

STATE OF ILLINOIS

CONTRACT

between the

DEPARTMENT OF HEALTHCARE
AND FAMILY SERVICES

and

[MCO]

for

Furnishing Health Services by a Managed Care Organization

2018-24-001

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***ADDENDUM #1:
IMMIGRANT ADULTS & IMMIGRANT SENIORS POPULATIONS*** **360**

THIS CONTRACT FOR FURNISHING HEALTH SERVICES (Contract), made pursuant to Section 5-11 of the Illinois Public Aid Code (305 ILCS 5/5-11), is by and between the **Illinois Department of Healthcare and Family Services** (HFS or Department) and **[MCO]** (Contractor), which certifies that it is a Managed Care Organization (MCO) known as **[MCO]** and whose principal office is located at **[MCO]**.

RECITALS

WHEREAS, Contractor: 1) is a Health Maintenance Organization (HMO) operating pursuant to a certificate of authority issued by the Illinois Department of Financial and Professional Regulation; OR 2) is a Managed Care Community Network (MCCN) operating pursuant to a certificate of authority issued by the Illinois Department of Healthcare and Family Services; AND 3) wishes to provide Covered Services (as defined herein) to Potential Enrollees (as defined herein); and

WHEREAS, the Department, pursuant to the laws of the State of Illinois, provides for medical assistance under the HFS Medical Program to Participants (as defined herein) wherein Potential Enrollees may enroll with Contractor to receive Covered Services; and

WHEREAS, Contractor warrants that it is able to provide or arrange to provide the Covered Services set forth in this Contract to Enrollees under the terms and conditions set forth herein;

NOW, THEREFORE, in consideration of the mutual covenants and promises contained herein, the Parties agree as follows:

INTRODUCTION

The Department and Contractor enter into this Contract in order to deliver integrated and quality managed care to Enrollees, supporting Seniors, Persons with a Disability, Families and Children, Special Needs Children, and adults qualifying for the HFS Medical Program under the Affordable Care Act (ACA Adults).

ARTICLE I: DEFINITIONS AND ACRONYMS

The following terms and acronyms as used in this Contract and the attachments, exhibits, addenda, and amendments hereto shall be construed and interpreted as follows, unless the context otherwise expressly requires a different construction or interpretation:

1.1 DEFINITIONS

- 1.1.1 **820 Payment File** means the electronic HIPAA transaction that Contractor retrieves from the Department that identifies each Enrollee for whom payment was made by the Department to Contractor.
- 1.1.2 **834 Audit File** means the electronic HIPAA transaction that Contractor retrieves monthly from the Department that reflects its Enrollees for the following calendar month.
- 1.1.3 **834 Daily File** means the electronic HIPAA transaction that Contractor retrieves from the Department each day that reflects changes in enrollment after the previous 834 Audit File.
- 1.1.4 **837D File** means the electronic HIPAA transaction that Contractor transfers to the Department that identifies healthcare claims for dental claims or Encounters.
- 1.1.5 **837I File** means the electronic HIPAA transaction that Contractor transfers to the Department that identifies healthcare claims for institutional claims and Encounters.
- 1.1.6 **837P File** means the electronic HIPAA transaction that Contractor transfers to the Department that identifies healthcare claims for professional claims and Encounters.
- 1.1.7 **Abuse** means:
- 1.1.7.1 a manner of operation that results in excessive or unreasonable costs to federal or State healthcare programs, generally used in conjunction with "Fraud" and "Waste"; or
 - 1.1.7.2 the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish (42 CFR §488.301), generally used in conjunction with "Neglect."
- 1.1.8 **Activities of Daily Living (ADL)** means activities such as eating, bathing, grooming, dressing, transferring, and continence.
- 1.1.9 **Administrative Allowance** means that portion of the Capitation allocated by

the Department for the administrative cost of the Contract. Both care management and healthcare quality initiatives shall be considered part of the Administrative Allowance for rating purposes.

- 1.1.10 **Admission, Discharge, and Transfer (ADT) System** means a system that holds Enrollee information and shares it with healthcare Providers, facilities, and systems to which it is connected. An ADT system may send ADT messages to alert of an Enrollee's admission to a hospital or healthcare facility.
- 1.1.11 **Administrative Rules** means the sections of the Illinois administrative code that govern the HFS Medical Program.
- 1.1.12 **Advance Directives** means an individual's written directives or instructions, such as a power of attorney for healthcare or a living will, for the provision of that individual's healthcare if the individual is unable to make his or her healthcare wishes known.
- 1.1.13 **Advanced Practice Nurse (APN)** means a Provider of medical and preventive services—including certified nurse midwives, certified family nurse practitioners, and certified pediatric nurse practitioners—who is licensed as an APN, holds a valid license in Illinois, is legally authorized under statute or rule to provide services, and is enrolled with the Department and employed by or contracted with Contractor.
- 1.1.14 **Adverse Benefit Determination** means:
- 1.1.14.1 the denial or limitation of authorization of a requested service;
 - 1.1.14.2 the reduction, suspension, or termination of a previously authorized service;
 - 1.1.14.3 the denial of payment for a service, not including a denial solely because the claim does not meet the definition of a "clean claim" at 42 CFR §447.45(b);
 - 1.1.14.4 the failure to provide services in a timely manner;
 - 1.1.14.5 the failure to respond to an Appeal or Grievance in a timely manner;
 - 1.1.14.6 solely with respect to an MCO that is the only Contractor serving a Rural Area, the denial of an Enrollee's request to obtain services beyond the travel time and distance standards established for an Enrollee who lives in a Rural Area as set forth in section 5.8.1.1; or,
 - 1.1.14.7 the denial of an Enrollee's request to dispute a financial liability, including cost sharing.
- 1.1.15 **Affiliate** means any individual, firm, corporation (including service corporation and professional corporation), partnership (including, without

limitation, general partnership, limited partnership, and limited liability partnership), limited liability company, joint venture, business trust, association, or other Contractor that now or in the future directly or indirectly controls, is controlled by, or is under common control with Contractor.

- 1.1.16 **Affordable Care Act Adult (ACA Adult)** means a Participant eligible for HFS Medical Programs through the ACA as of January 1, 2014, and pursuant to 305 ILCS 5/5-2(18).
- 1.1.17 **Anniversary Date** means the annual date of an Enrollee's initial enrollment in Contractor's Plan. For example, if an Enrollee's Effective Enrollment Date in Contractor's Plan is October 1, 2018, the Anniversary Date with that Contractor would be each October 1 thereafter.
- 1.1.18 **Appeal** means a request for review of a decision made by Contractor with respect to an Adverse Benefit Determination.
- 1.1.19 **Authorized Person(s)** means the Department's Office of Inspector General, the Medicaid Fraud Control Unit of the Illinois State Police, DHHS, the Illinois Auditor General, and other State and federal agencies with monitoring authority related to Medicaid Program and SCHIP.
- 1.1.20 **Behavioral Health** means conditions related to emotional wellness, trauma, mental disorders and substance use disorders and the services and supports found within the network of providers, or otherwise developed by the Contractor, specifically encompassing the prevention, identification, treatment and provision of recovery support for such conditions for the expressed purpose of increasing the stability of the Enrollee's functioning levels across various life domains.
- 1.1.21 **Behavioral Health Crisis** means an individual's significant mental reaction to an event which cannot be addressed by customary community and mental health services. May also be referred to as "Crisis."
- 1.1.22 **Business Day(s)** means Monday through Friday, 8:00 a.m. to 5:00 p.m. Central Time and including state holidays except for New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, and Christmas Day.
- 1.1.23 **Capitation** means the reimbursement arrangement in which a fixed rate of payment per Enrollee per month is made, regardless of whether the Enrollee receives Covered Services in that month, to Contractor for the performance of all of Contractor's duties and responsibilities pursuant to the Contract.
- 1.1.24 **Care Coordination** means the deliberate organization of Enrollee care activities by an individual or entity formally designated as primarily responsible for coordinating services furnished by Network Providers, community-based services providers and other providers involved in an

Enrollee's care.

- 1.1.25 **Care Coordination Claims Data (CCCD)** means the data set available to Department care coordination partners for recipients enrolled in their programs. CCCD contains the most recent two (2) years of Medical Programs claims data, the most recent seven (7) years of immunization and lead data and monthly updates of the above once the initial historical data have been sent.
- 1.1.26 **Care Coordinator** means an employee or subcontractor of Contractor who works with Enrollees and Providers to coordinate care needs for the Enrollee and ensure the IPoC is carried out and, through interaction with Network Providers, ensures the Enrollee receives necessary services.
- 1.1.27 **Care Management** means services that assist Enrollees in gaining access to needed services, including physical health, Behavioral Health, LTSS, social, educational, and other services, regardless of the funding source for the services.
- 1.1.28 **Case** means individuals who have been grouped together and assigned a common identification number by the Department or DHS, where the Department has determined at least one individual in that grouping to be a Potential Enrollee. An individual is added to a Case when the client information system maintained by DHS reflects that the individual is in the Case.
- 1.1.29 **Centers for Medicare & Medicaid Services (Federal CMS)** means the agency within DHHS that is responsible for the administration of the Medicare program and, in partnership with the states, administers Medicaid Program, the State Children's Health Insurance Program (SCHIP), and HIPAA.
- 1.1.30 **Certified Local Health Department** means an agency of local government authorized under 77 Ill. Adm. Code Part 600 to develop and administer programs and services that are aimed at maintaining a healthy community.
- 1.1.31 **Change of Control** means any transaction or combination of transactions resulting in:
- 1.1.31.1 the change in ownership of Contractor;
 - 1.1.31.2 the sale or transfer of fifty percent (50%) or more of the beneficial ownership of Contractor; or
 - 1.1.31.3 the divestiture, in whole or in part, of the business unit or division of a Party that is obligated to provide the products and services set forth in this Contract.
- 1.1.32 **Child(ren)** means any of the following: 1) an individual enrolled in one of the full-benefit Medical Assistance Programs administered by the Department,

who is between the age of zero (0) and, up to but not including, the age of twenty-one (21); or 2) a Medicaid eligible individual that is admitted before the age of twenty-one (21) to an inpatient psychiatric institution qualifying as inpatient psychiatric services for individuals under age twenty-one (21) pursuant to Federal Medicaid regulations codified at 42 CFR 440.160, until the individual is either discharged from the institution or until the individual's twenty-second (22nd) birthday, whichever comes first.

- 1.1.33 **Child and Family Team** is a group of individuals responsible for the development, implementation, and monitoring of a unified IPoC that engages and involves the Child and family. The Child and Family Team is composed of family members, significant people in the lives of the Child and family, and representatives of the community's human services agencies that can provide needed services.
- 1.1.34 **[This Section Intentionally Left Blank]**
- 1.1.35 **Chronic Health Condition** means a health condition with an anticipated duration of at least twelve (12) months.
- 1.1.36 **Cognitive Disabilities** means disabilities that affect the mental processes of knowledge, including awareness, perception, reasoning, and judgment. The term covers a wide range of conditions, from serious mental impairments caused by Alzheimer's disease, bipolar disorder, or medications to nonorganic disorders such as dyslexia, attention deficit disorder, poor literacy, or problems understanding information.
- 1.1.37 **Community Mental Health Center** means an agency certified by DHS or DCFS and enrolled with HFS to provide Medicaid community mental health services.
- 1.1.38 **Complaint** means a phone call, letter, or personal contact from a Participant, Enrollee, family member, Enrollee representative, or any other interested individual expressing a concern related to the health, safety, or well-being of an Enrollee.
- 1.1.39 **Computer-Aided, Real-Time Translation (CART)** means the instant translation of spoken word into text performed by a CART reporter using a stenotype machine, notebook computer, and real-time software.
- 1.1.40 **Confidential Information** means any material, data, or information disclosed by either Party to the other that, pursuant to agreement of the Parties or the State's grant of a proper request for confidentiality, are not generally known by or disclosed to the public or to Third Parties, including, without limitation:
- 1.1.40.1 all materials; know-how; processes; trade secrets; manuals; confidential reports; services rendered by the State; financial, technical,

and operational information; and other matters relating to the operation of a Party's business;

1.1.40.1.1 quarterly business review and ad hoc reports shall be presumed to be proprietary and confidential;

1.1.40.2 all information and materials relating to Third-Party Contractors of the State that have provided any part of the State's information or communications infrastructure to the State;

1.1.40.3 software; and

1.1.40.4 any other information that the Parties agree shall be kept confidential.

- 1.1.41 **Consumer Assessment of Healthcare Providers and Systems (CAHPS)** means the survey funded by the United States Agency for Healthcare Research and Quality, which works closely with a consortium of public and private organizations. The CAHPS program develops and supports the use of a comprehensive and evolving family of standardized surveys that ask consumers and patients to report on and evaluate their experience with ambulatory and facility-level care.
- 1.1.42 **Continuity of Care** means the continued care of an Enrollee as the Enrollee transitions between different MCOs or between Managed Care and FFS, whether due to eligibility changes or a change in MCO enrollment.
- 1.1.43 **Contract** means this document, inclusive of all attachments, exhibits, schedules, addenda, and countersigned letters, and any subsequent amendments hereto.
- 1.1.44 **Contracting Area** means those geographic areas as set forth in Attachment II.
- 1.1.45 **Contractor** means the MCO identified as Contractor on page 9 of this Contract.
- 1.1.46 **Contractor's Plan** see "Health Plan."
- 1.1.47 **Coverage Year** means the period described by this term as set forth in section 7.11.8.
- 1.1.48 **Covered Service(s)** means those benefits and services agreed to by the Parties as described in sections 5.1 and 5.2.
- 1.1.49 **CRAFFT Screening Tool** means a BH screening tool recommended by the American Academy of Pediatrics' Committee on Substance Abuse used with children under the age of twenty-one (21). The term CRAFFT is an acronym based upon the key components (Care, Relax, Alone, Forget, Friends, Trouble) of the six questions that constitute the instrument. Information regarding the

CRAFFT can be found at <http://www.ceasar-boston.org/CRAFFT/>.

- 1.1.50 **Crisis** see “Behavioral Health Crisis.”
- 1.1.51 **Crisis and Referral Entry Service (CARES)** means the single point of entry to the State’s Mobile Crisis Response system that provides telephone response and referral services for Enrollees requiring mental health crisis services.
- 1.1.52 **Crisis Intervention** means services provided by an emergency mental health services program to an individual in Crisis or in a situation that is likely to develop into a Crisis if supports such as assessment and planning, Crisis linkage and follow-up services, and Crisis stabilization services, are not provided.
- 1.1.53 **Crisis Safety Plan** means an individualized plan prepared for a Enrollees at high risk of experiencing a Behavioral Health Crisis.
- 1.1.54 **Critical Incident** is defined as any event indicated in Attachment XVII.
- 1.1.55 **Cultural Competence** means the tailoring of services and supports to the unique social, cultural, and linguistic needs of the Enrollee.
- 1.1.56 **Determination of Need (DON)** means the tool used by the Department or the Department’s authorized representative to determine eligibility (level of care) for NF services and HCBS Waivers for individuals with disabilities, HIV/AIDS, brain injury, supportive living, and the elderly. This assessment includes scoring for a mini-mental state examination, functional impairment levels, and unmet needs for care in fifteen (15) areas including ADL and IADL. The final score is calculated by adding the scores of the mini-mental state examination, the level of impairment, and the unmet need for care. To be eligible for NF services or HCBS Waivers, an individual must receive at least fifteen (15) points on the functional-impairment section and a minimum total score of twenty-nine (29) points.
- 1.1.57 **Developmental Disability (DD)** means a disability that:
- 1.1.57.1 is attributable to a diagnosis of intellectual disability or related condition, such as cerebral palsy or epilepsy;
 - 1.1.57.2 manifests before the age of twenty-two (22) and is likely to continue indefinitely;
 - 1.1.57.3 results in impairment of general intellectual functioning or adaptive behavior; and
 - 1.1.57.4 results in substantial functional limitations in three (3) or more areas of major life activities, such as self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living.

- 1.1.58 **DHHS** means the United States Department of Health and Human Services.
- 1.1.59 **DHS** means the Illinois Department of Human Services and any successor agency.
- 1.1.60 **DHS-DRS** means the Division of Rehabilitation Services within DHS that operates the Home Services Programs for individuals with disabilities (Persons with Disabilities HCBS Waiver), brain injury (Persons with Brain Injury HCBS Waiver), and HIV/AIDS (Persons with HIV/AIDS HCBS Waiver).
- 1.1.61 **DHS-OIG** means the Department of Human Services Office of Inspector General, which is the entity responsible for investigating allegations of Abuse and Neglect of people who receive mental health or Developmental Disabilities services in Illinois and for seeking ways to prevent such Abuse and Neglect. Annual reporting is conducted in response to the Department of Human Services Act (20 ILCS 1305/1-17) and the Adults with Disabilities Domestic Abuse Intervention Act (20 ILCS 2435). For more information, visit <https://www.oig.dhs.gov/>.
- 1.1.62 **Diagnostic-Related Grouping (DRG)** means the methodology by which a hospital is reimbursed based on the diagnoses and procedures performed during the hospital stay. The diagnoses associated with the hospital stay are placed into groups requiring a similar intensity of services. The DRG reimbursement, similar to the system used by the federal Medicare program, is based on the average cost of providing services for the specific diagnosis group, regardless of how long a specific Participant may have been in the hospital.
- 1.1.63 **Disaster** means an outage or failure of the Department's or Contractor's data, electrical, telephone, technical support, or back-up system, whether such outage or failure is caused by an act of nature, equipment malfunction, human error, or another source.
- 1.1.64 **Disease Management Program** means a program that employs a set of interventions designed to improve the health of individuals, especially those with Chronic Health Conditions. A Disease Management Program is typically part of a Care Management program. Disease Management Program services include:
- 1.1.64.1 a population identification process;
 - 1.1.64.2 the use and promotion of evidence-based guidelines;
 - 1.1.64.3 the use of collaborative practice models to include Physician and support service Providers;
 - 1.1.64.4 Enrollee self-management education (including primary prevention, behavioral modification, and compliance surveillance);

- 1.1.64.5 Care Management;
- 1.1.64.6 process and outcome measurement, evaluation, and management;
and
- 1.1.64.7 routine reporting/feedback loop (including communication with the Enrollee, Physician, and ancillary Providers, and practice profiling).
- 1.1.65 **DPH** means the Illinois Department of Public Health and any successor agency that is the State survey agency responsible for promoting the health of the people of Illinois through the prevention and control of disease and injury, and for conducting the activities related to licensure and certification of NFs and ICF/DD facilities.
- 1.1.66 **Dual-Eligible Adult** means a Participant who is eligible for Medicare Part A or enrolled in Medicare Part B.
- 1.1.67 **Early Periodic Screening Diagnosis and Treatment (EPSDT)** means a federally-required benefit for individuals under age twenty-one (21) that expands coverage for Children beyond adult limits to ensure availability of: (i) screening and diagnostic services to determine physical or mental defects and (ii) healthcare, treatment, and other measures to correct or ameliorate any defects and Chronic Health Conditions discovered (42 CFR 440.40 (b)). EPSDT requirements help to ensure access by Children to all Medically Necessary healthcare services within the federal definition of “medical assistance.”
- 1.1.68 **Effective Date** means January 1, 2018, or any such later date as announced by the Department by providing all MCOs written notice no less than thirty (30) days before such later date. All MCOs shall have the same Effective Date.
- 1.1.69 **Effective Enrollment Date** means the date on which a Potential Enrollee becomes an Enrollee in Contractor’s Plan.
- 1.1.70 **Emergency Medical Condition** means a medical condition manifesting itself in acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:
- 1.1.70.1 placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- 1.1.70.2 serious impairment to bodily functions; or
- 1.1.70.3 serious dysfunction of any bodily organ or part.
- 1.1.71 **Emergency Services** means inpatient and outpatient healthcare services that are Covered Services, including transportation, needed to evaluate or stabilize

an Emergency Medical Condition, and which are furnished by a Provider qualified to furnish Emergency Services.

- 1.1.72 **Encounter** means an individual service or procedure provided to an Enrollee that would result in a claim if the service or procedure were to be reimbursed as FFS under the HFS Medical Program.
- 1.1.73 **Encounter Data** means the compiled data elements relating to the receipt of any item(s) or service(s) by an Enrollee under a contract between the Department and Contractor that is subject to the requirements of 42 CFR §438.242 and 42 CFR §438.818. Specific requirements for Encounter Data submissions are defined by the Department and include information similar to that required in a claim for FFS payment under the HFS Medical Program.
- 1.1.74 **Enrollee** means a Participant who is enrolled in a MCO. "Enrollee" shall include the guardian where the Enrollee is a minor child or an adult for whom a guardian has been named, provided that Contractor is not obligated to cover services for any individual who is not enrolled as an Enrollee with Contractor.
- 1.1.75 **Enrollment Period** means the twelve (12)-month period an Enrollee will be enrolled with Contractor, beginning with the Effective Enrollment Date.
- 1.1.76 **Execution** means the point at which all the Parties have signed the Contract between Contractor and the Department.
- 1.1.77 **External Quality Review Organization (EQRO)** means an organization contracted with the Department that meets the competence and independence requirements set forth in 42 CFR §438.354, and performs external quality review (EQR) and EQR-related activities as set forth in 42 CFR §438.358.
- 1.1.78 **Family Driven Care** means a service delivery approach driven by the belief that families should have a primary decision-making role in the care of their own children as well as in the policies and procedures governing care for all children in their community, state, tribe, territory, and nation. This delivery approach includes choosing culturally and linguistically competent supports, services, and Providers; setting goals; designing, implementing and evaluating programs; monitoring outcomes; and partnering in funding decisions.
- 1.1.79 **Family Planning** means a full spectrum of family-planning options (all FDA-approved birth control methods) and reproductive-health services appropriately provided within the Provider's scope of practice and competence. Family-Planning and reproductive-health services are defined as those services offered, arranged, or furnished for the purpose of preventing an unintended pregnancy, or to improve maternal health and birth outcomes.
- 1.1.80 **Families and Children Population** means a Participant whose eligibility has been determined on the basis of being a Child, a parent, a pregnant woman, or

other caregiver relative eligible for Covered Services under Title XIX or Title XXI.

- 1.1.81 **Family Training** means training for family members, including instruction about treatment regimens, cardiopulmonary resuscitation (CPR), and use of equipment or other services identified in the IPoC.
- 1.1.82 **Federally Qualified Health Center (FOHC)** means a health center that meets the requirements of 89 IL Admin Code 140.461(d).
- 1.1.83 **Fee-for-Service (FFS)** means the payment model in which Providers charge separately for each Encounter or service rendered.
- 1.1.84 **Fraud** means knowing and willful deception, or a reckless disregard of the facts, with the intent to receive an unauthorized benefit. “Fraud” is generally used in conjunction with “Waste” and “Abuse”.
- 1.1.85 **Government-owned organization** means, for purposes of this Contract, an organization that is, or is operated by, a unit of government in the State of Illinois with a population greater than 3,000,000.
- 1.1.86 **Grievance** means an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Enrollee’s rights regardless of whether remedial action is requested. Grievance includes an Enrollee’s right to dispute an extension of time proposed by Contractor to make an authorization decision.
- 1.1.87 **Habilitation** means an effort directed toward the alleviation of a disability or toward increasing an individual’s level of physical, mental, social, or economic functioning. Habilitation may include diagnosis, evaluation, medical services, residential care, day care, special living arrangements, training, education, sheltered employment, protective services, and counseling.
- 1.1.88 **Head of Case** means the individual in whose name the Case is registered and to whom the HFS medical card is mailed.
- 1.1.89 **Health Insurance Portability and Accountability Act (HIPAA)** means the federal law that includes provisions that allow individuals to qualify immediately for comparable health insurance coverage when they change their employment relationships, and that authorizes DHHS to:
- 1.1.89.1 mandate standards for electronic exchange of healthcare data, including ADT;
- 1.1.89.2 specify what medical and administrative code sets should be used within those standards;
- 1.1.89.3 require the use of national identification systems for healthcare

patients, Providers, payers (or plans), and employers (or sponsors);
and

1.1.89.4 specify the types of measures required to protect the security and
privacy of Protected Health Information.

1.1.90 **Health Maintenance Organization (HMO)** means a Health Maintenance
Organization as defined in the Health Maintenance Organization Act (215 ILCS
125/1-1 *et seq.*).

1.1.91 **Health Plan** means a delivery system of coordinated services provided by an
MCO, including Contractor.

1.1.92 **Healthcare Effectiveness Data and Information Set (HEDIS®)** means the
Healthcare Effectiveness Data and Information Set established by the NCQA.

1.1.93 **HFS** means the Illinois Department of Healthcare and Family Services and any
successor agency. In this Contract, HFS may also be referred to as “the
Department.”

1.1.94 **HFS Medical Program** means: (i) the Illinois Medicaid Program; and, the
State Children’s Health Insurance Program, as authorized under the Illinois
Insurance Code (215 ILCS 106/1 *et seq.*) and Title XXI of the Social Security
Act, the State Children’s Health Insurance Program (SCHIP). For the purposes
of this Contract, HFS Medical Program does not include any program or
population excluded from coverage under this Contract as designated in
Attachment II.

1.1.95 **High Fidelity Wraparound** means an evidence-based process of
individualized care planning for Children with complex needs and their
families that proceeds through four phases and is guided by the National
Wraparound Initiative.

1.1.96 **High-Needs Child** means any Child who has been stratified as Level 3 (high-
risk).

1.1.97 **Home and Community-Based Services (HCBS) Waivers** means waivers
under Section 1915(c) of the Social Security Act that allow Illinois to cover
home and community services and provide programs that are designed to
meet the unique needs of individuals with disabilities and the elderly who
qualify for the level of care provided in an institution but who, with special
services, may remain in their homes and communities. In this Contract,
references to HCBS Waivers relate only to those HCBS Waivers for which a
service package under section 5.2 is then in effect.

1.1.98 **Homecare Service** means general nonmedical support by supervised and
trained homecare aides to assist Participants with their ADL and IADL.

1.1.99 **Hospitalist** means a Physician who works with a coordinated group of

Physicians and whose entire professional focus is the general medical care of hospitalized Enrollees in an acute-care facility. A Hospitalist's activities include Enrollee care; communication with families, significant others, and PCPs; and hospital leadership related to hospital medicine.

- 1.1.100 **Illinois Compiled Statutes (ILCS)** means the State database of laws as maintained by the Legislative Reference Bureau, an unofficial version of which can be viewed at <http://www.ilga.gov/legislation/ilcs/ilcs.asp>.
- 1.1.101 **Illinois Client Enrollment Services (ICES)** means the entity contracted by the Department to conduct enrollment activities for Potential Enrollees, including providing impartial education on healthcare delivery choices, providing enrollment materials, assisting with the selection of an MCO and PCP, and processing requests to change MCOs.
- 1.1.102 **Illinois Department on Aging (IDoA)** means the agency that operates the HCBS Waiver for the elderly (Persons Who are Elderly HCBS Waiver).
- 1.1.103 **Illinois Healthy Kids** means a Department-administered program for children who need comprehensive, affordable health insurance, regardless of family income, immigration status or health condition.
- 1.1.104 **Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM-CANS)** means a comprehensive, multi-purpose tool that provides a standardized, modular framework for assessing the global needs and strengths of individuals who require mental health treatment in Illinois.
- 1.1.104a **Illinois Medicaid Crisis Assessment Tool (IM-CAT)** means a screening tool used in the delivery of Mobile Crisis Response services. The IM-CAT is composed of a subset of items from the IM+CANS and is used as part of the crisis assessment to recommend whether an individual can be stabilized in the community or a higher level of care may be needed.
- 1.1.105 **Illinois Medicaid Program** means the program under the Illinois Public Aid Code (305 ILCS 5/5 *et seq.*) and Title XIX of the Social Security Act, Medicaid. May also be referred to as "Medicaid Program".
- 1.1.106 **Individual Plan of Care (IPoC)** means a written plan that identifies services and supports that an Enrollee requires. The IPoC is an enrollee-centered, goal-oriented, and culturally relevant plan, which reflects the full range of an Enrollee's physical and behavioral health service needs and include both Medicaid and non-Medicaid services, along with the informal supports necessary to address those needs.
- 1.1.107 **Individual Provider (IP)** means an individual co-employed by DHS and the DHS-DRS Home Services Program Enrollee who provides care to the Enrollee as provided in the HCBS Waiver service plan. Such individuals include: Personal Assistants, certified nursing assistants, licensed practical

nurses, registered nurses, physical therapists, occupational therapists, and speech therapists.

- 1.1.108 **Institutionalization** means residency in a Nursing Facility, an ICF/DD, or a State-operated facility, but it does not include admission in an acute care or rehabilitation hospital setting.
- 1.1.109 **Instrumental Activities of Daily Living (IADL)** means managing money, meal preparation, telephoning, laundry, housework, being outside the home, routine health, special health, and being alone.
- 1.1.110 [THIS SECTION INTENTIONALLY LEFT BLANK]
- 1.1.111 **Interdisciplinary Care Team (ICT)** means a diverse group of medical professionals (e.g., care coordinator Physicians, social workers, psychologists, occupational therapists, physical therapists) and nonclinical staff whose skills and professional experience will complement and support each other in the oversight of and Enrollees needs.
- 1.1.112 **Intermediate Care Facility (ICF)** means a facility that provides basic nursing care and other restorative services under periodic medical direction, including services that may require skill in administration, for Residents who have long-term illnesses or disabilities and who may have reached a relatively stable plateau.
- 1.1.113 **Intermediate Care Facility for the Developmentally Disabled (ICF/DD)** means a facility for Residents who have physical, intellectual, social, and emotional needs. An ICF/DD provides services primarily for ambulatory adults with Developmental Disabilities and focuses on the needs of individuals with mental disabilities or those with related conditions. Also known as an Intermediate Care Facility for the Mentally Retarded (ICF/MR).
- 1.1.114 **Key Oral Contact** means contact between Contractor and the Enrollee, Potential Enrollee, or Prospective Enrollee, including, but not limited to:
- 1.1.114.1 a contact with a Care Coordinator and other Contractor staff involved with direct Enrollee care;
 - 1.1.114.2 a contact to explain benefits, initial choice or change of PCP and WHCP;
 - 1.1.114.3 a telephone call to Contractor's toll-free phone line(s); or
 - 1.1.114.4 an Enrollee's face-to-face encounter with a Provider who is rendering care.
- 1.1.115 **Licensed Practitioner of the Healing Arts (LPHA)** means an individual who, within the scope of State law, has the ability and appropriate state licensure to independently make a clinical assessment, certify a

diagnosis and recommend treatment for individuals with a mental illness.

- 1.1.116 **Local Area Network (LAN)** means identified geographic boundaries across the State of Illinois. The LAN map can be found on the HFS website.
- 1.1.117 **Locus of Control** means the extent to which individuals believe that they can control events that affect them.
- 1.1.118 **Long-Term Services and Supports (LTSS)** means Covered Services, provided in a Nursing Facility or under an HCBS Waiver, designed to help meet the daily needs of Enrollees who are elderly or have disabilities and to improve their quality of life.
- 1.1.119 **Long-Term Care (LTC) Facility or Nursing Facility (NF)** means:
- 1.1.119.1 a facility that provides Skilled Nursing or intermediate LTC services, whether public or private and whether organized for profit or not for profit, that is subject to licensure by DPH under the Nursing Home Care Act (210 ILCS 45/1-101 et seq.), including a county nursing home directed and maintained under Section i 5-1005 of the Counties Code; and
- 1.1.119.2 a part of a hospital in which Skilled Nursing or intermediate LTC services within the meaning of Title XVIII or XIX of the Social Security Act are provided.
- 1.1.120 **Managed Care Community Network (MCCN)** means an entity other than an HMO that is owned, operated, or governed by Providers of healthcare services under contract with the Department exclusively to Persons participating in programs administered by the Department, as defined by 89 Ill. Admin. Code Part 143.100.
- 1.1.121 **Managed Care Organization (MCO)** means, for the purposes of this Contract, an entity that has, or is seeking to qualify for, a comprehensive risk contract with the Department to provide Covered Services under the HFS Medical Program, as provided in 42 CFR §438.2. MCOs include HMOs and MCCNs.
- 1.1.122 **Mandated Reporting** means the required, immediate reporting of suspected maltreatment when a mandated reporter has reasonable cause to believe that an individual known to the mandated reporter in a professional or official capacity may be subject to Abuse or Neglect.
- 1.1.123 **Marketing** means any written or oral communication from Contractor or its representative that can reasonably be interpreted as intended to influence a Participant to enroll, not to enroll, or to disenroll from a Health Plan. Marketing shall also include the meaning ascribed to it by HIPAA as defined by 45 CFR 164.501.

