STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

and

[Managed Care Organization]

AMENDMENT NO. 12 TO THE CONTRACT FOR FURNISHING HEALTH SERVICES BY A MANAGED CARE ORGANIZATION 2018-24-XXX-KA12

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. Subsections 1.1.110, 1.1.156, 1.2.5.4, 2.3.1.11, 5.7.9, 5.10.2, and 5.21.5 are deleted in their entirety and replaced with the following:

   1.1.110 [THIS SECTION INTENTIONALLY LEFT BLANK]

   1.1.156 **Primary Care Provider (PCP)** means a Provider, including a WHCP, who, within the Provider's scope of practice and in accordance with State certification requirements or State licensure requirements, is responsible for providing all preventive and primary care services to an Enrollee of the Contractor.

   1.2.5.4 [THIS SECTION INTENTIONALLY LEFT BLANK]

   2.3.1.11 [THIS SECTION INTENTIONALLY LEFT BLANK]

   5.7.9 [THIS SECTION INTENTIONALLY LEFT BLANK]

   5.10.2 [THIS SECTION INTENTIONALLY LEFT BLANK]

2. Subsection 2.3.1.16 is deleted in its entirety and replaced with the following:

2.3.1.16 **Compliance Officer.** The Compliance Officer shall be a full-time position, which shall develop and implement policies, procedures, and practices designed to ensure compliance with the requirements of the Contract. This position shall oversee Contractor's Program Integrity Program; the Complaint, Grievance, Special Investigations Unit; and the fair hearing process and ensure that Fraud, Waste, and Abuse is reported in accordance with the guidelines in 42 CFR §438.608 and the requirements of this Contract. This position shall report directly to the CEO and Board of Directors. Effective January 1, 2023, the Compliance Officer position is not subject to the requirement in Section 2.3.1 that the position is located in Illinois.

3. Section 4.17 is amended by adding new subsection 4.17.5 and subsections:

4.17.5 **Marketing, Outreach and Education Plan**. Beginning in calendar year 2023, on an annual basis, Contractor must submit to the Department for Prior Approval a Marketing, Outreach and Education Plan no later than November 15th that covers the period of the following calendar year. The Marketing, Outreach and Education Plan must reflect a focused approach and strategy that aligns with the program goals under the Department's Comprehensive Medical Programs Quality Strategy. Contractor's Marketing, Outreach and Education Plan must include the following:

4.17.5.1 an overview of how Contractor's marketing, outreach, and education strategy will contribute to improved quality of care, access to care, and performance outcomes for Enrollees;

4.17.5.2 equity-based strategies on:

4.17.5.2.1 increasing Enrollee self-care management including promoting Primary Care Provider selection to encourage preventive care, and appropriate health screenings;

4.17.5.2.2 education and outreach initiatives that are focused and designed to improve chronic disease management and Behavioral Health through health literacy and lifestyle programs focused on adults;

4.17.5.2.3 education and outreach initiatives on maternal and child healthcare;

4.17.5.2.4 education and outreach initiatives on Behavioral Health, including reducing barriers to diagnosis and ongoing care for all populations;

4.17.5.2.5 support Enrollee redetermination process for hard to reach populations;

4.17.5.3 a community-centric outreach and community engagement strategy for increasing awareness and educating Enrollees and Potential Enrollees;

4.17.5.4 sample marketing materials that follow the Department's marketing and outreach guidelines;

4.17.5.4.1 marketing and promotional social media, radio, print, and other collateral materials that promote the State of Illinois Medicaid Program must be co-branded with the Department's HealthChoice Illinois logo that has equal visual positioning; and

4.17.5.5 policy on prohibition against cold-calling, door-to-door marketing, and other prohibited activities and locations;

4.17.5.6 guidelines on gifts and incentives;

4.17.5.7 guidelines and goals, both quantitative and qualitative, for marketing activities and outreach events;

4.17.5.8 procedures for addressing marketing complaints; and

4.17.5.9 guidelines for securing Enrollee consent.

