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ATTACHMENT I: SERVICE PACKAGE II COVERED SERVICES

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					
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.	<p>DOA: 89 ILAdm.Code 240.1505-1590 Contract with DoA, Contract requirements,</p> <p>DRS: 89 ILAdm.Code 686.100</p>	<p>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.</p>	
Adult Day Service Transportation	x	x	x	x				<p>DOA: 89 ILAdm.Code 240.1505-1590</p> <p>DRS: 89 ILAdm.Code 686.100</p>	<p>No more than two (2) units of transportation shall be provided per Enrollee in a twenty-four (24)-hour period, and shall not include trips to a Physician, shopping, or other miscellaneous trips.</p>	
Environmental Accessibility Adaptations - Home		x	x	x			<p>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.</p> <p>Excluded are those adaptations or improvements to the home that are of general utility and are not of direct remedial benefit to the Enrollee.</p> <p>DSCC Vehicle modifications (wheelchair lifts and tie downs) are also provided under environmental modifications.</p>	<p>DRS: 89 ILAdm.Code 686.608</p> <p>DSCC: DSCC Home Care Manual, 53.20.30, (Rev.9/01) & 53.43 (Rev.9/01)</p>	<p>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.</p> <p>DSCC: All environmental modifications will be limited in scope to the minimum necessary to meet the Enrollee's medical needs.</p>	

Service	DoA		DHS-DRS		HFS Supportive Living Facility	Definition	Standards	HFS Fee-For-Service Service Limits
	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury				
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 Adm. 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 42 C.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.

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Nursing, Intermittent		x	x	x			<p>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.</p> <p>Nursing through the HCBS Waiver focuses on long-term rehabilitative 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.</p>	<p>DRS: Home Health Agency: 2.10 ILCS 55 Licensed Practical Nurse: 2.25 ILCS 65 Registered nurse: 2.25 ILCS 65</p> <p>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.</p>	
Nursing, Skilled (RN and LPN)		x	x	x			<p>Service provided by an individual that meets Illinois licensure standards for nursing services and provides shift nursing services.</p>	<p>DRS: Home Health Agency: 2.10 ILCS 55 Licensed Practical nurse: 2.25 ILCS 65 Registered nurse: 2.25 ILCS 65</p> <p>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.</p>	
Occupational Therapy		x	x	x			<p>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 rehabilitative needs rather than short-term acute restorative needs.</p>	<p>DRS: Occupational Therapist: 2.25 ILCS 75 Home Health Agency: 2.10 ILCS 55</p> <p>All HCBS Waiver clinical services require a prescription from a Physician.</p> <p>The duration and/or frequency of these services are dependent on continued authorization of the Physician, and relevance to the Enrollee's service plan.</p> <p>The amount, duration, and scope of services is based on the service plan and is included in the service cost maximum.</p>	

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	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury					
Physical Therapy		x	x	x			<p>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 rehabilitative needs rather than short-term acute restorative needs.</p>	<p>DRS: Physical Therapist 225 ILCS 90 Home Health Agency: 210 ILCS 55</p>	<p>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.</p>
Speech Therapy		x	x	x			<p>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 rehabilitation needs rather than short-term acute restorative needs.</p>	<p>DRS: Speech Therapist 225 ILCS 110 Home Health Agency: 210 ILCS 55</p>	<p>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.</p>
Prevocational Services				x			<p>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).</p>	<p>99 IL Adm. Code 530 99 il Admin Code 686.1300</p>	<p>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 rehabilitative, rather than explicit employment objectives.</p>

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	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury				
Habilitation- Day				x		<p>BI: Day habilitation assists with the acquisition, retention, or improvement in self-help, socialization, and adaptive skills, which takes place in a non-residential setting, separate from the home or facility 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 rein force skills or lessons taught in school, therapy, or other settings.</p> <p>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.</p>	<p>BI: 59 IL Adm. Code 119 IL Admin Code 686.1200</p>	<p>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.</p> <p>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.</p> <p>Services will require preauthorization by HFS and will be limited to a maximum of twelve (12) sessions per calendar year.</p>
Placement Maintenance Counseling						<p>Licensed Clinical Social Worker 225 ILCS 20 Medicaid Rehabilitation Option 59 IL Adm. Code 132 Licensed Clinical Psychologist 225 ILCS 15</p>		<p>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.</p>
Homemaker	x	x	x	x		<p>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)</p>	<p>DOA: 69 IL Adm. Code 240 DRS: 89 IL Adm. Code 686.200</p>	<p>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.</p>

Service	DHS-DRS			HFS Supportive Living Facility	Definition	Standards	HFS Fee-For-Service Service Limits
	DoA Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS				
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 2.40 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.

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Respite		x	x	x		<p>DRS: Respite services provide relief for unpaid family or primary care givers, who are currently meeting all service needs of the Enrollee.</p> <p>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.</p> <p>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.</p>	<p>Adult Day Care 89 IL Adm.Code 686.100 Home health aide 2.10 ILCS 45/3-206 RN/LPN 225 ILCS 65 Home health agency: 2.10 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</p>	<p>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.</p> <p>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.</p>
Nurse Training						<p>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.</p>	<p>DSCC Nursing agency requirements-DSCC Home Care Manual, 53.09.</p>	<p>This service cannot exceed the maximum of four (4) hours per nurse, per HCBS Waiver year.</p>
Family Training						<p>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).</p>	<p>Nursing Agency: Meet DSCC nursing agency requirements-DSCC Home Care Manual, 53.09</p> <p>Service Agency: Qualify to provide the service.</p>	<p>All Family Training must be included in the Enrollee Care Plan.</p>

Service	DoA		DHS-DRS		HFS Supportive Living Facility	Definition	Standards	HFS Fee-For-Service Service Limits
	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury				
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.	<p>DRS: 68 IL Adm. Code 1.253 Pharmacies 225.ILC.S.85 Medical Supplies 225.ILC.S.51</p> <p>DSCC: 225.ILC.S.51 If not licensed under 225 ILC.S.51, must be accredited by the Joint Commission on Accreditation of Healthcare Organizations, or other accrediting organization.</p> <p>Meet DSCC Home Medical Equipment (HME) requirements for the HCBS Waiver.</p> <p>A Medicaid enrolled pharmacy or durable medical equipment provider that provides items not available from a DSCC approved HME provider, (such as special formula).</p>	<p>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.</p> <p>DSCC: Medical supplies, equipment, and appliances are provided only on the prescription of the primary care Provider as specified in the Enrollee Care Plan.</p>
Behavioral Services (MA and PhD)						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.	<p>Speech Therapist 225 ILC.S.110/ Social Worker 225 ILC.S.20/ Clinical Psychologist 225 ILC.S.15/ Licensed Counselor 225 ILC.S.107/</p> <p>99 IL Admin Code 686.1100</p>	<p>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.</p> <p>The services are based on a clinical recommendation and are not covered under the State Plan.</p>

Service	DHS-DRS				HFS	Definition	Standards	HFS Fee-For-Service Service Limits
	DoA Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury				
Assisted Living					x	<p>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.</p> <p>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.</p>	<p>Supportive Living Facilities 89 IL Adm. Code 146 Sup Part B</p>	<p>SLFs are reimbursed through a global rate, which includes the following Covered Services:</p> <ul style="list-style-type: none"> 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					<p>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.</p>	<p>DoA: 89 IL. Adm. Code 240.237</p>	<p>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.</p>

ATTACHMENT XI: QUALITY ASSURANCE

- 1.1.1 Contractor shall establish procedures such that Contractor shall be able to demonstrate that it has an ongoing, fully implemented Quality Assurance (QA) program for health services that meets the requirements of the HMO Federal qualification regulations (42 CFR 417.106), the Medicare HMO/CMP regulations (42 CFR 417.418(c)), the Medicaid Managed Care quality assessment and performance improvement program regulations (42 CFR 438.330), and the regulations promulgated pursuant to the Balanced Budget Act of 1997 (42 CFR 438.200 et seq.). These regulations require that Contractor have an ongoing, fully implemented QA program for health services that:
 - 1.1.1.1 incorporates widely accepted practice guidelines that meet nationally recognized standards and are distributed to Network Providers, as appropriate, and to Enrollees and Potential Enrollees, upon request, and:
 - 1.1.1.1.1 are based on valid and reliable clinical evidence;
 - 1.1.1.1.2 consider the needs of Enrollees;
 - 1.1.1.1.3 are adopted in consultation with Network Providers; and
 - 1.1.1.1.4 are reviewed and updated periodically as appropriate;
 - 1.1.1.2 monitors the healthcare services Contractor provides, including assessing the appropriateness and quality of care;
 - 1.1.1.3 stresses health outcomes and monitors Enrollee risks status and improvement in health outcomes;
 - 1.1.1.4 provides a comprehensive program of Care Coordination, Care Management, and Disease Management, with needed outreach to assure appropriate care utilization and community referrals;
 - 1.1.1.5 describes its use of Care Coordination Claims Data (CCCD) files for risk stratification, risk management, Care Coordination, and Case Management of Enrollees or other uses;
 - 1.1.1.6 provides review by Physicians and other health professionals of the process followed in the provision of health services;

- 1.1.1.1.7 includes fraud control provisions;
- 1.1.1.1.8 establishes and monitors access standards;
- 1.1.1.1.9 uses systematic data collection of performance and Enrollee results, provides interpretation of these data to its Network Providers (including, without limitation, Enrollee-specific and aggregate data provided by the Department, such as HEDIS®- and State-defined measures in this Attachment XI), and institutes needed changes;
- 1.1.1.1.10 includes written procedures for taking appropriate remedial action and developing corrective action and quality improvement whenever, as determined under the Quality Assurance Program, inappropriate or substandard services have been furnished or Covered Services that should have been furnished have not been provided;
- 1.1.1.1.11 describes its implementation process for reducing unnecessary emergency room utilization and inpatient services, including thirty (30)-day readmissions;
- 1.1.1.1.12 describes its process for obtaining clinical results and findings, including emergency room and inpatient care, pharmacy information, lab results, feedback from other care providers, etc., to provide such data and information to the PCP or specialist, or others, as determined appropriate, on a real-time basis;
- 1.1.1.1.13 describes its process to assure follow-up services from inpatient care for Behavioral Health, with a Behavioral Health provider; follow up for inpatient medical care including delivery care, to assure women have access to contraception and postpartum care, or follow up after an emergency room visit;
- 1.1.1.1.14 details its process for determining and facilitating Enrollees needing nursing home or ICF/DD level of care, or to live in the community with HCBS supports;
- 1.1.1.1.15 describes its processes for addressing Abuse and Neglect and unusual incidents in the community setting;
- 1.1.1.1.16 details any compensation structure, incentives, pay-for-performance (P4P) programs, value-purchasing strategies, and other mechanisms utilized to promote the goals of Integrated Health Homes (IHHs) and accountable, coordinated care;

- 1.1.1.1.17 describes its health education procedures and materials for Enrollees; processes for training, monitoring, and holding providers accountable for health education; and oversight of Provider requirements to coordinate care and provide health education topics (e.g., childhood immunizations, well-child visits, prenatal care, obesity, heart smart activities, mental health and substance use resources) and outreach documents (e.g., about chronic conditions) using evidence-based guidelines and best-practice strategies;
- 1.1.1.1.18 describes its process for developing, implementing, and evaluating care plans for children transitioning to adulthood; and
- 1.1.1.1.19 provides for systematic activities to monitor and evaluate the dental services and Behavioral Health services rendered.
- 1.1.2 Contractor shall provide to the Department a written description of its Quality Assurance Plan (QAP) for the provision of clinical services (e.g., medical, medically related services, Behavioral Health services) and Care Coordination services (e.g., Care Management, intensive care management, perinatal care management, Disease Management). This written description must meet federal and State requirements, as outlined below
- 1.1.2.1 **Goals and objectives.** The written description shall contain a detailed set of Quality Assurance objectives that are developed annually and include a work plan and timetable for implementation and accomplishment.
- 1.1.2.2 **Scope.** The scope of the QAP shall be comprehensive, addressing both the quality of clinical care and non-clinical aspects of service such as and including availability, accessibility, coordination, and continuity of care.
- 1.1.2.3 **Methodology.** The QAP methodology shall provide for review of the entire range of care provided, by assuring that all demographic groups, care settings, (e.g., inpatient, ambulatory, home care), and types of services (e.g., preventive, primary, specialty care, Behavioral Health, dental, pharmacy, ancillary services) are included in the scope of the review. Documentation of the monitoring and evaluation plan shall be provided to the Department upon request.
- 1.1.2.4 **Activities.** The written description shall specify quality of care studies and other activities to be undertaken over a prescribed period of time, and methodologies and organizational arrangements to be used to accomplish them. Individuals responsible for the studies and other activities shall be clearly identified in the written work plan and shall be appropriately skilled or trained to undertake such tasks. The written description shall provide for continuous performance of the activities, including tracking of issues over time.