- 1.1.124 **Marketing Materials** means materials produced in any medium, by or on behalf of Contractor or its representative, that can reasonably be interpreted as intended to Market to Potential Enrollees. Marketing Materials includes written materials and oral presentations.
- 1.1.125 **Marketing Misconduct** means any activity by an employee or representative of Contractor that is in violation of any provisions related to Marketing.
- 1.1.126 **Medicaid Managed Care Program** means the Department's system of coordinated care for individuals under HFS Medical Programs.
- 1.1.127 **Medically Necessary** means services that, when recommended by a Provider for an Enrollee, are: for the purpose of preventing, diagnosing, or treating an illness, injury, disease or its symptoms; to assist in the Enrollee's ability to attain, maintain, or regain functional capacity; for the opportunity for an Enrollee receiving LTSS to have access to the benefits of community living, to achieve person centered goals, and live and work in the setting of the Enrollee's choice; or for an Enrollee to achieve age-appropriate growth and development. Medically Necessary services are requested in accordance with applicable policies and procedures, and provided in a manner that is: (1) in accordance with generally accepted standards of good medical practice in the medical community; (2) consistent with nationally recognized evidence-based guidelines; (3) clinically appropriate, in terms of type, frequency, extent, site, and duration; and (4) not primarily for the economic benefit of the Contractor or for the convenience of the Enrollee or Provider.
- 1.1.128 **Mental Illness** means a diagnosis of schizophrenia, delusional disorder, schizoaffective disorder, psychotic disorder not otherwise specified, bipolar disorder, or recurrent major depression resulting in substantial functional limitations.
- 1.1.129 **Minority-owned organization** means, for purposes of this RFP, a business that is at least fifty-one percent (51%) owned by one or more minority persons, or in the case of a corporation, that at least fifty-one percent (51%) of the stock of which is owned by one or more minority persons; and the management and daily business operations of which are controlled by one or more of the minority individuals who own it.
- 1.1.130 **Mobile Crisis Response** means an urgent twenty-four (24) hour response Crisis intervention and stabilization services for Enrollees and their families who are experiencing a Crisis related to psychiatric or behavioral problems.
- 1.1.131 **National Committee for Quality Assurance (NCQA)** means a private 501(c)(3) not-for-profit organization that is dedicated to improving healthcare quality and that has a process for providing accreditation, certification, and recognition, such as Health Plan accreditation.

- 1.1.132 **National Council for Prescription Drug Program** means the not-for-profit, multi-stakeholder forum for developing and promoting industry standards and business solutions that improve patient safety and health outcomes, while also decreasing costs. The work of the organization is accomplished through its members who bring high-level expertise and diverse perspectives to the forum. For more information, visit <https://www.ncpdp.org/>.
- 1.1.133 **Natural Supports** means social services such as respite, mentoring, and tutoring that may be provided by family members, neighbors, or other family-approved sources that can assist families in stabilizing potential adverse events or outcomes and avoid Behavioral Health Crisis.
- 1.1.134 **Neglect** may be either passive (nonmalicious) or willful and means a failure:
- 1.1.134.1 to notify the appropriate healthcare professional;
 - 1.1.134.2 to provide or arrange necessary services to avoid physical or psychological harm to an Enrollee; or
 - 1.1.134.3 to terminate the residency of a Participant whose needs can no longer be met, causing an avoidable decline in function.
- 1.1.135 **Negotiated Risk** means the process by which an Enrollee, or the Enrollee’s representative, may negotiate and document with Providers what risks each is willing to assume in the provision of Medically Necessary Covered Services and in the Enrollee’s living environment, and by which the Enrollee is informed of the risks of these decisions and of the potential consequences of assuming these risks.
- 1.1.136 **Network Provider** means any Provider, group of Providers or entity that has an agreement with Contractor, or a Subcontractor, who receives HFS Medical Program funding directly or indirectly to order, refer or render Covered Services as a result of this Contract. A Network Provider is not a Subcontractor by virtue of the Network Provider agreement. A group of Network Providers for an MCO may be referred to as a “Provider Network.”
- 1.1.137 **Nursing Facility (NF)**—See Long-Term Care Facility, section 1.1.119.
- 1.1.138 **Occupational Therapy** means a medically-prescribed service identified in the IPoC that is designed to increase independent functioning through adaptation of a patient’s tasks and environment, and that is provided by a licensed occupational therapist who meets Illinois licensure standards.
- 1.1.139 **Office of Inspector General (OIG)** means the Office of Inspector General for the Department as set forth in 305 ILCS 5/12-13.1. OIG has the primary responsibility for program integrity over the Illinois Medical

Assistance Program to prevent, detect, and eliminate Fraud, Waste, Abuse, mismanagement, and misconduct. OIG is the liaison with federal and state law enforcement, including but not limited to the Illinois State Police Medicaid Fraud Control Unit (ISP-MFCU).

- 1.1.140 **Open Enrollment Period** means the specific period each year in which an Enrollee shall have the opportunity to change from one MCO to another MCO.
- 1.1.141 **Out-of-Home Placements** means arrangements for Children who have significant behavioral health challenges or co-occurring disorders, and who are at risk of becoming homeless or being placed in: (1) detention, (2) secure care facilities, (3) psychiatric hospitals, (4) residential treatment facilities, (5) developmental disabilities facilities, (6) addiction facilities, (7) alternative schools, or (8) foster care.
- 1.1.142 **Participant** means any individual determined to be eligible for an HFS Medical Program.
- 1.1.143 **Party(ies)** means the State, through the Department, and Contractor.
- 1.1.144 **Performance Improvement Project (PIP)** means an ongoing program for improvement that focuses on clinical and nonclinical areas, and that involves:
- 1.1.144.1 measurement of performance using objective quality indicators;
 - 1.1.144.2 implementation of system interventions to achieve improvement in quality;
 - 1.1.144.3 evaluation of the effectiveness of the interventions; and
 - 1.1.144.4 planning and initiation of activities for increasing or sustaining improvement.
- 1.1.145 **Performance Measure(ment)** means a quantifiable measure to assess how well an organization carries out a specific function or process.
- 1.1.146 **Person** means any individual, corporation, proprietorship, firm, partnership, trust, association, governmental authority, contractor, or other legal entity whatsoever, whether acting in an individual, fiduciary, or other capacity.
- 1.1.147 **Person with a Disability** means an individual who meets the definition of blind or disabled under Section 1614(a) of the Social Security Act (42 USC 1382), and who are eligible for Medicaid.
- 1.1.148 **Person with Ownership or a Controlling Interest** means a Person who:

- 1.1.148.1 has a direct or indirect, singly or in combination, ownership interest equal to five percent (5%) or more in Contractor;
- 1.1.148.2 owns an interest of five percent (5%) or more in any mortgage, deed of trust, note, or other obligations secured by Contractor if that interest equals at least five percent (5%) of the value of the property or assets of Contractor;
- 1.1.148.3 is an officer or director of Contractor if Contractor is organized as a corporation;
- 1.1.148.4 is a member of Contractor if Contractor is organized as a limited liability company; or
- 1.1.148.5 is a partner in Contractor if Contractor is organized as a partnership.
- 1.1.149 **Personal Assistant** means an individual who provides Personal Care to an Enrollee when it has been determined by the Care Manager that the Participant has the ability to supervise the Personal Assistant.
- 1.1.150 **Personal Care** means assistance with meals, dressing, movement, bathing, or other personal needs or maintenance, or general supervision and oversight of the physical and mental well-being of a Participant.
- 1.1.151 **Personal Emergency Response System (PERS)** means an electronic device that enables a Participant who is at high risk of Institutionalization to secure help in an emergency.
- 1.1.152 **Physical Therapy** means a medically prescribed service that is provided by a licensed physical therapist and identified in the IPoC that utilizes a variety of methods to enhance an Enrollee's physical strength, agility, and physical capacity for ADL.
- 1.1.153 **Physician** means an individual licensed to practice medicine in all its branches in Illinois under the Medical Practice Act of 1987 (225 ILCS 60/1, *et seq.*) or any such similar statute of the state in which the individual practices medicine.
- 1.1.154 **Post-Stabilization Services** means Medically Necessary non-Emergency Services furnished to an Enrollee after the Enrollee is Stabilized following an Emergency Medical Condition, in order to improve or resolve the Enrollee's condition.
- 1.1.155 **Potential Enrollee** means a Participant who is subject to mandatory enrollment, or is eligible to voluntarily enroll, but is not yet an Enrollee of a Health Plan. Participants who are Potential Enrollees covered by this Contract are set forth in Attachment II. Potential Enrollee includes Participants within the Contracting Area who, pursuant to federal law or waiver, have the option to enroll with an MCO.

- 1.1.156 **Primary Care Provider (PCP)** means a Provider, including a WHCP, who, within the Provider's scope of practice and in accordance with State certification requirements or State licensure requirements, is responsible for providing all preventive and primary care services to an Enrollee of the Contractor.
- 1.1.157 **Prior Approval** means review and written approval by the Department of any Contractor materials or actions, as set forth in the Contract, including subcontracts, intended courses of conduct, or procedures or protocols that Contractor must obtain before such materials are used or such actions are executed, implemented, or followed.
- 1.1.158 **Prospective Enrollee** means a Potential Enrollee who has begun the process of enrollment with Contractor but whose coverage with Contractor has not yet begun.
- 1.1.159 **Protected Health Information (PHI)** shall have the same meaning as provided in HIPAA, 45 CFR 160.103, and for the purpose of this Contract shall be limited to the information received from the Department, or created, maintained, or received by Contractor on behalf of the Department, in connection with this Contract.
- 1.1.160 **Provider** means a Person or organization enrolled with the Department to provide Covered Services to a Participant.
- 1.1.161 **Provider Network** means a network of Providers and agencies that have entered into a contract or agreement with Contractor to provide Enrollees with a broad array of community based supports and resources.
- 1.1.162 **Quality Assessment and Performance Improvement (QAPI)** means the program required by 42 CFR §438.330, which requires MCOs to have an ongoing quality-assessment and performance-improvement program for the services provided to Enrollees, that includes, at a minimum:
- 1.1.162.1 Performance Improvement Projects;
 - 1.1.162.2 the collection and submission of Performance Measurement data;
 - 1.1.162.3 mechanisms to detect both underutilization and overutilization of services;
 - 1.1.162.4 mechanisms to assess the quality and appropriateness of care furnished to Enrollees who have special healthcare needs;
 - 1.1.162.5 when long-term services and supports are provided, mechanisms to assess the quality and appropriateness of care, including between care settings and comparison of authorized to delivered services; and
 - 1.1.162.6 when long-term services and supports are provided, participation in

Department efforts to prevent, detect and remediate Critical Incidents.

- 1.1.163 **Quality Assurance (QA)** means a formal set of activities to review, monitor, and improve the quality of services by a Provider or MCO, including quality assessment, ongoing quality improvement, and corrective actions to remedy any deficiencies identified in the quality of services provided directly to Enrollees as well as administrative and support services.
- 1.1.164 **Quality Assurance Plan (QAP)** means a written document developed by Contractor in consultation with its QAP Committee and medical director that details annual program goals and measurable objectives, UR activities, access, and other Performance Measures that are to be monitored with ongoing Physician profiling and focus on quality improvement.
- 1.1.165 **Quality Assurance Plan (QAP) Committee** means a committee established by Contractor, with the approval of the Department, that consists of a cross representation of all types of Providers, but shall, at a minimum, include primary care Providers, specialists, dentists, and LTC representatives from Contractor's network and throughout the entire Contracting Area. At the request of the Department, the QAP Committee shall also include Department staff in an advisory capacity.
- 1.1.166 **Quality Assurance Program** means Contractor's overarching mission, vision, and values, which, through its goals, objectives, and processes committed in writing in the QAP, are demonstrated through continuous improvement and monitoring of medical care, Enrollee safety, behavioral-health services, and the delivery of services to Enrollees, including ongoing assessment of program standards to determine the quality and appropriateness of care, Care Management, and coordination. It is implemented through the integration, coordination of services, and resource allocation throughout Contractor's organization, its partners, Providers, other entities delegated to provide services to Enrollees, and the extended community involved with Enrollees. The QAP is overseen by the QAP Committee.
- 1.1.167 **Quality Improvement Organization (QIO)** means an organization designated by Federal CMS, as set forth in Section 1152 of the Social Security Act and 42 CFR §476, that provides QA, quality studies, and inpatient UR for the Department in the FFS Medical Program, and QA and quality studies for the Department in the HCBS setting.
- 1.1.168 **Quality Improvement System for Managed Care (QISMC)** means a quality assessment and improvement strategy to strengthen an MCO's efforts to protect and improve the health and satisfaction of Enrollees.
- 1.1.169 **Readiness Review** means the process by which the Department or its designee assesses Contractor's ability to fulfill Contractor's duties and obligations under the Contract, including reviewing Contractor's model

Provider agreements, Provider Network, QA program, staffing for operations, and information systems.

- 1.1.170 **Recipient Identification Number (RIN)** means a unique nine (9)-digit number assigned to each individual who receives medical benefits from the State. The number is utilized by the Department to identify and pay medical bills to Providers.
- 1.1.171 **Referral** means an authorization provided by a primary care Provider to enable an Enrollee to seek medical care from another Provider.
- 1.1.172 **Rehabilitation** means the process of restoration of skills to an individual who has had an illness or injury to regain maximum self-sufficiency and function in a normal or near-normal manner in therapeutic, social, physical, behavioral, and vocational areas.
- 1.1.173 **Resident** means an Enrollee who is living in a facility, including NFs and ICFs, and whose facility services are eligible for Medicaid payment.
- 1.1.174 **Respite** means services that provide the needed level of care and supportive services to enable the Enrollee to remain in the community or in a home-like environment, while periodically relieving a nonpaid family member or other caregiver of caregiving responsibilities.
- 1.1.175 **Rule 132** refers to Title 59 of the Illinois Administrative Code, Part 132 – Medicaid Community Mental Health Services or its successor Rules.
- 1.1.176 **Rural Area** refers to an Illinois county not part of a metropolitan statistical area (MSA), as defined by the U.S. Census Bureau; or a county that is part of an MSA but has a population of fewer than 60,000 residents (see details in Attachment II).
- 1.1.177 **Rural Health Clinic (RHC)** means a Provider that has been designated by the Public Health Service, DHHS, or the governor of the State of Illinois, and approved by the Public Health Service, in accordance with the Rural Health Clinics Act (Public Law 95-210) as a Rural Health Center.
- 1.1.178 **Screening, Assessment and Support Services (SASS)** means the state’s historical program of intensive mental health services provided by an agency, including pre-admission inpatient psychiatric screening, Crisis stabilization, and follow-up services to children with a mental illness or emotional disorder who are at risk for psychiatric hospitalization.
- 1.1.179 **Senior** means an individual who is eligible for services through Title XIX and is aged 65 or older.
- 1.1.180 **Senior or Person with a Disability (SPD) population** means an individual categorized as a Senior or as a Person with a Disability. SPD population does not include Dual-Eligible Adults.

- 1.1.181 **Serious Mental Illness** refers to emotional or behavioral functioning so impaired as to interfere with the individual's capacity to remain in the community without supportive treatment.
- 1.1.182 **Service Authorization Request** means a request by an Enrollee, or by a Provider on behalf of an Enrollee, for the provision of a Covered Service.
- 1.1.183 **Skilled Nursing** means nursing services provided within the scope of the Illinois Nurse Practice Act (225 ILCS 65/50-1 *et seq.*) by registered nurses, licensed practical nurses, or vocational nurses licensed to practice in the State.
- 1.1.184 **Skilled Nursing Facility (SNF)** means a group care facility that provides Skilled Nursing care, continuous Skilled Nursing observations, restorative nursing, and other services under professional direction with frequent medical supervision, during the post-acute phase of illness or during recurrences of symptoms in long-term illness.
- 1.1.185 **Special Needs Children** means Children under the age of twenty-one (21) who are eligible under the Medicaid Program pursuant to Article III of the Public Aid Code (305 ILCS 5/3-1 *et seq.*) or Medicaid-eligible and eligible to receive benefits pursuant to Title XVI of the Social Security Act. Special Needs Children also includes certain Medicaid-eligible Children under the age of twenty-one (21) who receive services under the Specialized Care for Children Act (110 ILCS 345/0.01 *et seq.*) via the Division of Specialized Care for Children (DSCC) or such other entity that the Department may designate for providing such services and Children with special needs as specified in section 1932 (a)(2)(A) of the Social Security Act. In accordance with Public Act 100-0990, Special Needs Children does not include Children participating in the Medically Fragile and Technology Dependent (MFTD) 1915(c) waiver program, and Children authorized to receive EPSDT in-home shift nursing services.
- 1.1.186 **Speech Therapy** means a medically prescribed speech or language-based service that is provided by a licensed speech therapist and identified in the IPoC, and that is used to evaluate or improve an Enrollee's ability to communicate.
- 1.1.187 **Spend-Down** means the policy that allows an individual to qualify for the Medicaid Program by incurring medical expenses at least equal to the amount by which the individual's income or assets exceed eligibility limits. It operates similarly to deductibles in private insurance in that the Spend-Down amount represents medical expenses the individual is responsible for paying.
- 1.1.188 **Stabilization or Stabilized** means a determination with respect to an Emergency Medical Condition made by an attending emergency room Physician or other treating Provider that, within reasonable medical probability, no material deterioration of the condition is likely to result upon discharge or transfer to another facility.

- 1.1.189 **State** means the State of Illinois, as represented through any State agency, department, board, or commission.
- 1.1.190 **State-Operated Hospital (SOH)** means a hospital operated, owned, and managed by the Department of Human Services Division of Mental Health (DHS-DMH) that serves adults with Serious Mental Illness (SMI) who require inpatient treatment.
- 1.1.191 **State Fiscal Year** means the State’s Fiscal Year, which begins on the first day of July of each calendar year and ends on the last day of June of the following calendar year. For example, State Fiscal Year 2015 began on July 1, 2014, and ended on June 30, 2015.
- 1.1.192 **State Plan** means the Illinois State Plan approved by Federal CMS, in compliance with Title XIX of the Social Security Act.
- 1.1.193 **Subcontractor** means an entity, other than a Network Provider, with which Contractor has entered into a written agreement for the purpose of delegating responsibilities applicable to Contractor under this Contract, as provided in 42 CFR §438.2. When not used as a defined term, “subcontractor” means any subcontractor of Contractor, including Network Providers and Subcontractors.
- 1.1.194 **Supportive Living Facility (SLF)** means a residential apartment–style (assisted living) setting in Illinois that:
- 1.1.194.1 is certified by the Department to provide or coordinate flexible Personal Care services, twenty-four (24)–hour supervision and assistance (scheduled and unscheduled), activities, and health-related services with a service program and physical environment designed to minimize the need for Residents to move within or from the setting to accommodate changing needs and preferences;
 - 1.1.194.2 has an organizational mission, service programs, and physical environment designed to maximize Residents’ dignity, autonomy, privacy, and independence;
 - 1.1.194.3 encourages family and community involvement; and
 - 1.1.194.4 is subject to the Supportive Living Program HCBS Waiver administered by the Department (see 305 ILCS 5/5-5.01a).
- 1.1.195 **Systems of Care (SOC)** means a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of Children and their families, and that are family-driven, youth-guided, individualized, culturally and linguistically competent, and community-based.
- 1.1.196 **Third Party** means any Person other than the Department, Contractor, or

any of Contractor's Affiliates.

- 1.1.197 **Transition of Care** means the management and continuation of care as Enrollees transition between different Providers within the same Health Plan.
- 1.1.198 **Urban Area** refers to an Illinois county that is part of a metropolitan statistical area (MSA), as defined by the US Census Bureau and has a population equal to or greater than 60,000 residents (see details in Attachment II).
- 1.1.199 **Utilization Management Program** means a comprehensive approach and planned activities for evaluating the appropriateness, need, and efficiency of services, procedures, and facilities according to established criteria or guidelines. Utilization management typically includes new activities or decisions based upon the analysis of care, and describes proactive procedures, including discharge planning, concurrent planning, precertification, and clinical case Appeals. It also covers proactive processes, such as concurrent clinical reviews and Peer Reviews, as well as Appeals introduced by the Provider, payer, or Enrollee.
- 1.1.200 **Waste** means the overutilization or misuse of Covered and non-Covered services, resources, or materials that results in unnecessary costs to the healthcare system and, as a result, to the Medicaid program. "Waste" is often used in conjunction with "Fraud" and "Abuse."
- 1.1.201 **Wellness Program** means comprehensive services designed to promote and maintain the good health of an Enrollee.
- 1.1.202 **Williams Provider** means a mental health Provider contracted with the Mental Health Division of DHS to implement the consent decree entered in *Williams v. Quinn*, No. 05 C 4673 (N.D. Ill.) (Williams consent decree).
- 1.1.203 **Women's Healthcare Provider (WHCP)** means a Physician or other healthcare Provider who, within the Provider's scope of practice and in accordance with State certification requirements or State licensure requirements, specializes by certification or training in obstetrics, gynecology, or family practice.
- 1.1.204 **Wraparound Fidelity Assessment System (WFAS)** means a multi-method approach to assessing fidelity to the wraparound process and the quality of individualized care planning and management for children and youth with complex needs and their families, as specified by the National Wraparound Initiative by the National Wraparound Implementation Center (NWIC) (<http://www.nwic.org/>).
- 1.1.205 **Written Materials** means materials regarding choice of MCO, selecting a PCP, Enrollee handbooks, basic information as set forth in section 5.21.1,

and any information or notices distributed by Contractor or required to be distributed to Potential Enrollees, Prospective Enrollees or Enrollees by the Department, or regulations promulgated under 42 CFR §438 and in format specified under 42 CFR §438.10.

- 1.1.206 **Youth At Risk** means a Child who is a part of DCFS's Intact Family Services, which is a relatively intense short-term, in-home, community based intervention program (6–9 months) that works with families who have been identified by DCFS as at risk for foster care placement.

1.2 ABBREVIATIONS AND ACRONYMS

1.2.1	ADL:	Activities of Daily Living
1.2.2	ADT:	Admission, Discharge, and Transfer
1.2.3	AES:	Advanced Encryption Standard
1.2.4	APN:	Advanced Practice Nurse
1.2.5	ASOP:	Actuarial Standards of Practice
1.2.6	BEP:	Business Enterprise Program Act for Minorities, Females, and Persons with Disabilities
1.2.7	BH:	Behavioral Health
1.2.8	CAHPS:	Consumer Assessment of Healthcare Providers and Systems
1.2.9	CAP:	Corrective Action Plan
1.2.10	CARES:	Crisis and Referral Entry Service
1.2.11	CART:	Computer-Aided, Real-Time Translation
1.2.12	CCCD:	Care Coordination Claims Data (CCCD)
1.2.13	CFR:	Code of Federal Regulations
1.2.14	(S)CHIP:	(State) Children’s Health Insurance Program
1.2.15	CLIA:	Clinical Laboratory Improvement Amendments
1.2.16	CMHC:	Community Mental Health Center
1.2.17	CSPI:	Childhood Severity of Psychiatric Illness
1.2.18	DARTS:	DHS’s Automated Reporting and Tracking System
1.2.19	DCFS:	Illinois Department of Children and Family Services
1.2.20	DCMS:	Illinois Department of Central Management Services
1.2.21	DD:	Developmental Disability
1.2.22	DHHS:	US Department of Health and Human Services
1.2.23	DHS:	Illinois Department of Human Services
1.2.24	DHS-DMH:	Division of Mental Health with the Department of Human Services
1.2.25	DHS-DRS:	Division of Rehabilitation Services within DHS

- 1.2.26 DHS-OIG: Department of Human Services Office of Inspector General
- 1.2.27 DON: Determination of Need
- 1.2.28 DPH: Illinois Department of Public Health
- 1.2.29 DRG: Diagnostic-Related Grouping
- 1.2.30 DSCC: Division of Specialized Care for Children
- 1.2.31 EPDST: Early and Periodic Screening, Diagnosis and Treatment
- 1.2.32 EQRO: External Quality Review Organization
- 1.2.33 EUM: Encounter Utilization Monitoring
- 1.2.34 Federal CMS: Centers for Medicare & Medicaid Services
- 1.2.35 FFP: Federal Financial Participation
- 1.2.36 FFS: Fee-for-Service
- 1.2.37 FQHC: Federally Qualified Health Center
- 1.2.38 HCBS Waivers: Home and Community-Based Services Waivers
- 1.2.39 HEDIS®: Healthcare Effectiveness Data and Information Set
- 1.2.40 HFS: Illinois Department of Healthcare and Family Services
- 1.2.41 HIPAA: Health Insurance Portability and Accountability Act
- 1.2.42 HMO: Health Maintenance Organization
- 1.2.43 HSP: Home Services Program
- 1.2.44 IADL: Instrumental Activities of Daily Living
- 1.2.45 IBNP: Incurred but Not Paid
- 1.2.46 ICD-9-CM Codes: International Classification of Diseases, 9th Revision, Clinical Modification
- 1.2.47 ICES: Illinois Client Enrollment Services
- 1.2.48 ICF: Intermediate Care Facility
- 1.2.49 ICF/DD: Intermediate Care Facility for the Developmentally Disabled
- 1.2.50 ICF/MR: Intermediate Care Facility for the Mentally Retarded
- 1.2.51 ICT: Interdisciplinary Care Team

1.2.52 IDoA:	Illinois Department on Aging
1.2.53 IHCP	Indian Health Care Provider
1.2.54	[THIS SECTION INTENTIONALLY LEFT BLANK]
1.2.55 ILCS:	Illinois Compiled Statutes
1.2.56 IM-CANS: Strengths	Illinois Medicaid Comprehensive Assessment of Needs and Strengths
1.2.57 IP:	Individual Provider
1.2.58 IPoC:	Individualized Plan of Care
1.2.59 IPSEC:	Internet Protocol Security
1.2.60 LAN:	Local Area Network
1.2.61 LTSS:	Long-Term Supports and Services
1.2.62 LTC:	Long-Term Care
1.2.63 MCO:	Managed Care Organization
1.2.64 MCCN:	Managed Care Community Network
1.2.65 MFTD:	Medically Fragile/Technology-Dependent
1.2.66 MFP:	Money Follows the Person
1.2.67 MIS:	Management Information System
1.2.68 NCQA:	National Committee for Quality Assurance
1.2.69 NF:	Nursing Facility
1.2.70 OIG:	Office of Inspector General
1.2.71 PCP:	Primary Care Provider
1.2.72 PERS:	Personal Emergency Response System
1.2.73 PHI:	Protected Health Information
1.2.74 PIP:	Performance Improvement Project
1.2.75 PFRT:	Psychiatric Residential Treatment Facility
1.2.76 QA:	Quality Assurance
1.2.77 QAP:	Quality Assurance Plan

1.2.78 QAPI:	Quality Assessment and Performance Improvement
1.2.79 QIO:	Quality Improvement Organization
1.2.80 QISMC:	Quality Improvement System for Managed Care
1.2.81 RHC:	Rural Health Clinic
1.2.82 SCHIP:	State Children’s Health Insurance Program
1.2.83 SED:	Serious Emotional Disturbance
1.2.84 SLF:	Supportive Living Facility
1.2.85 SMI:	Serious Mental Illness
1.2.86 SNF:	Skilled Nursing Facility
1.2.87 SOC:	Systems of Care
1.2.88 SOH:	State-Operated Hospital
1.2.89 SPD:	Senior or Person with a Disability
1.2.90 TDD:	Telecommunications Device for the Deaf
1.2.91 TPL:	Third Party Liability
1.2.92 TTY:	Teletypewriter
1.2.93 USC:	United States Code
1.2.94 USPS:	United States Postal Service
1.2.95 UR:	Utilization Review
1.2.96 VPN:	Virtual Private Network
1.2.97 WFAS:	Wraparound Fidelity Assessment Form
1.2.98 WHCP:	Women’s Healthcare Provider

ARTICLE II: TERMS AND CONDITIONS

2.1 RULES OF CONSTRUCTION

Unless otherwise specified or the context otherwise requires:

- 2.1.1 Provisions apply to successive events and transactions.
- 2.1.2 “Or” is not exclusive.
- 2.1.3 The phrases “shall include,” “includes,” and “including” mean, respectively, “shall include, but not be limited to,” “includes, but is not limited to,” and “including, but not limited to.”
- 2.1.4 References to statutes, regulations, and rules include subsequent amendments and successors thereto.
- 2.1.5 The various headings of this Contract are provided for convenience only and shall not affect the meaning or interpretation of this Contract or any provision hereof.
- 2.1.6 If any payment or delivery hereunder between Contractor and the Department shall be due on any day that is not a Business Day, such payment or delivery shall be made on the next succeeding Business Day.
- 2.1.7 Words in the plural that should be singular by context shall be so read, and words in the singular shall be read as plural where the context dictates.
- 2.1.8 “Day” shall mean a calendar day; “Business Day” shall mean a day as defined in Article I.
- 2.1.9 References to masculine or feminine pronouns shall be interchangeable where the context requires.
- 2.1.10 Reference in the Contract to the Department may include, as the Department may so designate, another State agency or another entity with which the State has an agreement or contract to fulfill certain functions under this Contract.
- 2.1.11 References in the Contract to Potential Enrollee, Prospective Enrollee, and Enrollee shall include the parent, caregiver relative, or guardian where such Potential Enrollee, Prospective Enrollee, or Enrollee is a minor child or an adult for whom a guardian has been named, provided that this rule of construction does not require Contractor to provide Covered Services for a parent, caregiver relative, or guardian who is not separately enrolled as an Enrollee with Contractor.
- 2.1.12 Whenever this Contract requires that an Adverse Benefit Determination be taken within a specified period after receipt of a notice, document, report, or

other communication, the date that the notice, document, report, or other communication shall be deemed to have been received shall be in accordance with the following:

2.1.12.1 if sent by first class mail, on the date of postmark by the United States Postal Service (USPS);

2.1.12.2 if sent by registered or certified mail, on the date of signature on the USPS return receipt;

2.1.12.3 if sent by courier or hand-delivery, on the date of signature on the courier's receipt form;

2.1.12.4 if sent by e-mail, fax, or other electronic means, on the date of transmission.

2.1.13 Whenever this Contract requires that a notice, document, report, or other communication be sent within a specified period after another Adverse Benefit Determination, the date the notice, document, report, or other communication shall be deemed to have been sent shall be in accordance with the following:

2.1.13.1 if sent by first class, registered, or certified mail, on the date of postmark by the USPS;

2.1.13.2 if sent by courier, on the date of delivery to the courier;

2.1.13.3 if sent by e-mail, fax, or other electronic means, on the date of transmission.

2.2 PERFORMANCE OF SERVICES AND DUTIES

Contractor shall perform all services and other duties as set forth in this Contract in accordance with, and subject to, all applicable federal and State statutes, rules, and regulations.

