-date, and that is designed in a way that enables Enrollees and Providers to quickly and easily locate all relevant information. If directed by the Department, establish appropriate links on Contractor's website that direct users back to the Department's website portal;

F. Cooperate with the Department in its efforts to verify the accuracy of all Contractor data submissions to the Department;

G. Actively participate in any Illinois Systems Workgroup, as directed by the Department. The Workgroup shall meet in the location and on a schedule determined by the Department.

H. In accordance with 42 CFR 438.242(b)(1), upon the Department's request, provide to the Department data elements from the health information system necessary for program integrity, program oversight, and administration to cooperate with Department data processing and retrieval systems requirements.

I. Contractor shall comply with the Department's requirements, policies, and standards in the design and maintenance of its Systems including:

a. Contractor's Systems shall interface with the Department's Legacy Medicaid Management Information System (MMIS), the Department's MMIS system, the Illinois Virtual Gateway, and other Illinois IT architecture in accordance with *Section 1.2.36 E Data Security and Connectivity*.

b. Contractor shall have resources to support the MMIS interfaces. Contractor shall have the capability to successfully receive interface files, which include, but are not limited to:

i. Provider Extract File;

ii. HIPAA 834 Daily File;

iii. HIPAA 834 Audit File;

iv. HIPAA 820 File;

v. 834 Transaction Error File;

vi. Provider Error File;

vii. Claims Files;

viii. Prior Approval Files;

ix. NCPDP Response File;

x. LTC Patient Credit File; and

xi. Remittance Advice File.

c. Contractor shall conform to HIPAA compliant standards for data management and information exchange.

d. Contractor shall have controls to maintain information integrity.

e. Contractor shall maintain appropriate internal processes to determine the validity and completeness of data submitted to Illinois.

J. Contractor's Systems shall generate and transmit Encounter Data files according to the specifications outlined *Section 1.3.5 Encounter Reporting* of this Contract, as updated from time-to-time; and maintain processes to ensure the validity, accuracy and completeness of the Encounter Data in accordance with the standards specified *Section 1.3.5 Encounter Reporting.*

1.2.33 *Accepting and Processing Assessment Data*

A. System Access Management and Information Accessibility Requirements

a. Contractor shall make Systems and system information available to Department and other agency staff as determined by the Department to evaluate the quality and effectiveness of Contractor's data and Systems.

b. Contractor is prohibited from sharing or publishing Department data and information without prior written consent from the Department.

c. System Availability and Performance Requirements

i. Contractor shall ensure that its Enrollee and Provider web portal functions and phone-based functions are

available to Enrollees and Providers twenty-four (24) hours a day, seven (7) days a week.

ii. Contractor shall draft an alternative plan that describes access to Enrollee and Provider information in the event of system failure. Such plan shall be contained in Contractor's Continuity of Operations Plan (COOP) and shall be updated annually and submitted to the Department upon request. In the event of system failure or unavailability, Contractor shall notify the Department upon discovery and implement the COOP immediately.

iii. Contractor shall preserve the integrity of Enrollee-sensitive data that reside in both live and archived environments.

1.2.34 *Cultural Competence*

A. Contractor shall implement a Cultural Competence plan, and Covered Services shall be provided in a culturally competent manner by ensuring the Cultural Competence of all Contractor staff, from clerical to executive management, and Providers. Contractor shall implement the NCQA Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards).

a. involvement of executive management and Providers in the development and ongoing operation of the Cultural Competence plan;

b. the individual executive employee responsible for executing and monitoring the Cultural Competence plan;

c. be reflective of the geographical and cultural groups served by Contractor, and

B. the assurance of Cultural Competence at each level of care;

C. indicators within the Cultural Competence plan that Contractor will use as benchmarks toward achieving Cultural Competence;

D. Contractor's written policies and procedures for Cultural Competence;

E. Contractor's strategy and method for recruiting staff with backgrounds representative of Enrollees served;

F. the availability of interpretive services;

G. Contractor's ongoing strategy and method to ameliorate transportation barriers and its operation;

H. Contractor's ongoing strategy and method to meet the unique needs of Enrollees who have Developmental Disabilities and Cognitive Disabilities and its operation;

1.2.35 *Training*

A. Interdisciplinary Care Team Training: Members of the ICT must be trained on the following topics: person-centered planning processes, cultural and disability competencies, the Ombudsman program, compliance with the Americans with Disabilities Act (ADA), and independent living and recovery.

B. Cultural Competence Training: Contractor shall provide cultural competence training, including health equity and unconscious bias, at least annually in accordance with the NCQA Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards) to staff and Network Providers.

C. Care Coordination Training:

a. Contractor shall develop standards for Care Coordination Training which includes the following components:

i. Training curriculum including goals of training, competency standards, and frequency of retraining

ii. Quality Assurance program to identify inter/intra-rater reliability and core standards

iii. Continue Quality Assurance standards to ensure standards are being met

iv. Remediation training plan for employees who do not meet the standards

b. Care Coordinators shall be provided with adequate orientation and ongoing training on subjects relevant to the population served by Contractor. Documentation of training dates and staff attendance as well as copies of materials used shall be maintained by Contractor and be made available to the Department or its designee, upon request.

c. Contractor shall submit to the Department a complete listing of Care Coordination Trainings, scheduled for each calendar month by the 20th day of the prior month for quality assurance purposes. The listing shall include the training topic and description, instructor, date and time, target audience, and location or mode of delivery.

d. Care Coordinators who serve Enrollees within the DoA Persons who are Elderly HCBS Waiver, DHS-DRS Persons with a Brain Injury HCBS Waiver, DHS-DRS Persons with HIV/AIDS HCBS Waiver, DHS-DRS Persons with Disabilities HCBS Waiver, or HFS Supportive Living Program HCBS Waiver must meet the applicable training requirements set forth in *Attachment 5 Qualifications and Training Requirements of Care Coordinators for 1915c HCBS Waiver Services.* Care Coordinators for all other Enrollees must have the appropriate training to address the needs of Enrollees.

e. Contractor shall ensure that there is a structure in place to provide uniform training to all Care Coordinators, including formal training classes as well as mentoring-type opportunities for newly hired Care Coordinators. Continual training opportunities shall be provided minimally annually as well as more frequently for identified Quality Assurance areas of need.

f. Mandatory Annual trainings include but are not limited to:

   i. Nursing Facility Level of Care and Special Care Nursing Facility Level of Care

   ii. Special Care Nursing Facility Level of Care Need in the community

   iii. Medical Day Care Level of Care and Regulatory requirements

iv. Pre-Admission Screening and Resident Review (PASRR)

v. Newly hired Care Coordinators shall be provided orientation and training in a minimum of the following areas prior to receiving an active caseload of members:

vi. The role of the Care Coordinator in utilizing a person-centered approach to LTSS Care Coordination, including involving the Enrollee and the Enrollee's family in decision-making and service planning.

vii. The principle of most integrated, least restrictive settings for Enrollee placement

viii. All Enrollee rights and responsibilities.

ix. Care coordination responsibilities as outlined in this section, including, but not limited to Assessment, Options Counseling, service planning, back-up plans, Cost Effectiveness processes, Transitions, PASRR, Patient Pay Liability, reporting service gaps, Critical Incidents, Grievances and Appeals, and Notices of Action.

x. Care coordination procedures specific to Contractor.

xi. An overview of LTSS benefit structure.

xii. The continuum of LTSS services, including available service settings and service restrictions/limitations.

xiii. Contractor provider network by location, service type and capacity and should include information about community resources for non-LTSS covered services.

xiv. Information on local resources for housing, education, and employment services/program.

xv. Responsibilities related to monitoring for and reporting of quality-of-care concerns and critical incidents, including, but not limited to, suspected fraud, waste, abuse, neglect and/or exploitation.

xvi. General medical information, such as symptoms, medications, and treatments for diagnostic categories common to the LTSS population service by Contractor.

xvii. General social service information, such as family dynamics, care contracting, dealing with difficult people.

xviii. Behavioral health information, including identification of Enrollee's behavioral health needs, covered behavioral health services, the process for accessing those services within Contractor's network and the requirement to at least quarterly communicate with the PCP and behavioral health providers involved in the Enrollee's care.

xix. Care coordination techniques for managing special needs populations.

xx. Federal and State rules and regulations as they apply to human services programs.

xxi. Information systems and tools necessary to manage the assigned case load.

xxii. Participant direction service delivery model. All LTSS Care Coordinators are responsible for using and completing the Department designated assessment system for initial and re-evaluations.

g. Contractor shall ensure that Care Coordinators have access to an individual or entity who can provide expertise in assisting LTSS populations in areas such as housing, education and employment issues and who has local community knowledge about other resources available in Contractor's service area.

h. Contractor shall maintain adequate numbers of qualified and trained Care Coordinators to meet the needs of Enrollees.

1.2.36 *Data Security and Connectivity*

A. Contractor shall comply with all data security requirements for handling of sensitive data set forth in this section.

a. Pursuant to Executive Order 2019-08, the Department will provide Contractor on at least a monthly basis with highly sensitive data from the Illinois Department of Public Health (DPH) related to certain Contractor's Enrollees who have data in the DPH's HIV/AIDS Registry. Contractor shall handle such data in the strictest confidence in compliance with the privacy provisions of all applicable laws, rules, and regulations, including HIPAA, the AIDS Confidentiality Act (410 ILCS 305), the HIV/Aids Registry Act (410 ILCS 310), and the Illinois Sexually Transmissible Disease Control Act (410 ILCS 325), and with the provisions of this section. The purpose of the data exchange is to advance the goals of zero community transmissions of HIV and ensuring that persons living with HIV will get the care they need to thrive.

b. The details of the HIV-related data received from the DPH via the Department shall be closely held and accessible only to Contractor's Chief Medical Officer (CMO) and their designees, all of whom will be subject to the same standards and liability as the CMO. The data shall only be integrated into a repository for the sole purpose of Care Coordination and treatment of Enrollees living with HIV. Contractor's repository for the data shall have data security protocols, consistent with the requirements in this section, in place which shall be submitted to the Department for review and approval.

c. Contractor's CMO shall use the data received from the HIV/AIDS Registry, along with Contractor's pharmacy, medical, and other claims data, to provide alerts to Care Coordinators to prompt them to ensure all best practices regarding the management and treatment of HIV are being followed with respect to Enrollees, including periodic viral load testing, drug regimen prescribing and adherence, and annual physician visits. These alerts may be developed based on the data permitted to be shared under this Contract and may include viral suppression status ("suppressed" or "not suppressed"), the date of the last lab test, and name of the Provider that ordered the last lab test (if available). Contractor shall work with appropriate HIV consumer and legal advocacy groups for the target population to develop and implement best practices for outreach and engagement.

B. Protected Health Information (PHI). For all information systems that transmit, store, or access PHI, Contractor shall:

a. Establish an information security program in accordance with the Federal Information Security Management Act (FISMA) and follow the National Institute for Standards and Technology (NIST) Guidelines of the NIST Risk Management Framework (RMF), as amended. Contractor shall implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications, or other requirements of this subpart, considering those factors specified in 45 CFR 164.306(b)(2)(i), (ii), (iii), and (iv) [the Security Standards: General Rules, Flexibility of Approach]. This standard is not to be construed to permit or excuse an action that violates any other standard, implementation specification, or other requirements of this subpart. A covered entity may change its policies and procedures at any time, provided that the changes are documented and are implemented in accordance with this subpart.

b. Assess, review, and evaluate the information systems based upon security categorization and classification in accordance with Federal Information Processing Standards (FIPS) Publication 199 Standards for Security Categorization of Federal Information and Information Systems and FIPS Publication 200, Minimum Security Requirements for Federal Information, and Information Systems. Additional guidance on defining the information type can be obtained from NIST SP 800-60 Revision 1 Volume I and II.

c. Select the baseline controls described in FIPS 200 and NIST SP 800-53 to develop a System Security Plan (SSP). Contractor must develop a SSP, in accordance with this section, using the guidance from NIST RMF (NIST SP 800-18) to establish an information security program in accordance with the FISMA and demonstrate compliance.

d. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the system and the information processed that it creates, receives, maintains, or transmits based on NIST SP 800-66 Revision 1, An Introductory Resource Guide

for Implementing the Health Insurance Portability and Accountability Act (HIPAA) Security Rule.

e. Perform continuous monitoring of the system in compliance with NIST SP 800-137.

f. Implement four specifications with the Access Controls, unique user identification (required), automatic logoff (addressable), and encryption and decryption (addressable), which provides users with rights and/or privileges to access and perform functions using information systems, applications, programs, or files. Access controls shall enable authorized users to access the minimum necessary information needed to perform job functions. Rights and/or privileges shall be granted to authorized users based on a set of access rules that the covered entity is required to implement as part of 45 CFR 164.308(a)(4), the Information Access Management standard under the Administrative Safeguards section of the HIPAA Security Rule.

g. Implement audit controls that allow Contractor to adhere to policy and procedures developed to comply with the required implementation specification at 45 CFR 164.308(a)(1)(ii)(D) for Information System Activity review.

h. Implement policies and procedures to protect electronic protected health information from improper alteration or destruction. Integrity is defined in the HIPAA Security Rule, at 45 CFR 164.304, as "the property that data or information have not been altered or destroyed in an unauthorized manner." Protecting the integrity of EPHI is a primary goal of the Security Rule.

C. Contractor shall develop a System Security Plan (SSP). The SSP developed by Contractor shall including the following:

a. the requirements traceability matrix (RTM) cross-referenced to the specific system design function that meets each requirement related to system security;

b. descriptions of:

i. how the system is to be compliant with all the Federal and State laws regarding the security and privacy of personally identifiable information and Protected Health Information, including but not limited to 45 CFR 95.621; 45 CFR Parts 164, Subparts C and E; 1902(a)(7) of the SSA; and 42 CFR 431.300-307;

ii. the process Contractor will use to report security Breach incidents, regardless of severity or loss of actual data, to HFS within twenty-four (24) hours;

iii. measures to secure data and software;

iv. how data are encrypted in transit and in storage;

v. physical and equipment security measures;

vi. personnel security;

vii. software used for security;

viii. the user roles and the access capabilities of each role;

ix. how users are assigned certain roles;

x. contingency security procedures during a disaster recovery event;

xi. how Contractor works with HFS to conduct an annual security review;

xii. An identification of the staff responsible for controlling the system security;

xiii. Password security; and

xiv. Audit trails for all data access.

c. The Department shall have to right to review the SSP. If the Department finds deficiencies in the SSP, the Department, at its sole discretion, may deny Contractor access to Department systems or data until Contractor corrects the deficiencies in the SSP, as determined by the Department.

d. Contractor will be responsible for all costs associated with identity theft resulting from a security Breach.

D. Medicare and Medicaid Data Use

a. The Contractor shall restrict its use and disclosure of Medicare and Medicaid data obtained from CMS and the Department to those purposes directly related to the administration of this Contract. The Contractor shall only maintain data obtained from CMS and the Department that are needed to administer this Contract. The Contractor (or its First Tier, Downstream or other Related Entities) may not use or provide other entities with access to CMS or the Department data to support any line of business other than the Contract.

b. The Contractor further agrees that it shall limit the use of information it obtains from its Enrollees to those purposes directly related to the administration of this Contract, and only as allowed by law.

c. CMS may terminate the Contractor's access to the CMS data and data systems, and the Department may terminate the Contractor's access to the Department data and data systems, immediately upon determining that the Contractor has used its access to a data system, data obtained from such systems, or data supplied by its Medicare-Medicaid Enrollees beyond the scope for which CMS and the Department have authorized under this section 1.2.36.D. A termination of Contractor's access to CMS data and data systems or the Department's data and data systems may result in the Department terminating this Contract on the basis that the Contractor is no longer qualified to administer this Contract. This data use agreement shall remain in effect and survive the termination of this Contract. Any public use files or other publicly available reports or files that the Department makes available to the general public on their respective websites is excluded from this section.

E. Connectivity Specifications

a. Internet connection. The connection to the Department of Information Technology (DoIT) Data Center must be through a secure connection via the Internet. A secure connection over the

Internet will require a Site-to-Site Virtual Private Network (VPN) or the use of transport layer security (TLS) Session depending upon the communication requirements. NIST SP 800-52 rev 2 provides updated guidance on secure TLS configurations and recommends migration to the latest version of TLS, which is currently TLS 1.3. Contractor must Implement technical security measures to guard against unauthorized access to electronic protected health information that is being transmitted over an electronic communications network. This standard has two (2) implementation specifications:

i. integrity controls (addressable) and encryption (addressable); and

ii. the encryption implementation specification is addressable, similar to the addressable implementation specification at 45 CFR 164.312(a)(2)(iv), which addresses encryption and decryption.

b. Contractor shall comply with Internet Site-to-Site VPN Requirements. Contractor will be responsible for the cost of the connection between Contractor and its Internet Service Provider (ISP), troubleshooting and any redundancy requirements associated with Contractor's connection to the Internet or for Disaster recovery. Contractor shall procure, install, and support any VPN equipment required at Contractor's location to support secure Site-to-Site VPN communications via the Internet with DoIT. HFS will coordinate with Contractor to ensure that any authorization/certificate paperwork required for the establishment of the VPN connection is completed. Please note that DoIT can only accept public assigned IP ranges from Contractor (No RFC-1918 addresses).

c. Contractor shall comply with Internet TLS Requirements for File Transfer Protocol. If Contractor's only communication requirement is to send or receive data files, the connection may be made using secure SFTP via the Internet. Contractor will be responsible for the cost of the connection between Contractor and its Internet Service Provider (ISP), troubleshooting and any redundancy requirements associated with Contractor's connection to the Internet or for Disaster recovery. Contractor is

responsible for any costs associated with obtaining a secure FTP client that supports TLS. Contractor will be responsible for initiating the secure FTP sessions to the DoIT Data Center and performing any necessary firewall changes to reach the provided IP address and FTP control and data ports.

d. Contractor shall work with HFS to determine the configuration and define any connection parameters between Contractor and the DoIT Data Center. This will include any security requirements DoIT requires for the specific connection type Contractor is using. Contractor shall work with both HFS and DoIT in exchanging configuration information required to make the connection secure and functional for all parties.

e. Contractor shall cooperate in the coordination of the interface with DoIT and HFS. TCP/IP (Transmission Control Protocol/Internet Protocol) must be used for all connections from Contractor to the DoIT Data Center.

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

F. SOC Reporting

a. Contractor shall certify it has undergone an independent third-party audit in accordance with Statement on Standards for Attestation Engagements (SSAE-18) Certification and must provide the State with System and Organization Controls 2, Type 1 (SOC 2, Type 1) report at initial implementation and System and Organization Controls 2, Type 2 (SOC 2, Type 2) report annually thereafter with applicable Bridge/Gap letter.

b. Contractor shall certify it has undergone an independent third-party audit in accordance with Statement on Standards for Attestation Engagements (SSAE-18) Certification and must provide the State with System and Organization Controls 1, Type 1 (SOC 1, Type 1) report at initial implementation and System and Organization Controls 1, Type 2 (SOC 1, Type 2) report annually thereafter with applicable Bridge/Gap letter.

1.2.37 *Artificial Intelligence Technology***.** Any use of artificial intelligence shall comply with all current Federal and State rules, regulations, policies, and/or guidelines for acceptable use of artificial intelligence. Including at a minimum:

A. AI systems should not be used, or deployed in ways that could potentially discriminate against individuals or groups based on race, gender, religion, ethnicity, disability, economic status, or any other protected characteristic

B. AI systems should comply with all relevant data privacy laws and regulations, ensuring the secure and responsible handling of personal information, and avoiding copyright infringement.

C. AI systems should not be used to spread misinformation, deceive users, or manipulate public opinion.

D. AI systems should not make decisions autonomously. AI systems especially that support decision making must have a "human in the loop" to ensure that all decisions are made by humans.

E. AI systems shall have ongoing human oversight to review and intervene in cases of potential bias, errors, or potential adverse impacts.

F. AI systems must not be used to undermine human rights or enable harmful activities. If the solution has users interact with an AI system, the solution shall clearly state that the user is interacting with an AI system.

G. In the event that the solution employs artificial intelligence (AI) to assist in decision-making, the contractor agrees to provide the agency with detailed documentation of the architecture used in this process.

H. Data collected for use by AI system should be relevant, accurate, and necessary for the intended purpose.

I. The contractor shall be responsible for the quality and governance of the training data used to support the AI system utilized.

1.2.38 *Sanctions*

A. Contractor must comply with Department sanctions in accordance with 42 CFR 438.700 et seq., and the following:

B. Contractor may have imposed by the Department civil money penalties, late fees, performance penalties (collectively, "monetary sanction"), and other sanctions, for Contractor's failure to substantially comply with the terms of this Contract. Monetary sanctions imposed pursuant to this section may be collected by deducting the amount of the monetary sanction from any payments due to Contractor or by demanding immediate payment by Contractor.

C. An installment payment plan may be established by the Department, at its sole discretion, for payment of any monetary sanction. The determination of the amount of any monetary sanction shall be at the sole discretion of the Department, within the ranges set forth below.

D. Self-reporting by Contractor will be taken into consideration in determining the amount of any monetary sanction. The Department shall not impose any monetary sanction where the noncompliance is directly caused by the Department's action or failure to act or where a force majeure delays performance by Contractor.

E. The Department, in its sole discretion, may waive the imposition of a monetary sanction for failures that it judges to be minor or insignificant. Upon determination of substantial noncompliance, the Department shall give written notice to Contractor describing the noncompliance, the opportunity to cure the noncompliance at the discretion of the Department, or where a cure is not otherwise disallowed under this Contract, and the monetary sanction that the Department will impose hereunder.

F. The Department may disallow an opportunity to cure when noncompliance is willful, egregious, persistent, part of a pattern of noncompliance, or incapable of being cured, or when a cure is otherwise not allowed under this Contract.

G. The Department reserves the right to terminate this Contract or in lieu of, imposing one or more monetary sanctions. At the end of each subsequent period of thirty (30) days in which no demonstrated progress is made toward compliance, the Department may, without further notice, impose additional performance penalties of equal amount. The State reserves the right to amend these sanctions and sanction amounts at any time, with sixty (60) days' notice provided to Contractor. Where a sanction references an enrollment hold, at the discretion of the Department this may be either one or both of the following:

a. a suspension of default enrollment for Potential Enrollees; or

b. a suspension of enrollment for Potential Enrollees.

H. If Contractor fails to submit any report or other material required by this Contract to be submitted to the Department, other than Encounter Data, by the date due, the Department may, at its sole discretion and without further notice, impose a late fee of up to US $50,000 for the late report. The date due will be either the date imposed by the Department or the date agreed to by the Department at Contractor's request. At the end of each subsequent due date for which the specific report is not submitted, the Department may, without further notice:

a. impose an additional late fee equal to the amount of the original late fee;

b. impose a performance penalty of up to US $50,000;

c. impose an enrollment hold on Contractor; or

d. impose all the above.

I. If Contractor fails to submit any ad hoc report in an accurate, complete, and timely manner, the Department may, at its sole discretion and without notice, impose a monetary sanction of up to US $50,000. The Department may also, without further notice, impose an additional monetary sanction until an accurate and complete response is submitted.

J. If Contractor fails to submit cost report data in a timely or accurate manner, the Department may, without further notice, impose one or more of the following:

a. Failure to submit draft cost report by required submission deadline: US $10,000 penalty per business day.

b. Failure to submit final cost report by required submission deadline: US $10,000 penalty per business day.

c. Failure to address or respond to draft observations, in final cost report submission:

i. First instance: written warning;

ii. Second instance: US $50,000 penalty;

iii. Additional instances: US $100,000 penalty per submission.

d. Change in prior period aggregate expenses (excluding additional months of paid claims), revenue, or eligibility of more than 10% in subsequent quarterly or cost report submission, unless a result of a Department data issue or programmatic variance.

i. First instance: written warning;

ii. Second instance: US $50,000 penalty;

iii. Additional instances: US $100,000 penalty per submission.

e. There will be no limit on sanctions associated with cost report submissions for each calendar year period. A written warning will be provided upon the first instance in each separate calendar year.

K. In addition to the remedies provided in 30 ILCS 575/8(3) if the Department determines that a) Contractor did not meet the BEP goal established in this contract; b) Contractor has not made good-faith efforts as required in 30 ILCS 575/7(3) to meet the BEP goal established in this contract; c) Contractor has provided false or misleading information concerning compliance, certification status, eligibility of certified Contractors, its good-faith efforts to meet the BEP goal, or any other material fact or representation, the Department may, upon providing Contractor with written notice, withhold whichever is the larger amount of:

a. a performance penalty of US $100,000; and

b. the difference between the BEP goal and the amount of money paid to BEP- certified subcontractors during the State Fiscal Year.

L. The Department and Contractor acknowledge and agree that they will work in good faith to implement mutually agreed-upon system requirements resulting in the complete and comprehensive transfer and acceptance of Encounter Data, and that such mutual agreement shall not be unreasonably withheld. Contractor shall submit complete and

accurate data quarterly to the Department in accordance with the Illinois Medicaid Health Plan Encounter Utilization Monitoring (EUM) requirements document, as set forth in Department-issued written policy (specifically, policy number 058), for each evaluation period. If Contractor does not meet the standards by the evaluation date as set forth in Department's written policy, the Department, without further notice, may:

a. impose a monetary penalty of up to US $100,000;

b. impose a monetary penalty of up to US $100,000 for each unmet standard

c. impose an enrollment hold on Contractor; or

d. impose all the above.

M. If the Department determines that Contractor has not accurately conducted and submitted quality and Performance Measures as required, and the Department reasonably determines the failure warrants imposing a late fee, the Department may, without further notice, impose a late fee of up to US $50,000 for each measure not accurately conducted or submitted.

N. If the Department determines that Contractor has not made sufficient improvements on Consumer Report Card metrics on an annual basis the Department may impose a performance penalty of up to US $50,000 for each metric.

O. If the Department determines that Contractor has not fully participated in the PIP, the Department may impose a performance penalty of up to US $100,000. At the end of each subsequent period of thirty (30) days in which no demonstrated progress is made toward full compliance, the Department may, without further notice, impose an additional performance penalty of up to US $100,000.

P. If the Department determines that Contractor has not made significant progress in monitoring or carrying out its QAP, implementing quality improvement plan or demonstrating improvement in areas of deficiencies, as identified in quality monitoring, or PIP, the Department will provide notice to Contractor that Contractor may be required to

develop a formal Corrective Action Plan (CAP) to remedy the Breach of Contract.

a. Contractor shall submit a CAP within thirty (30) days after the date of notification by the Department. Contractor's CAP will be evaluated by the Department to determine whether it satisfactorily addresses the actions needed to correct the deficiencies. If Contractor's CAP is unsatisfactory, the Department will indicate the sections requiring revision and any necessary additions, and request that another CAP be submitted by Contractor, unless otherwise specified, within thirty (30) days after receipt of the Department's second notice. If Contractor's second CAP is unsatisfactory, the Department may declare a material Breach.

b. Within ninety (90) days after Contractor has submitted an acceptable CAP, Contractor must demonstrate progress toward improvement. The Department, or its designee, may review Contractor's progress through an on-site or off-site process. Thereafter, Contractor must show improvement for each ninety (90)–day period until Contractor is compliant with the applicable requirements of this Contract.

c. If Contractor does not submit a satisfactory CAP within the required timeframes or show the necessary improvements, the Department, without further notice, may impose a performance penalty of US $50,000 for each thirty (30)–day period thereafter.

d. The CAP must be submitted with the signature of Contractor's chief executive officer and is subject to approval by the Department. The CAP must include the following:

    i. the specific problems that require corrective action;

    ii. the type of corrective action to be taken for improvement of each specific problem;

    iii. the goals of the corrective action;

    iv. the timetable and work plan for action;

    v. the identified changes in processes, structure, and internal and external education;

vi. the type of follow-up monitoring, evaluation, and improvement; and

vii. the identified improvements and enhancements of existing outreach and care-management activities, if applicable.

Q. If the Department determines that Contractor has imposed a charge on an Enrollee that is prohibited, or otherwise not allowed, under the Medicaid program, the Department may impose a civil money penalty of up to US $25,000.

R. If the Department determines that Contractor has misrepresented or falsified information furnished to a Potential Enrollee, Enrollee, or Provider, the Department may impose a civil money penalty of US $10,000 to US $25,000 for each determination. If the Department determines that Contractor has misrepresented or falsified information furnished to the Department or CMS, the Department may impose a civil money penalty of up to US $100,000 for each determination.

S. If the Department determines that Contractor has failed to comply with the Physician incentive plan requirements of *Section 5.2.33 Physician Incentive Plans*, the Department may impose a civil money penalty of up to US $25,000 for each determination.

T. If the Department determines that Contractor has not met the Provider-to-Enrollee access standards established in *Section 1.2.18.G Network Management*, the Department will send Contractor a notice of noncompliance. If Contractor has not met these requirements by the end of the thirty (30)–day period following the notice, the Department may, without further notice:

a. impose a performance penalty of up to US $50,000;

b. impose an enrollment hold on Contractor; or

c. impose both.

U. If the Department determines that Contractor has substantially failed to provide, or arrange to provide, a Medically Necessary service that Contractor is required to provide under law or this Contract, the Department may:

a. impose a civil money penalty of US $50,000 for each determination, or

b. impose an enrollment hold on Contractor, or

c. impose both.

V. If the Department determines that discrimination has occurred in relation to an Enrollee's preexisting condition or medical history indicating a probable need for substantial medical services in the future, the Department may:

a. impose a civil money penalty of up to US $50,000 for each determination; or

b. impose an enrollment hold on Contractor; or

c. impose both.

d. For each beneficiary not enrolled because of a discriminatory practice, the Department may impose a civil money penalty of up to US $15,000.

W. If the Department determines that there is Marketing Misconduct or a pattern of Marketing failures, the Department may:

a. impose a civil money penalty of up to US $25,000 for each determination; or

b. impose an enrollment hold on Contractor; or

c. impose both.

X. Failure to develop a written proposal intended to resolve a disputed claim within required timeframe. If the Department determines that Contractor fails to develop a written proposal addressing a Provider's disputed claim that has been submitted to the Department's Provider complaint portal within the timeframes delineated in the Department's policies and procedures, or, if the Department determines a timely written proposal is demonstrably inadequate such that resolution is improbable, the Department may:

a. impose a late fee of up to US $50,000 for the initial determination;

b. impose a late fee of up to US $50,000 for each subsequent determination;

c. impose an enrollment hold on Contractor; or

d. impose all the above.