- 1.1.2.5 **Provider review.** The written description shall document how Physicians and other health professionals will be involved in reviewing quality of care and the provision of health services and how feedback to health professionals and Contractor staff regarding performance and Enrollee results will be provided.
- 1.1.2.6 **Focus on health outcomes.** The QAP methodology shall address health outcomes; a complete description of the methodology shall be fully documented and provided to the Department.
- 1.1.2.7 **Systematic process of quality assessment and improvement.** The QAP shall objectively and systematically monitor and evaluate the quality, appropriateness of, and timely access to care and service to Enrollees, and pursue opportunities for improvement on an ongoing basis. Documentation of the monitoring activities and evaluation plan shall be provided to the Department.
- 1.1.2.8 **Enrollee and advocate input.** The QAP shall detail its operational and management plan for including Enrollee and advocate input into its QAP processes.
- 1.1.3 Contractor shall provide the Department with QAP written guidelines that delineate the QA process, specifying the following:
- 1.1.3.1 **Clinical areas to be monitored.** The monitoring and evaluation of clinical care shall reflect the population served by Contractor in terms of age groups, disease categories, and special risk status, and shall include quality improvement initiatives as determined appropriate by Contractor or as required by the Department.
- The QAP shall, at a minimum, monitor and evaluate care and services in certain priority clinical areas of interest specified by the Department, based on the needs of Enrollees.
- At its discretion or as required by the Department, Contractor's QAP must monitor and evaluate other important aspects of care and service, including coordination with community resources.
- At a minimum, the following areas shall be monitored for all populations:
- 1.1.3.1.1 emergency room utilization;
 - 1.1.3.1.2 inpatient hospitalization;

- 1.1.3.1.3 thirty (30)-day readmission rate;
 - 1.1.3.1.4 assistance to Enrollees accessing services outside the Covered Services, such as housing, social service agencies, and senior centers;
 - 1.1.3.1.5 health education provided;
 - 1.1.3.1.6 coordination of primary and specialty care;
 - 1.1.3.1.7 coordination of care, Care Management, Disease Management, and other activities;
 - 1.1.3.1.8 Individualized Plan of Care (IPOC);
 - 1.1.3.1.9 utilization of dental benefits;
 - 1.1.3.1.10 utilization of Family Planning services;
 - 1.1.3.1.11 preventive healthcare for Enrollees (e.g., annual health history and physical exam; mammography; Papanicolaou test, immunizations);
 - 1.1.3.1.12 PCP or Behavioral Health follow-up after emergency room or inpatient hospitalization; and
 - 1.1.3.1.13 utilization of Behavioral Health services;
- At a minimum, the following areas shall be monitored for pregnant women:
- 1.1.3.1.14 timeliness and frequency of prenatal visits;
 - 1.1.3.1.15 postpartum care rate;
 - 1.1.3.1.16 provision of American Congress of Obstetricians and Gynecologists (ACOG) recommended prenatal screening tests;

- 1.1.3.1.17 birth outcomes;
 - 1.1.3.1.18 birth intervals;
 - 1.1.3.1.19 early elective delivery (EED) policies of contracted hospitals of delivery;
 - 1.1.3.1.20 development of reproductive life plans;
 - 1.1.3.1.21 utilization of 17P;
 - 1.1.3.1.22 referral to the Perinatal Centers, as appropriate;
 - 1.1.3.1.23 length of hospitalization for the mother;
 - 1.1.3.1.24 length of hospital stay for the infant;
 - 1.1.3.1.25 utilization of postpartum Family-Planning services, including LARC; and
 - 1.1.3.1.26 assistance to Enrollees in finding an appropriate primary care Provider/pediatrician for the infant.
- At a minimum, the following areas shall be monitored for children from birth through age twenty (20):
- 1.1.3.1.27 number of preventive and well-child visits appropriate for age;
 - 1.1.3.1.28 immunization status;
 - 1.1.3.1.29 lead screenings conducted (measured using HEDIS® Lead Screening in Children [LSC] measure or another Department-approved measure), and blood-level status;
 - 1.1.3.1.30 objective developmental screenings and evaluations conducted (measured as per guidelines in the Handbook for Providers of Healthy Kids Services);
 - 1.1.3.1.31 number of hospitalizations;

- 1.1.3.1.32 length of hospitalizations; and
- 1.1.3.1.33 medical management for a limited number of medically complicated conditions as agreed to by Contractor and Department.

At a minimum, the following areas shall be monitored for people with Chronic Health Conditions (such conditions specifically including, without limitation, diabetes, asthma, congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease, Behavioral Health, including those with one or more comorbidities):

- 1.1.3.1.34 appropriate treatment, follow-up care, and coordination of care for all Enrollees;
- 1.1.3.1.35 identification of Enrollees with special healthcare needs and processes in place to assure adequate, ongoing risk assessments, care plan developed with the Enrollee's participation in consultation with any specialists caring for the Enrollee, to the extent possible, the appropriateness and quality of care, and if approval is required, such approval occurs in a timely manner; and
- 1.1.3.1.36 care coordination, Care Management, Disease Management, and Chronic Health Conditions action plan, as appropriate.

At a minimum, the following areas shall be monitored for Behavioral Health:

- 1.1.3.1.37 Behavioral Health network adequate to serve the Behavioral Health needs of Enrollees, including mental health and substance abuse services sufficient to provide care within the community in which the Enrollee resides;
- 1.1.3.1.38 assistance sufficient to access Behavioral Health services, including but not limited to transportation and escort services;
- 1.1.3.1.39 Enrollee access to timely Behavioral Health services;
- 1.1.3.1.40 an IPoC or Service Plan and provision of appropriate level of care;
- 1.1.3.1.41 coordination of care between Providers of medical and Behavioral Health services to assure follow-up and continuity of care;

- 1.1.3.1.42 involvement of the PCP in aftercare;
 - 1.1.3.1.43 Enrollee satisfaction with access to and quality of Behavioral Health services;
 - 1.1.3.1.44 Mental Health outpatient and inpatient utilization, and follow up; and
 - 1.1.3.1.45 chemical dependency outpatient and inpatient utilization and follow up.
- At a minimum, the following areas shall be monitored for Enrollees in NFs and Enrollees receiving HCBS Waiver services:
- 1.1.3.1.46 maintenance in, or movement to, community living;
 - 1.1.3.1.47 number of hospitalizations and length of hospital stay;
 - 1.1.3.1.48 falls resulting in hospitalization;
 - 1.1.3.1.49 behavior resulting in injury to self or others;
 - 1.1.3.1.50 Enrollee non-compliance of services;
 - 1.1.3.1.51 medical errors resulting in hospitalizations; and
 - 1.1.3.1.52 Occurrences of pressure ulcers, unintended weight loss, and infections;

1.1.3.2 **Use of quality indicators.** Quality indicators are measurable variables relating to a specified clinical area, which are reviewed over a period of time to monitor the process of outcomes of care delivered in that clinical area:

- 1.1.3.2.1 Contractor shall identify and use quality indicators that are objective, measurable, and based on current knowledge and clinical experience.
- 1.1.3.2.2 Contractor shall document that methods and frequency of data collected are appropriate and sufficient to detect the need for a program change.

1.1.3.2.3 For the priority clinical areas specified by the Department, Contractor shall monitor and evaluate quality of care through studies, which address, but are not limited to, the quality indicators also specified by the Department including those specified in this attachment.

1.1.3.3 **Analysis of clinical care and related services, including Behavioral Health, Long-Term Care, and HCBS Waiver services.** Appropriate clinicians shall monitor and evaluate quality through review of individual cases where there are questions about care, and through studies analyzing patterns of clinical care and related service.

1.1.3.3.1 Multidisciplinary teams shall be used, where indicated, to analyze and address systems issues.

1.1.3.3.2 Clinical and related services requiring improvement shall be identified and documented, and a corrective action plan shall be developed and monitored.

1.1.3.4 **Performance Improvement Projects (PIPs)/Quality Improvement Projects (QIPs).** PIPs/QIPs (42 C.F.R. 438.330) shall be designed to achieve, through ongoing measurements and intervention, significant improvement of the quality of care rendered, sustained over time, and resulting in a favorable effect on health outcome and Enrollee satisfaction. Performance measurements and interventions shall be submitted to the Department annually as part of the QA/UR/PR Annual Report and at other times throughout the year upon request by the Department. If Contractor implements a PIP/QIP that spans more than one (1) year, Contractor shall report annually the status of such project and the results thus far. The PIPs/QIPs topics and methodology shall be submitted to the Department for Prior Approval.

1.1.3.5 **Implementation of remedial or corrective actions.** The QAP shall include written procedures for taking appropriate remedial action whenever, as determined under the QAP, inappropriate or substandard services are furnished, including in the area of Behavioral Health, or services that should have been furnished were not. Quality Assurance actions that result in remedial or corrective actions shall be forwarded by Contractor to the Department on a timely basis. Written remedial or corrective action procedures shall include:

1.1.3.5.1 specification of the types of problems requiring remedial or corrective action;

1.1.3.5.2 specification of the person(s) or entity responsible for making the final determinations regarding quality problems;

1.1.3.5.3 specific actions to be taken;

- 1.1.3.5.4 a provision for feedback to appropriate health professionals, providers and staff;
- 1.1.3.5.5 the schedule and accountability for implementing corrective actions;
- 1.1.3.5.6 the approach to modifying the corrective action if improvements do not occur; and
- 1.1.3.5.7 procedures for notifying a PCP group that a particular Physician is no longer eligible to provide services to Enrollees.

1.1.3.6 **Assessment of effectiveness of corrective actions.** Contractor shall monitor and evaluate corrective actions taken to assure that appropriate changes have been made. Contractor shall assure follow-up on identified issues to ensure that actions for improvement have been effective and provide documentation of the same.

1.1.3.7 **Evaluation of continuity and effectiveness of the QAP.** At least annually, Contractor shall conduct a regular examination of the scope and content of the QAP to ensure that it covers all types of services, including Behavioral Health services, in all settings, through an Executive Summary and Overview of the Quality Improvement Program, including Quality Assurance (QA), Utilization Review (UR) and Peer Review (PR).

At the end of each year (as specified in Attachment XIII), a written report on the QAP shall be prepared by Contractor and submitted to the Department as a component part of the QA/UR/PR Annual Report. The report shall include an Executive Summary that provides a high-level discussion/analysis of each area of the Annual Report of findings, accomplishments, barriers and continued need for quality improvement. The report shall, at a minimum, provide detailed analysis of each of the following:

- 1.1.3.7.1 QA/UR/PR Plan with overview of goal areas;
- 1.1.3.7.2 major initiatives to comply with the State Quality Strategy;
- 1.1.3.7.3 quality improvement and work plan monitoring;
- 1.1.3.7.4 Contractor Network Access and Availability and Service Improvements, including access and utilization of dental services;

- 1.1.3.7.5 cultural competency;
- 1.1.3.7.6 Fraud, Waste, and Abuse monitoring;
- 1.1.3.7.7 population profile;
- 1.1.3.7.8 improvements in Care Coordination/Care Management and Clinical Services/Programs;
- 1.1.3.7.9 effectiveness of Care Coordination Model of Care;
- 1.1.3.7.10 effectiveness of quality program structure;
- 1.1.3.7.11 summary of monitoring conducted pertaining to Attachment XI including issues or barriers addressed or pending remediation;
- 1.1.3.7.12 comprehensive quality improvement work plans;
- 1.1.3.7.13 Chronic Health Conditions;
- 1.1.3.7.14 Behavioral Health (includes mental health and substance use services);
- 1.1.3.7.15 dental care;
- 1.1.3.7.16 discussion of health education program;
- 1.1.3.7.17 member satisfaction;
- 1.1.3.7.18 Enrollee safety;
- 1.1.3.7.19 Fraud, Waste, and Abuse and privacy and security; and
- 1.1.3.7.20 delegation.

