STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

and

[MANAGED CARE ORGANIZATION]

AMENDMENT NO. 2 TO THE CONTRACT FOR FURNISHING HEALTH SERVICES BY A MANAGED CARE ORGANIZATION 2018-24-XXX-KA2

WHEREAS, the Parties to the Contract for Furnishing Health Services by a Managed Care Organization (“Contract”), the **Illinois Department of Healthcare and Family Services**, 201 South Grand Avenue East, Springfield, Illinois 62763-0001 (“Department”), acting by and through its Director, and **[Managed Care Organization]** (“Contractor”), desire to amend the Contract; and

WHEREAS, pursuant to Section 9.1.18, the Contract may be modified or amended by the mutual consent of the Parties; and

WHEREAS, the Contract has been previously amended;

NOW THEREFORE, the Parties agree to amend the Contract further as follows:

1. Article I is amended by deleting and replacing subsections 1.1.45, 1.1.104, 1.1.127, 1.1.139, 1.1.185, and 1.2.56 as follows:

   1.1.45 **Contractor** means the MCO identified as Contractor on page 9 of the Contract.

   1.1.104 **Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM-CANS)** means the Illinois Medicaid version of a multi-purpose tool developed for services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services.

   1.1.127 **Medically Necessary** 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 the Contractor or for the convenience of the Enrollee or Provider.

1.1.139 **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 State Police Medicaid Fraud Control Unit (ISP-MFCU).

1.1.185 **Special Needs Children** means Children under the age of twenty-one (21) who are eligible under the Medicaid Program pursuant to Article III of the Public Aid Code (305 ILCS 5/3-1 et seq.) or Medicaid-eligible and eligible to receive benefits pursuant to Title XVI of the Social Security Act. Special Needs Children also includes certain Medicaid-eligible Children under the age of twenty-one (21) who receive services under the Specialized Care for Children Act (110 ILCS 345/0.01 et seq.) via the Division of Specialized Care for Children (DSCC) or such other entity that the Department may designate for providing such services and Children with special needs as specified in section 1932 (a)(2)(A) of the Social Security Act. In accordance with Public Act 100-0990, Special Needs Children does not include Children participating in the Medically Fragile and Technology Dependent (MFTD) 1915(c) waiver program, and Children authorized to receive EPSDT in-home shift nursing services.

1.2.56 IM-CANS: Illinois Medicaid Comprehensive Assessment of Needs and Strengths

2. Subsection 2.5.1 is deleted in its entirety and replaced with the following:

   2.5.1 No obligation imposed herein on Contractor shall relieve Contractor of any other obligation imposed by court order, law or regulation, including 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); Section 1557 of the Patient Protection and Affordable Care Act; and regulations promulgated by the Illinois Department of Financial and Professional Regulation, and the Illinois Department of Insurance, the Illinois Department of Public Health, or Federal CMS. The Department shall report to the appropriate agency any information it receives that indicates a violation of a law or regulation. The Department will inform Contractor of any such report unless the appropriate agency to which the Department has reported requests that the Department not inform Contractor.

3. Subsection 4.14.4 is deleted in its entirety and replaced with the following:

   4.14.4 Disenrollment from Contractor as provided in sections 4.10.3 and 4.14.5 may only occur upon receipt by Contractor of written approval of such disenrollment by the Department. Disenrollment shall be effective at 11:59 p.m. on the last day of the month in which the Department approves the disenrollment, or of the next month if the Department is unable to give the Enrollee at least ten (10) days' notice before termination of coverage, takes effect. The approved disenrollment date shall be effective no later than 11:59 p.m. on the last day of the month following the month the Department received the request from Contractor. If the Department fails to make a disenrollment determination within this timeframe, the disenrollment is considered approved for such effective date.

4. Subsections 5.3.1 and 5.3.2 are deleted and replaced with the following:

5.3.1 Pharmacy Formulary Effective January 1, 2018 through December 31, 2019.

5.3.2 Pharmacy Formulary Effective January 1, 2020.

5. Subsections 5.3.1.4 and 5.3.1.10.4 are deleted and replaced with the following:

5.3.1.4 Contractor may determine its own utilization controls, including, but not limited to, step therapy and prior authorization, unless otherwise prohibited under this Contract, to ensure appropriate utilization. Contractor shall utilize the Department's step therapy and prior authorization requirements for family planning drugs and devices pursuant to Attachment XXI.

5.3.1.10.4 utilization controls, including step therapy, prior authorization, dosage limits, gender or age restrictions, quantity limits, and other policies;

6. Subsection 5.3.2.9.4 is deleted and replaced with the following:

5.3.2.9.4 utilization controls, including step therapy, prior authorization, dosage limits, gender or age restrictions, quantity limits, and other policies;

7. Section 5.3 is further amended by adding new subsection 5.3.3 and its subsections 5.3.3.1 through 5.3.3.6:

5.3.3 Drug Utilization Review Designed to Reduce Opioid-Related Fraud, Abuse and Misuse

Contractor shall comply with the drug utilization review provisions included in Section 1004 of the *Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act* (Support Act), including the following:

5.3.3.1 **Safety Edits.** Contractor shall have prospective safety edits that identify subsequent fills of opioid prescriptions that exceed Contractor established limitations on duplicate fills, early fills, and drug quantity limitations.

5.3.3.2 **Claims Review Process**. Contractor shall have a retrospective automated claims review process to examine patterns of subsequent fills for opioids and identify subsequent fills that exceed Contractor established limitations.

5.3.3.3 **Maximum Daily Morphine Milligram Equivalents (MME).** Contractor shall have prospective safety edits on maximum MMEs that can be prescribed to an Enrollee for treatment of chronic pain and an automated claims review process that indicates when an Enrollee is prescribed the morphine equivalent for such treatment in excess of Contractor's established maximum MME dose limitation.

5.3.3.4 **Concurrent Utilization Alerts:** Contractor shall have an automated process for claims review that monitors when an Enrollee is concurrently prescribed opioids and benzodiazepines or opioids and antipsychotics.

5.3.3.5 Contractor shall have a program to monitor and manage the appropriate use of antipsychotic medications by Children.

5.3.3.6 Contractor shall have a process that identifies potential Fraud or Abuse of controlled substances by Enrollees, Providers that prescribe drugs to Enrollees, and Providers that dispense drugs to Enrollees.

8. Subsection 5.7.1.2 is deleted in its entirety and replaced with the following:

5.7.1.2 Contractor shall enter into a contract with any willing and qualified Provider in the Contracting Area that renders Nursing Facility or HCBS Waivers services, as set forth in Attachment I, so long as the Provider agrees to Contractor's rate (with the exception of county nursing homes as referenced at 1.1.119.1) and adheres to Contractor's QA requirements. To be considered a qualified Provider, the Provider must be in good standing with the Department's FFS Medical Program. Contractor may establish quality standards in addition to those State and federal requirements and contract only with Providers that meet such standards. Such standards must be approved by the Department, in writing, and Contractors may only terminate a contract of a Provider based on failure to meet such standards if two (2) criteria are met: a) such standards have been in effect for at minimum one (1) year, and b) Providers are informed at the time such standards come into effect.

9. Subsection 5.7.1.5 is amended by adding new subsection 5.7.1.5.4:

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

10. Subsection 5.7.3 is amended by deleting and replacing in its entirety subsection 5.7.3.2, and adding new subsections 5.7.3.3 and 5.7.3.4:

5.7.3.2 Contractor shall make a good-faith effort to give written notice of termination of a Provider as soon as practicable, but in no event later than fifteen (15) days after issuance of a termination notice by Contractor to a Provider, or receipt of a termination notice from a Provider. Each Enrollee who was served by the 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.