Y. If the Department determines that Contractor is in substantial noncompliance with any material terms of this Contract, or any State or federal laws affecting Contractor's conduct under this Contract, that are not specifically enunciated in *Section 3 Term and Termination*, but for which the Department reasonably determines imposing a performance penalty or other sanction is warranted, the Department, may:

a. impose a performance penalty of US $20,000 to US $50,000 per determination;

b. impose an enrollment hold on Contractor; or

c. impose both.

1.3 **Milestones and Deliverables: All deliverables are due in accordance with Attachment 2 Required Deliverables, Submissions and Reporting unless stated otherwise in this section.**

1.3.1 *Readiness Review*. From the date of contract execution readiness review activities must be completed prior to enrollment effective on 1/1/2026.

1.3.2 *Health Risk Assessment Tool***.** Contractor shall administer a health risk assessment(s) provided by the Department within ninety (90) days after enrollment to collect information about the Enrollee's medical, psychosocial, social, functional, cognitive, health related social needs, social determinants of health, and behavioral health (including substance abuse) history.

1.3.3 *Data Submissions, Reporting Requirements, and Surveys*

A. General Requirements for Data. Contractor must provide:

a. All information the Department requires under the Contract related to the performance of Contractor's responsibilities,

including non-medical information for the purposes of research and evaluation; and

b. Any information the Department requires to comply with all applicable federal or State laws and regulations; and

c. Any information the Department requires for external rapid cycle evaluation, including, but not limited to, program expenditures, service utilization rates, rebalancing from institutional to community settings, Enrollee satisfaction, Enrollee Complaints and Appeals and enrollment/disenrollment rates.

B. General Reporting Requirements. Contractor must:

a. Submit to the Department all applicable D-SNP reporting requirements;

b. Submit to the Department all required reports and data in accordance with the specifications, templates and time frames described in this Contract, unless otherwise directed or agreed to by the Department;

c. Report to the Department, HEDIS®,and CAHPS data, as well as measures related to LTSS. HEDIS®,and CAHPS measures will be reported consistent with Medicaid requirements and measures determined by the Department.

d. Pursuant to 42 CFR 438.3(g), comply with any reporting requirements on Provider Preventable Conditions in the form and frequency as may be specified by the Department; and

e. Submit at the request of the Department additional ad hoc or periodic reports or analyses of data related to the Contract.

f. Data, documentation, or information Contractor submits to the State must be certified by either Contractor's Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual who reports directly to the CEO or CFO with delegated authority to sign so the CEO or CFO is ultimately responsible for the certification. The certification, pursuant to 42 CFR 438.604(a), 438.606, and 438.608(d)(3), must be submitted concurrently

with the submission of data and must attest, that based on best information, knowledge, and belief, the data are accurate, complete, and truthful.

1.3.4 *Default Enrollment Reporting*. Contractor shall report the following data quarterly to the Department of its default enrollment process activities and results:

A. Number of Potential Enrollees identified by Contractor as eligible for default enrollment based on age or disability.

B. Number of Potential Enrollees, separated by eligibility based on age or disability, that were noticed by Contractor at least 60 calendar days prior to the effective date of default enrollment.

C. Number of Potential Enrollees who opt out of (decline) default enrollment prior to the effective date. Differentiate between those who opt out by telephone or in writing, as well as eligibility based on age or disability.

D. At the end of the first month of enrollment, specify the number of Enrollees who disenroll within their first month of default enrollment. Continue to track for rapid disenrollments within the first three months of a dually eligible member's default enrollment effective date.

1.3.5 *Encounter Reporting*

A. Contractor must meet any diagnosis and/or Encounter reporting requirements that are in place for D-SNP, as may be updated from time to time. Contractor's Systems shall generate and transmit Encounter Data files to the Department according to specifications provided by the Department and updated from time to time. Contractor shall maintain processes to ensure the validity, accuracy, and completeness of the Encounter Data in accordance with the standards specified in this section. The Department will provide technical assistance to Contractor for developing the capacity to meet Encounter reporting requirements.

B. Requirements. Contractor shall:

a. Collect and maintain one hundred percent (100%) Encounter Data for all Covered Services provided to Enrollees, including from any sub-capitated sources. Such data must be able to be linked to the Department's eligibility data;

b. Participate in site visits and other reviews and assessments by the Department, or its designee, for the purpose of evaluating Contractor's collection and maintenance of Encounter Data;

c. Upon request by the Department, or their designee, provide medical records of Enrollees and a report from administrative databases of the Encounters of such Enrollees to conduct validation assessments. Such validation assessments may be conducted annually;

d. Produce Encounter Data according to the specifications, format, and mode of transfer reasonably established by the Department, or their designee, in consultation with Contractor. Such Encounter Data shall include elements and level of detail determined necessary by the Department. As directed by the Department, such Encounter Data shall also include the National Provider Identifier (NPI) of the ordering and referring Physicians and professionals and any National Drug Code (NDC);

e. Provide Encounter Data to the Department on a monthly basis or within time frames and frequency specified by the Department in consultation with Contractor to comply with any and all applicable statutes, rules, regulations and guidance;

f. Submit Encounter Data that is at a minimum standard for completeness and accuracy as defined by the Department including, as directed by the Department, all Medicare Advantage encounter data submitted to CMS for the enrollees covered under this Contract. Contractor must also correct and resubmit denied Encounters as necessary; and

g. If the Department, or Contractor, determines at any time that Contractor's Encounter Data is not in accordance with the standards identified by the Department, Contractor shall:

   i. Notify the Department, prior to Encounter Data submission, that the data is not complete or accurate, and provide an action plan and timeline for resolution;

   ii. Submit for the Department approval, within a time frame established by the Department, which shall in no event exceed thirty (30) days from the day Contractor identifies

or is notified that it is not in compliance with the Encounter Data requirements, a corrective action plan to implement improvements or enhancements to bring the accuracy and/or completeness to an acceptable level;

iii. Implement the Department-approved corrective action plan within a time frame approved by the Department, which shall in no event exceed 30 days from the date that Contractor submits the corrective action plan to the Department for approval; and

iv. Participate in a validation study to be performed by the Department, and/or their designee, following the end of a twelve-month period after the implementation of the corrective action plan to assess whether the Encounter Data is complete and accurate. Contractor may be financially liable for such validation study.

h. Report as a voided claim in the monthly Encounter Data submission any claims that Contractor pays, and then later determines should not have paid.

C. Failure to Submit Encounter Data to the Department. The Department and Contractor acknowledge and agree that they will work in good faith to implement mutually agreed upon system requirements resulting in the complete and comprehensive transfer and acceptance of Encounter Data and that such mutual agreement shall not be unreasonably withheld. The Department shall also review on a quarterly basis the Encounter Data submitted per the requirements in this section and in accordance with the Illinois Medicaid Health Plan Encounter Utilization Monitoring (EUM) Requirements provided by the Department. If Contractor does not meet the standards by the evaluation date as set forth in EUM Requirements, the Department, may impose sanctions, which may include monetary penalties as described in *Section 1.2.38 Sanctions*.

1.3.6 *Daily Transaction Reply Report*. Contractor must allow the state or its authorized representative to be designated to receive the Daily Transaction Reply Report (DTRR) file via the dual routing process with CMS.

1.3.7 *SDoH Data Reporting*. Contractor must submit a quarterly SDoH Report which includes all information collected from the SDoH assessments to the Department in a timeframe and manner prescribed by the Department.

1.3.8 *Quarterly Business Review Executive Summary Report*. Contractor shall submit an Executive Summary that summarizes MCO performance and quality data metrics and programs as requested by the Department, and as outlined in each Quarterly Business Review agenda and reporting template.

1.3.9 *Managed Care Organization Performance Reporting (MPR) System***.** Contractor shall, upon direction by the Department, enter its performance metric data directly into the MPR System, based on the MPR Handbook guidance and procedures provided by the Department. Contractor shall:

A. Complete the quarterly MCO Performance Metric Dashboard Summary Report as instructed by the Department.

B. MCO shall apply the report guidance and data submission requirements outlined in the MPR Handbook when submitting required or ad hoc MPR reports to the Department.

1.4 Vendor/Staff Specifications:

1.4.1. *D-SNP Status*. Contractor shall be and maintain FIDE SNP status with CMS. For FIDE SNP status the legal entity that holds this contract must be the same legal entity that holds the Medicare Advantage (MA) contract with CMS.

1.4.2. *Key Positions List***.** Upon Execution of this Contract, Contractor shall provide to the Department a list of individuals in key positions outlined in section 1.4.3 authorized by Contractor who have responsibility for monitoring and ensuring the performance of each of the duties and obligations under this Contract.

A. Contractor shall maintain an administrative and organizational structure that supports a high-quality, comprehensive managed-care system.

B. Contractor shall fill vacant key positions to ensure such vacancies do not detract from or conflict with the obligation to provide the equivalent of full-time resources to meet Contract requirements.

C. Contractor shall employ or contract for senior-level managers with experience and expertise in healthcare management and employ or contract with skilled clinicians for medical management activities.

D. Contractor shall ensure all key position offices shall be based in Illinois., unless otherwise given prior approval by the Department.

E. Individuals in an administrative capacity, and their résumés, shall be updated by Contractor throughout the term of this Contract as necessary and as changes occur. An updated list of positions shall be provided to the Department upon request.

F. Contractor shall provide written notice of such staffing position changes to the Department no later than two (2) business days after such changes occur.

G. At a minimum, Contractor shall provide the key positions identified in this section either through direct employment or contract. (The Department acknowledges that the position titles in this section may not be the position titles that Contractor currently uses and that position titles may change from time to time. The Department further acknowledges that employees who are required to be full time may also have some responsibilities for Contractor's other operations.)

H. Contractor warrants that such responsibilities shall never detract from or conflict with the obligation to provide the equivalent of full-time resources to ensure the Contract requirements are met. Failure to meet the requirements of this section may result in a monetary performance penalty pursuant to *Section 1.2.38* Sanctions.

1.4.3. *Key Positions***.** Contractor shall ensure the following key positions in accordance with this section.

A. Chief Executive Officer (CEO). The CEO shall be a full-time position, with clear authority over general administration and implementation of requirements set forth in the Contract.

B. Chief Operating Officer (COO). The COO shall be a full-time position, with clear authority over operations of Contractor's business including overseeing the strategy and implementation of all non-clinical responsibilities of this Contract. This position shall be responsible for the daily conduct and operations of Contractor's Plan.

C. Chief Financial Officer (CFO). The CFO shall be a full-time position, with oversight of the budget and accounting systems of Contractor. This position shall, at a minimum, ensure that Contractor meets the Department's requirements for financial performance and for Contractor's reporting.

D. Chief Medical Officer (CMO). The CMO shall be a full-time position, a board-certified Illinois-licensed Physician and have a minimum of eight (8) years of experience practicing medicine. This position will lead and oversee Contractor's clinical strategy and clinical programs (both physical and behavioral health). This position will be responsible for Contractor's Utilization Management Program, Care Coordination, Long-Term Services and Support, quality improvement, accreditation, credentialing, pharmacy, Appeals and Grievances, health services, Behavioral Health services, and medical policy. This position shall manage Contractor's Quality Assessment and Performance Improvement Program. This position shall attend all quarterly quality meetings.

E. Medical Director. The Medical Director shall be an Illinois-licensed Physician with a minimum of five (5) years of experience practicing in internal medicine, or primary care. This position shall be actively involved in all major clinical program components of 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 Contractor. This position shall devote sufficient time to Contractor's Plan to ensure timely medical decisions, including after-hours consultation as needed.

F. Chief Psychiatrist. The Chief Psychiatrist shall be a full-time senior executive who is a board-certified, Illinois-licensed psychiatrist with a minimum of eight (8) years of experience in mental health, substance use, or children services. This position shall be responsible for all Behavioral Health activities.

G. Enrollee Services Director. The Enrollee Services Director shall be a full-time position that coordinates communications with Enrollees and other Enrollee services, such as acting as an Enrollee advocate. This position shall ensure that Contractor maintains Enrollee service staff to enable Enrollees to receive prompt resolution of their problems or inquiries.

H. Provider Service Director. The Provider Service Director shall be a full-time position that coordinates communications between Contractor and its Network Providers and other Subcontractors.

I. Management Information System Director (MIS Director). The MIS Director shall be a full-time position that oversees and maintains Contractor's data-management system such that is capable of valid data collection and processing, timely and accurate reporting, and correct

claims payment. This individual shall be trained and experienced in information systems, data processing, data reporting and the Department's unique claims-processing requirements to the extent required to oversee all information system aspects identified in this Contract.

J. Care Management Manager. The Care Management Manager shall be a full-time position. This position shall be a licensed Physician, licensed registered nurse, or other professional as approved by the Department. This position will direct all activities pertaining to Case Management and Care Coordination activities and monitor utilization of Enrollees' physical health and behavioral health.

K. Long-Term Services and Supports Program Manager. The LTSS Program Manager shall be a full-time position that administers managed Long-Term Care programs and services and oversees and trains LTSS care coordination staff. This position shall ensure that LTSS staff are knowledgeable and adhere to the requirements of the Illinois HCBS Waivers, IPoC and service plans, Contract standards, the Money Follows the Person Program, Illinois Long-Term Care rules and regulations, and the Williams and Colbert consent decrees. This position shall coordinate all communications between LTSS State agency liaisons, including HFS, IDoA, DHS-DRS, and DHS-DDD. This position shall oversee report submissions specific to the LTSS membership.

L. Olmstead Director. The Olmstead Director shall be a full-time position that administers the Community Transitions Initiative program and any additional programs and services developed to ensure the state's compliance with Olmstead Consent Decrees. This position shall ensure that the health plan's programs and services are provided, documented, and reported in accordance with Department's existing and future policies. Additionally, this position shall consult and advise on health plan policies and operations broadly to ensure that they uphold the principles of the Supreme Court Olmstead Decision.

M. Community Liaison. The Community Liaison shall be a full-time position that develops and maintains relationships with community resources, State agencies, and community entities that traditionally provide services for Enrollees or Potential Enrollees. This individual will coordinate the provision of Community-Based Services to Enrollees, assist in Enrollee outreach, and manage community engagement activities.

N. Quality-Management Coordinator. The Quality-Management Coordinator shall be a full-time position. This position shall be an Illinois-licensed Physician, Illinois-licensed registered nurse, or another Illinois-licensed clinician, as approved by the Department. This position shall, at a minimum, direct the activities of the quality-improvement staff in monitoring and auditing Contractor's healthcare delivery system to meet the Department's goal of providing healthcare services that improve the health status and health outcomes of Contractor's Enrollees.

O. Utilization Management Coordinator. The Utilization Management Coordinator shall be a full-time position. This position shall be an Illinois-licensed Physician, Illinois-licensed registered nurse, or other professional as approved by the Department. This position will oversee prior authorizations and manage the inpatient certification review staff for inpatient initial, concurrent, and retrospective reviews. The review staff shall consist of RNs, Physicians, Physician assistants, or licensed practical nurses who are experienced in inpatient reviews and who operate under the direct supervision of a Registered Nurse, Physician, or Physician assistant.

P. Compliance Officer. The Compliance Officer shall be a full-time position, which shall develop and implement policies, procedures, and practices designed to ensure compliance with the requirements of the Contract. This position shall oversee Contractor's Program Integrity Program; the Grievance Committee and the Special Investigations Unit; and the fair hearing process and ensure that Fraud, Waste, and Abuse is reported in accordance with the guidelines in 42 CFR 438.608 and the requirements of this Contract. Per 42 CFR 438.608 (a)(1)(ii), this position shall report directly to the CEO and Board of Directors.

Q. Registered Pharmacist. The Registered Pharmacist shall be a full-time position and shall oversee pharmaceutical prior authorizations.

R. Transition Officer. The Transition Officer shall be a full-time position and shall assist Contractor in the transition from Contractor's implementation team to regular ongoing operations. This position shall be filled no later than the start date of the Contract and shall continue through one hundred twenty (120) days after the start date of operations, or until all administrative roles are fully staffed, whichever is later.

S. Health Equity Director. The Health Equity Director shall be a full-time position. The Health Equity Director must: (1) hold at least a bachelor's

degree from a recognized college or university and a minimum of five years professional work experience, preferably in public health, social/human services, social work, public policy, health care, education, community development, or justice; (2) have demonstrated community and stakeholder engagement experience; and (3) have experience in actively applying or overseeing the application of science-based quality improvement methods to reduce health disparities. Primary role and responsibilities include: oversee Contractor's strategic design, implementation, and evaluation of health equity efforts in the context of Contractor's population health initiatives; inform decision-making around best payer practices related to disparity reductions, including the provision of health equity and social determinant of health resources and research to leadership and programmatic areas; collaborate with Contractor's MIS Director to ensure Contractor collects and meaningfully uses race, ethnicity, and language data to identify disparities; ensure that efforts addressed at improving health equity, reducing disparities, and improving cultural competence are designed collaboratively with other contracted managed care entities to have a collective impact for the population and the lessons learned are incorporated into future decision-making. This position shall report directly to the CEO.

T. Other key personnel identified by Contractor.

1.4.4. *Care Coordinator Qualifications*. Care Coordinators who serve Enrollees within the IDoA Persons who are Elderly HCBS Waiver, DHS-DRS Persons with a Brain Injury HCBS Waiver, DHS-DRS Persons with HIV/AIDS HCBS Waiver, or DHS-DRS Persons with Disabilities HCBS Waiver must meet the applicable qualifications set forth in *Attachment 5 Qualifications and Training Requirements of Care Coordinators for 1915c HCBS Waiver Services*. Care Coordinators for all other Enrollees must have the appropriate qualifications to address the needs of Enrollees.

1.4.5. *Diverse Staff*. Contractor shall proactively attempt, within the conditions imposed by any court order or consent decree, to hire staff who reflect the diversity of Enrollee demographics.

1.5 Transportation and Delivery: N/A

1.6 Subcontracting

1.6.1 *Subcontractors are allowed*.

1.6.2 *Will subcontractors be utilized*? ☒ Yes ☐ No

A. A subcontractor pursuant to 42 CFR 438 that enters into a contractual agreement with a total value of US $10,000 or more with a person or entity who has a contract subject to the Illinois Procurement Code pursuant to which the person or entity provides some or all of the goods, services, real property, remuneration, or other monetary forms of consideration that are the subject of the primary State contract, including subleases from a lessee of a State contract.

1.6.3 *Identification of Subcontractors*. Please identify Attachment 10 subcontracts with an annual value of US $100,000 or more that will be utilized in the performance of the contract, the names and addresses of the subcontractors, and a description of the work to be performed by each

A. Subcontractor Name: Please see attachment 10

Amount to Be Paid: Please see attachment 10

Address: Please see attachment 10

Description of Work: Please see attachment 10

If additional space is necessary to provide subcontractor information, please attach an additional page.

1.6.4 *Standard Illinois Certifications*. All contracts with the subcontractors identified above must include the Standard Illinois Certifications completed.

1.6.5 *Subcontractor Compliance*. Contractor shall require that its Subcontractors comply with Contractor's Cultural Competence plan and complete Contractor's initial and annual Cultural Competence training. Contractor's oversight committee, established pursuant to *Section 6.2 Subcontracts* shall ensure compliance by Subcontractors with contractual and statutory requirements, including the Illinois Human Rights Act, the US Civil Rights Act, and Section 504 of the federal Rehabilitation Act.

1.6.6 *Subcontractor Financial Disclosures and Conflicts of Interest*. If the annual value of any the subcontracts is more than US $100,000, then the Contractor must provide to the State the Financial Disclosures and Conflicts of Interest for that subcontractor.

1.6.7 *Notification of Change of Subcontractors*. If at any time during the term of the Contract, Contractor adds or changes any subcontractors, Contractor is required to promptly notify, in writing, the State Purchasing Officer or the Chief Procurement Officer of the names and addresses and the expected amount of money that each new or replaced subcontractor will receive pursuant to this Contract. Any subcontracts entered into prior to award of this Contract are done at the sole risk of the Contractor and subcontractor(s).

1.7 Successor Vendor

☐ Yes ☐ No This contract is for services subject to 30 ILCS 500/25-80. Heating and air conditioning service contracts, plumbing service contracts, and electrical service contracts are not subject to this requirement. Non-service contracts, construction contracts, qualification-based selection contracts, and professional and artistic services contracts are not subject to this requirement.

If yes is checked, then the Vendor certifies:

(i) that it shall 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 who perform substantially similar work to the work that will be performed pursuant to this contract.

1.8 Where Services are to be Performed: Unless otherwise disclosed in this section all services shall be performed in the United States. If the Vendor performs the services purchased hereunder in another country in violation of this provision, such action may be deemed by the State as a breach of the contract by Vendor.

1.8.1 *Service Location and Service Value*. Vendor shall disclose the locations where the services required shall be performed and the known or anticipated value of the services to be performed at each location.

1.8.2 *Services in the United States*. If the Vendor received additional consideration in the evaluation based on work being performed in the United States, it shall be a breach of contract if the Vendor shifts any such work outside the United States.

A. Location where services will be performed: United States

Value of services performed at this location: 100%

B. Location where services will be performed: Click here to enter text

Value of services performed at this location: Click here to enter text

2. PRICING

2.1 **Type of Pricing:** The Illinois Office of the Comptroller requires the State to indicate whether the contract price is firm or estimated at the time it is submitted for obligation. The total price of this contract is estimated.

2.2 **Expenses Allowed:** Expenses are not allowed.

2.3 **Discount:** The State may receive a N/A % discount for payment within N/A days of receipt of correct invoice. This discount will not be a factor in making the award.

2.4 **Vendor's Pricing**: The Department's actuary will set actuarially sound capitation rates for each rate cell. The methodologies used to support the development of actuarially sound capitation rates for each rate cell will be documented in a formal rate certification for submission to CMS.

2.4.1 *Capitation Payments*:

A. Contractor will receive monthly payments for each Enrollee from the Department as full compensation of Medicaid services. The legal entity holding a Medicare Advantage contract with CMS for the D-SNP named within this Contract receives direct capitation from HFS to provide coverage of the Medicaid benefits described in this Contract for enrollees in the D-SNP covered under this contract. The legal name of that entity is xxxxx.

B. Except as otherwise stated, capitation rate updates will take place on January 1st of each calendar year.

C. Underlying Rate Structure for the Medicaid Services

a. The Department shall pay Contractor on a Capitation basis, based on the rate cell of the Enrollee, a sum equal to the product of the approved Capitation Rate and the number of Enrollees enrolled in that rate cell as of the first day of that month. An Enrollee's rate cell will be determined by the Enrollee's residential status (e.g., NF Resident, HCBS Waiver) as of the first day of the month. The Department will use its eligibility system to determine an Enrollee's rate cell. Delays in changes to an Enrollee's residential status being reflected in the Department's eligibility system will cause adjustments to past Capitation payments to be made.

b. The rate cells for the Medicaid Enrollees are stratified by age (21-64 and 65+), geographic Service Area, and setting-of-care as follows:

i. Nursing Home. The Nursing Home will be paid for Enrollees residing in a NF on the first of the month in which the payment is made.

ii. HCBS Waiver Rate Cell. The HCBS Waiver rate cell will be paid for Enrollees enrolled in an HCBS Waiver and not residing in a NF on the first of the month in which the payment is made.

iii. Community Residents Rate Cell. The Community Residents rate cell will be paid for Enrollees who do not meet the State's nursing home level of care criteria and do not reside in a NF or qualify for an HCBS Waiver.

iv. The Department shall pay Contractor a separate, State-funded-only monthly Capitation payment for an Enrollee who is residing in an Institution for Mental Diseases on the first day of the month (this rate cell is for IMD stays of more than 15 days in a calendar month and is State-funded only).

c. 820 Payment Files. For each payment made, the Department will make available an 820 Payment File. This file will include identification of each Enrollee for whom payment is being made and the rate cell that the Enrollee is in. Contractor shall retrieve this file electronically.

d. Payment file reconciliation. Within thirty (30) days after the 820 Payment File is made available, Contractor shall notify the Department of any discrepancies, and Contractor and the Department will work together to resolve the discrepancies. Discrepancies include the following:

i. Enrollees who Contractor believes are in its plan but who are not included on the 820 Payment File;

ii. Enrollees who are included on the 820 Payment File but who Contractor believes have not been enrolled with Contractor; and

iii. Enrollees who are included on the 820 Payment File but whom Contractor believes are in a different rate cell.

e. For Enrollees electing hospice services while Residents of a NF, the Medicaid payment to the hospice Provider for the "room and board" component will be the responsibility of the D-SNP.

f. Capitation rates shall include any Medicare Part A and B cost sharing described in 1.2.11(N). Contractor agrees that the capitation rates are full compensation for the Department's Medicare cost sharing obligations.

2.4.2 *Medical Loss Ratio (MLR)*

A. Medical Loss Ratio Guarantee.

a. Contractor shall calculate, and report to the Department, a medical loss ratio (MLR) for each calendar year (MLR reporting year), consistent with MLR standards in 42 CFR 438.8(a). The MLR calculation shall be determined as set forth below; however, the Department may adopt NAIC reporting standards and protocols after giving written notice to Contractor.

b. Effective with calendar year (MLR reporting year) 2026, the minimum MLR is eighty-eight percent (88%). The Department retains the right to adjust the minimum MLR in adherence to 42 CFR 438.8.

B. **MLR Calculations.**

a. Contractor shall calculate the MLR to be submitted to CMS for each MLR reporting year as the ratio of the numerator (as defined in accordance with 42 CFR 438.8(e)) to the denominator (as defined in accordance with 42 CFR 438.8(f)) with nine (9) months claims run out; and

b. For the purpose of an MLR remittance as described in section 2.4.2.G Contractor shall calculate the MLR for each MLR reporting year as the ratio of the numerator (as defined in accordance with 42 CFR 438.8(e)) to the denominator (as defined in accordance with 42 CFR 438.8(f)) except that revenue and expenses associated with separate payment term state directed payments will be excluded from the numerator and denominator and the calculation will be performed with eighteen (18) months

of claims run out. Separate payment term state directed payments are defined as state directed payment arrangements that are not associated with an insurance risk to the Contractor during the MLR reporting year.

C. For each MLR calculation, Contractor shall:

a. In accordance with 42 CFR 438.8 (g)(1)(i), include each of Contractor's expenses under only one (1) type of expense, unless a portion of the expense fits under the definition of, or criteria for, one (1) type of expense and the remainder fits into a different type of expense, in which case the expense must be prorated between types of expenses; and

b. In accordance with 42 CFR 438.8(g)(1)(ii), report expenditures that benefit multiple contracts or populations, or contracts other than those being reported, on pro rata basis.

D. For each MLR calculation, Contractor shall, in accordance with 42 CFR 438.8(g)(2), shall:

a. base expense allocation on a generally accepted accounting method that is expected to yield the most accurate results;

b. apportion shared expenses, including expenses under the terms of a management contract, pro rata to the contract incurring the expense; and

c. ensure that those expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities.

E. Credibility Adjustment. For each MLR calculation:

a. Contractor may add a credibility adjustment, in accordance with 42 CFR 438.8(h), to a calculated MLR if the MLR reporting year experience is partially credible.

b. Contractor shall add the credibility adjustment, if any, to the reported MLR calculation before calculating any remittances, if required.

c. Contractor may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible.

d. If Contractor's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards.

F. The Contract specifies that the Contractor will aggregate data for all Medicaid eligibility groups covered under the contract with the State unless the State requires separate reporting and a separate MLR calculation for specific populations. [42 CFR 438.8(i)]

G. Contractor shall refund to the State, for each MLR reporting year, an amount equal to the difference between the calculated MLR and the minimum MLR multiplied by the MLR reporting year revenue based on the MLR calculation prepared in accordance with section 2.4.2.B.b. The Department, at its discretion, may require Contractor to invest the amount otherwise due to be refunded to the state in a manner specifically directed by the Department to further the goals of the Medicaid Program rather than refund the amount to the State.

H. For each MLR calculation, Contractor shall submit an MLR report, in a format specified by the Department that includes, for each MLR reporting Year:

a. Total incurred claims, including incentive payments fully in compliance with the requirements described under section 2.4.3.E;

b. Expenditures on quality-improving activities meeting the requirements under 42 CFR 438.8 (e)(3);

c. Expenditures related to activities compliant with program integrity requirements;

d. Non-claims costs;

e. Premium revenue, which, for purposes of the MLR calculation, will consist of the Capitation payments, as risk-adjusted -, due from the Department for services provided during the MLR reporting year, including withheld amounts earned and paid pursuant to section 2.4.3.A;

f. Taxes;

g. Licensing fees;

h. Regulatory fees;

i. Methodology(ies) for allocation of expenditures, in accordance with 42 CFR 438.8(k)(1)(vii), which must include a detailed description of the methods used to allocate corporate expenses included in section 2.4.2.H.a through d and 2.4.2.H.f through h. to each health insurance market (Medicaid, Medicare, commercial, etc.) Contractor participates in and in each State, including Illinois, where Contractor has a Medicaid contract, in addition to how each specific expense meets the criteria for the type of expense in which it is categorized, as well as the method by which it was aggregated;

j. Any credibility adjustment applied;

k. The calculated MLR;

l. Any remittance owed to the state, if applicable;

m. A comparison of the information reported with the audited financial reports;

n. A description of the aggregation method used to calculate total incurred claims; and

o. The number of Enrollee months.

I. Data Submission. Contractor shall submit to the Department in the form and manner prescribed by the Department the data described in 2.4.2.H. Benefit expense claims must be submitted as required under this Contract. For each MLR reporting year, Contractor must submit to the Department all data and information specified (including format) in 42 CFR 438.8(k) and by 43 CFR 438.242. Contractor must attest to the accuracy of all data, including benefit expense claims, and of the MLR calculation.

a. Contractor shall submit the MLR calculation described in section 2.4.2.B.a. within twelve (12) months of the end of the MLR reporting year.

b. Contractor shall submit the MLR calculation described in section 2.4.2.B.b. within twenty-one (21) months of the end of the MLR reporting year.

J. For each MLR calculation, Contractor shall require any Third-Party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to Contractor within one hundred eighty

(180) days after the end of the MLR reporting year or within thirty (30) days after a request by Contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.