1.1.4 Contractor shall have a QAP Committee. Contractor shall have a governing body to which the QA Committee shall be held accountable (“Governing Body”). The Governing Body of Contractor shall be the Board of Directors or, where the Board’s participation with quality improvement issues is not direct, a designated committee of the senior management of Contractor. This Board of Directors or Governing Body shall be ultimately responsible for the execution of the QAP. However, changes to the medical Quality Assurance Program shall be made by the chair of the QA Committee. Responsibilities of the Governing Body include:

1.1.4.1 Oversight of QAP. Contractor shall document that the Governing Board has approved the overall Quality Assurance Program and an annual QAP.

1.1.4.2 Oversight entity. The Governing Board shall document that it has formally designated an accountable entity or entities within the organization to provide oversight of QA, or has formally decided to provide such oversight as a committee of the whole.

1.1.4.3 QAP progress reports. The Governing Body shall routinely receive written reports from the QAP Committee describing actions taken, progress in meeting QA objectives, and improvements made.

1.1.4.4 Annual QAP review. The Governing Body shall formally review on a periodic basis (but no less frequently than annually) a written report on the QAP which includes: studies undertaken, results, subsequent actions, and aggregate data on utilization and quantity of services rendered, to assess the QAP’s continuity, effectiveness and current acceptability. Behavioral Health shall be included in the Annual QAP Review.

1.1.4.5 Program modification. Upon receipt of regular written reports from the QAP Committee delineating actions taken and improvements made, the governing body shall take action when appropriate and direct that the operational QAP be modified on an ongoing basis to accommodate review findings and issues of concern within Contractor. This activity shall be documented in the minutes of the meetings of the governing board in sufficient detail to demonstrate that it has directed and followed up on necessary actions pertaining to Quality Assurance.

1.1.5 The QAP shall delineate an identifiable structure responsible for performing QA functions within Contractor. Contractor shall describe its committees’ structure in its QAP and shall be submitted to the Department for approval. This committee or committees and other structure(s) shall have:

1.1.5.1 Regular meetings. The QAP Committee shall meet on a regular basis with specified frequency to oversee QAP activities. This frequency shall be sufficient to demonstrate that the structure/committee is following-up on all findings and

required actions, but in no case shall such meetings be held less frequently than quarterly. A copy of the meeting summaries/minutes shall be submitted to the Department no later than thirty (30) days after the close of the quarterly reporting period.

- 1.1.5.2 Established parameters for operating. The role, structure and function of the QAP Committee shall be specified.
- 1.1.5.3 Documentation. There shall be records kept documenting the QAP Committee's activities, findings, recommendations and actions.
- 1.1.5.4 Accountability. The QAP Committee shall be accountable to the Governing Body and report to it on a scheduled basis on activities, findings, recommendations and actions.
- 1.1.5.5 Membership. There shall be meaningful participation in the QAP Committee by the Medical Director, practicing physicians, senior leadership and other appropriate personnel.
- 1.1.5.6 Enrollee advisory and community stakeholder committee. There shall be an Enrollee Advisory and Community Stakeholder Committee that will provide feedback to the QAP Committee on the Plan's performance from Enrollee and community perspectives. The committee shall recommend program enhancements based on Enrollee and community needs; review Provider and Enrollee satisfaction survey results; evaluate performance levels and telephone response timelines; evaluate access and provider feedback on issues requested by the QAP Committee; identify key program issues; such as disparities, that may impact community groups; and offer guidance on reviewing Enrollee materials and effective approaches for reaching enrollees. The Committee will be comprised of randomly selected Enrollees, family members and other caregivers, local representation from key community stakeholders such as churches, advocacy groups, and other community-based organizations. Contractor will educate Enrollees and community stakeholders about the committee through materials such as handbooks, newsletters, websites and communication events.
- 1.1.6 There shall be a designated Quality Management Coordinator as set forth in section 2.3.1.14 of the Contract. Contractor's Medical Director shall have substantial involvement in QA activities and shall be responsible for the required reports.
 - 1.1.6.1 Adequate resources. The QAP shall have sufficient material resources, and staff with the necessary education, experience, and/or training to effectively carry out its specified activities.
 - 1.1.6.2 Provider participation in the QAP.

1.1.6.2.1 Network Providers shall be kept informed about the written QAP.

1.1.6.2.2 Contractor shall include in all agreements with Network Providers and Subcontractors a requirement securing cooperation with the QAP.

1.1.6.2.3 Contracts shall specify that Network Providers and Subcontractors shall allow access to the medical records of its Enrollees to Contractor and the Department.

1.1.7 Contractor shall remain accountable for all QAP functions, even if certain functions are delegated to other entities. If Contractor delegates any QA activities to subcontractors:

1.1.7.1 There shall be a written description of the following: the delegated activities; the subcontractor's accountability for these activities; and the frequency of reporting to Contractor.

1.1.7.2 Contractor shall have written procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the actual quality of care being provided.

1.1.7.3 Contractor shall be held accountable for subcontractor's performance and must assure that all activities conform to this Contract's requirements.

1.1.7.4 There shall be evidence of continuous and ongoing evaluation and oversight of delegated activities, including approval of quality improvement plans and regular specified reports, as well as a formal review of such activities. Oversight of delegated activities must include no less than an annual audit, analyses of required reports and encounter data, a review of Enrollee complaints, grievances, Provider complaints, appeals, and quality of care concerns raised through encounter data, monitoring activities, or other venues. Outcomes of the annual audit shall be submitted to the Department as part of the QA/UR/PR Annual Report.

1.1.7.5 Contractor shall be responsible for, directly or through monitoring of delegated activities, credentialing and re-credentialing, and shall review such credentialing files performed by the delegated entity no less than annually, as part of the annual audit.

1.1.7.6 If Contractor or subcontractor identifies areas requiring improvement, Contractor and subcontractor, as appropriate, shall take corrective action and implement a quality improvement initiative. If one or more deficiencies are identified, the subcontractor must develop and implement a corrective action plan, with protections put in place by Contractor to prevent such deficiencies from recurring. Evidence of ongoing monitoring of the delegated activities sufficient to assure corrective action shall be provided to the Department through quarterly or annual reporting, or through a timeframe established by the Department with Contractor.

1.1.8 The QAP shall contain provisions to assure that Network Providers, are qualified to perform their services and are credentialed by Contractor. Contractor's written policies shall include procedures for selection and retention of Physicians and other Providers.

1.1.9 All services coordinated by Contractor shall be in accordance with Departmental policies and prevailing professional community standards. Contractor shall provide EPSDT services in conformance with the Handbook for Providers of Healthy Kids Services, including future revisions. All clinical practice guidelines shall be based on established evidence-based best practice standards of care, promulgated by leading academic and national clinical organizations, and shall be adopted by Contractor's QAP Committee with sources referenced and guidelines documented in Contractor's QAP. Contractor's QAP shall be updated no less than annually and when new significant findings or major advancements in evidence-based best practices and standards of care are established. Contractor shall provide ongoing education to Network Providers on required clinical guideline application and provide ongoing monitoring to assure that its Network Providers are utilizing them. At a minimum, clinical practice guidelines and best practice standards of care shall be adopted by Contractor for the following conditions and services at a minimum, and not necessarily limited to:

1.1.9.1 asthma;

1.1.9.2 congestive heart failure (CHF);

1.1.9.3 coronary artery disease (CAD);

1.1.9.4 chronic obstructive pulmonary disease (COPD);

1.1.9.5 diabetes;

1.1.9.6 adult preventive care;

- 1.1.9.7 EPSDT for children from birth through age 20;
- 1.1.9.8 smoking cessation;
- 1.1.9.9 Behavioral Health (Mental Health and substance use) screening, assessment, and treatment, including medication management and PCP follow-up;
- 1.1.9.10 psychotropic medication management;
- 1.1.9.11 clinical pharmacy medication review;
- 1.1.9.12 coordination of community support and services for Enrollees in HCBS Waivers;
- 1.1.9.13 dental services;
- 1.1.9.14 pharmacy services;
- 1.1.9.15 community reintegration and support;
- 1.1.9.16 Long-Term Care (LTC) residential coordination of services;
- 1.1.9.17 prenatal, obstetrical, postpartum, and reproductive healthcare; and
- 1.1.9.18 other conditions and services as deemed by Contractor and/or the Department.
- 1.1.10 Contractor shall put a basic system in place which promotes continuity of Care Management. Contractor shall provide documentation on:
 - 1.1.10.1 Monitoring the quality of care across all services and all treatment modalities.
 - 1.1.10.2 Studies, reports, protocols, standards, worksheets, minutes, or such other documentation as may be appropriate, concerning its QA activities and corrective actions and make such documentation available to the Department upon request.

1.1.11 The findings, conclusions, recommendations, actions taken, and results of the actions taken as a result of QA activity, shall be documented and reported to appropriate individuals within the organization and through the established QA channels. Contractor shall document coordination of QA activities and other management activities.

1.1.11.1 QA information shall be used in recontracting, and annual performance evaluations.

1.1.11.2 QA activities shall be coordinated with other performance monitoring activities, including utilization management, risk management, and resolution and monitoring of Enrollee complaints and grievances.

1.1.11.3 There shall be a linkage between QA and the other management functions of Contractor such as:

1.1.11.3.1 network changes;

1.1.11.3.2 benefits redesign;

1.1.11.3.3 medical management systems (e.g, precertification);

1.1.11.3.4 practice feedback to Physicians;

1.1.11.3.5 other services, such as dental, vision, pharmacy, etc.;

1.1.11.3.6 Member services;

1.1.11.3.7 care management, disease management; and

1.1.11.3.8 Enrollee education.

1.1.11.4 In the aggregate, without reference to individual Physicians/Providers or Enrollee identifying information, all Quality Assurance findings, conclusions, recommendations, actions taken, results or other documentation relative to QA shall be reported to Department on a quarterly basis or as requested by the Department. The Department shall be notified of any Provider or Subcontractor who ceases to be a Network Provider or Subcontractor for a quality of care issue.

1.1.12 Contractor shall, at the direction of the Department, cooperate with the external, independent quality review process conducted by the EQRO. Contractor shall address the findings of the external review through its Quality Assurance Program by developing and implementing performance improvement goals, objectives and activities, which shall be documented in the next quarterly report submitted by Contractor following the EQRO's findings.

1.1.13 Contractor's Quality Assurance Program shall systematically and routinely collect data to be reviewed for quality oversight, monitoring of performance, and Enrollee care outcomes. The Quality Assurance Program shall include provision for the interpretation and dissemination of such data to Contractor's Network Providers. The Quality Assurance Program shall be designed to perform quantitative and qualitative analytical activities to assess opportunities to improve efficiency, effectiveness, appropriate healthcare utilization, and Enrollee health status per 42 C.F.R. 438.242 (2). Contractor shall ensure that data received from Providers and included in reports are accurate and complete by (i) verifying the accuracy and timeliness of reported data; (ii) screening the data for completeness, logic, and consistency; and (iii) collecting service information in standardized formats to the extent feasible and appropriate. Contractor shall have in effect a program consistent with the utilization control requirements of 42 CFR Part 456. This program will include, when required by the regulations, written plans of care and certifications of need of care.

1.1.14 Contractor shall perform and report the Healthcare and Quality of Life Performance Measures identified in Attachment XI, Table 1, "Healthcare and quality of life measures," using HEDIS® and HEDIS®-like Quality Measure Specifications methodology, as provided by the Department. Contractor shall not modify the reporting specifications methodology prescribed by the Department without first obtaining the Department's written approval. Contractor must obtain an independent validation of its HEDIS® and HEDIS®-like findings by a recognized entity, e.g., NCQA-certified auditor, as approved by the Department. The Department's External Quality Review Organization will perform an independent validation of at least a sample of Contractor's findings.

1.1.15 Contractor shall perform and report the performance measures in "Table 2: Service Package II HCBS Wavier performance measures" using measure specifications methodology, as provided by the Department. Contractor shall not modify the reporting specifications methodology prescribed by the Department without first obtaining the Department's written approval.

1.1.16 Contractor shall monitor other Performance Measures as required by the Federal CMS in accordance with notification by the Department.