5.7.3.3 Contractor shall give at least sixty (60) days 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. 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.

5.7.3.4 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.

11. Subsection 5.7.12 is deleted in its entirety and replaced with the following:

5.7.12 **Care Coordination for Children's Behavioral Health**. Contractor shall ensure that the provision of Care Coordination and services for Children's Behavioral Health is compliant with Attachment XXII. Nothing in this section 5.7.12 and Attachment XXII is intended to limit the Children's Behavioral Health and Care Coordination services that are Covered Services. Contractor must provide Children's Behavioral Health services to all enrolled Children who meet eligibility criteria. To the extent possible, family members and Natural Supports of Children with Behavioral Health conditions should be included in all planning and treatment for the Child.

12. Subsection 5.7.14 is deleted in its entirety and replaced with the following:

5.7.14 **DSCC Care Coordination contracting requirement.** The Department encourages and reserves the right to require Contractor to contract with the University of Illinois, Division of Specialized Care for Children (DSCC), to provide Care Coordination services to designated Special Needs Children populations. The Department shall provide Contractor written notice of this requirement no less than sixty (60) days prior to the effective date. The Department may designate other entities that demonstrate the requisite capability and experience to appropriately provide Care Coordination services for Special Needs Children populations with which Contractor may contract for providing such Care Coordination services.

13. Subsection 5.8.1.1 is amended by adding new subsection 5.8.1.1.8:

5.8.1.1.8 *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.

14. Subsection 5.9.1 is deleted in its entirety and replaced with the following, and further amended by adding new subsection 5.9.1.1:

5.9.1 In accordance with 42 CFR 438.214, Provider enrollment in the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system constitutes Illinois' Medicaid managed care uniform credentialing and re-credentialing process. To participate in Contractor's Provider Network, Contractor must verify that provider is enrolled in IMPACT.

5.9.1.1 Upon receipt of a Provider's completed and accurate Universal Roster Template, Contractor shall load the Provider information into its system within thirty (30) days.

15. Section 5.10 is amended by deleting and replacing in their entirety subsections 5.10.10 and 5.10.11, and adding new subsection 5.10.12:

5.10.10 **Provider communication.** Contractor must maintain a regular means of communicating and providing information on changes in policies and procedures to Providers. Contractor shall provide no less than thirty (30) days' notice to Providers of policy changes prior to implementation by Contractor. Contractor must notify Providers of any changes to prior authorization policies no less than thirty (30) days before the date of implementation. In circumstances where the Department provides Contractor

with less than thirty (30) days' notice from the effective date of a policy change, Contractor must notify Providers within three (3) Business Days of receipt of the Department's notification.

5.10.11 **Provider services.** Contractor shall maintain sufficient and adequately trained Provider service staff to enable Network and non-Network Providers to receive prompt resolution of their problems or inquiries. Contractor shall ensure that Contractor staff, employees, agents, subcontractors, and others acting on its behalf have received all required training and education to effectively service Network Providers.

5.10.12 **Evaluation.** The Department in consultation with Contractor may establish a process for Network Providers to evaluate the performance of Contractor staff.

16. Subsection 5.12.1 is deleted in its entirety and replaced with the following:

    5.12.1 Contractor shall offer Care Management to the following populations: Enrollees stratified as Level 3 (high-risk) and Level 2 (moderate-risk) as described at section 5.13.1.4.1, pregnant Enrollees, Dual-Eligible Adult Enrollees, Enrollees residing in a Nursing Facility, and Enrollees who receive Covered Services under an HCBS Waiver. In addition, any Enrollee may request Care Management.

17. Subsection 5.13.1.4 is deleted in its entirety and replaced with the following:

    5.13.1.4 **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 screening, health-risk assessment, and other relevant tools and data. Ongoing restratification shall occur as described at section 5.16 of this Contract. Enrollees shall be assigned to one (1) of three (3) levels:

18. Subsections 5.13.2, 5.13.2.1, 5.13.2.2, 5.13.2.3, and 5.13.2.4 are deleted in their entirety and replaced with the following; subsection 5.13.2.1 is further amended by adding new subsection 5.13.2.1.1:

    5.13.2 **Health-risk assessment.** Contractor shall use its best efforts to complete a health-risk assessment within thirty (30) days for any Enrollee whose health-risk screening indicates a need for further assessment. For the purpose of this section 5.13.2, the Department will define best efforts on an annual basis. However, Contractor shall complete a health-risk assessment for the following populations:

    5.13.2.1 All Enrollees stratified as Level 3 (high-risk) or Level 2 (moderate-risk). The assessment will be conducted, in-person or over the phone, within ninety (90) days after enrollment.

    5.13.2.1.1 Special Needs Children shall be stratified as Level 3 (high-risk) and receive an in-person health-risk assessment within ninety (90) days after enrollment.

    5.13.2.2 Enrollees receiving HCBS Waiver services or residing in NFs as of their Effective Enrollment Date with Contractor. The health-risk assessment must be in-person and completed within ninety (90) days after enrollment.

5.13.2.3 Enrollees transitioning to NFs. The health-risk assessment 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 Nursing Facility.

5.13.2.4 Enrollees deemed newly eligible for HCBS Waiver services. The health-risk assessment must be in-person and completed within fifteen (15) days after Contractor is notified that the Enrollee is determined eligible for HCBS Waiver services.

19. Subsection 5.15.1 is deleted in its entirety and replaced with the following:

5.15.1 Contractor shall develop a comprehensive, person-centered IPoC for Enrollees stratified as Level 3 (high-risk) or Level 2 (moderate-risk), Enrollees residing in a Nursing Facility, and Enrollees receiving HCBS Waiver services, within ninety (90) days after enrollment. 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. 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:

20. Subsections 5.15.1.5 and 5.15.1.5.1 are deleted in their entirety and replaced with the following, and new subsections 5.15.1.5.1.1 through 5.15.1.5.1.4 are added:

5.15.1.5 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:

5.15.1.5.1 *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. The planning process shall be led, when possible, by the Enrollee and include individuals chosen 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 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).

5.15.1.5.1.1 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 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.

5.15.1.5.1.2 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)-(5); (2) the Enrollee's strengths and preferences; (3) the clinical and support needs identified through the Determination of Need; (4) person-centered goals and desired outcomes; (5) paid and unpaid services and supports that will assist Enrollee to achieve identified goals, 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.

5.15.1.5.1.3 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.

5.15.1.5.1.4 Contract 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.

21. Subsection 5.15.1.5 is further amended by adding new subsection 5.15.1.5.4:

5.15.1.5.4 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's existing HCBS Waiver Provider(s) in writing of Contractor' service authorization termination date no later than seven (7) days from such date.

22. Section 5.16 is deleted in its entirety and replaced with the following:

5.16 **ONGOING ASSESSMENT AND STRATIFICATION**

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 created or updated. For Enrollees whose risk level is updated to Level 3 (high-risk) or Level 2 (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 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. At a minimum, Contractor shall conduct a health-risk reassessment annually for each Enrollee who has an IPoC. In addition, Contractor shall conduct a face-to-face 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 five (5) Business Days.

23. Subsection 5.19.1.1 is deleted in its entirety and replaced with the following:

5.19.1.1 Contractor must offer an initial ninety (90)–day transition period for Enrollees new to the Health Plan, in which Enrollees may maintain a current course of treatment with a Provider who is

currently not a part of Contractor's Provider Network. 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. 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.