K. In any instance where the Department makes a retroactive change to the Capitation payments for a MLR reporting year(s) and the MLR report(s) for that MLR reporting year(s) has already been submitted to the Department, Contractor shall:

a. recalculate the MLR for all MLR reporting years affected by the change; and

b. submit a new MLR report meeting the applicable requirements of this Contract.

L. Medicare MLR Reporting. Contractor is required to submit all CMS Medicare MLR Data Report(s) to the Department.

2.4.3 *Contractor Payment Terms*

A. Timing of Capitation Payments

a. Enrollments. The Department will make monthly per member per month Capitation payments to Contractor. The PMPM Capitation payment for a particular month will reflect payment for the Enrollees with effective enrollment into Contractor's D-SNP as of the first day of that month.

b. Disenrollments. The final per member per month Capitation payment made by the Department to Contractor for each Enrollee will be for the month in which the disenrollment was submitted, the Enrollee loses eligibility, or the Enrollee dies.

c. Timing of Medicaid Payment

i. Capitation paid by the Department for Medicaid Services is due to Contractor by the fifteenth (15th) day of the service month. Payments due from the Department, including late charges, will be paid in accordance with the State Prompt Payment Act (30 ILCS 540) and rules (74 Ill. Admin. Code 900) when applicable. Collection of underlying amounts owed plus interest shall be Contractor's sole financial remedy against the

Department for late payments by the State. Payment terms contained on Contractor's invoices shall have no force and effect.

ii. Adjustments to amounts paid by the Department due to lags in the eligibility system shall be reconciled.

d. Modifications to Capitation Rates. The Department will notify Contractor in advance and in writing as soon as practicable, but in no event less than thirty (30) days prior to processing the change to the Capitation Rate, of any proposed changes to the Capitation Rates, and Contractor shall accept such changes as payment in full. Any mid-year rate changes would be articulated in a rate report.

i. Rates will be updated using a similar process for each calendar year. Changes to the Medicaid baseline outside of the annual Medicaid rate update will be made only if and when the Department determines the change is necessary to calculate accurate payment rates for the D-SNP. Such changes may be based on the following factors: shifts in enrollment assumptions; major changes or discrepancies in Federal law and/or State policy compared to assumptions about Federal law and/or State law or policy used in the development of baseline estimates; and changes in coding intensity.

ii. If other statutory changes enacted after the annual baseline determination and rate development process are determined by the Department to have a material change in baseline estimates for any given payment year, baseline estimates and corresponding standardized payment rates shall be updated outside of the annual rate development process.

iii. Any material changes in the Medicaid State Plan, including pertaining to Covered Services, payment schedules and related methodologies, shall be reflected in corresponding Capitation payment adjustments. Contractor will not be required to implement such changes without advance notice and corresponding adjustment in the Capitation payment. In addition, to the extent other Medicaid costs are incurred absent the D-

SNP, such costs shall be reflected in corresponding Capitation payment adjustments.

e. Quality Withhold Policy for Medicaid. The Department shall apply a Withhold, defined as a Withhold Arrangement under 42 CFR 438.6(a), percentage of total Capitation rates each month. The withheld amount will be two percent (2%) in the measurement years. Contractor may earn a percentage of the funds withheld from the Contractor's capitation payments based on its performance with respect to a Department-determined metrics. The Department and Contractor will agree to the measures through a counter-signed letter annually. The letter will include but not be limited to the measures, baselines, targets, and any weighting assigned to metrics as it relates to the withhold.

f. American Recovery and Reinvestment Act of 2009

i. All payments to Contractor are conditioned on compliance with the provisions below and all other applicable provisions of the American Recovery and Reinvestment Act of 2009 (ARRA).

ii. Contractor shall maintain sufficient Indian Health Care Providers in the Provider network to ensure timely access to Covered Services for Indian Enrollees who are eligible to receive services;

iii. Contractor shall make prompt payment to Indian Health Care Providers;

iv. Contractor shall pay Indian Health Care Providers, whether participating in the network or not, for covered items and services provided to Indian Enrollees who are eligible to receive services from the Indian Health Care Providers either at a negotiated rate between Contractor and the Indian Health Care Provider, or if there is no negotiated rate, at a rate no less than the level and amount of payment that would be made if the Provider were not an Indian Health Care Provider.

v. Contractor shall pay non-network Indian Health Care Providers that are FQHCs for the provision of services to an Indian Enrollee at a rate equal to the rate that

Contractor would pay to a network FQHC that is not an Indian Health Care Provider, including any supplemental payment from the State to make up the difference between the contract amount and what the Indian Health Care Provider would have received Medicaid Fee For Service.

vi. Contractor shall not reduce payment that is due under Medicaid to the Indian Health Care Provider through Referral under contract health services for furnishing an item or service to an Indian Enrollee. The State must pay these Providers the full Medicaid payment rate for furnishing the item or service.

vii. Contractor shall not impose enrollment fees, premiums, or similar charges on Indian Enrollees regardless of payer. Contractor must exempt from all cost sharing any Indian Enrollee who is currently receiving or has ever received an item or service furnished by an Indian Health Care Provider or through Referral under contract health services.

B. Medicaid Payment Reconciliation

a. HFS will implement a process to reconcile Enrollment and Capitation Payments for the D-SNP that will take into consideration the following circumstances: transitions between rate cells; retroactive changes in eligibility or rate cells; and changes through new Enrollment, disenrollment, or death. The reconciliation may identify underpayments or overpayments to Contractor.

b. Within thirty (30) days after the 820 Payment File is made available, Contractor shall notify the Department of any discrepancies, including Enrollees who Contractor believes are in its D-SNP and not on the 820 Payment File, Enrollees included on the 820 Payment File who Contractor believes have not been enrolled with Contractor, and Enrollees included on the 820 Payment File who Contractor believes are in a different rate cell. Contractor and the Department will work together to resolve these discrepancies.

c. Payments to Contractor will be adjusted for retroactive disenrollment of Enrollees, changes to Enrollee information that affect the Capitation Rates (e.g., eligibility classification), monetary sanctions, rate changes, and other miscellaneous adjustments provided for herein. Adjustments shall be retroactive, no more than eighteen (18) months, unless otherwise agreed to by Contractor and the Department.

d. Notwithstanding the foregoing, any adjustment for retroactive disenrollment of Enrollees shall not exceed two (2) months except in instances of the death of an Enrollee or when the Enrollee moves out of the State.

C. Audits/Monitoring. The Department will conduct periodic audits to validate rate cell assignments or other coding. Audits may be conducted by a peer review organization or other entity assigned this responsibility by the Department.

D. Payment in Full

a. Contractor must accept, as payment in full for all Covered Services, the Capitation Rate(s) and the terms and conditions of payment set forth herein.

b. Notwithstanding any contractual provision or legal right to the contrary, the Department and Contractor, agree there shall be no redress against either party, or their actuarial contractors, over the actuarial soundness of the Capitation Rates.

c. Contractor accepts that the Capitation Rate(s) offered is reasonable; that operating within this Capitation Rate(s) is the sole responsibility of Contractor; and that while data is made available by the Federal Government and the State to Contractor, any entity participating in the D-SNP must rely on their own resource to project likely experience under the D-SNP.

d. Community Transition Initiative payments.

i. When Contractor achieves the specified performance target for successful community transitions under *Section 1.2.14.S.f Care Coordination*, the Department will make an incentive payment of $5,000.00 for each transition.

ii. When Contractor achieves the specified performance target for Department-approved comprehensive community transition evaluations documenting impairments that preclude transition, the Department will make an incentive payment of $500.00 for each approved evaluation.

iii. The Department will require successful bidders be able, within 90 days of the Department providing the necessary information, to process payments to pay the State via ACH or electronic transfer.

E. Incentive Payments –Contractor shall comply with the provisions of 42 CFR 422.208 and 42 CFR 422.210. If to confirm to these regulations, Contractor performs Enrollee-satisfaction surveys, such surveys may be combined with those otherwise required by the Department pursuant to this Contract.

a. In accordance with 42 CFR 438.3(i)(3), for each incentive payment contract with a network provider, Contractor shall:

i. Have a defined performance period that can be tied to the applicable MLR reporting periods as set forth in this contract for the MLR reporting year.

ii. Be signed and dated by all appropriate parties before the commencement of the applicable performance period.

iii. Include clearly defined, objectively measurable, and well-documented clinical or quality improvement that the provider must meet to receive the incentive payment.

iv. Specify a dollar amount or a percentage of a verifiable dollar amount that can be clearly linked to successful completion of the metrics defined in the incentive payment contract, including a date of payment.

b. For each incentive payment contract with a network provider, contractor shall make available upon request and at any frequency during the MLR reporting year:

i. an executed copy of the contract that documents requirements for the incentive payment contract as

defined in this section for the applicable MLR reporting year;

ii. supporting documentation of the results of the Provider's quality improvement or performance metrics along with the determination that each metric has been met or not met;

iii. supporting documentation necessary to verify completion of the payment date and amount to the Provider in accordance with the executed contract; and

iv. the Department reserves the right to request additional supporting documentation of Contractor's Provider incentive payment contracts upon request and at any routine frequency to ensure compliance with 42 CFR 438.3(i)(3).

c. Contractor shall submit to the Department, in the form and manner prescribed by the Department, the data described in this section. For each MLR reporting year, Contractor must submit to the Department all data and supporting documentation in accordance with 42 CFR 438.3(i)(4)(i) as specified (including format).

d. A corporate officer of the Contractor must attest to the accuracy of all supporting documentation and data provided to ensure compliance with this section.

e. Attestations are not allowed to be used as stand-alone supporting documentation for data that factor into the MLR calculation in accordance with 42 CFR 438.3(i)(4)(ii).

f. Contractor shall submit documentation of compliance with this section in a format defined by the Department within thirty (30) days of the beginning of the MLR reporting year.

g. Contractor shall submit the supporting documentation required by this section in a format defined by the Department and in conjunction with the MLR report timeline described in this Contract.

2.5 **Maximum Amount:** The total payments under this contract shall not exceed $ $1,258,500,000.00 without a formal amendment.

3. TERM AND TERMINATION

3.1 **Term of this Contract:** This contract has an initial term of four and a half (4 1/2) years from July 1, 2025, to December 31, 2029, or the term shall commence upon the last dated signature of the Parties, whichever is later.

3.2 **BidBuy**. For procurements conducted in BidBuy, the State may include in this contract the BidBuy Purchase Order as it contains the agreed term.

3.2.1 *Contract Term*. In no event will the total term of the contract, including the initial term, any renewal terms and any extensions, exceed ten (10) years. 30 ILCS 500/20-60

3.2.2 *Commencement of Billable Work*. Vendor shall not commence billable work in furtherance of the contract prior to final execution of the contract except when permitted pursuant to 30 ILCS 500/20-80.

3.3 **Renewal:**

3.3.1 *Renewal Terms and Options*. Any renewal is subject to the same terms and conditions as the original contract unless otherwise provided in the pricing section. The State may renew this contract for any or all the option periods specified, may exercise any of the renewal options early, and may exercise more than one option at a time based on continuing need and favorable market conditions, when in the best interest of the State. The contract may neither renew automatically nor renew solely at the Vendor's option.

3.3.2 *Pricing for the renewal term(s)*: For all years of the contract renewal periods, Contractors shall be paid a per member per month risk-based capitation payment developed by the HFS contracted actuaries in accordance with rate development requirements of 42 CFR Part 438.

3.3.3 *State Right to Renew for a Certain Term*. The State reserves the right to renew for a total of five and a half (5 ½) years in any one of the following manners:

A. One renewal covering the entire renewal allowance;

B. Individual one-year renewals up to and including the entire renewal allowance; or

C. Any combination of full or partial year renewals up to and including the entire renewal allowance.

3.4 Termination for Cause: The State may terminate this contract, in whole or in part, immediately upon notice to the Vendor if: (a) the State determines that the actions or inactions of the Vendor, its agents, employees or subcontractors have caused, or reasonably could cause, jeopardy to health, safety, or property, or (b) the Vendor has notified the State that it is unable or unwilling to perform the contract.

3.4.1 *Materiality and Financial Resources Termination*. If Vendor fails to perform to the State's satisfaction any material requirement of this contract, is in violation of a material provision of this contract, or the State determines that the Vendor lacks the financial resources to perform the contract, the State shall provide written notice to the Vendor to cure the problem identified within the period of time specified in the State's written notice. If not cured 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.

3.4.2 *Readiness Review Termination*. The Department has the right to terminate the contract prior to 1/1/2026 if the Contractor does not successfully meet CMS readiness review activities.

3.4.3 *State Right to Legal or Equitable Remedies and Damages*. For termination due to any of the causes contained in this section, the State retains its rights to seek any available legal or equitable remedies and damages.

3.5 Termination for Convenience: The State may, for its convenience and with thirty (30) days prior written notice to Vendor, terminate this contract in whole or in part and without payment of any penalty or incurring any further obligation to the Vendor.

3.5.1 *Compensation*. Upon submission of invoices and proof of claim, the Vendor shall be entitled to compensation for supplies and services provided in compliance with this contract up to and including the date of termination.

3.5.2 *Continuing Duties In Event of Termination*: Upon termination of this Contract, the Parties are obligated to perform those duties that survive under this Contract. Such duties include payment to Network or non-Network Providers, including resolution of aged unpaid claims; completion of Enrollee satisfaction surveys; cooperation with medical records review; all reports for periods of operation, including Encounter Data; retention of records; and preservation of confidentiality and security of PHI. Termination of this Contract does not eliminate Contractor's responsibility to the Department for overpayments, which the Department determines in a subsequent audit may have been made to

Contractor, nor does it eliminate any responsibility the Department may have for underpayments to Contractor. Contractor warrants that if this Contract is terminated, Contractor shall promptly supply all information in its possession or that may be reasonably obtained that is necessary for the orderly transition of Enrollees and completion of all Contract responsibilities. Contractor must, for a period of time specified by the Department, provide all reasonable transition assistance requested by the Department.

3.5.3 *Availability for Appropriation***:** This contract is contingent upon and subject to the availability of funds. 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 (1) 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 (30 ILCS 500/20-60), (2) the Governor decreases the Agency's funding by reserving some or all of the Agency's appropriation(s) pursuant to power delegated to the Governor by the Illinois General Assembly, or (3) the Agency determines, in its sole discretion or as directed by the Office of the Governor, that a reduction is necessary or advisable based upon actual or projected budgetary considerations. Contractor will be notified in writing of the failure of appropriation or of a reduction or decrease.

4 STANDARD BUSINESS TERMS AND CONDITIONS

4.1 Payments Terms and Conditions:

4.1.1 *Late Payment*: Payments, including late payment charges, will be paid in accordance with the State Prompt Payment Act and rules when applicable. 30 ILCS 540; 74 III. Adm. Code 900. This shall be Vendor's sole remedy for late payments by the State. Payment terms contained in Vendor's invoices shall have no force or effect.

4.1.2 *Minority Contractor Initiative*: Any Contractor awarded a contract of $1,000 or more under Section 20-10, 20-15, 20-25 or 20-30 of the Illinois Procurement Code (30 ILCS 500) is required to pay a fee of $15. The Comptroller shall deduct the fee from the first check issued to the Vendor under the contract and deposit the fee in the Comptroller's Administrative Fund. 15 ILCS 405/23.9.

4.1.3 *Expenses*: The State will not pay for supplies provided or services rendered, including related expenses, incurred prior to the execution of this contract by the Parties even if the effective date of the contract is prior to execution.

4.1.4 *Prevailing Wage*: As a condition of receiving payment Contractor must (i) be in compliance with the contract, (ii) pay its employees prevailing wages when required by law, (iii) pay its suppliers and subcontractors according to the terms of their respective contracts, and (iv) provide lien waivers to the State upon request. Examples of prevailing wage categories include public works, printing, janitorial, window washing, building and grounds services, site technician services, natural resource services, security guard and food services. The prevailing wages are revised by the Illinois Department of Labor (DOL) and are available on DOL's official website, which shall be deemed proper notification of any rate changes under this subsection. Contractor is responsible for contacting DOL at 217-782-6206 or (*https://labor.illinois.gov*) to ensure understanding of prevailing wage requirements.

4.1.5 *Federal Funding*: This contract may be partially or totally funded with Federal funds. If Federal funds are expected to be used, then the percentage of the good/service paid using Federal funds and the total Federal funds expected to be used will be provided to the awarded Vendor in the notice of intent to award.

4.1.6 *Invoicing*: By submitting an invoice, Vendor certifies that the supplies or services provided meet all requirements of this contract, and the amount billed and expenses incurred are as allowed in this contract. Invoices for supplies purchased, services performed, and expenses incurred through June 30 of any year must be

submitted to the State no later than July 31 of that year; otherwise, Vendor may have to seek payment through the Illinois Court of Claims. 30 ILCS 105/25. All invoices are subject to statutory offset. 30 ILCS 210.

A. Contractor shall not bill for any taxes unless accompanied by proof that the State is subject to the tax. If necessary, Contractor may request the applicable Agency's Illinois tax exemption number and Federal tax exemption information.

B. Contractor does not invoice for services of the contract. Contractor is paid per Capitation rate as described in *Section 2.4.1 Capitation Payments*.

4.1.7 *BidBuy*. For procurements conducted in BidBuy, the Agency may include in this contract the BidBuy Purchase Order as it contains the Bill To address.

4.2 **Assignment**: This contract may not be assigned or transferred in whole or in part by Contractor without the prior written consent of the State.

4.3 **Subcontracting:** For purposes of this section, subcontractors are those with contracts with an annual value exceeding $100,000 and who are specifically hired to perform all or part of the work covered by this contract. Contractor must receive prior written approval before use of any subcontractors in the performance of this contract. Contractor shall describe, in an attachment if not already provided, the names and addresses of all authorized subcontractors to be 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. If required, Contractor shall provide a copy of any subcontracts within fifteen (15) days after execution of this contract. All subcontracts must include the same certifications that Contractor must make as a condition of this contract. Contractor shall include in each subcontract the Standard Illinois Certifications form available from the State. If at any time during the term of the Contract, Contractor adds or changes any subcontractors, then Contractor must promptly notify, by written amendment to the Contract, the State Purchasing Officer or the Chief Procurement Officer of the names and addresses, the expected amount of money that each new or replaced subcontractor will receive pursuant to the Contract, and the general type of work to be performed. 30 ILCS 500/20-120.

4.4 **Audit/Retention of Records:** Contractor and its subcontractors shall maintain books and records relating to the performance of this contract and any subcontract necessary to support amounts charged to the State pursuant this contract or subcontract. Books and records, including information stored in databases or other computer systems, shall be maintained by Contractor for a period of three (3) 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 three (3) years from the later of final payment under the term or completion of the subcontract. If Federal funds are used to pay contract costs, Contractor and its subcontractors must retain their respective records for ten (10) years. Books and records required to be maintained under this section shall be available for review or audit by representatives of the procuring Agency, the Auditor General, the Executive Inspector General, the Chief Procurement Officer, State of Illinois internal auditors or 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 this contract or any subcontract for which adequate books and records are not available to support the purported disbursement. Contractor or subcontractors shall not impose a charge for audit or examination of Contractor's or subcontractor's books and records. 30 ILCS 500/20-65.

4.5 **Time is of the Essence:** Time is of the essence with respect to Contractor's performance of this Contract. Unless otherwise directed by the Department, Contractor shall continue to perform its obligations while any dispute concerning the Contract is being resolved.

4.6 **No Waiver of Rights:** Except as specifically waived in writing, failure by a Party to exercise or enforce a right does not waive that Party's right to exercise or enforce that or other rights in the future.

4.7 **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 this contract without penalty if performance does not resume within thirty (30) days of the declaration.

4.8 **Confidential Information:** It is understood that each Party to this Contract, including its agents and Subcontractors, may have or gain access to Confidential Information or data owned or maintained by the other Party in the course of carrying out its responsibilities under this Contract. Contractor shall presume that all information received from the State or to which it gains access pursuant to this Contract is confidential. Contractor's information (excluding information regarding rates paid by Contractor to its Providers and Subcontractors), unless clearly marked as confidential and exempt from disclosure under the Illinois Freedom of Information Act, shall be considered public. 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 term of the Contract or thereafter, or as otherwise set forth in

this Contract. The receiving Party must return any and all data collected, maintained, created, or used in the course of the performance of the duties of this Contract, in whatever form they are maintained, promptly at the end of the term of this Contract, or earlier at the request of the disclosing Party, or notify the disclosing Party in writing of the data's destruction. The foregoing obligations shall not apply to confidential data or information that: 1) are lawfully in the receiving Party's possession prior to its acquisition from the disclosing Party: 2) are received in good faith from a Third Party not subject to any confidentiality obligation to the disclosing Party: 3) are now, or become, publicly known through no Breach of confidentiality obligation by the receiving Party; or 4) *is independently developed by the receiving Party without the use or benefit of the disclosing Party's Confidential Information.*

4.9 **Use of Ownership:** All work performed or supplies created by Vendor 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 in writing. 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. Contractor acknowledges the State may use the work product for any purpose. Confidential data or information contained in such work shall be subject to the confidentiality provisions of this contract.

4.10 **Indemnification and Liability:** Contractor shall 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 certifications, representations, warranties, covenants or agreements; (b) any actual or alleged death or injury to any person, damage to any real or personal property, or any other damage or loss claimed to result in whole or in part from Contractor's negligent performance; (c) any act, activity or omission of Contractor or any of its employees, representatives, subcontractors or agents; or (d) any actual or alleged claim that the services or goods provided under this contract infringe, misappropriate, or otherwise violate any intellectual property (patent, copyright, trade secret, or trademark) rights of a third party. In accordance with Article VIII, Section 1(a),(b) of the Constitution of the State of Illinois, the State may not indemnify private parties absent express statutory authority permitting the indemnification. Neither Party shall be liable for incidental, special, consequential, or punitive damages.

4.11 **Insurance:** Contractor shall, at all times during the term of this contract and any renewals or extensions, maintain and provide a Certificate of Insurance naming the State as an additionally insured for all required bonds and insurance. Certificates may not be

modified or canceled until at least thirty (30) days' notice has been provided to the State. Contractor shall provide: (a) General Commercial Liability insurance in the 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 the amount required by law. Insurance shall not limit Contractor's obligation to indemnify, defend, or settle any claims.

4.12 **Independent Contractor:** Contractor shall act as 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.

4.13 **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.

4.14 **Compliance with the Law:** 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. Contractor shall be in compliance with applicable tax requirements and shall be current in payment of such taxes. Contractor shall obtain at its own expense, all licenses and permissions necessary for the performance of this contract.

4.15 **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 and subcontractor's officers, employees or agents. Contractor or subcontractor shall immediately reassign any individual who, in the opinion of the State, does not pass the background check. At minimum, the Department will require background checks be conducted for Contractor's and Subcontractor's key personnel positions outlined in *Section 1.4 Vender/Staff Specifications* along with any individual in an Enrollee-facing, a Provider-facing, or a financial role.

4.16 **Applicable Law:**

4.16.1 *Prevailing Law*: This contract shall be construed in accordance with and is subject to the laws and rules of the State of Illinois.

4.16.2 *Equal Opportunity*: The Department of Human Rights' Equal Opportunity requirements are incorporated by reference. 44 Ill. Adm. Code 750.

4.16.3 *Court of Claims; Arbitration; Sovereign Immunity***:** 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 dispute arising out of this contract. The State of Illinois does not waive sovereign immunity by entering into this contract.

4.16.4 *Official Text***:** The official text of the statutes cited herein is incorporated by reference. An unofficial version can be viewed at (*www.ilga.gov/legislation/ilcs/ilcs.asp*).

4.17 **Anti-Trust Assignment:** If Contractor does not pursue any claim or cause of action it has arising under Federal or State antitrust laws relating to the subject matter of this contract, then upon request of the Illinois Attorney General, Contractor shall assign to the State all of Contractor's rights, title and interest to the claim or cause of action.

4.18 **Contractual Authority:** The Agency that signs this contract on behalf of the State of Illinois shall be the only State entity responsible for performance and payment under this contract. When the Chief Procurement Officer or authorized designee or State Purchasing Officer signs in addition to an Agency, he/she does so as approving officer and shall have no liability to Contractor. When the Chief Procurement Officer or authorized designee or State Purchasing Officer signs a master contract on behalf of State agencies, only the Agency that places an order or orders with Contractor shall have any liability to Contractor for that order or orders.

4.19 **Expatriated Entities:** Except in limited circumstances, no business or member of a unitary business group, as defined in the Illinois Income Tax Act, shall submit a bid for or enter into a contract with a State agency if that business or any member of the unitary business group is an expatriated entity.

4.20 **Notices:** Notices and other communications provided for herein shall be given in writing via electronic mail whenever possible. If transmission via electronic mail is not possible, then notices and other communications shall be given in writing via registered or certified mail with return receipt requested, via receipted hand delivery, via courier (UPS, Federal Express or other similar and reliable carrier), or via facsimile showing the date and time of successful receipt. Notices shall be sent to the individuals who signed this 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. Except as otherwise provided herein, notices shall be sent to the Contract monitors. By giving notice, either Party may change its contact information.

4.21 **Modification and Survival:** 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.

4.22 Performance Record/Suspension: Upon request of the State, Contractor shall meet to discuss performance or provide contract performance updates to help ensure proper performance of this contract. The State may consider Contractor's performance under this contract and compliance with law and rule to determine whether to continue this contract, suspend Contractor from doing future business with the State for a specified period of time, or whether Contractor can be considered responsible on specific future contract opportunities.

4.23 Freedom of Information Act: This contract and all related public records maintained by, provided to, or required to be provided to the State are subject to the Illinois Freedom of Information Act (FOIA) notwithstanding any provision to the contrary that may be found in this contract. 5 ILCS 140. If the Department receives a request for a record relating to Contractor under this Contract, Contractor's provision of services, or the arranging of the provision of services under this Contract, the Department shall provide notice to Contractor as soon as practicable. Within the period available under FOIA, Contractor may identify those records, or portions thereof, that it in good faith believes to be exempt from production and the justification for such exemption. The Department shall make good-faith efforts to notify Contractor regarding a request for a record that has been the subject of a previous request under FOIA.

4.24 Schedule of Work: Any work performed on State premises shall be performed during the hours designated by the State and performed in a manner that does not interfere with the State and its personnel.

4.25 Warranties for Supplies and Services:

4.25.1 *Warranty Requirements*. Contractor warrants that the supplies furnished under this contract will: (a) conform to the standards, specifications, drawing, samples or descriptions furnished by the State or furnished by Contractor and agreed to by the State, including but not limited to all specifications attached as exhibits hereto; (b) be merchantable, of good quality and workmanship, and free from defects for a period of twelve months or longer if so specified in writing, and fit and sufficient for the intended use; (c) comply with all federal and state laws, regulations and ordinances pertaining to the manufacturing, packing, labeling, sale and delivery of the supplies; (d) be of good title and be free and clear of all liens and encumbrances and; (e) not infringe any patent, copyright or other intellectual property rights of any third party. Contractor agrees to reimburse the State for any losses, costs, damages or expenses, including without limitations,

reasonable attorney's fees and expenses, arising from failure of the supplies to meet such warranties.

4.25.2 *Transfer of Warranties*. Contractor shall ensure that all manufacturers' warranties are transferred to the State and shall provide to the State copies of such warranties. These warranties shall be in addition to all other warranties, express, implied or statutory, and shall survive the State's payment, acceptance, inspection or failure to inspect the supplies.

4.25.3 *Performance Warranties.* Contractor warrants that all services will be performed to meet the requirements of this contract in an efficient and effective manner by trained and competent personnel. Contractor shall monitor performances of each individual and shall immediately reassign any individual who does not perform in accordance with this contract, who is disruptive or not respectful of others in the workplace, or who in any way violates the contract or State policies.

4.26 Reporting, Status and Monitoring Specifications: Contractor shall immediately notify the State of any event that may have a material impact on Contractor's ability to perform this contract.

4.27 Employment Tax Credit: Contractors who hire qualified veterans and certain ex-offenders may be eligible for tax credits. 35 ILCS 5/216, 5/217. Please contact the Illinois Department of Revenue (telephone #: 217-524-4772) for information about tax credits.

5. STATE SUPPLEMENTAL PROVISIONS

☐ **5.1 Agency Definitions**

1. **820 Payment File** means the electronic Health Insurance Portability and Accountability Act of 1996 (HIPAA) transaction that Contractor retrieves from the Department that identifies each Enrollee for whom payment was made by the Department to the Contractor.

2. **834 Audit File** means the electronic HIPAA transaction that Contractor retrieves monthly from the Department that reflects its Enrollees for the following calendar month.

3. **834 Daily File** means the electronic HIPAA transaction that the Contractor retrieves from the Department each day that reflects changes in enrollment subsequent to the previous 834 Enrollment File.

4. **834 Enrollment File** means the electronic HIPAA transaction that Contractor retrieves monthly from the Department that reflects its Enrollees for the following calendar month.

5. **837D File** means **t**he electronic HIPAA transaction that Contractor transfers to the Department that identifies healthcare claims for dental claims or Encounters.

6. **837I File** means the electronic HIPAA transaction that Contractor transfers to the Department that identifies healthcare claims for institutional claims and Encounters.

7. **837P File** means the electronic HIPAA transaction that Contractor transfers to the Department that identifies healthcare claims for professional claims and Encounters.

8. **Abuse** means a manner of operation that results in excessive or unreasonable costs to the Federal or State health care programs, generally used in conjunction with Fraud; or (ii) the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish (42 CFR 488.301), generally used in conjunction with Neglect.

9. **Activities of Daily Living (ADL)** means activities such as eating, bathing, grooming, dressing, transferring and continence.

10. **Administrative Allowance** means the portion of the Capitation, paid and allocated by the Department, for the administrative cost of the Contract attributable to the Medicaid component of the Contract.

11. **Admission, Discharge, and Transfer (ADT) System** means a system that holds Enrollee information and shares it with healthcare Providers, facilities, and systems to which it is connected. An ADT system may send ADT messages to alert of an Enrollee's admission to a hospital or healthcare facility.

12. **Administrative Rules** means the sections of the Illinois administrative code that govern the HFS Medical Program.

13. **Advance Directive** means an individual's written directives or instructions, such as a power of attorney for healthcare 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.

14. **Advanced Practice Nurse (APN)** means 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, is a Provider, and has a contract with the Contractor.