Table 1 to Attachment XI: Healthcare and Quality of Life Performance Measures

Acronym	Performance measure	Further description	Source
FUH	Follow-Up After Hospitalization for Mental Illness	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider.	HEDIS
FUM	Follow-Up After Emergency Department Visit for Mental Illness	The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness.	HEDIS
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD.	HEDIS
MPT	Mental Health Utilization	<p>This measure summarizes the number and percentage of members receiving the following mental health services during the measurement year:</p> <ul style="list-style-type: none"> • Inpatient • Intensive outpatient or partial hospitalization • Outpatient • ED • Telehealth • Any Service 	HEDIS

Acronym	Performance measure	Further description	Source
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	<p>The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following:</p> <ul style="list-style-type: none"> <i>Initiation of AOD Treatment.</i> The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of the diagnosis. <i>Engagement of AOD Treatment.</i> The percentage of members who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit. 	HEDIS
ADD	Follow-up Care for Children Prescribed ADHD Medications	The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed.	HEDIS
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	The percentage of children and adolescents 1-17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.	HEDIS

Acronym	Performance measure	Further description	Source
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	The percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing.	HEDIS
AMB	Ambulatory Care: ED Visits measure	This measure summarizes utilization of ambulatory care in the following category: ED Visits	HEDIS/CM S Child Core Set
WCV	Child and Adolescent Well-Care Visits (WCV)	The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	HEDIS
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents)	The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year. <ul style="list-style-type: none"> • BMI percentile documentation. • Counseling for nutrition. • Counseling for physical activity. 	HEDIS
CIS	Childhood Immunization Status	Percentage of children 2 years of age who had four DTap; three IPV; one MMR; three HiB; three HepB; one VZV; four PCV; one HepA; two or three RV; and two Flu vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.	HEDIS
IMA	Immunizations for Adolescents	The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday.	HEDIS

Acronym	Performance measure	Further description	Source
ADV	Annual Dental Visits	The percentage of members 2–20 years of age who had at least one dental visit during the measurement year.	HEDIS
	Mobile Crisis Response Services that Result in Hospitalization for Children and Adolescents	The percentage of mobile crisis response (MCR) services for members ages 0 through 20 years who had a subsequent inpatient admission within three days of the MCR service.	HFS Custom
	Emergency Department (ED) Visits that Result in an Inpatient Admission for Children and Adolescents	The percentage of ED visits for members ages 0 through 20 years with a diagnosis of mental illness or intentional self-harm, that resulted in an inpatient admission.	HFS Custom
	Inpatient Behavioral Health (BH) Utilization – Hospitalizations for Children and Adolescents	This measure summarizes the utilization of acute BH inpatient care and services for members ages 0 through 20 years reported as: Inpatient BH Utilization Average Length of Stay	HFS Custom
	Repeat Behavioral Health Hospitalizations for Children and Adolescents	The number and percentage of repeat BH hospitalizations for members ages 0 through 20 years during the measurement period.	HFS Custom

ATTACHMENT XII: UTILIZATION REVIEW AND PEER REVIEW

- 1.1.1 Contractor shall have a utilization review and peer review committee(s) whose purpose will be to review data gathered and the appropriateness and quality of care. The committee(s) shall review and make recommendations for changes when problem areas are identified and report suspected Fraud and Abuse in the HFS Medical Program to the Department's Office of Inspector General. The committees shall keep minutes of all meetings, the results of each review and any appropriate action taken. A copy of the minutes shall be submitted to the Department as needed, and within ten (10) Business Days after the Department's request. At a minimum, these programs must meet all applicable federal and State requirements for utilization review. Contractor and the Department may further define these programs.
- 1.1.2 Contractor shall implement a Utilization Review Plan, including medical, behavioral health and dental peer review as required. Contractor shall provide the Department with documentation of its utilization review process. The process shall include:
- 1.1.2.1 **Written program description.** Contractor shall have a written Utilization Management Program description which includes, at a minimum, procedures to evaluate medical and behavioral health necessity criteria used and the process used to review and approve the provision of medical and behavioral health services.
 - 1.1.2.2 **Scope.** The program shall have mechanisms to detect under-utilization as well as over-utilization.
 - 1.1.2.3 **Preauthorization and concurrent review requirements.** For organizations with preauthorization and concurrent review programs:
 - 1.1.2.3.1 Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions;
 - 1.1.2.3.2 Utilize practice guidelines that have been adopted, pursuant to Attachment XI.
 - 1.1.2.3.3 Review decisions shall be supervised by qualified medical, behavioral health or dental professionals and any decision to deny a Service Authorization Request or to authorize a service in an amount, duration or scope that is less than requested must be made by a qualified professional who has appropriate clinical expertise in treating the Enrollee's condition or disease;
 - 1.1.2.3.4 Efforts shall be made to obtain all necessary information, including pertinent clinical information, and consultation with the treating Provider, as appropriate;

- 1.1.2.3.5 The reasons for decisions shall be clearly documented and available to the Enrollee and the requesting Provider, provided, however, that any decision to deny a service request or to authorize a service in an amount, duration or scope that is less than requested shall be furnished in writing to the Enrollee;
- 1.1.2.3.6 There shall be written well-publicized and readily available Appeal mechanisms for both Providers and Enrollees;
- 1.1.2.3.7 Decisions and appeals shall be made in a timely manner as required by the circumstances and shall be made in accordance with the timeframes specified in this Contract for standard and expedited authorizations;
- 1.1.2.3.8 There shall be mechanisms to evaluate the effects of the program using data on Enrollee satisfaction, Provider satisfaction or other appropriate measures;
- 1.1.2.3.9 If Contractor delegates responsibility for utilization management, it shall have mechanisms to ensure that these standards are met by the subcontractor.
- 1.1.3 Contractor further agrees to review the utilization review procedures, at regular intervals, but no less frequently than annually, for the purpose of amending same, as necessary in order to improve said procedures. All amendments must receive Prior Approval. Contractor further agrees to supply the Department and its designee with the utilization information and data, and reports prescribed in its approved utilization review system or the status of such system. This information shall be furnished in accordance to Attachment XIII of this Contract or upon request by the Department.
- 1.1.4 Contractor shall establish and maintain a peer review program, subject to Prior Approval, to review the quality of care being offered by Contractor, employees, and subcontractors. This program shall provide, at a minimum, the following:
 - 1.1.4.1 A peer review committee comprised of Physicians, behavioral health professionals and dentists, formed to organize and proceed with the required reviews for both the health professionals of Contractor's staff and any Affiliated Providers which include:
 - 1.1.4.1.1 a regular schedule for review;
 - 1.1.4.1.2 a system to evaluate the process and methods by which care is given; and
 - 1.1.4.1.3 a medical record review process.

- 1.1.4.2 Contractor shall maintain records of the actions taken by the peer review committee with respect to Providers and those records shall be available to the Department upon request.
- 1.1.4.3 A system of internal review, including medical, behavioral health, dental, waiver and long-term care services, medical evaluation studies, peer review, a system for evaluating the processes and outcomes of care, health education, systems for correcting deficiencies, and utilization review.
- 1.1.4.4 At least two (2) clinical evaluation studies must be completed annually that analyze pressing problems identified by Contractor, the results of such studies and appropriate action taken. One of the studies may address an administrative problem noted by Contractor and one may address a clinical (e.g, medical, behavioral health, or dental care) problem or diagnostic category. One brief follow-up study shall take place for each medical evaluation study in order to assess the actual effect of any action taken. Contractor's clinical evaluation studies' topic and design must receive Prior Approval.
- 1.1.4.5 Contractor shall participate in the annual collaborative PIPS/QIPs, as mutually agreed upon and directed by the Department.
- 1.1.5 Contractor further agrees to review the peer review procedures, at regular intervals, but no less frequently than annually, for the purpose of amending same in order to improve said procedures. All amendments must be approved by the Department. Contractor shall supply the Department and its designee with the information and reports related to its peer review program upon request.
- 1.1.6 The Department may request that peer review be initiated on specific Providers.
- 1.1.7 The Department may conduct its own peer reviews at its discretion.

ATTACHMENT XIV: DATA SECURITY AND CONNECTIVITY SPECIFICATIONS

For all information systems that transmit, store, or access Protected Health Information:

- 1.1.1 Contractor shall:
- 1.1.1.1 Establish an information security program in accordance with the Federal Information Security Management Act (FISMA), and follow the National Institute for Standards and Technology (NIST) Guidelines of the NIST Risk Management Framework (RMF), as amended. Contractor shall implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications, or other requirements of this subpart, taking into account those factors specified in 45 CFR §164.306(b)(2)(i), (ii), (iii), and (iv) [the Security Standards: General Rules, Flexibility of Approach]. This standard is not to be construed to permit or excuse an action that violates any other standard, implementation specification, or other requirements of this subpart. A covered entity may change its policies and procedures at any time, provided that the changes are documented and are implemented in accordance with this subpart.
 - 1.1.1.2 Assess, review, and evaluate the information systems based upon security categorization and classification in accordance with Federal Information Processing Standards (FIPS) Publication 199 Standards for Security Categorization of Federal Information and Information Systems and FIPS Publication 200, Minimum Security Requirements for Federal Information and Information Systems. Additional guidance on defining the information type can be obtained from NIST SP 800-60 Revision 1 Volume I and II.
 - 1.1.1.3 Select the baseline controls described in FIPS 200 and NIST SP 800-53 to develop a System Security Plan (SSP). Contractor must develop a SSP, in accordance with Section A.2 of this Attachment XIV, using the guidance from NIST RMF (NIST SP 800-18) to establish an information security program in accordance with the FISMA and demonstrate compliance.
 - 1.1.1.4 Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the system and the information processed that it creates, receives, maintains, or transmits based on NIST SP 800-66 Revision 1, An Introductory Resource Guide for Implementing the Health Insurance Portability and Accountability Act (HIPAA) Security Rule.
 - 1.1.1.5 Perform continuous monitoring of the system in compliance with NIST SP 800-137.

- 1.1.1.6 Implement four specifications with the Access Controls, unique user identification (required), automatic logoff (addressable), and encryption and decryption (addressable), which provides users with rights and/or privileges to access and perform functions using information systems, applications, programs, or files. Access controls shall enable authorized users to access the minimum necessary information needed to perform job functions. Rights and/or privileges shall be granted to authorized users based on a set of access rules that the covered entity is required to implement as part of 45 CFR §164.308(a)(4), the Information Access Management standard under the Administrative Safeguards section of the HIPPA Security Rule.
- 1.1.1.7 Implement audit controls that allow Contractor to adhere to policy and procedures developed to comply with the required implementation specification at 45 CFR §164.308(a)(1)(ii)(D) for Information System Activity review.
- 1.1.1.8 Implement policies and procedures to protect electronic protected health information from improper alteration or destruction. Integrity is defined in the HIPPA Security Rule, at 45 CFR §164.304, as “the property that data or information have not been altered or destroyed in an unauthorized manner.” Protecting the integrity of EPHI is a primary goal of the Security Rule.

1.1.2 System Security Plan (SSP).

- 1.1.2.1 The SSP developed by Contractor shall including the following:
 - 1.1.2.1.1 The requirements traceability matrix (RTM) cross-referenced to the specific system design function that meets each requirement related to system security;
 - 1.1.2.1.2 A description of how the system is to be compliant with all the Federal and State laws regarding the security and privacy of personally identifiable information and Protected Health Information, including but not limited to 45 CFR 95.62; 45 CFR Parts 164, Subparts C and E; 1902(a)(7) of the Social Security Act; and 42 CFR 431.300-307;
 - 1.1.2.1.3 A description of the process Contractor will use to report security Breach incidents, regardless of severity or loss of actual data, to HFS within four (4) hours;
 - 1.1.2.1.4 A description of measures to secure data and software;
 - 1.1.2.1.5 A description of how data are encrypted in transit and in storage;
 - 1.1.2.1.6 A description of physical and equipment security measures;

- 1.1.2.1.7 A description of personnel security;
 - 1.1.2.1.8 A description of software used for security;
 - 1.1.2.1.9 A description of the user roles and the access capabilities of each role;
 - 1.1.2.1.10 A description of how users are assigned certain roles;
 - 1.1.2.1.11 An identification of the staff responsible for controlling the system security;
 - 1.1.2.1.12 A description of contingency security procedures during a disaster recovery event;
 - 1.1.2.1.13 A description of how Contractor works with HFS to conduct an annual security review;
 - 1.1.2.1.14 Password security; and
 - 1.1.2.1.15 Audit trails for all data access.
- 1.1.2.2 The Department shall have to right to review the SSP. If the Department finds deficiencies in the SSP, the Department, at its sole discretion, may deny Contractor access to Department systems or data until Contractor corrects the deficiencies in the SSP, as determined by the Department.
- 1.1.3 Contractor will be responsible for all costs associated with identity theft resulting from a security Breach.