24. Subsection 5.19.8.3 is deleted in its entirety and replaced with the following:

5.19.8.3 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, the Contractor must pay for the service if it is a Covered Service, provided that the request is consistent with the policies and procedures of the Contractor.

25. Subsection 5.20.1.1.1 is deleted in its entirety and replaced with the following:

5.20.1.1.1 Contractor shall not impose any requirements for prior authorization of Emergency Services, including emergency medical screening, or restrict coverage of Emergency Services on the basis of lists of diagnoses or symptoms.

26. Subsection 5.21.1.3 is deleted in its entirety and replaced with the following:

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

27. Subsection 5.21.2.1 is deleted in its entirety and replaced with the following:

5.21.2.1 to each Enrollee or Prospective Enrollee no later than five (5) Business Days following receipt of the Enrollee's initial enrollment record on the 834 Audit File, and to each Enrollee within thirty (30) days before a significant change to the basic information; and

28. Subsection 5.21.3 is amended by adding new subsection 5.21.3.4 and making grammatical changes to 5.21.3.2 and 5.21.3.3:

5.21.3.2 practice guidelines maintained by Contractor in accordance with 42 CFR §438.236;

5.21.3.3 information about Network Providers of healthcare services, including education, board certification, and recertification, if appropriate; and

5.21.3.4 any Physician incentive plans in place as set forth at 42 CFR §438.3(i).

29. Subsection 5.21.4 is amended by adding new subsection 5.21.4.5:

5.21.4.5 *Font size and taglines*. Contractor's Written Materials must be produced using a font size no smaller than 12 point. Written Materials must include taglines, in the prevalent non-English languages and in a large print font size that is no smaller than 18 point, explaining the availability of written translation or oral interpretation to understand the information provided, the toll-free and TTY/TDY telephone number of Contractor's member customer service unit, and information on how to request auxiliary aids and services, including the provision of the materials in alternative formats.

30. Subsection 5.21.6.1 is deleted in its entirety and replaced with the following:

5.21.6.1 Contractor shall establish a toll-free telephone number, available twenty-four (24) hours a day, seven (7) days a week, for Enrollees to confirm eligibility for benefits and for Providers to seek prior authorization for treatment where required by Contractor, and shall assure twenty-four (24)–hour access, via telephone(s), to medical professionals, either to Contractor directly or to PCPs, for consultation to obtain medical care.

31. Subsection 5.22.4 is deleted in its entirety and replaced with the following:

5.22.4 Contractor shall have a Utilization Management Program that includes a utilization-review plan, a utilization-review committee, and appropriate mechanisms covering prior authorization and review requirements.

32. Subsection 5.23.1.4 is deleted in its entirety and replaced with the following:

5.23.1.4 Contractor shall train all of Contractor's external-facing employees, Network Providers, Affiliates, and Subcontractors to recognize potential concerns related to Abuse, Neglect, and exploitation, and will train them 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 disciplinary action from Contractor, its Network Providers, Affiliates, or Subcontractors.

33. Subsection 5.23.1.10 is deleted in its entirety and replaced with the following:

5.23.1.10 Contractor shall provide the Department, upon request, with its protocols for reporting suspected Abuse, Neglect, and exploitation and other Critical Incidents that are reportable, including those in Attachment XVII, Attachment XVIII, and Attachment XIX.

34. Section 5.25 is deleted in its entirety and replaced with the following:

5.25 **PROHIBITED RELATIONSHIPS**

5.25.1 Contractor shall not employ, subcontract with, or affiliate itself with or otherwise have a relationship with an excluded individual or entity, as defined in section 9.1.33. Contractor and its Subcontractors shall provide written disclosure to the Department of any prohibited affiliation under 42 CFR §438.610.

5.25.2 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:

5.25.2.1 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

5.25.2.2 an individual or entity who is an affiliate of a person described at 5.25.2.1.

5.25.2.3 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.

35. Subsection 5.27.3 is amended by deleting and replacing in their entirety subsections 5.27.3.4, 5.27.3.5, 5.27.3.6; and by adding new subsection 5.27.3.7:

5.27.3.4 submit Encounter Data to the Department in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format as appropriate, and as required by CMS under 42 CFR §438.818;

5.27.3.5 meet the ASC X12 5010 electronic transaction standards, including eligibility (270/271), claim status (276/277), referrals/authorizations (278), claims (837), and remittances (835);

5.27.3.6 use standard ASC X12 claim codes; and

5.27.3.7 submit with Enrollee Encounter Data a certification signed by either Contractor's Chief Executive Officer, Chief Financial Officer, or an individual who reports directly to and has delegated authority to sign for the Chief Executive Officer or Chief Financial Officer that attests based on best information, knowledge and belief, the data is accurate, complete and truthful.

36. Subsection 5.29.1 is deleted in its entirety and replaced with the following:

5.29.1 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. 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.

37. Subsection 5.29.2 is deleted in its entirety and replaced with the following:

5.29.2 Contractor shall pay for all Post-Stabilization Services as a Covered Service 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 did not respond to a request to authorize such services within one (1) hour, Contractor could not be contacted, or, 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, in which case 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. 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.

38. Subsection 5.29.5 is deleted and replaced with the following:

5.29.5 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.

39. Subsection 5.29.6 is deleted in its entirety and replaced with the following that includes new subsections 5.29.6.1, 5.29.6.2, and 5.29.6.2.1:

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

5.29.6.1 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

5.29.6.2 pay all Minimum Data Set (MDS) rates retroactive to the effective date.

5.29.6.2.1 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.

40. Subsections 5.29.7, 5.29.7.1, and 5.29.7.2 are deleted in their entirety and replaced with the following; subsection 5.29.7 is further amended by adding new subsections 5.29.7.3 and 5.29.7.4:

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

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

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

5.29.7.3 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

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

41. Subsection 5.29.8 is deleted in its entirety and replaced with the following:

5.29.8 Contractor shall adhere to the Department's Provider complaint portal process policies and procedures. The Department shall provide, prior to implementation, no less than thirty (30) days' written notice to Contractor of changes to the Provider complaint portal process policies and procedures.

42. Subsection 5.29.9 is deleted in its entirety and replaced with the following:

5.29.9 Contractor shall comply with requirements concerning the reporting and payment of Provider-preventable conditions as set forth in 42 CFR §434.6(a)(12), §438.3(g) and §447.26. Contractor shall require, as a condition of payment, that Providers identify and report Provider-preventable conditions associated with claims for payment or with courses of treatment for which payment would otherwise be made. Contractor shall report identified Provider-preventable conditions to the Department as required in Attachment XIII. Contractor shall reduce payment to Provider for health care-acquired conditions and shall not pay Provider for other Provider-preventable conditions as identified in the State Plan. Contractor shall not reduce payment to Provider for a Provider-preventable condition when that condition existed prior to the initiation of treatment for an Enrollee by that Provider.

43. Section 5.29 is amended by adding new subsection 5.29.13:

5.29.13 Contractor shall pay county nursing homes, as referenced at 1.1.119.1, a rate no less than the Department's Medicaid cost-based rate.

44. Subsection 5.31.2 is deleted in its entirety and replaced with the following:

5.31.2 Contractor shall administer IDoA's Participant Outcomes and Status Measures (POSM) Quality of Life Survey to each IDoA Persons who are Elderly HCBS Waiver Enrollee at each annual reassessment to determine each Enrollee's perception of the quality of life.

45. Subsection 5.32.2 is amended by adding new subsection 5.32.2.4:

5.32.2.4 Contractor shall, no later than January 1, 2020, require that Subcontractors delegated to perform claims processing and payment activities offer Network Providers the option to utilize an electronic billing system.