15. **Adverse Benefit Determination** –means: (i) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a Covered Service; (ii) the reduction, suspension, or termination of a previously authorized service; (iii) the denial, in whole or in part, of payment for a service; (iv) the failure to provide services in a timely manner, as defined by the State; (v) the failure of the Contractor to act within the required timeframes for the standard resolution of Grievances and Appeals; (vi) for a Resident of a rural area with only one D-SNP, the denial of an Enrollee's request to obtain services outside of the network; or (vii) the denial of an Enrollee's request to dispute a financial liability.

16. **Affordable Care Act Adult (ACA Adult)** means a Participant eligible for HFS Medical Programs through the ACA as of January 1, 2014, and pursuant to 305 ILCS 5/5-2(18).

17. **Affiliate** means any individual, 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 contractor that now or in the future directly or indirectly controls, is controlled by, or is under common control with the Contractor.

18. **Aligned enrollment** means the enrollment in a dual eligible special needs plan of full-benefit dual eligible individuals whose Medicaid benefits are covered under a Medicaid managed care organization contract under section 1903(m) of the Act between the applicable State and: the dual eligible special needs plan's (D–SNP's) MA organization, the D–SNP's parent organization, or another entity that is owned and controlled by the D–SNP's parent organization. When State policy limits a D–SNP's membership to individuals with aligned enrollment, this condition is referred to as exclusively aligned enrollment.

19. **Anniversary Date** means the annual date of an Enrollee's initial enrollment in the D-SNP. For example, if an Enrollee's enrollment in a D-SNP became effective on October 1, 2024, the Anniversary Date with that D-SNP would be each October 1 thereafter.

20. **Appeal** means an Enrollee's request for formal review of an Adverse Benefit Determination of the Contractor in accordance with *Section 1.2.24 Integrated/Unified Non-Part D Organization Determination and Appeals* of the Contract.

21. **Authorized Person(s)** means the Department's Office of Inspector General, the Medicaid Fraud Control Unit of the Illinois State Police, DHHS, the Illinois Auditor General, and other State and federal agencies with monitoring authority related to Medicaid Program and SCHIP.

22. **Behavioral Health** means conditions related to emotional wellness, trauma, mental disorders and substance use disorders and the services and supports found within the network of providers, or otherwise developed by the Contractor, specifically encompassing the prevention, identification, treatment and provision of recovery support for such conditions for the expressed purpose of increasing the stability of the Enrollee's functioning levels across various life domains.

23. **Behavioral Health Crisis** means an individual's behaviors prevent them from functioning at their usual level or indicate they might harm themselves or others and require immediate intervention to prevent further decline in functioning or harm to self or others which cannot be addressed by customary community and mental health services.

24. **Business Day** means Monday through Friday, including State holidays except for New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day and Christmas Day.

25. **Capitation** means the reimbursement arrangement in which a fixed rate of payment per Enrollee per month is made, regardless of whether the Enrollee receives Covered Services in that month, to the Contractor for the performance of all the Contractor's duties and responsibilities pursuant to the Contract.

26. **Care Coordination** means the deliberate organization of Enrollee care activities by an individual or entity formally designated as primarily responsible for coordinating services furnished by

Network Providers, community-based services providers and other providers involved in an Enrollee's care.

27. **Care Coordination and Support Organization (CCSO)** means a provider with responsibility for delivering Mobile Crisis Response and Care Coordination to eligible Enrollees within a designated service area.

28. **Care Coordination Claims Data (CCCD)** means the data set available to Department care coordination partners for recipients enrolled in their programs. CCCD contains the most recent two (2) years of Medical Programs claims data, the most recent seven (7) years of immunization and lead data and monthly updates of the above once the initial historical data have been sent.

29. **Care Coordinator** means an employee or delegated subcontractor of the Contractor who provides Care Management, and together with an Enrollee and care team, establishes an Individualized Plan of Care (IPoC) for the Enrollee and, through interaction with network Providers, ensures the Enrollee receives necessary services.

30. **Care Management** means 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. Care Management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services (both Medicare and Medicaid) required to meet an Enrollee's needs across the continuum of care.

31. **Centers for Medicare & Medicaid Services (CMS)** means the federal agency under the Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.

32. **Certified Local Health Department** means 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.

33. **Change of Control** means any transaction or combination of transactions resulting in: (i) the change in ownership of a contractor; (ii) the sale or transfer of fifty percent (50%) or more of the beneficial ownership of a contractor; 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 set forth in this Contract.

34. **Chronic Health Condition** means a health condition with an anticipated duration of at least twelve (12) months.

35. **Cognitive Disabilities** means a disability that may cover a wide range of needs and abilities that vary for each specific individual. Conditions range from individuals having a serious mental impairment caused by Alzheimer's disease, bipolar disorder or medications to non-organic disorders such as dyslexia, attention deficit disorder, poor literacy or problems understanding information. At a basic level, these disabilities affect the mental process of knowledge, including aspects such as awareness, perception, reasoning, and judgment.

36. **Colbert Contractor** means the Contractor having a contract with the Department to implement the consent decree entered in *Colbert v. Quinn*, No. 07 C 4737 (N.D. Ill.) (Colbert consent decree).

37. **Community Transition Initiative** means initiative specific to achieving transitions from institutional settings to the community for Enrollees who have continuously resided in a Nursing Facility or a specialized mental health Rehabilitation facility for a minimum of ninety (90) days.

38. **Community Mental Health Center** means an agency certified by DHS and enrolled with HFS to provide Medicaid community mental health services.

39. **Complaint** means any Complaint or dispute, other than one that constitutes an organization determination under 42 CFR 422.566, expressing dissatisfaction with any aspect of the Contractor's or Provider's operations, activities, or behavior, regardless of whether remedial action is requested. 42 CFR 422.561. Possible subjects for Complaints include, but are not limited to, a concern related to the health, safety or well-being of an Enrollee, quality of care or services provided, aspects of interpersonal relationships such as rudeness of a Primary Care Provider or employee of Contractor, or failure to respect the Enrollee's rights. Complaints may be received via a phone call, letter or personal contact from a Participant, Enrollee, family member, Enrollee representative or any other interested individual expressing a concern related to the health, safety or well-being of an Enrollee. See also "Grievance."

40. **Computer-Aided, Real-Time Translation (CART)** means the instant translation of spoken word into text performed by a CART reporter using a stenotype machine, notebook computer, and real-time software.

41. **Confidential Information** means any material, data, or information disclosed by any Party to another Party that, pursuant to agreement of the Parties or a Party'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: (i) all materials, know-how, processes, trade secrets, manuals, confidential reports, services rendered by the State, financial, technical and operational information, and other matters relating to the operation of a Party's business; (ii) all information and materials relating to Third Party contractors of the State that have provided any part of the State's information or communications infrastructure to the State; (iii) software; and (iv) any other information that the Parties agree should be kept confidential.

42. **Consumer Assessment of Healthcare Providers and Systems (CAHPS)** means the survey developed by the program funded by the U.S. Agency for Healthcare Research and Quality that works closely with a consortium of public and private organizations. The CAHPS program develops and supports the use of a comprehensive and evolving family of standardized surveys that ask consumers and patients to report on and evaluate their experience with ambulatory and facility level care.

43. **Continuity of Care** means the continued care of an Enrollee as the Enrollee transitions between different MCOs or between Managed Care and FFS, whether due to eligibility changes or a change in MCO enrollment.

44. **Contract Operational Start Date** means the first date on which any enrollment into the Contractor's D-SNP Plan is effective.

45. **Contractor** means a Managed Care Organization (MCO) approved by CMS and the Department that enters into a Contract with the Department in accordance with and to meet the purposes specified in this Contract.

46. **Covered Services** means the set of services required to be provided by Contractor.

47. **Crisis and Referral Entry Service (CARES)** means the single point of entry to the State's Mobile Crisis Response system that provides telephone response and referral services for Enrollees requiring mental health crisis services.

48. **Crisis Intervention** means services provided by an emergency mental health services program to an individual in Crisis or in a situation that is likely to develop into a Crisis if supports such as assessment and planning, Crisis linkage and follow-up services, and Crisis stabilization services, are not provided.

49. **Crisis Safety Plan** means an individualized plan prepared for Enrollees at high risk of experiencing a Behavioral Health Crisis.

50. **Critical Incident means** any event indicated in *Attachment 7 Illinois Department of Human Services, Division of Rehabilitation Services Critical Incident Definitions*.

51. **Cultural Competence** means the tailoring of services and supports to the unique social, cultural, and linguistic needs of the Enrollee.

52. **Days** means business days for ten (10) days or less. Days means calendar days if more than ten (10) days.

53. **Designated Liaisons** means liaisons designated by the Contractor. The Contractor shall designate the following liaisons. No individual shall serve in more than two (2) designated liaison roles. Designated liaisons will include:

    a. A liaison who will be a consumer advocate for Enrollees who need Behavioral Health services. This position shall be responsible for internal advocacy for these Enrollees' interests, including ensuring input in policy development, planning, decision-making, and oversight, as well as coordination of recovery and resilience activities.

    b. A liaison who will be responsible for all population health and related issues, including population health activities and coordination between Behavioral Health services.

54. **Demonstration** means the program, administered by CMS and the Department for providing integrated care to Medicare-Medicaid Enrollees prior to this Contract.

55. **Determination of Need (DON)** means the tool used by the Department or the Department's authorized representative to determine eligibility (level of care) for Nursing Facility (NF) and HCBS Waivers for individuals 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 fifteen (15) areas including ADL and IADL. 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 NF or HCBS Waiver services, an individual

must receive at least fifteen (15) points on functional impairment section and a minimum total score of twenty-nine (29) points.

56. **Developmental Disability(ies) (DD)** means a disability that (i) is attributable to a diagnosis of mental retardation or related condition such as cerebral palsy or epilepsy, (ii) manifests before the age of twenty-two (22) and is likely to continue indefinitely, (iii) results in impairment of general intellectual functioning or adaptive behavior, and (iv) results in substantial functional limitations in three (3) 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.

57. **DHHS** means the United States Department of Health and Human Services.

58. **DHS** means the Illinois Department of Human Services, and any successor agency.

59. **DHS-DDD** means the Division of Developmental Disabilities within DHS that operates programs for individuals with Developmental Disabilities.

60. **DHS-DMH** means the Division of Mental Health within DHS that is the State mental health authority.

61. **DHS-DRS** means the Division of Rehabilitation Services within DHS that operates the home services programs for individuals with disabilities (Persons with Disabilities Waiver), brain injury (HCBS Waiver for Persons with Brain Injury), and HIV/AIDS (HCBS Waiver for Persons with HIV/AIDS).

62. **DHS-OIG** means the Department of Human Services Office of Inspector General, which is the entity responsible for investigating allegations of Abuse and Neglect of people who receive mental health or Developmental Disabilities services in Illinois and for seeking ways to prevent such Abuse and Neglect. 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). For more information, visit https://www.oig.dhs.gov/.

63. **Disease Management Program** means a program that employs a set of interventions designed to improve the health of individuals, especially those with Chronic Health Conditions. 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) Care 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). A Disease Management Program may be a part of a Care Management program.

64. **DPH** means the Illinois Department of Public Health, and any successor agency, that is the State survey agency responsible for promoting the health of the people of Illinois through the prevention and control of disease and injury, and conducting the activities related to licensure and certification of NF's and ICF/DD facilities.

65. **Dual-Eligible Adult** means an individual who is eligible for full Medicaid benefits and enrolled or entitled to Medicare Part A and enrolled in Medicare Parts B and D.

66. **Effective Enrollment Date** means the date on which an Potential Enrollee becomes a member of the Contractor's D-SNP.

67. **"Eligibility "Deeming" Period** – For purposes of this contract, a 90-day period of continued enrollment in the D-SNP following a loss of Medicaid eligibility for individuals who lose Medicaid eligibility but are expected to regain Medicaid coverage within the 90-day period.

68. **Emergency Medical Condition** means a medical condition, mental or physical, manifesting itself by acute symptoms of sufficient severity (including, but not limited to, severe pain (including severe pain, psychiatric disturbances and/or symptoms of substance abuse(s)) 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 or, with respect to a pregnant woman who is having contractions, (a) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (b) that transfer may pose a threat to the health or safety of the woman or the unborn child.

69. **Emergency Services** means inpatient and outpatient services covered under this Contract, including transportation that are furnished by a Provider qualified to furnish such services and that are needed to evaluate or stabilize an Enrollee's Emergency Medical Condition.

70. **Encounter** means an individual service or procedure provided to an Enrollee that would result in a claim if the service or procedure were to be reimbursed as Fee-For-Service (FFS) under the HFS Medical Program.

71. **Encounter Data** means the record of an Enrollee receiving any item(s) or service(s) provided through Medicaid or Medicare under a prepaid, capitated, or any other risk basis payment methodology submitted to the Department. This record must incorporate HIPAA security, Privacy, and transaction standards and be submitted in the ASC X12N 837 format or any successor format.

72. **Enrollee** means any Potential or Prospective Enrollee who is enrolled with a Contractor. "Enrollee" shall include the guardian where the Enrollee is an adult for whom a guardian has been named; provided, however, that Contractor is not obligated to cover services for any individual who is not enrolled as an Enrollee with Contractor.

73. **Enrollee Communications** means materials designed to communicate plan benefits, policies, processes and/or Enrollee rights to Enrollees. This includes pre-enrollment, post-enrollment, and operational materials.

74. **Enrollment Period** means the twelve (12)–month period an Enrollee will be enrolled with Contractor, beginning with the Effective Enrollment Date.

75. **Equity** means providing every employee, individual, community, or population what is needed to succeed, so everyone can reach their full potential by examining differences in outcomes for various populations and working to mitigate negative impacts.

76. **Exclusively Aligned Enrollment** -- A limited enrollment in a D-SNP to full-benefit dual eligible individuals who are enrolled in a D-SNP for their Medicare benefits and a MCO and the D-SNP and MCO are both owned and controlled by the same parent organization.

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

78. **Face to Face** refers to enrollee contact by means of video or tele-health.

79. **Family Planning (FP)** means a full spectrum of Family Planning options (all FDA-approved birth control methods) and reproductive health services appropriately provided within the Provider's scope of practice and competence. Family Planning and reproductive health services are defined as those services offered, arranged, or furnished for the purpose of preventing an unintended pregnancy, or to improve maternal health and birth outcomes.

80. **Federally-Qualified Health Center (FQHC)** means an entity that has been determined by CMS to satisfy the criteria set forth in 42 U.S.C. 1396d(a)(2)(C) and meets the requirements of 89 IL Admin Code 140.461(d).

81. **Fee-For-Service (FFS)** means the method of paying Providers for each Encounter or service rendered.

82. **D-SNP (Full-Benefit Dual Eligible - Special Needs Plan)** means a FIDE SNP provides coverage of Medicare and Medicaid benefits under a single legal entity that holds both: (1) an Medicare Advantage contract with CMS; and (2) a contract with the state Medicaid agency that meets the requirements of a managed care organization as defined in section 1903(m) of the SSA Act. FIDE SNPs must cover at least Medicaid primary and acute care services and long-term services and supports (LTSS), including at least 180 days of nursing facility coverage during the plan year. FIDE SNPs must also coordinate Medicare and Medicaid benefits "using aligned care management and specialty care network methods for high-risk beneficiaries" and employ "policies and procedures approved by CMS and the State to coordinate or integrate beneficiary communication materials, enrollment, communications, grievances and appeals, and quality improvement" (42 CFR 422.2).

83. **Fraud** means knowing and willful deception, or a reckless disregard of the facts, with the intent to receive an unauthorized benefit. Includes any act that constitutes Fraud under federal or state law.

84. **Government Owned Organization means**, for purposes of this Contract, an organization that is, or is operated by, a unit of government in the State of Illinois with a population.

85. **Grievance** means any Complaint or dispute, other than one that constitutes an organization determination under 42 CFR 422.566 or Adverse Benefit Determination under 42 CFR 400,

expressing dissatisfaction with any aspect of the Contractor's or Provider's operations, activities, or behavior, regardless of whether remedial action is requested pursuant to 42 CFR 422.561. (Possible subjects for Grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships such as rudeness of a Primary Care Provider or employee of the Contractor, or failure to respect the Enrollee's rights, as provided for in *Attachment 6 Enrollee Rights* of this Contract).

86. **Habilitation** means an effort directed toward the alleviation of a disability or toward increasing an individual'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.

87. **Healthcare Effectiveness Data and Information Set (HEDIS®)** means tool developed and maintained by the National Committee for Quality Assurance that is used by health plans to measure performance on dimensions of care and service in order to maintain and/or improve quality.

88. **Health Insurance Portability and Accountability Act (HIPAA)** means the federal law that includes provisions that allow individuals to qualify immediately for comparable health insurance coverage when they change their employment relationships, and that authorizes DHHS to:

    a. mandate standards for electronic exchange of healthcare data, including ADT;

    b. specify what medical and administrative code sets should be used within those standards;

    c. require the use of national identification systems for healthcare patients, Providers, payers (or plans), and employers (or sponsors); and

    d. specify the types of measures required to protect the security and privacy of Protected Health Information.

89. **Health Maintenance Organization (HMO)** means a health maintenance organization as defined in the Health Maintenance Organization Act (215 ILCS 125/1-1 et seq.).

90. **Health Plan** means a delivery system of coordinated services provided by an MCO, including Contractor.

91. **Health-related social needs (HRSN)** are an individual's unmet needs that may have an adverse effect on a person's health. HRSN can be understood as the result of SDoH.

92. **HFS** means The Illinois Department of Healthcare and Family Services and any successor agency. In this Contract, HFS may also be referred to as "Agency" or "the Department".

93. **HFS Medical Program** means The Illinois Medicaid Program, and, the State Children's Health Insurance Program, as authorized under the Illinois Insurance Code (215 ILCS 106/1 *et seq*.) and Title XXI of the SSA (SCHIP). For the purposes of this Contract, HFS Medical Program does not include any program or population excluded from coverage under this Contract.

94. **Home and Community-Based Services (HCBS) Waivers** means waivers under Section 1915(c) of the SSA that allow the State 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.

95. **Homecare Service** means General non-medical support by supervised and trained homecare aides to assist Participants with their ADL and IADL.

96. **Hospitalist** means a Physician who is part of a coordinated group working together, whose 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 hospital leadership related to hospital medicine.

97. **Illinois Compiled Statutes (ILCS)** means The State database of laws maintained by the Legislative Reference Bureau, an unofficial version of which can be viewed at http://www.ilga.gov/legislation/ilcs/ilcs.asp.

98. **IDoA** means The Illinois Department on Aging, and any successor agency, that operates the HCBS Waiver for the elderly (HCBS Waiver for Persons who are Elderly).

99. **Illinois Client Enrollment Broker (ICEB)** means the entity contracted by the Department to track enrollment activities for Potential Enrollees and Enrollees,

100. **Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM-CANS)** means a comprehensive, multi-purpose tool that provides a standardized, modular framework for assessing the global needs and strengths of individuals who require mental health treatment in Illinois.

101. **Illinois Medicaid Crisis Assessment Tool (IM-CAT)** means a screening tool used in the delivery of Mobile Crisis Response services. The IM-CAT is composed of a subset of items from the IM+CANS and is used as part of the crisis assessment to recommend whether an individual can be stabilized in the community or a higher level of care may be needed.

102. **Illinois Medicaid Program** means the program under the Illinois Public Aid Code (305 ILCS 5/5 *et seq*.) and Title XIX of the SSA, Medicaid. May also be referred to as "Medicaid Program".

103. **Independent Review Entity (IRE)** means an outside organization that has a contract with CMS to review decisions about Medicare coverage and timely Appeals decisions.

104. **Indian Enrollee** means an Enrollee who is an Indian (as defined at 25 USC 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR 136.12.) This includes an Enrollee is a member of a Federally recognized tribe; resides in an urban center and meets one or more of four criteria including: is member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member; is an Eskimo or Aleut or other Alaska Native; is considered by the Secretary of the Interior to be an Indian for any purpose; or is determined to

be an Indian under regulations issued by the Secretary; is considered by the Secretary of the Interior to be an Indian for any purpose; or is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian Health Services.

105. **Indian Health Care Provider** means a health care program, operated by the Indian Health Services (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

106. **Individual Plan of Care (IPoC)** means a written plan that identifies services and supports that an Enrollee requires. The IPoC is an Enrollee-centered, goal-oriented, and culturally relevant plan, which reflects the full range of an Enrollee's physical and behavioral health service needs and includes Medicare, Medicaid, non-Medicare, and non-Medicaid services, along with the informal supports necessary to address those needs.

107. **Individual Provider (IP)** means an individual co-employed by the DHS-DRS Home Services Program Enrollee and DHS who provides care to the Enrollee as provided in the HCBS Waiver service plan (Person-Centered Service Plan). Such individuals include, but are not limited to: Personal Assistants, certified nursing assistants, licensed practical nurses, registered nurses, physical therapists, occupational therapists, and speech therapists.

108. **In-Person** means individuals (such as enrollee and responsible contractor personnel) are in the same physical location and meeting together.

109. **Institutionalization** means Residency in a NF, ICF/DD or State operated facility, but does not include admission in an acute care or Rehabilitation hospital setting.

110. **Instrumental Activities of Daily Living (IADL)** means activities related to living independently in the community, including but not limited to, meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communicating by phone or other media, and traveling around and participating in the community.

111. **Interdisciplinary Care Team (ICT)** means a diverse group of professionals (e.g., Care Coordinator, Physicians, social workers, psychologists, occupational therapists, physical therapists) and nonclinical staff whose skills and professional experience will complement and support each other in the oversight of an Enrollees' needs.

112. **Integrated appeal** means any of the procedures that deal with, or result from, adverse integrated organization determinations by an applicable integrated plan on the health care services the enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for a service. Integrated appeals cover procedures that would otherwise be defined and covered, for non-applicable integrated plans, as an appeal defined in 422.561 or the procedures required for appeals in accordance with 438.400 through 438.424 of this chapter. Such procedures include integrated reconsiderations.

113. **Integrated grievance** means a dispute or complaint that would be defined and covered, for grievances filed by an enrollee in non-applicable integrated plans, under 422.564 or 438.400

through 438.416 of this chapter. Integrated grievances do not include appeals procedures and QIO complaints, as described in 422.564(b) and (c). An integrated grievance made by an enrollee in an applicable integrated plan is subject to the integrated grievance procedures in 422.629 and 422.630.

114. **Integrated organization determination** means an organization determination that would otherwise be defined and covered, for a non-applicable integrated plan, as an organization determination under 422.566, an adverse benefit determination under 438.400(b), or an action under 431.201 of this chapter. An integrated organization determination is made by an applicable integrated plan and is subject to the integrated organization determination procedures in 422.629, 422.631, and 422.634.

115. **Integrated reconsideration** means a reconsideration that would otherwise be defined and covered, for a non-applicable integrated plan, as a reconsideration under 422.580 and appeal under 438.400(b) of this chapter. An integrated reconsideration is made by an applicable integrated plan and is subject to the integrated reconsideration procedures in 422.629 and 422.632 through 422.634.

116. **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)** means 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 individuals with mental disabilities or those with related conditions. Also known as Intermediate Care Facility for the Mentally Retarded (ICF/MR) or Intermediate Care Facility for the Developmentally Disabled (ICF/DD).

117. **Licensed Practitioner of the Healing Arts (LPHA)** means an individual who, within the scope of State law, has the ability and appropriate state licensure to independently make a clinical assessment, certify a diagnosis and recommend treatment for individuals with a mental illness.

118. **Long-Term Care (LTC) Facility or Nursing Facility (NF)** means (i) 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 DPH under the Nursing Home Care Act, including a county nursing home directed and maintained under Section 5-1005 of the Counties Code; and (ii) a part of a hospital in which Skilled Nursing or intermediate long-term care services within the meaning of Title XVIII or XIX of the SSA are provided.

119. **Long-Term Services and Supports (LTSS)** means those Covered Services provided in a NF or under an HCBS Waiver, intended to help an Enrollee with a disability, or who is elderly, to meet the Enrollee's daily needs for assistance and improve the quality of life.

120. **Managed Care Organization (MCO)** means an entity that meets the definition of managed care organization as defined at 42 CFR 438.2.

121. **Mandated Reporting** means the required, immediate reporting of suspected maltreatment when a mandated reporter has reasonable cause to believe that an individual known to the mandated reporter in a professional or official capacity may be subject to Abuse or Neglect.

122. **Marketing** means any written or oral communication from the Contractor or its representative that can reasonably be interpreted as intended to influence a Participant to enroll, not to enroll,

or to disenroll from a health plan. Marketing shall also include the meaning ascribed to it by HIPAA as defined by 45 CFR 164.501.

123. **Marketing Materials** means materials produced in any medium, by or on behalf of the Contractor or its representative that can reasonably be interpreted as intended to market to Potential Enrollees. Marketing Materials includes Written Materials and oral presentations.

124. **Marketing Misconduct** means any activity by an employee or representative of Contractor that is in violation of any provisions related to Marketing.

125. **Medical Electronic Data Interchange (MEDI)** means the Medical Electronic Data Interchange (MEDI) system is a system maintained by HFS that provides health plans and Providers the ability to verify a patient's Medicaid eligibility.

126. **Medicaid Managed Care Program** means the Department's system of coordinated care for individuals under HFS Medical Programs.

127. **Medicaid Program or Medicaid** means the program under Title XIX of the SSA that provides medical benefits to eligible individuals, including certain people with low incomes. In Illinois, it is the program under 305 ILCS 5/5 *et seq*. and Title XIX of the SSA, "Grants to States for Medical Assistance Programs" (Medicaid).

128. **Medically Necessary Services** means services that, when recommended by a Provider for an Enrollee, are: for the purpose of preventing, diagnosing, or treating an illness, injury, disease or its symptoms; to assist in the Enrollee's ability to attain, maintain, or regain functional capacity; for the opportunity for an Enrollee receiving LTSS to have access to the benefits of community living, to achieve person centered goals, and live and work in the setting of the Enrollee's choice; or for an Enrollee to achieve age-appropriate growth and development. Medically Necessary services are requested in accordance with applicable policies and procedures, and provided in a manner that is: (1) in accordance with generally accepted standards of good medical practice in the medical community; (2) consistent with nationally recognized evidence-based guidelines; (3) clinically appropriate, in terms of type, frequency, extent, site, and duration; and (4) not primarily for the economic benefit of Contractor or for the convenience of the Enrollee or Provider. In accordance with 215 ILCS 5/370c, Contractor shall make Medically Necessary determinations for substance use disorders use care guidelines with appropriate patient placement criteria established by the American Society of Addiction Medicine. No additional criteria may be used to make Medically Necessary determinations for substance use disorders. In conducting utilization review of Covered Services for the diagnosis, prevention, and treatment of substance use disorders, Contractor shall use care guidelines with the most recent edition of the patient placement criteria established by the American Society of Addiction Medicine. Contractor shall provide evidence that its care guidance is in compliance with these requirements.

129. **Medicare-Medicaid Enrollee** means for the purposes of this Contract, individuals who are entitled to or enrolled in Medicare Part A, and Medicare Parts B, eligible to enroll in Medicare Part D, and receive full Medicaid benefits under the State Plan, and otherwise meet eligibility criteria for D-SNP.

130. **Medicare** means Title XVIII of the SSA, the federal health insurance program for people age 65 or older, people under 65 with certain disabilities, and people with End Stage Renal Disease

(ESRD) or Amyotrophic Lateral Sclerosis. Medicare Part A provides coverage of inpatient hospital services and services of other institutional Providers, such as Skilled Nursing Facilities and home health agencies. Medicare Part B provides supplementary medical insurance that covers Physician services, outpatient services, some home health care, durable medical equipment, and laboratory services and supplies, generally for the diagnosis and treatment of illness or injury. Medicare Part C provides Medicare beneficiaries with the option of receiving Part A and Part B services through a private health plan. Medicare Part D provides outpatient prescription drug benefits.

131. **Medicare Advantage (MA)** means the Medicare managed care options that are authorized under Title XVIII as specified at Part C and 42 CFR 422.

132. **Mental Illness** means a diagnosis of schizophrenia, delusional disorder, schizoaffective disorder, psychotic disorder not otherwise specified, bipolar disorder, or recurrent major depression resulting in substantial functional limitations.

133. **Mobile Crisis Response** means an urgent twenty-four (24) hour response Crisis intervention and stabilization services for Enrollees who are experiencing a Crisis related to psychiatric or behavioral problems.

134. **National Committee for Quality Assurance (NCQA)** means a private 501(c)(3) not-for-profit organization that is dedicated to improving health care quality and that has a process for providing accreditation, certification and recognition, e.g., health plan accreditation.

135. **National Council for Prescription Drug Program (NCPDP)** means the not-for-profit, multi-stakeholder forum for developing and promoting industry standards and business solutions that improve patient safety and health outcomes, while also decreasing costs. The work of the organization is accomplished through its members who bring high-level expertise and diverse perspectives to the forum. For more information, visit https://www.ncpdp.org/.

136. **N.B. Consent Decree** means the consent decree entered by the United States District Court for the Northern District of Illinois in the *N.B. v. Eagleson*, 11-cv-6866 (U.S. Dist. Ct. N.D. Ill) litigation, and further includes any and all subsequent orders, implementation plans, and matters related to compliance with the consent decree and its implementation requirements. Among other things, the N.B. Consent Decree requires the development of a behavioral health delivery "Model" to provide Class Members with a continuum of Medicaid-authorized and required mental and behavioral health services, including home- and community-based services.

137. **Necessary Information** means information that includes the results of any face-to-face or in-person clinical evaluation, second opinion, or other clinical information that is directly applicable to a service requested by an enrollee that Contractor believes is required to evaluate the request.

138. **Neglect** means a failure (i) to notify the appropriate health care professional, (ii) to provide or arrange necessary services to avoid physical or psychological harm to a Resident, or (iii) to terminate the residency of a Participant whose needs can no longer be met, causing an avoidable decline in function. Neglect may be either passive (non-malicious) or willful.

139. **Negotiated Risk** means the process by which an Enrollee, or their representative, may negotiate and document with Providers what risks each is willing to assume in the provision of Medically Necessary Covered Services and the Enrollee's living environment, and by which the Enrollee is informed of the risks of these decisions and of the potential consequences of assuming these risks.

140. **Network Provider** means any Provider, group of Providers or entity that has an agreement with Contractor, or a Subcontractor, who receives HFS Medical Program funding directly or indirectly to order, refer or render Covered Services as a result of this Contract. A Network Provider is not a Subcontractor by virtue of the Network Provider agreement. A group of Network Providers for an MCO may be referred to as a "Provider Network."