4. Section 4.9 and subsections 4.16.2, 4.16.2.1, 5.21.2.1, and 5.21.5 are deleted in their entirety and replaced with the following:

4.9 ENROLLEE WELCOME PACKET
Within five (5) Business Days after receipt of the 834 Audit File from the Department confirming that an enrollment was accepted, or, no later than five (5) Business Days prior to an Enrollee's Effective Enrollment Date, Contractor shall send an Enrollee welcome packet to the Enrollee. The packet shall include all basic information as set forth in section 5.21.1.

4.16.2 Contractor shall send the identification cards to the Enrollee no later than five (5) Business Days after receipt of the monthly 834 Audit File, or, no later than five (5) Business Days prior to an Enrollee's Effective Enrollment Date.

4.16.2.1 For Dual-Eligible Enrollees whose enrollments are received by Contractor after receipt of the monthly 834 Audit File, Contractor shall send the identification card no later than five (5) Business Days after receipt of the 834 Daily File, or, no later than five (5) Business Days prior to an Enrollee's Effective Enrollment Date.

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, or, no later than five (5) Business Days prior to an Enrollee's Effective Enrollment Date, and thereafter to each Enrollee within thirty (30) days before a significant change to the basic information; and

5.21.5 **Enrollee handbook**. Department will provide Contractor with an Enrollee handbook template. Contractor shall complete and submit the template to the Department for Prior Approval before the first enrollment, when revised, and upon the Department's request. Contractor shall mail an Enrollee handbook to new Enrollees no later than five (5) Business Days following receipt of the Enrollee's initial enrollment record on the 834 Audit File, or, no later than five (5) Business Days prior to an Enrollee's Effective Enrollment Date. Contractor must include terms defined by the Department as provided in 42 CFR §438.10(c)(4)(i) and follow the requirements of 42 CFR §438.10(g). At a minimum, the Enrollee handbook must contain:

5. To correct a placement error in a previous contract amendment, subsection 5.3.2.4 is amended by adding new subsection 5.3.2.4.1 and subsection 5.3.1.4.1 is deleted in its entirety:

5.3.2.4.1 Effective for dates of service on and after January 1, 2022, Contractor shall utilize the Department's prior authorization requirements for long-acting injectable medications administered for treatment of Behavioral Health disorders in an inpatient hospital setting.

6. Subsection 5.7.13 is deleted in its entirety and replaced with the following:

5.7.13 **Governmental Provider entities contracting requirement.** Contractor shall contract with the University of Illinois, Cook County, by and through its Cook County Health and Hospitals System, and Southern Illinois University (collectively, governmental Provider entities) in order to provide certain Covered Services to Enrollees if such governmental Provider entity is located within Contractor's Contracting Area set forth in Attachment II. Contractor shall reimburse the University of Illinois for inpatient hospital, outpatient hospital, and for Physician services for the period January 1, 2018 through December 31, 2020, at no less than their rates as determined by the Medicaid approved reimbursement methodologies, as provided to Contractor by the Department, including claims where the University of Illinois charges less than the Medicaid State Plan rate, as allowed by 42 CFR §410.2. Contractor shall reimburse Southern Illinois University for Physician services at no less than its rate as determined by the Medicaid-approved reimbursement methodologies, as provided to Contractor by the Department, for the period January 1, 2018 through December 31, 2020. For the period January 1, 2018 through December 31, 2019, Contractor shall reimburse Cook County for inpatient hospital, outpatient hospital, Physician services, and encounter rate clinics at no less than their rates as determined by the Medicaid approved reimbursement methodologies, as provided to Contractor by the Department. Contractor shall not limit equal access to such Providers.

7. Section 5.16 is deleted 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 ten (10) Business Days.

8. Subsections 5.19.1.2.1 through 5.19.1.2.5 are deleted in their entirety and replaced with the following:

5.19.1.2.1 a health screening and a comprehensive assessment, if necessary, are complete;

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

5.19.1.2.3 the Enrollee agrees to the transition prior to the expiration of the transition period.