46. Section 5.35, including all subsections, is deleted in its entirety and replaced with the following:

5.35 **PROGRAM INTEGRITY**

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, Abuse, mismanagement, and misconduct, 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 Social Security Act (SSA).

5.35.1 **Provider agreements.** Contractor shall include in its Network Provider agreements, a provision requiring as a condition of receiving payment, that the Provider comply with section 5.35 of this Contract.

5.35.2 **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 438.608, that includes, at a minimum, the following:

5.35.2.1 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.

5.35.2.2 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.

5.35.2.3 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.

5.35.2.4 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.

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

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

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

5.35.2.8 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.

5.35.2.8.1 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.

5.35.3 Contractor shall have a provision for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential Fraud, to the OIG.

5.35.4 Contractor shall notify the OIG within ten (10) Business Days of receiving information that may affect an Enrollee's eligibility to participate in the Medical Assistance program, including changes in an Enrollee's address or death of an Enrollee.

5.35.5 Contractor shall notify the OIG within ten (10) Business Days of receiving information about 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 the Contractor's Provider agreement.

5.35.6 Contractor shall maintain a recipient verification procedure and provide a summary of results to the OIG as described in Attachment XIII.

5.35.7 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, Abuse, mismanagement, and misconduct 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, Abuse, mismanagement, and misconduct.

5.35.8 Contractor shall promptly inform the OIG of any potential Fraud, Waste, Abuse, mismanagement, or misconduct. At the direction of the OIG, Contractor shall promptly inform the Illinois State Police Medicaid Fraud Control Unit (ISP-MFCU) of any potential criminal activity.

5.35.9 **Prepayment review.** In the event Contractor subjects a Network Provider to prepayment review or any review requiring the Provider to submit documentation to support a claim prior to the Contractor considering it for payment as a result of suspected Fraud, Waste, Abuse, mismanagement, or misconduct, Contractor shall adhere to the following within ninety (90) days of requiring such action:

5.35.9.1 Conduct a medical and coding review on the claims subject to prepayment review. When Fraud, Waste, Abuse, mismanagement, or misconduct is still suspected after conducting the review, submit to the OIG a suspected Fraud referral, including all referral components as required by the OIG.

5.35.9.2 A prepayment review shall not be conducted for a Provider listed as under investigation or litigation involving the federal or state government or other circumstances as deemed appropriate by the OIG.

5.35.10 **Prohibitions on Contractor recoveries.**

5.35.10.1 Contractor is prohibited from taking any actions to recover or withhold improper payments paid or due 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:

5.35.10.1.1 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;

5.35.10.1.2 When the issues, services, or claims that are the basis of the recovery or withhold are currently being investigated, audited, within the recovery process by the state, or are the subject of pending federal or state litigation or investigation;

5.35.10.1.3 Contractor shall determine if the prohibition to recover or withhold improper payments paid or due is applicable utilizing methods as directed by the OIG;

5.35.10.1.4 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, the Contractor shall notify the OIG and take all action in accordance with written instructions from the OIG; and

5.35.10.1.5 In the event Contractor fails to adhere to the prohibitions and requirements of this section, Contractor may be subject to forfeiture of the funds described in section 5.35.11 to the Department and the imposition of civil monetary penalties.

5.35.11 **Recoveries of overpayments by Contractor**. Contractor and its Subcontractors shall have internal policies and procedures to identify and recover overpayments within timeframes as determined by the OIG, specifically for the recovery of overpayments due to Fraud, Waste, Abuse, mismanagement, and misconduct. Contractor shall exclude from their identification process all overpayment identification prohibitions as defined in section 5.35.10.

5.35.11.1 Contractor shall promptly report any overpayments made to a Subcontractor or Network Provider to the OIG.

5.35.11.2 Contractor shall notify the OIG of any overpayment identified through Fraud, Waste, Abuse, mismanagement, or misconduct detection, or for which recovery is prohibited under section 5.35.10. Contractor shall not take actions to recover the overpayment without written authorization from the OIG.

5.35.11.3 Contractor shall report on a claim and service line level detail to the OIG all overpayments identified through Fraud, Waste, Abuse, mismanagement, or misconduct detection, and recovered on a quarterly basis. Within sixty (60) days' written notice from the Department, Contractor shall include claim and service line level detail in the quarterly report.

5.35.11.4 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.

5.35.12 **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.

5.35.13 **Reporting and investigating suspected Fraud, Waste, Abuse, mismanagement, and misconduct.**

5.35.13.1 Contractor and its Subcontractors shall cooperate with all appropriate federal and state agencies in the detection and prevention of Fraud, Waste, Abuse, mismanagement, and misconduct.

5.35.13.2 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.

5.35.13.3 In accordance with the OIG guidelines, Contractor shall report all internal and external observations or reports that have potential implications of Network Provider billing anomalies, and, potential risk of harm concerns for all Enrollees. Contractor shall take steps to triage and substantiate such information and provide timely updates to the OIG, and ISP-MFCU as applicable under section 5.35.8, when concerns or allegations are authenticated.

5.35.13.4 Contractor shall report, as specified by OIG, all suspected Fraud, Waste, Abuse, mismanagement, and misconduct as follows:

> 5.35.13.4.1 Within three (3) Business Days, all alleged criminal conduct;
>
> 5.35.13.4.2 Monthly, any program integrity case opened within the previous month;
>
> 5.35.13.4.3 Quarterly, reports as defined under the Reporting Tool Guidelines; and,
>
> 5.35.13.4.4 Annually, a compliance plan required by this Contract and applicable federal and state laws. Prior Approval by the OIG of the annual compliance plan is required.

5.35.13.5 Contractor shall promptly perform a preliminary investigation of all incidents of suspected or confirmed Fraud, Waste, Abuse, mismanagement, or misconduct. Unless prior approval is obtained from the OIG, Contractor shall not take any of the following actions as they specifically relate to the incident:

> 5.35.13.5.1 Contact the subject of the investigation about any matters related to the investigation;
>
> 5.35.13.5.2 Enter into or attempt to negotiate any settlement or agreement regarding the incident; or,
>
> 5.35.13.5.3 Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.

5.35.13.6 Contractor shall promptly provide the results of its preliminary investigation to the OIG.

5.35.13.7 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 employees and consultants, including but not limited to those with expertise in the administration of the Medical Assistance Program, in medical or pharmaceutical questions, or in any matter related to an investigation.

5.35.13.8 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 ISP-MFCU or other relevant law enforcement entities.

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

5.35.13.10 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).

5.35.13.11 Contractor shall terminate a Subcontractor or Network Provider when notified by the OIG pursuant to section 5.32.10.3.

47. Section 7.3 and its subsections are deleted in their entirety and replaced with the following:

7.3 **PAYMENT FILE RECONCILIATION**

7.3.1 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:

7.3.1.1 Enrollees who Contractor believes are in its plan but who are not included on the 820 Payment File;

7.3.1.2 Enrollees who are included on the 820 Payment File but who Contractor believes have not been enrolled with Contractor; and

7.3.1.3 Enrollees who are included on the 820 Payment File but who Contractor believes are in a different rate cell.

7.3.2 Contractor shall notify the Department within sixty (60) days of identifying Capitation or other payment amounts in excess of amounts specified in this Contract.