2.2.1 **Contract Provisions Related to the COVID-19 Public Health Emergency** Effective March 1, 2020 and through the duration of the Novel Coronavirus Disease (COVID-19) public health emergency as declared by the federal or State government, and any extensions thereof, Contractor shall perform services and duties in such a manner that incorporates all applicable provisions of flexibility provided in the Department's Section 1135 and Section 1115 Waivers as approved by federal CMS, the CMS-approved HCBS 1915(c) Waivers' Appendix K, Disaster State Plan Amendments, written concurrence from federal CMS, and applicable provisions provided by the "Federal CMS COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers." The Department will provide Contractor with written notice of all applicable provisions. Furthermore, throughout the duration of the

COVID-19 public health emergency as declared by the federal or State government, the following revised Contract provisions are effective:

- 2.2.1.1 Contractor shall implement all changes made by the Department for the FFS Medicaid Program regarding prior authorization requirements related to COVID-19 public health emergency flexibilities.
- 2.2.1.2 Contractor's Care Management duties that require in-person contact with an Enrollee may be replaced with HIPAA-compliant audio-only real-time telephonic interaction, or a virtual real-time visit, either of which must be sufficient in both substance and duration to meet the key components of an in-person contact. These visits can be counted and reported in lieu of in-person contacts on the Department's required monthly Care Management reports.
- 2.2.1.3 An acceptable form of required signature to finalize an Enrollee's initial or revised IPoC is a verbal agreement by Enrollee that is documented in writing by Contractor.
- 2.2.1.4 Contractor shall cover Medically Necessary Covered Services provided by a non-Network IMPACT-registered Provider for the diagnosis and treatment of COVID-19. Contractor may not require prior authorization as a condition for payment for such services.
- 2.2.1.5 Effective May 19, 2020, all Potential Enrollees will be directly enrolled by automatic assignment to an MCO. All such Enrollees will have a ninety (90)-day change period after the Effective Enrollment Date to select another MCO as provided in section 4.10.1.

2.3 LIST OF INDIVIDUALS IN AN ADMINISTRATIVE CAPACITY

- 2.3.1 **Key positions.** Upon Execution of this Contract, Contractor shall provide to the Department a list of individuals authorized by Contractor who have responsibility for monitoring and ensuring the performance of each of the duties and obligations under this Contract and their résumés. Contractor shall maintain an administrative and organizational structure that supports a high-quality, comprehensive managed-care system. Contractor shall fill vacant key positions in a timely manner. Contractor shall employ or contract for senior-level managers with sufficient experience and expertise in healthcare management and employ or contract with skilled clinicians for medical management activities. Contractor shall ensure all positions are located in Illinois. This list of individuals in an administrative capacity, and their résumés, shall be updated by Contractor throughout the term of this Contract as necessary and as changes occur. Contractor shall provide written notice of

such changes to the Department no later than two (2) Business Days after such changes occur. At a minimum, Contractor shall provide the key positions identified in this section (either through direct employment or contract). The Department acknowledges that the position titles in this section may not be the position titles that Contractor currently uses and that position titles may change from time to time. The Department further acknowledges that employees who are required to be full time may also have some responsibilities for Contractor's other operations. Contractor warrants that such responsibilities shall never detract from or conflict with the obligation to provide the equivalent of full-time resources to ensure the Contract requirements are met. Failure to meet the requirements of this section 2.3 may result in a monetary performance penalty pursuant to section 7.16 and any other applicable provision of Article VII of this Contract.

2.3.1.1 Chief Executive Officer (CEO). The CEO shall be a full-time position, with clear authority over general administration and implementation of requirements set forth in the Contract.

2.3.1.2 Chief Operating Officer (COO). The COO shall be a full-time position, with clear authority over operations of Contractor's business including overseeing the strategy and implementation of all non-clinical responsibilities of this Contract. This position shall be responsible for the daily conduct and operations of Contractor's Plan.

2.3.1.3 Chief Financial Officer (CFO). The CFO shall be a full-time position, with oversight of the budget and accounting systems of Contractor. This position shall, at a minimum, ensure that Contractor meets the Department's requirements for financial performance and for Contractor's reporting.

2.3.1.4 Chief Medical Officer (CMO). The CMO shall be a full-time position, a board-certified Illinois-licensed Physician and have a minimum of eight (8) years of experience practicing medicine. This position will lead and oversee Contractor's clinical strategy and clinical programs (both physical and behavioral health). This position will be responsible for Contractor's Utilization Management Program, Care Coordination, Long-Term Services and Support, quality improvement, accreditation, credentialing, pharmacy, Appeals and Grievances, health services, Behavioral Health services, and medical policy. This position shall manage Contractor's Quality Assessment and Performance Improvement Program. This position shall attend all quarterly quality meetings.

2.3.1.5 Medical Director. The Medical Director shall be an Illinois-licensed Physician with a minimum of five (5) years of experience practicing in internal medicine, primary care, or pediatrics. This position shall be actively involved in all major clinical program components of

Contractor's Plan, including review of medical care provided, medical professional aspects of Provider contracts, and other areas of responsibility as may be designated by Contractor. This position shall devote sufficient time to Contractor's Plan to ensure timely medical decisions, including after-hours consultation as needed.

- 2.3.1.6 **Chief Psychiatrist.** The Chief Psychiatrist shall be a full-time senior executive who is a board-certified, Illinois-licensed psychiatrist with a minimum of eight (8) years of experience in mental health, substance use, or children services. This position shall be responsible for all Behavioral Health activities.
- 2.3.1.7 **Enrollee Services Director.** The Enrollee Services Director shall be a full-time position that coordinates communications with Enrollees and other Enrollee services, such as acting as an Enrollee advocate. This position shall ensure that Contractor maintains sufficient Enrollee service staff to enable Enrollees to receive prompt resolution of their problems or inquiries.
- 2.3.1.8 **Provider Service Director.** The Provider Service Director shall be a full-time position that coordinates communications between Contractor and its Network Providers and other Subcontractors.
- 2.3.1.9 **Management Information System Director (MIS Director).** The MIS Director shall be a full-time position that oversees and maintains Contractor's data-management system such that is capable of valid data collection and processing, timely and accurate reporting, and correct claims payment. This individual shall be trained and experienced in information systems, data processing, data reporting and the Department's unique claims-processing requirements to the extent required to oversee all information system aspects identified in this Contract.
- 2.3.1.10 **Care Management Manager.** The Care Management Manager shall be a full-time position. This position shall be a licensed Physician, licensed registered nurse, or other professional as approved by the Department based on Contractor's ability to demonstrate that the professional possesses the training and education necessary to meet the requirements for Case Management and Disease Management Program activities required in the Contract. This position will direct all activities pertaining to Case Management and Care Coordination activities and monitor utilization of Enrollees' physical health and behavioral health.
- 2.3.1.11 [THIS SECTION INTENTIONALLY LEFT BLANK]
- 2.3.1.12 **Long-Term Services and Supports Program Manager.** The LTSS Program Manager shall be a full-time position that administers

managed Long-Term Care programs and services and oversees and trains LTSS care coordination staff. This position shall ensure that LTSS staff are knowledgeable and adhere to the requirements of the Illinois HCBS Waivers, IPoC and service plans, Contract standards, the Money Follows the Person Program, Illinois Long-Term Care rules and regulations, and the Williams and Colbert consent decrees (as per section 9.1.40). This position shall coordinate all communications between LTSS State agency liaisons, including HFS, IDoA, DHS-DRS, DHS-DDD, and UIC-DSCC. This position shall oversee report submissions specific to the LTSS membership.

2.3.1.13 **Community Liaison.** The Community Liaison shall be a full-time position that develops and maintains relationships with community resources, State agencies, and community entities that traditionally provide services for Enrollees or Potential Enrollees. This individual will coordinate the provision of Community-Based Services to Enrollees, assist in Enrollee outreach, and manage community engagement activities.

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

2.3.1.15 **Utilization Management Coordinator.** The Utilization Management Coordinator shall be a full-time position. This position shall be an Illinois-licensed Physician, Illinois-licensed registered nurse, or other professional as approved by the Department based on Contractor's ability to demonstrate that the professional possesses the training and education necessary to meet the requirements for UR activities required in the Contract. This position will oversee prior authorizations and manage the inpatient certification review staff for inpatient initial, concurrent, and retrospective reviews. The review staff shall consist of RNs, Physicians, Physician assistants, or licensed practical nurses who are experienced in inpatient reviews and who operate under the direct supervision of a Registered Nurse, Physician, or Physician assistant.

2.3.1.16 **Compliance Officer.** The Compliance Officer shall be a full-time

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

2.3.1.17 **Registered Pharmacist.** The Registered Pharmacist shall be a full-time position and shall oversee pharmaceutical prior authorizations; support Fraud, Waste, and Abuse staff; and participate in Department-led formulary reviews.

2.3.1.18 **Transition Officer.** The Transition Officer shall be a full-time position and shall assist Contractor in the transition from Contractor's implementation team to regular ongoing operations. This position shall be filled no later than the start date of the Contract and shall continue through one hundred twenty (120) days after the start date of operations, or until all administrative roles are fully staffed, whichever is later.

2.3.1.19 **Health Equity Director.** The Health Equity Director shall be a full-time position, filled by Contractor no later than the second quarter of CY2022. The Health Equity Director must: (1) hold at least a bachelor's degree from a recognized college or university and a minimum of five years professional work experience, preferably in public health, social/human services, social work, public policy, health care, education, community development, or justice; (2) have demonstrated community and stakeholder engagement experience; and (3) have experience in actively applying or overseeing the application of science-based quality improvement methods to reduce health disparities. Primary role and responsibilities include: oversee Contractor's strategic design, implementation, and evaluation of health equity efforts in the context of Contractor's population health initiatives; inform decision-making around best payer practices related to disparity reductions, including the provision of health equity and social determinant of health resources and research to leadership and programmatic areas; collaborate with Contractor's MIS Director to ensure Contractor collects and meaningfully uses race, ethnicity, and language data to identify disparities; ensure that efforts addressed at improving health equity, reducing disparities, and improving cultural competence are designed collaboratively with other contracted managed care entities to have a collective impact for the population

and the lessons learned are incorporated into future decision-making. This position shall report directly to the CEO.

2.3.1.20 Children’s Behavioral Health (CBH) Program Manager. The Children’s Behavioral Health Program Manager shall be a full-time position filled by Contractor, no later than the second quarter of calendar year 2022, that oversees and ensures alignment of Contractor’s Behavioral Health service delivery system for Children with Department requirements, Attachment XXII of this Contract, the N.B. implementation plan dated December 2, 2019, and any subsequent revisions. The Children’s Behavioral Health Program Manager shall: (1) serve as the single point of contact for HFS related to Children’s Behavioral Health; (2) maintain annual certification in the IM+CANS; (3) attend training on the Behavioral Health services available to N.B. class members and achieve certification in the Wraparound process; (4) ensure that Contractor’s reports and other information specific to N.B. class members are submitted timely and accurately to the Department or its designee; and, (5) co-chair Contractor’s Family Leadership Council and participate in the Children’s Behavioral Health Family Leadership Workgroup as required by the N.B. implementation plan.

2.3.1.21 Other key personnel identified by Contractor.

2.3.2 Designated liaisons. Contractor shall designate the following liaisons, who may also serve in a key position outlined in section 2.3.1. No individual shall serve in more than two (2) designated liaison roles. Designated liaisons will include:

2.3.2.1 A liaison who will serve as an account manager to the Department to facilitate communications between the Department and Contractor’s executive leadership and staff.

2.3.2.2 A liaison who will serve as an account manager to DCFS to facilitate communications between DCFS and Contractor’s executive leadership and staff.

2.3.2.3 A liaison who will be a consumer advocate for High-Needs and Special Needs Children. This individual shall be responsible for internal advocacy for these Enrollees’ interests, including ensuring input in policy development, planning, decision-making, and oversight.

2.3.2.4 A liaison who will be a consumer advocate for Enrollees who need Behavioral Health services. This position shall be responsible for internal advocacy for these Enrollees’ interests, including ensuring

input in policy development, planning, decision-making, and oversight, as well as coordination of recovery and resilience activities.

2.3.2.5 A liaison who will be a consumer advocate for Dual-Eligible Adults. This position shall be responsible for internal advocacy for these Enrollees' interests, including ensuring input in policy development, planning, decision-making, and oversight.

2.3.2.6 A liaison who will be responsible for all population health and related issues, including population health activities and coordination between Behavioral Health services.

2.3.2.7 A liaison who will ensure timely and accurate submission of Encounter Data and cooperate on other issues related to Contractor's information systems.

2.3.2.8 A liaison who will interact with other relevant policy groups.

2.3.2.9 A liaison who will interact with designated staff at the Department to ensure adherence to and understanding of the Department's unique billing requirements and to cooperate on other applicable billing issues.

2.3.3 **Training.** Contractor shall provide timely, relevant training that will help staff members competently perform their duties and targeted training to individual staff members as necessary.

2.3.4 **Background checks.** Contractor must clear each newly hired staff member through an industry-standard background check before such staff member assumes duties with Contractor.

2.4 CERTIFICATE OF AUTHORITY

If organized as an HMO, Contractor must obtain and maintain during the term of this Contract a valid certificate of authority as an HMO under 215 ILCS 125/1-1, *et seq.* Contractor shall provide proof of certificate of authority upon the Department's request. If organized as an MCCN, for so long as Contractor meets the requirements of 89 Ill. Admin. Code Part 143, Contractor may be deemed by the Department to be a certified MCCN.

2.5 OBLIGATION TO COMPLY WITH OTHER LAWS

2.5.1 No obligation imposed herein on Contractor shall relieve Contractor of any other obligation imposed by court order, law or regulation, including those imposed by the Managed Care Reform and Patient Rights Act (215 ILCS 134/1 *et seq.*); the federal Balanced Budget Act of 1997 (Public Law 105-33); Section 1557 of the Patient Protection and Affordable Care Act; and regulations

promulgated by the Illinois Department of Financial and Professional Regulation, and the Illinois Department of Insurance, the Illinois Department of Public Health, or Federal CMS. The Department shall report to the appropriate agency any information it receives that indicates a violation of a law or regulation. The Department will inform Contractor of any such report unless the appropriate agency to which the Department has reported requests that the Department not inform Contractor.

- 2.5.2 If Contractor believes that it is impossible to comply with a provision of this Contract because of a contradictory provision of applicable State or federal law, Contractor shall immediately notify the Department. The Department then will determine whether a Contract amendment is necessary. The fact that either the Contract or an applicable law imposes a more stringent standard than the other does not, in and of itself, render it impossible to comply with both.

2.6 PROVISION OF COVERED SERVICES THROUGH NETWORK PROVIDERS

Where Contractor does not employ Physicians or other Providers to provide direct healthcare services, every provision in this Contract by which Contractor is obligated to provide Covered Services of any type to Enrollees—including provisions stating that Contractor shall “provide Covered Services,” “provide quality care,” or provide a specific type of healthcare service, such as the Covered Services in section 5.2—shall be interpreted to mean that Contractor shall arrange for the provision of those Covered Services through its Provider Network.

2.7 CULTURAL COMPETENCE

- 2.7.1 Contractor shall implement a Cultural Competence plan, and Covered Services shall be provided in a culturally competent manner by ensuring the Cultural Competence of all Contractor staff, from clerical to executive management, and Providers. Contractor shall implement the NCQA Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards).

- 2.7.2 **Cultural Competence plan.** Contractor’s Cultural Competence plan shall address the challenges of meeting the healthcare needs of Enrollees. Contractor’s Cultural Competence plan shall, at a minimum, address the following:

2.7.2.1 involvement of executive management and Providers in the development and ongoing operation of the Cultural Competence plan;

2.7.2.2 the individual executive employee responsible for executing and monitoring the Cultural Competence plan;

2.7.2.3 the creation and ongoing operation of a committee or group within Contractor to assist Contractor to meet the cultural needs of its

Enrollees. This committee shall:

- 2.7.2.3.1 be reflective of the geographical and cultural groups served by Contractor, and
 - 2.7.2.3.2 at minimum have fifty-one percent (51%) of its committee members be Enrollees or community-based participants;
 - 2.7.2.4 the assurance of Cultural Competence at each level of care;
 - 2.7.2.5 indicators within the Cultural Competence plan that Contractor will use as benchmarks toward achieving Cultural Competence;
 - 2.7.2.6 Contractor's written policies and procedures for Cultural Competence;
 - 2.7.2.7 Contractor's strategy and method for recruiting staff with backgrounds representative of Enrollees served;
 - 2.7.2.8 the availability of interpretive services;
 - 2.7.2.9 Contractor's ongoing strategy and method to ameliorate transportation barriers and its operation;
 - 2.7.2.10 Contractor's ongoing strategy and method to meet the unique needs of Enrollees who have Developmental Disabilities and Cognitive Disabilities and its operation;
 - 2.7.2.11 Contractor's ongoing strategy and method to provide services for home-bound Enrollees and the strategy's operation;
 - 2.7.2.12 Contractor's ongoing strategy and method to engage local organizations to develop or provide cultural-competency training and collaborate on initiatives to increase and measure the effectiveness of culturally competent service delivery and its operation; and
 - 2.7.2.13 a description of how Cultural Competence is and will continue to be linked to health outcomes.
- 2.7.3 **Staff.** Contractor shall proactively attempt, within the conditions imposed by any court order or consent decree, to hire staff who reflect the diversity of Enrollee demographics. Contractor shall require all staff, including employees and contract personnel, to complete linguistic and Cultural Competence training upon hire and no less frequently than annually thereafter.
- 2.7.4 **Providers.** Contractor shall contract with a culturally-diverse network of Providers of both genders and prioritize recruitment of bilingual or multi-lingual Providers. Contractor's contracts with Providers shall require that Providers comply with Contractor's Cultural Competence plan. Contractor shall confirm the languages used by Providers, including American Sign

Language, and ensure physical access to Providers' office locations.

- 2.7.5 **Subcontractors.** Contractor shall require that its Subcontractors comply with Contractor's Cultural Competence plan and complete Contractor's initial and annual Cultural Competence training. Contractor's oversight committee, established pursuant to section 5.40.4, shall ensure compliance by Subcontractors with contractual and statutory requirements, including the Illinois Human Rights Act, the US Civil Rights Act, and Section 504 of the federal Rehabilitation Act.
- 2.7.6 **Provider monitoring.** Contractor shall perform QA evaluations of Provider practices, which shall include monitoring of Enrollee accessibility to ensure linguistic and physical accessibility. Contractor shall support Providers in achieving accessibility.
- 2.7.7 **Readiness Review.** Contractor shall submit its completed Cultural Competence plan to the Department at least two (2) weeks prior to the Department's Readiness Review.

2.8 PROVIDER SITE ACCESS

All Provider locations where Enrollees receive services shall comply with the requirements of the Americans with Disabilities Act (ADA). Contractor's network shall have Provider locations that are able to accommodate the needs of individual Enrollees.

2.9 BUSINESS ENTERPRISE PROGRAM GOALS

- 2.9.1 On an annual basis, Contractor shall meet the Business Enterprise Program (BEP) subcontracting goals set by the Department. The goal will be set as percentages of the Administrative Allowance included in Capitation payments made to Contractor as set forth in Attachment IV, multiplied by the anticipated Enrollee months during the State Fiscal Year. The calculation for State Fiscal Year 2018 is twenty percent (20%). For subsequent State Fiscal Years, the Department may submit addenda to Attachment VII upon written notice to Contractor without requiring amendment of this Contract. The percentages for the sub-goals shall be as follows:
- 2.9.1.1 eleven percent (11%) for minority-owned businesses;
 - 2.9.2.2 seven percent (7%) for female-owned businesses; and
 - 2.9.2.3 two percent (2%) for businesses owned by individuals with disabilities.
- 2.9.2 Contractor shall report quarterly to DCMS on BEP vendor payments and goal attainment during each State Fiscal Year, in a format specified by DCMS, with

a copy to the Department's BEP liaison. Contractor shall maintain a record of all relevant data with respect to the utilization of BEP certified subcontractors, including payroll records, invoices, canceled checks, and books of account, for a period of at least five (5) years after the completion of the Contract. Upon three (3) Business Days' written notice, Contractor shall grant full access to these records to any Authorized Person. The Department shall have the right to obtain from Contractor any additional data reasonably related or necessary to verify any representation by Contractor.

- 2.9.3 Contractor shall submit to the Department's BEP liaison its initial BEP utilization plan and related letters of intent no later than sixty (60) days after the Effective Date. After submission, Contractor shall cooperate with the Department to achieve a BEP utilization plan that is acceptable to the State. Any approved BEP utilization plan shall be incorporated as part of this Contract as Attachment VII.

ARTICLE III: ELIGIBILITY

3.1 DETERMINATION OF ELIGIBILITY

The Department, consistent with all applicable federal laws and its State Plan, has the exclusive right to determine an individual's eligibility. Such determination shall be final and is not subject to review or appeal by Contractor. Nothing in Article III prevents Contractor from providing the Department with information Contractor believes indicates that an Enrollee's eligibility was incorrectly determined or has changed so that enrollment with Contractor is no longer appropriate or that the Capitation rate for that Enrollee should be adjusted. By mutual agreement of the Parties, enrollment with Contractor may be expanded to other categories of individuals receiving health coverage from the Department upon the Department providing Contractor with written notice no fewer than one-hundred eighty (180) days in advance, unless otherwise agreed to by the Parties, before the first enrollment under such expansion. Such notice shall include:

- 3.1.1 the definition of any new category of individuals;
- 3.1.2 the number of Potential Enrollees within any new category of individuals; and
- 3.1.3 the Capitation rates applicable to any new category of individuals.

3.2 NONDISCRIMINATION

Contractor shall not discriminate against a Potential Enrollee, Prospective Enrollee, or Enrollee on any basis prohibited by section 9.1.22.

ARTICLE IV: ENROLLMENT, COVERAGE, AND TERMINATION OF COVERAGE

4.1 ENROLLMENT GENERALLY

- 4.1.1 All Potential Enrollees who live in the Contracting Area shall be required to become Enrollees in a Health Plan, except those Potential Enrollees who, pursuant to federal law or a waiver approved by Federal CMS, are subject only to voluntary enrollment or are part of an excluded population. The ICES shall be responsible for the enrollment of Potential Enrollees, including the provision of all education regarding Health Plan choices, enrollment by active choice, and enrollment by automatic assignment. Contractor shall continue to accept Potential Enrollees for enrollment until the Department determines that any further enrollments would exceed Contractor's capacity based on a review conducted pursuant to section 4.15. Contractor shall accept each Potential Enrollee whose name appears on the 834 Audit File and 834 Daily File. Enrollment shall be without restriction and shall be in the order in which Potential Enrollees apply or are assigned. Contractor will not discriminate against Potential Enrollees based on health status or need for healthcare services. Contractor shall not participate in facilitating enrollment, including during the Open Enrollment Period. Contractor may educate a Potential Enrollee regarding the specific elements of Contractor, provided that Contractor engages in no Marketing activities prohibited under section 4.17. Contractor shall refer all requests for enrollment to the ICES, which shall not be considered "facilitating enrollment." Nothing in this Contract shall be deemed to be a guarantee of any Potential Enrollee's enrollment with Contractor.
- 4.1.2 For new Enrollees transferring from another MCO, the Department will notify Contractor of the Enrollee's previous MCO, and Contractor shall request the Enrollee's IPoC from that MCO.
- 4.1.3 For past Enrollees who have left Contractor's Health Plan, Contractor shall provide an Enrollee's IPoC within ten (10) Business Days after receiving a request for it from the MCO in which the individual is enrolled.

4.2 ILLINOIS CLIENT ENROLLMENT SERVICES

All enrollments will be processed by the ICES. The Department will provide Contractor with samples of the enrollment information mailed to Potential Enrollees by the ICES. Contractor may provide comments, for the Department's consideration, relating to the accuracy of that information as it pertains to the Contract. Contractor may be asked to provide material or other information for the enrollment information mailed by the ICES.

4.3 INITIAL PROGRAM IMPLEMENTATION

Beginning on the Effective Date, the initial enrollment of Potential Enrollees in the Contracting Area will be phased according to a schedule set by the Department in order to ensure a smooth transition and to minimize disruption of care. The Department retains the right to begin on a later date and to stagger enrollment in its sole discretion. An Enrollee with Contractor who does not exercise the right to actively enroll with another MCO when the Enrollee has the opportunity will automatically remain an Enrollee with Contractor.

4.4 CHOICE IN ENROLLMENT

- 4.4.1 Individuals who were enrolled with Contractor on the day before the Effective Date will be assigned as Enrollees with Contractor on the Effective Date. Such Enrollees will have a ninety (90) day change period after assignment to select another MCO as provided in section 4.10.1.
- 4.4.2 Individuals who were enrolled on the day before the Effective Date with a MCO that does not have a contract with the Department on the Effective Date will be assigned as Enrollees to a contracted MCO on the Effective Date using an algorithm defined by the Department. Such Enrollees will have a ninety (90)-day change period after assignment to select another MCO as provided in section 4.10.1.
- 4.4.3 All Potential Enrollees not explicitly described in section 4.4.1 or section 4.4.2 will have an opportunity to choose a MCO. These Potential Enrollees will have a thirty (30)-day enrollment period to select a MCO. When a selection is not made within that period, the Potential Enrollees will be enrolled by automatic assignment to a MCO. All such Enrollees will have a ninety (90)-day change period after the Effective Enrollment Date to select another MCO as provided in section 4.10.1. A Potential Enrollee will have the opportunity to select a PCP when choosing an MCO. On a daily basis, the ICES will inform Contractor of the Prospective Enrollees who have chosen Contractor and the PCPs that were selected.
- 4.4.4 Enrollees already enrolled with Contractor will be given priority to continue such enrollment over Potential Enrollees if Contractor does not have capacity to accept all those seeking enrollment with Contractor.

4.5 ENROLLMENT BY AUTOMATIC ASSIGNMENT

A Potential Enrollee who is subject to mandatory enrollment and who does not select an MCO will be enrolled by automatic assignment to a qualified MCO by the ICES. To be a qualified MCO, Contractor cannot be subject to the intermediate sanction described in 42 CFR 438.702(a)(4), and must have the capacity to enroll Prospective Enrollees. On a daily basis, the ICES will inform Contractor of Prospective Enrollees

who have been enrolled with Contractor by automatic assignment and the PCPs to whom they were assigned. The Department and the ICES will design and implement an algorithm for enrollment by automatic assignment. The algorithm will consider existing PCP relationships based on 42 CFR 438.54(d)(7), residence, family member assignments, geography, and cost. In no event will assignments or enrollments exceed the capacity of an MCO. The Department shall provide Contractor with a description of the algorithm for enrollment by automatic assignment of Enrollees.

4.5.1 The Department reserves the right to reevaluate and modify the algorithm for enrollment by automatic assignment at any time for any reason during the term of this Contract, and may provide that the algorithm considerations include Contractor's performance on quality measures, operational performance, and other measures relevant to program effectiveness. The Department shall provide written notice to Contractor at least sixty (60) days before implementation of any significant modification, as determined by the Department, of the algorithm for enrollment by automatic assignment.

4.5.2 The Department reserves the right to develop an algorithm for Enrollee PCP assignment, when no active choice is made by an Enrollee, that may be based upon PCPs' performance measures and metrics as determined by the Department. The Department shall provide written notice to Contractor at least sixty (60) days before implementation of any significant modification, as determined by the Department, of the algorithm for Enrollee PCP assignment.

4.6 ENROLLMENT OF NEWBORNS, INFANTS, AND CHILDREN

4.6.1 Enrollment of Newborns, infants, and Children who are added to the case of the mother whose RIN is on the IES transaction and who is enrolled with the Contractor, are enrolled automatically as follows: If the newborn is added to the case before the newborn is forty-six (46) days old, the newborn's Effective Enrollment Date with Contractor is retroactive to the newborn's date of birth. Contractor shall provide coverage of the newborn Enrollee retroactively to the date of birth, based on the Enrollment Effective Date determined by the Department and provided to Contractor on the 834 Audit File. Contractor shall not require prior authorization for inpatient newborn claims for newborns retroactively enrolled pursuant to this section.

4.6.2 Enrollment of Newborns, infants, and Children who are added to the case of the mother whose RIN is on the IES transaction and who is enrolled with the Contractor, are enrolled automatically as follows: If an infant is added to the case after the age of forty-five (45) days and up to, but not including, one (1) year old, the newborn's Effective Enrollment Date with Contractor will be prospective as provided in section 4.7. Contractor shall provide coverage of the infant Enrollee prospectively as provided in section 4.7, based on the Effective Enrollment Date determined by the Department and provided to Contractor on the 834 Audit File.

4.6.3 Children under the age of nineteen (19), excluding newborns and infants, who are added to the case of a sibling, mother, or head of household and whose RIN is on the IES transaction and who is enrolled with the Contractor, are enrolled automatically. Contractor shall provide coverage of the child Enrollee prospectively as provided in section 4.7.

4.6.4 For newborn claims where newborn has not yet been determined Medicaid eligible and assigned a RIN, Contractor shall follow the claims processing rules for newborns not yet assigned a RIN established by the Department for fee-for-service claims.

4.7 EFFECTIVE ENROLLMENT DATE

If a request for enrollment is received and entered by the ICES, and it is accepted by the Department's database prior to the applicable cut-off date, coverage shall begin on the first day of the following calendar month. If the ICES receives and enters an enrollment after the applicable cut-off date, and it is accepted by the Department's database after the applicable cut-off-date, coverage shall begin no later than the first day of the second calendar month following the date the enrollment is accepted by the Department's database.

4.8 UPDATE OF ENROLLMENT INFORMATION

Within five (5) Business Days after receipt of the 834 Audit File, Contractor shall update all electronic systems maintained by Contractor to reflect the information contained in the 834 Audit File received from the Department. Contractor shall use the 834 Audit File to verify Contractor's Enrollees for the subsequent calendar month. Contractor shall not wait for the 820 Payment File to update eligibility.

4.9 ENROLLEE WELCOME PACKET

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

4.10 CHANGE OF MANAGED CARE ORGANIZATION

4.10.1 **Initial enrollment and change period.** During the initial ninety (90) days after the Effective Enrollment Date, whether the Enrollee actively selected the MCO or was enrolled by automatic assignment, the Enrollee shall have the opportunity to select a different MCO. Except as provided in section 4.10.3, the Enrollee shall not be allowed to change MCOs again until the Open Enrollment Period. If the Enrollee contacts Contractor to request a change of

MCO during this ninety (90)-day period, Contractor shall attempt to identify and resolve the Enrollee's concerns and if not resolved to the Enrollee's satisfaction, Contractor shall refer the Enrollee to the ICES. The MCO to which the Enrollee changes to is responsible for Care Coordination and Transition of Care planning. Unless otherwise specified in section 5.19, the MCO in which the Enrollee was first enrolled is responsible for payment for Covered Services through the effective disenrollment date and for cooperating with the Care Coordination and Transition of Care planning.

4.10.2 Open Enrollment Period. After the initial Enrollment Period as set forth in section 4.10.1, and once every twelve (12) months thereafter, each Enrollee shall have a sixty (60)-day period in which to change MCOs in which the Enrollee is enrolled. No later than sixty-four (64) days prior to each Enrollee's Anniversary Date, the ICES shall send notice to the Enrollee of the Enrollee's opportunity to change MCOs and the sixty (60)-day deadline for doing so. If the Enrollee selects a different MCO during the Open Enrollment Period, enrollment in the new MCO will be effective on the Enrollee's Anniversary Date. Enrollees who make no selection will continue to be enrolled with the same MCO. Enrollees may not change MCOs at any time other than the Open Enrollment Period, except as provided in section 4.10.3.

4.10.3 Disenrollment by Enrollee. All disenrollment must be pursuant to 42 CFR §438.56.

4.10.3.1 When an Enrollee is subject to voluntary managed care enrollment under the Medicaid Managed Care Program, an Enrollee may disenroll from Contractor at any time and for any reason by notifying ICES.

4.10.3.2 When an Enrollee is subject to mandatory managed care enrollment under the Medicaid Managed Care Program, an Enrollee may request to disenroll for cause from Contractor for any of the following reasons at any time by notifying Contractor, orally or in writing, of the Enrollee's request to disenroll. Subject to the requirements in section 4.14.4, such a request shall be granted by the Department when the reason matches any of the following as determined by the Department:

4.10.3.2.1 the Enrollee moves out of the Contracting Area;

4.10.3.2.2 Contractor, due to its exercise of right of conscience pursuant to section 5.6, does not provide the Covered Service that the Enrollee seeks;

4.10.3.2.3 the Enrollee needs related Covered Services to be performed at the same time, not all the related services are available through Contractor, and the Enrollee's Provider determines that receiving the services

separately would subject the Enrollee to unnecessary risk;

- 4.10.3.2.4 when a change in Enrollee's LTSS Provider (residential, institutional, or employment support) from a Network Provider to a non-Network Provider results in a disruption to residence or employment; or,
- 4.10.3.2.5 other reasons, including: poor quality of care; a sanction imposed by the Department pursuant to 42 CFR 438.702(a)(4); lack of access to Covered Services; lack of access to Providers experienced in dealing with the Enrollee's healthcare needs; if the Enrollee is automatically re-enrolled pursuant to section 4.11 and such loss of coverage causes the Enrollee to miss the open Enrollment Period; or an Enrollee's Primary Care Provider's contract with Contractor is terminated resulting in disruption to the Enrollee.