9. Subsection 5.20.2 is amended by adding new subsections 5.20.2.4, 5.20.2.4.1, 5.20.2.4.1.1, and 5.20.2.4.1.2:

5.20.2.4 Preventive prenatal, perinatal, and postpartum services.

5.20.2.4.1 In accordance with 305 ILCS 5/5-5.24(b), Contractor shall accept claims from non-Network Providers of preventive prenatal, perinatal, and postpartum services. Contractor shall make payment to non-Network Providers of all such services according to the Department's applicable Medicaid FFS reimbursement schedule, unless:

5.20.2.4.1.1 a different reimbursement rate is agreed upon between Contractor and the non-Network Provider; or,

5.20.2.4.1.2 the service(s) are not Emergency Services, and: (1) the non-Network Provider is a perinatal hospital and has, within the twelve (12) months preceding the date of service, rejected a contract that was offered in good faith by Contractor as determined by the Department; or (2) Contractor has terminated a contract with the non-Network Provider for cause, and the Department has not deemed the contract termination to have been without merit.

10. Subsection 5.21.7 is deleted in its entirety and replaced with the following:

5.21.7 **Engaging Enrollees.** Contractor shall use a multifaceted approach to locate and engage Enrollees, which may include employing community health workers or subcontracting with community-based organizations that employ community health workers, and shall capitalize on every Enrollee contact to obtain and update Enrollee contact information and engage Enrollees in their own care. Input will be solicited from Contractor's Enrollee advisory and community stakeholder committee to help develop strategies to increase motivation of Enrollees to participate in their own care.

11. Subsection 5.21.7.1 is deleted in its entirety and replaced with the following:

5.21.7.1 *Member relationship management system.* Contractor shall have a system dedicated to the management of information about Enrollees, specifically designed to collect Enrollee-related data and to process workflow needs in healthcare administration. Contractor shall notify the Department in writing as soon as practicable, but no later than five (5) days following a material change in Contractor's system. The system shall have, at a minimum, three (3) core integrated components:

12. 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 from the Effective Date through April 30, 2022. Beginning May 1, 2022, Contractor shall administer questions at each annual reassessment to determine the Enrollee's perception of their quality of life using a questionnaire format of Contractor's choice. In the event an Enrollee reports a negative perception of their quality of life, Contractor's Care

Coordinator shall document steps taken and interventions implemented to assist the Enrollee in attaining an improved perception of quality of life.

13. Section 5.31 is amended by adding new subsection 5.31.3:

5.31.3 Effective May 1, 2022, Contractor shall administer the DHS-DRS Personal Assistant Evaluation to each DHS-DRS HCBS Waiver Enrollee (Persons with Disabilities HCBS Waiver, Persons with Brain Injury HCBS Waiver, and Persons with HIV/AIDS HCBS Waiver) at each annual reassessment to determine each Enrollee's satisfaction and evaluation of their Individual Provider. Contractor's Care Coordinators must follow-up on non-favorable evaluations with Enrollees to identify areas of improvement.

14. Subsection 7.16.6 is deleted and replaced with the following:

7.16.6 **Failure to submit Encounter Data**. The Department and Contractor acknowledge and agree that they will work in good faith to implement mutually agreed-upon system requirements resulting in the complete and comprehensive transfer and acceptance of Encounter Data, and that such mutual agreement shall not be unreasonably withheld. Contractor shall submit complete and accurate data quarterly to the Department in accordance with the Illinois Medicaid Health Plan Encounter Utilization Monitoring (EUM) requirements document, as set forth in Department-issued written policy (specifically, policy number 058), for each evaluation period. If Contractor does not meet the standards by the evaluation date as set forth in Department's written policy, the Department, without further notice, may:

15. Section 7.23 is amended by deleting subsections 7.23.2 and 7.23.2 and replacing with the following:

7.23.2 Incentive Payments for Evaluations Documenting Impairments. Effective March 1, 2022 and through December 31, 2022, the Department will pay Contractor an incentive payment of $500 for each Department-approved evaluation of a Colbert or Williams class member documenting an impairment, cognitive and/or medical, so significant that community transition is not a safe and viable option.

7.23.3 Performance Targets. The Department will establish separate annual minimum performance targets for successful community transitions of Colbert class members and Williams class members. For each calendar year, transition performance targets will be specified in a counter-signed letter between the Department and Contractor.