48. Subsection 7.4.1 is deleted in its entirety and replaced with the following:

7.4.1 Capitation rates under this Contract, excluding the portion attributable to supplemental payments and other fees not retained by the MCOs, will be risk-adjusted by each population category against the other full-risk MCOs providing Covered Services to the same population category within the same rate-setting region. The population categories that will be risk-adjusted are adults and Children eligible under Title XIX and Title XXI; Affordable Care Act expansion–eligible adults; Medicaid-eligible older adults; adults with disabilities who are not eligible for Medicare; Dual-Eligible Adults receiving LTSS, excluding those receiving partial benefits or enrolled in the Illinois Medicare-Medicaid Alignment Initiative (MMAI); and Special-Needs Children, excluding Children in the care of DCFS. Beneficiaries under the age of two (2) will not be risk-adjusted. Capitation rates calculated under this Contract will be adjusted in accordance with publicly available risk-adjustment software. Risk adjustment will be performed on a semiannual basis. For an Enrollee's individual claims data to be the basis for a risk adjustment score hereunder, such Enrollee must have been enrolled in the HFS Medical Program (i.e., either managed care or Fee-For-Service) for at least six (6) full months during the time period from which claims data are used to calculate the adjustment. In the event an Enrollee has not been enrolled in the HFS Medical Program for at least six (6) full months, then such Enrollee shall receive a risk score

equal to Contractor's average risk score. The risk scores shall be established for each MCO across all rate cells. As necessary, the risk scores will be established using a credibility formula for each MCO. The credibility formula to be used will be determined by an independent actuary. All diagnosis codes submitted by Contractor shall be included in calculations of risk scoring irrespective of placement of such diagnosis codes in the Encounter Data records. Diagnosis codes from claims or encounters that included a lab and radiology procedure or revenue code on any line, with the exception of those associated with an inpatient hospital claim, will not be collected for the risk-adjustment analysis. It is assumed that these diagnosis codes could be for testing purposes and may not definitively indicate a beneficiary's disease condition. Encounter records may not be supplemented by medical record data. Diagnosis codes may only be recorded by the Provider at the time of the creation of the medical record and may not be retroactively adjusted except to correct errors. A significant change in risk scores by an MCO may warrant an audit of the diagnosis collection and submission methods. To the extent that the Department's contracted actuarial firm believes Encounter Data limitations are resulting in risk score variances between MCOs, the Department reserves the right to request diagnosis codes and other information to perform risk adjustment.

49. Subsection 7.5.1 is deleted in its entirety and replaced with the following:

7.5.1 The Capitation rates provide for all reasonable, appropriate, and attainable costs that are required under terms of the Contract and for the operation of the managed Health Plan for the time period and population covered under the terms of the Contract, and such Capitation rates were developed in accordance with the requirements under 42 CFR 438.4(b).

50. Section 7.7 is deleted in its entirety and replaced with the following:

7.7 **ADJUSTMENTS**

Payments to Contractor will be adjusted for retroactive disenrollment of Enrollees, changes to Enrollee information that affect the Capitation rates (for example, eligibility classification), monetary sanctions imposed in accordance with section 7.16 that are not paid by Contractor, rate changes in accordance with updates to Attachment IV, or other miscellaneous adjustments provided for herein. Adjustments shall be retroactive up to twenty-four (24) months. Adjustments can go beyond twenty-four (24) months at the discretion of the Department in instances including but not limited to death, incarceration, or other systematic corrections made by the Department. The Department will make retroactive enrollments only in accordance with sections 4.6 and 4.11.

51. Subsection 7.9.1 is deleted in its entirety and replaced with the following, and is further amended by adding new subsections 7.9.1.1 and 7.9.1.2:

7.9.1 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 one percent (1%) in the first measurement year, one-and-one-half percent (1.5%) in the second measurement year, and two percent (2%) in the third and subsequent measurement years. Contractor may earn a percentage of the withhold based on its performance with respect to a Department-determined combination of: (i) quality metrics set forth in Attachment XI; (ii) operational and implementation metrics as defined and published on the Department's website. The Department and Contractor will

agree to the measures through a counter-signed letter annually. The letter will include any weighting assigned to quality, operational or implementation metrics as it relates to the withhold.

7.9.1.1 Withhold arrangements shall be available to both public and private contractors under the same terms of performance.

7.9.1.2 Participation by Contractor in withhold arrangements are not a condition of Contractor entering into or adhering to intergovernmental transfer arrangements.

52. Subsection 7.9.6 is amended by adding new subsections 7.9.6.1 and 7.9.6.2:

7.9.6.1 An incentive payment program shall be available to both public and private contractors under the same terms of performance.

7.9.6.2 Participation by Contractor in an incentive payment program is not a condition of Contractor entering into or adhering to intergovernmental transfer arrangements.

53. Subsection 7.11.4 is deleted in its entirety and replaced with the following:

7.11.4 **Submission certification.** Contractor's Chief Executive Officer, Chief Financial Officer, or an individual who reports directly to and has delegated authority to sign for the Chief Executive Officer or Chief Financial Officer shall attest, based on best information, knowledge and belief, the accuracy, completeness and truthfulness of each quarterly and annual cost report submission provided to the Department.

54. Section 7.16 is amended by moving language of subsection 7.16.17 to a new subsection 7.16.18, and adding the following as new subsection 7.16.17:

7.16.17 **Failure to develop a written proposal intended to resolve a disputed claim and 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:

7.16.17.1 impose a late fee of up to US $50,000 for the initial determination;

7.16.17.2 impose a late fee of up to US $50,000 for each subsequent determination;

7.16.17.3 impose an enrollment hold on Contractor; or

7.16.17.4 impose both.

7.16.18 **Other failures.** 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 this article VII but for which the Department reasonably determines imposing a performance penalty or other sanction is warranted, the Department, may:

7.16.18.1 impose a performance penalty of US $20,000 to US $50,000;

7.16.18.2 impose an enrollment hold on Contractor; or

7.16.18.3 impose both.

55. Section 7.21 and its subsections are deleted in their entirety and replaced with the following:

7.21 NON-CONTRACTUAL RECOVERIES

If the Department 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, Contractor shall immediately notify the Department of any amount recovered, and, as agreed to by the Parties:

7.21.1 Contractor shall immediately provide the amount recovered to the Department; or

7.21.2 the Department shall withhold the amount recovered from a payment otherwise owed to Contractor.

56. Subsections 9.1.32, 9.1.32.1, and 9.1.32.2 are deleted in their entirety and replaced with the following:

9.1.32 **Excluded individuals/entities.** Contractor shall ensure that all current and prospective employees and Subcontractors are screened prior to engaging their services under this Contract and at least monthly thereafter, by:

9.1.32.1 requiring current and prospective employees and Subcontractors to disclose whether they are excluded individuals/entities; and

9.1.32.2 reviewing the list of sanctioned Persons maintained by the OIG, the Federal CMS Data Exchange System (DEX), the excluded parties list system maintained by the U.S. General Services Administration, or any other such database that is required by State or federal law.

57. Subsection 9.1.33.2 is deleted in its entirety and replaced with the following:

9.1.33.2 has not been reinstated in the Medical Assistance Program after a period of exclusion, suspension, debarment, or ineligibility; or

58. Subsection 9.1.34 is deleted in its entirety and replaced with the following:

9.1.34 Contractor shall terminate its relations with any employee, Subcontractor, Network Provider, or non-Network Provider immediately upon learning that such employee, Subcontractor, Network Provider, or non-Network Provider meets the definition of an excluded individual/entity, and shall notify the OIG of the termination.