4.11 RE-ENROLLMENT AFTER RESUMPTION OF ELIGIBILITY

If an Enrollee with Contractor is disenrolled due to the loss of HFS Medical Program coverage, but the Enrollee's HFS Medical Program coverage is reinstated within ninety (90) days, the Department will attempt to re-enroll the Enrollee with Contractor, provided that the Enrollee's eligibility status is still valid for participation and, subject to section 4.14.1.3, the Enrollee resides in the Contracting Area.

4.12 INSOLVENCY

If Contractor becomes insolvent or is subject to insolvency proceedings as set forth in 215 ILCS 125/1-1 *et seq.*, Contractor shall be liable for all claims for Covered Services and shall remain responsible for the provision of Covered Services and the management of care provided to all Enrollees until the Contract is terminated or expires.

4.13 CHANGE OF PRIMARY CARE PROVIDER OR WOMEN'S HEALTHCARE PROVIDER

Contractor shall process an Enrollee's oral or written request to change PCP or WHCP within thirty (30) days after the receipt of the request.

4.14 TERMINATION OF COVERAGE

- 4.14.1 The Department shall terminate an Enrollee's coverage when the Enrollee becomes ineligible for HFS Medical Program or otherwise is not within the population described as being Enrollees under this Contract, or upon the occurrence of any of the following conditions:

- 4.14.1.1 Upon the Enrollee's death. Termination of coverage shall take effect at 11:59 p.m. on the last day of the month in which the Enrollee dies. Termination may be retroactive to this date.
- 4.14.1.2 When an Enrollee elects to change MCOs during the change period (section 4.10.1) or Open Enrollment Period (section 4.10.2). Termination of coverage with the previous MCO shall take effect at 11:59 p.m. on the day immediately preceding the Enrollee's Effective Enrollment Date with the new MCO.
- 4.14.1.3 When an Enrollee no longer resides in the Contracting Area. If an Enrollee is to be disenrolled at the request of Contractor under the provisions of this section 4.14.1.3 Contractor must first provide documentation satisfactory to the Department that the Enrollee no longer resides in the Contracting Area. Termination of coverage shall take effect at 11:59 p.m. on the last day of the month prior to the month in which the Department determines that the Enrollee no longer resides in the Contracting Area. Termination may be retroactive if the Department is able to determine the month in which the Enrollee moved from the Contracting Area.
- 4.14.1.4 When the Department determines that an Enrollee has other significant insurance coverage or is placed in Spend-Down status. The Department shall notify Contractor of such disenrollment on the 834 Daily File. This notification shall include the effective disenrollment date.
- 4.14.1.5 When the Department is made aware that an Enrollee is incarcerated in a county jail, Illinois Department of Corrections facility, or federal penal institution. Termination of coverage shall take effect at 11:59 p.m. on the last day of the month prior to the month in which the Enrollee was incarcerated.
- 4.14.1.6 When an Enrollee enters DCFS custody. Termination of coverage shall take effect at 11:59 p.m. on the day prior to the day on which the court grants DCFS custody of the Enrollee.
- 4.14.2 The termination or expiration of this Contract terminates coverage for all Enrollees with Contractor. Termination will take effect at 11:59 p.m. on the last day of the month in which this Contract terminates or expires, unless otherwise agreed to, in writing, by the Parties.
- 4.14.3 Except as otherwise provided in this Article IV, termination of an Enrollee's coverage shall take effect at 11:59 p.m. on the last day of the month following the month the disenrollment is processed by the Department.
- 4.14.4 Disenrollment from Contractor as provided in sections 4.10.3 and 4.14.5 may only occur upon receipt by Contractor of written approval of such

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

4.14.5 Contractor shall not seek to terminate enrollment because of an adverse change in an Enrollee's health status, or because of the Enrollee's utilization of Covered Services, diminished mental capacity, or uncooperative or disruptive behavior resulting from such Enrollee's special needs (except to the extent such Enrollee's continued enrollment with Contractor seriously impairs Contractor's ability to furnish Covered Services to the Enrollee or other Enrollees). Any attempts to seek to terminate enrollment in violation of this section 4.14.5 will be considered a Breach of this Contract.

4.14.6 Contractor shall not seek to terminate enrollment of an Enrollee who attempts to exercise, or is exercising, the Enrollee's Appeal or Grievance rights. Any attempts to seek to terminate enrollment in violation of this section 4.14.6 will be considered a Breach of this Contract.

4.15 CAPACITY

4.15.1 The number of Enrollees enrolled with Contractor will be limited to a level that will not exceed Contractor's physical, professional, and Provider Network capacity. The Department may establish an enrollment threshold for Contractor, expressed as a percentage of Contractor's maximum enrollment capacity, as a component of the Readiness Review. The Department may also, at any time, set a maximum enrollment capacity based upon other factors including quality indicators or sanctions imposed pursuant to section 7.16.

4.15.2 Upon request by the Department, or at the times set forth in section 4.15.2.1, Contractor shall provide to the Department documentation that sets forth Contractor's physical, professional, and network capacity. The documentation must demonstrate that Contractor offers an appropriate range of preventive services, primary care, Behavioral Health, and specialty services that is adequate for the anticipated number of Enrollees, and that Contractor maintains a Provider Network that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Enrollees.

4.15.2.1 The Department will review the documentation:

4.15.2.1.1 each year on the anniversary of the Effective Date of this

Contract, or such other date as the Department may designate;

- 4.15.2.1.2 when Contractor requests a review and the Department agrees to such review;
- 4.15.2.1.3 when there is a change in Covered Services, categories of Potential Enrollees, Contracting Area, or Capitation that can reasonably be expected to affect Contractor's capacity;
- 4.15.2.1.4 when there is a Change of Control, or a sale or transfer of Contractor; or
- 4.15.2.1.5 when the Department determines that Contractor's operating or financial performance reasonably indicates a lack of Provider or administrative capacity.

4.15.2.2 If the Department determines that Contractor does not have the necessary Provider or administrative capacity to provide Covered Services to any additional Enrollees, the Department shall provide written notice of such determination to Contractor, containing an explanation of the methodology used by the Department to determine Contractor's Provider and administrative capacity and allowing Contractor sixty (60) days to restore Provider and administrative capacity. In the event the Department reasonably finds that Contractor has failed to restore Provider and administrative capacity within sixty (60) days after Contractor receives such notice, the Department may suspend enrollment (through automatic assignment, enrollment by Enrollee choice, or both), upon written notice to Contractor of such findings. Such suspension of enrollment may, at the sole discretion of the Department, be for an area that is not the entire Contracting Area. Thereafter, Contractor may, at any time, submit written evidence to the Department that Contractor has increased Provider and administrative capacity, which evidence the Department shall review in good faith. The Department shall, within thirty (30) days following the Department's receipt of such evidence, provide written notice to Contractor of its findings. If the Department finds that Contractor's Provider and administrative capacity has increased to the Department's satisfaction, the Department will resume Contractor's enrollment.

4.16 IDENTIFICATION CARD

4.16.1 Contractor shall send each new Enrollee an identification card bearing:

- 4.16.1.1 the name of Contractor;
 - 4.16.1.2 the Effective Enrollment Date;
 - 4.16.1.3 the name of Enrollee;
 - 4.16.1.4 the Enrollee's RIN;
 - 4.16.1.5 Contractor-assigned enrollee ID number, if applicable;
 - 4.16.1.6 the twenty-four (24)-hour telephone number to confirm eligibility for benefits and authorization for services; and
 - 4.16.1.7 the name and phone number of the Enrollee's PCP (do not include for Dual-Eligible Enrollees).
- 4.16.2 Contractor shall send the identification cards to the Enrollee no later than five (5) Business Days after receipt of the monthly 834 Audit File, or, no later than five (5) Business Days prior to an Enrollee's Effective Enrollment Date.
- 4.16.2.1 For Dual-Eligible Enrollees whose enrollments are received by Contractor after receipt of the monthly 834 Audit File, Contractor shall send the identification card no later than five (5) Business Days after receipt of the 834 Daily File, or, no later than five (5) Business Days prior to an Enrollee's Effective Enrollment Date.
- 4.16.3 Contractor shall send a draft of the identification card described herein to the Department for Prior Approval no fewer than five (5) Business Days prior to the Readiness Review and when the card content is revised. Contractor shall not be required to submit format changes to the card for Prior Approval, provided there is no change in the information conveyed.

4.17 MARKETING

- 4.17.1 Contractor must comply with the requirements in 42 CFR §438.104 and 45 CFR 164.508(a)(3) regarding Marketing activities. Contractor shall not use any subcontractors, including Network Providers, to engage in any Marketing on behalf of Contractor except as allowed under section 4.17.
- 4.17.2 Marketing by any medium, including mail, mass-media advertising, and community-oriented, and the content of all Marketing Materials will be allowed subject to the Department's Prior Approval. Contractor shall comply with the Department's outreach guidelines as updated from time to time. Contractor shall be responsible for all costs of such Marketing, including labor costs. The Department reserves the right to determine and set the sole process of, and payment for, Marketing by mail, using names and addresses of Potential Enrollees supplied by the Department, including the right to limit Marketing by mail to a vendor that has entered into a confidentiality

agreement with the Department and the terms and conditions set forth in that vendor agreement. Contractor must distribute any such permitted Marketing Materials throughout the Contracting Area.

4.17.3 Face-to-face Marketing by Contractor directed at Participants or Potential Enrollees, including direct or indirect door-to-door contact, telephone contact, e-mail, texting, or other cold-call activities, is strictly prohibited. Events that may involve Contractor staff educating groups of Participants or Potential Enrollees shall not be considered “face-to-face” Marketing.

4.17.4 Without Prior Approval, Contractor shall not engage in otherwise prohibited Marketing activities, including:

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

4.17.4.2 providing gifts or incentives to Potential Enrollees or Prospective Enrollees unless such gifts or incentives are also provided to the general public and do not exceed US \$10 in value per individual gift or incentive and no more than a cumulative annual value of US \$50;

4.17.4.3 providing gifts or incentives to Enrollees unless such gifts or incentives are provided conditionally based on the Enrollee receiving preventive care or other health-related activity, are not in the form of cash or an instrument that may be converted to cash;

4.17.4.4 seeking to influence a Potential Enrollee’s enrollment with Contractor in conjunction with the sale of any other insurance;

4.17.4.5 inducing Providers or employees of the Department or DHS to reveal Confidential Information regarding Participants or otherwise use such Confidential Information in a fraudulent manner; or

4.17.4.6 threatening, coercing, or making untruthful or misleading statements to Potential Enrollees, Prospective Enrollees, or Enrollees regarding the merits of enrollment with Contractor or any other MCO, including any statement that the Potential Enrollee, Prospective Enrollee, or Enrollee must enroll with Contractor in order to obtain benefits or in order not to lose benefits, or any statement that Contractor is endorsed by Federal CMS, by the federal or State government, or by any similar entity.

4.17.5 **Marketing, Outreach and Education Plan.** Beginning in calendar year 2023, on an annual basis, Contractor must submit to the Department for Prior Approval a Marketing, Outreach and Education Plan no later than November 15th that covers the

period of the following calendar year. The Marketing, Outreach and Education Plan must reflect a focused approach and strategy that aligns with the program goals under the Department's Comprehensive Medical Programs Quality Strategy. Contractor's Marketing, Outreach and Education Plan must include the following:

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

4.17.5.2 equity-based strategies on:

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

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

4.17.5.2.3 education and outreach initiatives on maternal and child healthcare;

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

4.17.5.2.5 support Enrollee redetermination process for hard to reach populations;

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

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

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

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

4.17.5.6 guidelines on gifts and incentives;

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

4.17.5.8 procedures for addressing marketing complaints; and

4.17.5.9 guidelines for securing Enrollee consent.

4.18 READINESS REVIEW

Contractor is not entitled to any enrollment until it has passed a Readiness Review conducted by the Department, or otherwise received notice from the Department, indicating that, to the Department's satisfaction, Contractor is ready to provide services to Enrollees in a safe and efficient manner. A Readiness Review will be conducted prior to implementation of any service package set forth in section 5.2.

4.19 ENROLLEE RESTRICTION

4.19.1 Contractor must have an Enrollee restriction program in place, in which, at a minimum, Contractor must restrict an Enrollee for a reasonable period to a designated PCP or Provider of pharmacy services when:

4.19.1.1 the Department indicates the Enrollee was included in the Department's Recipient Restriction Program pursuant to 89 Ill. Admin. Code 120.80 prior to enrollment with Contractor; or

4.19.1.2 Contractor determines that the Enrollee is over-utilizing Covered Services. Contractor's criteria for such determination, and the conditions of the restriction, must meet the standards of 42 CFR §431.54(e).

4.19.2 Contractor's policies on Enrollee restriction must receive Prior Approval and shall include the right of the Enrollee to file a Grievance or Appeal.

ARTICLE V: DUTIES OF CONTRACTOR

5.1 AMOUNT, DURATION, AND SCOPE OF COVERAGE

Contractor shall comply with the terms of 42 CFR §438.206 (b) and (c) and provide, or arrange to have provided, to all Enrollees the services described in 89 Ill. Adm. Code, Part 140, 59 Ill. Adm. Code, Part 132, the State Plan and related waivers, as amended from time to time and not specifically excluded therein in accordance with the terms of this Contract. Covered Services shall be provided in the amount, duration, and scope as set forth in 89 Ill. Adm. Code, Part 140, in 59 Ill. Adm. Code, Part 132, in the State Plan and related waivers, and in this Contract, and shall be sufficient to achieve the purposes for which such Covered Services are furnished. This duty shall commence at the time of initial coverage for each Enrollee. Contractor shall, at all times, cover the appropriate level of service for all Emergency Services and non-Emergency Services in an appropriate setting. Contractor shall notify the Department in writing as soon as practicable, but no later than five (5) days following a change in Contractor's Provider Network that renders Contractor unable to provide one (1) or more Covered Services within the access-to-care standards set forth in section 5.8. Contractor shall not refer Enrollees to publicly supported healthcare entities to receive Covered Services for which Contractor receives payment from the Department, unless such entities are Network Providers with Contractor or are operated by Contractor. Such publicly supported healthcare entities include, but are not limited to, the Chicago Department of Public Health and its clinics, and the Certified Local Health Departments. Contractor shall provide a mechanism for an Enrollee to obtain a second opinion from a qualified Provider, whether Network or non-Network, at no cost to the Enrollee. Contractor will assist in coordinating and obtaining any second opinion from a non-Network Provider.

5.2 COVERED SERVICES

5.2.1 Covered Services for all Enrollees except Dual-Eligible Adults receiving long-term services and supports in an institutional care setting or through an HCBS waiver (MLTSS) are as follows:

5.2.1.1 **Service Package I.** Contractor shall provide, or arrange for the provision of, all Covered Services for Service Package I, to Enrollees at all times during the term of this Contract, whenever Medically Necessary. Service Package I includes all federally approved Medicaid services, including EPSDT screenings and services, except those included in Service Package II (see Attachment I). Additional services that are explicitly excluded from Service Package I are listed in section 5.4.

5.2.1.2 **Service Package II.** Contractor shall provide, or arrange for the provision of, all Covered Services for Service Package II, to Enrollees at

all times during the term of this Contract. Service Package II includes all Covered Services identified in Attachment I. Personal Assistant services in Service Package II shall be considered Covered Services only if such services can be included in a manner consistent with any existing collective bargaining agreement, or pertinent side letter, between DCMS and SEIU Healthcare Illinois. Contractor must abide by the rules and policies provided in each HCBS Waiver.

5.2.1.3 **Service Package III.** Service Package III includes Developmental Disability waiver services and ICF/DD services. The Department reserves the right to require Contractor to provide Service Package III services. The Department will provide contractor one-hundred eighty (180) days' notice, in writing, before requiring the provision of these services.

5.2.2 **MLTSS.** MLTSS Services include the Behavioral Health and non-emergency transportation services from Service Package I and the Nursing Facility and waiver services from Service Package II that are not covered by Medicare (see Attachment I). Medicare remains the primary payer of Medicare-covered services for MLTSS Enrollees. Crossover claims and other federally approved Medicaid services not covered by Medicare are not covered MLTSS Services and will be billed to Fee-for-Service. Personal Assistant services shall be considered MLTSS Services only if such services can be included in a manner consistent with any existing collective bargaining agreement, or pertinent side letter, between DCMS and SEIU Healthcare Illinois. Contractor must abide by the rules and policies provided in each HCBS Waiver.

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

5.2.4 Contractor shall obtain Prior Approval from the Department before offering any additional service or benefit to Enrollees not required under this Contract. Contractor shall provide thirty (30) days' prior written notice to Enrollees and Prospective Enrollees before discontinuing an additional service or benefit. The notice must receive Prior Approval from the Department.

5.2.5 Contractor shall implement any Behavioral Health service plan developed by

DHS Contractors for an Enrollee who is a class member under the Williams consent decree, unless the Enrollee and the Enrollee's Williams Provider consent to a modification of such plan. Contractor is responsible for payment of services under such plan only to the extent the services are Covered Services. The State, or its designee, will provide Contractor with a timely copy of any such plan. To the extent that Covered Services in such plan would not have been paid by Contractor due to Contractor's utilization controls, Contractor is not obligated to pay until Contractor has received a copy of the plan.

5.2.6 In fulfilling the requirements of the American Recovery and Reinvestment Act of 2009:

5.2.6.1 The Department shall notify Contractor through the 834 Audit File which Enrollees have been identified as Indian as defined in 42 CFR §438.14(a).

5.2.6.2 The Department shall notify Contractor which Providers have been designated as an Indian Health Care Provider (IHCP) as defined at 42 CFR §438.14(a).

5.2.6.3 Contractor shall demonstrate that there are sufficient IHCPs in Contractor's Provider Network to ensure timely access to Covered Services for eligible Indian Enrollees.

5.2.6.4 Contractor shall reimburse IHCPs, whether Network Providers or not, for Covered Services provided to Indian Enrollees who are eligible to receive Covered Services from such Providers as follows:

5.2.6.4.1 at a rate negotiated between Contractor and the IHCP; or

5.2.6.4.2 in the absence of a negotiated rate, at a rate not less than the level and amount of payment that Contractor would make for the Covered Services to a Network Provider that is not an IHCP; and

5.2.6.4.3 make payment to all IHCPs that are Network Providers in a timely manner as required for payments to practitioners in individual or group practices under 42 CFR §447.45 and 447.46.

5.2.6.5 Contractor shall not impose any copayment on Enrollees identified as Indian for a Covered Service received from an IHCP or any Medicaid Provider.

5.2.6.6 Contractor shall not impose cost sharing on Enrollees identified as Indian if the Enrollees have ever received services from an IHCP.

5.2.6.7 An Enrollee identified as an Indian is exempt from all cost sharing if

the Enrollee has ever received a referral from an IHCP.

5.2.6.8 Contractor shall permit any Indian Enrollee to obtain Covered Services from non-Network IHCPs from whom the Enrollee is otherwise eligible to receive such Covered Services.

5.2.6.9 Contractor shall permit any Indian Enrollee who is eligible to receive Covered Services from an IHCP PCP that is a Network Provider, to choose that IHCP as the Enrollee's PCP, as long as that Provider has capacity to provide the Covered Services.

5.2.6.10 If the Department determines that timely access to Covered Services cannot be ensured due to few or no in-State IHCPs, Contractor will be considered to have met the requirement in section 5.2.6.3 if:

5.2.6.10.1 Indian Enrollees are permitted by Contractor to access out-of-State IHCPs; or

5.2.6.10.2 this circumstance is deemed to be good cause for disenrollment from both Contractor and participation in the State's managed care program under this Contract in accordance with 42 CFR §438.56(c).

5.2.6.11 Contractor shall permit a non-Network IHCP to refer an Indian Enrollee to a Network Provider.

5.3 PHARMACY REQUIREMENTS

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

5.3.1.1 Contractor shall submit its Pharmacy Formulary for Prior Approval initially and annually thereafter.

5.3.1.2 Contractor shall provide coverage of drugs in all classes of drugs for which the Department's FFS program provides coverage.

5.3.1.3 Contractor shall cover only drugs made by manufacturer who participate in the federal Medicaid drug rebate program, which applies to both prescription and over-the-counter drugs, but does not apply to non-drug items such as blood-glucose test strips. The department will provide a listing of manufacturers that participate in the federal Medicaid drug rebate program.

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

pursuant to Attachment XXI.

- 5.3.1.5 Contractor shall establish and maintain a generic drug Maximum Allowable Cost (MAC) dispute resolution process, subject to approval by the Department. The MAC dispute resolution process shall enable pharmacies to report pricing disputes to the Contractor up to 60 days from the claim date and the Contractor is required to resolve the pricing dispute within 21 days by adjusting the reimbursement rate to represent the acquisition cost of the drug, or by informing the pharmacy of alternative generic equivalent products that can be purchased at or below the Contractor's existing MAC price.
- 5.3.1.6 **340B drug billing.** Contractor shall ensure that it requires pharmacy, medical, and hospital Providers to identify 340B-purchased drugs on pharmacy, medical, and hospital claims following the Department billing guidelines applied in the FFS program. Contractor shall ensure that its Encounter claims to the Department also identify these drugs.
- 5.3.1.7 **Drug utilization reporting.** For outpatient drugs not identified in section 5.3.2.15, Contractor shall collect information on the total number of units of each dosage form, and strength, and package size by the National Drug Code of each covered outpatient drug dispensed to Enrollees.
- 5.3.1.8 Contractor shall report to the Department quarterly, in a format and in the detail specified by the Department, information on the total number of units of each dosage form, and strength and package size by the National Drug Code of each covered outpatient drug identified in section 5.3.2.16 dispensed to Enrollees.
- 5.3.1.9 **Drug utilization program and reporting.** Contractor shall develop and implement a system of policies and procedures, coverage criteria, and processes for Contractor's Drug Utilization Review (DUR) program. The DUR program shall include a prospective review process for all drugs prior to dispensing, all non-formulary drug requests, and a retrospective DUR process to detect patterns in prescribing, dispensing, or administration of medication and to prevent inappropriate use or abuse. Contractor is required to report prospective and retrospective DUR activities to the DHFS Medical Program annually, and assist in data collection and reporting to the Department of data necessary to complete the Federal CMS DUR annual report.
- 5.3.1.10 Contractor's electronic and print formularies shall display the following:
- 5.3.1.10.1 brand and generic medications covered;

- 5.3.1.10.2 if medication is preferred or non-preferred and each term's definition;
 - 5.3.1.10.3 each medication's tier and the definition of each tier;
 - 5.3.1.10.4 utilization controls, including step therapy, prior authorization, dosage limits, gender or age restrictions, quantity limits, and other policies;
 - 5.3.1.10.5 cost sharing;
 - 5.3.1.10.6 glossary of key terms and explanation of utilization controls and cost sharing;
 - 5.3.1.10.7 a key for all utilization controls visible on every page in which specific medication coverage is displayed;
 - 5.3.1.10.8 directions to obtain more information if a medication is not covered or listed in the formulary;
 - 5.3.1.10.9 an e-mail and toll-free number to which an individual can report inaccuracies in the formulary; and
 - 5.3.1.10.10 a disclosure that identifies the date of publication, a statement that the formulary is up to date as of publication, and contact information for questions and requests to receive updated information.
- 5.3.1.11 The Department shall send a pharmacy formulary template for Contractor to complete annually.
- 5.3.1.12 Contractor shall publish formulary on its program website and make the formulary easily understandable and publicly accessible without a password, user name, or personality identifiable information.
- 5.3.1.13 Contractor shall provide printed formularies upon request.
- 5.3.1.14 Upon reports of formulary inaccuracies, Contractor must investigate and make correction to the data displayed. Data correction shall be completed within three (3) Business Days.
- 5.3.1.15 Contractor shall attest to the Department on a quarterly basis that it is making updates to the pharmacy formulary within three (3) Business Days after investigation of reported inaccuracies.
- 5.3.2 Pharmacy Formulary and Preferred Drug List (PDL) Effective January 1, 2020.

5.3.2.1 Federal Medicaid drug rebate program. Contractor shall cover only drugs made by manufacturers who participate in the federal Medicaid drug rebate program. This requirement applies to both prescription and over-the-counter drugs. This requirement does not apply to non-drug items, such as glucose monitoring supplies, as those products are not drugs and are not eligible for the federal Medicaid drug rebate program. The Department will routinely provide Contractor an updated report of manufacturers that participate in the federal Medicaid drug rebate program.

5.3.2.2 Covered outpatient drugs. Contractor shall provide coverage of covered outpatient drugs as defined in Section 1927(k)(2) of the Social Security Act. Non-preferred drugs meet the definition of a covered outpatient drug and cannot be excluded from coverage. In the event a covered outpatient drug is not covered through Contractor's pharmacy benefit, it must be covered through Contractor's medical benefit. In the event Contractor does not include a covered outpatient drug on its pharmacy formulary, Contractor must have a process for Enrollees to access that drug through a prior authorization process, in accordance with 42 CFR §438.3(s)(1).

5.3.2.3 Compliance with preferred and non-preferred products.

5.3.2.3.1 Contractor shall cover as a preferred product all products listed as preferred on the Department's weekly Preferred Drug List (PDL) NDC file.

5.3.2.3.2 Contractor shall cover as a non-preferred product all products listed as non-preferred on the Department's weekly PDL NDC file.

5.3.2.3.3 Contractor shall not disadvantage any preferred product to another preferred or non-preferred product in the same drug class on the Department's PDL.

5.3.2.3.4 Where the Department lists a brand name product as preferred, and its generic equivalent as non-preferred, Contractor must also list and treat the brand name product as preferred and the generic drug as non-preferred.

5.3.2.4 Prior authorization status. Contractor shall not require prior authorization for any preferred drug for which the Department does not require prior authorization. Contractor may request authorization from the Department to require a clinical prior authorization on all preferred drugs in a class, where HFS does not require prior

authorization for that class, and the Contractor may require a clinical prior authorization only if approved in advance by the Department. In those classes where the Department requires a clinical prior authorization for all preferred drugs in the class, products are listed as “Preferred Requires Prior Authorization” on the Department’s PDL. Contractor may allow, without a prior authorization requirement, products that are listed on the Department’s PDL as “Preferred Requires Prior Authorization.” If Contractor does so, Contractor must make all preferred products available without a requirement for prior authorization in that class. Contractor may determine its own clinical prior authorization criteria unless otherwise stipulated by the Department.

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

5.3.2.5 **Requirement to use preferred products.** Contractor shall require Enrollees to use preferred products unless there is a clinical reason the Enrollee must use a non-preferred product.

5.3.2.5.1 *Age limits.* Contractor shall be no more restrictive than the Department in regard to age limitations for PDL products.

5.3.2.5.2 *Days’ supply.* Contractor shall be no more restrictive than the Department in regard to days’ supply allowed for PDL products.

5.3.2.6 **Rebates for drugs and other products on the PDL.** Contractor, including Contractor’s Pharmacy Benefit Manager (PBM) or its Subcontractors, is prohibited from negotiating any rebates with manufacturers for drugs or other products listed on the Department’s PDL. In the event Contractor, its PBM or other Subcontractors have an existing rebate agreement with a manufacturer, all products listed on the Department’s PDL must be exempt from such rebate agreements.

5.3.2.7 Unless otherwise prohibited in this contract, Contractor may establish clinically appropriate utilization controls, such as quantity and dose limits. Contractor shall utilize the Department’s step therapy and prior authorization requirements for family-planning drugs and devices pursuant to the Department’s PDL and Attachment XXI.

5.3.2.8 **PDL file.** The Department will provide Contractor a PDL file. Contractor shall provide the PDL file to their Pharmacy Benefit Manager (PBM) within two (2) Business Days of receipt.

5.3.2.8.1 *PDL file format and frequency.* The Department will provide Contractor, on a weekly basis, the PDL file at a National Drug Code (NDC) level. The PDL file will be a full file containing all NDCs included on the Department's PDL and include age limitations, days' supply allowances, and drug class. Contractor shall load the file within seven (7) Business Days of receipt of the file.

5.3.2.8.2 *Negative formulary changes.* The Department will provide Contractor with negative formulary changes at least forty-five (45) days prior to the effective date of the change. Contractor shall make all system and programming changes necessary to implement the change on the effective date.

5.3.2.8.3 *New NDCs.* When Contractor loads new NDCs for products that are listed on the Department's PDL, Contractor shall code the product's preferred or non-preferred status the same as other drugs that are the same drug, dosage form, strength, and route of administration. When the drug is multi-source, and the brand/innovator product and generic/non-innovator products are coded differently, then the new NDCs for a non-innovator/generic drug shall be coded the same as the non-innovator/generic NDCs, and the new NDCs for brand/innovator products shall be coded the same as the innovator/brand NDCs.

5.3.2.8.4 Contractor shall report any discrepancies it identifies on the PDL file to the Department, in a format and manner prescribed by the Department, within three (3) Business Days of identification of the discrepancy.

5.3.2.9 **Attestation.** Contractor shall submit an attestation of its adherence to the Department's PDL for the first quarter of calendar year 2020, and quarterly thereafter, on a schedule and in a format provided by the Department.

5.3.2.10 **Compliance.** Compliance is the measure of preferred prescription drug utilization relative to all products in a class on the PDL. The

Department will monitor Contractor's PDL compliance. Compliance will be measured as a count of preferred product claims paid by Contractor in a PDL class relative to the entirety of product claims paid by Contractor in that PDL class over a calendar quarter. Encounter claims data will be used for determining calendar quarter utilization. Encounters claims will be pulled sixty (60) days after the end of the quarter. PDL classes will be based upon class listings on the Department's PDL. When a product is listed with the brand preferred over its generic equivalent, the use of generic will count as non-preferred utilization.

5.3.2.11 **Grandfathering.** On January 1, 2020, for Enrollees prescribed non-preferred drugs that the Department has identified as grandfathered on the PDL, Contractor shall continue to cover that non-preferred drug. The initial grandfathering period shall be one (1) year, and the Enrollee shall be re-evaluated at the end of the one (1)-year period to determine whether grandfathering continues to be clinically appropriate for the Enrollee. Where the Department prefers a brand over its generic equivalent in a class that is grandfathered, Contractor shall grandfather Enrollees on the brand product rather than the generic equivalent.

5.3.2.12 **Format of published formulary inclusive of the PDL.** Contractor's electronic and print formularies shall comply with the standardized format developed by the Department. Contractor shall adopt the Department's PDL categorization of drug classes and shall use the class names listed on the PDL. Contractor's published formulary shall contain, at minimum, the following:

- 5.3.2.12.1 brand and generic medications covered;
- 5.3.2.12.2 if medication is preferred or non-preferred and each term's definition;
- 5.3.2.12.3 each medication's tier and the definition of each tier;
- 5.3.2.12.4 utilization controls, including step therapy, prior approval, dosage limits, gender or age restrictions, quantity limits, and other policies;
- 5.3.2.12.5 cost sharing;
- 5.3.2.12.6 glossary of key terms and explanation of utilization controls and cost sharing;

- 5.3.2.12.7 a key for all utilization controls visible on every page in which specific medication coverage is displayed;
 - 5.3.2.12.8 directions to obtain more information if a medication is not covered or listed in the formulary;
 - 5.3.2.12.9 an e-mail and toll-free number to which an individual can report inaccuracies in the formulary; and
 - 5.3.2.12.10 a disclosure that identifies the date of publication, a statement that the formulary is up to date as of publication, and contact information for questions and requests to receive updated information.
- 5.3.2.13 Contractor shall publish its formulary on its program website and make the formulary easily understandable and publicly accessible without a password, user name, or personality identifiable information.
- 5.3.2.14 Contractor shall provide printed formularies upon request.
- 5.3.2.15 Upon reports of formulary inaccuracies, Contractor must investigate and make correction to the data displayed. Data correction shall be completed within three (3) Business Days of notification of the error.
- 5.3.2.16 Contractor shall attest to the Department on a quarterly basis that it is making updates to the pharmacy formulary within three (3) Business Days after investigation of reported inaccuracies.
- 5.3.2.17 **340B drug billing.** Contractor shall ensure that it requires pharmacy, medical, and hospital Providers to identify 340B-purchased drugs on pharmacy, medical, and hospital claims following the Department billing guidelines applied in the FFS Medical Program. Contractor shall ensure that its Encounter claims to the Department also identify these drugs.
- 5.3.2.18 **Drug utilization reporting.** For outpatient drugs not identified in section 5.3.2.17, Contractor shall collect information on the total number of units of each dosage form, and strength, and package size by the National Drug Code of each covered outpatient drug dispensed to Enrollees. This requirement is considered met through the detail included on the pharmacy claims submitted to Contractor for pharmacy reimbursement.