16. Section 7.27 is amended by deleting subsections 7.27.1, 7.27.1.1, 7.27.1.2, 7.27.1.6 and 7.27.2 and replacing with the following; is also amended by deleting in their entirety subsections 7.27.3, 7.27.3.1 through 7.27.3.8, and 7.27.4; and is further amended by deleting subsection 7.27.5 in its entirety and replacing with a new subsection 7.27.3:

7.27.1 **VBP Plan.** Contractor shall have a written VBP Plan for the adoption, evolution, and growth of APMs in its Provider Network. The VBP Plan shall include the most recent APM experience, the current status of Contractor's VBP efforts, and strategies to enhance or further those efforts over the two subsequent calendar years. Contractor's initial VBP Plan shall be submitted to the Department for Prior Approval no later than May 1, 2022. Each annual VBP Plan thereafter shall, at a minimum, include:

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

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

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

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

7.27.3 **VBP Improvement.** Effective calendar year 2023, Contractor must realize annual improvement in the level of VBP penetration as a percentage of its relevant spending for medical services governed under VBP arrangements with Providers. The Department will take this figure from the Contractors' annual VBP Plan referenced in section 7.27.1, which will include detailed specifications regarding the methodology for calculating this percentage. Upon sixty (60) days written notice to Contractor, the Department reserves the right to add specific VBP penetration targets, including potential targets for the adoption of more advanced VBP (i.e., HCP-LAN categories 3-4) in future calendar years. Any additions or revisions to specific VBP penetration targets shall be effective the calendar year immediately following notice from the Department.

17. Article VII is amended by adding a new section 7.28:

7.28 **AUDITED FINANCIAL REPORTS**

In accordance with 42 CFR 438.3(m) Contractor must submit to the Department on an annual basis an audited financial report specific to this Contract. The audit must be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards. The audited financial report for calendar year 2022 is due to the Department no later than July 31, 2023.

Contractor shall conduct the audit on an annual basis and submit future financial reports to the Department no later than July 31st of the following calendar year.

18. Subsection 9.1.38.3 is deleted and replaced with the following:

9.1.38.3 If verified existence of Third Party Liability (TPL) has been established by Contractor at the time the claim is filed with Contractor, Contractor shall cost avoid (reject) the claim and return it to the Provider for a determination of the amount of any TPL, unless the claim falls under 42 U.S.C. § 1396(a)(25)(E) and 42 C.F.R. § 433.139, or is a HCBS waiver service. For pediatric preventative services, Contractor shall make payments to the Provider without regard to potential TPL, unless a determination has been made related to cost-effectiveness and access to care that warrants cost avoidance for ninety (90) days. Verification of TPL includes determination that the policy is active, enforceable and for Covered Services.

19. *Attachment II: Contracting Areas and Potential Enrollees* is amended by deleting and replacing the fourth category of excluded populations as follows:

- Premium Level 2, effective January 1, 2018 through September 30, 2022;

20. *Attachment XI: Quality Assurance* is amended by deleting subsection 1.1.16 and replacing with the following:

1.1.1.16 details any compensation structure, incentives, pay-for-performance (P4P) programs, value-purchasing strategies, and other mechanisms utilized to promote the goals of accountable, coordinated care;

21. *Attachment XIII: Required Deliverables, Submissions and Reporting* is deleted and replaced in its entirety.

22. *Attachment XXIV – Requirements Specific to DCFS Youth in Care Enrollees* is amended by deleting subsection 1.3.1 and replacing with the following; and is further amended by deleting section 1.5 and subsection 1.5.1 and replacing with the following:

1.3.1 Within five (5) Business Days of receipt of the 834 Daily file from the Department confirming that an enrollment was accepted, or, no later than five (5) Business Days prior to an Enrollee's Effective Enrollment Date, Contractor shall send an Enrollee welcome packet to the individual(s) designated by the State.

1.5 [THIS SECTION INTENTIONALLY LEFT BLANK]

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

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IN WITNESS WHEREOF, the Parties have hereunto caused this Amendment No. 12 to the Contract to be executed by their duly authorized representatives, effective as of the date of last signature.

[MANAGED CARE ORGANIZATION]

By:_____

Printed Name:_____

Title:_____

Date:_____

FEIN:_____

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

By:_____

Printed Name:_____

Title: Director _____

Date:_____

ATTACHMENT XIII: REQUIRED DELIVERABLES, SUBMISSIONS AND REPORTING

NOTE: Separate reports shall be submitted for all populations unless otherwise stated in the report description and requirements. Contractor shall be prepared to report all data by county, provider type, and eligibility category.