1.2 CONNECTIVITY SPECIFICATIONS

- 1.2.1 **Internet connection.** The connection to the DoIT Data Center must be through a secure connection via the Internet. A secure connection over the Internet will require a Site-to-Site Virtual Private Network (VPN) or the use of TLS Session depending upon the communication requirements. Many compliance mandates reference NIST standards, including PCI, HIPAA, FIPS, Common Criteria, and so on. NIST SP 800-52 rev 1 provides updated guidance on secure TLS configurations and recommends migration to TLS 1.2. Implement technical security measures to guard against unauthorized access to electronic protected health information that is being transmitted over an electronic communications network. This standard has two (2) implementation specifications: integrity controls (addressable) and encryption (addressable). The encryption implementation specification is addressable, similar to the addressable implementation specification at 45 CFR §164.312(a)(2)(iv), which addresses encryption and decryption.

- 1.2.2 **Internet Site-to-Site VPN Requirements.** Contractor will be responsible for the cost of the connection between Contractor and its Internet Service Provider (ISP), troubleshooting and any redundancy requirements associated with Contractor's connection to the Internet or for Disaster recovery. Contractor shall procure, install, and support any VPN equipment required at Contractor's location to support secure Site-to-Site VPN communications via the Internet with DoIT. HFS will coordinate with Contractor to ensure that any authorization/certificate paperwork required for the establishment of the VPN connection is completed. Please note that DoIT can only accept public assigned IP ranges from Contractor (No RFC-1918 addresses).
- 1.2.3 **Internet TLS Requirements for File Transfer Protocol.** If Contractor's only communication requirement is to send or receive data files, the connection may be made using secure FTP (FTPS) via the Internet. Contractor will be responsible for the cost of the connection between Contractor and its Internet Service Provider (ISP), troubleshooting and any redundancy requirements associated with Contractor's connection to the Internet or for Disaster recovery. Contractor is responsible for any costs associated with obtaining a secure FTP client that supports TLS. Contractor will be responsible for initiating the secure FTP sessions to the DoIT Data Center and performing any necessary firewall changes to reach the provided IP address and ftp control and data ports.
- 1.2.4 **Exchanging Configuration Information.** HFS will work with Contractor to determine the configuration and define any connection parameters between Contractor and the DoIT Data Center. This will include any security requirements DoIT requires for the specific connection type Contractor is using. Contractor shall work with both HFS and DoIT in exchanging configuration information required to make the connection secure and functional for all parties.
- 1.2.5 **Transmission Control Protocol/Internet Protocol (TCP/IP).** Contractor shall cooperate in the coordination of the interface with DoIT and HFS. TCP/IP (Transmission Control Protocol/Internet Protocol) must be used for all connections from Contractor to the DoIT Data Center.
- 1.2.6 **Firewall devices.** Contractor shall be responsible for the installation, configuration, and troubleshooting of any firewall devices required on Contractor's side of the data communication link.

ATTACHMENT XVI: QUALIFICATIONS AND TRAINING REQUIREMENTS OF CERTAIN CARE COORDINATORS AND OTHER CARE PROFESSIONALS

1.1 QUALIFICATIONS OF CERTAIN CARE COORDINATORS

1.1.1 Persons with Disabilities Waiver. Care Coordinators must meet one (1) of the nine (9) following requirements:

- 1.1.1.1 Registered Nurse (RN)
- 1.1.1.2 Licensed clinical social worker (LCSW)
- 1.1.1.3 Licensed marriage and family therapist (LMFT)
- 1.1.1.4 Licensed clinical professional counselor (LCPC)
- 1.1.1.5 Licensed professional counselor (LPC)
- 1.1.1.6 Doctorate of Philosophy (PhD)
- 1.1.1.7 Doctorate in psychology (PsyD)
- 1.1.1.8 Bachelor or master's degree prepared in human-services related field
- 1.1.1.9 Licensed practical nurse (LPN)

1.1.2 Persons with Brain Injury Waiver. Care Coordinators must meet one (1) of the seven (7) following requirements:

- 1.1.2.1 Registered nurse (RN) licensed in Illinois
- 1.1.2.2 Certified or licensed social worker
- 1.1.2.3 Unlicensed social worker: minimum of bachelor's degree in social work, social sciences, or counseling
- 1.1.2.4 Vocational specialist: certified rehabilitation counselor or at least three (3) years' experience working with people with disabilities

1.1.2.5 Licensed clinical professional counselor (LCPC)

1.1.2.6 Licensed professional counselor (LPC)

1.1.2.7 Certified case manager (CCM)

1.1.3 **Persons with HIV/AIDS HCBS Waiver.** Care Coordinators must meet one (1) of the three (3) following requirements:

1.1.3.1 A Registered nurse (RN) licensed in Illinois and a bachelor's degree in nursing, social work, social sciences or counseling, or four (4) years of case management experience.

1.1.3.2 A social worker with a bachelor's degree in either social work, social sciences, or counseling (A bachelor's of social work or a masters of social work from a school accredited by any organization nationally recognized for the accreditation of schools of social work is preferred).

1.1.3.3 Individual with a bachelor's degree in a human-services field with a minimum of five (5) years of case management experience.

In addition, it is mandatory that the Care Coordinator for Enrollees within the Persons with HIV/AIDS HCBS Waiver have experience working with:

1.1.3.4 Addictive and dysfunctional family systems

1.1.3.5 Racial and ethnic minorities

1.1.3.6 Homosexuals and bisexuals

1.1.3.7 Persons with AIDS, and

1.1.3.8 Substance abusers

1.1.4 **High-Needs Children.**

1.1.4.1 Care Coordinators must meet the following requirements:

1.1.4.1.1 Bachelor's degree in nursing, social sciences, social work, or related field

1.1.4.1.2 One (1) year of supervised clinical experience in a human-services field

1.1.4.2 Care Coordinator supervisors must meet the following requirements:

1.1.4.2.1 Master's degree in nursing, social sciences, social work, or related field

1.1.4.2.2 No fewer than three (3) years of supervised experience in a human-services field

1.1.4.3 Contractor must employ at least one (1) certified trainer in IM-CANS.

1.1.4.4 Care Coordinator qualifications for High-Needs Children apply to all Enrollees in the DCFS Youth Managed Care Specialty Plan.

1.2 QUALIFICATIONS FOR OTHER HEALTHCARE PROFESSIONAL ROLES

1.2.1 **Mental health professional (MHP)** shall have the same definition as the Medical Rehabilitation Option (MRO) Section of the Illinois State Plan, including any amendments or modifications after the Effective Date. As of the Effective Date, the Illinois State MRO defines MHP as: a practical nurse licensed pursuant to the Illinois Nursing and Advanced Practice Nursing Act [225 ILCS 65]; an individual possessing a certificate of psychiatric rehabilitation from a DHS-approved program, plus a high school diploma or GED, plus two (2) years' experience in providing mental health services; a Certified Recovery Support Specialist (CRSS) in good standing with the Illinois Alcohol and Other Drug Abuse Professional Certification Association, Inc.; a Certified Family Partnership Professional (CFPP) in good standing with the Illinois Alcohol and Other Drug Abuse Professional Certification Association, Inc.; a licensed occupational therapy assistant with at least one (1) year of experience in a mental health setting; an individual with a high school diploma or GED and a minimum of five (5) years supervised clinical experience in mental health or human services; any individual employed as an MHP prior to July 1, 2013 may continue to be so designated unless employment changes. In addition, an MHP is an individual possessing a bachelor's degree in counseling and guidance, rehabilitation counseling, social work, education, vocational counseling, psychology, pastoral counseling, family therapy, or related human-service field; or a bachelor's degree in any other field with two (2) years of supervised clinical experience under a (qualified mental health professional (QMHP) in a mental health setting.

1.2.2 **Qualified mental health professional (QMHP)** shall have the same definition as the Medical Rehabilitation Option (MRO) Section of the Illinois State Plan, including any amendments or modifications after the Effective Date. As of the Effective Date, the Illinois State MRO defines QMHP as: a registered nurse licensed pursuant to the Illinois Nursing and Advanced Practice Nursing Act [225 ILCS 65] with at least one (1) year of clinical experience in a mental health setting or master's degree in

psychiatric nursing; an occupational therapist licensed pursuant to the Illinois Occupational Therapy Practice Act [225 ILCS 75] with at least one (1) year of clinical experience in a mental health setting who meets the requirements and qualifications in 42 CFR 440.110; licensed social worker (LSW); and, licensed professional counselor (LCP). A QMHP also means an individual possessing a master's or doctoral degree in counseling and guidance, rehabilitation counseling, social work, psychology, pastoral counseling, family therapy, or a related field, and who has a) successfully completed a practicum or internship that includes one thousand [1,000] hours, or b) one (1) year of clinical experience under the supervision of a Licensed Practitioner of the Healing Arts (LPHA).

1.3 TRAINING REQUIREMENTS OF CERTAIN CARE COORDINATORS

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

1.3.1.1 Persons with Brain Injury Waiver.

1.3.1.1.1 Training relevant to the provision of services to persons with brain injuries

1.3.1.2 Persons with HIV/AIDS Waiver.

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

1.3.1.3 High-Needs Children.

1.3.1.3.1 All Care Coordinators must attend introductory Wraparound and System of Care trainings offered by the Department's approved training resource and any follow-up training modules developed and made available by the State.

1.3.2 Care Coordinators for the DCFS Youth Managed Care Specialty Plan shall be familiar with DCFS required assessments for DCFS Youth in Care and the DCFS team-based decision-making process. Contractor shall train Care Coordinators in various aspects of the Illinois child welfare system to include trauma informed care, the psychotropic consent process, Illinois Medicaid Child

and Adolescent Needs and Strengths (IM-CANS), motivational interviewing, and other relevant information that receives the Department's Prior Approval.

1.4 TRAINING FUNCTIONS NOT OTHERWISE REFERENCED

- 1.4.1 Contractor shall make available to all Network Providers its trauma screening toolkit within thirty (30) days of the Effective Date. Contractor may periodically update or revise the contents of the trauma screening toolkit. As of the Contract Addendum Effective Date, the trauma screening toolkit includes, but is not limited to:
- Trauma Events Screening Inventory Child Report Form Revised (TESI-CRF-R);
 - Child PTSD Symptom Scale for DSM 5 (CPSS5);
 - Mood and Feeling Questionnaire (MFQ);
 - Center for Epidemiological Studies Depression Scale for Children (CES-DC);
 - Screening for Anxiety and Related Emotional Disorders (SCARED); and
 - NCTSN Child Welfare Referral Tool (CWRT).
- 1.4.2 On an annual basis, Contractor shall offer training in trauma informed care to all Network Providers. Training material content and format must receive Prior Approval from the Department.

ATTACHMENT XIX

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ATTACHMENT XXI: REQUIRED MINIMUM STANDARDS OF CARE

1. SCOPE

Contractor shall provide or arrange to provide to all Enrollees a list of Covered Services and locations serving the Contracting Area that assure timely availability and accessibility.

2. IMPLEMENTATION

Contractor will implement written and verbal methods to notify and inform Enrollees of the need for and benefits of evidence-based initial and periodic health screenings and physical examinations. Contractor will provide or arrange to provide in a timely manner all such examinations to its Enrollees.