59. Subsection 9.2.34, but not its subsections, is deleted in its entirety and replaced with the following:

9.2.34 **Disclosure of interest.** Contractor shall comply with the disclosure requirements specified in 42 CFR §455, including filing with the Department, upon the Execution of this Contract, upon renewal or extension of this Contract, and within thirty-five (35) days after a change in ownership occurs, a disclosure statement containing the following:

60. *Attachment I: Service Package II Covered Services and MLTSS Covered Services* is deleted in its entirety and replaced with the attached Attachment I.

61. *Attachment II: Contracting Areas and Potential Enrollees* is deleted in its entirety and replaced with the attached Attachment II.

62. *Exhibit A to Attachment VI: Notification of Unauthorized Access, Use, or Disclosure* is deleted in its entirety and replaced with the attached Exhibit A.

63. *Table 1 to Attachment XI: Healthcare and Quality of Life Performance Measures* is amended by deleting pages 245 and 246 of the HealthChoice Illinois contract and replacing with the attached pages.

64. *Attachment XIII: Required Deliverables, Submissions, and Reporting* is amended by deleting pages 284, 285, and 286 of the HealthChoice Illinois contract and replacing with the attached pages.

65. *Attachment XV: Contract Monitors* is deleted in its entirety and replaced with the attached Attachment XV.

66. *Attachment XVI: Qualifications and Training Requirements of Certain Care Coordinators and Other Care Professionals* is amended by deleting subsection 1.1.5.3 and renumbering 1.1.5.4 to 1.1.5.3 as follows:

    1.1.5.3 Contractor must employee at least one (1) certified trainer in IM-CANS.

67. *Attachment XXIII: Illinois Medicaid Health Plan Encounter Utilization Monitoring (EUM) Requirements* is deleted in its entirety and replaced with the attached Attachment XXIII.

IN WITNESS WHEREOF, the Parties have hereunto caused this Amendment No. 2 to the Contract to be executed by their duly authorized representatives, effective as of the date of last signature.

[MANAGED CARE ORGANIZATION]	DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
By:_________________________________	By:____
Printed Name:________________________	Printed Name:_______________________________
Title:________________________________	Title:______________________________________
Date:________________________________	Date:______________________________________
FEIN:________________________________	

Attachment I: Service Package II Covered Services and MLTSS Covered Services

Service	DoA	DHS-DRS			HFS			
	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury	Supportive Living Facility	Definition	Standards	HFS Fee-For-Service Service Limits
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 per MFP Enrollee in a twenty-four (24)–hour period, and shall not include trips to a Physician, shopping, or other miscellaneous trips.
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. **DSCC** Vehicle modifications (wheelchair lifts and tie downs) are also provided under environmental modifications.	**DRS:** 89 Il.Adm.Code 686.608 **DSCC:** DSCC Home Care Manual, 53.20.30, (Rev.9/01) &53.43 (Rev.9/01)	**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. **DSCC:** All environmental modifications will be limited in scope to the minimum necessary to meet the Enrollee's medical needs.

Service	DoA	DHS-DRS			HFS			
	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury	Supportive Living Facility	Definition	Standards	HFS Fee-For-Service Service Limits
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.

Service	DoA	DHS-DRS			HFS			
	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury	Supportive Living Facility	Definition	Standards	HFS Fee-For-Service Service Limits
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.
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.

Service	DoA	DHS-DRS			HFS			
	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury	Supportive Living Facility	Definition	Standards	HFS Fee-For-Service Service Limits
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.
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.

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 Facility			
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.
Placement Maintenance Counseling						This service provides short-term, issue-specific family or individual counseling for the purpose of maintaining the Enrollee in the home placement. This service is prescribed by a Physician based upon the Physician's judgment that it is necessary to maintain the child in the home placement.	Licensed Clinical Social Worker 225 ILCS 20 Medicaid Rehabilitation Option 59 Il.Adm.Code 132 Licensed Clinical Psychologist 225 ILCS 15	Services will require preauthorization by HFS and will be limited to a maximum of twelve (12) sessions per calendar year.
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.

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 Facility			
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.
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.	**DOA:** Standards for Emergency Home Response 89 Il.Adm.Code 240 **DRS:** 89 Il. Adm. Code 686.300	PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

Service	DoA	DHS-DRS				HFS			
	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury		Supportive Living Facility	Definition	Standards	HFS Fee-For-Service Service Limits
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 care, 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. **DSCC:** Respite care services allow for the needed level of care and supportive services to enable the Enrollee to remain in the community, or home-like environment, while periodically relieving the family of caregiving responsibilities. These services will be provided in the Enrollee's home or in a Children's Community-Based Health Care Center Model, licensed by the Illinois Department of Public Health.	Adult Day Dare 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 **DSCC:** Healthcare center 77 Il.Adm.Code 260 Nursing agency: Meet DSCC nursing agency requirements-DSCC Home Care Manual, 53.09	**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. **DSCC:** Respite care services will be limited to an annual limit of fourteen (14) days or three hundred thirty-six (336) hours. Exceptions may be made on an individual basis based on extraordinary circumstances.
Nurse Training							This service provides child-specific training for nurses, under an approved nursing agency, in the use of new or unique prescribed equipment, or special care needs of the child.	DSCC Nursing agency requirements-DSCC Home Care Manual, 53.09.	This service cannot exceed the maximum of four (4) hours per nurse, per HCBS Waiver year.
Family Training							Training for the families of Enrollees served on this HCBS Waiver. Training includes instruction about treatment regimens and use of equipment specified in the Enrollee Care Plan and shall include updates as necessary to safely maintain the Enrollee at home. It may also include training such as cardiopulmonary resuscitation (CPR).	Nursing Agency: Meet DSCC nursing agency requirements-DSCC Home Care Manual, 53.09 Service Agency: Qualify to provide the service.	All Family Training must be included in the Enrollee Care Plan.

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 Facility			
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 **DSCC:** 225.ILCS.51 If not licensed under 225 ILCS 51, must be accredited by the Joint Commission on Accreditation of Healthcare Organizations, or other accrediting organization. Meet DSCC Home Medical Equipment (HME) requirements for the HCBS Waiver. A Medicaid enrolled pharmacy or durable medical equipment provider that provides items not available from a DSCC approved HME provider, (such as special formula).	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. **DSCC:** Medical supplies, equipment, and appliances are provided only on the prescription of the primary care Provider as specified in the Enrollee Care Plan.
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	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 Facility			
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 Facilities (SLFs) are required to meet the scheduled and unscheduled needs of Residents twenty-four (24) hours a day.	Supportive Living Facilities 89 Il. Adm.Code 146 SupPart B	SLFs 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	The amount, duration, and scope of services is based on the service plan and is included in the service cost maximum/monthly cost limit. Participant must meet screening criteria prior to receiving service.

MLTSS Covered Services

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	Medicar 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 SLF 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

Attachment II: Contracting Areas and Potential Enrollees

<table>
<tr><td>Contracting Areas</td><td>There are nineteen (19) Urban Areas in Illinois and eighty-three (83) Rural Areas. Urban Area counties are highlighted in bold below.