Failure to submit required deliverables, submissions and reports outlined in this section will be grounds for the imposition of sanctions as described in Error! Reference source not found.**.**

Name of report/submission	Frequency	HFS Prior Approval	Report description and requirements
Administrative			
Encounter Data	At least monthly	No	**Submission.** Contractor shall submit Encounter Data as provided herein. These data shall include all services received by Enrollees, including services reimbursed by Contractor through a Capitation arrangement. The report must provide the Department with HIPAA Compliant transactions, including the NCPDP, 837D File, 837I File and 837P File, prepared with claims level detail, as required herein, for all institutional and non-institutional Provider services received by Enrollee and paid by or on behalf of Contractor during a given month. Contractor shall submit administrative denials in the format and medium designated by the Department. The report must include all institutional and HCBS Waiver Services. Contractor shall submit Encounter Data such that it is accepted by the Department within one-hundred twenty (120) days after Contractor's payment or final rejection of the claim or, for services paid through a Capitation arrangement, within one-hundred twenty (120) days after the date of service. Any claims processed by Contractor for services provided subsequent to submission of an Encounter Data file shall be reported on the next Encounter Data file. **Testing.** Upon receipt of each submitted Encounter Data file, the Department shall perform two distinct levels of review: The first level of review and edits performed by the Department shall check the data file format. These edits shall include, but are not limited to the following: check the data file for completeness of records; correct sort order of records; proper field length and composition; and correct file length. To be accepted by the Department, the format of the file must be correct.

Name of report/submission	Frequency	HFS Prior Approval	Report description and requirements
			Once the format is correct, the Department shall then perform the second level of review. This second review shall be for standard claims processing edits. These edits shall include, but are not limited to, the following: correct Provider numbers; valid Enrollee numbers; valid procedure and diagnosis codes; and cross checks to assure Provider and Enrollee numbers match their names. The acceptable error rate of claims processing edits of the Encounter Data provided by Contractor shall be determined by the Department. Once an acceptable error rate has been achieved, as determined by the Department, Contractor shall be instructed that the testing phase is complete and that data must be sent in production. **Production.** Once Contractor's testing of data specified above is completed, Contractor will be certified for production. Once certified for production, Contractor shall continue to submit Encounter Date in accordance with these requirements. The Department will continue to review the Encounter Data for correct format and quality. Contractor shall submit as many files as necessary, in a time frame agreed upon by the Department and Contractor, to ensure all Encounter Data are current. Records that fail the edits described above will be returned to Contractor for correction. Corrected Encounter Data must be returned to the Department for reprocessing. **Electronic data certification.** In a format determined by the Department, Contractor shall certify by the 5th day of each month that all electronic data submitted during the previous calendar month are accurate, complete and true.
Disclosure statement	Initially, annually, on request, and as changes occur	No	Contractor shall submit disclosure statements as specified in 42 CFR, Part 455.
Report of transactions with Parties of Interest	Annually	No	Contractor shall report all "transactions" with a "party of interest" (as such terms are defined in Section 1903(m)(4)(A) of the Social Security Act and SMM 2087.6(A-B)), as required by Section 1903(m)(4)(A) of the Social Security Act.
Adjudicated claims inventory summary	Frequency as provided in the MCO MPR Guidelines	No	Reporting will follow the MCO Performance Reporting (MPR) Guidelines.