5.3.2.19 Contractor shall report to the Department through pharmacy Encounter claims information on the total number of units of each dosage form, strength, and package size by the National Drug Code of each covered outpatient drug identified in section 5.3.2.18 dispensed to Enrollees.

5.3.2.20 **MAC price dispute resolution process.** Contractor shall establish and maintain a process for resolving disputes over generic drug maximum allowable costs (MAC), which is subject to approval by the Department. The MAC dispute-resolution process shall enable pharmacies to report pricing disputes to Contractor up to sixty (60) days from the claim and Contractor is required to resolve the pricing dispute within twenty-one (21) days after the report of the pricing dispute by adjusting the reimbursement rate to represent the acquisition cost of the drug, or by informing the pharmacy of alternative generic equivalent products that can be purchased at or below Contractor's existing MAC price.

5.3.2.21 **Drug Utilization Review (DUR).** Contractor shall develop and implement a system of policies and procedures, coverage criteria, and processes for DUR program. The DUR program shall include a prospective review process for all drugs prior to dispensing, all non-formulary drug requests, and a retrospective DUR process to detect patterns in prescribing, dispensing, or administration of medication and to prevent inappropriate use or abuse. Contractor is required to complete the Federal CMS MCO DUR annual report and return it to the Department for submission to CMS.

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

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

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

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

- 5.3.3.3 **Maximum Daily Morphine Milligram Equivalents (MME).** Contractor shall have prospective safety edits on maximum MMEs that can be prescribed to an Enrollee for treatment of chronic pain and an automated claims review process that indicates when an Enrollee is prescribed the morphine equivalent for such treatment in excess of Contractor's established maximum MME dose limitation.
- 5.3.3.4 **Concurrent Utilization Alerts.** Contractor shall have an automated process for claims review that monitors when an Enrollee is concurrently prescribed opioids and benzodiazepines or opioids and antipsychotics.
- 5.3.3.5 Contractor shall have a program to monitor and manage the appropriate use of antipsychotic medications by Children.
- 5.3.3.6 Contractor shall have a process that identifies potential Fraud or Abuse of controlled substances by Enrollees, Providers that prescribe drugs to Enrollees, and Providers that dispense drugs to Enrollees.

5.4 EXCLUDED SERVICES

The following services are not Covered Services:

- 5.4.1 services that are provided through a local education agency (LEA);
- 5.4.2 services that are experimental or investigational in nature;
- 5.4.3 services that are provided by a non-Network Provider and not authorized by Contractor, unless this Contract specifically requires that such services be Covered Services;
- 5.4.4 services that are provided without a required Referral or prior authorization as set forth in Contractor's Provider handbook;
- 5.4.5 medical and surgical services that are provided solely for cosmetic purposes;
- 5.4.6 diagnostic and therapeutic procedures related to infertility or sterility;
- 5.4.7 early-intervention services, including Care Management, provided pursuant to the Early Intervention Service System Act;
- 5.4.8 services funded through the Juvenile Rehabilitation Services Medicaid Matching Fund;
- 5.4.9 services or items furnished for the purpose of causing, or for the purpose of assisting in causing, the death of an Enrollee, such as assisted suicide, euthanasia, or mercy killing, except as otherwise permitted by P. L. 105-12, Section 3(b), which is incorporated by Section 1903(i)(16) of the Social

Security Act;

5.4.10 services for which Contractor uses any portion of a Capitation payment to fund roads, bridges, stadiums, or any other items or services that are not Covered Services; and

5.4.11 effective November 1, 2019, abortion services.

5.5 LIMITATIONS ON COVERED SERVICES

The following services and benefits shall be limited as Covered Services:

5.5.1 For the period January 1, 2018 through October 31, 2019, Contractor may provide termination of pregnancy only as allowed by applicable State and federal law. In any such case, Contractor shall fully comply with the requirements of such laws, complete HFS Form 2390, and file the completed form in the Enrollee's medical record. Contractor shall not provide termination of pregnancy to Enrollees who are eligible under SCHIP (215 ILCS 106).

5.5.2 Contractor may provide sterilization services only as allowed by State and federal law (see 42 CFR §441, Subpart F). In any such case, Contractor shall fully comply with the requirements of such laws, complete HFS Form 2189, and file the completed form in the Enrollee's medical record.

5.5.3 If Contractor provides a hysterectomy, Contractor shall complete HFS Form 1977 and file the completed form in the Enrollee's medical record.

5.6 RIGHT OF CONSCIENCE

5.6.1 The Parties acknowledge that, pursuant to 745 ILCS 70/1 et seq., Contractor may choose to exercise a right of conscience by refusing to pay or arrange for the payment of certain Covered Services if such refusal is documented in its ethical guidelines, mission statement, constitution, bylaws, articles of incorporation, regulations, or other governing documents. If Contractor chooses to exercise this right, Contractor must promptly notify the Department in writing of its intent to exercise its right of conscience and submit proof that such refusal is incorporated in Contractor's governing documents in accordance with 745 ILCS 70/11.2. Such notification shall contain the otherwise Covered Services that Contractor refuses to pay, or to arrange for the payment of, pursuant to the exercise of the right of conscience. The Parties agree that upon such notice the Department shall adjust the Capitation payment to Contractor.

5.6.2 If Contractor chooses to exercise this right, Contractor must notify Potential Enrollees, Prospective Enrollees, and Enrollees that it has chosen not to render certain Covered Services, as follows:

to Potential Enrollees, prior to enrollment;

to Prospective Enrollees, during enrollment; and

to Enrollees, within ninety (90) days after adopting a policy with respect to any particular service that previously was a Covered Service, but in all events, Enrollees shall be informed no fewer than thirty (30) days before implementation of such a policy.

5.6.3 Such notice shall include information on how Potential Enrollees, Prospective Enrollees, and Enrollees can obtain information from the Department regarding those Covered Services subject to this section 5.6.

5.6.4 If any Network Provider exercises the right of conscience, Contractor must require such Network Provider, upon request by an Enrollee, to refer or transfer the Enrollee to, or provide written information to the Enrollee about, other Providers who Contractor reasonably believes may offer the Covered Service the Network Provider refuses to permit, perform, or participate in because of a conscience-based objection. Contractor also shall require Network Providers in such an event, and if requested by the Enrollee, to provide copies of medical records to the Enrollee or to the Provider.

5.7 PROVIDER NETWORK

5.7.1 **Network Providers.** Contractor shall establish, maintain, and monitor a Provider Network, including hospitals, primary care Providers, WHCPs, specialist Physicians, clinical laboratories, dentists, OB/GYNs, oral surgeons, pharmacies, behavioral-health Providers, substance-abuse Providers, CMHCs, and all other provider types.

5.7.1.1 This network shall be sufficient to provide adequate access to all Covered Services under the Contract, taking into consideration:

5.7.1.1.1 the anticipated number of Enrollees;

5.7.1.1.2 the expected utilization of services, in light of the characteristics and healthcare needs of Contractor's Enrollees;

5.7.1.1.3 the number and types of Providers required to furnish the Covered Services;

5.7.1.1.4 the number of Network Providers who are not accepting new patients; and

5.7.1.1.5 the geographic location of Providers and Enrollees, taking into account distance, travel time, the means of transportation, and whether the location provides

physical access for Enrollees with disabilities.

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

5.7.1.3 For NFs and SLFs, Contractor must maintain the adequacy of its Provider Network sufficient to provide Enrollees with reasonable choice within each county of the Contracting Area, provided that each Network Provider meets all applicable State and federal requirements for participation in the HFS Medical Program. Contractor may require as a condition for participation in its network that a NF agree to provide access to Contractor's or Subcontractor's Care Management team to permit qualified members of the team to write medication and lab orders, to access Enrollees to conduct physical examinations, and to serve as PCP for an Enrollee.

5.7.1.4 For Providers of each of the Covered Services identified in this section 5.7.1.4 under an HCBS Waiver, Contractor must enter into contracts with a sufficient number of such Providers within each county in the Contracting Area to assure that the Network Providers served at least eighty percent (80%) of the number of Participants in each county who received such services on the day immediately preceding the day such services became Covered Services. For counties served by more than one (1) Provider of such Covered Services, Contractor shall enter into contracts with at least two (2) such Providers, so long as such Providers accept Contractor's rates, even if one (1) Provider served more than eighty percent (80%) of the Participants, unless the Department grants Contractor an exception, in writing. These Covered Services include:

- 5.7.1.4.1 adult day care;
- 5.7.1.4.2 homecare/in-home services;
- 5.7.1.4.3 day habilitation;

- 5.7.1.4.4 supported employment;
- 5.7.1.4.5 home-delivered meals;
- 5.7.1.4.6 home health aides;
- 5.7.1.4.7 nursing services;
- 5.7.1.4.8 Occupational Therapy;
- 5.7.1.4.9 Speech Therapy; and
- 5.7.1.4.10 Physical Therapy.

5.7.1.5 For the following Covered Services that are services under an HCBS Waiver, the requirements are as follows:

- 5.7.1.5.1 *environmental accessibility adaptations for the home.* Contractor shall make its best efforts, and document those efforts, to ensure that the work required to meet the need for the Covered Service is satisfactorily completed by a qualified Provider within ninety (90) days after Contractor becomes aware of the need.
- 5.7.1.5.2 *Personal Assistants.* Contractor shall refer Enrollees, as necessary and appropriate, to the Centers for Independent Living or other available resources for assistance in locating potential Personal Assistants.
- 5.7.1.5.3 *Personal Emergency Response System.* Contractor shall enter into contracts that meet the requirements of 89 Ill. Admin. Code 240.235 with at least one (1) Provider serving each county within a Contracting Area.
- 5.7.1.5.4 *Automated Medication Dispenser.* Contractor shall enter into contracts that meet the requirements of 89 Ill. Admin. Code 240.1543 and shall authorize the automated medication dispenser service in accordance with 89 Ill. Admin. Code 240.741.

5.7.1.6 If Contractor is unable to contact an Enrollee in an HCBS Waiver within ninety (90) days after enrollment, Contractor must, after documenting all forms of no fewer than five (5) attempts to contact the Enrollee, contact the appropriate operating agency, provide documentation of the various attempts to contact the Enrollee, and request the Enrollee no longer be in an HCBS Waiver.

5.7.1.7 In arranging for Covered Services for Enrollees under the IDoA Persons Who are Elderly HCBS Waiver for such Enrollees who do not

express a choice of a Provider of such Covered Services, Contractor shall fairly distribute such Enrollees, taking into account all relevant factors among those Network Providers who are willing and able to accept such Enrollees, and who meet applicable quality standards.

5.7.2 **Provider contracts.** Contractor shall ensure all Network Provider contracts are tailored to the requirements of this Contract. Contractor shall be responsive to Network Providers with respect to contract negotiation.

5.7.3 **Network Provider enrollment and termination.** Contractor shall ensure that all Network Providers, including out-of-state Network Providers, are enrolled in the HFS Medical Program, if such enrollment is required by the Department's rules or policy in order to submit claims for reimbursement or otherwise participate in the HFS Medical Program. Once a Contractor is aware that a Network Provider serving one-hundred (100) or more active Enrollees will be terminated, Contractor must inform the Department of this termination in writing (e-mail or letter) within three (3) Business Days.

5.7.3.1 This written notification must include:

- 5.7.3.1.1 the Provider name;
- 5.7.3.1.2 the reason for termination;
- 5.7.3.1.3 the expected termination date;
- 5.7.3.1.4 the current number of Enrollees served by (that is, who received primary care from, or was seen on a regular basis by) the terminated Provider; and
- 5.7.3.1.5 the plan of action for transferring Enrollees to another Provider.

5.7.3.2 Contractor shall make a good-faith effort to give written notice of termination of a Provider as soon as practicable, but in no event later than fifteen (15) days after issuance of a termination notice by Contractor to a Provider, or receipt of a termination notice from a Provider. Each Enrollee who was served by the Provider shall receive notice that Provider was terminated. In this notification, Contractor will provide direction to the Enrollee regarding how the Enrollee may select a new Provider.

5.7.3.3 Contractor shall give at least sixty (60) days written notice in advance of its nonrenewal or termination effective date of a Provider to the Provider and to each Enrollee served by the Provider. The notice shall include a name and address to which the Provider or an Enrollee may direct comments and concerns regarding the nonrenewal or termination. In the notification to the Enrollee,

Contractor will provide direction regarding how the Enrollee may select a new Provider. Contractor may provide immediate written notice when a Provider's license has been disciplined by a State licensing board.

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

5.7.4 **Network adequacy analysis.** Contractor shall analyze the geographic distribution of the Provider Network and provide the results of this analysis to the Department on a quarterly basis. Contractor shall also monitor other network adequacy indicators, such as Enrollee and Provider complaints related to access; call center requests from Enrollees, Providers, advocates, and external organizations for help with access; and the percentage of completely open primary care Provider panels versus the percentage open only to existing patients. Contractor shall generate geographic distribution tables and maps to plot Enrollee and Network Provider locations by zip code and analyze the information, considering the prevalent modes of transportation available to Enrollees, Enrollees' ability to travel, and Enrollees' ability to be in an office setting. When material gaps in the Contractor's Provider Network are identified, Contractor shall, within five (5) Business Days, develop and implement a recruitment strategy to fill the gaps and immediately thereafter submit its strategy and proposed timeline to the Department.

5.7.5 **Safety-net Providers.** Contractor will prioritize recruiting safety-net Providers, such as FQHCs and RHCs as Network Providers. Contractor shall not refuse to contract with a FQHC or RHC that is willing to accept Contractor's rates and contractual requirements and meets Contractor's quality standards.

5.7.6 **Non-Network Providers.** It is understood that in some instances, Enrollees will require specialty care not available from a Network Provider and that Contractor will arrange that such services be provided by a non-Network Provider. In such event, Contractor will promptly negotiate an agreement (single-case agreement) with a non-Network Provider to treat the Enrollee until a qualified Network Provider is available. Contractor shall ensure that any non-Network Provider billing for services rendered in Illinois is enrolled in the HFS Medical Program prior to paying a claim.

5.7.7 **Provider reimbursement.** The Department may define an alternative payment methodology to which Contractor must adhere to when reimbursing Providers for provided services.

5.7.7.1 For all FQHCs and RHCs that elect to use the Department's alternative payment methodology, Contractor shall pay contracted FQHCs and

RHCs at least the Department's full cost-based per-visit rate for Covered Services.

- 5.7.8 **Provider agreements.** Contractor's Provider Agreements shall require that Network Providers submit benefit expense claim data, as defined in 0, for all Covered Services provided to Enrollees.
- 5.7.9 [THIS SECTION INTENTIONALLY LEFT BLANK]
- 5.7.10 **Specialty care.** Contractor shall establish a comprehensive network to ensure the availability and accessibility of specialists and subspecialists to meet the needs of Enrollees. Care Coordinators shall have the authority to authorize services and will not require approval by Contractor's medical director for the majority of services in accordance with recognized Medically Necessary criteria. For Enrollees with special healthcare needs who require an ongoing course of treatment or regular care monitoring, Contractor must provide mechanism for Enrollee to directly access specialists, as appropriate for the conditions and needs.
- 5.7.11 **Hospitalist program.** Contractor shall provide Hospitalist services, either through direct employment as a Network Provider, or through a subcontractual relationship.
- 5.7.12 [This Section Intentionally Left Blank]
- 5.7.13 **Governmental Provider entities contracting requirement.** Contractor shall contract with the University of Illinois, Cook County, by and through its Cook County Health and Hospitals System, and Southern Illinois University (collectively, governmental Provider entities) in order to provide certain Covered Services to Enrollees if such governmental Provider entity is located within Contractor's Contracting Area set forth in Attachment II. Contractor shall reimburse the University of Illinois for inpatient hospital, outpatient hospital, and for Physician services for the period January 1, 2018 through December 31, 2020, at no less than their rates as determined by the Medicaid approved reimbursement methodologies, as provided to Contractor by the Department, including claims where the University of Illinois charges less than the Medicaid State Plan rate, as allowed by 42 CFR §410.2. Contractor shall reimburse Southern Illinois University for Physician services at no less than its rate as determined by the Medicaid-approved reimbursement methodologies, as provided to Contractor by the Department, for the period January 1, 2018 through December 31, 2020. For the period January 1, 2018 through December 31, 2019, Contractor shall reimburse Cook County for inpatient hospital, outpatient hospital, Physician services, and encounter rate clinics at no less than their rates as determined by the Medicaid approved reimbursement methodologies, as provided to Contractor by the Department. Contractor shall not limit equal access to such Providers.
- 5.7.14 **DSCC Care Coordination contracting requirement.** The Department

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

5.7.15 Directed and Pass-through Payments. Contractor shall comply with the Department's instructions in disbursing payments pursuant to CMS-approved directed payment programs and pass-through payments pursuant to 42 CFR 438.6. Directed payments must be made directly to an account of the Provider and cannot be made to an intermediary. The Department will transmit to Contractor detailed instructions on the distribution of funds at the time such funds are paid to Contractor. The instructions will indicate the amounts to be paid to each eligible Provider and the timeframe for making the payments.

5.8 ACCESS-TO-CARE STANDARDS

5.8.1 Network adequacy standards. Contractor's Provider Network must include all necessary Provider types, including primary care Providers, Behavioral Health Providers, OB/GYNs, dental care Providers, hospitals, other specialists, and pharmacies, with sufficient capacity to provide timely Covered Services to Enrollees in accordance with the standards outlined herein. For each Provider type, Contractor must provide access to at least ninety percent (90%) of Enrollees within each county of the Contracting Area within the prescribed time and distance standard required by this section 5.8.1, with the exception of pharmacy services, which must provide one-hundred percent (100%) coverage to Enrollees as required in section 5.8.1.1.7. Exceptions to the time and distance standards may be considered and approved at the discretion of the Department. Exception requests must be submitted to the Department in writing.

5.8.1.1 Travel time and distance standards. Travel time and distance standards to which Contractor will adhere are provided below, by Provider type. An Enrollee may elect to travel beyond the distance standards when the Enrollee exercises choice in selecting a Provider. The free exercise of such choice by the Enrollee will not negatively impact the results of any reporting by Contractor on access to care.

5.8.1.1.1 Primary care Provider access. Contractor shall ensure an Enrollee has access to at least two (2) primary care Providers within a thirty (30)-mile radius of or thirty

(30)-minute drive from the Enrollee's residence. If an Enrollee lives in a Rural Area, the Enrollee shall have access to at least one (1) primary care Provider within a sixty (60)-mile radius of or sixty (60)-minute drive from the Enrollee's residence.

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

5.8.1.1.3 *OB/GYN access.* Contractor shall ensure an Enrollee has access to at least two (2) OB/GYN Providers within a thirty (30)-mile radius of or thirty (30)-minute drive from the Enrollee's residence. If an Enrollee lives in a Rural Area, the Enrollee shall have access to at least one (1) OB/GYN Provider within a sixty (60)-mile radius of or sixty (60)-minute drive from the Enrollee's residence.

5.8.1.1.4 *Dental access for Children.* Contractor shall ensure an Enrollee has access to at least one (1) dentist, who serves Children, within a thirty (30)-mile radius of or thirty (30)-minute drive from the Enrollee's residence. If an Enrollee lives in a Rural Area, the Enrollee shall have access to at least one (1) dentist, who serves Children, within a sixty (60)-mile radius of or sixty (60)-minute drive from the Enrollee's residence.

5.8.1.1.5 *Hospital access.* Contractor shall ensure an Enrollee has access to at least one (1) hospital within a thirty (30)-mile radius of or thirty (30)-minute drive from the Enrollee's residence. If an Enrollee lives in a Rural Area, the Enrollee shall have access to at least one (1) hospital within a sixty (60)-mile radius of or sixty (60)-minute drive from the Enrollee's residence.

5.8.1.1.6 *Other specialist Provider access.* Contractor shall ensure an Enrollee has access to at least one (1) specialty services Provider within a sixty (60)-mile radius of or sixty (60)-minute drive from the Enrollee's residence. If an Enrollee lives in a Rural Area, the Enrollee shall have access to at least one (1) specialty services Provider

within a ninety (90)-mile radius of or ninety (90)-minute drive from the Enrollee's residence.

5.8.1.1.7 *Pharmacy access.* Contractor shall ensure an Enrollee has access to at least one (1) pharmacy within a fifteen (15)-mile radius of or fifteen (15)-minute drive from the Enrollee's residence. If an Enrollee lives in a Rural Area, the Enrollee shall have access to at least one (1) pharmacy within a sixty (60)-mile radius of or sixty (60)-minute drive from the Enrollee's residence.

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

5.8.1.2 **Other access standards.** For LTSS Provider types that travel to Enrollee to deliver services, Contractor shall adhere to the Department-defined standards by January 1, 2019.

5.8.2 **Accessibility of Provider locations.** Contractor must ensure Providers provide physical access, reasonable accommodations, and accessible equipment for Enrollees with physical or mental disabilities. Contractor shall collect sufficient information from Providers to assess compliance with the Americans with Disabilities Act (ADA). As necessary to serve Enrollees, Provider locations where Enrollees receive services shall be ADA compliant. In addition, Contractor shall include within its Provider Network, Provider locations that are able to accommodate the needs of individual Enrollees.

5.8.3 **Appointments.** Contractor shall require that time-specific appointments for routine preventive care are available within five (5) weeks from the date of request for such care, and within two (2) weeks from the date of request for infants under age six (6) months. Enrollees with more serious problems not deemed Emergency Medical Conditions shall be triaged and, if necessary or appropriate, immediately referred for urgent Medically Necessary care or provided with an appointment within one (1) Business Day after the request. Enrollees with problems or Complaints that are not deemed serious shall be seen within three (3) weeks from the date of request for such care. Initial prenatal visits without expressed problems shall be made available within two (2) weeks after a request for an Enrollee in her first trimester, within one (1) week for an Enrollee in her second trimester, and within three (3) days for an Enrollee in her third trimester. Network Providers shall offer hours of

operation that are no less than the hours of operation offered to Persons who are not Enrollees.

5.8.3.1 Contractor shall ensure that an initial appointment for outpatient treatment for mental, emotional, nervous, or substance use disorders or conditions is available within ten (10) Business Days from the date of request for an Enrollee. Follow-up appointments for outpatient treatment for mental, emotional, nervous, or substance use disorders or conditions shall be available within twenty (20) Business Days from the date of request for an Enrollee. The Contractor will not be held responsible if the Enrollee or provider voluntarily chooses to schedule an appointment outside of these required time frames.

5.8.4 **After hours.** Primary care and specialty Providers shall provide coverage for their respective practices twenty-four (24) hours a day, seven (7) days a week, and they shall have a published after-hours telephone number; voicemail alone after hours is not acceptable.

5.8.5 **Choice of PCP.** Contractor shall afford to each Enrollee a choice of PCP, which may be, where appropriate, a WHCP. Contractor shall provide direct access to a WHCP for routine and preventative women's healthcare Covered Services when a female Enrollee's PCP is not a WHCP.

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

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

5.8.8 **Primary care Provider-to-Enrollee ratio.** Contractor's maximum primary care Provider panel size shall be as set forth below. If Contractor does not satisfy the primary care Provider requirements set forth below, Contractor may demonstrate compliance with these requirements by demonstrating that Contractor's full-time-equivalent primary care Provider ratios exceed ninety percent (90%) of the requirements set forth below, and that Covered Services are being provided in a manner that is timely and otherwise satisfactory. Contractor shall comply with Section 1932(b)(7) of the Social Security Act.

5.8.8.1 For the Families and Children Population and ACA Adult Enrollees, Contractor's maximum primary care Provider panel size shall be one-

thousand eight-hundred (1,800) Enrollees. An additional maximum of nine hundred (900) of such Enrollees is allowed for each resident Physician, nurse practitioner, Physician assistant, and APN who is one-hundred percent (100%) full-time equivalent employee or contractor.

5.8.8.2 For Seniors and Persons with Disabilities Enrollees, Contractor's maximum primary care Provider panel size shall be six hundred (600) Enrollees. An additional maximum of three hundred (300) of such Enrollees is allowed for each resident Physician, nurse practitioner, Physician assistant, and APN who is one hundred percent (100%) full-time equivalent employee or contractor.

5.8.9 **Family Planning.** Contractor shall demonstrate that its network includes sufficient Family-Planning Providers to ensure timely access to Covered Services as provided in 42 CFR §438.206.

5.8.10 **Parity in Mental Health and Substance Use Disorder Benefits.**

5.8.10.1 Contractor may not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder Covered Services.

5.8.10.2 Contractor will not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to Enrollees (whether or not the benefits are furnished by the same MCO).

5.8.10.3 When an Enrollee is provided mental health or substance use disorder benefits in any classification of benefits (inpatient, outpatient, emergency care, or prescription drugs), Contractor shall provide mental health or substance use disorder benefits to the Enrollee in every classification in which medical/surgical benefits are provided.

5.8.10.4 Contractor may not apply any cumulative financial requirements for mental health or substance use disorder benefits in a classification (inpatient, outpatient, emergency care, prescription drugs) that accumulates separately from any established for medical/surgical benefits in the same classification.

5.8.10.5 Contractor may not impose any non-quantitative treatment limitation (NQTL) for mental health or substance use disorder benefits in any classification unless, under the policies and procedures of Contractor as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification

are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification.

5.8.10.6 Contractor shall establish and demonstrate compliance with 42 CFR part 438, subpart K regarding parity in mental health and substance use disorder benefits. Contractor shall provide the necessary documentation, reporting, and analyses in the format and frequency required by the Department.

5.9 UNIFORM PROVIDER CREDENTIALING AND RE-CREDENTIALING

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

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

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

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

5.9.4 Contractor is prohibited from requiring providers to undergo additional credentialing processes that are not a part of this Contract.

5.10 PROVIDER SERVICES AND EDUCATION

Prior to any enrollment of Enrollees under this Contract and thereafter, Contractor shall conduct Network Provider education regarding Contractor policies and procedures, including as provided in section 5.35.1.9.

5.10.1 **Provider orientation.** Contractor shall conduct orientation sessions for Network Providers and their office staff.

5.10.2 [THIS SECTION INTENTIONALLY LEFT BLANK]

5.10.3 **Cultural Competence.** Contractor will provide Cultural Competence requirements at orientation, training sessions, and updates as needed. Contractor, upon request of Provider, shall agree to allow Provider to certify compliance with this provision if completed through another Contractor in the Medicaid program.

5.10.4 **Provider manual.** The Provider manual shall be a comprehensive online reference tool for Providers and staff regarding administrative, eligibility verification, prior authorization, and Referral processes; claims and Encounter submission processes; Provider claim dispute and authorization dispute processes; Enrollee Grievance and Appeal processes; and plan benefits. The Provider manual shall also address topics such as clinical practice guidelines, availability and access standards, Care Management and Utilization Review programs, and Enrollee rights.

5.10.5 **Provider portal.** Prior to the Effective Date, Contractor shall establish and maintain a secure Provider web portal, which shall include population health, quality, utilization, eligibility verification, prior authorization, and claims information for PCP Enrollee populations. The Department retains the right to define minimum content requirements for the Provider portal.

5.10.6 **Provider directory.** Contractor shall meet all Provider directory requirements under 305 ILCS 5/5-30.3 and 42 CFR §438.10, including:

5.10.6.1 Ensure its Provider directory is available to Enrollees and Providers via Contractor's web portal and in paper form upon request.

5.10.6.2 Request, at least annually, Provider office hours for each Provider type and publish such hours in the Provider directory.

5.10.6.3 Confirm with Providers who have not submitted claims within the six (6) months prior to the start of this Contract that the Provider intends to remain in the network and correct any incorrect Provider directory information.

5.10.6.4 Conspicuously display an e-mail address and a toll-free number to which any individual may report an inaccuracy in the Provider directory.

5.10.6.5 Provider directory information in paper form must be updated at least monthly and electronic Provider directories must be updated no later than thirty (30) days after Contractor receives updated Provider information.

5.10.6.6 Investigate and correct any inaccurate information communicated from any person or from Department within thirty (30)

days after receiving the report.

5.10.7 **Provider-based health education for Enrollees.** Contractor shall encourage PCPs to provide health education to Enrollees. Contractor shall ensure that Providers have the preventive-care, disease-specific, and plan-services information necessary to support Enrollee education in an effort to promote compliance with treatment directives and to encourage self-directed care.

5.10.8 **Health, safety, and welfare education.** As part of its Provider education, Contractor shall include information related to identifying, preventing, and reporting Abuse, Neglect, exploitation, and Critical Incidents, including the information in Attachment XVII, Attachment XVIII, and Attachment XIX.

5.10.9 **DHS HCBS Waiver Provider education.** Contractor shall distribute Provider packets, which the State or its designee will provide, to Enrollees and educate each Enrollee regarding the Enrollee's responsibility to ensure Personal Assistants and all other Individual Providers who provide Covered Services under the Persons with disabilities HCBS Waiver, Persons with HIV/AIDS HCBS Waiver, or Persons with brain injury HCBS Waiver receive the Provider packets. Contractor shall further educate Enrollees that such Providers may not begin providing Covered Services until the fully and correctly completed packets have been returned to, and accepted by, the local DHS-DRS office.

5.10.10 **Provider communication.** Contractor must maintain a regular means of communicating and providing information on changes in policies and procedures to Providers. Contractor shall provide no less than thirty (30) days' notice to Providers of policy changes prior to implementation by Contractor. Contractor must notify Providers of any changes to prior authorization policies no less than thirty (30) days before the date of implementation. In circumstances where the Department provides Contractor with less than thirty (30) days' notice from the effective date of a policy change, Contractor must notify Providers within three (3) Business Days of receipt of the Department's notification.

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

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

5.10.13 **IDoA HCBS Waiver Homecare Service Provider training.** Effective January 1, 2020, Contractor, upon request of a Homecare Service Provider,

shall agree to allow Provider to certify compliance with Contractor's training requirements for Provider's personnel, when comparable training has been completed in accordance with requirements of 89 Ill. Admin. Code 240.1535. Contractor shall require Provider to utilize the Department's Attestation of Training Completion form and certify by individual employee.

5.11 COORDINATION TOOLS

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

- 5.11.1 **Enrollee profile.** Contractor shall use technology and processes that effectively integrate data from a variety of sources to profile, measure, and monitor Enrollee profiles. Profiles will include demographics, eligibility data, claims payment information, care opportunities, care gap alerts, and Enrollee preferences.
- 5.11.2 **Care Management system.** Contractor's Care Coordinators will use the Care Management system to review assessments, interventions, and management of Chronic Health Conditions to gather information to support IPoCs and identification of Enrollees' needs. Contractor shall have fully operational portals, which provide Enrollees and Providers access to relevant information from the Care Management system.
- 5.11.3 **Admissions, Discharge, and Transfer (ADT) system.** Upon the effective date, the Department reserves the right to select an ADT system to be used by all MCOs within the State. Contractor must implement and integrate the Department's ADT system once determined by the Department. The Department will provide one hundred eighty (180) days' notice to Contractor, in writing, prior to the requirement of this section 5.11.3 being in effect.
- 5.11.3.1. Pursuant to the Department's written notice provided as required in section 5.11.3, Contractor shall work with the Department's selected ADT system vendor to implement the ADT system. Throughout implementation of the ADT system, Contractor shall submit all ad hoc reports as requested by the Department until such time ADT-related reports are established as ongoing reporting requirements.