141. **Non-Traditional Medicaid Provider** means providers that provide medical services outside of traditional Medicaid. Examples from the 1115 Waiver include 1) medical assistance to individuals with Substance Abuse Disorder (SUD); 2) SUD case management; 3) supported employment services; 4) targeted pre-release services to eligible individuals and improve the health of communities and populations in Illinois; 5) HRSN services; 6) violence prevention and intervention services; and 7) non-medical transportation. Non-traditional Medicaid providers are subject to expand based on service types provided, such as Social Determinants of Health services, fertility preservation or pediatric pallative providers.

142. **Nursing Facility (NF)** see Long Term Care Facility (LTC)

143. **Occupational Therapy** means a medically prescribed service identified in the Enrollee IPoC that is designed to increase independent functioning through adaptation of the tasks and environment, and that is provided by a licensed occupational therapist who meets Illinois licensure standards.

144. **Office of Inspector General (OIG)** means the Office of Inspector General for the Department as set forth in 305 ILCS 5/12-13.1. OIG has the primary responsibility for program integrity over the Illinois Medical Assistance Program to prevent, detect, and eliminate Fraud, Waste, Abuse, mismanagement, and misconduct. OIG is the liaison with federal and state law enforcement, including but not limited to the Illinois Medicaid Fraud Control Unit (MFCU).

145. **Open Enrollment Period** means the specific period each year in which an Enrollee shall have the opportunity to change from one MCO to another MCO.

146. **Ombudsman** means the entity designated by the State, and independent of the Department, that advocates and investigate on behalf of Enrollees to safeguard due process and to serve as an early and consistent means of identifying systematic problems with the D-SNP as provided for in State administrative rules and in accordance with the Older Americans Act of 1965.

147. **PACE (Program of All-Inclusive Care for the Elderly)** means a capitated benefit for frail elderly who meet the State's criteria for Nursing Facility level of care, authorized by the Balanced Budget Act 1997 (BBA) that features a comprehensive service delivery system an integrated Medicare and Medicaid financing. PACE is a three-way partnership between the Federal Government, a State, and the PACE organization.

148. **Performance Improvement Project (PIP)** means an ongoing program for improvement that focuses on clinical and nonclinical areas, and that involves measurement of performance using objective quality indicators; implementation of system interventions to achieve improvement in quality; evaluation of the effectiveness of the interventions; and planning and initiation of activities for increasing or sustaining improvement.

149. **Performance Measure(ment)** means a quantifiable measure to assess how well an organization carries out a specific function or process.

150. **Person** means any individual, corporation, proprietorship, firm, partnership, trust, association, governmental authority, contractor, or other legal entity whatsoever, whether acting in an individual, fiduciary, or other capacity.

151. **Person-Centered Service Plan** means a personalized plan generated from the Enrollee's DON, or other assessment tool adopted by the State, that meets the Enrollee's specific HCBS Waiver needs.

152. **Personal Assistant** means an individual who provides Personal Care to a Participant when it has been determined by the care coordinator that the Participant has the ability to supervise the Personal Assistant.

153. **Personal Care** means 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 an Enrollee's ADLs and IADLs.

154. **Personal Emergency Response System (PERS)** means an electronic device that enables a Participant who is at high risk of Institutionalization to secure help in an emergency.

155. **Person with a Disability** means an individual who meets the definition of blind or disabled under Section 1614(a) of the SSA (42 USC 1382), and who are eligible for Medicaid.

156. **Person with Ownership or a Controlling Interest** means a Person who:

    a. has a direct or indirect, singly or in combination, ownership interest equal to five percent (5%) or more in Contractor;

    b. owns an interest of five percent (5%) or more in any mortgage, deed of trust, note, or other obligations secured by Contractor if that interest equals at least five percent (5%) of the value of the property or assets of Contractor;

    c. is an officer or director of Contractor if Contractor is organized as a corporation;

    d. is a member of Contractor if Contractor is organized as a limited liability company; or

    e. is a partner in Contractor if Contractor is organized as a partnership.

157. **"Pharmacy Benefit Manager (PBM)"** means a person, business, or entity, including a wholly or partially owned or controlled subsidiary of a Pharmacy Benefit Manager, that provides claims processing services or other prescription drug or device services, or both, for Contractor.

158. **Physical Therapy** means a medically-prescribed service that is provided by a licensed physical therapist and identified in the Enrollee IPoC that utilizes a variety of methods to enhance an Enrollee's physical strength, agility and physical capacity for ADL.

159. **Physician** means an individual licensed to practice medicine in all its branches in Illinois under the Medical Practice Act of 1987 (225 ILCS 60/1, et seq.) or any such similar statute of the state in which the individual practices medicine.

160. **Post-Stabilization Services** means 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, or, under the circumstances described in 42 CFR 438.114 to improve or resolve the Enrollee's condition.

161. **Potential Enrollee** means an individual who is eligible for Enrollment in the D-SNP, but is not yet an Enrollee of a D-SNP. Potential Enrollee includes individuals within the Service Area who, pursuant to federal law, have the option to enroll with a D-SNP.

162. **Prevalent Languages** means those languages that meet the more stringent of either (1) Medicare's five (5%) threshold for language translations; or (2) the Department's Prevalent Language requirements. Currently, the Department's Prevalent Language requirements include Spanish and other languages, as determined by the Department where there is a prevalent single-language minority within the low income households in the relevant DHS local office area, which for purposes of this Contract shall exist when five percent (5%) or more such households speak a language other than English, as determined by the Department according to published Census Bureau data).

163. **Primary Care Provider (PCP)** means 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 an Enrollee of Contractor.

164. **Prior Approval** means 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 the Contractor must obtain before such materials are used or such actions are executed, implemented or followed.

165. **Privacy** means requirements established in HIPAA, and implementing regulations, as well as relevant Illinois privacy laws.

166. **Prospective Enrollee** means a Potential Enrollee who has begun the process of enrollment with Contractor but whose coverage with Contractor has not yet begun.

167. **Protected Health Information (PHI)** means shall have the same meaning as provided in HIPAA, 45 CFR 160.103, and for the purpose of this Contract shall be limited to the information received

from the Department, or created, maintained, or received by Contractor on behalf of the Department, in connection with this Contract.

168. **Provider** means a Person or organization enrolled with the Department to provide Medicaid Covered Services to a Participant, unless otherwise stated as a Medicare provider.

169. **Provider Type 36** means the State Provider registration category for community mental health centers (CMHC). Providers must be registered with the Medicaid Assistance Program as Provider Type 36 Mental Health Services Provider to be eligible for reimbursement of CMHC services.

170. **Provider Network** means a network of Providers and agencies that have entered into a contract or agreement with Contractor to provide Enrollees with a broad array of community based supports and resources.

171. **Quality Assessment and Performance Improvement** means the program required by 42 CFR 438.330, which requires MCOs to have an ongoing quality-assessment and performance-improvement program for the services provided to Enrollees, that includes, at a minimum:

    a. Performance Improvement Projects;

    b. the collection and submission of Performance Measurement data;

    c. mechanisms to detect both underutilization and overutilization of services;

    d. mechanisms to assess the quality and appropriateness of care furnished to Enrollees who have special healthcare needs;

    e. when long-term services and supports are provided, mechanisms to assess the quality and appropriateness of care, including between care settings and comparison of authorized to delivered services; and

    f. when long-term services and supports are provided, participation in Department efforts to prevent, detect and remediate Critical Incidents.

172. **Quality Assurance (QA)** means a formal set of activities to review, monitor and improve the quality of services by a Provider or D-SNP, including quality assessment, ongoing quality improvement and corrective actions to remedy any deficiencies identified in the quality of direct Enrollee, administrative and support services.

173. **Quality Assurance Plan (QAP)** means a written document developed by Contractor 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.

174. **Quality Assurance Plan (QAP) Committee** means a committee established by Contractor, with the approval of the Department, that consists of a cross representation of all types of Providers, but shall, at a minimum, include primary care Providers, specialists, dentists, and LTC representatives from Contractor's network and throughout the entire Contracting Area. At the

request of the Department, the QAP Committee shall also include Department staff in an advisory capacity.

175. **Quality Assurance Program** means Contractor's overarching mission, vision, and values, which, through its goals, objectives, and processes committed in writing in the QAP, are demonstrated through a focus on Equity, 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, Care Management, and coordination. It is implemented through the integration, coordination of services, and resource allocation throughout Contractor's organization, its partners, Providers, other entities delegated to provide services to Enrollees, and the extended community involved with Enrollees. The QAP is overseen by the QAP Committee.

176. **Quality Improvement Organization (QIO)** means an organization designated by CMS as set forth in Section 1152 of the SSA and 42 CFR 476, that provides QA, quality studies and inpatient utilization review for the Department in the FFS program and QA and quality studies for the Department in the HCBS setting.

177. **Quality Improvement Project (QIP)** means an ongoing program for improvement that focuses on clinical and nonclinical areas, and that involves: (i) measurement of performance using objective quality indicators; (ii) implementation of system interventions to achieve improvement in quality; (iii) evaluation of the effectiveness of the interventions; and (iv) planning and initiation of activities for increasing or sustaining improvement.

178. **Quality indicators** means measurable variables relating to a specified clinical area, which are reviewed over a period of time to monitor the process of outcomes of care delivered in that clinical area.

179. **Readiness Review** means the evaluation of each Contractor's ability to comply with the D-SNP requirements, including but not limited to, the ability to quickly and accurately process claims and enrollment information, accept and transition new Enrollees, and provide adequate access to all Medicare and Medicaid-covered Medically Necessary Services. The Department use the results to inform its decision of whether the Contractor is ready to begin accepting enrollment under the D-SNP. At a minimum, each Readiness Review includes a desk review and potentially a site visit to the prospective Contractor's headquarters.

180. **Recipient Identification Number (RIN)** means a unique nine (9)-digit number assigned to each individual who receives medical benefits from the State. The number is utilized by the Department to identify and pay medical bills to Providers.

181. **Referral** means an authorization provided by a PCP to enable an Enrollee to seek medical care from another Provider.

182. **Rehabilitation** means the process of restoration of skills to an individual 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.

183. **Resident** means an Enrollee who is living in a facility and whose facility services are eligible for Medicaid and Medicare payment.

184. **Respite** means 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 a non-paid family member or other caregiver of care-giving responsibilities.

185. **Rule 132** means a reference to Title 59 of the Illinois Administrative Code, Part 132 – Medicaid Community Mental Health Services or its successor Rules.

186. **Rural Health Clinic (RHC)** means a Provider that has been designated by the Public Health Service, DHHS, or the Governor of the State of Illinois, and approved by the Public Health Service, in accordance with the Rural Health Clinics Act (Public Law 95-210) as a RHC.

187. **Serious Mental Illness** means an emotional or behavioral functioning so impaired as to interfere with the individual's capacity to remain in the community without supportive treatment.

188. **Service Authorization Request** means a request by an Enrollee or by a Provider on behalf of an Enrollee for the provision of a Covered Service.

189. **Skilled Nursing** means nursing services provided within the scope of the Illinois Nurse Practice Act by registered nurses, licensed practical nurses, or vocational nurses licensed to practice in the State.

190. **Skilled Nursing Facility (SNF)** means 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.

191. **Social determinants of health (SDoH)** refers to the social conditions in which people are raised and live in (e.g., access to transportation, housing, food insecurity, employment, social isolation (loneliness) and conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks).

192. **Specialized Services** means health services that focus on a specific area of medicine or services for specific types of symptoms and conditions, including all services except primary care.

193. **Speech Therapy** means a medically-prescribed speech or language-based service that is provided by a licensed speech therapist and identified in the Enrollee IPoC, and that is used to evaluate or improve an Enrollee's ability to communicate.

194. **Stabilization or Stabilized** Medical means with respect to an Emergency Medical Condition (1) to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, (2) with respect to an Emergency Medical Condition to deliver (including the placenta) that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to an Emergency Medical Condition), that the woman has delivered (including the placenta).

195. **Stand-Down Order** means a directive from the OIG to Contractor to temporarily refrain from taking any actions related to an identified Provider, and to notify the OIG if any actions have been taken, or are proceeding, against the Provider including, but not limited to, investigations, review, audits, and/or recoupments.

196. **State** means the State of Illinois, as represented through any State agency, department, board, or commission.

197. **State Fiscal Year** means the State's Fiscal Year, which 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, State Fiscal Year 2026 began on July 1, 2025, and ended on June 30, 2026.

198. **State Operated Hospital (SOH)** means a hospital operated, owned, and managed by the Department of Human Services, Division of Mental Health that serves adults with Serious Mental Illness who require inpatient psychiatric treatment.

199. **State Plan** means the Illinois Medicaid State Plan filed with CMS, in compliance with Title XIX of the SSA.

200. **SSA** means Social Security Act. The SSA consists of sets of federal laws located within 42 United States Code (U.S.C.), sections 301 through 1397mm. The SSA is divided into 21 Titles, including Title XVIII "Health Insurance for the Aged and Disabled" (Medicare) SSA 1801 through 1899B (42 U.S.C 1395 through 1395lll); Title XIX "Grants to States for Medical Assistance Programs" (Medicaid) SSA 1901 through 1946 (42 U.S.C. 1396–1 through 42 U.S.C. 1396w-5); and Title XXI "State Children's Health Insurance Program" SSA 2101 through 2113 (42 U.S.C. 1397aa through 1397mm).

201. **Subcontractor** means an individual or entity that has a contract with an MCO, PIHP, PAHP, or PCCM entity that relates directly or indirectly to the performance of the MCO's, PIHP's, PAHP's, or PCCM entity's obligations under its contract with the State. A network provider is not a subcontractor by virtue of the network provider agreement with the MCO, PIHP, or PAHP as provided in 42 CFR 438.

202. **Substance Use Disorder** means the recurrent use of alcohol and/or drugs that causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.

203. **Supportive Living Facility (SLF)** means a residential apartment-style (assisted living) setting in Illinois that is (i) certified by the Department to provide or coordinate 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 preferences; (ii) has an organizational mission, service programs and physical environment designed to maximize Residents' dignity, autonomy, privacy and independence; (iii) encourages family and community involvement; and, (iv) administered by HFS under the Supportive Living Program HCBS Waiver.

204. **Systems of Care (SOC)** means a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing

needs of Children and their families, and that are family-driven, youth-guided, individualized, culturally and linguistically competent, and community-based.

205. **Telehealth** means the use of electronic information and telecommunication technologies to support long-distance clinical health care, patient and professional health-related education, health administration, and public health.

206. **Third Party** means any Person other than the Department, Contractor, or any of Contractor's Affiliates.

207. **Transition of Care** means the act of transitioning an Enrollee from an institutional setting to another institutional setting or a community setting with the goal of achieving a seamless, efficient transition with minimal impact to an Enrollees care.

208. **Urgent Care** means medical services required promptly to prevent impairment of health due to symptoms that do not constitute an Emergency Medical Condition, but that are the result of an unforeseen illness, injury, or condition for which medical services are immediately required. Urgent Care is appropriately provided in a clinic, Physician's office, or in a hospital emergency department if a clinic or Physician's office is inaccessible. Urgent Care does not include primary care services or services provided to treat an Emergency Medical Condition.

209. **Utilization Management** means 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 the D-SNP. Utilization Management typically includes new activities or decisions based upon the analysis of 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.

210. **Waste** means the overutilization or misuse of Covered and non-Covered services, resources, or materials that results in unnecessary costs to the healthcare system and, as a result, to the Medicaid program. “Waste” is often used in conjunction with “Fraud” and “Abuse.”

211. **Wellness Programs** means comprehensive services designed to promote and maintain the good health of an Enrollee.

212. **Williams Provider** means a mental health Provider having a contract with the Mental Health Division of DHS to implement the consent decree entered in Williams v. Quinn, No. 05 C 4673 (N.D. Ill.) (Williams consent decree).

213. **Women’s Health Care Provider (WHCP)** means a Physician or other health care Provider, who within the Provider’s scope of practice and in accordance with State certification requirements or State licensure requirements, specializes by certification or training in obstetrics, gynecology or family practice.

214. **Written Materials** means materials regarding choice of D-SNP, selecting a PCP or WHCP, Enrollee Handbooks, Basic Information as set forth in *Section 1.2.29 Marketing, Outreach, and Enrollee Communications Standards*, and any information or notices distributed by the Contractor or required to be distributed to Potential Enrollees, Prospective Enrollees or Enrollees by CMS and

the Department or regulations promulgated from time to time under 42 CFR 438 and 422.111, Subpart V 422.2260-422.2274, 423.120(b) and (c), 423.128, and Subpart V 423.2260-423.2274, and the Medicare Communications and Marketing Guidelines.

215. **Z-Codes** means ICD-10-CM diagnosis codes Z55 through Z65 used to document SDOH data (e.g., housing, food insecurity, transportation, etc.).

☐ Required Federal Clauses, Certifications and Assurances

☐ Public Works Requirements (construction and maintenance of a public work) 820 ILCS 130/4.

☐ Prevailing Wage (janitorial cleaning, window cleaning, building and grounds, site technician, natural resources, food services, security services, and printing, if valued at more than $200 per month or $2,000 per year) 30 ILCS 500/25-60.

5.2 Agency Supplemental Terms and Conditions

5.2.1 *Confidentiality of Program Recipient Information*. Vendor 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 use and disclosure by Vendor and Vendor's employees, by Vendor's corporate affiliates and their employees, and by Vendor's subcontractors and their employees, pursuant to 305 ILCS 5/11-9, 11-10, and 11-12; 42 USC 654(26); 42 CFR Part 431, Subpart F; and 45 CFR Part 160 and 45 CFR Part 164, and The Health Information Technology for Economic and Clinical Health Act (the HITECH Act) of the American Recovery and Reinvestment Act of 2009.

A. Personal Data. Contractor must inform each of its employees having any involvement with personal data or other Confidential Information, whether with regard to design, development, operation, or maintenance of the laws and regulations relating to confidentiality.

B. Data Security. Contractor must take reasonable steps to ensure the physical security of personal data or other Confidential Information under its control, including, but not limited to: fire protection; protection against smoke and water damage; alarm systems; locked files, guards, or other devices reasonably expected to prevent loss or unauthorized removal of manually held data; passwords, access logs, badges, or other methods reasonably expected to prevent loss or unauthorized access to electronically or mechanically held data by ensuring limited terminal access; limited access to input documents and output documents; and design provisions to limit use of Enrollee names. Contractor must put all appropriate administrative, technical, and physical safeguards in place

before the start date to protect the Privacy and security of Protected Health Information in accordance with 45 CFR 164.530(c). Contractor must meet the security standards, requirements, and implementation specifications as set forth in the HIPAA Security Rule, 45 CFR part 164, subpart C. Contractor must follow the National Institute for Standards and Technology (NIST) Guidelines for the Risk Management Framework (RMF) to establish an information security program in accordance with the Federal Information Security Management Act (FISMA).

C. Return of Personal Data. Contractor must return any and all personal data, with the exception of medical records, furnished pursuant to the Contract promptly at the request of the Department in whatever form it is maintained by Contractor. Upon the termination or completion of this Contract, Contractor shall not use any such data or any material derived from the data for any purpose, and, where so instructed by the Department, will destroy such data or material.

D. Destruction of Personal Data. For any PHI received regarding an Eligible Beneficiary referred to Contractor by the Department who does not enroll in Contractor's plan, Contractor must destroy the PHI in accordance with standards set forth in NIST Special Publication 800-88, Guidelines for Media Sanitizations, and all applicable State and federal Privacy and security laws including HIPAA and its related implementing regulations, at 45 CFR Parts 160, 162, and 164, as may be amended from time to time. Contractor shall also adhere to standards described in OMB Circular No. A-130, Appendix III-Security of Federal Automated Information Systems and NIST Federal Information Processing Standard 200 entitled "Minimum Security Requirements for Federal Information and Information Systems" while in possession of all PHI.

E. Research Data. Contractor must seek and obtain prior written authorization from CMS and the Department for the use of any data pertaining to this Contract for research or any other purposes not directly related to Contractor's performance under the Contract.

5.2.2 *Nondiscrimination*. Vendor and Vendor's principals, employees and subcontractors shall abide by federal Executive Orders 11246 and 11375. Vendor 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 the Contract.

5.2.3 *Business Enterprise for Minorities, Women, and Persons with Disabilities Act Participation and Utilization Plan*. The Business Enterprise Program Act for

Minorities, Females and Persons with Disabilities (BEP) establishes a goal for contracting with businesses that have been certified as owned and controlled by persons who are minorities, female, or persons with disabilities (BEP certified vendor). 30 ILCS 575. The solicitation contained a goal of 1%. In response to the solicitation, Vendor submitted a BEP Utilization Plan and Letter(s) of Intent, which HFS approved. The Vendor shall remain in compliance with the BEP goals set forth in the solicitation, the Utilization Plan and the Letter(s) of Intent. Failure to meet the stated goal, may be grounds for termination of the Contract by the State.

5.2.4 *Business Enterprise for Minorities, Women, and Persons with Disabilities Act Participation and Utilization Plan Renewal*: 30 ILCS 575/8i pertains to the Business Enterprise Program (BEP) in Illinois. This section of the law mandates that state agencies and universities must recalculate the level of participation for businesses owned by minorities, women, and persons with disabilities (BEP participants) during contract renewals or extensions. The recalculation ensures that these businesses continue to have fair opportunities in state contracts. The specific participation goals and requirements are reviewed and adjusted based on current availability and other relevant factors at the time of the contract renewal.

5.2.5 *Child Support*. Vendor shall ensure that its employees who provide services under the contract are in compliance with child support payments pursuant to a court or administrative order of this or any other State. Vendor will not be considered out of compliance with the requirements of this Section if, upon request by the Agency, Vendor provides:

A. Proof of payment of past-due amounts in full;

B. Proof that the alleged obligation of past-due amounts is being contested through appropriate court or administrative proceedings and Vendor provides proof of the pendency of such proceedings; or

C. Proof of entry into payment arrangements acceptable to the appropriate State agency.

5.2.6 *Notice of Change in Circumstances*. In the event Vendor, Vendor's parent, or a related corporate entity becomes a party to any litigation, investigation or transaction that may reasonably be considered to have a material impact on Vendor's ability to perform under the Contract, Vendor will immediately notify the Agency in writing.

5.2.7 *Performance of Services and Duties*. Vendor shall perform all services and other duties as set forth in the Contract in accordance with, and subject to, applicable Administrative Rules and Agency policies including rules and regulations which may be issued or promulgated from time to time during the term of the Contract. Vendor shall be provided copies of such upon Vendor's written request.

5.2.8 *Employee Handbook*. Vendor shall ensure that its employees who provide services under this contract at a location controlled by the Agency abide by applicable provisions of the Agency's Employee Handbook. The Agency's Handbook may be found here: HFS Employee Handbook (illinois.gov).

5.2.9 *Record Keeping*. Record keeping shall be in accordance with sound accounting standards.

5.2.10 *Retention of Payments*.

A. Pursuant to 44 Ill. Admin. Code 1.2065(c), the Agency may deduct from whatever is owed Vendor on the or any other contract an amount sufficient to compensate the State of Illinois for any damage resulting from termination or rescission.

B. The additional cost of supplies or services bought elsewhere;

C. The cost of repeating the procurement procedure;

D. Any expenses incurred because of delay in receipt of supplies or services;

E. Any other damages caused by Vendor's breach of contract or unlawful act; and

F. If any failure of Vendor to meet any requirement of this Contract results in the withholding of federal funds from the State, the Agency may withhold and retain an equivalent amount from payments to Vendor until such federal funds are released to the State, at which time the Agency will release to Vendor the equivalent withheld funds.

5.2.11 *Deductions from Payments*. Any payment to Vendor may be reduced or suspended when a provision of this Contract requires a payment or refund to the Agency or an adjustment to payment to Vendor.

5.2.12 *Computational Error*. The Agency reserves the right to correct any mathematical or computational error in payment subtotals or total contractual obligation. The Agency will notify Vendor of any such corrections.

5.2.13 *Disputes Between Vendor and Other Parties*. Any dispute between Vendor and any third party, including any subcontractor, shall be solely between such third party and Vendor, and the Agency shall be held harmless by Vendor. Vendor agrees to assume all risk of loss and to indemnify and hold the Agency 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 Vendor's failure to pay any subcontractor, either timely or at all, regardless of the reason.

5.2.14 *Fraud and Abuse*. Vendor 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 the contract by any parties directly or indirectly affiliated with this Contract including but not limited to, Vendor staff, Vendor Subcontractor, Agency employee or Agency contractor. Vendor shall make this report within three days after first suspecting fraud, abuse or misconduct. Vendor shall not conduct any investigation of the suspected fraud, abuse or misconduct without the express concurrence of the OIG; the foregoing notwithstanding, the Vendor may conduct and continue investigations necessary to determine whether reporting is required under this paragraph. Vendor shall cooperate with all investigations of suspected fraud, abuse or misconduct reported pursuant to this paragraph. The Vendor shall require adherence with these requirements in any contracts it enters into with Subcontractors. Nothing in this paragraph precludes the Vendor or 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.

5.2.15 *Gifts*. Vendor and Vendor's principals, employees and subcontractors are prohibited from giving gifts to Agency employees, and from giving gifts to, or accepting gifts from, any person who has a contemporaneous contract with the Agency involving duties or obligations related to the Contract.

5.2.16 *Media Relations and Public Information*. Subject to any disclosure obligations of Vendor under applicable law, rule, or regulation, news releases pertaining to the Contract or the services or project to which it relates shall only be made with prior approval by, and in coordination with, the Agency. Vendor shall not disseminate any publication, presentation, technical paper, or other information related to Vendor's duties and obligations under the Contract unless such dissemination has been previously approved in writing by the Agency.

5.2.17 *Excluded Individuals/Entities*. Vendor shall screen all current and prospective employees, contractors and subcontractors prior to engaging their services under the Contract and at least annually thereafter, by:

A. Requiring that current or prospective employees, contractors or sub-contractors to disclose whether they are Excluded Individuals/Entities; and

B. 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 Excluded Parties List System maintained by the U.S. General Services Administration (available at https://www.sam.gov/portal/public/SAM/).

C. For purposes under this section, "Excluded Individual/Entity" shall mean a person or entity which:

a. Under Section 1128 of the SSA, 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 IV, XVIII, XIX, XX or XXI of the SSA;

b. Has not been reinstated in the program after a period of exclusion, suspension, debarment, or ineligibility; or

c. Has been convicted of a criminal offense related to the provision of items or services to a federal, state or local government entity within the last ten (10) years.

D. Vendor 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.

5.2.18 *Nonexclusion*. Vendor certifies that:

A. Vendor is not currently barred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal or State department or agency, or is currently barred or suspended from contracting with the State under Section 50-35(f), 50-35(g) or 50-65 of the Illinois Procurement Code, 30 ILCS 500/1-1 et seq.

B. If at any time during the term of this Agreement, Vendor becomes barred, suspended, or excluded from participation in this transaction, Vendor shall, within thirty (30) days after becoming barred, suspended or excluded, provide to the Agency a written description of each offense causing the exclusion, the date(s) of the offense, the action(s) causing the offense(s), any penalty assessed or sentence imposed, and the date any penalty was paid or sentence complete.

C. During the last five (5) years, no order judgment or decree of any Federal authority has been issued barring, suspending or otherwise limiting Vendor's right to contract with any governmental entity, including school districts, or to engage in any business practice or activity. Vendor shall include this certification within every subcontract related to performance under the Contract.

5.2.19 *Conflict of Interest*. In addition to any other provision in this Contract governing conflicts of interest, Vendor certifies that neither Vendor, nor any party directly or indirectly affiliated with Vendor, including, but not limited to, Vendor's officers, directors, employees and subcontractors, and the officers, directors and employees of Vendor's subcontractors, shall have or acquire any Conflict of Interest in performance of the Contract.

A. For purposes of this section, "Conflict of Interest" shall mean an interest of Vendor, or any entity described above, which may be direct or indirect, professional, personal, financial, or beneficial in nature that, in the sole discretion of the Agency, compromises, appears to compromise, or gives the appearance of impropriety with regard to Vendor's duties and responsibilities under the Contract. This term shall include potential Conflicts of Interest. A Conflict of Interest may exist even if no unethical or improper act results from it or may arise where Vendor becomes a party to any litigation, investigation, or transaction that materially impacts Vendor's ability to perform under the Contract. Any situation where Vendor's role under the Contract competes with Vendor's professional or personal role may give rise to an appearance of impropriety. Any conduct that would lead a reasonable person, knowing all the circumstances, to a conclusion that bias may exist or that improper conduct may occur or gives the appearance of the existence of bias or improper conduct, is a Conflict of Interest.

B. Vendor shall disclose in writing any Conflicts of Interest to the Agency no later than seven (7) calendar days after learning of the Conflict of Interest. The Agency may initiate any inquiry as to the existence of a

Conflict of Interest. Vendor shall cooperate with all inquiries initiated pursuant to this section. Vendor shall have an opportunity to discuss the Conflict of Interest with the Agency and suggest a remedy under this section.

C. Notwithstanding any other provisions in the Contract, the Agency shall, in its sole discretion, determine whether a Conflict of Interest exists or whether Vendor failed to make any required disclosure. This determination shall not be subject to appeal by Vendor. If the Agency concludes that a Conflict of Interest exists, or that Vendor failed to disclose any Conflict of Interest, the Agency may impose one or more remedies, as set forth below.

D. The appropriate remedy for a Conflict of Interest shall be determined in the sole discretion of the Agency and shall not be subject to appeal by Vendor. Available remedies shall include, but not be limited to, the elimination of the Conflict of Interest or the non-renewal or termination of the Contract.

5.2.20 *Clean Air Act and Clean Water Act*. Vendor certifies that Vendor 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.

5.2.21 *Lobbying* .

A. Vendor certifies to the best of Vendor's knowledge and belief, that no federally appropriated funds have been paid or will be paid by or on behalf of Vendor, 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.

B. 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, Vendor shall complete and submit Standard Form LLL, "Disclosure Forms to Report Lobbying," in accordance with its instructions. Such Form is to be obtained at Vendor's request from the Agency's Bureau of Fiscal Operations.

C. Vendor 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.

D. This certification is a material representation of fact upon which reliance was placed when the 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.