Statewide: Adams, Alexander, Bond, Boone, Brown, Bureau, Calhoun, Carroll, Cass, Champaign, Christian, Clark, Clay, Clinton, Coles, Cook, Crawford, Cumberland, DeKalb, DeWitt, Douglas, DuPage, Edgar, Edwards, Effingham, Fayette, Ford, Franklin, Fulton, Gallatin, Greene, Grundy, Hamilton, Hancock, Hardin, Henderson, Henry, Iroquois, Jackson, Jasper, Jefferson, Jersey, Jo Daviess, Johnson, Kane, Kankakee, Kendall, Knox, Lake, LaSalle, Lawrence, Lee, Livingston, Logan, Macon, Macoupin, Madison, Marion, Marshall, Mason, Massac, McDonough, McHenry, McLean, Menard, Mercer, Monroe, Montgomery, Morgan, Moultrie, Ogle, Peoria, Perry, Piatt, Pike, Pope, Pulaski, Putnam, Randolph, Richland, Rock Island, Saline, Sangamon, Schuyler, Scott, Shelby, St. Clair, Stark, Stephenson, Tazewell, Union, Vermilion, Wabash, Warren, Washington, Wayne, White, Whiteside, Will, Williamson, Winnebago, Woodford

http://www.icahn.org/files/Rural_Health_Clinic/Rural_urban_counties.pdf</td></tr>
<tr><td>Potential Enrollees</td><td>Potential Enrollees include: families and children eligible for Medicaid through Title XIX or Title XXI (Children’s Health Insurance Program); Affordable Care Act expansion Medicaid-eligible adults; Medicaid-eligible adults with disabilities who are not eligible for Medicare; Medicaid-eligible older adults who are not eligible for Medicare; Dual-Eligible Adults receiving long-term services and supports (LTSS) in an institutional care setting or through an HCBS waiver; and Special Needs Children. Members excluded from the scope of this Contract are as follows:
• Dual-Eligible Adults enrolled in MMAI;
• Dual-Eligible Adults not receiving nursing facility or waiver services;
• Participants who are American Indian/Alaskan Natives unless they voluntarily enroll in an MCO;
• Premium Level 2;
• Participants only eligible with a Spend-Down;
• All Presumptive Eligibility categories;
• Participants who are incarcerated in a county jail, Illinois Department of Corrections facility, or federal penal institution;
• Participants in a State facility operated as a psychiatric hospital as a result of a forensic commitment;
• Participants enrolled in partial/limited benefits programs; and,
• Participants with comprehensive third-party insurance.</td></tr>
</table>

EXHIBIT A TO ATTACHMENT VI: NOTIFICATION OF UNAUTHORIZED ACCESS, USE, OR DISCLOSURE

Contractor must complete this form to notify the Department of any unauthorized access, use, or disclosure of Protected Health Information (PHI). In accordance with the Contract, notice must occur immediately.

Notice shall be provided to:

1) Contract Administrator Bureau Chief – Bureau of Managed Care, in compliance with the Notice Requirements of the Underlying Agreement, at:

   Illinois Department of Healthcare and Family Services
   Attn: Bureau Chief – Bureau of Managed Care
   Bloom Building, 3rd Floor
   201 South Grand Avenue East
   Springfield, Illinois 62763

2) HFS Privacy Officer, in compliance with the Notice Requirements of the Underlying Agreement at:

   Illinois Department of Healthcare and Family Services
   Attn: Privacy Officer
   Bloom Building, 3rd Floor
   201 South Grand Avenue East
   Springfield, Illinois 62763
   HFS.Privacy.Officer@illinois.gov

Information to be submitted by Contractor:

Contract information:
Contract number:
Contract title:
Contact person for this incident:
Contact person's title:
Contact's address:
Contact's e-mail:
Contact's telephone number:

NOTIFICATION:
Contractor hereby notifies the Department that there has been an unauthorized access, use, or disclosure of Protected Health Information that Contractor had access to under the terms of Contractor, as described in detail below:

Date of Discovery:
Detailed Description:

Types of Unsecured Protected Health Information involved in the Unauthorized Access, Use, or Disclosure (such as full name, SSN, Date of Birth, Address, Account Number, Disability Code, etc. – List All).
What steps are being or have been taken to investigate the unauthorized access, use, or disclosure; mitigate losses; and protect against any further incidents?
Number of individuals impacted. If more than 500, identify whether individuals live in multiple states.

Submitted by:

Signature:____ **Date:** ________________________________

Printed name and title: ____

Table 1 to Attachment XI: **Healthcare and quality of life performance measures**

Acronym	Performance measure	Further description	Reporting methodology	Source
		following: • Hemoglobin A1c (HbA1c) testing. • Eye exam (retinal) performed. • Medical attention for nephropathy.	Hybrid / Admin	HEDIS
SPD	Statin Therapy for Patients With Diabetes	Percentage of members 40-75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria. Two rates are reported: 1) *Received Statin Therapy*. Members who were dispensed at least one statin medication of any intensity during measurement year. 2) *Statin Adherence 80%*. Members who remained on a statin medication of any intensity for at least 80% of the treatment period.	Admin	HEDIS
MPM	Annual Monitoring for Patients on Persistent Medications	Percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. Report each of the three rates separately and as a total rate. • Annual monitoring for members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB). • Annual monitoring for members on digoxin. • Annual monitoring for members on diuretics. • Total Rate (the sum of the three numerators divided by the sum of the three denominators.	Admin	HEDIS
MMA	Medication Management for People With Asthma	Percentage of member's 5–64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are	Admin	HEDIS

		reported. 1) Percentage of members who remained on an asthma controller medication for at least 50% of their treatment period. 2) Percentage of members who remained on an asthma controller medication for at least 75% of their treatment period. (Report 5 age groups)		
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	Percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing. (Report three age stratifications and total)	Admin	HEDIS
FUH	Follow-Up After Hospitalization for Mental Illness	Percentage of discharges for member's 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported: 1) Percentage of discharges for which the member received follow-up within 30 days of discharge. 2) Percentage of discharges for which the member received follow-up within 7 days of discharge.	Admin	HEDIS
CDF-HH	Screening for Clinical Depression and Follow-Up Plan	Percentage of Health Home enrollees age 12 and older screened for clinical depression on the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen.	Hybrid or e-measure	CMS
PQI92-HH	Chronic Condition Hospital Admission Composite—PQI	Number of inpatient hospital admissions for ambulatory care sensitive chronic conditions per 100,000 enrollee months for Health Home enrollees age 18 and older. This measure includes adult hospital admissions for diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, or angina without a cardiac procedure.	Admin	AHRQ

HEDIS® and State-Defined Plan Goals	Quarterly	No	Contractor shall submit a HEDIS® measures report that is based on the Performance Measures required by this Contract, and that includes HEDIS® measures, modified HEDIS® measures, and State defined measures. This report shall include the numerator, denominator and rate for each measure and will display information in a manner that includes trending data, based on previous quality indicators.
Physician Quality Measurement Report	As needed, and within ten (10) Business Days after the Department's request	No	Contractor shall submit a report for each Provider or Provider group that shows actual performance relative to measures of performance.
Enrollee Profiles/ Statistics for Care Integration	As needed, and within ten (10) Business Days after the Department's request	No	Contractor shall submit a report that provides comprehensive information on Contractor's care integration systems for Enrollees' care. This report shall include, but not be limited to, an annual summary of physical and behavioral health conditions, service utilization such as primary care Provider and specialist visits, Emergency Services, inpatient hospitalizations and pharmacy utilization.
Processes and Procedures to Receive Reports of Critical Incidents	Initially and as revised	Yes	Contractor shall submit Critical Incident Processes and 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. Contractor may submit one set of processes and procedures that includes all care coordination programs in which it participates; however, Contractor shall identify all areas that differ among care coordination programs.
Critical Incidents – Detail Report	Monthly	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; 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.