5.12 CARE MANAGEMENT

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

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

5.12.2.1 If Contractor enters into any contract with any entity that also administers the determination of need (DON) or prescreening required under HCBS Waivers, Contractor shall immediately provide the name of that Provider to the Department.

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

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

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

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

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

5.12.3.1 *Qualifications.* Care Coordinators who serve High-Needs Children, Special Needs Children, Enrollees within the IDoA Persons Who are Elderly HCBS Waiver, DHS-DRS Persons with a Brain Injury HCBS Waiver, DHS-DRS Persons with HIV/AIDS HCBS Waiver, or DHS-DRS Persons with Disabilities HCBS Waiver must meet the applicable qualifications set forth in Attachment XVI. Care Coordinators for all other Enrollees must have the appropriate qualifications to address the needs of Enrollees.

5.12.3.2 *Training requirements.* Care Coordinators who serve High-Needs Children, Special Needs Children, Enrollees within the IDoA Persons Who are Elderly HCBS Waiver, DHS-DRS Persons with a Brain

Injury HCBS Waiver, DHS-DRS Persons with HIV/AIDS HCBS Waiver, DHS-DRS Persons with Disabilities HCBS Waiver, or HFS Supportive Living Program HCBS Waiver must meet the applicable training requirements set forth in Attachment XVI. Care Coordinators for all other Enrollees must have the appropriate training to address the needs of Enrollees.

5.13 ASSESSMENTS AND CARE PLANNING

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

5.13.1.1 *Health-risk screening.* Contractor will develop and maintain a health-risk screening tool, which includes Behavioral Health risk, and will provide that tool to the Department. Contractor shall administer the tool to all new Enrollees within sixty (60) days after enrollment to collect information about the Enrollee's physical, psychological, and social health. Contractor will use the results to guide the administration of more in-depth health assessments. Contractor may administer a health-risk assessment in place of the health-risk screening, provided it is administered within sixty (60) days after enrollment. Contractor shall notify the appropriate PCP of the enrollment of any new Enrollee who has not completed a health-risk screening within the time period set forth above and whom Contractor has been unable to contact. Contractor shall conduct outreach to their Enrollees and to schedule visits.

5.13.1.2 *Predictive modeling.* Contractor shall utilize claims and CCD to risk stratify the population and to identify high-risk conditions requiring immediate Care Management.

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

5.13.1.4 **Stratification.** Based upon an analysis of the information gathered through the process in this section, Contractor shall stratify all Enrollees to determine the appropriate level of intervention by its Care Management program. Contractor shall systematically assign an initial risk level within the first fifteen (15) days after enrollment. Initial risk levels shall be evaluated and updated to reflect the results

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

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

5.13.1.4.1 Contractor shall stratify Enrollee groups using the minimum requirements provided below:

	Minimum percentages of Enrollees	
	Level 2 and 3 (combined moderate- and high-risk)	Level 3 (high-risk)
Population		
Families and Children Population	N/A	2%
ACA Adult population	N/A	2%
Special-Needs Children	40%	20%
Seniors or Persons with Disabilities	20%	5%
Dual-Eligible Adults	90%	20%

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

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

5.13.2.2 Enrollees receiving HCBS Waiver services or residing in NFs as of their Effective Enrollment Date with Contractor. The health-risk

assessment must be in-person and completed within (90) days after enrollment.

5.13.2.3 Enrollees transitioning to NFs. The health-risk assessment must be in-person and completed within ninety (90) days of Contractor's receipt of the 834 Daily File that indicates an Enrollee has transitioned to a Nursing Facility.

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

5.13.3 **Outreach.** Contractor shall use its best efforts to locate all Enrollees who are identified through risk stratification as being high-risk or moderate-risk. For the purpose of this section, the Department will define best efforts on an annual basis. Where appropriate, Contractor shall use community-based organizations to locate and engage such Enrollees.

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

5.13.5 **Self-directed care.** Contractor will encourage Providers to support Enrollees in directing their own care and developing an IPoC.

5.14 INTERDISCIPLINARY CARE TEAM (ICT)

5.14.1 Contractor shall support an ICT for all Enrollees stratified as high-risk (Level 3), Dual-Eligible Adult Enrollees, and Enrollees who receive Covered Services under an HCBS Waiver. The ICT will ensure the integration of the Enrollee's medical and Behavioral Health services, and, if appropriate, Service Package II services. Duties of the ICT are separate from utilization management duties.

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

5.14.3 ICT functions shall include:

5.14.3.1 providing Care Management for Enrollees; assisting in the development, implementation, and monitoring of IPoCs, including

HCBS service plans where applicable; and, assisting in assuring integration of services and coordination of care across the spectrum of the healthcare system;

- 5.14.3.2 ensuring a primary Care Coordinator is responsible for coordination of all benefits and services the Enrollee may need (Care Coordinators will have prescribed caseload limits as set forth in section 5.17.2);
- 5.14.3.3 assigning a Care Coordinator who has the experience most appropriate to support the Enrollee;
- 5.14.3.4 using motivational interviewing techniques;
- 5.14.3.5 explaining alternative care options to the Enrollee; and
- 5.14.3.6 maintaining frequent contact with the Enrollee through various methods including face-to-face visits, e-mail, and telephone, as appropriate to the Enrollee's needs and risk level or upon the Enrollee's request.

5.15 INDIVIDUALIZED PLANS OF CARE AND SERVICE PLANS

5.15.1 Contractor shall develop a comprehensive, person-centered IPoC for Enrollees stratified as Level 3 (high-risk) or Level 2 (moderate risk), Enrollees residing in a Nursing Facility, and Enrollees receiving HCBS Waiver services, within ninety (90) days after enrollment. Contractor shall engage Enrollees in the development of the IPoC as much as possible. An IPoC may not be finalized until signature from the Enrollee or authorized representative has been received either by hand, e-signature or voice recording. For an Enrollee receiving HCBS Waiver services, a written signature is required for the IPoC, in accordance with 42 CFR §441.301(c)(2)(ix). Enrollees must be provided with a copy of the IPoC upon completion, and may request a copy at any time. The IPoC is considered an Enrollee-owned document. The IPoC must:

- 5.15.1.1 incorporate all of the Enrollee's care needs, including: medical, Behavioral Health, Service Package II care, social, and functional needs;
- 5.15.1.2 include identifiable short- and long-term treatment and service goals to address the Enrollee's needs and preferences and to facilitate monitoring of the Enrollee's progress and evolving service needs;
- 5.15.1.3 include, in the development, implementation, and ongoing assessment of the IPoC, an opportunity for Enrollee participation and an opportunity for input from the PCP, other Providers, a legal or personal representative, and the family or caregiver if appropriate;
- 5.15.1.4 include, as appropriate, the following elements:

- 5.15.1.4.1 the Enrollee’s personal or cultural preferences, such as types or amounts of services;
 - 5.15.1.4.2 the Enrollee’s preference of Providers and any preferred characteristics, such as gender or language;
 - 5.15.1.4.3 the Enrollee’s living arrangements;
 - 5.15.1.4.4 Covered Services and non-Covered Services to address each identified need, provided that Contractor shall not be required to pay for non-Covered Services;
 - 5.15.1.4.5 actions and interventions necessary to achieve the Enrollee’s objectives;
 - 5.15.1.4.6 follow-up and evaluation;
 - 5.15.1.4.7 collaborative approaches to be used;
 - 5.15.1.4.8 desired outcome and goals, both clinical and nonclinical;
 - 5.15.1.4.9 barriers or obstacles;
 - 5.15.1.4.10 responsible parties;
 - 5.15.1.4.11 standing Referrals;
 - 5.15.1.4.12 community resources;
 - 5.15.1.4.13 informal supports;
 - 5.15.1.4.14 timeframes for completing actions;
 - 5.15.1.4.15 status of the Enrollee’s goals;
 - 5.15.1.4.16 home visits as necessary and appropriate for Enrollees who are homebound (as defined in 42 U.S.C. 1395n(a)(2)), who have physical or Cognitive Disabilities, or who may be at increased risk for Abuse, Neglect, or exploitation;
 - 5.15.1.4.17 back-up plan arrangements for critical services;
 - 5.15.1.4.18 Crisis Safety Plans for an Enrollee with Behavioral Health conditions; and
 - 5.15.1.4.19 Wellness Program plans;
- 5.15.1.5 include an HCBS Waiver person-centered service plan for Enrollees receiving HCBS Waiver services. Contractor shall ensure the person-centered service plan is developed in accordance with 42 CFR

441.301(c) and as follows:

5.15.1.5.1 *Planning Process.* Contractor shall ensure that the person-centered planning process is initiated and the service plan is developed within fifteen (15) days after Contractor is notified that the Enrollee is determined eligible for HCBS Waiver services. The planning process shall be led, when possible, by the Enrollee and include individuals chosen by the Enrollee. An Enrollee's HCBS Provider(s), or those who have an interest in or are employed by the HCBS Provider(s), shall not participate in the planning process, unless the provision at 42 CFR 441.301(c)(1)(vi) is met. Contractor is responsible for procedures to assist Enrollees in the planning process, including how to resolve conflicts and disagreements that includes conflict-of-interest guidelines. The Enrollee's Care Coordinator will assist the Enrollee in leading the HCBS Waiver person-centered service planning and will coordinate with the Interdisciplinary Care Team (ICT).

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

5.15.1.5.1.2 *Service Plan Contents.* Each person-centered service plan must be written in a manner that is understandable to the Enrollee and include: (1) documentation that the setting in which the Enrollee resides is chosen by the Enrollee, is integrated into and supports access to the community, and meets, when applicable, the HCBS Settings rule requirements at 42 CFR 441.301(c)(4)-(5); (2) the Enrollee's strengths and preferences; (3) the clinical and support needs identified through the Determination of Need; (4) person-centered goals and desired outcomes; (5) paid and unpaid services and supports that will assist Enrollee to achieve identified goals, the Providers of those services and supports, including those self-directed by the Enrollee; (6) identified

risk factors and strategies, including back-up plans, to minimize potential undesirable outcomes associated with those risks; and (7) the individual or entity responsible for monitoring the service plan.

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

5.15.1.5.1.4 Contractor shall ensure that an Enrollee's person-centered service plan is reviewed and revised upon reassessment of functional need at least every twelve (12) months, when an Enrollee's circumstances or needs change significantly, or at the Enrollee's request.

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

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

5.15.1.5.4 For an Enrollee who is receiving HCBS Waiver services through Contractor and who ceases to be eligible for Contractor services, Contractor shall notify the Enrollee's existing HCBS Waiver Provider(s) in writing of Contractor's service authorization termination date no later than seven (7) days from such date.

- 5.15.2 Contractor shall identify and evaluate risks associated with the Enrollee's care. Factors considered include the potential for deterioration of the Enrollee's health status; the Enrollee's ability to comprehend risk; caregiver qualifications; appropriateness of the residence for the Enrollee; and behavioral or other compliance risks. Contractor shall incorporate the results of the assessment of risks into the IPoC. IPoCs that include Negotiated Risks shall be submitted to Contractor's medical director for review. Negotiated Risks shall not allow or create risks for other Residents in a group setting.
- 5.15.3 For Enrollees transferring MCOs for whom an IPoC has been developed, Contractor will use the Enrollee's existing service plan, and that service plan will remain in effect for at least a ninety (90)-day transition period unless changed with the input and consent of the Enrollee and only after completion of a face-to-face health-risk assessment.
- 5.15.4 The Enrollee or the Enrollee's authorized representative must review and sign the IPoC and all subsequent revisions. Acceptable forms of signature include electronic forms such as e-signatures and voice recordings. In the event the Enrollee refuses to sign the IPoC, Contractor shall:
- 5.15.4.1 document in detail the specific reason why the Enrollee refuses to sign the IPoC; and
 - 5.15.4.2 document actions taken by the Care Coordinator to address Enrollee's concerns.
- 5.15.5 Contractor shall ensure that the Enrollee's IPoC is communicated to all of the Enrollee's ICT members and Providers, as appropriate.

5.16 ONGOING ASSESSMENT AND STRATIFICATION

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

5.17 CASELOAD REQUIREMENTS

5.17.1 Care Coordinators responsible for the Care Management of Enrollees with varying risk levels shall have their overall caseload weighted and a blended overall caseload limit set. The maximum weighted caseload for a Care Coordinator is six hundred (600) with Level 1 (low-risk) weighted as one (1), Level 2 (moderate-risk) weighted as four (4), and Level 3 (high-risk) weighted as eight (8). The Department may review existing caseloads at any time and may require a change in methodology or an Enrollee's assignment to a caseload.

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

5.17.2.1 Maximum caseloads for Care Coordinators for the stratified categories identified in section 5.13.1.4.1 are defined in the table below and shall be adhered to by Contractor unless specified in section 5.17.2.2.

Risk category	Caseload maximum (cases per Care Coordinator)
Level 1	600:1
Level 2	150:1
Level 3	75:1

5.17.2.2 Contractor will adhere to the following caseload maximum requirements for specific populations: For Enrollees in the Persons with Brain Injury Waiver or the Persons with HIV/AIDS Waiver, the caseloads shall not exceed 30:1.

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

5.17.3.1 *Persons who are elderly.* The Care Coordinator shall have a face-to-face contact with the Enrollee not less often than once every ninety (90) days.

5.17.3.2 *Persons with brain injury.* The Care Coordinator shall have

contact with the Enrollee not less often than one (1) time per month.

5.17.3.3 *Persons with HIV/AIDS.* The Care Coordinator shall contact the Enrollee not less than one (1) time per month, and not less than one (1) face-to-face contact every two (2) months.

5.17.3.4 *Persons with Disabilities.* The Care Coordinator shall have a face-to-face contact with the Enrollee no less often than once every ninety (90) days in the Enrollee's home.

5.17.3.5 *Persons living in a Supportive Living Facility.* The Care Coordinator shall contact the Enrollee no less often than one (1) time per year.

5.18 TRANSITION OF CARE

5.18.1 **Transition-of-Care process.** Contractor will manage Transition of Care and Continuity of Care for new Enrollees and for Enrollees moving from an institutional setting to a community setting. Contractor's process for facilitating Continuity of Care will include:

5.18.1.1 identification of Enrollees deemed critical for Continuity of Care;

5.18.1.2 communication with entities involved in Enrollees' transition;

5.18.1.3 Stabilization and provision of uninterrupted access to Covered Services;

5.18.1.4 assessment of Enrollees' ongoing care needs;

5.18.1.5 monitoring of continuity and quality of care, and services provided; and

5.18.1.6 medication reconciliation.

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

5.18.3 **Transition-of-Care team.** Contractor shall have an interdisciplinary Transition-of-Care team to design and implement the Transition-of-Care plan, as part of the IPoC, and provide oversight and management of all Transition-of-Care processes. The team will consist of skilled personnel with extensive knowledge and experience transitioning Enrollees with special healthcare needs.

5.18.4 **Transition of Care for new Enrollees.** Contractor will identify new Enrollees

who require transition services by using a variety of sources, including:

- 5.18.4.1 prior claim history as provided by the Department;
- 5.18.4.2 IPoC provided by the previous Contractor;
- 5.18.4.3 health-risk screenings completed by new Enrollees;
- 5.18.4.4 Providers requesting information and service authorizations for Enrollees (existing prior authorizations for new Enrollees shall be honored by Contractor);
- 5.18.4.5 communications from Enrollees; and
- 5.18.4.6 communication with existing agencies or service Providers that are supporting Enrollees at the time of transition.

5.18.5 Money follows the Person (MFP). Upon termination of MFP program, Contractor shall assume the lead role in supporting individuals transitioning from institutional settings to the community. Contractor will work in collaboration with the existing community agencies that provide MFP transition coordination services.

5.18.6 Community Transitions Initiative (CTI)

Effective January 1, 2020, Contractor shall implement an initiative specific to achieving transitions from institutional settings to the community for Enrollees who have continuously resided in a Nursing Facility or a Specialized Mental Health Rehabilitation Facility for a minimum of ninety (90) days. Contractor shall prioritize community transitions for class members of the *Williams v. Quinn* and *Colbert v. Quinn* consent decrees.

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

5.18.6.2 Contractor shall serve as the fiscal agent for the State-funded transition assistance funds made available by the Department to Colbert and Williams class members, consistent with Department-issued policy.

5.19 CONTINUITY OF CARE

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

- 5.19.1.1 Contractor must offer an initial ninety (90)-day transition

period for Enrollees new to the Health Plan, in which Enrollees may maintain a current course of treatment with a Provider who is currently not a part of Contractor's Provider Network. Contractor must offer a ninety (90)-day transition period for Enrollees switching from another Health Plan to Contractor. The ninety (90)-day transition period is applicable to all Providers, including Behavioral Health Providers and Providers of LTSS. Contractor shall pay for Covered Services rendered by a non-Network Provider during the ninety (90)-day transition period at the same rate the Department would pay for such services under the Illinois Medicaid FFS methodology. Non-Network Providers and specialists providing an ongoing course of treatment will be offered agreements to continue to care for an individual Enrollee on a case-by-case basis beyond the transition period if the Provider remains outside the Network or until a qualified Network Provider is available.

5.19.1.1.1 Effective upon the implementation date of the HealthChoice Illinois – Children with Special Needs 1915(b) Waiver, the provisions of Section 5.19.1.1 apply for Special Needs Children Enrollees, with the exception that the transition period must be no less than one-hundred eighty (180) days.

5.19.1.2 Contractor may choose to transition Enrollees to a Network Provider during the transition period only if:

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

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

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

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

5.19.3 **Effective Enrollment Date for hospital admissions.** If an Enrollee is receiving medical care or treatment as an inpatient in an acute-care hospital on the Effective Enrollment Date, Contractor shall assume responsibility for the management of such care and shall be liable for all claims for Covered Services from that date. For hospital stays that would otherwise be reimbursed under the HFS Medical Program on a per-diem basis, Contractor's liability shall begin on the Effective Enrollment Date. Notwithstanding the foregoing, for hospital stays that would otherwise be reimbursed under the

HFS Medical Program on a DRG basis, Contractor will have no liability for the hospital stay.

5.19.4 Continuity of Care for hospital stays. If an Enrollee is receiving medical care or treatment as an inpatient in an acute-care hospital at the time coverage under this Contract is terminated, Contractor shall arrange for the Continuity of Care or treatment for the current episode of illness until such medical care or treatment has been fully transferred to a treating Provider who has agreed to assume responsibility for such medical care or treatment for the remainder of that hospital episode and subsequent follow-up care. Contractor must maintain documentation of such transfer of responsibility of medical care or treatment. For hospital stays that would otherwise be reimbursed under the Department's medical program on a per-diem basis, Contractor shall be liable for payment for any medical care or treatment provided to an Enrollee until the effective disenrollment date. For hospital stays that would otherwise be reimbursed under the Department's medical program on a DRG basis, Contractor shall be liable for payment for any inpatient medical care or treatment provided to an Enrollee where the discharge date is after the effective disenrollment date.

5.19.5 Continuity of Care for NF residents

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

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

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

5.19.7 Authorization of services. Contractor shall have in place and follow written policies and procedures when processing requests for initial and continuing authorizations of Covered Services. Such policies and procedures shall provide for consistent application of review criteria for authorization decisions by a healthcare professional or professionals with expertise in addressing the Enrollee's medical, Behavioral Health, or LTSS needs. Contractor shall consult with the Provider requesting such authorization when appropriate and provided that LTSS authorizations are based on the Enrollee's current needs assessment and Person-centered service plan. If Contractor declines to authorize Covered Services that are requested by a Provider or authorizes one or more services in an amount, scope, or duration that is less than that requested, Contractor shall notify the Provider orally or in writing and shall furnish the Enrollee with written notice of such decision. Such notice shall meet the requirements set forth in 42 CFR §438.404.

5.19.8 Services requiring prior authorization. Contractor shall authorize or deny Covered Services that require prior authorization, including pharmacy services, as expeditiously as the Enrollee's health condition requires. Ordinarily, requests for authorizations shall be reviewed and decided on within four (4) days after receiving the request for authorization from a Provider, with a possible extension of up to four (4) additional days, if the Enrollee requests the extension or Contractor informs the Provider that there is a need for additional written justification demonstrating that the Covered Service is Medically Necessary and the Enrollee will not be harmed by the extension. If the Provider indicates, or Contractor determines, that following the ordinary review and decision time frame could seriously jeopardize the Enrollee's life or health, Contractor shall authorize or deny the Covered Service no later than forty-eight (48) hours after receipt of the request for authorization. Contractor shall authorize or deny a prior authorization request for pharmacy services no later than twenty-four (24) hours after receipt of the request for authorization.

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

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

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

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

5.20 SERVICE ACCESS REQUIREMENTS

5.20.1 Direct service access requirements.

5.20.1.1 *Emergency services.* Contractor shall cover Emergency Services for all Enrollees whether the Emergency Services are provided by a Network or a non-Network Provider.

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

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

5.20.1.1.3 Contractor shall cover Emergency Services regardless of whether the emergency department Provider or hospital notified the Enrollee's PCP or Contractor of the Enrollee's services in the emergency department.

5.20.1.1.4 Unless a representative of Contractor instructed the Enrollee to seek Emergency Services, Contractor shall have no obligation to cover medical services provided on an emergency basis that are not Covered Services under this Contract.

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

shall not be covered if the Enrollee is outside the Contracting Area against medical advice, unless the Enrollee is outside of the Contracting Area due to circumstances beyond her control. Contractor must educate the Enrollee regarding the medical and financial implications of leaving the Contracting Area and the importance of staying near the treating Provider throughout the last month of pregnancy.

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

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

5.20.1.1.8 The determination of the attending emergency Physician, or the Provider treating the Enrollee, of whether an Enrollee is sufficiently Stabilized for discharge or transfer to another facility shall be binding on Contractor.

5.20.1.1.9 Contractor shall not hold an Enrollee liable for payment of subsequent screening and treatment needed to diagnose the specific condition or to stabilize the Enrollee.

5.20.1.2 *Post-Stabilization Services.* Contractor shall cover Post-Stabilization Services provided by a Network or non-Network Provider in any of the following situations:

5.20.1.2.1 Contractor authorized such services;

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

5.20.1.2.3 Contractor does not respond to a request to authorize further Post-Stabilization Services within one (1) hour, Contractor could not be contacted, or Contractor and the treating Provider cannot reach an agreement concerning the Enrollee's care and a Network Provider is

unavailable for a consultation, in which case the treating Provider must be permitted to continue the care of the Enrollee until a Network Provider is reached and either concurs with the treating Provider's plan of care or assumes responsibility for the Enrollee's care.

5.20.1.3 *Family-Planning services.* Subject to sections 5.5 and 5.6, Contractor shall cover Family-Planning services for all Enrollees, whether the Family-Planning services are provided by a Network or a non-Network Provider.

5.20.1.4 *School dental program.* Contractor shall cover dental services that are Covered Services provided in a school for Enrollees who are under the age of twenty-one (21). Contractor shall accept claims from non-Network Providers of such services outside of its Contracting Area. Contractor shall make payment to non-Network Providers of such services according to the Department's applicable Medicaid FFS reimbursement schedule. Contractor may require the program to follow Contractor's protocols for communication regarding services rendered in order to further care coordination.

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

5.20.2 **Special service access requirements.**

5.20.2.1 **School-based health centers.**

5.20.2.1.1 Contractor shall offer contracts to all the school health centers recognized by the Department of Public Health that are in Contractor's Contracting Area. Contractor shall not require prior authorization or a Referral as a condition of payment for school-based health center services provided by those school-based health centers with which Contractor has contracts.

5.20.2.1.2 For Illinois school-based health centers outside of the Contracting Area, Contractor shall accept claims from non-Network Providers of school-based health center services. Contractor shall make payment to non-Network Providers of such services according to the Department's applicable Medicaid FFS reimbursement schedule. Contractor may require school-based health centers to follow Contractor's protocols for communication

regarding services rendered in order to further care coordination.

5.20.2.2 Community Mental Health Centers (CMHCs) and Behavioral Health Clinics (BHCs).

5.20.2.2.1 Contractor shall enter into a contract with any willing and qualified CMHC (Medicaid Provider Type 36) and BHC (Medicaid Provider Type 27) in the Contracting Area so long as the Provider agrees to Contractor's rate and adheres to Contractor's QA requirements. Contractor may establish quality standards in addition to those State and federal requirements and, after the first (1st) year of contracting, contract with only those CMHCs and BHCs that meet such standards, provided that each contracting CMHC or BHC is informed of any such additional standards no later than ninety (90) days after the start of its contract and that the Department has given Prior Approval. Any such standards that are not established within ninety (90) days after the start of the contract with the CMHC or BHC must be in effect for one (1) year before Contractor may terminate a contract of a CMHC or BHC based on a failure to meet such standards.

5.20.2.3 Local health departments.

5.20.2.3.1 Contractor shall offer contracts to all the local health departments recognized by the Department of Public Health that are in Contractor's Contracting Area. Contractor shall not require prior authorization or a Referral as a condition of payment for local health department services provided by those local health departments with which Contractor has contracts.

5.20.2.3.2 For local health departments outside of the Contracting Area, Contractor shall accept claims from non-Network Providers of local health department services. Contractor shall make payment to non-Network Providers of such services according to the Department's applicable Medicaid FFS reimbursement schedule. Contractor may require local health departments to follow Contractor's protocols for communication regarding services rendered in order to further care coordination.

5.20.2.4 Preventive prenatal, perinatal, and postpartum services.

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

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

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

5.21 ENROLLEE SERVICES

5.21.1 **Basic information.** "Basic information" as used herein shall mean information regarding:

5.21.1.1 the types of benefits and the amount, duration, and scope of such benefits available under this Contract, with sufficient detail to ensure that Enrollees understand the Covered Services they are entitled to receive, including behavioral-health services and EPSDT screenings and services;

5.21.1.2 the procedures for obtaining Covered Services, including authorization and Referral requirements, and any restrictions Contractor may place on an Enrollee pursuant to section 4.19;

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

5.21.1.4 the extent to which after-hours coverage and Emergency Services are provided, including the following specific information:

5.21.1.4.1 definitions of "Emergency Medical Condition,"

- “Emergency Services,” and “Post-Stabilization Services” that are consistent with the definitions set forth herein;
- 5.21.1.4.2 the fact that prior authorization is not required for Emergency Services;
 - 5.21.1.4.3 the fact that, subject to the provisions of this Contract, an Enrollee has a right to use any hospital or other setting to receive Emergency Services;
 - 5.21.1.4.4 the process and procedures for obtaining Emergency Services; and
 - 5.21.1.4.5 the location of Emergency Services and Post-Stabilization Services Providers that are Network Providers;
- 5.21.1.5 the procedures for obtaining Post-Stabilization Services in accordance with the terms set forth in section 5.20.1.2;
 - 5.21.1.6 the policy on Referrals for specialty care and for Covered Services not furnished by an Enrollee’s PCP;
 - 5.21.1.7 cost sharing, if any;
 - 5.21.1.8 the rights, protections, and responsibilities of an Enrollee as specified in 42 CFR § 438.100, such as those pertaining to enrollment and disenrollment and those provided under State and federal law;
 - 5.21.1.9 Grievance and fair-hearing procedures and time frames, provided that such information must be submitted to the Department for Prior Approval before distribution;
 - 5.21.1.10 Appeal rights and procedures and time frames, provided that such information must be submitted to the Department for Prior Approval before distribution;
 - 5.21.1.11 Contractor’s website URL and the types of information contained on the website, including certificate of coverage or document of coverage, Provider directory, and the ability to request a hard copy of these through Enrollee services;
 - 5.21.1.12 a copy of Contractor’s certificate of coverage or document of coverage;
 - 5.21.1.13 names, locations, telephone numbers, and non-English languages spoken by current Network Providers, including identification of those who are not accepting new Enrollees;
 - 5.21.1.14 information on NF Covered Services and HCBS Waiver Covered

Services to Enrollees receiving or determined to need Covered Services under Service Package II;

5.21.1.15 Enrollee packets, which the State or its designee will provide to Contractor, and which Contractor shall distribute to Enrollees receiving Covered Services from Personal Assistants or other Individual Providers under the Persons with Disabilities HCBS Waiver, Persons with HIV/AIDS HCBS Waiver, or Persons with Brain Injury HCBS Waiver. Contractor shall educate Enrollees regarding the content of the Enrollee packets.

5.21.2 **Obligation to provide basic information.** Contractor shall provide basic information to the following Participants, and shall notify such Participants that translated materials in Spanish and other prevalent languages are available and how to obtain them, once a year:

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

5.21.2.2 to any Potential Enrollee who requests it.

5.21.3 **Other information.** Contractor shall provide the following additional information when requested by any Enrollee, Prospective Enrollee, or Potential Enrollee:

5.21.3.1 MCO licensure or county MCCN certification (whichever is applicable to Contractor), and the healthcare facility licensure;

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

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

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

5.21.4 **Communications with Prospective Enrollees, Potential Enrollees, and Enrollees.** The requirements outlined in this section 5.21.4 apply to all Key Oral Contacts and Written Materials. Contractor shall proactively attempt, within the conditions imposed by any court order or consent decree, to promote the hiring of local staff to ensure Cultural Competence. All Contractor staff will receive training on all Contractor policies and procedures during

new-hire orientation and ongoing job-specific training to ensure effective communication with a diverse Enrollee population, including translation assistance, assistance to the hearing impaired, and assistance to those with limited English proficiency. Contractor shall meet quarterly with its Enrollee advisory and community stakeholder committee to assess the results of Enrollee calls. Enrollee feedback will be sought at the close of each contact to inquire if the Enrollee's needs or issues have been resolved. Contractor shall conduct targeted Enrollee focus groups to obtain additional input on Contractor materials and program information, and shall also seek input from local organizations that serve Enrollees.

5.21.4.1 *Interpretive services.* Contractor shall make oral interpretation services available free of charge in all languages to all Potential Enrollees, Prospective Enrollees, or Enrollees who need assistance understanding Key Oral Contacts or Written Materials. Contractor must include in all Key Oral Contacts and Written Materials notification that such oral interpretation services are available and how to obtain such services. Contractor shall conduct Key Oral Contacts with a Potential Enrollee, Prospective Enrollee, or Enrollee in a language the Potential Enrollee, Prospective Enrollee, or Enrollee understands. If a Participant requests interpretive services by a family member or acquaintance, Contractor shall not allow such services by anyone who is under the age of eighteen (18). Contractor shall accept such Participant's verification of the age of the individual providing interpretive services unless Contractor has a valid reason for requesting further verification.

5.21.4.2 *Reading level.* All of Contractor's written communications with Potential Enrollees, Prospective Enrollees, and Enrollees must be produced at a sixth (6th)-grade reading level and easily understood by individuals with sixth (6th)-grade reading skills. Contractor will use the Flesch Reading Ease and Flesch-Kincaid Grade level tests, or other reading level test as approved by the Department, to ensure appropriate reading level. Written Materials will be presented in a layout and manner that enhance Enrollees' understanding in a culturally competent manner.

5.21.4.3 *Alternative methods of communication.* Contractor shall make Key Oral Contacts and Written Materials available in such alternative formats as large print, Braille, sign language provided by interpreters in accordance with the Interpreters for the Deaf Act (225 ILCS 442), CART reporters, audio CDs, TDD/TTY, video relay interpretation, or video relay services, and in a manner that takes into consideration the special needs of those who are visually impaired, hearing impaired, or with limited reading proficiency. Contractor shall inform Potential Enrollees, Prospective Enrollees, and Enrollees, as appropriate, that

information is available in alternative formats and how to access those formats. Contractor must provide TDD/TTY service upon request for communicating with Potential Enrollees, Prospective Enrollees, and Enrollees who are deaf or hearing impaired. Contractor shall arrange interpreter services through Contractor's Enrollee services department when necessary (such as for Provider visits or consultations). These services will be made available at no cost to the Enrollee.