5.2.22 *Rules of Construction*. Unless the context otherwise requires or unless otherwise specified, the following rules of construction apply to the Contract:

A. Provisions apply to successive events and transactions;

B. "Or" is not exclusive;

C. References to statutes and rules include subsequent amendments and successors thereto;

D. The various headings of the Contract are provided for convenience only and shall not affect the meaning or interpretation of the Contract or any provision hereof;

E. 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;

F. “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;

G. 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;

H. Words in the plural which should be singular by context shall be so read, and vice versa; and

I. References to "Illinois Department of Healthcare and Family Services," "Department" or "Agency" shall include any successor agency or agencies thereto.

5.2.23 *Social Security Administration (SSA) Required Provisions for SSA Supplied Data Security*.

A. The VENDOR shall comply with limitations on access, use, treatment, storage, security and safeguarding of SSA supplied data under Section 1106(a) of the SSA (42 U.S.C. 1306); the regulations promulgated pursuant to that section (20 CFR Part 401); the Privacy Act of 1974 (5 U.S.C. 552a), as amended by the Computer Matching and Privacy Protection Act of 1988; related Office of Management and Budget (OMB) guidelines; the Federal Information Security Management Act of 2002 (FISMA) (44 U.S.C. 3541, et seq.); and related National Institute of Standards and Technology (NIST) guidelines and applicable federal and state laws and regulations.

B. The VENDOR shall not duplicate in a separate file or disseminate, without prior written permission from Department, the SSA supplied data governed by the Contract for any purpose other than that set forth in this Contract for the administration of the Department. Should the VENDOR propose a redisclosure of said SSA supplied data, the VENDOR must specify in writing to the Department the SSA supplied data the VENDOR proposes to redisclose, to whom the redisclosure would be made, the reasons that justify the redisclosure, and the secure means by which the SSA supplied data will be disclosed. The Department will not give permission for such redisclosure unless the redisclosure is required by law or essential to the administration of Department.

C. The VENDOR shall restrict access to the SSA supplied data obtained from Department to only those authorized employees who need such SSA supplied data to perform their official duties in connection with purposes identified in the Contract. The VENDOR shall not further duplicate, disseminate, or disclose such SSA supplied data without obtaining Department's prior written approval.

D. The VENDOR shall specify in its Contracts with any agent or subcontractor that will have access to SSA supplied data that such agent

or subcontractor agrees to be bound by the same restrictions, terms, and conditions that apply to the VENDOR pursuant to the Contract.

E. The VENDOR shall maintain a current list of the employees of VENDOR and any agents or subcontractors and their employees with access to SSA supplied data and provide such lists to Department upon request and at any time there are changes.

F. The VENDOR shall ensure that VENDOR's employees, agents, or subcontractors:

a. Properly safeguard PHI, PII, and SSA supplied data furnished by Department under this Contract from loss, theft, or unauthorized disclosure;

b. Receive regular, relevant, and sufficient SSA supplied data related training, including use, access, and disclosure safeguards and information regarding penalties for misuse of information;

c. Understand and acknowledge that they are responsible for safeguarding this information at all times, regardless of whether or not the VENDOR employee, agent, or subcontractor is at his or her regular duty station;

d. Ensure that laptops and other electronic devices and media containing PHI, PII, and SSA supplied data are either encrypted or password protected;

e. Send emails containing PHI, PII, and SSA supplied data only if the information is encrypted or if the transmittal is secure as set forth below in Section 5.2.23.G;

f. Limit disclosure of the information and details relating to a suspected or actual loss, theft, or unauthorized access to PHI, PII, and SSA supplied data only to those employees of the University of Illinois and Office of Medicaid Innovation (OMI) employees, agents, or subcontractors if it is required in their official duties.

G. The VENDOR or its agents or subcontractors will ensure that their use of the SSA supplied data exchanged under the Contract complies with the security and safeguarding requirements of the Privacy Act, as amended by the CMPPA, related OMB guidelines, FISMA, related NIST guidelines, and the current revision of IRS Publication 1075, Tax Information Security Guidelines for Federal, State and Local Agencies, available at

http://www.irs.gov. In addition, the VENDOR or agents and subcontractors will have in place administrative, technical, and physical safeguards for the matched SSA supplied data and results of such matches. Additional administrative, technical, and physical security requirements governing all SSA supplied data provides electronically to the Department, including SSA's Electronic Information Exchange Security Requirements and Procedures for State and local Agencies Exchanging Electronic Information with SSA, as well as specific guidance on safeguarding and reporting responsibilities for PII, are set forth in the IEAs at

https://hfs.illinois.gov/info/legal/ssaagreements.html

H. The VENDOR employees, agents, or subcontractors who access, use, or disclose Department or SSA supplied data in a manner or purpose not authorized by this Contract may be subject to civil and criminal sanctions pursuant to applicable federal statutes.

5.2.24 *Loss or Suspected Loss of SSA Supplied Data*. If an employee, agent or subcontractor of the VENDOR becomes aware of suspected or actual loss of SSA supplied data, the VENDOR must notify Department within one (1) hour of the actual or suspected loss. The VENDOR must provide Department with timely updates as any additional information about the loss of SSA supplied data becomes available. For purposes of this subsection, "loss" means the suspected or actual loss, theft, or unauthorized access to SSA supplied data.

A. If the VENDOR experiences a loss of SSA supplied data, Department will determine whether notice to individuals whose SSA supplied data has been lost shall be provided and whether mitigation efforts will be required. The VENDOR shall bear all costs associated with any required notice or mitigation.

B. Department may immediately and unilaterally suspend the SSA supplied data flow under this Contract, or terminate this Contract, if Department, in its sole discretion, determines that the VENDOR has: (1) made an unauthorized use or disclosure of SSA supplied data; or (2) violated or failed to follow the terms and conditions of this Section.

C. This Section further carries out Section 1106(a) of the SSA (42 U.S.C. 1306); the regulations promulgated pursuant to that section (20 CFR Part 401); the Privacy Act of 1974 (5 U.S.C. 552a), as amended by the Computer Matching and Privacy Protection Act of 1988; related OMB guidelines; FISMA; and related NIST guidelines, which provide the

requirements that the SSA stipulates that VENDOR must follow with regard to use, treatment, and safeguarding SSA supplied data in the event SSA supplied data is exchanged with a federal information system.

D. SPECIAL REQUIREMENTS FOR USING, ACCESSING OR DISCLOSING SOCIAL SECURITY ADMINISTRATION (SSA) DATA. The VENDOR and any agents or subcontractors, if allowed by the Contract, acknowledge that the duties specified herein require access, use, or disclosure of SSA supplied data provided to the Department by SSA, and agrees not to access, use or disclose such SSA supplied data in any manner inconsistent with the provisions of the Contract and any Appendices or Exhibits thereto, including the provisions of the Information Exchange Agreements (IEA) and Computer Matching and Privacy Protection Act (CMPPA) between the Department and the SSA at https://hfs.illinois.gov/info/legal/ssaagreements.html,, which are expressly incorporated by reference herein. The VENDOR shall restrict access to, and disclosure of, the SSA supplied data to only authorized personnel who need the SSA supplied data to perform their official duties in connection with the administration of public aid in the manner specified in the Contract. The VENDOR shall ensure that all Contracts with agents or subcontractors, if permitted, contain language requiring compliance with the terms and conditions of the IEA and CMPPA.

E. MONITORING OF AUTHORIZED PERSONNEL, CERTIFICATES OF UNDERSTANDING, AND NECESSARY PRIVACY AND SECURITY TRAINING.

a. The VENDOR and any agents or subcontractors, if permitted under the Contract, shall establish and maintain ongoing management oversight and quality assurance capabilities to ensure that only authorized personnel have access to Department SSA supplied data. The VENDOR shall deliver security awareness training, as provided by the Department, for authorized personnel and maintain a copy of the training received. The training shall include information about the responsibility authorized personnel for proper use and protection of the SSA supplied data, and the possible sanctions for misuse. All authorized personnel shall receive security awareness training prior to accessing the SSA supplied data, and at least annually thereafter. The training shall address the Privacy Act of 1974, other federal and state laws governing computer security and the use and misuse of PHI, IIHI, and Social Security Numbers (SSNs) as applicable.

b. The VENDOR and, if allowed by the Contract, any agent's or subcontractor's authorized personnel shall sign the External Certificate of Understanding and Confidentiality Contract which outline the permissible purposes for which the Data, including SSA supplied data, may be used and the civil and criminal penalties for unauthorized use. Prior to any services being performed or Data, including SSA supplied data, being accessed pursuant to the Contract, The VENDOR shall provide the Department with a list of VENDOR authorized personnel who have access to Department Data, including SSA supplied data. VENDOR is responsible for contacting the Department in a timely manner to add, remove or edit authorized personnel access. The VENDOR shall maintain records of authorized personnel under the Contract. The records shall contain a copy of each individual's signed Certificate of Understanding and Confidentiality Contract and proof of the individual's participation in security awareness training and HIPAA training. The VENDOR shall make such records available to the Department within two (2) working days of a request for such records. Such records are to be maintained for three (3) years.

F. TRIENNAL COMPLIANCE REVIEWS. The VENDOR and any agent or subcontractor, if permitted under the Contract, agrees to allow the Department, in accordance with SSA requirements, access to any books, systems, policies and procedures to conduct triennial compliance reviews to ensure that standards in the IEA and CMPPA are being met. If requested by the Department or SSA, the VENDOR agree to provide written certification that such standards are being met within the timeframe specified by the requestor. To the extent the VENDOR or any agent or subcontractor will be involved with any offsite processing, handling, or transmission of information provided to the Department by SSA, the Department may perform onsite reviews of such offsite facility to ensure that the following meet SSA's requirements:

a. safeguards for sensitive information,

b. technological safeguards on computer(s) that have access to SSA-provided information,

c. security controls and measures to prevent, detect, and resolve unauthorized access to, use of, and redisclosure of SSA-provided information, and

d. continuous monitoring of the contractors, subcontractors or agent's network infrastructures and assets.

5.2.25 *Internal revenue service (IRS) required provisions for federal tax information (FTI) shared under contract for technology services*.

A. Performance. In performance of the Contract, Vendor agrees to comply with and assume responsibility for compliance by officers or employees with the following requirements:

a. All work will be performed under the supervision of Vendor.

b. Vendor and Vendor's officers or employees to be authorized access to FTI must meet background check requirements defined in IRS Publication 1075. Vendor will maintain a list of officers or employees authorized access to FTI. Such list will be provided to Agency and, upon, request, to the IRS.

c. FTI in hardcopy or electronic format shall be used only for the purpose of carrying out the provisions of the Contract. FTI in any format shall be treated as confidential and shall not be divulged or made known in any manner to any person except as may be necessary in the performance of the Contract. Inspection or disclosure of FTI to anyone other than Vendor or Vendor's officers or employees authorized is prohibited.

d. FTI will be accounted for upon receipt and properly stored before, during, and after processing. In addition, any related output and products require the same level of protection as required for the source material.

e. Vendor will certify that FTI processed during the performance of the Contract will be completely purged from all physical and electronic data storage with no output to be retained by Vendor at the time the work is completed. If immediate purging of physical and electronic data storage is not possible, Vendor will certify that any FTI in physical or electronic storage will remain safeguarded to prevent unauthorized disclosures.

f. Any spoilage or any intermediate hard copy printout that may result during the processing of FTI will be given to the Agency. When this is not possible, Vendor will be responsible for the destruction of the spoilage or any intermediate hard copy

printouts and will provide the Agency with a statement containing the date of destruction, description of material destroyed, and the destruction method.

g. All computer systems receiving, processing, storing or transmitting FTI must meet the requirements in IRS Publication 1075. To meet functional and assurance requirements, the security features of the environment must provide for the managerial, operational, and technical controls. All security features must be available and activated to protect against unauthorized use of and access to FTI.

h. No work involving FTI furnished under the Contract will be subcontracted without prior written approval of the IRS.

i. Vendor will ensure that the terms of FTI safeguards described herein are included, without modification, in any approved subcontract for work involving FTI.

j. To the extent the terms, provisions, duties, requirements, and obligations of this Contract apply to performing services with FTI, Vendor shall assume toward the subcontractor all obligations, duties and responsibilities that the Agency under the Contract assumes toward Vendor, and the subcontractor shall assume toward Vendor all the same obligations, duties and responsibilities which Vendor assumes toward the Agency under the Contract.

k. In addition to the subcontractor's obligations and duties under an approved subcontract, the terms and conditions of the Contract apply to the subcontract, and the subcontractor is bound and obligated to Vendor hereunder by the same terms and conditions by which Vendor is bound and obligated to the Agency under the Contract.

l. For purposes of this Section 5.1.27, the term "Vendor" includes any officer or employee of Vendor with access to or who uses FTI, and the term "subcontractor" includes any officer or employee of the subcontractor with access to or who uses FTI.

m. The Agency will have the right to void the contract if Vendor fails to meet the terms of FTI safeguards described herein.

B. Criminal and Civil Sanctions

a. Each officer or employee of Vendor to whom FTI is or may be disclosed shall be notified in writing that FTI disclosed to such officer or employee can be used only for a purpose and to the extent authorized herein, and that further disclosure of any FTI for a purpose not authorized herein constitutes a felony punishable upon conviction by a fine of as much as $5,000 or imprisonment for as long as 5 years, or both, together with the costs of prosecution.

b. Each officer or employee of Vendor to whom FTI is or may be accessible shall be notified in writing that FTI accessible to such officer or employee may be accessed only for a purpose and to the extent authorized herein, and that access/inspection of FTI without an official need-to-know for a purpose not authorized herein constitutes a criminal misdemeanor punishable upon conviction by a fine of as much as $1,000 or imprisonment for as long as 1 year, or both, together with the costs of prosecution.

c. Each officer or employee of Vendor to whom FTI is or may be disclosed shall be notified in writing that any such unauthorized access, inspection or disclosure of FTI may also result in an award of civil damages against the officer or employee in an amount equal to the sum of the greater of $1,000 for each unauthorized access, inspection, or disclosure, or the sum of actual damages sustained as a result of such unauthorized access, inspection, or disclosure, plus in the case of a willful unauthorized access, inspection, or disclosure or an unauthorized access/inspection or disclosure which is the result of gross negligence, punitive damages, plus the cost of the action. These penalties are prescribed by IRC sections 7213, 7213A and 7431 and set forth at 26 CFR 301.6103(n)-1.

d. Additionally, it is incumbent upon Vendor to inform its officers and employees of the penalties for improper disclosure imposed by the Privacy Act of 1974, 5 U.S.C. 552a. Specifically, 5 U.S.C. 552a(i)(1), which is made applicable to contractors by 5 U.S.C. 552a(m)(1), provides that any officer or employee of a contractor, who by virtue of his/her employment or official position, has possession of or access to agency records which contain individually identifiable information, the disclosure of

which is prohibited by the Privacy Act or regulations established thereunder, and who knowing that disclosure of the specific material is prohibited, willfully discloses the material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than $5,000.

e. Granting Vendor access to FTI must be preceded by certifying that each officer or employee understands the Agency's security policy and procedures for safeguarding FTI. Vendor and each officer or employee must maintain their authorization to access FTI through annual recertification of their understanding of the Agency's security policy and procedures for safeguarding FTI. The initial certification and recertifications must be documented and placed in the Agency's files for review. As part of the certification and at least annually afterwards, Vendor and each officer or employee of Vendor must be advised of the provisions of IRC sections 7213, 7213A, and 7431 (see Exhibit 4 of IRS Publication 1075, Sanctions for Unauthorized Disclosure, and Exhibit 5 of IRS Publication 1075, Civil Damages for Unauthorized Disclosure). The training on the Agency's security policy and procedures provided before the initial certification and annually thereafter must also cover the incident response policy and procedure for reporting unauthorized disclosures and data breaches. (See Section 10 of IRS Publication 1075). For the initial certification and the annual recertifications, Vendor and each officer or employee must sign, either with ink or electronic signature, a confidentiality statement certifying their understanding of the security requirements.

C. Inspection. The IRS and the Agency, with 24 hour notice, shall have the right to send its inspectors into the offices and plants of Vendor to inspect facilities and operations performing any work with FTI under this Contract for compliance with requirements defined in IRS Publication 1075. The IRS' right of inspection shall include the use of manual and/or automated scanning tools to perform compliance and vulnerability assessments of information technology (IT) assets that access, store, process or transmit FTI. Based on the inspection, corrective actions may be required in cases where Vendor is found to be noncompliant with FTI safeguard requirements.

5.2.26 *Obligation to comply with federal and state law*. The requirement to comply with any obligation imposed by federal or State law, regulation, or rule shall be

an ongoing obligation of Contractor. For purposes of this provision, federal or State law, rule or regulation imposing obligations on Medicaid Managed Care Organizations shall become an enforceable provision of this contact as if terms of the law, regulation or rule were specifically included in this Contract. If a law, regulation, or rule imposes an obligation on the State for requirements and limits including, but not limited to, specific services for Enrollees, payment, and quality assurance, including reporting thereon, it shall be an obligation of Contractor to provide such services to Enrollees, and assurances, information, and reporting to the Department so that the State can comply with such law, regulation, or rule. The Department and Contractor shall confer to develop protocols, processes, and policies necessary to effectuate compliance with such laws, regulations, and rules as a Party or Parties become aware of such laws, regulations, or rules.

5.2.27 *Notification of HPMS filings*. Contractor must notify the Department of all filings in HPMS no later than five (5) business days after the HPMS filing.

5.2.28 *Assignment*. Contractor may not assign or transfer any right or interest in this Contract to any successor entity or other entity without the prior written consent of the Department, which may be withheld for any reason or for no reason at all.

5.2.29 *Independent Contractors*

A. Contractor, its employees, and any other of its agents in the performance of this Contract, shall act in an independent capacity and not as officers, agents or employees of, or joint venturers with the State of Illinois.

B. Contractor must ensure it evaluates the prospective Medicaid Providers' and Subcontractors' abilities to perform activities to be delegated.

5.2.30 *Subrogation*. Subject to Illinois lien and Third-Party recovery rights, Contractor must:

A. Be subrogated and succeed to any right of recovery of an Enrollee against any person or organization, for any services, supplies, or both provided under this Contract up to the amount of the benefits provided hereunder;

B. Require that the Enrollee pay to Contractor all such amounts recovered by suit, settlement, or otherwise from any third person or their insurer to the extent of the benefits provided hereunder, up to the value of the benefits provided hereunder. Contractor may ask the Enrollee to:

a. Take such action, furnish such information and assistance, and execute such instruments as Contractor may require to facilitate enforcement of its rights hereunder, and take no action prejudicing the rights and interest of Contractor hereunder; and

b. Notify Contractor hereunder and authorize Contractor to make such investigations and take such action as Contractor may deem appropriate to protect its rights hereunder whether or not such notice is given.

5.2.31 *Prohibited Affiliations*. In accordance with 42 USC 1396 u-2(d)(1), Contractor shall not knowingly have an employment, consulting, or other agreement for the provision of items and services that are significant and material to Contractor's obligations under this Contract with any person, or Affiliate of such person, who is excluded, under federal law or regulation, from certain procurement and non-procurement activities. Further, no such person may have beneficial ownership of more than five percent (5%) of Contractor's equity or be permitted to serve as a director, officer, or partner of Contractor.

5.2.32 *Disclosure Requirements*. Contractor must disclose to the Department information on ownership and control, business transactions, and persons convicted of crimes in accordance with 42 CFR Part 455, Subpart B. Contractor must obtain federally required disclosures from all Network Providers and applicants in accordance with 42 CFR 455 Subpart B and 42 CFR 1002.3, and as specified by the Department, including but not limited to obtaining such information through Provider enrollment forms and credentialing and recredentialing packages. Contractor must maintain such disclosed information in a manner which can be periodically searched by Contractor for exclusions and provided to the Department in accordance with the Contract and relevant State and federal laws and regulations. In addition, Contractor must comply with all reporting and disclosure requirements of 42 USC 1396b(m)(4)(A) if Contractor is not a federally qualified Health Maintenance Organization under the Public Health Service Act.

5.2.33 *Physician Incentive Plans*

A. Contractor must comply with all applicable requirements governing Physician incentive plans, including but not limited to such requirements appearing at 42 CFR Parts 417, 422, 434, 438.3(i), and 1003. Contractor must submit all information required to be disclosed to the Department in the manner and format specified by CMS and the Department, which, subject to Federal approval, must be consistent with the format required by CMS for Medicare contracts.

B. Contractor shall be liable for any and all loss of federal financial participation (FFP) incurred by Illinois that results from Contractor's or its subcontractors' failure to comply with the requirements governing Physician incentive plans at 42 CFR Parts 417, 434 and 1003; however, Contractor shall not be liable for any loss of FFP under this provision that exceeds the total FFP reduction attributable to Enrollees in Contractor's D-SNP, and Contractor shall not be liable if it can demonstrate, to the satisfaction of CMS and the Department, that it has made a good faith effort to comply with the cited requirements. Federal financial participation is not available for any amounts paid to Contractor if Contractor could be excluded from participation in Medicare or Medicaid under section 1128(b)(8)(B) of the SSA or for any of the reasons listed in 42 CFR 431.55(h).

C. Physician Identifier. Contractor must require each Physician providing Covered Services to Enrollees under the Contract to have a unique identifier in accordance with the system established under 42 U.S.C. 1320d-2(b). Contractor must provide such unique identifier to the Department for each of its PCPs in the format and time-frame established by the Department in consultation with Contractor.

5.2.34 *Timely Provider Payments*. Contractor must make timely payments to Medicaid Providers. Contractor must ensure that ninety percent (90%) of payment claims from Physicians who are in individual or Group Practice, which can be processed without obtaining additional information from the Physician or from a Third Party (hereinafter "Clean Claim"), from Providers for Covered Services will be paid within thirty (30) days after the date of receipt of the claim. Contractor must ensure that ninety-nine percent (99%) of Clean Claims from Providers for Covered Services will be paid within ninety (90) days after the date of receipt of the claim. Contractor and its Providers may by mutual agreement, in writing, establish an alternative payment schedule provided that payment is no less timely than provided herein.

A. Contractor shall pay for Family Planning services, subject to Attachment 3 HCBS Service Package II Covered Services, rendered by a non-Network Provider, for which Contractor would pay if rendered by an Network 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 Contractor and the non-Network Provider.

B. Contractor shall accept claims for non-Network Providers for at least one hundred eighty (180) days after the date the services are provided. Contractor shall not be required to pay for claims initially submitted by such non-Network Providers more than one hundred eighty (180) days after the date of service.

5.2.35 *Protection Of Enrollee-Provider Communications*. In accordance with 42 USC 1396 u-2(b)(3), 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 options for the Enrollee's condition or disease; information the Enrollee needs in order to decide among all relevant treatment options; risk, benefits and consequences of treatment or non-treatment; and/or the Enrollee's rights to participate in decisions about their health care, including the right to refuse treatment and to express preferences about future treatment decisions; regardless of whether benefits for such care or treatment are provided under the Contract, if the Provider is acting within the lawful scope of practice.

5.2.36 *Protecting Enrollee from Liability For Payment*. Contractor must:

A. In accordance with 42 CFR 438.106, not hold an Enrollee liable for:

a. Debts of Contractor, in the event of Contractor's insolvency;

b. Covered Services provided to the Enrollee in the event that Contractor fails to receive payment from the Department for such services; or

c. Payments to a clinical entity in excess of the amount that would be owed by the Enrollee if Contractor had directly provided the services;

B. Not charge Enrollees coinsurance, co-payments, deductibles, financial penalties, or any other amount in full or part, for any service provided under the Contract, except as otherwise provided in Attachment 3 HCBS Service Package II Covered Services;

C. Not deny any service provided under the Contract to an Enrollee for failure or inability to pay any applicable charge; and

D. Not deny any service provided under the Contract to an Enrollee who, prior to becoming Medicare and Medicaid eligible, incurred a bill that has not been paid.

5.2.37 *Moral or Religious Objections*. Contractor is not required to provide, reimburse for, or provide coverage of, a counseling or Referral service that would otherwise be required if Contractor objects to the service on moral or religious grounds. If Contractor elects not to provide, pay for, or provide coverage of, a counseling or Referral service because of an objection on moral or religious grounds, it must promptly notify the Department in writing of its intent to exercise the objection. It must furnish information about the services it does not cover as follows:

A. To the State;

B. With its application for a contract;

C. Whenever it adopts the policy during the term of the contract; and

D. The information provided must be:

E. Consistent with the provisions of 42 CFR 438.10 and 438.102(b);

F. Provided to Eligible Beneficiaries before and during enrollment; and

G. Provided to Enrollees within ninety (90) days after adopting the policy with respect to any particular service.

5.2.38 *Third Party Liability*

A. Coordination of Benefits. The Department shall provide Contractor with all Third Party health insurance information on Enrollees where it has verified that Third Party health insurance exists.

B. The Department shall refer to Contractor the Enrollee's name and pertinent information where the Department knows an Enrollee has been in an accident or had a traumatic event where a liable Third Party may exist.

C. Contractor shall:

a. Designate a Third Party Liability (TPL) Benefit Coordinator who shall serve as a contact person for Benefit Coordination issues related to the Contract.

b. Designate one or more recoveries specialist(s), whose function shall be to investigate and process all transactions related to the identification of TPL.

c. Perform Benefit Coordination in accordance with this section. Contractor shall work with Department via interface transactions with the MMIS system using HIPAA standard formats to submit information regarding TPL investigations and recoveries.

5.2.39 *Third Party Health Insurance Information*. Contractor shall implement procedures to (1) determine if an Enrollee has other health insurance except Medicare Part A and B and Medicaid, and (2) identify other health insurance that may be obtained by an Enrollee using, at a minimum, the following sources:

A. The HIPAA 834 outbound Enrollment File;

B. Claims Activity;

C. Point of Service Investigation (Enrollee Service, Member Services and Utilization Management);

D. Any TPL information self-reported by an Enrollee;

E. If Contractor also offers commercial policies or Illinois Integrated Care Program plans, Contractor shall perform a data match within their own commercial plan and D-SNP Plan subscriber/member / Enrollee lists. If an Enrollee is found to also be enrolled in Contractor's commercial plan or D-SNP Plan, the Enrollee's information shall be sent to the Department. The Department shall verify the Enrollee's enrollment Integrated Care Program and eligibility status. If the Department determines that Contractor was correct, the Department will disenroll the Enrollee retroactive to the effective date of the other insurance; and

F. Reviewing claims for indications that other insurance may be active (e.g. explanation of benefit attachments or Third-Party payment).

5.2.40 *Third Party Health Insurance Cost-Avoidance, Pay and Recover Later and Recovery*

A. Once an Enrollee is identified as having other health insurance, Contractor must cost avoid claims for which another insurer may be liable, except in the case of prenatal services per 42 U.S.C. 1396(a)(25)(E) and 42 CFR 433.139.

B. Contractor shall perform the following activities to cost-avoid, pay and recover later, or recover claims when other health insurance coverage is available:

a. Cost-Avoidance. Contractor shall:

i. On the Daily Inbound Demographic Change File provide all TPL information on Contractor's Enrollees;

ii. Pend claims that are being investigated for possible Third Party health insurance coverage in accordance with the Department's guidelines;

iii. Deny claims submitted by a Provider when the claim indicates the presence of other health insurance;

iv. Instruct Providers to use the TPL Indicator Form to notify the Department of the potential existence of other health insurance coverage and to include a copy of the Enrollee's health insurance card with the TPL Indicator Form if possible; and

v. Distribute TPL Indicator Forms at Contractor's Provider orientations.

b. Pay and Recover Later. Contractor shall take all actions necessary to comply with the requirements of 42 U.S.C. 1396a(a)(25)(E) and 42 CFR 433.139.

c. Recovery. Contractor shall:

d. Identify claims it has paid inappropriately when primary health insurance coverage is identified. Identification will be achieved through data matching processes and claims analyses;

e. Implement policies and procedures and pursue recovery of payments made where another payer is primarily liable; and

f. Develop procedures and train staff to ensure that Enrollees who have comprehensive Third Party health insurance are identified and reported to the Department.

5.2.41 *Third Party Reporting*. Semi-annually, Contractor shall report to the Department the following:

A. Other Insurance – the number of Referrals sent by Contractor on the Inbound Demographic Change File, and the number of Enrollees

identified as having TPL on the monthly HIPAA 834 inbound Enrollment file;

B. Pay and Recover Later – the number and dollar amount of claims that were paid and recovered later consistent with the requirements of 42 U.S.C. 1396a(a)(25)(E) and 42 CFR 433.139;

C. Cost avoidance – the number and dollar amount of claims that were denied by Contractor due to the existence of other health insurance coverage on a semi-annual basis, and the dollar amount per Enrollee that was cost avoided on the denied claim; and

D. Recovery - Claims that were initially paid but then later recovered by Contractor as a result of identifying coverage under another health insurance plan, on a semi-annual basis, and the dollar amount recovered per Enrollee from the other liable insurance carrier or Provider.

5.2.42 *Accident and Trauma Identification and Recovery Identification*

A. Cost Avoidance and Recovery. Contractor shall recover or cost avoid claims where an Enrollee has been involved in an accident or lawsuit.

B. Claims Editing and Reporting. Contractor shall utilize the following claims editing and reporting procedures to identify potential accident and/or other TPL cases:

a. Claims Reporting – Specific diagnosis ranges that may indicate potential accident and casualty cases;

b. Provider Notification – Claims where Providers have noted accident involvement;

c. Patient Questionnaires – Questionnaires will be sent to Enrollees who are suspected of having suffered an injury as a result of an accident; and

d. Questionnaires will be based on a predetermined diagnosis code range.

C. Medical Management. Contractor shall identify any requested medical services related to motor vehicle accidents, or work related injuries, and refer these claims to the recoveries specialist for further investigation.

D. Reporting. On a semi-annual basis, Contractor will provide the Department with cost avoidance and recovery information on accidents and trauma cases.

5.2.43 *Medicaid Drug Rebate*.

A. Non-Part D covered outpatient drugs dispensed to Enrollees shall be subject to the same rebate requirements as the Department is subject under section 1927 of the SSA and that the Department shall collect such rebates from pharmaceutical manufacturers.

B. Contractor shall submit to the Department, on a timely and periodic basis no later than forty-five (45) calendar days after the end of each quarterly rebate period, information on the total number of units of each dosage form and strength and package size by National Drug Code of each non-Part D covered outpatient drug dispensed to Enrollees for which Contractor is responsible for coverage and other data as the Department determines.