Name of report/submission	Frequency	HFS Prior Approval	Report description and requirements
Compliance certification	Annually, no later than July 31	No	Contractor shall submit a Certification confirming that Contractor and its subcontractors are in compliance with Section 9.2 and each subsection thereof.
Enrollee Materials			
Certificate of Coverage, Description of Coverage, and any changes or amendments	Initially and as revised	Yes	Contractor shall submit the Certificate of Coverage and Description of Coverage for Prior Approval that comply with the Managed Care Reform and Patient Rights Act (215 ILCS 134) and the Illinois Administrative Code, Title 50, Chapter 1, Subchapter kkk, Part 5421.
Enrollee Handbook	Initially and as revised	Yes	Contractor shall submit an Enrollee Handbook for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed.
Identification Card	Initially and as revised	Yes	Contractor shall submit the Enrollee identification card for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed.
Provider Directory Attestation	Monthly	No	Contractor shall submit an attestation that they have met the provider directory requirements in 305 ILCS 5/5-30.3(b)(1) and 305 ILCS 5/5 30.1(f)(2).
Fraud and Abuse			
Fraud and Abuse Referral	Immediately upon notification or knowledge of suspected Fraud and Abuse	N/A	Contractor shall report all suspected Fraud and Abuse to the Department as required in Article V and Article IX of this Contract. Contractor shall provide a preliminary investigation report as each occurrence is identified.
Fraud and Abuse Report	Quarterly	No	Contractor shall provide a summary report of referrals made and program integrity activities conducted in the previous quarter.
Recipient Verification Procedure	Initially, annually and as revised	Yes	Contractor shall submit Contractor's plan for verifying with Enrollees whether services billed by Providers were received, as required by 42 CFR 455.20, for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in information conveyed. This does not need to be provided to the Department separately by population.

Name of report/submission	Frequency	HFS Prior Approval	Report description and requirements
Recipient Verification Results	Annually and within ten (10) Business Days after the Department's request	No	Contractor shall submit a summary of the results of the Recipient Verification Procedure.
Fraud and Abuse Compliance Plan	Initially and annually	Yes	Per 42 CFR 438.608, Contractor shall submit its compliance plan designed to guard against Fraud and Abuse to the Department for Prior Approval. This does not need to be provided to the Department separately by population.
Marketing			
Marketing Gifts and Incentives	Initially and as revised	Yes	Contractor shall submit all plans to distribute gifts and incentives, as well as description of gifts and incentives, for Prior Approval.
Marketing Materials	Initially and as revised	Yes	Contractor shall submit all Marketing Materials for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed.
Marketing, Outreach and Education Plan	Annually	Yes	As described in Section 4.17.5, Contractor shall submit descriptions of proposed Marketing concepts, strategies, and procedures for Prior Approval.
Community Outreach Events	Monthly, by the last day of the reporting month	No	Contractor shall submit to the Department a list of all previously approved community outreach events that occurred during the submission month. The report must include the Event name, date, time, address/location, county, audience type, estimated number of attendees and date of Department approval.

Provider Network			
Primary care Provider, Hospital, and Affiliated Specialist File (CEB Provider File)	No less often than weekly	Yes	Contractor shall submit to the Department or its designee, in a format and medium designated by the Department, an electronic file of Contractor's PCPs, Hospitals and Affiliated Specialists. The primary care Providers must include, but not limited to, the following information: • Provider name, Provider number, office address, and telephone number; • Type of specialty (e.g., family practitioner, internist, oncologist, etc.), subspecialty if applicable, and treatment age ranges; • Identification of Group Practice, if applicable; • Geographic service area, if limited; • Areas of board-certification, if applicable; • Language(s) spoken by Provider and office staff; • Office hours and days of operation; • Special services offered to the deaf or hearing impaired (i.e., sign language, TDD/TTY, etc.); • Wheelchair accessibility status (e.g., parking, ramps, elevators, automatic doors, personal transfer assistance, etc.); • PCP indicator; • Primary care Provider gender and panel status (open or closed); and • Primary care Provider hospital affiliations, including information about where the primary care Provider has admitting privileges or admitting arrangements and delivery privileges (as appropriate).
Provider Terminations	As each occurs	No	Contractor shall submit Provider Termination reports, in a format and medium designated by the Department.
Provider Grievance-Resolution System and Procedures	Initially and as revised	Yes	Contractor shall submit details of its Provider Grievance-resolution system and related 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.
Summary of Provider Complaints and Resolutions – Summary Report	Frequency as provided in the MCO MPR Guidelines	No	Reporting will follow the MCO Performance Reporting (MPR) Guidelines.