5.21.4.4 *Translated materials.* Translated Written Materials and scripts for translated Key Oral Contacts require Prior Approval and must be accompanied by Contractor's certification that its certified translator confirms the translation is accurate and complete, and that the translation is easily understood by individuals with a sixth (6th)-grade reading level and is culturally appropriate. Contractor's first submittal of the translated materials to the Department for Prior Approval must be accompanied by a copy of the Department's approval of the English version and the required translation certification. Contractor shall make all Written Materials distributed to English-speaking Potential Enrollees, Prospective Enrollees and Enrollees, as appropriate, available in Spanish and other prevalent languages, as determined by the Department in accordance with Section 1557 of the Affordable Care Act. Where there is a prevalent single-language minority within the low-income households in the relevant DHS local office area, which for purposes of this Contract shall exist when five percent (5%) or more of such households speak a language other than English, as determined by the Department according to published Census Bureau data, Contractor's Written Materials provided to Potential Enrollees, Prospective Enrollees, or Enrollees must be available in that language as well as in English.

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

5.21.5 **Enrollee handbook.** Department will provide Contractor with an Enrollee handbook template. Contractor shall complete and submit the template to the Department for Prior Approval before the first enrollment, when revised, and upon the Department's request. Contractor shall mail an Enrollee handbook to new Enrollees no later than five (5) Business Days following receipt of the

Enrollee's initial enrollment record on the 834 Audit File, or, no later than five (5) Business Days prior to an Enrollee's Effective Enrollment Date. Contractor must include terms defined by the Department as provided in 42 CFR §438.10(c)(4)(i) and follow the requirements of 42 CFR §438.10(g). At a minimum, the Enrollee handbook must contain:

- 5.21.5.1 Contractor's contact information, including the toll-free telephone number for member services, medical management and any other unit providing services directly to Enrollees;
- 5.21.5.2 the Enrollee's rights and responsibilities and the Enrollee's freedom to exercise those rights without negative consequences. The Enrollee's rights include the right to:
 - 5.21.5.2.1 be treated with respect and with due consideration for the Enrollee's dignity and privacy;
 - 5.21.5.2.2 receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's condition and ability to understand;
 - 5.21.5.2.3 participate in decisions regarding the Enrollee's healthcare, including the right to refuse treatment;
 - 5.21.5.2.4 be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;
 - 5.21.5.2.5 request and receive a copy of the Enrollee's medical records, and to request that the records be amended or corrected; and
 - 5.21.5.2.6 exercise the Enrollee's rights, with the assurance that the exercise of those rights will not adversely affect the way the Enrollee is treated;
- 5.21.5.3 the PCP network and the PCP's role in directing and managing the Enrollee's care;
- 5.21.5.4 an explanation of open enrollment and the Open Enrollment Period;
- 5.21.5.5 how to select and change a PCP, change "for cause," whether Contractor may impose a restriction on the number of times the Enrollee can change PCPs during the Enrollment Period, and the circumstances under which an Enrollee may select a specialist as a PCP;
- 5.21.5.6 the amount, duration, and scope of benefits available, in

sufficient detail to ensure that the Enrollee understands the benefits to which the Enrollee is entitled as well as any benefits that may be excluded pursuant to section 5.6;

- 5.21.5.7 how and the extent to which the Enrollee may obtain direct-access services, including Family-Planning services;
- 5.21.5.8 the policies and procedures for obtaining services, including clinical advice, self-referred services, services requiring prior authorization, and services requiring a Referral;
- 5.21.5.9 how to access after-hours, nonemergency care;
- 5.21.5.10 the procedures for obtaining Emergency Services. The information shall specify that Emergency Services do not require a Referral, directions regarding the 911 telephone system, and refer the Enrollee to the Provider directory or the call center for a list of facilities providing Emergency Services and Post-Stabilization Services. The information shall clearly communicate that the Enrollee has a right to use any hospital or other setting for Emergency Services;
- 5.21.5.11 how to identify what constitutes an Emergency Medical Condition, Emergency Services, or the need for Post-Stabilization Services, as defined by 42 CFR §438.114(a);
- 5.21.5.12 Contractor's Grievance and Appeals process and the State's Appeal and fair-hearing process, including how to register a Grievance or Appeal;
- 5.21.5.13 how to access and receive written and oral information in languages other than English and in alternate language formats, including TDD/TTY;
- 5.21.5.14 the formulary and how to obtain prescription drugs;
- 5.21.5.15 the Disease Management Program and the services offered, and how to access these services;
- 5.21.5.16 care coordination and services provided by a Care Coordinator;
- 5.21.5.17 how to exercise an advance directive;
- 5.21.5.18 how to access auxiliary aids and services;
- 5.21.5.19 how to report suspected fraud or abuse; and
- 5.21.5.20 any basic information, as set forth in section 5.21.1, that is not otherwise specifically set forth in this section 5.21.5.

5.21.6 Telephone access.

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

5.21.6.2 Contractor shall establish a toll-free number that will be available at a minimum from 8:30 a.m. until 5:00 p.m. Central Time on Business Days. This number will be used at a minimum for Enrollees to file Complaints or Grievances, to request disenrollment, to ask questions, or to obtain other administrative information.

5.21.6.3 Contractor may use one (1) toll-free number for these purposes or may establish separate numbers.

5.21.6.4 On-hold messaging for the Enrollee services telephone line will include health education briefs, general reminders, and Contractor benefits and services information. The messaging will be changed periodically to meet identified Enrollee trends or topical issues.

5.21.6.5 Contractor's administrative QA and improvement policies and procedures shall contain standards and a monitoring plan for all telephone access and call-center performance on an ongoing basis, and Contractor shall take immediate corrective action when standards are not met. Contractor shall analyze data collected from its phone system as requested by the Department and as necessary to perform QA and improvement tasks, monitor compliance with performance standards, and ensure adequate staffing of the call centers. Upon request from the Department, Contractor shall document compliance in these areas.

5.21.6.6 Contractor shall record all incoming calls for quality control, program integrity, and training purposes. Staff at Contractor's call center shall advise callers that calls may be monitored and recorded for QA purposes. Administrative lines do not need to be recorded. Contractor shall archive the recordings for no fewer than twelve (12) months or as otherwise required by law.

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

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

5.21.7.1.1 Enrollee demographics tracking and information;

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

5.21.7.1.3 technology for use in inbound Enrollee contact and query management.

5.21.7.2 *Telephonic outreach.* Contractor will implement a telephonic outreach program to educate and assist Enrollees in accessing services and managing their care. Calls will be made by Contractor staff to new Enrollees and to targeted populations such as Enrollees who are identified or enrolled in disease or Care Management, who have frequent emergency-room utilization, or who are due or past due for services.

5.21.7.3 *Enrollee portal.* Contractor shall establish and maintain a secure Enrollee Web portal and mobile application that shall include, at a minimum, the following functions or capabilities:

5.21.7.3.1 information about Contractor;

5.21.7.3.2 "contact us" information;

5.21.7.3.3 local health events and news;

5.21.7.3.4 Provider search;

5.21.7.3.5 access to the Enrollee's IPoC;

5.21.7.3.6 access to the Enrollee's care gaps; and

5.21.7.3.7 access to health-education materials.

5.21.7.4 *Written contacts.* Contractor shall produce mailings to all Enrollees enrolled in care management that will include reminders about the benefits of participating in the care-management program

and of receiving the screenings and preventive care required for their condition. The mailing shall include Contractor's toll-free phone number and invite Enrollees to contact the ICT or the nurse advice line with any questions. Contractor mailings shall include reminders about needed preventive services or screenings, reminders about the risks associated with progression of the Enrollee's disease, and information about any available incentives for receiving a needed service.

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

5.21.8.1 *Collaborative education development and oversight.* Contractor's medical management department and Medical Director shall be responsible for development, maintenance, and oversight of Enrollee health-education programs.

5.21.8.2 *Health education outreach.* Contractor will identify regional community health education opportunities, improve outreach and communication with Enrollees and community-based organizations, and actively promote healthy lifestyles through activities such as disease prevention and health promotion.

5.21.8.3 *Flu-prevention program.* Contractor shall make a flu-prevention program available for all Enrollees and will provide targeted outreach to high-risk Enrollees. The program will educate Enrollees about preventing the transmission of the influenza virus.

5.21.8.4 *New-Enrollee welcome packet.* Contractor shall send to each new Enrollee a welcome packet that contains the Enrollee handbook and addresses important topics, such as how to get needed care; a benefits summary; and information about the Complaint, Grievance, and Appeal processes. This may be combined with the Enrollee welcome packet required in section 4.9.

5.21.8.5 *Welcome calls.* Contractor will conduct welcome calls to each new Enrollee within thirty (30) days after the Effective Enrollment Date. When an Enrollee has been successfully contacted, Contractor will provide health education, respond to questions about Covered Services and how to access them, and conduct a health-risk screening to identify an Enrollee's potential need for services and care management.

5.21.8.6 *Enrollee newsletters.* Contractor will distribute quarterly Enrollee newsletters that include health education and Contractor events, and a calendar listing of health fairs, screening days, and other Contractor-sponsored or organized health activities.

5.21.8.7 *Education through Care Coordinators.* Contractor's Care Coordinators will attempt to contact all Enrollees who frequently use or recently visited an emergency room to determine whether the Enrollees are experiencing barriers to primary and preventive care; to help resolve those barriers, if any; and to educate Enrollees on the appropriate use of emergency-room services and the Enrollees' health home.

5.21.8.8 *Enrollee support to ensure compliance.* To the extent possible, Contractor shall involve the Enrollee in IPoC development. Enrollee education will occur through telephone contact, face-to-face contact, education groups, and educational mailings. Education shall include information about monitoring daily disease-specific indicators. If appropriate, the Care Coordinator will link the Enrollee with available community-based disease-specific educational programs and support groups.

5.21.9 **Transient Enrollees.** Contractor shall utilize various strategies and methodologies as appropriate to connect with transient Enrollees, including the following.

5.21.9.1 *Web portal.* Contractor shall provide educational materials on the Enrollee Web portal.

5.21.9.2 *Enrollee contact.* Contractor shall verify Enrollee address and phone numbers during each contact.

5.21.9.3 *Other methods.* Contractor shall use other methods available to locate and educate transient Enrollees, such as community organizations, Physicians, family, the Internet, and reverse phone number look-up systems to locate active phone numbers and Enrollee demographics on paid claims. Contractor representatives may be dispatched to an Enrollee's home when a valid phone number is not found.

5.22 **QUALITY ASSURANCE, UTILIZATION REVIEW, AND PEER REVIEW**

5.22.1 All services provided, or arranged to be provided, by Contractor shall be in accordance with prevailing community standards. Contractor must have in effect a program consistent with the utilization control requirements of 42 CFR §456. This program will include, when so required by the regulations, written plans of care and certifications of need of care.

5.22.2 Contractor shall ensure Network Providers' labs are capable of reporting lab values to Contractor directly. Contractor shall use the electronic lab values to calculate HEDIS® Performance Measures.

- 5.22.3 Contractor shall adopt practice guidelines that meet the minimum standards of care set forth in Attachment XXI and shall comply with such guidelines. Contractor shall provide guidelines to all affected Providers and, upon request, to Enrollees and Potential Enrollees.
- 5.22.4 Contractor shall have a Utilization Management Program that includes a utilization-review plan, a utilization-review committee, and appropriate mechanisms covering prior authorization and review requirements.
- 5.22.5 Contractor shall establish and maintain a Peer Review program approved by the Department to review the quality of care being offered by Contractor and its employees, Subcontractors, and Network Providers.
- 5.22.6 Contractor agrees to comply with the QA standards attached hereto as Attachment XI.
- 5.22.7 Contractor agrees to comply with the utilization-review standards and peer-review standards attached hereto as Attachment XII.
- 5.22.8 Contractor agrees to conduct a program of ongoing review that evaluates the effectiveness of its QA and performance improvement strategies designed in accordance with the terms of this section 5.22.
- 5.22.9 Contractor shall not compensate individuals or entities that conduct utilization-review activities on its behalf in a manner that is structured to provide incentives for the individuals or entities to deny, limit, or discontinue Covered Services that are Medically Necessary for any Enrollee.

5.23 HEALTH, SAFETY, AND WELFARE MONITORING

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

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

5.23.1.2 Contractor shall comply with Critical Incident reporting

requirements of the DHS-DRS, IDoA, and HFS HCBS Waivers for incidents and events that do not rise to the level of Abuse, Neglect, or exploitation. Such reportable incidents include those identified in Attachments XVII, XVIII, and XIX for the appropriate HCBS Waivers.

- 5.23.1.3 Contractor shall comply with HCBS Waiver reporting requirements to assure compliance with federal waiver assurances for health, safety, and welfare as set forth in the approved HCBS Waivers. Contractor, on an ongoing basis, shall identify, address, and seek to prevent the occurrence of Abuse, Neglect, and exploitation. Performance Measures regarding health, safety, welfare, and critical-incident reporting are included in Table 2 to Attachment XI.
- 5.23.1.4 Contractor shall train all of Contractor's external-facing employees, Network Providers, Affiliates, and Subcontractors to recognize potential concerns related to Abuse, Neglect, and exploitation, and will train them on their responsibility to report suspected or alleged Abuse, Neglect, or exploitation. Contractor's employees who, in good faith, report suspicious or alleged Abuse, Neglect, or exploitation to the appropriate authorities shall not be subjected to any disciplinary action from Contractor, its Network Providers, Affiliates, or Subcontractors.
- 5.23.1.5 Contractor shall train Providers, Enrollees, and Enrollees' family members about the signs of Abuse, Neglect, and exploitation; what to do if they suspect Abuse, Neglect, or exploitation; and the scope of Contractor's responsibilities regarding these issues. Training sessions will be customized to the target audience. Training will include general indicators of Abuse, Neglect, and exploitation and the time-frame requirements for reporting suspected Abuse, Neglect, and exploitation.
- 5.23.1.6 Reports regarding Enrollees who are age eighteen (18) and older and living in the community are to be made to the Illinois Department on Aging by utilizing the Adult Protective Services hotline.
- 5.23.1.7 Reports regarding Enrollees in NFs must be made to the Department of Public Health's nursing home complaint hotline.
- 5.23.1.8 Reports regarding Enrollees aged eighteen (18) to fifty-nine (59) receiving mental health or Developmental Disability services in programs that are operated, licensed, certified, or funded by DHS are to be made to Illinois Department of Human Services Office of the Inspector General hotline.
- 5.23.1.9 Reports regarding Enrollees in Supportive Living Facilities (SLFs) must be made to the Department of Healthcare and Family Services' Supportive Living Program (SLP) complaint hotline.

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

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

5.23.2 Critical-incident reporting.

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

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

5.23.2.3 Contractor shall have systems in place to report, monitor, track, and resolve Critical Incidents concerning restraints and restrictive interventions.

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

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

5.23.2.3.3 Contractor will comply with decision made by investigating authority within the timeframe given.

5.24 PHYSICIAN INCENTIVE PLAN REGULATIONS

Contractor shall comply with the provisions of 42 CFR §422.208 and 42 CFR §422.210. If, to conform to these regulations, Contractor performs Enrollee-satisfaction surveys, such surveys may be combined with those otherwise required by the Department pursuant to section 5.31 of this Contract.

5.25 PROHIBITED RELATIONSHIPS

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

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

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

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

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

5.26 RECORDS

5.26.1 **Maintenance of business records.** Contractor shall maintain all business

and professional records that are required by the Department in accordance with generally accepted business and accounting principles. Such records shall contain all pertinent information about the Enrollee, including the information required under this section 5.26.

5.26.2 Availability of business records. Records shall be made available in Illinois to the Department and Authorized Persons for inspection, audit, and reproduction as required in section 9.1.2. These records will be maintained as required by 45 CFR §74. As a part of these requirements, Contractor will retain one (1) copy in any format of all records for at least ten (10) years after final payment is made under the Contract. If an audit, litigation, or other action involving the records is started before the end of the ten (10) year period, the records must be retained until all issues arising out of the action are resolved.

5.26.3 Patient records. Contractor shall require that a permanent medical record shall be maintained by each Enrollee's PCP. The medical record shall be available to the PCP, the WHCP, and other Providers. Copies of the medical record shall be sent to any new PCP to which the Enrollee transfers. Contractor shall require that the medical record contain documented efforts to obtain the Enrollee's consent when required by law. Contractor shall require that copies of records shall be released only to Authorized Persons upon request. Original medical records shall be released only in accordance with federal or State law, including court orders or subpoenas, or a valid records-release form executed by an Enrollee. Contractor shall assist Enrollees in accessing their records in a timely manner. Contractor shall protect the confidentiality and privacy of Enrollee and abide by all federal and State laws regarding the confidentiality and disclosure of medical records, mental-health records, and any other information about Enrollee. Contractor shall require that Network Providers maintain and share such records for the Department upon request and in accordance with professional standards. Medical records must include Provider identification. Medical-records reporting requirements shall be adequate to provide for acceptable Continuity of Care to Enrollees. All entries in the medical record must be legible, accurate, complete, and dated, and include the following, where applicable:

5.26.3.1 Enrollee identification;

5.26.3.2 personal health, social history and family history, with updates as needed;

5.26.3.3 risk assessment;

5.26.3.4 obstetrical history and profile;

5.26.3.5 hospital admissions and discharges;

5.26.3.6 relevant history of current illness or injury and physical

- findings;
- 5.26.3.7 diagnostic and therapeutic orders;
- 5.26.3.8 clinical observations, including results of treatment;
- 5.26.3.9 reports of procedures, tests, and results;
- 5.26.3.10 diagnostic impressions;
- 5.26.3.11 Enrollee disposition and pertinent instructions to the Enrollee for follow-up care;
- 5.26.3.12 immunization record;
- 5.26.3.13 allergy history;
- 5.26.3.14 periodic exam record;
- 5.26.3.15 weight and height information and, as appropriate, growth charts;
- 5.26.3.16 referral information;
- 5.26.3.17 health education and anticipatory guidance provided; and
- 5.26.3.18 Family Planning and counseling.

5.27 HEALTH INFORMATION SYSTEMS

5.27.1 Contractor shall maintain a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of this Contract. The system must provide information on areas including utilization, claims, grievances and appeals, and disenrollments for reasons other than loss of Medicaid eligibility.

5.27.2 Contractor shall, at a minimum, comply with the following:

- 5.27.2.1 Section 6504(a) of the Affordable Care Act, which requires that claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems operated by the Department to meet the requirements of Section 1903(r)(1)(F) of the Social Security Act;
- 5.27.2.2 collect data on Enrollee and Provider characteristics as specified by the Department, and on all Covered Services furnished to Enrollees through an Encounter Data system or other methods as may be specified by the Department;
- 5.27.2.3 ensure that data received from Providers are accurate and

complete as required in section 5.28.

5.27.3 Contractor shall:

- 5.27.3.1 collect and maintain sufficient Enrollee Encounter Data to identify the Provider who delivers any item(s) or service(s) to Enrollees;
- 5.27.3.2 submit Enrollee Encounter Data to the Department at the frequency and level of detail specified by CMS and the Department, based on program administration, oversight, and program integrity needs as determined by CMS and the Department;
- 5.27.3.3 submit all Enrollee Encounter Data that the Department is required to report to CMS under 42 CFR §438.818;
- 5.27.3.4 submit Encounter Data to the Department in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format as appropriate, and as required by CMS under 42 CFR §438.818;
- 5.27.3.5 meet the ASC X12 5010 electronic transaction standards, including eligibility (270/271), claim status (276/277), referrals/authorizations (278), claims (837), and remittances (835);
- 5.27.3.6 use standard ASC X12 claim codes; and
- 5.27.3.7 submit with Enrollee Encounter Data a certification signed by either Contractor's Chief Executive Officer, Chief Financial Officer, or an individual who reports directly to and has delegated authority to sign for the Chief Executive Officer or Chief Financial Officer that attests based on best information, knowledge and belief, the data is accurate, complete and truthful.

5.28 INFORMATION-REPORTING AND INFORMATION TECHNOLOGY REQUIREMENTS

5.28.1 Information-reporting requirements.

- 5.28.1.1 *Regular information-reporting requirements.* Contractor shall submit to the Department, or its designee, regular reports and additional information as set forth in this section 5.28 and Attachment XIII. Contractor shall ensure that data received from Providers and included in reports are accurate and complete by:
 - 5.28.1.1.1 verifying the accuracy and timeliness of reported data, including data from Network Providers that Contractor is compensating on the basis of Capitation payments;
 - 5.28.1.1.2 screening the data for completeness, logic, and

consistency;

5.28.1.1.3 collecting data from Providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State Medicaid quality improvement and Care Coordination efforts; and

5.28.1.1.4 collecting service information in standardized formats to the extent feasible and appropriate.

5.28.1.2 *Data reporting.* All data collected by Contractor shall be available to the Department and, upon request, to Federal CMS. Such reports and information shall be submitted in a format and medium designated by the Department or having received Prior Approval. A schedule of all reports and information submissions and the frequency required for each under this Contract are provided in Attachment XIII. For purposes of this section 5.28, the following terms shall have the following meanings: “initially” means upon Effective Date of this Contract; “annual” means the State Fiscal Year; and “quarter” means three (3) consecutive calendar months of the State Fiscal Year beginning with the first (1st) day of July. Unless otherwise specified, Contractor shall submit all reports to the Department or its designee within thirty (30) days from the last day of the reporting period or as defined in Attachment XIII. The Department shall advise Contractor in writing of the appropriate format for such reports and information submissions. The Department will provide adequate notice before requiring production of any new regular reports or information, and will consider concerns raised by Contractor about potential burdens associated with producing the proposed additional reports. The Department will provide the reason for any such request.

5.28.1.3 *Ad hoc information requests.* Contractor shall submit to the Department an accurate and complete response to any ad hoc request received from the Department by the due date given by the Department. If Contractor cannot meet the due date, Contractor shall request an extension no later than forty-eight (48) hours before such due date. The Department may approve, deny, or allow for such shorter extension within its sole discretion.

5.28.1.4 *Impact of noncompliance.* Failure of Contractor to materially comply with reporting requirements may subject Contractor to any of the applicable monetary sanctions in article VII of this Contract. Any Contractor obligation(s) to provide reporting to the Department shall be contingent on the Department’s ability to deliver to Contractor the information or necessary business specifications reasonably required by Contractor to complete its reporting requirements, as applicable.

5.28.2 Information technology requirements. Contractor will adhere to the data security and connectivity specifications provided in Attachment XIV.

5.28.3 Insure Kids Now (IKN) website. In accordance with the Children’s Health Insurance Program Reauthorization Act (CHIPRA) of 2009, Contractor shall submit required dental provider data file(s) through the IKN data management website on a quarterly basis.

5.29 PAYMENTS TO PROVIDERS

Contractor shall make payments to Providers (including the fiscal agent making payments to Personal Assistants under the HCBS Waivers; see Attachment XX) for Covered Services on a timely basis consistent with the claims payment procedure described at 42 U.S.C. § 1396a(a)(37)(A) and 215 ILCS 5/368a. Complaints or disputes concerning payments for the provision of services as described in this section 5.29 shall be subject to Contractor’s Provider complaint resolution system pursuant to section 5.29.7. Contractor must pay ninety percent (90%) of all clean claims from Providers for Covered Services within thirty (30) days following receipt. Contractor must pay ninety-nine percent (99%) of all clean claims from Providers for Covered Services within ninety (90) days following receipt. For purposes of this section 5.29, a “clean claim” means a claim from a Provider for Covered Services that can be processed without obtaining additional information from the Provider of the service or from a Third Party, except that it shall not mean a claim submitted by or on behalf of a Provider who is under investigation for Fraud or Abuse, or a claim that is under review for determining whether it was Medically Necessary. For purposes of an Enrollee’s admission to an NF, a “clean claim” means that the admission is reflected on the patient credit file that Contractor receives from the Department. Contractor will not be considered to be in Breach of this section 5.29, and the Department will not impose a monetary sanction pursuant to section 7.16.18 for Contractor’s failure to meet the requirements of this section 5.29 if such purported breach or failure occurs at a time when the Department has not paid any of the required Capitation to Contractor for two (2) consecutive months. Contractor shall make all expedited payments in accordance with the timeframes listed in the Expedited Provider Report, which will be provided monthly by the Department.

5.29.1 Contractor shall pay for all appropriate Emergency Services rendered by a non-Network Provider within thirty (30) days after receipt of a clean claim. If Contractor determines it does not have sufficient information to make payment, Contractor shall request all necessary information from the non-Network Provider within thirty (30) days after receiving the claim, and shall pay the non-Network Provider within thirty (30) days after receiving such information. Such payment shall be made at the same rate the Department would pay for such services according to the level of services provided and exclusive of disproportionate share payments. Determination of appropriate levels of service for payment shall be based upon the symptoms and condition of the Enrollee at the time the Enrollee is initially examined by the non-

Network Provider and not upon the final determination of the Enrollee's actual medical condition, unless the actual medical condition is more severe. Within the time limitation stated above, Contractor may review the need for, and the intensity of, the services provided by non-Network Providers.

- 5.29.2 Contractor shall pay for all Post-Stabilization Services as a Covered Service in any of the following situations: (i) Contractor authorized such services; (ii) such services were administered to maintain the Enrollee's Stabilized condition within one (1) hour after a request to Contractor for authorization of further Post-Stabilization Services; or, (iii) Contractor did not respond to a request to authorize such services within one (1) hour, Contractor could not be contacted, or, if the treating Provider is a non-Network Provider, Contractor and the treating Provider could not reach an agreement concerning the Enrollee's care and a Network Provider was unavailable for a consultation, in which case Contractor must pay for such services rendered by the treating non-Network Provider until a Network Provider was reached and either concurred with the treating non-Network Provider's plan of care or assumed responsibility for the Enrollee's care. Contractor shall pay for Post-Stabilization Services rendered by a non-Network Provider at the same rate the Department would pay for such services according to the level of services provided and exclusive of disproportionate share payments.
- 5.29.3 Contractor shall pay for Family-Planning services, subject to sections 5.5 and 5.6 hereof, rendered by a non-Network Provider, for which Contractor would pay if rendered by a Network Provider, at the same rate the Department would pay for such services exclusive of disproportionate share payments, unless a different rate was agreed upon by Contractor and the non-Network Provider.
- 5.29.4 Contractor shall accept claims from non-Network Providers for at least six (6) months after the date the services are provided. Contractor shall not be required to pay for claims initially submitted by such non-Network Providers more than six (6) months after the date of service.
- 5.29.5 Contractor shall pay all Providers of HCBS Waiver services at a rate no less than the rate in effect for the Department for such Covered Services.
- 5.29.5.1 Contractor shall pay Provider agencies that provide in-home services under the Persons Who are Elderly HCBS Waiver and that also offer health insurance to their in-home service workers, at a rate that includes the enhanced rate set forth at 89 Ill. Admin. Code 240.1970. If any other HCBS Waiver becomes subject to a duly promulgated State rule that includes a similar enhanced rate, Contractor shall pay the affected Provider agencies at a rate that includes such enhanced rate.
- 5.29.5.2 Contractor shall not discriminate against Providers of HCBS Waiver services that offer health insurance to their in-home services

workers.

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

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

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

5.29.6.2.1 A Minimum Data Set rate is comprised of the nursing component, capital component and support component of each Nursing Facility, and when applicable, an add-on component when a Nursing Facility qualifies for enhanced rates.

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

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

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

5.29.7.3 a system that creates a standardized tracking number per complaint in a format designated by the Department that maintains the date the complaint was filed and the date of resolution if applicable. The Department in consultation with Contractor may change parameters around the tracking number. The Department shall provide Contractor with ninety (90) days' written notice of any such change; and

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

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

5.29.9 Contractor shall comply with requirements concerning the reporting and payment of Provider-preventable conditions as set forth in 42 CFR §434.6(a)(12), §438.3(g) and §447.26. Contractor shall require, as a condition of payment, that Providers identify and report Provider-preventable conditions associated with claims for payment or with courses of

treatment for which payment would otherwise be made. Contractor shall report identified Provider-preventable conditions to the Department as required in Attachment XIII. Contractor shall reduce payment to Provider for health care-acquired conditions and shall not pay Provider for other Provider-preventable conditions as identified in the State Plan. Contractor shall not reduce payment to Provider for a Provider-preventable condition when that condition existed prior to the initiation of treatment for an Enrollee by that Provider.

- 5.29.10 Contractor shall establish and follow a uniform process for post-authorization of, and payment for, non-Emergency transportation that is consistent with the procedures and requirement established by the Department and set forth in the Medicaid Managed Care Provider Manual.
- 5.29.11 The Department will notify Contractor of any applicable patient credit amounts for Enrollees who are in a NF or SLF by the monthly patient credit file.
- 5.29.11.1 Contractor shall delegate collection of patient credit to the NF and SLF, and shall pay such facility the difference between the patient credit amount and the rate agreed to by such facility.
- 5.29.11.2 Within one (1) year after the Effective Date, Contractor shall electronically process patient credit information received by Contractor from the Department.
- 5.29.11.3 Contractor shall complete retroactive adjustments for up to twenty-four (24) months to Nursing Facilities, Supportive Living Facilities, and Specialized Mental Health Rehabilitation Facilities to account for patient credit liability amount changes.
- 5.29.11.3.1 Contractor shall pay claims and retroactive adjustments beyond twenty-four (24) months to Nursing Facilities, Supportive Living Facilities, and Specialized Mental Health Rehabilitation Facilities in cases due to delays in the State's eligibility processing of long-term care admissions and income changes that prevented Contractor from processing a payment or adjustment.
- 5.29.12 Contractor shall offer Network Providers the ability to enroll in electronic funds transfer (EFT).
- 5.29.13 Contractor shall pay county nursing homes, as referenced at 1.1.119.1, a rate no less than the Department's Medicaid cost-based rate.
- 5.29.14 Effective July 1, 2019, Contractor shall pay critical access pharmacies a rate no less than the Department's Medicaid rate for the professional dispensing fee associated with filling a prescription for an Enrollee.

5.30 ENROLLEE GRIEVANCE AND APPEAL SYSTEM

Contractor shall have a formally structured Grievance and Appeal system that is compliant with Sections 45 of the Managed Care Reform and Patient Rights Act, 215 ILCS 134, and 42 CFR §431 Subpart E and §438 Subpart F to handle all Grievances and Appeals subject to the provisions of such Sections of the Act and regulations.

5.30.1 **Grievances.** Contractor shall establish and maintain a procedure for reviewing Grievances by an Enrollee or an Enrollee's Authorized Representative. A Grievance may be submitted orally or in writing, using any medium, at any time, and all Grievances shall be registered with Contractor. Contractor's procedures must:

5.30.1.1 be submitted to the Department in writing and approved in writing by the Department;

5.30.1.2 provide for prompt resolution; and

5.30.1.3 assure the participation of individuals with authority, no previous involvement of review, and appropriate clinical expertise to require corrective action.

At a minimum, the following elements must be included in the Grievance process:

5.30.1.4 Contractor will acknowledge the receipt of a Grievance within forty-eight (48) hours.

5.30.1.5 Contractor shall attempt to resolve all Grievances as soon as possible but no later than ninety (90) days from receipt of a Grievance. Contractor may inform an Enrollee of the resolution orally or in writing.

5.30.1.6 An Enrollee may appoint any individual, including a guardian, caregiver relative, or Provider, to represent the Enrollee throughout the Grievance process as an authorized representative. Contractor shall provide a form and instructions on how an Enrollee may appoint an authorized representative.

5.30.1.7 Contractor shall submit to the Department, in the format required by the Department, a quarterly report summarizing all Grievances and the responses to and disposition of those matters.