3. COVERED SERVICES

All Covered Services provided by or arranged to be provided by Contractor shall be in accordance with current Department policies and prevailing professional community standards. All clinical practice guidelines shall be based on established, evidence-based, best-practice standards of care, either required by federal and State statutes (including IL Public Act 099-0433 relating to breast cancer diagnosis and care), Center for Medicare and Medicaid Services (CMS) rules, guidance and conditions of federal match, or promulgated by the United States Preventive Services Task Force (USPSTF), the *Handbook for Providers of Healthy Kids Services* issued by the Department, the CDC recommended immunizations, leading academic and national clinical and specialty based organizations, and shall be adopted by Contractor's Quality Assessment and Performance (QAP) Committee with sources referenced and guidelines documented in Contractor's QAP plan. When there is conflict between clinical practice guidelines, standards or recommendations issued by above entities, Contractor will look to the Department for direction or clarification, and absent that, will have the option to adopt any one of those with appropriate documentation in Contractor's QAP plan. Contractor shall provide ongoing education to Network Providers on required clinical guideline application and provide ongoing monitoring to assure that its Network Providers are utilizing them. Minimum Covered Services include:

- 3.1.1 **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services to Enrollees under the age of twenty-one (21).** All Enrollees under twenty-one (21) years of age shall receive screening services inclusive of a comprehensive health history; developmental history (including assessment of both physical and mental health development); a comprehensive physical exam (with clothes off when clinically appropriate); laboratory tests (including blood lead level assessment); health education; vision screening and necessary follow-up services; dental screening and necessary follow-up services; hearing screening and necessary follow-up services; other necessary healthcare, diagnostic services, treatment, and other measures to

ameliorate defects, physical, and mental illnesses and conditions identified; and appropriate childhood immunizations at intervals specified by the Early Periodic Screening Diagnosis and Treatment (EPSDT) Program as set forth in §§1902(a)(43) and 1905(a)(4)(B) of the Social Security Act and 89 Ill. Adm. Code 140.485. Contractor shall provide EPSDT services in conformance with the *Handbook for Providers of Healthy Kids Services*, which can be found on Illinois.gov/hfs under the *Medical Provider Handbooks* section, including future revisions.

- 3.1.1.1 Contractor shall employ strategies to ensure that Child Enrollees receive comprehensive child health services, initially and per the Department's recommended periodicity schedule or more frequently, as needed, and shall perform Provider training to ensure that best-practice guidelines are followed in relation to well-child services and to meet acute and Chronic Health Condition care needs. Immunizations will be administered according to the latest annual update of the CDC's *Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger, UNITED STATES*, which can be found on cdc.gov, under the *Vaccines and Immunizations* section.
- 3.1.1.2 Contractor shall inform eligible families of scheduled health (when an EPSTD visit is coming due and needs to be scheduled, or when a visit scheduled long in advance is forthcoming), vision, hearing, and dental screening periods. The child's parent, designated legal guardian, or adult caretaker, if applicable, shall receive notification of the next scheduled health, vision, hearing, and dental screening periods not less than ten (10) working days before the date on which the screening period begins as determined by the child's birthday, the periodicity schedule, and the date of the child's eligibility for services.
- 3.1.1.3 Any condition discovered during the screening examination or screening test requiring further diagnostic study, referral, or treatment must be provided if within the scope of Covered Services. Contractor shall refer the Enrollee to an appropriate source of care for any required services that are not Covered Services. If, as a result of EPSDT services, Contractor determines an Enrollee is in need of services that are not Covered Services but are services otherwise provided for under the HFS Medical Program, Contractor will ensure that the Enrollee is referred to an appropriate source of care. Contractor shall have no obligation to pay for services that are not Covered Services, however, appropriate referral for necessary care remains Contractor's responsibility.
- 3.1.1.4 Contractor shall, at least annually, inform Enrollees about the EPSDT program, including but not limited to the following: the importance of preventive healthcare; the services that are available; how to request assistance in identifying a willing and qualified Network Provider; how to request assistance in obtaining transportation to and from healthcare appointments; and that the services are available at no cost to an eligible recipient, except as may be limited by a spenddown requirement.

- 3.1.1.4.1 Contractor shall inform eligible families by mail or e-communication (e.g., e-mail) within sixty (60) calendar days after the Effective Enrollment Date and thereafter at least annually using a combination of written and oral methods of communication.
- 3.1.1.5 Contractor shall inform pregnant women about the availability of EPSDT services for children under age twenty-one (21), including children eligible as newborns.
- 3.1.1.6 Contractor shall assist pregnant women and new mothers, or their legal guardians, to enroll their newborns in Medicaid and to identify a PCP for the newborn. It is suggested that plans use HFS Form 4691 as an educational tool, but plans may use other means, including direct assistance, to help in enrollment.
- 3.1.2 **Preventive medicine schedule (services to Enrollees age twenty-one [21] years or older).** Contractor shall ensure that a complete health history and physical examination is provided to each Enrollee initially within the first twelve (12) months of his or her Effective Enrollment Date. Thereafter, for Enrollees from the age of twenty-one to sixty-four (21-64), Contractor shall ensure that a complete health history and physical examination is conducted every one to three (1-3) years, as indicated by Enrollee's assessed needs and clinical care guidelines. For Enrollees age sixty-five (65) or older, Contractor shall ensure that a complete health history and physical examination is conducted annually.
- For purposes of this section, a "complete health history and physical examination" shall include, at a minimum, the following health services regardless of age and gender of each Enrollee:
- 3.1.2.1 initial and interval history, including past medical and surgical history of each Enrollee, history of allergies, an updated list of medications used (prescribed and over the counter), and a family medical history;
- 3.1.2.2 height and weight measurement for body mass index (BMI) calculation;
- 3.1.2.3 blood pressure, temperature, and pulse rate measurement;
- 3.1.2.4 nutrition and physical activity assessment and counseling;
- 3.1.2.5 assessment of social and economic determinants of health: housing, transportation availability, and employment;
- 3.1.2.6 screening for alcohol, tobacco, marijuana, opioids, and other substance use, intimate partner violence, and depression screening and counseling;
- 3.1.2.7 counseling for advanced directives (living will and healthcare power of attorney) and collection of those documents, if

available;

3.1.2.8 verification of contact information for medical follow up when necessary such as postal address, e-mail, and phone number (landline, mobile, and alternate number for a family member if unable to reach patient directly); and

3.1.2.9 health promotion and anticipatory guidance, as clinically appropriate.

Any known condition or condition discovered during the complete health history and physical examination requiring further Medically Necessary diagnostic study, specialty consultation, or treatment and follow up must be provided if within the scope of Covered Services. However, appropriate referral for further Medically Necessary care remains Contractor's responsibility, even when those services are not Covered Services.

For preventive services, the Department minimally requires coverage of the *United States Preventive Services Task Force (USPSTF) A and B Recommendations*, which are updated periodically (see Appendix I and II below) and can be found on uspreventiveservicestaskforce.org, under the *Recommendations* section.

The USPSTF grade definitions can be found on uspreventiveservicestaskforce.org, under the *Public Comments and Nominations* section.

Additional preventive services may be recommended based on a higher-than-average risk patient, clinical judgment of the practitioner, or alternative guidelines issued by leading academic and national clinical and specialty-based organizations, and included in Contractor's QAP plan, with appropriate qualifiers described above in item number three (3), Covered Services.

Immunizations will be administered according to the latest annual update of the CDC's *Recommended Immunization Schedule for Adults Aged 19 Years or Older, United States*, which can be found on cdc.gov, under the *Vaccines and Immunizations* section. In addition to following the USPSTF recommendations A and B, which include those for breast cancer and BRCA screening, Contractor will assure compliance with IL statute, PA 99-0433.

3.1.3 Family Planning and reproductive healthcare. Contractor shall ensure provision of the full spectrum of Family Planning options and reproductive health services within the practitioner's scope of practice and demonstrated competence. Contractor shall follow federal and State laws regarding minor consents and confidentiality. Family Planning and reproductive health services are defined as those services offered, arranged, or furnished for the purpose of preventing an unintended pregnancy or to improve maternal health and birth outcomes. Contractor must ensure that nationally recognized standards of care and guidelines for sexual and reproductive health are followed, and drugs and devices are prescribed or placed in accordance with guidance from the USPSTF, Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA) in its

approved product information label (also called PI or package insert) or the American College of Obstetricians and Gynecologists (ACOG). Compliance with the requirements of the Affordable Care Act, and other applicable federal and State statutes is also required.

Contractor policies shall not present barriers or restrictions to access to care, such as prior authorizations or step-failure therapy requirements. Contractor shall cover and offer all Food and Drug Administration (FDA)–approved birth control methods with education and counseling on the safest and most effective methods, if clinically appropriate for a particular patient.

Contractor shall provide education and counseling for the following Family Planning and reproductive health services and offer clinically safe and appropriate services, drugs, and devices:

- 3.1.3.1 a reproductive life plan, which may include a preconception care risk assessment (see HFS Form 27, *Preconception Screening Checklist*, which can be found on Illinois.gov/hfs under the *Medical Programs Forums* section) and preconception and interconception care discussions;
- 3.1.3.2 all safe, effective and clinically appropriate contraceptive methods, with emphasis on the most effective methods first, and encourage use of long-acting reversible contraceptives (LARCS), such as IUDs and implants when clinically appropriate, and consistent with FDA approved product information label;
- 3.1.3.3 contraceptive methods must also include over-the-counter and prescription emergency contraception, if indicated;
- 3.1.3.4 permanent methods of birth control, including tubal ligation, transcervical sterilization, and vasectomy, if clinically appropriate and desired by the patient;
- 3.1.3.5 basic infertility counseling, consisting of medical/sexual history review and fertility awareness education, if indicated. (Infertility medications and procedures are not Covered Services.);
- 3.1.3.6 reproductive health exam if medically necessary to determine safety and provision of contraception;
- 3.1.3.7 sexually transmitted infection (STI) screenings in accordance with USPSTF A and B recommendations;
- 3.1.3.8 universal HIV testing, counseling, and screening in accordance with USPSTF A and B recommendations;
- 3.1.3.9 lab and screening tests that are clinically necessary for safe and prudent delivery of Family Planning and reproductive health services;

- 3.1.3.10 Cervical, breast and other cancer screening in accordance with USPSTFs A and B recommendations
- 3.1.3.11 vaccines for preventable reproductive health in accordance with current CDC recommended immunization schedule, updated annually;
- 3.1.3.12 genetic counseling and testing, if clinically indicated;
- 3.1.3.13 maternity care: Contractor shall demonstrate capability for provision of evidence-based, timely care for pregnant Enrollees. At a minimum, Contractor shall provide the following services:
 - 3.1.3.13.1 a comprehensive prenatal evaluation, examination, testing, and care in accordance with the latest standards recommended by ACOG, USPSTF and other leading academic and national clinical or specialty based organizations, which shall include: ongoing risk assessment and development of an Individualized Plan of Care (IPoC) most likely to result in a successful outcome of pregnancy and a healthy baby, and takes into consideration the medical, psychosocial, cultural/linguistic, and educational needs of the Enrollee and her family;
 - 3.1.3.13.2 Contractor shall have systems and protocols in place to handle regular appointments; early prenatal care appointments; after-hours care with emergency appointment slots; a seamless process for timely transmittal of prenatal records to the delivering facility; and a Provider Network for social services support, and specialty care referrals including those for complex maternal and fetal health, genetic, emotional and Behavioral Health consultations, if indicated. Contractor must refer all pregnant Enrollees to the Women, Infants, and Children's (WIC) Supplemental Nutrition Program and have or be linked to case management services for identified high-risk Enrollees. Contractor must demonstrate ability to provide equally high-quality obstetrical care to special populations such as adolescents, homeless women, and women with developmental or intellectual disabilities;
 - 3.1.3.13.3 specific areas to be addressed by Contractor in collaboration with network practitioners and Enrollees regarding the provision of prenatal care include but are not limited to the following items:
 - 3.1.3.13.3.1 risk detection by appropriate inquiry, testing and consultation if necessary, counseling and treatment if indicated for: various chronic medical conditions including hypertension and diabetes mellitus; STI/HIV; intimate partner violence; teratogen exposure; alcohol, tobacco, and substance use including prescription opioids and marijuana; and, to prevent when possible, potential of preeclampsia and eclampsia, a stillbirth, prematurity, low birth weight, fetal alcohol

syndrome, and neonatal abstinence syndrome among other issues. Contractor must put in place and be able to demonstrate that various evidence based strategies and interventions (including 17 P and referral to substance use, alcohol and tobacco abstinence programs, when indicated) to reduce adverse maternal and birth outcomes are operational;