Critical Incidents – Summary Report	Quarterly	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, 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; ACA Expansion Adults; Non-Disabled Children; Non-Disabled Adults; Special Needs Children; and IMD Residents.
Transition of Care Plan	Initially 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.
Cultural Competence Plan	At least two (2) weeks prior to the Department's Readiness Review	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 2.7.2 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.
Executive Summary	Quarterly	No	Contractor shall submit an Executive Summary that summarizes the data within the reports submitted to the Department for that quarter (including monthly and quarterly reports). The Executive Summary shall contain, at a minimum, an analysis of the reports submitted during the quarter, an explanation of the data submitted, and highlights from the reports.
Children with Special Health Care Needs (CSHN) Plan	Initially and as revised	No	Contractor shall submit the Children with Special Health Care Needs Plan to conduct timely identification and screening, comprehensive assessments, and appropriate case management services for any CSHN.

Provider-preventable Conditions Report	Quarterly	No	Contractor shall report provider-preventable conditions that are identified in the State Plan to the Department.
Utilization Review			
Utilization Management Report	Monthly	No	Contractor shall submit an analysis of Inpatient and Emergency Services utilization. Inpatient services shall be based on inpatient days and be categorized as follows: Utilization for total Inpatient, Medical/Surgical, Rehabilitation, Mental Health including Substance Use, Emergency Services, and Outpatient visits. Data will be based on utilization per 1,000 Enrollees and Total utilization. Reporting for Inpatient, Emergency Services, and Outpatient visits utilization shall be divided into separate worksheets for LTC, HCBS Waiver for Persons with Developmental Disabilities, HCBS Waiver for Persons with Disabilities, HCBS Wavier for Persons with Brain Injury, HCBS Waiver for Persons with HIV/AIDS, HCBS Waiver for Persons who are Elderly, HCBS Waiver for Assisted Living, Supportive Living Program, and total population as defined by Department standards.
Pharmacy			
Pharmacy Monitoring Report	Monthly	No	Contractor shall submit pharmacy data utilization reports based on total utilization, claims summaries, cost summaries and cost per claim.
Psychotropic Review Report	Monthly	No	Contractor shall submit a summary report of Enrollees' Psychotropic medication utilization and the prescribing patterns of Providers. The report must include information on the following criteria: use of 5 or more psychotropics for 60 or more days, use of 2 or more ADHD medications for 60 or more days, use of 3 or more antidepressants for 60 or more days, use of 5 or more drugs for bipolar disorder (mood stabilizers, atypical antipsychotics, antidepressants) for 60 or more days, use of 2 or more SSRIs for 60 or more days, use of 2 or more antipsychotics for 60 or more days, use of 2 or more atypical antipsychotics for 60 or more days, and use of 2 or more benzodiazepine or benzodiazepine hypnotics for 60 or more days.
Drug Utilization Review Report	Annually	No	Contractor shall report its prospective and retrospective Drug Utilization Review activities to the Department.

ATTACHMENT XV: CONTRACT MONITORS

For the Department:

Bureau Chief
Bureau of Managed Care
Division of Medical Programs
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East
Springfield, IL 62763

Telephone:
Fax:
E-mail:

For Contractor:

Contact Person:
Contact Title:
Address:

Telephone:
E-mail:
Fax:

ATTACHMENT XXIII: ILLINOIS MEDICAID HEALTH PLAN ENCOUNTER UTILIZATION MONITORING (EUM) REQUIREMENTS

State of Illinois
Department of Healthcare and Family Services
2019 HealthChoice MCO EUM Requirements - DRAFT
Table 1: Appendix A Spend and Encounters and Appendix F Rejection Waterfall Analysis

	Data Limitations			Due Dates				$100,000 Financial Penalty		Auto-Assignment shut-off
Eval Period	Scored Service Dates (CY)	Submitted Service Dates (CY)	Run-out Date	Preliminary Appendix A	Final Appendix A	Final Appendix F	Final Evaluation Date	All Services Threshold	Subcategory Threshold	All Services Threshold
1	2017Q1 - 2018Q2	2017Q1 - 2018Q4	12/31/2018	1/31/2019	2/28/2019	3/15/2019	3/15/2019	95%	85%	90%
2	2017Q2 - 2018Q3	2017Q1 - 2019Q1	3/31/2019	4/30/2019	5/31/2019	6/14/2019	6/14/2019	96%	85%	90%
3	2017Q3 - 2018Q4	2017Q1 - 2019Q2	6/30/2019	7/31/2019	8/30/2019	9/14/2019	9/14/2019	96%	85%	90%
4	2017Q4 - 2019Q1	2017Q1 - 2019Q3	9/30/2019	10/31/2019	11/29/2019	12/13/2019	12/13/2019	96%	85%	90%

Appendix A General Implementation Procedures:

1. The 2019 EUM Data Methodology report details the guidelines for the spend data to be included and provided in Appendix A. Failure to send accurate spend data by the deadline will result in both the Financial Penalty and Auto-Assignment shut-off to occur.

   All final Medicaid spend data submitted must be accompanied by an attestation letter (provided in Appendix A) signed by Contractor's Executive Director or CEO. This attestation letter must be printed, signed, and emailed to HFS; it cannot be signed electronically. An attestation letter is not required for the preliminary Medicaid spend data submission.

2. The Financial Penalty is up to $100,000 per Evaluation Period. The Financial Penalty will be assessed if the All Services EUM score OR any identified Subcategory EUM score is below the percentages listed above.

3. **HFS Accepted Encounter greater than MCO Reported Spend** – The Medicaid spend should not be less than the amount of HFS accepted encounters, which would result in a scored percentage of greater than 100%. For subcategories of service where the HFS accepted encounter expenditures are greater than the MCO reported Medicaid spend, the amount of HFS accepted encounters above the amount of the reported spend in a subcategory will not be included for purposes of calculating the total "All Services" percentage. For example, if dental services are reported by the plan at $100,000 and HFS has accepted encounters of $150,000, the value used to score this subcategory would be $100,000 resulting in a score of 100%. The remaining $50,000 would not be included in the subcategory score or the total composite score.

4. Contractor shall email all related data to the Department's designated e-mail account (HFS.encounters@illinois.gov) and Milliman (Milliman.IL.Encounters@milliman.com). The file name should include the name of the MCO and the date of submission (e.g. "MCO Name Prelim Appendix A CY19 Eval 1 – 20190131").

State of Illinois Department of Healthcare and Family Services 2019 EUM Requirements Table 2: Auto-Assignment Process								
	Initial Evaluation		30-Day Reevaluation			60-Day Reevaluation		
Eval Period	Client Enrollment Broker Notified	Auto-Assignment Shut-off	MCO provides supplemental data	Reevaluation and CEB Notification Date	Auto-Assignment Restart	MCO provides supplemental data	Reevaluation and CEB Notification Date	Auto-Assignment Restart
1	3/15/2019	4/1/2019	4/12/2018	4/15/2019	5/1/2019	5/10/2019	5/13/2018	6/1/2019
2	6/14/2019	7/1/2019	7/12/2018	7/16/2019	8/1/2019	8/9/2019	8/12/2018	9/1/2019
3	9/14/2019	10/1/2019	10/11/2019	10/14/2019	11/1/2019	11/15/2019	11/18/2018	12/1/2019
4	12/13/2019	1/1/2020	1/10/2020	1/13/2020	2/1/2020	2/14/2020	2/17/2018	3/1/2020

Auto-Assignment Shut-off Implementation Procedures:

1. If Auto-Assignment is shut-off, it will be reevaluated at 30 days. If Contractor meets or exceeds the objective, Auto-Assignment will be restarted on the first of the following month. If Contractor does not reach the objective at the 30-day reevaluation, it will be reevaluated at 60 day.