C. Contractor shall require its Subcontractors contracted for the delivery or administration of the Medicaid covered outpatient drug benefit to report separately to Contractor the amounts related to: (i) the incurred claims described in 438.8(e)(2) such as reimbursement for the Medicaid covered outpatient drug, payments for other patient services, and the fees paid to providers or pharmacies for dispensing or administering a Medicaid covered outpatient drug; and (ii) administrative costs, fees and expenses of the Subcontractor.

5.2.44 *Contractor Certifications*

A. Contractor certifies that it and its employees will comply with applicable provisions of the US 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 the Contract.

B. Contractor certifies that it is a properly formed and existing legal entity and as applicable, has obtained an assumed-name certificate from the appropriate authority; or has registered to conduct business in Illinois and is in good standing with the Illinois Secretary of State.

C. Contractor certifies it is a "covered entity" as defined at 45 CFR 160.103.

D. Disclosure of interest. Contractor shall comply with the disclosure requirements specified in 42 CFR 455, including filing with the

Department, upon the Execution of the resulting Contract, upon renewal or extension of the resulting Contract, and within thirty-five (35) days after a change in ownership occurs, a disclosure statement containing the following:

a. the name, federal employer identification number, and address of each Person with Ownership or a Controlling Interest in Contractor; for individuals, include home address, work address, date of birth, Social Security number, and gender;

b. whether any of the individuals so identified are related to another so identified as the individual's spouse, child, brother, sister, or parent;

c. the name of any Person with Ownership or a Controlling Interest in Contractor who also is a Person with Ownership or a Controlling Interest in another MCO that has a contract with the Department to furnish services under the DHFS Medical Program, and the name or names of the other MCO;

d. the name and address of any Person with Ownership or a Controlling Interest in Contractor or an agent or employee of Contractor who has been convicted of a criminal offense related to the involvement of that Person with Ownership or a Controlling Interest in any program under federal law, including any program under Titles XVIII, XIX, XX, or XXI of the SSA, since the inception of such programs;

e. whether any Person identified in this section is currently terminated, suspended, barred, or otherwise excluded from participation in, or has voluntarily withdrawn from as the result of a settlement agreement, any program under federal law including any program under Titles XVIII, XIX, XX, or XXI of the SSA, or has within the past five (5) years been reinstated to participation in any program under federal law including any program under Titles XVIII, XIX, XX, or XXI of the SSA and prior to said reinstatement had been terminated, suspended, barred, or otherwise excluded from participation in, or has voluntarily withdrawn from, as the result to a settlement agreement, such programs; and

f. whether the medical director of the plan is a Person with Ownership or a Controlling Interest.

6. SUBCONTRACTS

6.1 **Subcontractor Relationships**. Contractor may provide or arrange to provide any Covered Services through subcontracts with Medicaid Providers per the terms in Section *1.2.17.H Provider Network*, or fulfill any other obligations under this Contract, by means of sub-contractual responsibilities and relationships per this section. This section may impose additional terms on the Contractor in addition to the required Medicaid Provider subcontract terms in *Section 1.2.17.H Provider Network*.

6.2 **Subcontractor oversight committee**. The Contractor shall have a Subcontractor oversight committee that meets, at minimum, on a quarterly basis. This committee shall, at a minimum, conduct the following with regard to each Subcontractor: a predelegation audit, a quarterly delegation oversight review of Subcontractor performance, monthly joint operation meetings, an annual audit of Subcontractors, regular monitoring of Enrollee Complaints, documentation of issues, and development of a Corrective Action Plan (CAP), as warranted, to improve performance.

6.3 **Written Requirements**. All subcontracts entered into by Contractor must be in writing and meet the requirements of 42 CFR 422 Subpart K, 423 Subpart K, and 438.230, and are subject to the additional following requirements:

6.3.1 *When Subcontractor is Bound by the Contract Terms and Conditions*. The Subcontractors shall be bound by the terms and conditions of this Contract that are appropriate to the service or activity delegated under the subcontract.

6.3.2 *Subcontractor Delegation of Claims Process and Payment*. Contractor shall require that Subcontractors delegated to perform claims processing and payment activities offer Network Providers the option to utilize an electronic billing system.

6.3.3 *Subcontracts submission to the Department*. Contractor shall be responsible for submitting its model subcontracts, including model Medicaid Provider subcontracts initially and upon revision. Executed contracts shall be submitted upon request of the Department.

6.3.4 *Pharmacy Benefit Manager (PBM) Contracts*. In addition to all requirements set forth in 42 CFR Part 423, Contractor shall ensure its PBM contracts are in accordance with Public Act 104-0027, 215 ILCS 5/513b1 and 305 ILCS 5/5-36 (e) and (h) and submitted to the Department initially, annually no later than July 31, and upon revision within thirty (30) days of execution for Department review. Contractor shall have a liaison who will interact with designated staff at the Department to ensure timely and accurate disclosure by Contractor's PBM of the information described in 305 ILCS 5/5-36(e) upon request by the Department.

6.3.5 *Responsibility*. Contractor shall be responsible for the performance of any of its responsibilities delegated to subcontractors.

6.3.6 *Prohibited Termination*. No subcontract can terminate the legal responsibilities of Contractor to the Department to assure that all the activities under this Contract will be carried out.

6.3.7 *Lobbying Certification*. All subcontracts, including Medicaid Provider subcontracts, must comply with the lobbying certification contained in this Contract.

6.3.8 *Grievance and Appeals*. All subcontractors, including Medicaid Provider subcontractors, shall be furnished with information about Contractor's Grievance and Appeal procedures at the time the Medicaid Provider enters into an agreement with Contractor and within fifteen (15) days following any substantive change to such procedures.

6.3.9 *Termination Rights*. Contractor must retain the right to terminate any subcontract or impose other sanctions if the performance of the Subcontractor is inadequate.

6.3.10 *Excluded persons*. Contractor shall not subcontract with any Person who is currently terminated, suspended, barred, or otherwise excluded from participation in, or has voluntarily withdrawn from as the result of a settlement agreement, any program under federal law including any program under Titles XVIII, XIX, XX, or XXI of the SSA, or has within the past five (5) years been reinstated to participation in any program under federal law including any program under Titles XVIII, XIX, XX, or XXI of the SSA.

6.4 **Provider subcontracts submission to the Department**. Contractor shall be responsible for submitting its model subcontracts and model provider agreements initially and upon revision. Executed contracts shall be submitted upon request of the Department.

6.5 **Responsibility**. Contractor shall be responsible for the performance of any of its responsibilities delegated to Network Providers, subcontractors and other entities to which duties are delegated.

6.6 **Prohibited Termination**. No Provider agreement or subcontract can terminate the legal responsibilities of Contractor to the Department to assure that all the activities under this Contract will be carried out.

6.7 **HFS Medical Program Enrollment**. All Network Providers providing Covered Services for Contractor under this Contract must be enrolled as Providers in the HFS Medical Program. Contractor shall not contract or subcontract with an excluded Person, or a Person who

has voluntarily withdrawn from the HFS Medical Program as the result of a settlement agreement.

6.8 **Lobbying Certification**. All Provider agreements and subcontracts must comply with the lobbying certification contained in this Contract.

6.9 **Grievance and Appeals**. All Network Providers shall be furnished with information about Contractor's Grievance and Appeal procedures at the time the Provider enters into an agreement with Contractor and within fifteen (15) days following any substantive change to such procedures.

6.10 **Termination Rights**. Contractor must retain the right to terminate any Provider agreement or subcontract or impose other sanctions if the performance of the Network Provider or Subcontractor is inadequate.

6.11 **Compensation**. Provider-compensation models shall reimburse for Covered Services provided and may reimburse for performance. Contractor shall not permit any payment to a Network Provider for Covered Services other than the payment made by Contractor, except when specifically required by the Contract or applicable law as provided in 42 CFR 438.60.

6.12 **Provider Agreement and Subcontractor Warrants**. With respect to all Provider agreements and subcontracts made by Contractor, Contractor further warrants:

6.12.1 *Binding*; that such Provider agreements and subcontracts are binding;

6.12.2 *Inadequate Performance*; that it will promptly terminate all contracts with Network Providers and Subcontractors or impose other sanctions if the performance of the Network Provider or Subcontractor is inadequate, as determined by either the Department or Contractor;

6.12.3 *Excluded Providers*; that it will promptly terminate contracts with Providers that are terminated, barred, or suspended, or have voluntarily withdrawn, as a result of a settlement agreement under Section 1902(kk)(8) of the SSA, from participating in any program under federal law including any program under Titles XVIII, XIX, XX, or XXI of the SSA or are otherwise excluded from participation in the HFS Medical Program;

6.12.4 *Laboratory Testing Sites and Network Provider and Subcontractor Performance Monitoring*; that all laboratory testing sites providing services under the resulting Contract must possess a valid Clinical Laboratory Improvement Amendments (CLIA) certificate and comply with the CLIA regulations found at 42 CFR 493; and that it will monitor the performance of all Network Providers and Subcontractors on an ongoing basis, subject each Network 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 Network Provider or Subcontractor take appropriate corrective action.

6.12.5 *Covered Entity Certification*. Provider certifies it is a "covered entity" as defined at 45 CFR 160.103.

6.12.6 *Reports of Transactions*. Contractor shall make any reports of transactions between Contractor and parties in interest that are provided to the state, or other agencies available to enrollees upon reasonable request pursuant to 1903(m)(4)(B) of the SSA

D-SNP Attachment 1
Department of Healthcare and Family Services
State of Illinois County List
BidBuy #: 25-479HFS-DIREC-P-xxxxx |**Agency Reference Number:** 2026-24-001

Statewide Illinois County List:

***Bold are Urban Counties**

1. Adams
2. Alexander
3. Bond
4. Boone
5. Brown
6. Bureau
7. Calhoun
8. Carroll
9. Cass
10. **Champaign**
11. Christian
12. Clark
13. Clay
14. Clinton
15. Coles
16. **Cook**
17. Crawford
18. Cumberland
19. **DeKalb**
20. DeWitt
21. Douglas
22. **Dupage**
23. Edgar
24. Edwards
25. Effingham
26. Fayette
27. Ford
28. Franklin
29. Fulton
30. Gallatin
31. Greene
32. Grundy
33. Hamilton
34. Hancock
35. Hardin
36. Henderson
37. Henry
38. Iroquois
39. Jackson
40. Jasper
41. Jefferson
42. Jersey
43. Jo Daviess
44. Johnson
45. **Kane**
46. **Kankakee**
47. Kendall
48. Knox
49. **Lake**
50. LaSalle
51. Lawrence
52. Lee
53. Livingston
54. Logan
55. **Macon**
56. Macoupin
57. **Madison**
58. Marion
59. Marshall
60. Mason
61. Massac
62. McDonough
63. **McHenry**
64. **McLean**
65. Menard
66. Mercer
67. Monroe
68. Montgomery
69. Morgan
70. Moultrie
71. Ogle
72. **Peoria**
73. Perry
74. Piatt
75. Pike
76. Pope
77. Pulaski
78. Putnam
79. Randolph
80. Richland
81. **Rock Island**
82. Saline
83. **Sangamon**
84. Schuyler
85. Scott
86. Shelby
87. **St. Clair**
88. Stark
89. Stephenson
90. **Tazewell**
91. Union
92. **Vermilion**
93. Wabash
94. Warren
95. Washington
96. Wayne
97. White
98. Whiteside
99. **Will**
100. Williamson
101. **Winnebago**
102. Woodford

D-SNP Attachment 2
Department of Healthcare and Family Services
Required Deliverables, Submissions, and Reporting
BidBuy #: 25-478HFS-DIREC-P-xxxxx |**Agency Reference Number:** 2026-24-001

NOTE: This Attachment corresponds to Section 1.3 Milestones and Deliverables of the Contract. Separate reports shall be submitted for all populations unless otherwise stated in the report description and requirements. Contractor shall be prepared to report all data by county, provider type, and eligibility category.

Failure to submit required deliverables, submissions and reports outlined in this section will be grounds for the imposition of sanctions as described in Section 1.2.38 of the Contract.

Name of report/submission	Frequency	HFS Prior Approval	Report description and requirements
1. Administrative			
A. Encounter Data	As specified in the Encounter Utilization Monitoring Procedures	No	Contractor shall submit Encounter Data as provided by the Department in the Encounter Utilization Monitoring Procedures.
B. Electronic Data Certification	Monthly, due by the 5th calendar day of the following month	No	In a format determined by the Department, Contractor shall certify by the 5th day of each month that all electronic data submitted during the previous calendar month are accurate, complete, and true.
C. Disclosure statement	Initially, annually, no later than July 31, and as changes occur	No	Contractor shall submit disclosure statements as specified in 42 CFR, Part 455.
D. Report of transactions with Parties of Interest	Annually, no later than July 31	No	Contractor shall report 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.
E. Compliance certification	Annually, no later than July 31	No	Contractor shall submit a Certification confirming that Contractor and its subcontractors are in compliance with Section 5.18.

Name of report/submission	Frequency	HFS Prior Approval	Report description and requirements
F. Monthly TPL Report	Monthly, by the last day of each reporting month	No	Contractor shall submit a monthly TPL report that complies with the TPL guidance and template provided by the Department.
G. Key position changes	No later than two (2) Business Days after such change occurs.	Yes	Contractor shall submit Key Position changes no later than two (2) business days after such change occurs.
H. Social and Structural Determinants of Health (SSDOH) Work Plan	Initially, and annually, no later than July 31, or as requested by HFS	Yes	Contractor shall develop and implement a SSDOH work plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on factors such as age, race, ethnicity, gender, primary language, and disability status. Contractor shall submit the SSDOH work plan to the Department for Prior Approval and then annually pursuant to Section 1.2.14.AA of the Contract.
I. Corrective Action Reporting	Quarterly	N/A	The Contractor shall report to the Department through quarterly reporting, as required by the Department, evidence of ongoing monitoring sufficient to assure the Department that corrective action is being provided for areas identified by Contractor or First Tier, Downstream, or Related Entity as requiring corrective action plan(s) or quality improvement initiative(s) with protections put in place by the Contractor to prevent such deficiencies from reoccurring.
2. Enrollee Materials			

Name of report/submission	Frequency	HFS Prior Approval	Report description and requirements
A. Certificate of Coverage, Description of Coverage, and any changes or amendments	Initially and as revised	Yes	Contractor shall submit the Certificate of Coverage and Description of Coverage for Prior Approval that comply with the Managed Care Reform and Patient Rights Act (215 ILCS 134) and the 50 Ill. Adm. Code 4521.
B. Enrollee Handbook	Initially and as revised	Yes	Contractor shall submit an Enrollee Handbook for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed.
C. Identification Card	Initially and as revised	Yes	Contractor shall submit the Enrollee identification card for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed.
D. Provider Directory Attestation	Monthly, by the 5th calendar day of each reporting month	No	Contractor shall submit an attestation that they have met the provider directory requirements in 305 ILCS 5/5-30.3(b)(1) and 305 ILCS 5/5 30.1(f)(2).
3. Fraud and Abuse			
A. Fraud, Waste, and Abuse Audit and Investigation Activity	Ongoing	N/A	Contractor shall report all audit and investigative activity related to Fraud, Waste, and Abuse to OIG through its reporting portal as required in the Program Integrity section of this Contract. Contractor shall provide a preliminary investigation report as each occurrence is identified.

Name of report/submission	Frequency	HFS Prior Approval	Report description and requirements
B. Fraud, Waste, and-Abuse Referral	Ongoing	N/A	Contractor shall provide a summary report of findings of Fraud, Waste, or Abuse in Illinois' Medical Assistance Program through OIG's reporting portal.
C. Overpayment Recovery Request	Ongoing	Yes	Contractor shall submit requests for approval to recover overpayments resulting from Fraud, Waste, or Abuse from its Network Providers through OIG's reporting portal.
D. Enrollee Restriction Program	Initially, annually, no later than July 31, and as revised	Yes	Contractor shall submit for prior approval its policies and procedures governing its enrollee restriction program.
E. Enrollee Restriction Program Results	Monthly, no later than the 10th of the month	No	Contractor shall submit a monthly report in a format and manner established by OIG providing data on its enrollee restrictions and its determinations regarding OIG referrals for enrollee restrictions.
F. Recipient Verification Procedure	Initially, annually, no later than July 31, and as revised	Yes	Contractor shall submit Contractor's plan for verifying with Enrollees whether services billed by Providers were received, as required by 42 CFR 455.20, for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in information conveyed.
G. Recipient Verification Results	Annually no later than July 31 and within ten (10) Business Days after the Department's request	No	Contractor shall submit a summary of the results of the Recipient Verification Procedure.

Name of report/submission	Frequency	HFS Prior Approval	Report description and requirements
H. Fraud and Abuse Compliance Plan	Initially and annually, no later than July 31	Yes	Per 42 CFR 438.608, Contractor shall submit for prior approval its compliance plan designed to guard against Fraud and Abuse
4. Marketing			
A. Marketing Gifts and Incentives	Initially, annually no later than January 1, and as revised	Yes	Contractor shall submit all plans to distribute gifts and incentives, as well as dollar value and description of gifts and incentives, for Prior Approval.
B. Marketing Materials	Initially, annually no later than January 1, and as revised	Yes	Contractor shall submit all Marketing Materials for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed.
C. Marketing, Outreach and Education Plan	Initially and, annually no later than Nov 15	Yes	As described in Section 1.2.29 of the Contract, Contractor shall submit descriptions of proposed Marketing concepts, strategies, and procedures for Prior Approval.
D. Community Outreach Events	Monthly, by the last day of the reporting month	No	Contractor shall submit to the Department a list of all previously approved community outreach events that occurred during the submission month. The report must include at a minimum the Event name, date, time, address/location, county, audience type, estimated number of attendees and date of Department approval.

5. Medicaid Provider Network			
Name of report/submission	**Frequency**	**HFS Prior Approval**	**Report description and requirements**
A. Enrollment and Education Provider Network File (CEB Provider File)	No less often than weekly, or as requested by the Department	Yes	Contractor shall submit to the Department or its designee, in a format and medium designated by the Department, an electronic file of Contractor's Medicaid Provider Network. The file shall include all data identified by the Department or its designee for education and enrollment purposes.
B. Provider network file (complete)	Monthly, and as requested by the Department	No	Contractor shall submit to the Department or its designee, in a format and medium designated by the Department, an electronic file of Contractor's full provider network.
C. Provider Terminations	As each occurs	No	Contractor shall submit Provider termination reports, in a format and medium designated by the Department.
D. Provider Network Updates	Quarterly, no later than the end of the month following the report quarter	No	Contractor shall submit a network adequacy analysis report pursuant to Section 1.2.17 of the Contract in order to address network coverage across the Contractors service area, identify any gaps, and plans and timeframes to resolve the gaps.
E. Provider Grievance-Resolution System and Procedures	Initially and annually, no later than July 31	Yes	Contractor shall submit details of its Provider Grievance-resolution system and related procedures.
6. Quality Assurance			
Name of report/submission	**Frequency**	**HFS Prior Approval**	**Report description and requirements**
A. Grievance and Appeals Procedures	Initially and annually, no later than July 31	Yes	Contractor shall submit Grievance and Appeals Procedures for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed.

B. Quality Assurance, Utilization Review and Peer Review (QA/UR/PR) Annual Report / Program Evaluation	Annually, no later than ninety (90) days after close of reporting period provided by the Department	No	Contractor shall submit a QA/UR/PR Annual Report/Program Evaluation reviewing the effectiveness of Contractor's QAP. The summary shall address all guidelines and requirements, in a comprehensive manner, provided by the Department for the annual reporting period.
C. Care Management and Disease Management Program Descriptions	Initially, annually, no later than July 31, and as revised	Yes	Contractor shall submit the descriptions of its Care Management and Disease Management programs for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed. Contractor shall identify all areas in its CM/DM program that differ among care coordination programs.
D. Care Gap Plan, Policy and Procedures	Annually, no later than July 31	No	Contractor shall submit its plan for ensuring provision of services missed by Enrollees, including, but not limited to, annual preventive exams, immunizations, women's healthcare, PAP and missed services for Chronic Health Conditions and Behavioral Health follow-up. Contractor may submit one plan that includes all care coordination programs in which it participates; however, Contractor must clearly identify program-specific activities.

E. Quality Performance Reporting	Quarterly, no later than the last day of the month following the report quarter	No	Contractor shall submit a quality measures report that is based on the Performance Measures required by this Contract, and that may include HEDIS® measures, modified HEDIS® measures, and State defined measures. This report shall include, as requested by the Department, the numerator, denominator and rate for each measure and will display information in a manner that includes trending data, based on previous quality indicators.
F. Processes and Procedures to Receive Reports of Critical Incidents	Initially, annually no later than July 31st.	Yes	Contractor shall submit Critical Incident Processes and Procedures
G. Critical Incidents – Detail Report	Monthly, no later than 15 calendar days after the report month	No	Contractor shall submit a detailed report on Critical Incidents providing Enrollee name, Enrollee Medicaid number, incident summary, date received, source, incident date, date referred, referral entity, date resolved, and resolution summary, grouped in the following categories: Abuse; Neglect; Exploitation; Unexplained Death and Other. Contractor shall report Critical Incidents for each of the following: Nursing Facility Services; HCBS Waiver for Persons who are Elderly; HCBS Waiver for Assisted Living, Supportive Living Program; HCBS Waiver for Persons with Physical Disabilities; HCBS Waiver for Persons with HIV/AIDS; HCBS Waiver for Persons with Brain Injury; ACA Expansion Adults; Non-Disabled Children; Non-Disabled Adults; Special Needs Children; and IMD Residents.

H. Critical Incidents – Summary Report	Quarterly, no later than 15 calendar days after the report quarter	No	Contractor shall submit a summary report on Critical Incidents that includes the total Critical Incidents and the total Critical Incidents referred. Contractor shall submit a summary count of Critical Incidents in the following categories: Abuse, Neglect, Exploitation, Unexplained Death and Other. Contractor shall report Critical Incidents separately for each of the following: Nursing Facility Services; HCBS Waiver for Persons who are Elderly; HCBS Waiver for Assisted Living, Supportive Living Program; HCBS Waiver for Persons with Physical Disabilities; HCBS Waiver for Persons with HIV/AIDS; HCBS Waiver for Persons with Brain Injury; and IMD Residents.
I. Transition of Care Plan	Initially, annually not later than January 1, as requested by the Department, and as revised	Yes	Contractor shall submit its Transition of Care Plan to the Department for review and Prior Approval. The Transition of Care Plan shall include policies and procedures and a staffing model designed to achieve a seamless, efficient transition with minimal impact to an Enrollee's care. Contractor may submit one plan that includes all care coordination programs in which it participates; however, Contractor shall identify all areas that differ among care coordination programs.

J. Cultural Competence Plan	At least two (2) weeks prior to the Department's Readiness Review, annually no later than January 1, and as requested by the Department	No	Contractor shall submit its Cultural Competence Plan that addresses the challenges of meeting the healthcare needs of Enrollees. Contractor's Cultural Competence Plan shall contain, at a minimum, the provisions listed in Section 1.2.34 of the Contract. Contractor may submit one plan that includes all care coordination programs in which it participates; however, Contractor shall identify all areas that differ among care coordination programs.
K. QBR Executive Summary	Quarterly, as directed by the Department.	No	Contractor shall submit an Executive Summary that summarizes the data requested by the Department as instructed in each Quarterly Business Review agenda and reporting template.
L. Provider-preventable Conditions Report	Quarterly, no later than 15 calendar days after the report quarter	No	Contractor shall report provider-preventable conditions that are identified in the State Plan to the Department.
M. HIV Quality Metrics	Annually	No	Contractor shall track, and report quality metrics related to HIV, including the CQMC HIV Consensus Core Set.
7. Subcontracts and Provider Agreements			
Name of report/submission	**Frequency**	**HFS Prior Approval**	**Report description and requirements**
A. Model Subcontracts	Initially, annually no later than July 31, and as revised	N/A	Contractor shall submit copies of each model subcontract relating to an arrangement for the provision of Covered Services *Contractor shall submit copies of executed subcontractor agreements to the Department upon request.

B. Pharmacy Benefit Manager Contracts	Initially, annually no later than July 31, and as revised	N/A	Contractor shall submit Pharmacy Benefit Manager Contracts which shall be written in accordance with 215 ILCS 5/513b1 and 305 ILCS 5/5-30(h).
C. Model Provider Agreements	Initially, annually no later than July 31, and as revised	N/A	Contractor shall submit copies of each model provider agreement relating to an arrangement for the provision of Covered Services, *Contractor shall submit copies of executed Provider agreements to the Department upon request.
D. Value-Based Payment Arrangements	Annually, no later than May 1	N/A	Contractor shall report on its progress towards enrolling its providers in arrangements that incentivize value-based care. Contractor shall submit description of each model, as well number of providers, number of members, and total spend, with a breakdown of upside-only versus upside and downside risk arrangements for each. Breakdown outlined above shall be reported by region.
8. Business Enterprise Program Act for Minorities, Females and Persons with Disabilities			
A. BEP Quarterly Report	Quarterly, no later than the last day of the month following the report quarter	N/A	Contractor shall submit the information as directed in the Diversity Contract Monitoring System. State of Illinois Commission on Equity and Inclusion (diversitysoftware.com)
B. BEP Annual Report	Annually, no later than March 1	N/A	Contractor shall report on all requirements of 305 ILCS 5/5-30.13
9. Financial Reports			
A. Annual Financial Statements Report	Annually, no later than June 1	N/A	Annual financial statements audits conducted in accordance with auditing standards generally accepted in the United States of America (“GAAS”).

B. Annual Financial Report - GAAP	Annually, no later than July 31	N/A	In accordance with 42 CFR 438.3(m) Contractor must submit to the Department on an annual basis an audited financial report specific to this Contract.
10. Behavioral Health			
Name of report/submission	**Frequency**	**HFS Prior Approval**	**Report description and requirements**
A. Mobile Crisis Response	Monthly, by the 15th of the month following the reporting	No	The Contractor will report all escalated access to MCR instances and their remediation to HFS on a monthly basis.
B. Behavioral Health Crises and their remediation	Monthly, by the 15th of the month following the reporting	No	The Contractor will report all escalated access to care instances for Behavioral Health Crises and their remediation to HFS on a monthly basis.
C. BH Emergency Services & Discharge	Monthly, by the 15th of the month following the reporting	No	The Contractor will report all instances in which an Enrollee requiring psychiatric inpatient hospitalization remains in an Emergency Department for a period of 24 hours or greater due to the inability to locate a hospital willing or able to admit the Enrollee; and remediation of each instance.
D. Enrollee risk of inpatient continuation after medically cleared for discharge	Monthly, by the 15th of the month following the reporting	No	The Contractor will report all instances of an Enrollee identified as at significant risk of remaining at the inpatient facility after the Enrollee has been medically cleared for discharge and remediation of each instance.

D-SNP Attachment 3
Department of Healthcare and Family Services
HCBS Service Package II Covered Services
BidBuy #: 25-478HFS-DIREC-P-xxxxx |**Agency Reference Number:** 2026-24-001

Service	DoA	DHS-DRS			HFS	Definition	Standards	HFS Fee-For-Service Service Limits
	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury	Supportive Living Program			
Adult Day Service	x	x	x	x		Adult day service is the direct care and supervision of adults aged sixty (60) or older in a community-based setting for the purpose of providing personal attention; and promoting social, physical, and emotional well-being in a structured setting.	**DOA:** 89 Il.Adm.Code 240.1505-1590 Contract with DoA, Contract requirements, **DRS:** 89 Il.Adm.Code 686.100	**DOA, 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 HCBS Waiver.
Adult Day Service Transportation	x	x	x	x			**DOA:** 89 Il.Adm.Code 240.1505-1590 **DRS:** 89 Il.Adm.Code 686.100	No more than two (2) units of transportation shall be provided to a customer in a twenty-four (24)–hour period for transporting the customer to the ADS and back home. The ADS may not bill for daily outings, activities, trips to a Physician, shopping, etc.
Environmental Accessibility Adaptations- -Home		x	x	x		Those physical adaptations to the home, required by the Enrollee Care Plan, 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. Excluded are those adaptations or improvements to the home that are of general utility and are not of direct remedial benefit to the Enrollee.	**DRS:** 89 Il.Adm.Code 686.608	**DRS:** The cost of environmental modification, when amortized over a twelve (12)–month period and added to all other monthly service costs, may not exceed the service cost maximum.

Service	DoA	DHS-DRS			HFS	Definition	Standards	HFS Fee-For-Service Service Limits
	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury	Supportive Living Program			
Supported Employment				x		Supported employment services consist of intensive, ongoing supports that enable an Enrollee for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of the Enrollee's disabilities, needs supports, to perform in a regular work setting. It may include assisting the Enrollee to locate a job or develop a job on behalf of the Enrollee, and is conducted in a variety of settings; including work sites where persons without disabilities are employed.	**DHS:** 89 Il.Adm.Code 530 89 Il.Admin.Code 686.1400	**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 Enrollees receiving HCBS 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. The amount, duration, and scope of services are based on the determination of need (DON) assessment conducted by the case manager and the service cost maximum determined by the DON score.
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 42C.F.R. 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 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 DON assessment conducted by the case manager and the service cost maximum determined by the DON.
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. Nursing through the HCBS Waiver focuses on long-term habilitative needs rather than short-term acute restorative needs. HCBS Waiver intermittent nursing services are in addition to any Medicaid State Plan nursing services for which the Enrollee may qualify.	**DRS:** Home Health Agency: 210 ILCS 55 Licensed Practical Nurse: 225 ILCS 65 Registered nurse: 225 ILCS 65	The amount, duration, and scope of services are based on the DON assessment conducted by the case manager and the service cost maximum determined by the DON score. All HCBS 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 Enrollee's service plan.

Service	DoA	DHS-DRS			HFS			
	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury	Supportive Living Program	Definition	Standards	HFS Fee-For-Service Service Limits
Nursing,Skilled (RN and LPN)		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: 210 ILCS 55 Licensed Practical nurse: 225 ILCS 65 Registered nurse: 225 ILCS 65	**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 HCBS Waiver.
Occupational Therapy		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 Enrollee may qualify. Occupational Therapy through the HCBS Waiver focuses on long-term habilitative needs rather than short-term acute restorative needs.	**DRS:** Occupational Therapist: 225 ILCS 75 Home Health Agency: 210 ILCS 55	**DRS:** All HCBS 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 Enrollee's service plan. The amount, duration, and scope of services is based on the service plan and is included in the service cost maximum.
Physical Therapy		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 Enrollee may qualify. Physical Therapy through the HCBS Waiver focuses on long-term habilitative needs rather than short-term acute restorative needs.	**DRS:** Physical Therapist 225 ILCS 90 Home Health Agency: 210 ILCS 55	**DRS:** All HCBS 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 Enrollee's service plan. The amount, duration, and scope of services is based on the service plan and is included in the service cost maximum.