- 3.1.3.13.3.2 screening for diagnosing, and treating depression before, during, and after pregnancy with a standard screening tool (refer to the *Handbook for Providers of Healthy Kids Services* for a list of approved screening tools);
- 3.1.3.13.3.3 health maintenance promotion, with attention to nutrition, exercise, dental care, CDC recommended immunizations, management of current Chronic Health Conditions, over-the-counter and prescription medication, breastfeeding counseling, appropriate weight gain in pregnancy, obesity counseling, signs and symptoms of common pregnancy ailments and management of the same, and provision of appropriate maternal education and support, including training classes to help with childbirth, breastfeeding, and various other helpful maternity education tools, platforms and materials;
- 3.1.3.13.3.4 routine laboratory screening per ACOG and USPSTF recommendations, physical exam, and dating by ultrasound for accurate gestational age. Every prenatal exam at a minimum should include weight and blood pressure check, fetal growth assessment, and fetal heart rate check. Genetic screening and counseling, if indicated, should be offered depending on risk factors (Enrollee's age, previous birth history, medical/family history, and ethnic background); and
- 3.1.3.13.3.5 visits close to the third (3rd) trimester should include labor preparation, education regarding preeclampsia, warning signs of miscarriage, fetal movements/kick count, preterm labor and labor, options for intrapartum care, including options for anesthesia, breastfeeding encouragement, postpartum Family Planning for selection of most appropriate and safe contraceptive method with informed consent obtained prior to labor and delivery when indicated, circumcision, newborn care, car seat, sudden infant death syndrome (SIDS), the importance of waiting at least thirty-nine (39) weeks to deliver unless medical necessity or safety of mother and fetus dictates otherwise, referral to parenting classes and WIC, and transition of maternal healthcare after the postpartum visit. Contractor shall have all protocols in place to facilitate appropriate continuity of care after the current pregnancy;

- 3.1.3.13.4 Contractor shall assure, and provide a plan to the Department, for provision of early identification of high-risk pregnancies and, if clinically indicated, ability to arrange for evaluation by a maternal fetal medicine specialist or transfer to Level III perinatal facilities in accordance with ACOG guidelines and the Illinois Perinatal Act requirements. Risk-appropriate care shall be ongoing during the perinatal period;
- 3.1.3.13.5 Contractor shall require that all contracted hospitals and birthing centers have policies in place that safely reduce c-sections and early elective deliveries (EED). Contractor shall enable Enrollees to receive timely and evidence-based postpartum care. At a minimum, Contractor shall provide and document the following services:
- 3.1.3.13.5.1 postpartum visits, in accordance with the Department's approved schedule, to assess and provide education on areas such as perineum care, breastfeeding/feeding practices, nutrition, exercise, immunization, sexual activity, effective Family Planning, pregnancy intervals, physical activity, SIDS, and the importance of ongoing well-woman care, and referral to parenting classes, maternity education tools, platforms and materials and WIC;
- 3.1.3.13.5.2 postpartum depression screening during the one (1)-year period after delivery to identify high-risk mothers who have an acute or long-term history of depression, using an HFS-approved screening tool (refer to the *Handbook for Providers of Healthy Kids Services* for a list of approved screening tools). After delivery and discharge, the Enrollee shall have a mechanism to readily communicate with her health team and not be limited to a single six (6)-week postpartum visit;
- 3.1.3.13.5.3 Contractor must continue to engage the Enrollee in health promotion and Chronic Health Condition maintenance by supporting the postpartum mother with seamless referrals, if Medically Necessary, to avoid interruption of care;
- 3.1.3.13.5.4 Contractor shall assure that Enrollees are transitioned to a medical home for ongoing well-woman care, as needed. After the postpartum period, Contractor shall identify and closely follow Enrollees who delivered and who are at risk of or diagnosed with diabetes, hypertension, heart disease, depression, alcohol, tobacco or other substance use, obesity, or renal disease; and
- 3.1.3.13.5.5 Contractor shall provide or arrange for interconception care management services for identified high-risk women for twenty-four (24) months following delivery;
- 3.1.3.14 Well-woman exam: Contractor shall ensure provision of evidence-based annual well-woman care to female Enrollees,

which will include preconception care, interconception care, and reproductive life planning.

3.1.3.14.1 At a minimum, Contractor shall provide and document an annual exam that includes ACOG and USPSTF recommended screening, counseling, evaluation, education, and age appropriate CDC recommended immunizations. Anticipatory guidance related to reproductive health issues, Family Planning and management of identified chronic diseases must be addressed.

3.1.3.14.2 Appropriate referrals should be made to support services including WIC, interconception core management, and classes that enhance pregnancy, labor and delivery and parenting experiences and outcomes.

3.1.3.14.3 A routine pelvic exam should be performed when clinically and age appropriate.

3.1.3.14.4 Cervical and breast screening per USPSTF A and B recommendations.

Refer to the Department's Provider notices relating to Family Planning and reproductive healthcare as they become available.

3.1.3.15 complex and serious medical conditions: Contractor shall provide or arrange to provide high quality care for Enrollees with complex and serious medical conditions. At a minimum, Contractor shall provide and document the following:

3.1.3.15.1 timely identification of Enrollees with complex and serious medical conditions;

3.1.3.15.2 assessment of such conditions and identification of appropriate medical procedures necessary for optimal monitoring, treatment, and early identification and management of complications; and

3.1.3.15.3 A chronic care action plan that is clinically based and developed in conjunction with the Enrollee. A copy of this chronic care action plan shall be provided to the Enrollee, members of the healthcare team including specialty consultants and assigned Care Coordinator.

3.1.3.16 Contractor shall have procedures in place to identify Enrollees with special healthcare needs to identify any ongoing special conditions that require a course of treatment or regular monitoring including indicated examinations and tests. Appropriate healthcare professionals, acting within the scope of their licenses or certifications, shall make these assessments. Such procedures must be delineated in Contractor's QAP plan, and ongoing monitoring shall occur in compliance with Attachment XI sections 3.a.iv(b) and (c) ("For pregnant women" and "For children, ages birth through twenty [20]", respectively).

3.1.3.17 Contractor shall have procedures and specialty networks in place to enable Enrollees with special healthcare needs, as defined by HFS and specified in its quality strategy, and assure direct access to a specialist as appropriate for each Enrollee's condition and identified needs.

3.1.4 **Coordination with other service providers.** Contractor shall encourage Network Providers and Subcontractors to cooperate and communicate with other service providers who serve Enrollees. Such other service providers may include WIC programs, Head Start programs, Early Intervention programs, day care programs, and school systems, among others. Such cooperation may include performing annual health examinations for school and the sharing of information (with the consent of the Enrollee, parent or legal guardian, if the Enrollee is underage). Annual health examinations for school include an age-appropriate developmental screening, and an age-appropriate social and emotional screening, as required by Public Act 99-927.

Contractor shall coordinate with the Family Case Management (FCM) and Better Birth Outcomes (BBO) programs, which shall include, but is not limited to:

- 3.1.4.1 coordinating services and sharing information with existing FCM/BBO providers for its Enrollees;
- 3.1.4.2 developing internal policies, procedures, and protocols for the organization and its provider network for use with FCM/BBO Providers serving Enrollees; and
- 3.1.4.3 conducting periodic meetings with FCM/BBO Providers performing problem resolution and handling of Grievances and issues, including policy review and technical assistance.

ATTACHMENT XXII: CHILDREN'S BEHAVIORAL HEALTH SERVICE REQUIREMENTS

1.1 ATTACHMENT XXII CONSTRUCTION

1.1.1 Contractor acknowledges that for the purposes of this Attachment XXII, "Enrollee" shall be defined as a Child (see Section 1.1.32) who is enrolled with Contractor.

1.2 COMPLIANCE WITH THE CHILDREN'S MENTAL HEALTH ACT

1.2.1 Contractor shall ensure that all Enrollees potentially requiring psychiatric inpatient hospitalization, acute care, or subacute care in a Psychiatric Residential Treatment Facility (PRTF), are screened, prior to admission, for the viability of stabilization in the community, as required by the Children's Mental Health Act of 2003 (405 ILCS 49/1 *et seq.*).

1.3 CHILDREN'S BEHAVIORAL HEALTH PROGRAM DESIGN

1.3.1 Contractor acknowledges that the State is committed to a child's physical health and Behavioral Health, as well as to providing support to families that is based upon the values and principles of quality wraparound (e.g., National Wraparound Implementation Center (NWIC)), Systems of Care, and the program design outlined in this attachment. Contractor agrees to design its delivery systems consistently with these values and principles.

1.3.2 Family Driven Care.

1.3.2.1 Family Driven Care Plan.

1.3.2.1.1 Contractor shall establish a Family Driven Care Plan, focused on establishing opportunities for Enrollees and families to provide Contractor with input and feedback regarding its service delivery system. Contractor shall submit its initial Family Driven Care Plan to the Department for review and approval ninety (90) days prior to the Effective Enrollment Date of the first Enrollee. Contractor shall thereafter annually update its Family Driven Care Plan and submit it to the Department for review and approval by no later than the anniversary of the Effective Date. The Family Driven Care Plan shall, at a minimum:

1.3.2.1.1.1 Address how Contractor will establish and maintain a service delivery system that is person and family centric;

- 1.3.2.1.1.2 Address how Contractor will promote and ensure family and Enrollee input across all of the Contracting Area;
 - 1.3.2.1.1.3 State the annual goals, objectives, and activities Contractor will complete related to family and youth driven care; and
 - 1.3.2.1.1.4 Establish the role of the Family Leadership Council (FLC) in the Family Driven Care Plan. Contractor shall ensure that the FLC reviews and provides official comment on the Family Driven Care Plan prior to Contractor submitting the Family Driven Care Plan for review and approval by the Department.
- 1.3.2.2 Family Leadership Council.
- 1.3.2.2.1 Contractors shall establish an FLC to create opportunities to engage families directly regarding issues in Children's Behavioral Health within ninety (90) days after the Effective Enrollment Date of the first Enrollee.
 - 1.3.2.2.2 Contractor shall establish, through its FLC, a mechanism for providing Contractor with a direct Enrollee feedback loop. The FLC shall not be used to review the needs of each individual Enrollee.
 - 1.3.2.2.3 The FLC shall be co-chaired by a young adult, or the parent or guardian of a young adult, with lived experience within at least one of the public child-serving systems (e.g., mental health, child welfare, and education) and a member of Contractor's leadership team with the authority to speak to program design and issues.
 - 1.3.2.2.4 Contractor shall ensure that the FLC membership is comprised of, at a minimum of fifty-one percent (51%), Enrollees or parents/guardians of Enrollees from across the Contracting Area who have lived experience with the public child-serving systems.
 - 1.1.1.8.1 1.3.2.2.5 Contractor shall seek to include representatives from across the Contracting Area in the FLC's membership, ensuring the FLC is reflective of the Contractor's enrolled membership.
 - 1.3.2.2.6 Contractor shall ensure Children's Behavioral Health is a component of the broader managed care Community Stakeholder Council, under section 5.40.8 of the Contract.

1.3.3 Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM-CANS).

- 1.3.3.1 Contractor shall ensure the utilization of the IM-CANS, as defined or selected by the Department, as the standardized mental health assessment and treatment plan for all Enrollees requiring mental health services.
- 1.3.3.2 Contractor shall ensure the completion of the IM-CANS on all Enrollees who require mental health services within the timelines established by the Department.
- 1.3.3.3 Contractor shall provide the Department with data related to the IM-CANS on an ongoing basis, in a manner established by the Department.

1.4 MOBILE CRISIS RESPONSE SERVICES

- 1.4.1 Contractor acknowledges the existence of the State-funded Screening, Assessment, and Support Services (SASS) Program, cooperatively administered by the Department of Children and Family Services (DCFS), the DHS Division of Mental Health, and the Department.
- 1.4.2 Contractor shall establish a dedicated Behavioral Health Crisis line for Enrollees, family members of Enrollees, or other concerned parties seeking to refer the Enrollee to Behavioral Health Crisis services.
 - 1.4.2.1 Contractor shall ensure that Contractor's Crisis line shall not require callers to navigate a telephonic menu in order to make a referral for Crisis services.
 - 1.4.2.2 Contractor shall ensure that the Crisis line is answered by staff who are:
 - 1.4.2.2.1 Capable of addressing a Behavioral Health Crisis upon direct answer;
 - 1.4.2.2.2 Knowledgeable and authorized to engage Contractor's Mobile Crisis Response system; and
 - 1.4.2.2.3 Knowledgeable about Contractor's Disease Management Model for Children's Mental Health.
- 1.4.3 Contractor shall ensure the availability of Mobile Crisis Response Services, including a face-to-face crisis screening within ninety (90) minutes of notification, to all Enrollees experiencing a Behavioral Health Crisis.
- 1.4.4 Contractor shall ensure that Mobile Crisis Response services are available every day of the year and twenty-four (24) hours per day.
- 1.4.5 Contractor shall inform the Enrollees and families of all Enrollees how to seek Mobile Crisis Response Services with

Contractor's Network Providers.