Provider network file (complete)	Quarterly and as requested	No	Contractor shall submit to the Department or its designee, in a format and medium designated by the Department, an electronic file of Contractor's full provider network.
Pharmacy Formulary Attestation	Quarterly	No	Contractor shall submit an attestation that they have met pharmacy formulary requirements in 305 ILCS 5/5-30(b)(1).
Quality Assurance/medical			
Grievance and Appeals Procedures	Initially and as revised	Yes	Contractor shall submit Grievance and Appeals Procedures for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed.
Summary of Grievances, Appeals and Resolutions and External Independent Reviews and Resolutions – Summary Report	Frequency as provided in the MCO MPR Guidelines	No	Reporting will follow the MCO Performance Reporting (MPR) Guidelines
Quality Assurance, Utilization Review and Peer Review (QA/UR/PR) Annual Report / Program Evaluation	Annually, no later than ninety (90) days after close of reporting period identified by the Department	No	Contractor shall submit a QA/UR/PR Annual Report/Program Evaluation reviewing the effectiveness of Contractor's QAP. The summary shall contain Contractor's processes for Quality Assurance, utilization review and peer review. This report shall include a comprehensive description of Contractor's network and an annual work-plan outlining Contractor's intended activities relating to QA, utilization review, peer review and health education. Contractor may submit one report that includes all care coordination programs in which it participates; however, Contractor must clearly identify program-specific activities.
Care Management and Disease Management Program Descriptions	Initially and as revised	Yes	Contractor shall submit the descriptions of its Care Management and Disease Management programs for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed. Contractor shall identify all areas in its CM/DM program that differ among care coordination programs.
Care Coordination effectiveness Summary Report	Frequency as provided in the MCO MPR Guidelines	No	Reporting will follow the MCO Performance Reporting (MPR) Guidelines

Care Gap Plan	Annually	No	Contractor shall submit its plan for ensuring provision of services missed by Enrollees, including, but not limited to, annual preventive exams, immunizations, women's healthcare, PAP and missed services for Chronic Health Conditions and Behavioral Health follow-up. Contractor may submit one plan that includes all care coordination programs in which it participates; however, Contractor must clearly identify program-specific activities.
Outreach Summary Report	Frequency as provided in the MCO MPR Guidelines	No	Reporting will follow the MCO Performance Reporting (MPR) Guidelines
Prior Authorization Report	Frequency as provided in the MCO MPR Guidelines	No	Reporting will follow the MCO Performance Reporting (MPR) Guidelines
Quality Performance Reporting	Quarterly	No	Contractor shall submit a report that is based on the Performance Measures required by this Contract, and that may include HEDIS® measures, modified HEDIS® measures, and State defined measures. This report shall include, as requested by the Department, the numerator, denominator and rate for each measure and will display information in a manner that includes trending data, based on previous quality indicators.
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	Frequency as provided in the MCO MPR Guidelines	No	Reporting will follow the MCO Performance Reporting (MPR) Guidelines
Pharmacy			
Drug Utilization Review Report	Annual	No	Contractor shall report its prospective and retrospective Drug Utilization Review activities to the Department.
Subcontracts and Provider agreements			
Executed Subcontracts	Within ten (10) Business Days after the Department's request	N/A	Contractor shall submit copies of each executed subcontract relating to an arrangement for the provision of Covered Services, but not those subcontracts for the direct provision of Covered Services. For example, a subcontract with a behavioral health or dental administrator shall be submitted to the Department, but an agreement with a therapist or dentist providing direct care to an Enrollee need not be submitted unless otherwise required or requested by the Department.
Executed Provider Agreements	Within ten (10) Business Days after the Department's request	N/A	Contractor shall submit copies of executed Provider agreements to the Department upon request.

Model Subcontracts and Provider Agreements	Initially and annually	N/A	Contractor shall submit copies of model subcontracts and Provider agreements related to Covered Services, assignment of risk and data reporting functions, inclusive of all proposed schedules or exhibits, intended to be used therewith. Contractor shall provide the Department with any substantial revisions to, or deviations from, these model subcontracts and Provider agreements.
Value-Based Payment Arrangements	Annually	N/A	As described in Section 7.27, Contractor shall report on its progress towards enrolling its providers in arrangements that incentivize value-based care. Contractor shall submit description of each model, as well number of providers, number of members, and total spend, with a breakdown of upside-only versus upside and downside risk arrangements for each. Breakdown outlined above shall be reported by region.
Business Enterprise Program Act for Minorities, Females and Persons with Disabilities			
BEP Report	Quarterly and annually	N/A	Contractor shall submit the information required in Section 2.9 of the Contract.