Service	DoA	DHS-DRS			HFS			
	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury	Supportive Living Program	Definition	Standards	HFS Fee-For-Service Service Limits
Speech Therapy		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 Enrollee may qualify. Speech Therapy through the HCBS Waiver focuses on long-term habilitation needs rather than short-term acute restorative needs.	**DRS:** Speech Therapist 225 ILCS 110 Home Health Agency: 210 ILCS 55	**DRS:** All HCBS 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 Enrollee's service plan. The amount, duration, and scope of services is based on the service plan and is included in the service cost maximum.
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 workforce or participate in a transitional sheltered workshop within one (1) year (excluding supported employment programs).	89 Il.Adm.Code 530 89 IL Admin Code 686.1300	The amount, duration, and scope of services are based on the DON assessment conducted by the case manager and the service cost maximum determined by the DON score. All prevocational services will be reflected in the Enrollee Care Plan as directed to habilitative, rather than explicit employment objectives.
Habilitation-Day				x		**BI:** Day habilitation assists with the acquisition, retention, or improvement in self-help, socialization, and adaptive skills, which takes place in a nonresidential setting, separate from the home or facility in 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 Enrollee Care Plan. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.	**BI:** 59 Il.Adm.Code 119 **IL Admin Code 686.1200**	**BI:** The amount, duration, and scope of services are based on the DON assessment conducted by the case manager and the service cost maximum determined by the DON score. 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 Enrollee Care Plan.

Service	DoA	DHS-DRS			HFS			
	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury	Supportive Living Program	Definition	Standards	HFS Fee-For-Service Service Limits
Homemaker	x	x	x	x		Homemaker service is defined as general nonmedical 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 Enrollees in their own homes in accordance with the authorized Enrollee Care Plan. (i.e., in-home care)	**DOA:** 89 Il.Adm.Code 240 **DRS:** 89 Il. Adm. Code 686.200	**DOA, DRS:** The amount, duration, and scope of services are based on the DON 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. This service is designed primarily for the client who cannot prepare his/her own meals but is able to feed him/herself.	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. This service will be provided as described in the service plan and will not duplicate any other services.
Individual Provider (contingent upon compliance with collective bargaining agreement and accompanying side letter between SEIU and the State.)		x	x	x		Individual Providers 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 Enrollee Care Plan, 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 Individual Provider is the employee of the consumer. The State acts as fiscal agent for the Enrollee.	89 Il. Adm. Code 686.10	The amount, duration, and scope of services is based on the DON assessment conducted by the case manager and the service cost maximum as determined by the DON score. These services may include assistance with preparation of meals but does not include the cost of the meals themselves. 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			HFS			
	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury	Supportive Living Program	Definition	Standards	HFS Fee-For-Service Service Limits
Personal Emergency Response System (PERS)	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 individual's phone and programmed to signal a response center once a "help" button is activated. Trained professionals staff the response center. Customers in the Elderly waiver may choose between a basic EHRS pendant, an EHRS pendant with fall detection, and/or a GPS-based unit with or without a fall detection. Services cover both initial one-time installation and monthly rental costs.	**DOA:** Standards for Emergency Home Response 89 Il.Adm.Code 240 DOA EHRS rules: ilga.gov/commission/jcar/admincode/089/089002400O15410R.html **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. The amount, duration and scope of services is based on the comprehensive care assessment and only the monthly service cost is included in the service cost maximum/monthly cost limit. The installation fee should not be included in the customer's SCM. Participant must meet screening criteria prior to receiving service.
Respite		x	x	x		**DRS:** Respite services provide relief for unpaid family or primary care givers, who are currently meeting all service needs of the Enrollee. Services are limited to Individual Provider, homemaker, nurse, Adult Day Services, and provided to an Enrollee to support the Enrollee's activities of daily living during the periods of time it is necessary for the family or primary care giver to be absent.	Adult Day Service 89 Il. Adm.Code 686.100 Home health aide 210 ILCS 45/3-206 RN/LPN 225 ILCS 65 Home health agency: 210 ILCS 55 Homemaker 89 Il.Adm.Code 686.200 PA 89 Il.Adm.Code 686.10	**DRS:** The amount, duration, and scope of services is based on the DON assessment conducted by the case manager and the service cost maximum determined by the DON score.

Service	DoA	DHS-DRS			HFS			
	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury	Supportive Living Program	Definition	Standards	HFS Fee-For-Service Service Limits
Specialized Medical Equipment and Supplies		x	x	x		Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the Enrollee Care Plan, 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:** 68 Il. Adm. Code 1253 Pharmacies 225.ILCS.85 Medical Supplies 225.ILCS.51	Items reimbursed with HCBS 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.
Behavioral Services (MA and PhD)				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 Enrollees in managing their behavior and cognitive functioning and to enhance their capacity for independent living.	Speech Therapist 225 ILCS 110/ Social Worker 225 ILCS 20/ Clinical Psychologist 225 ILCS 15/ Licensed Counselor 225 ILCS 107/ 89 IL Admin Code 686.1100	The amount, duration, and scope of services are based on the DON assessment conducted by the case manager and the service cost maximum determined by the DON score. The services are based on a clinical recommendation and are not covered under the State Plan.

Service	DoA	DHS-DRS			HFS			
	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury	Supportive Living Program	Definition	Standards	HFS Fee-For-Service Service Limits
Assisted Living					x	The Supportive Living Program serves as an alternative to Nursing Facility (NF) placement, providing an option for seniors sixty-five (65) years of age or older and persons with physical disabilities between twenty-two (22) and sixty-four (64) years of age who require assistance with activities of daily living, but not the full medical model available through a Nursing Facility. Enrollees reside in their own private apartments with kitchen or kitchenette, private bath, individual heating and cooling system, and lockable entrance. Supportive Living -Program providers (SLP) are required to meet the scheduled and unscheduled needs of Residents twenty-four (24) hours a day.	Supportive Living Facilities PART 146 SPECIALIZED HEALTH CARE DELIVERY SYSTEMS : Sections Listing (ilga.gov)	SLPs are reimbursed through a global rate, which includes the following Covered Services: • nursing services • Personal Care • medication administration, oversight, and assistance in self-administration • laundry • housekeeping • maintenance • social and recreational programming • ancillary services • twenty-four (24)–hour response/security staff • health promotion and exercise • Emergency call system • daily checks • Quality Assurance Plan • management of resident funds, if applicable
Automated Medication Dispenser	x					Automated Medication Dispensers are portal, mechanical devices programmed to dispense or alert a participant to take non-liquid oral medications. It provides tracking and caregiver notification of missed medication doses. For adults aged sixty (60) or older in a community-based setting for the purpose of improving medication adherence.	DoA: 89 Il. Adm. Code 240.237 ilga.gov/commission/jcar/admincode/089/08900240 0B02370R.html	The amount, duration, and scope of services is based on the service plan and only the monthly service cost is included in the service cost maximum/monthly cost limit. The installation cost should not be included in the customer's SCM. Participant must meet screening criteria prior to receiving service.

. **D-SNP Attachment 4**
Department of Healthcare and Family Services
MLTSS Covered Services
BidBuy #: 25-478HFS-DIREC-P-xxxx |Agency Reference Number: 2026-24-001

The Department plans to incorporate the MLTSS population into the D-SNP Contract in 2027.

Category of service	Definition	MLTSS coverage
001	Physician Services	EXCLUDED
002	Dental Services	EXCLUDED
003	Optometric Services	EXCLUDED
004	Podiatric Services	EXCLUDED
005	Chiropractic Services	EXCLUDED
006	Physicians Psychiatric Services	EXCLUDED
007	Development Therapy, Orientation and Mobility Services (Waivers)	EXCLUDED
008	DSCC Counseling/Fragile Children	EXCLUDED
009	DCFS Rehab Option Services	EXCLUDED
010	Nursing service	EXCLUDED
011	Physical Therapy Services	EXCLUDED
012	Occupational Therapy Services	EXCLUDED
013	Speech Therapy/Pathology Services	EXCLUDED
014	Audiology Services	EXCLUDED
015	Sitter Services	EXCLUDED
016	Home Health Aides	EXCLUDED
017	Anesthesia Services	EXCLUDED
018	Midwife Services	EXCLUDED
019	Genetic Counseling	EXCLUDED
020	Inpatient Hospital Services (General)	EXCLUDED
021	Inpatient Hospital Services (Psychiatric)	EXCLUDED
022	Inpatient Hospital Services (Physical Rehabilitation)	EXCLUDED
023	Inpatient Hospital Services (ESRD)	EXCLUDED
024	Outpatient Services (General)	EXCLUDED
025	Outpatient Services (ESRD)	EXCLUDED
026	General Clinic Services	EXCLUDED
027	Psychiatric Clinic Services (Type 'A')	EXCLUDED
028	Psychiatric Clinic Services (Type 'B')	EXCLUDED
029	Clinic Services (Physical Rehabilitation)	EXCLUDED
030	Healthy Kids Services	EXCLUDED
031	Early Intervention Services	EXCLUDED
032	Environmental modifications (waiver)	EXCLUDED
033	Mental Health Clinic Option Services	EXCLUDED
034	Mental Health Rehab Option Services	COVERED SERVICE
035	Alcohol and Substance Abuse Rehab. Services	COVERED SERVICE
036	Juvenile Rehabilitation	EXCLUDED

037	Skilled Care - Hospital Residing	EXCLUDED
038	Exceptional Care	COVERED SERVICE
039	DD/MI Non-Acute Care - Hospital Residing	EXCLUDED
040	Pharmacy Services (Drug and OTC)	EXCLUDED
041	Medical equipment/prosthetic devices	EXCLUDED
042	Family planning service	EXCLUDED
043	Clinical Laboratory Services	EXCLUDED
044	Portable X-Ray Services	EXCLUDED
045	Optical Supplies	EXCLUDED
046	Psychiatric Drugs	EXCLUDED
047	Targeted case management service (mental health)	COVERED SERVICE
048	Medical Supplies	EXCLUDED
049	DCFS Targeted Case Management Services	EXCLUDED
050	Emergency Ambulance Transportation	EXCLUDED
051	Non-Emergency Ambulance Transportation	COVERED SERVICE
052	Medicare Transportation	COVERED SERVICE
053	Taxicab Services	COVERED SERVICE
054	Service Car	COVERED SERVICE
055	Auto transportation (private)	COVERED SERVICE
056	Other Transportation	COVERED SERVICE
057	Nurse Practitioners Services	EXCLUDED
058	Social work service	COVERED SERVICE
059	Psychologist service	COVERED SERVICE
060	Home Care	EXCLUDED
061	General Inpatient	EXCLUDED
062	Continuous Care Nursing	EXCLUDED
063	Respite Care	EXCLUDED
064	Other Behavioral Health Services	COVERED SERVICE
065	LTC Full Medicare Coverage	EXCLUDED
066	Home Health Services	EXCLUDED
067	All Kids application agent (valid on provider file only)	EXCLUDED
068	Targeted case management service (early intervention)	EXCLUDED
069	Subacute Care Program	EXCLUDED
070	LTC - Skilled	COVERED SERVICE
071	LTC - Intermediate	COVERED SERVICE
072	LTC--NF skilled (partial Medicare coverage)	EXCLUDED
073	LTC--ICF/MR	EXCLUDED
074	LTC--ICF/MR skilled pediatric	EXCLUDED
075	LTC - MI Recipient age 22-64	COVERED SERVICE
076	LTC - Specialized Living Center - Intermediate MR	EXCLUDED
077	SOPF--MI recipient over 64 years of age	COVERED SERVICE
078	SOPF--MI recipient under 22 years of age	COVERED SERVICE
079	SOPF--MI recipient non-matchable	COVERED SERVICE
080	Rehabilitation option service (special LEA service)	EXCLUDED
081	Capitation Services	EXCLUDED
082	LTC--Developmental training (level I)	EXCLUDED

083	LTC--Developmental training (level II)	EXCLUDED
084	LTC--Developmental training (level III)	EXCLUDED
085	LTC - Recipient 22-64 in IMD not MI or MR	COVERED SERVICE
086	LTC -SLP Dementia Care	COVERED SERVICE
087	LTC - Supportive Living Facility (Waivers)	COVERED SERVICE
088	Licensed Clinical Professional Counselor (LCPC)	COVERED SERVICE
089	LTC - MR Recipient - Inappropriately Placed	EXCLUDED
090	Case Management	EXCLUDED
091	Homemaker	COVERED SERVICE
092	Agency Providers RN, LPN, CNA and Therapies	COVERED SERVICE
093	Individual Providers PA, RN, LPN, CNA and Therapies	COVERED SERVICE
094	Adult Day Health	COVERED SERVICE
095	Habilitation Services	COVERED SERVICE
096	Respite Care	COVERED SERVICE
097	Other HCFA Approved Services	COVERED SERVICE
098	Electronic Home Response/EHR Installation (MARS), MPE Certification (Provider), Automated Medication Dispenser	COVERED SERVICE
099	Transplants	EXCLUDED
100	Genetic counseling	EXCLUDED
102	Fluoride varnish	EXCLUDED

D-SNP Attachment 5
Department of Healthcare and Family Services
Qualifications and Training Requirements of Care Coordinators for 1915c HCBS Waiver Services
BidBuy #: 25-478HFS-DIREC-P-xxxx Agency Reference Number: 2026-24-001

(This Attachment corresponds to Section 1.2.14 B (b) Care Coordination of the Contract)

1. Qualifications of Certain Care Coordinators

   A. Persons who are Elderly Waiver

      a. Care Coordinators must meet one (1) of the four (4) following requirements:

         i. Registered Nurse (RN) licensed in Illinois

         ii. Bachelor's degree in nursing, social sciences, social work, or related field

         iii. Licensed Practical Nurse (LPN) with one (1) year experience in conducting comprehensive assessments and provision of formal service for the elderly and/or authorizing service provisions,

         iv. One (1) year of satisfactory program experience, which is defined as assessment, provision, and/or authorization of formal services for the elderly, may replace one year of college education, at least four (4) years of experience replacing baccalaureate degree

   B. Persons with Disabilities Waiver

      a. Care Coordinators must meet one (1) of the nine (9) following requirements:

         i. Registered Nurse (RN)

         ii. Licensed Clinical Social Worker (LCSW)

         iii. Licensed Marriage and Family Therapist (LMFT)

         iv. Licensed Clinical Professional Counselor (LCPC)

         v. Licensed Professional Counselor (LPC)

         vi. Doctor of Philosophy (PhD)

         vii. Doctorate in Psychology (PsyD)

         viii. Bachelor's or master's Degree prepared in human services related field

         ix. Licensed Practical Nurse (LPN)

   C. Persons with Brain Injury Waiver

      a. Care Coordinators must meet one (1) of the seven (7) following requirements:

         i. Registered Nurse (RN) licensed in Illinois

ii. Certified or Licensed social worker

iii. Unlicensed social worker: minimum of bachelor's degree in social work, social sciences, or counseling

iv. Vocational specialist: certified Rehabilitation counselor or at least three (3) years' experience working with people with disabilities

v. Licensed Clinical Professional Counselor (LCPC)

vi. Licensed Professional Counselor (LPC)

vii. Certified Case Manager (CCM)

D. Persons with HIV/AIDS Waiver

a. Care Coordinators must meet one (1) of the three (3) following requirements:

i. A Registered Nurse (RN) licensed in Illinois and a bachelor's degree in nursing, social work, social sciences, or counseling or one (1) years of case management experience.

ii. A Social worker with a bachelor's degree in either social work, social sciences, or counseling (A Bachelor of Social Work or a Master of Social Work from a school accredited by any organization nationally recognized for the accreditation of schools of social work is preferred).

iii. Individual with a bachelor's degree in a human services field (including, but not limited to sociology, special education, rehabilitation counseling) with a minimum of one (1) years of case management experience.

2. In addition, it is mandatory that the Care Coordinator for Enrollees within the Persons with HIV/AIDS Waiver have experience in working with racial and ethnic minorities, as well as one or more of the following:

A. Domestic Abuse

B. The lesbian, gay, bisexual, transgender, queer (LBGTQ+) community

C. Persons living with HIV/AIDS, and

D. Persons with substance use disorders

D-SNP Attachment 6
Department of Healthcare and Family Services
Enrollee Rights
BidBuy #: 25-478HFS-DIREC-P-xxxx **Agency Reference Number:** 2026-24-001

(This Attachment corresponds with Section 1.2.17.J.g Provider Network and 1.2.29.J Marketing, Outreach and Enrollee Communications Standards of the Contract)

The Contractor must have written policies regarding the Enrollee rights specified in this Attachment, as well as written policies specifying how information about these rights will be disseminated to Enrollees. Enrollees must be notified of these rights and protections at least annually, and in a manner that takes into consideration cultural considerations, Functional Status, and language needs. Enrollee rights include, but are not limited to, those rights and protections provided by 42 C.F.R. § 438.100,42 C.F.R. §422 Subpart C, and the State. Specifically, Enrollees must be guaranteed:

A. The right to be treated with dignity and respect.

B. The right to be afforded Privacy and confidentiality in all aspects of care and for all health care information, unless otherwise required by law.

C. The right to be provided a copy of their medical records, upon request, and to request corrections or amendments to these records, as specified in 45 C.F.R. part 164.

D. The right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's condition, Functional Status, and language needs.

E. The right not to be discriminated against based on race, ethnicity, national origin, religion, sex, age, sexual orientation, medical or claims history, mental or physical disability, genetic information, or source of payment.

F. The right to have all plan options, rules, and benefits fully explained, including through use of a qualified interpreter if needed.

G. Access to an adequate network of primary and specialty Providers who are capable of meeting the Enrollee's needs with respect to physical access, and communication and scheduling needs, and are subject to ongoing assessment of clinical quality including required reporting.

H. The right to receive a second opinion on a medical procedure and have the Contractor pay for the second opinion consultation visit.

I. The right to choose a plan and Provider at any time, including a plan outside of the Demonstration, and have that choice be effective the first calendar day of the following month.

J. The right to have a voice in the governance and operation of the integrated system, Provider or health plan, as detailed in this three-way contract.

K. The right to participate in all aspects of care and to exercise all rights of Appeal. Enrollees have a responsibility to be fully involved in maintaining their health and making decisions about their health care, including the right to refuse treatment if desired, and must be appropriately informed and supported to this end. Specifically, Enrollees must:

a. Receive an in-person Comprehensive Assessment upon enrollment in a plan and to participate in the development and implementation of an IPoC. The assessment must include considerations of social, functional, medical, behavioral, Wellness and prevention domains, an evaluation of the Enrollee's strengths and weaknesses, and a plan for managing and coordination Enrollee's care. Enrollees, or their designated representative, also have the right to request a reassessment by the interdisciplinary team, and be fully involved in any such reassessment.

b. Receive complete and accurate information on their health and Functional Status by the interdisciplinary team.

c. Be provided information on all program services and health care options, including available treatment options and alternatives, presented in a culturally appropriate manner, taking in to consideration Enrollee's condition and ability to understand. An Enrollee who is unable to participate fully in treatment decisions has the right to designate a representative. This includes the right to have translation services available to make information appropriately accessible. Information must be available:

    i. Before enrollment.

    ii. At enrollment.

    iii. At the time a Potential Enrollee's or Enrollee's needs necessitate the disclosure and delivery of such information in order to allow the Potential Enrollee or Enrollee to make an informed choice.

d. Be encouraged to involve caregivers or family members in treatment discussions and decisions.

e. Have Advance Directives explained and to establish them, if the participant so desires, in accordance with 42 C.F.R. §§ 489.100 and 489.102.

f. Receive reasonable advance notice, in writing, of any transfer to another treatment setting and the justification for the transfer.

g. Be afforded the opportunity file an Appeal if services are denied that he or she thinks are medically indicated, and to be able to ultimately take that Appeal to an independent external system of review.

L. The right to receive medical and non-medical care from a team that meets the beneficiary's needs, in a manner that is sensitive to the beneficiary's language and culture, and in an appropriate care setting, including the home and community.

M. The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

N. Each Enrollee is free to exercise their rights and that the exercise of those rights does not adversely affect the way the Contractor and its Providers or the State Agency provide, or arrange for the provision of, medical services to the Enrollee.

O. The right to receive timely information about plan changes. This includes the right to request and obtain the information listed in the Orientation materials at least once per year, and the right to receive notice of any significant change in the information provided in the Orientation materials at least thirty (30) days prior to the intended effective date of the change. See 438.10(g),(h)(i).

P. The right to be protected from liability for payment of any fees that are the obligation of the Contractor

D-SNP Attachment 7
Department of Healthcare and Family Services
Illinois Department of Human Services, Division of Rehabilitation Services Critical Incident Definitions
BidBuy #: 25-478HFS-DIREC-P-xxxx |**Agency Reference Number:** 2026-24-001

(This Attachment corresponds to Section 1.2.20 Critical Incidents and Other HCBS Required Reporting in the Contract)

Death, DHS-DRS Waiver Enrollees	Contractor shall report deaths of an unusual nature to HFS OIG and DHS-DRS. Criteria for reporting deaths of an unusual nature include, but are not limited to, a recent allegation of Abuse, Neglect or exploitation, or that Enrollee was receiving home health services at time of passing. Contractor shall cooperate in any investigation conducted by HFS OIG or DHS-DRS.
Death, Other parties	Events that result in significant event for Enrollee. For example, Enrollee's caregiver dies in the process of giving Enrollee bath, thereby leaving Enrollee stranded in home without care for several days. Passing of immediate family members is not necessary unless the passing creates a resulting turn of events that are harmful to Enrollee.
Physical abuse of Enrollee	Non-accidental use of force that results in bodily injury, pain or impairment. Includes but not limited to being slapped, burned, cut, bruised or improperly physically restrained.
Verbal/Emotional abuse of Enrollee	Includes but is not limited to name calling, intimidation, yelling and swearing. May also include ridicule, coercion, and threats.
Sexual abuse of Enrollee	Unwanted touching, fondling, sexual threats, sexually inappropriate remarks or other sexual activity with an adult with disabilities.
Exploitation of Enrollee	The illegal use of assets or resources of an adult with disabilities. It includes, but is not limited to, misappropriation of assets or resources of the alleged victim by undue influence, by Breach of fiduciary relationship, by fraud, deception, extortion, or in any manner contrary to law.
Neglect of Enrollee	The failure of another individual to provide an adult with disabilities with, or the willful withholding from an adult with disabilities of the necessities of life including but not limited to food, clothing, shelter, or medical care
Sexual Harassment by provider	Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature that tends to create a hostile or offensive work environment.
Sexual Harassment by Enrollee	Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature that tends to create a hostile or offensive work environment.

Sexually problematic behavior	Inappropriate sexual behaviors exhibited by either the Enrollee or individual provider which impacts the work environment adversely.
Significant Medical event of Provider	A recent event to a provider that has the potential to impact upon an Enrollee's care.
Significant Medical Event of Enrollee	This includes a recent event or new diagnosis that has the potential to impact on the Enrollee's health or safety. Also included are unplanned hospitalizations or errors in medication administration by provider.
Enrollee arrested, charged with or convicted of a crime	In an instance where the arrest, charge, or conviction has a risk or potential risk upon the Enrollee's health and safety shall be reported.
Provider arrested, charged with or convicted of a crime	In an instance where the arrest, charge, or conviction has a risk or potential risk upon the Enrollee's health and safety shall be reported.
Fraudulent activities or theft on the part of the Enrollee or the Provider	Executing or attempting to execute a scheme or ploy to defraud the Home Services program, or obtaining information by means of false pretenses, deception, or misrepresentation in order to receive services from our program. Theft of Enrollee property by a provider, as well as theft of provider property by an Enrollee is included.
Self-Neglect	Individual neglects to attend to the individual's basic needs, such as personal hygiene, appropriate clothing, feeding, or tending appropriately to medical conditions.
Enrollee is missing	Enrollee is missing or whereabouts are unknown for provision of services.
Problematic possession or use of a weapon by an Enrollee.	Enrollees should never display or brandish a weapon in staff's presence. Any perceived threat through use of weapons shall be reported. In some cases, persons with SMI are not allowed to possess firearms, and this shall be documented if observed.
Enrollee displays physically aggressive behavior	Enrollee uses physical violence that results in harm or injury to the provider.
Property damage by Enrollee of $50 or more	Enrollee causes property damage to in the amount of $50 or more to provider property.
Suicide attempt by Enrollee	Enrollee attempts to take own life.
Suicide ideation/threat by Enrollee	An act of intended violence or injurious behavior towards self, even if the end result does not result in injury.

Suspected alcohol or substance use by Enrollee	Use of alcohol or other substances that appears compulsive and uncontrolled and is detrimental to Enrollee's health, personal relationships, safety of self and others.
Seclusion of an Enrollee	Seclusion is defined as placing a person in a locked or barricaded area that prevents contact with others.
Unauthorized Restraint of an Enrollee	Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely.
Media involvement/media inquiry	Any inquiry or report/article from a media source concerning any aspect of an Enrollee's case shall be reported via an incident report.
Threats made against DRS/HSP Staff	Threats and/or intimidation manifested in electronic, written, verbal, physical acts of violence, or other inappropriate behavior
Falsification of credentials or records	To falsify medical documents or other official papers for the expressed interest of personal gain, either monetary or otherwise.
Report against DHS/DRS employee	Deliberate and unacceptable behavior initiated by an employee of DRS against an Enrollee or provider.
Bribery or attempted bribery of an DHS/DRS	Money or favor given to an employee in exchange to influence the judgment or conduct of a person in a position of authority.

D-SNP Attachment 8
Department of Healthcare and Family Services
Illinois Department on Aging Adult Protective Services Definitions
BidBuy #: 25-478HFS-DIREC-P-xxxx **Agency Reference Number:** 2026-24-001

(This Attachment corresponds to Section 1.2.20 Critical Incidents and Other HCBS Required Reporting in the Contract)

The program provides services to people over the age of sixty (60) and to adults with disabilities age eighteen (18) to fifty-nine (59) who may be victims of abuse as prescribed below:

1. **Abandonment** means the desertion or willful forsaking of an eligible adult by an individual responsible for the care and custody of that eligible adult when a reasonable person would continue to provide care and custody. Nothing in this Act shall be construed to mean that an eligible adult is a victim of abandonment because of health care services provided or not provided by licensed health care professionals.

2. **Confinement** means restraining or isolating, without legal authority, an eligible adult for other than medical reasons, as ordered by a physician.

3. **Emotional Abuse** means verbal assaults, threats of maltreatment, harassment, or intimidation intended to compel the eligible adult to engage in conduct from which he or she wishes and has a right to abstain, or to refrain from conduct in which the eligible adult wishes and has a right to engage.

4. **Financial Exploitation** means the use of an eligible adult's resources by another to the disadvantage of that adult or the profit or advantage of a person other than that adult.

5. **Neglect** means another individual's failure to provide an eligible adult with or willful withholding from an eligible adult the necessities of life including, but not limited to, food, clothing, shelter, or health care.

6. **Passive Neglect** means another individual's failure to provide an eligible adult with the necessities of life including, but not limited to, food, clothing, shelter, or medical care because of failure to understand the eligible adult's needs, lack of awareness of services to help meet needs, or a lack of capacity to care for the eligible adult. This definition does not create any new affirmative duty to provide support to eligible adults; nor shall it be construed to mean that an eligible adult is a victim of neglect because of health care services provided or not provided by licensed health care professionals.

7. **Physical Abuse** means causing the infliction of physical pain or injury to an eligible adult.

8. **Self-Neglect** means a condition that is the result of an eligible adult's inability, due to physical or mental impairments, or both, or a diminished capacity, to perform essential self-care tasks that substantially threaten his or her own health, including: providing essential food, clothing, shelter, and health care; and obtaining goods and services necessary to maintain physical health, mental health, emotional well-being, and general safety.

9. **Sexual Abuse** means touching, fondling, sexual threats, sexually inappropriate remarks, or any other sexual activity with an eligible adult when he or she is unable to understand, unwilling to consent, threatened, or physically forced to engage in sexual behavior.

10. **Willful Deprivation** means deliberate denial of medications, medical care, shelter, food, therapeutic devices, or other physical assistance to a person who, because of age, health, or disability, requires such assistance and thereby exposes that person to the risk of physical, mental, or emotional harm because of such denial; except with respect to medical care or treatment when the dependent person has expressed an intent to forego such medical care or treatment and has the capacity to understand the consequences.

D-SNP Attachment 9
Department of Healthcare and Family Services
Illinois Department of Healthcare and Family Services Incident Reporting for Supportive Living Program (SLP) Settings
BidBuy #: 25-478HFS-DIREC-P-xxxxx **Agency Reference Number:** 2026-24-001

(This Attachment corresponds to Section 1.2.20 Critical Incidents and Other HCBS Required Reporting in the Contract)

Examples of incidents that must be reported to the Department include, but are not limited to the following:

1. Abuse or suspected Abuse of any nature including alleged physical, sexual, emotional or financial abuse by anyone, including another Resident, staff, volunteer, family, friend, etc.;
2. Allegations of theft when a Resident chooses to involve local law enforcement. Allegations of theft by staff must always be reported;
3. Elopement of Residents/missing Residents;
4. Seclusion of restraints;
5. Attempted suicide;
6. Death other than by natural causes;
7. Any crime that occurs on facility property;
8. Fire alarm activation for any reason that results in on-site response by local fire department personnel. This does not include fire department response that is a result of Resident cooking mishaps that only cause minimal smoke limited to a Resident's apartment and that do not result in any injuries or damage to the apartment. Examples of what do not need to be reported include but are not limited to: burnt toast or burnt popcorn'
9. Physical injury suffered by Residents during a fire, power or mechanical failure or force of nature;
10. Loss of electrical power, water, or emergency call system in excess of an hour; and
11. Evacuation of Residents for any reason.

Department of Healthcare and Family Services

DSNP Contract Attachment #10

BidBuy #: 25-478HFS-DIREC-P-xxxxx |Agency Reference Number: 2026-24-001

Subcontractors

Subcontractor Name	Estimated Amount to be Paid	Address	Description of Work