1.4.6 Contractor shall require, as a provision of its Provider agreement with Network Providers of Mobile Crisis Response services, that staff responsible for providing the services hold the following credentials:

1.4.6.1 Mental Health Professional (MHP) with direct access to a Qualified Mental Health professional (QMHP);

1.4.6.2 Qualified Mental Health Professional; or

1.4.6.3 Licensed Practitioner of the Healing Arts.

1.4.7 Contractor shall require the utilization of the prevailing Illinois decision support tool, the Illinois Medicaid Childhood Severity of Psychiatric Illness (IM-CSPI) or any State-defined successor, for all face-to-face mobile Crisis screening.

1.4.7.1 Contractor shall report clinical IM-CSPI data, in a manner defined by the Department, for all Enrollees receiving Mobile Crisis Response services.

1.4.8 Contractor shall make available the details of its Mobile Crisis service model to the Department as required in Attachment XI, "Quality Assurance." As a component of the QA/UR/PR Annual Report, Contractor shall provide a report relating to the previous State Fiscal Year on its Mobile Crisis Response service model to the Department, in a format developed by the Department that includes a detailed report of utilization, outcomes, and hospitalization rates.

1.5 MOBILE CRISIS SERVICE DISPOSITION

1.5.1 **Community Stabilization.** Contractor shall require Network Providers responsible for providing Mobile Crisis Response services to provide immediate Crisis and Stabilization services when an Enrollee in Crisis can be stabilized in the community.

1.5.1.1 Contractor shall require its Network Providers responsible for providing Mobile Crisis Response services to establish a Crisis Safety Plan unique to the Enrollee and circumstances that includes concrete interventions and techniques that will assist in ameliorating the circumstances leading to the Crisis situation.

1.5.1.2 Contractor's Mobile Crisis Response Services shall include policies defining the delivery of Crisis and stabilization services, which shall not require Contractor's prior authorization, for an established period of time post-Crisis that shall not be less than thirty (30) days.

1.5.1.3 Contractor shall require, in lieu of utilizing the publicly funded Crisis and Referral Entry Service (CARES) line service

(Attachment XXII, section 10 below), Network Providers responsible for providing Mobile Crisis Response services to provide the Enrollee's family with contact information that may be used at any time, twenty-four (24) hours a day, to contact Contractor's Mobile Crisis Response system in moments of Crisis.

1.5.1.4 Contractor shall include within its network of Network Providers the necessary levels of care, with sufficient intensity, required to meet the needs of Enrollees in order to provide true alternatives to institutions (e.g., PRTFs and hospitals) when clinically appropriate.

1.5.2 **Crisis Safety Plan development.** Contractor shall require its Network Providers responsible for providing Mobile Crisis Response services to:

- 1.5.2.1 Create a Crisis Safety Plan for all Enrollees that present in Behavioral Health Crisis, in collaboration with the Enrollee and the Enrollee's family;
- 1.5.2.2 Provide Enrollees and families of Enrollees with physical copies of the Crisis Safety Plans consistent with the following timelines:
 - 1.5.2.2.1 Prior to the completion of the Crisis screening as provided in Attachment XXII, section 9(b) for any Enrollee stabilized in the community; and
 - 1.5.2.2.2 Prior to the Enrollee's discharge from an inpatient psychiatric hospital setting for any Enrollee that is admitted to such a facility.
- 1.5.2.3 Educate and orient the Enrollee's family to the components of the Crisis Safety Plan, to ensure that the plan is reviewed with the family regularly, and to detail how the plan is updated as necessary; and
- 1.5.2.4 Share the Crisis Safety Plan with all necessary medical professionals, including Care Coordinators, consistent with the authorizations established by consent or release.
- 1.5.2.5 If an Enrollee experiences a Crisis event, Contractor shall convene a ICT meeting for the Enrollee within fourteen (14) days after the event if the Enrollee is community stabilized and within fourteen (14) days after discharge if the Enrollee is hospitalized.
- 1.5.2.6 Contractor shall ensure that the Enrollee has a scheduled appointment with a Behavioral Health Provider and the Enrollee's primary care Provider or psychiatric resource within thirty (30) days after the Enrollee's discharge from hospitalization.

1.5.2.7 When Contractor receives notification from DCFS that an Enrollee in Contractor's plan has been designated a Youth at Risk, Contractor will involve DCFS on the Enrollee's ICT.

- 1.5.3 **Inpatient institutional treatment.** Contractor shall require its Network Providers responsible for providing Mobile Crisis Response Services to facilitate the Enrollee's admission to an appropriate inpatient institutional treatment setting when the Enrollee in Crisis cannot be stabilized in the community.
- 1.5.3.1 Contractor shall require its Network Providers responsible for providing Mobile Crisis Response services to inform the Enrollee's parents, guardian, caregivers, or residential staff about all of the available Network Providers and any pertinent policies needed to allow the involved parties to select an appropriate inpatient institutional treatment setting.
- 1.5.3.2 Contractor shall arrange for the necessary transportation when an Enrollee requires transportation assistance to be admitted to an appropriate inpatient institutional treatment setting.
- 1.5.3.3 Contractor shall require its inpatient psychiatric Network Providers to administer a physical examination to the Enrollee within twenty-four (24) hours after admission when an Enrollee requires admission to an appropriate inpatient institutional treatment setting.
- 1.5.3.4 Contractor shall provide and have documented procedures for its Network Providers regarding discharge and transitional planning, consistent with the following:
- 1.5.3.4.1 Planning shall begin upon admission;
 - 1.5.3.4.2 Community-based Providers responsible for providing service upon the Enrollee's discharge shall participate in all inpatient staffing by phone, videoconference, or in person;
 - 1.5.3.4.3 The Enrollee's Care Coordinator shall notify the Enrollee's family and caregiver of key dates and events related to the admission, staffing, discharge, and transition of the Enrollee, and he or she shall make every effort to involve the Enrollee and the Enrollee's family and caregiver in decisions related to these processes;
 - 1.5.3.4.4 The Enrollee's Care Coordinator shall speak directly with the Enrollee at least once each week;
 - 1.5.3.4.5 The Enrollee's Care Coordinator or Network Provider shall educate and train the Enrollee's family on how

to use the Crisis Safety Plan while the Enrollee is receiving inpatient institutional treatment; and

1.5.3.4.6 The Enrollee's Care Coordinator shall participate in and oversee staffing, discharge, and transition processes.

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

1.5.3.6 Contractor shall coordinate all necessary follow-up appointments and referrals for the Enrollee upon transition back into the community. Appointments shall be established prior to discharge to ensure continuity across care providers.

1.5.4 Psychiatric resource and pharmacological services.

1.5.4.1 For all Enrollees referred for Mobile Crisis Response services, Contractor shall facilitate priority access to a psychiatric resource to provide consultation and medication management services, as medically necessary, within the following timeframes:

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

1.5.4.1.2 Within three (3) calendar days after the date of the Crisis event for an Enrollee for whom community-based services were put in place in lieu of psychiatric hospitalization.

1.5.4.2 Contractor shall have procedures for communicating to the Enrollee's PCP the psychiatric resource and medication efforts performed as part of Mobile Crisis Response service, consistent with all consents and releases.

1.5.4.3 Contractor shall attempt to supplement the psychiatric resources available through its network with tele-psychiatry services. Tele-psychiatry services may include identifying available psychiatric resources and enhancing access outside the Coverage Area by connecting such resources to the Coverage Area or utilizing resources within the Coverage Area more efficiently by making such resources available to more rural Enrollees via electronic means. All tele-health services must be delivered consistent with the rules on tele-health established by HFS.

1.6 INTERFACE WITH ILLINOIS CRISIS AND REFERRAL ENTRY SERVICE (CARES)

1.6.1 Contractor acknowledges the existence of the State-funded Crisis and Referral Entry Service (CARES) cooperatively

administered by DCFS, the DHS Division of Mental Health, and the Department.

- 1.6.2 Contractor acknowledges that the Department shall issue the CARES per call rate annually.
- 1.6.3 Contractor shall provide CARES with the details of its Mobile Crisis Response System, including the telephone numbers needed to access its Crisis response team.
- 1.6.4 If an Enrollee seeks Crisis intervention service outside of Contractor's Mobile Crisis Response service system and a Crisis call is routed to CARES for a Crisis referral, Contractor shall reimburse CARES at the annual CARES per call rate.
 - 1.6.4.1 Contractor shall accept invoices from CARES on a monthly basis.
 - 1.6.4.2 Contractor shall remit payment to CARES within forty-five (45) days after receiving an invoice for Crisis referral services.
- 1.6.5 Contractor shall have provisions in the Provider agreements of its Network Providers responsible for providing Mobile Crisis Response services for CARES to authorize and dispatch Mobile Crisis Response services, which shall be reimbursed by Contractor.
 - 1.6.5.1 In the event that CARES is unable to dispatch Contractor's Mobile Crisis Response service, CARES shall engage the fee-for-service SASS Program to ensure Crisis response to the Enrollee.
 - 1.6.5.2 In the event that an Enrollee is screened, due to necessity, by a Non-Network Provider of SASS services, Contractor shall pay for the screening at the Medicaid rate.
- 1.6.6 Contractor shall notify CARES of any changes to its contact numbers before any known changes or updates are made. When changes are necessary due to urgent or emergent circumstances, Contractor shall notify CARES as soon as possible.

1.7 DISCHARGE PLANNING AND TRANSITIONAL SERVICES

- 1.7.1 Contractor shall provide Enrollees with access to discharge planning and transitional services when being discharged from higher levels of care to lower levels or community-based services. Contractor shall work with the involved parties to facilitate appropriate follow-up services, including the scheduling of follow-up treatment appointments.
- 1.7.2 Contractor shall require the Care Coordinator to retain accountability and responsibility for the Enrollee as the transition between levels of care occurs.

- 1.7.3 Contractor shall encourage the Enrollee and the Enrollee's family to contact the Enrollee's Care Coordinator whenever a biological, psychological, or social intervention is required or requested. Contractor shall ensure that the entry and exit from any level of care is managed effectively, efficiently, and, when possible and appropriate, within Contractor's Provider Network.
- 1.7.4 Contractor shall establish and implement procedures for Enrollees to obtain access to non-Network Providers and to facilitate the timely provision of necessary and appropriate records to those non-Network Providers.
- 1.7.5 Contractor shall provide oversight regarding admissions and discharge dates for the Enrollees. This oversight shall include facilitating the link between the institutional-based care Providers and Contractor's Care Coordinators. Contractor shall initiate follow-up care within seven (7) days after discharge from higher levels of care (e.g., hospital, PRTF, residential, and Crisis respite), and provide oversight that appropriate levels of services are being provided.
- 1.7.6 Contractor shall develop, implement, and follow a procedure to confirm that a medication management review has been completed prior to discharge from higher levels of care (e.g., hospital, PRTF, residential, and Crisis respite); to confirm that PCPs are made aware of any medications that have been prescribed for Enrollees during treatment at an institutional setting; and to confirm with the Enrollees that they have the ability to get prescribed medications.
- 1.7.7 Contractor shall communicate directly with the Enrollee or Enrollee's family within forty-eight (48) hours after transition and shall see the Enrollee in person in the Enrollee's home, or another location as mutually agreed by the Enrollee or the Enrollee's family and Contractor, within seven (7) days after the discharge from higher levels of care (e.g., hospital, PRTF, residential, and Crisis respite).
- 1.7.8 Contractor shall assist the Enrollee in attending all post-discharge appointments for follow-up care. Contractor shall provide appropriate care management based on concurrent assessment for an appropriate period of time following discharge, involving other parties (e.g. Mobile Crisis Response provider, DCFS caseworker) in the care management as necessary.
- 1.7.9 Contractor shall include a provision in its contracts or other agreements with its hospitals and Network Providers to notify Contractor or the Mobile Crisis Response team, as appropriate, at least twenty-four (24) hours in advance of any discharge from inpatient hospital stays, including psychiatric hospital stays.
- 1.7.10 Upon discharge, Contractor shall monitor and manage the Enrollee's care as necessary.