5.30.2 **Appeals.** Contractor shall establish and maintain a procedure for reviewing Appeals by Enrollees or an Enrollee's Authorized Representative pursuant to 42 CFR §438 Subpart F. An Appeal may be submitted orally or in writing, and all Appeals shall be registered initially with Contractor and may later be appealed to the State, as provided herein. Contractor's procedures must:

- 5.30.2.1 be submitted to the Department in writing and approved in writing by the Department;
 - 5.30.2.2 provide for resolution within the times specified herein;
 - 5.30.2.3 provide for only one level of Appeal by Enrollee; and
 - 5.30.2.4 assure the participation of individuals with authority, no previous involvement of review, and appropriate clinical expertise to require corrective action.
- 5.30.3 Contractor must have a committee in place for reviewing Appeals made by Enrollees. At a minimum, the following elements must be included in the Appeal process:
- 5.30.3.1 An Enrollee may file an oral or written Appeal within sixty (60) days following the date of the Adverse Benefit Determination that generates such Appeal. The notice must include Contractor's Adverse Benefit Determination; reasons for the determination; right of Enrollee to request and be provided, free of cost, access to and copies of all relevant information; right of Enrollee to request an Appeal and procedures to request an Appeal, including an expedited Appeal; and the Enrollee's right to request and have benefits continue during the Appeal process. Contractor must comply with the timing of notice requirements required at 42 CFR §438.404(c).
 - 5.30.3.2 An Enrollee may appoint any authorized representative, including a guardian, caregiver relative, or Provider, to represent the Enrollee throughout the Appeal process. Contractor shall provide a form and instructions on how an Enrollee may appoint a representative.
 - 5.30.3.3 If an Enrollee requests an expedited Appeal pursuant to 42 CFR §438.410, Contractor shall notify the Enrollee within twenty-four (24) hours after the submission of the Appeal, of all information from the Enrollee that Contractor requires to evaluate the Appeal. Contractor shall render a decision on an expedited Appeal within twenty-four (24) hours after receipt of the required information. Contractor shall not discriminate or take punitive action against a Provider who either requests an expedited resolution of Appeal or supports an Enrollee's Appeal pursuant to 42 CFR §438.410(b).
 - 5.30.3.4 If an Enrollee does not request an expedited Appeal, Contractor shall make its decision on the Appeal within fifteen (15) Business Days after submission of the Appeal. Contractor may extend this time frame for up to fourteen (14) days if the Enrollee requests an extension, or if Contractor demonstrates to the satisfaction of the appropriate State agency's hearing office that there is a need for additional information

and the delay is in the Enrollee's interest.

5.30.3.4.1 If Contractor extends time frame not at request of Enrollee, Contractor must: make reasonable efforts to give Enrollee prompt oral notice of delay, give Enrollee written notice within two (2) days, and resolve the Appeal expeditiously, but no later than expiration date of extension.

5.30.3.5 Final decisions of Appeals, including expedited Appeals, not resolved wholly in favor of the Enrollee may be appealed by the Enrollee to the State under its fair hearings system within one hundred twenty (120) days after the date of Contractor's decision notice. If Contractor fails to meet notice and timing requirements, the Enrollee is deemed to have exhausted the Appeals process and may initiate a State fair hearing.

5.30.3.6 Except for a denial of Waiver services, which may not be reviewed by an external independent entity, Contractor shall have procedures allowing an Enrollee to request an external independent review, at no cost to the Enrollee, on both standard and expedited time frames, of Appeals that are denied by Contractor within thirty (30) days after the date of Contractor's decision notice.

5.30.3.7 If an Appeal is filed with the State fair hearing system, Contractor will participate in the prehearing process, including scheduling coordination and submission of documentary evidence at least three (3) Business Days prior to the hearing, and shall participate in the hearing, including providing a witness to offer testimony supporting the decision of Contractor.

5.30.3.8 If Contractor or the State fair hearing officer reverses a decision to deny, limit, or delay services, and those services were not furnished while the Appeal was pending, Contractor must authorize or provide the disputed services as expeditiously as the Enrollee's health condition requires, but no later than seventy-two (72) hours from the date Contractor receives notice reversing the decision.

5.30.3.9 If Contractor or the State fair hearing officer reverses a decision to deny authorization of services and the Enrollee received the disputed services while the Appeal was pending, Contractor must pay for those services, in accordance with State policy and regulations.

5.30.3.10 If an Enrollee files for continuation of benefits on or before the latter of ten (10) days of Contractor sending the Adverse Benefit Determination, or the intended Effective Date of the proposed Adverse Benefit Determination, Contractor must continue the Enrollee's benefits during the Appeal process. A Provider, serving as Enrollee's

authorized representative for the Appeal process, cannot file for continuation of benefits. Pursuant to 42 CFR §438.420, if the final resolution of the Appeal is adverse to the Enrollee, Contractor may recover the cost of the services that were furnished to the Enrollee.

5.30.3.11 Contractor shall submit to the Department, in the format required by the Department, a quarterly report summarizing all Appeals filed by Enrollees and the responses to and disposition of those matters (including decisions made following an external independent review).

5.30.4 Contractor must maintain records of Grievances and Appeals. At a minimum, the record must contain: general description of reason for Grievance or Appeal, date received, date reviewed, and resolution, including date, at each level, and name of Person for whom the Grievance or Appeal was filed.

5.30.5 Contractor shall review its Grievance and Appeal procedures at least annually to amend such procedures when necessary. Contractor shall amend its procedures only upon receiving the written Prior Approval of the Department. This information shall be provided to the Department.

5.31 ENROLLEE SATISFACTION SURVEY

5.31.1 Contractor shall conduct an annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey as approved by the Department. The survey sampling and administration must follow specifications contained in the most current HEDIS® volume. Contractor must contract with an NCQA-certified HEDIS® survey vendor to administer the survey and submit results as provided in the HEDIS® survey specifications. Contractor shall submit its findings and explain what actions it will take on its findings as part of the comprehensive annual QA/UR/PR report.

5.31.2 Contractor shall administer IDoA's Participant Outcomes and Status Measures (POSM) Quality of Life Survey to each IDoA Persons who are Elderly HCBS Waiver Enrollee at each annual reassessment to determine each Enrollee's perception of the quality of life from the Effective Date through April 30, 2022. Beginning May 1, 2022, Contractor shall administer questions at each annual reassessment to determine the Enrollee's perception of their quality of life using a questionnaire format of Contractor's choice. In the event an Enrollee reports a negative perception of their quality of life, Contractor's Care Coordinator shall document steps taken and interventions implemented to assist the Enrollee in attaining an improved perception of quality of life.

5.31.3 Effective May 1, 2022 Contractor shall administer the DHS-DRS Personal Assistant Evaluation to each DHS-DRS HCBS Waiver Enrollee (Persons with Disabilities HCBS Waiver, Persons with Brain Injury HCBS Waiver, and Persons with HIV/AIDS HCBS Waiver) at each annual reassessment to determine each

Enrollee's satisfaction and evaluation of their Individual Provider. Contractor's Care Coordinators must follow-up on non-favorable evaluations with Enrollees to identify areas of improvement.

5.32 PROVIDER AGREEMENTS AND SUBCONTRACTS

5.32.1 Contractor may provide or arrange to provide any Covered Services with Network Providers, or fulfill any other obligations under this Contract, by means of subcontractual relationships.

5.32.2 All Provider agreements and subcontracts entered into by Contractor must be in writing, must specify the delegated activities, duties or obligations, including any related reporting responsibilities, and are subject to the following conditions:

5.32.2.1 The Network Providers and Subcontractors shall be bound by the terms and conditions of this Contract that are appropriate to the service or activity delegated under the agreement or subcontract. Such requirements include the record keeping and audit provisions of this Contract, such that the Department or Authorized Persons shall have the same rights to audit and inspect Network Providers and Subcontractors as they have to audit and inspect Contractor.

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

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

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

- 5.32.3 Contractor shall remain responsible for the performance of any of its responsibilities delegated to Network Providers, subcontractors and other entities to which duties are delegated.
- 5.32.4 No Provider agreement or subcontract can terminate the legal responsibilities of Contractor to the Department to assure that all the activities under this Contract will be carried out.
- 5.32.5 All Network Providers providing Covered Services for Contractor under this Contract must be enrolled as Providers in the HFS Medical Program. Contractor shall not contract or subcontract with an excluded Person, or a Person who has voluntarily withdrawn from the HFS Medical Program as the result of a settlement agreement.
- 5.32.6 All Provider agreements and subcontracts must comply with the lobbying certification contained in article IX of this Contract.
- 5.32.7 All Network Providers shall be furnished with information about Contractor's Grievance and Appeal procedures at the time the Provider enters into an agreement with Contractor and within fifteen (15) days following any substantive change to such procedures.
- 5.32.8 Contractor must retain the right to terminate any Provider agreement or subcontract or impose other sanctions if the performance of the Network Provider or Subcontractor is inadequate.
- 5.32.9 Provider-compensation models shall reimburse for Covered Services provided and may reimburse for performance. Contractor shall not permit any payment to a Network Provider for Covered Services other than the payment made by Contractor, except when specifically required by this Contract or applicable law as provided in 42 CFR §438.60.
- 5.32.10 With respect to all Provider agreements and subcontracts made by Contractor, Contractor further warrants:
- 5.32.10.1 that such Provider agreements and subcontracts are binding;
- 5.32.10.2 that it will promptly terminate all contracts with Network Providers and Subcontractors or impose other sanctions if the performance of the Network Provider or Subcontractor is inadequate, as determined by either the Department or Contractor;
- 5.32.10.3 that it will promptly terminate contracts with Providers that are terminated, barred, or suspended, or have voluntarily withdrawn, as a result of a settlement agreement under either Section 1128 or Section 1128A of the Social Security Act, from participating in any program under federal law including any program under Titles XVIII, XIX, XX, or XXI of the Social Security Act or are otherwise excluded from

participation in the HFS Medical Program;

- 5.32.10.4 that all laboratory testing sites providing services under this Contract must possess a valid Clinical Laboratory Improvement Amendments (CLIA) certificate and comply with the CLIA regulations found at 42 CFR §493; and
- 5.32.10.5 that it will monitor the performance of all Network Providers and Subcontractors on an ongoing basis, subject each Network Provider and Subcontractor to formal review on a triennial basis, and, to the extent deficiencies or areas for improvement are identified during an informal or formal review, require that the Network Provider or Subcontractor take appropriate corrective action.
- 5.32.11 Upon request by the Department, Contractor will make available Provider agreements and subcontracts as provided in Attachment XIII. The Department reserves the right to require Contractor to amend any Provider agreement or subcontract as reasonably necessary to conform to Contractor's duties and obligations under this Contract.
- 5.32.12 Contractor may designate in writing certain information disclosed under this section 5.32 as confidential and proprietary. If Contractor makes such a designation, the Department shall consider said information exempt from copying and inspection under Section 7(1)(b) or (g) of the State Freedom of Information Act (5 ILCS 140/1 *et seq.*). If the Department receives a request for said information under the State Freedom of Information Act, however, it may require Contractor to submit justification for asserting the exemption. The Department may honor a properly executed criminal or civil subpoena for such documents without such being deemed a Breach of this Contract or any subsequent amendment hereto.
- 5.32.13 Prior to entering into a Provider agreement or subcontract, Contractor shall submit a disclosure statement to the Department specifying any Provider agreement or subcontract and Providers or Subcontractors in which any of the following have a financial interest of five percent (5%) or more:
- 5.32.13.1 any Person also having a five percent (5%) or more financial interest in Contractor or its Affiliates as defined by 42 CFR §455.101;
- 5.32.13.2 any director, officer, trustee, partner, or employee of Contractor or its Affiliates; or
- 5.32.13.3 any member of the immediate family of any person designated above.
- 5.32.14 Any contract or subcontract between Contractor and an FQHC or a RHC shall be executed in accordance with Sections 1902(a)(13)(C) and 1903(m)(2)(A)(ix) of the Social Security Act, as amended by the Balanced

Budget Act of 1997, and shall provide payment that is not less than the level and amount of payment that Contractor would make for the Covered Services if the services were furnished by a Provider that was not an FQHC or a RHC.

5.32.15 Contractor shall not allow a subcontractor that is not subject to the jurisdiction of the United States of America to access any Department information technology system that contains PHI.

5.33 ADVANCE DIRECTIVES

Contractor shall comply with all rules concerning the maintenance of written policies and procedures with respect to Advance Directives set forth in 42 CFR §422.128. Contractor shall provide adult Enrollees with oral and written information on Advance Directives policies and include a description of applicable State law. Such information shall reflect changes in State law as soon as possible, but no later than ninety (90) days after the effective date of the change.

5.34 FEES TO ENROLLEES PROHIBITED

Neither Contractor, its Network Providers, nor non-Network Providers shall seek or obtain funding through fees or charges to any Enrollee receiving Covered Services pursuant to this Contract, except as permitted or required by the Department in 89 Ill. Adm. Code 125 and the Department's FFS copayment policy then in effect, and subject to section 7.8. Contractor acknowledges that imposing charges in excess of those permitted under this Contract is a violation of Section 1128B(d) of the Social Security Act and subjects Contractor to criminal penalties. Contractor shall have language in all its Provider agreements or subcontracts reflecting this requirement.

5.35 PROGRAM INTEGRITY

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

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

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

- 5.35.2.1 Written policies, procedures, and standards of conduct that demonstrate compliance with all applicable requirements and standards under the Contract and all federal and state requirements related to program integrity.
- 5.35.2.2 A designated Compliance Officer who is responsible for developing and implementing policies and procedures designed to ensure compliance with program integrity requirements. The Compliance Officer shall report directly to Contractor's CEO and Board of Directors.
- 5.35.2.3 A Regulatory Compliance Committee, consisting of members of the Board of Directors and senior management, which is responsible for oversight of the Contractor's compliance program.
- 5.35.2.4 A system of training and education for the Compliance Officer, Board of Directors, senior managers, and employees regarding Contractor's obligation to comply with federal and state requirements.
- 5.35.2.5 Effective lines of communication between the Compliance Officer and Contractor's employees, Subcontractors, and Network Providers.
- 5.35.2.6 Effective lines of communication between Contractor's Compliance Officer, Contractor's employees and the Office of Inspector General (OIG).
- 5.35.2.7 Enforcement of regulatory standards and program integrity-related requirements through well-publicized disciplinary guidelines.
- 5.35.2.8 A system of established and implemented procedures that includes surveillance and utilization controls conducted by a designated Special Investigations Unit (SIU) of dedicated staff adequate in number for routine internal monitoring, auditing of program integrity compliance risks, prompt response to compliance issues, investigation of potential compliance problems identified in the course of self-evaluation and audits, correction of identified compliance problems through corrective action plans, and ongoing compliance with program integrity-related requirements.
 - 5.35.2.8.1 Under the purview of the Compliance Officer, Contractor shall employ Fraud, Waste and Abuse Investigators at a minimum ratio of one (1) Investigator to every 100,000 Enrollees.

- 5.35.3 Contractor shall have a provision for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential Fraud, to the OIG.
- 5.35.4 Contractor shall notify the OIG within ten (10) Business Days of receiving information that may affect an Enrollee's eligibility to participate in the Medical Assistance program, including changes in an Enrollee's address or death of an Enrollee.
- 5.35.5 Contractor shall notify the OIG within ten (10) Business Days of receiving information about a change in a Network Provider's circumstances that may affect the Provider's eligibility to participate in the Medical Assistance Program, including termination of the Contractor's Provider agreement.
- 5.35.6 Contractor shall maintain a recipient verification procedure and provide a summary of results to the OIG as described in Attachment XIII.
- 5.35.7 Contractor shall establish written policies and procedures for all employees, Subcontractors, Network Providers, and agents that provide detailed information about the False Claims Act and other federal and state laws described in section 1902(a)(68) of the SSA, including administrative, civil, and criminal remedies for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting Fraud, Waste, Abuse, mismanagement, and misconduct in federal health care programs. Contractor shall include in any employee handbook a description of these laws, the rights of employees to be protected as whistleblowers, and Contractor's policies and procedures for detecting and preventing Fraud, Waste, Abuse, mismanagement, and misconduct.
- 5.35.8 Contractor shall promptly inform the OIG of any potential Fraud, Waste, Abuse, mismanagement, or misconduct. At the direction of the OIG, Contractor shall promptly inform the Illinois State Police Medicaid Fraud Control Unit (ISP-MFCU) of any potential criminal activity.
- 5.35.9 **Prepayment review.** In the event Contractor subjects a Network Provider to prepayment review or any review requiring the Provider to submit documentation to support a claim prior to the Contractor considering it for payment as a result of suspected Fraud, Waste, Abuse, mismanagement, or misconduct, Contractor shall adhere to the following within ninety (90) days of requiring such action:
- 5.35.9.1 Conduct a medical and coding review on the claims subject to prepayment review. When Fraud, Waste, Abuse, mismanagement, or misconduct is still suspected after conducting the review, submit to the

OIG a suspected Fraud referral, including all referral components as required by the OIG.

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

5.35.10 **Prohibitions on Contractor recoveries.**

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

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

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

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

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

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

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

identification process all overpayment identification prohibitions as defined in section 5.35.10.

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

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

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

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

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

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

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

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

5.35.13.3 In accordance with the OIG guidelines, Contractor shall report all internal and external observations or reports that have potential implications of Network Provider billing anomalies, and, potential risk of harm concerns for all Enrollees. Contractor shall take steps to triage

and substantiate such information and provide timely updates to the OIG, and ISP-MFCU as applicable under section 5.35.8, when concerns or allegations are authenticated.

- 5.35.13.4 Contractor shall report, as specified by OIG, all suspected Fraud, Waste, Abuse, mismanagement, and misconduct as follows:
 - 5.35.13.4.1 Within three (3) Business Days, all alleged criminal conduct;
 - 5.35.13.4.2 Monthly, any program integrity case opened within the previous month;
 - 5.35.13.4.3 Quarterly, reports as defined under the Reporting Tool Guidelines; and,
 - 5.35.13.4.4 Annually, a compliance plan required by this Contract and applicable federal and state laws. Prior Approval by the OIG of the annual compliance plan is required.
- 5.35.13.5 Contractor shall promptly perform a preliminary investigation of all incidents of suspected or confirmed Fraud, Waste, Abuse, mismanagement, or misconduct. Unless prior approval is obtained from the OIG, Contractor shall not take any of the following actions as they specifically relate to the incident:
 - 5.35.13.5.1 Contact the subject of the investigation about any matters related to the investigation;
 - 5.35.13.5.2 Enter into or attempt to negotiate any settlement or agreement regarding the incident; or,
 - 5.35.13.5.3 Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.
- 5.35.13.6 Contractor shall promptly provide the results of its preliminary investigation to the OIG.
- 5.35.13.7 Contractor and its Subcontractors shall cooperate fully in any further investigation or prosecution by any duly authorized government agency, whether administrative, civil, or criminal. Such cooperation shall include providing, upon request, information, access to records, and access to interview Contractor's employees and consultants, including but not limited to those with expertise in the

administration of the Medical Assistance Program, in medical or pharmaceutical questions, or in any matter related to an investigation.

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

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

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

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

5.36 ENROLLEE-PROVIDER COMMUNICATIONS

Subject to this section 5.36 and in accordance with the Managed Care Reform and Patient Rights Act, Contractor shall not prohibit or otherwise restrict a Provider from advising an Enrollee about the health status of the Enrollee or medical care or treatment for the Enrollee's condition or disease, regardless of whether benefits for such care or treatment are provided under this Contract, if the Provider is acting within the lawful scope of practice. Contractor shall not retaliate against a Provider for so advising Enrollee.

5.37 HIPAA COMPLIANCE

Contractor shall comply with the HIPAA requirements set forth in Attachment VI.

5.38 INDEPENDENT EVALUATION

Contractor will cooperate in the conduct of any independent evaluation of this Contract or program performed by the Department or another State agency, or its designee or subcontractor.

5.39 ACCREDITATION REQUIREMENTS

Pursuant to 305 ILCS 5/5-30 (a) and (h), if Contractor is serving at least 5,000 SPDs or 15,000 individuals in other populations covered by the HFS Medical Program and has received full-risk Capitation for at least one (1) year, then Contractor is considered eligible for accreditation and shall achieve accreditation by the NCQA within two (2) years after the date Contractor became eligible for accreditation. Subject to the foregoing:

- 5.39.1 Contractor must achieve and maintain a status of “excellent,” “commendable,” or “accredited.” If Contractor receives a “provisional” accreditation status, Contractor shall complete a “re-survey” within twelve (12) months after the accreditation determination.
- 5.39.2 During the period in which Contractor is in a “provisional” accreditation status, the Department may limit enrollment. If the subsequent “re-survey” results in a “provisional” or “denied” status, such status shall constitute a Breach of this Contract, and Contractor’s failure to achieve full accreditation may result in the termination of this Contract.
- 5.39.3 Upon completion of each annual accreditation survey, Contractor must immediately authorize the NCQA to submit directly to the Department a copy of the final accreditation survey. Thereafter and on an annual basis between accreditation surveys, Contractor must submit a copy of the accreditation summary report issued as a result of the annual HEDIS® update to the Department no later than ten (10) days after receipt from NCQA. Upon the Department’s request, Contractor must provide any and all documents related to achieving accreditation. The Department will thereafter annually review Contractor’s accreditation status as of September 15 of each year.

5.40 MEETINGS AND COMMITTEES

- 5.40.1 **Leadership meetings and committee structure.** Contractor must have in place a schedule of leadership meetings and committee structure to provide appropriate oversight to the program as required by this Contract. At minimum, this will include a quarterly quality and performance meeting with the Department.
- 5.40.2 **Quality Assurance Plan (QAP) committee.** Contractor shall have a QA plan committee that meets quarterly. Duties of the QAP committee are outlined in Attachment XI.
- 5.40.3 **Utilization Review committee.** Contractor shall have a UR committee that meets on a quarterly basis. Duties of the UR committee are outlined in Attachment XII.
- 5.40.4 **Subcontractor oversight committee.** Contractor shall have a Subcontractor

oversight committee that meets, at minimum, on a quarterly basis. This committee shall, at a minimum, conduct the following with regard to each Subcontractor: a predelegation audit, a quarterly delegation oversight review of Subcontractor performance by the Subcontractor oversight committee, monthly joint operation meetings, an annual audit of Subcontractors, regular monitoring of Enrollee Complaints, documentation of issues, and development of a Corrective Action Plan (CAP), as warranted, to improve performance.

- 5.40.5 **Enrollee advisory and community stakeholder committee.** Contractor shall have an Enrollee advisory and community stakeholder committee that meets, at minimum, on a quarterly basis. Members of the committee will be geographically, culturally, and racially diverse to best reflect the profile of Contractor's Enrollee base, and must include a reasonably representative group of Enrollees, or other individuals representing those Enrollees, receiving LTSS. The committee shall establish an ongoing mechanism for the community to provide Contractor with direct feedback on Contractor's implementation and operations of the Medicaid Managed Care Program. Contractor will keep minutes for all meetings.
- 5.40.6 **Grievance and Appeals committee.** Contractor shall have a Grievance and Appeals committee that meets, at minimum, on a quarterly basis.
- 5.40.7 **Regulatory Compliance committee.** Contractor shall have a Regulatory Compliance committee that meets, at minimum, on a quarterly basis.
- 5.40.8 **Family Leadership Council (FLC).** Contractor shall establish the FLC within ninety (90) days after the Special Needs Children population is brought into managed care under the scope of this Contract, as defined by the Department, to create opportunities to engage families directly regarding issues in Children's Behavioral Health. The role of the FLC shall be outlined in Contractor's plan for Family Driven Care, as required by Attachment XXII of this Contract. Contractor shall establish a meaningful feedback loop through its FLC to inform its service delivery system and the delivery of Behavioral Health services that are person- and family-centric. The FLC shall meet, at a minimum, on a quarterly basis. The FLC shall not be used to review the needs of individual Enrollees.
- 5.40.8.1 Each FLC meeting shall minimally include opportunities and dedicated agenda items for FLC members to provide input and feedback to Contractor on its policies, procedures, operations, and special initiatives related to Children's Behavioral Health. Contractor shall specifically seek input on its Mobile Crisis Response service system, its implementation of the various components of the N.B. consent decree, and access and availability of Behavioral Health services. Contractor shall provide the FLC with available aggregated data to inform its recommendations including number of Enrollees

served, service utilization, access, wait times, lengths of stay, and other relevant system reports.

5.40.8.2 FLC meeting agendas, minutes, and any formal recommendations to Contractor from the FLC shall be shared with the Children's Behavioral Health Family Leadership Workgroup convened by the Department on a frequency and format to be defined by the Department.

5.40.8.3 The FLC will have a committee charter detailing the selection of members and co-chairs and the role/functions of the co-chairs and members, including length of tenure in role.

5.40.8.4 The FLC shall be cochaired by an Enrollee who is a young adult, or the parent or guardian of an Enrollee, with lived experience within public child-serving systems (e.g., mental health, welfare, education) and the Contractor's CBH Program Manager.

5.40.8.5 The FLC membership shall be comprised of a minimum of fifty-one percent (51%) Enrollees or parents/guardians of Enrollees from across the Coverage Area who have lived experience with the public child-serving systems. Contractor shall ensure the FLC membership is reflective of Contractor's enrolled membership.

5.40.8.6 Contractor shall ensure Children's Behavioral Health topics, including feedback from the FLC, is a component of the Enrollee Advisory and Community Stakeholder Committee, as outlined under Section 5.40.5.

5.40.9 **Quality Management Committee.** Contractor shall establish the Quality Management Committee (QMC) within one hundred eighty (180) days after the Effective Date of this Contract. The QMC shall establish an ongoing mechanism for reviewing and ensuring continuous quality improvement.

5.40.9.1 The QMC shall be chaired by Contractor's Quality Management Coordinator and a member of the Family Leadership Council (FLC).

5.40.9.2 Contractor may initially designate Contractor's Medical Director as a QMC co-chair, for a period to last no longer than one hundred eighty (180) days, while the FLC is being developed.

5.40.9.3 Contractor's executive team shall nominate prospective QMC members for approval by the FLC to establish the membership of the QMC.

5.40.9.4 Contractor will seek to include on the QMC Enrollees or parents/guardians of Enrollees sufficient to reasonably represent Contractor's Contracting Area.

5.40.9.5 QMC Duties. To enforce the local Locus of Control related to Systems of Care, the QMC shall:

5.40.9.5.1 review consumer satisfaction, performance, and outcome data at least twice (2 times) per year to determine whether new processes or further review are necessary; and

5.40.9.5.2 prepare the official Quality Management Committee Report, as detailed in Attachment XI.

5.41 Handling of Sensitive Data

5.41.1 Pursuant to Executive Order 2019-08, the Department will provide Contractor on at least a monthly basis with highly sensitive data from the Illinois Department of Public Health (DPH) related to certain of Contractor's Enrollees who have data in the DPH's HIV/AIDS Registry. Contractor shall handle such data in the strictest confidence in compliance with the privacy provisions of all applicable laws, rules, and regulations, including HIPAA, the AIDS Confidentiality Act (410 ILCS 305), the HIV/Aids Registry Act (410 ILCS 310), and the Illinois Sexually Transmissible Disease Control Act (410 ILCS 325), and with the provisions of this section 5.41. The purpose of the data exchange is to advance the goals of zero community transmissions of HIV and ensuring that persons living with HIV will get the care they need to thrive.

5.41.2 The details of the HIV-related data received from the DPH via the Department shall be closely held and accessible only to Contractor's Chief Medical Officer (CMO) and their designees, all of whom will be subject to the same standards and liability as the CMO. The data shall only be integrated into a repository for the sole purpose of Care Coordination and treatment of Enrollees living with HIV. Contractor's repository for the data shall have data security protocols, consistent with those outlined in Attachment XIV, in place which shall be submitted to the Department for review and approval.

5.41.3 Contractor's CMO shall use the data received from the HIV/AIDS Registry, along with Contractor's pharmacy, medical, and other claims data, to provide alerts to Care Coordinators to prompt them to ensure all best practices regarding the management and treatment of HIV are being followed with respect to Enrollees, including periodic viral load testing, drug regimen prescribing and adherence, and annual physician visits. These alerts may be developed based on the data permitted to be shared under this Contract and may include viral suppression status ("suppressed" or "not suppressed"), the date of the last lab test, and name of the Provider that ordered the last lab test (if available). Contractor shall work with appropriate HIV consumer and legal advocacy groups for the target population to develop and implement best practices for outreach and engagement.

5.41.4 Contractor shall track, and report quality metrics related to HIV, including the CQMC HIV Consensus Core Set, as directed by the Department.

5.42 SOCIAL AND STRUCTURAL DETERMINANTS OF HEALTH (SSDOH) WORK PLAN

Contractor shall develop and implement a SSDOH work plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on factors such as age, race, ethnicity, gender, primary language, and disability status. Contractor shall submit the SSDOH work plan to the Department for Prior Approval no later than July 1, 2022. At a minimum, the SSDOH must include:

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

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

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

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

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

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

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

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

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

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

ARTICLE VI: DUTIES OF THE DEPARTMENT

6.1 ENROLLMENT

Once the Department has determined that a Participant is a Potential Enrollee, and after the Potential Enrollee has selected, or been enrolled by automatic assignment to, Contractor, such Participant shall become a Prospective Enrollee. A Prospective Enrollee shall become an Enrollee on the Effective Enrollment Date. Coverage shall begin as specified in section 4.7. The Department shall make an 834 Audit File available to Contractor prior to the first day of each month.

6.2 PAYMENT

The Department shall pay Contractor for the performance of Contractor's duties and obligations hereunder. Such payment amounts shall be as set forth in Article VII of this Contract and Attachment IV hereto. Unless specifically provided herein, no payment shall be made by the Department for extra charges, supplies, or expenses, including Marketing costs incurred by Contractor.

6.3 DEPARTMENT REVIEW OF MARKETING MATERIALS

Review of all Marketing Materials that are required by this Contract to be submitted to the Department for Prior Approval shall be completed by the Department on a timely basis, not to exceed thirty (30) days after the date of receipt by the Department; provided, however, that if the Department fails to notify Contractor of approval or disapproval of submitted materials within thirty (30) days after receiving such materials, Contractor may begin to use such materials. The Department, at any time, reserves the right to disapprove any materials that Contractor used or distributed prior to receiving the Department's express written approval. In the event the Department disapproves any materials, Contractor shall immediately cease use and distribution of such materials.

6.4 HISTORICAL CLAIMS DATA

The Department shall provide Contractor with CCCD for each new Enrollee monthly.

ARTICLE VII: PAYMENT AND FUNDING

7.1 CAPITATION PAYMENT

- 7.1.1 The Department shall pay Contractor on a Capitation basis, based on the rate cell of the Enrollee as shown on the table in Attachment IV, a sum equal to the product of the approved Capitation rate and the number of Enrollees enrolled in that category as of the first day of that month. The Capitation rates for the nursing facility rate cell and the HCBS other waivers rate cell will include a component for Service Package I and Service Package II. In such circumstance, an Enrollee's rate cell will be determined by the Enrollee's residential status (e.g., NF resident, HCBS Waiver) as of the first day of the month. The Department will use its eligibility system to determine an Enrollee's rate cell. Delays in changes to an Enrollee's residential status being reflected in the Department's eligibility system will cause adjustments to past Capitation payments to be made. Capitation is due to Contractor by the fifteenth (15th) day of the service month. Rates reflected in Attachment IV are for the period as set forth in Attachment IV, except as adjusted pursuant to this Article VII. Rates may be updated periodically to reflect future time periods, additional service packages, additional populations, or changes that affect the cost of providing covered services that the Department determines to be actuarially significant. The Department will provide Contractor with an opportunity to review, comment on, and accept in writing any such update, including supporting data, before such update is implemented. The parties will work together to resolve any discrepancies.
- 7.1.2 The Department shall pay Contractor a monthly Capitation payment for an Enrollee receiving inpatient treatment in an Institution for Mental Diseases provided all requirements of 42 CFR §438.6(e) are met.
- 7.1.3 The Department shall pay Contractor a separate, State-funded-only monthly Capitation payment for an Enrollee who is residing in an Institution for Mental Diseases on the first day of the month. The monthly Capitation is shown as "State Only IMD" rate cell in Attachment IV.

7.2 820 PAYMENT FILES

For each payment made, the Department will make available an 820 Payment File. This file will include identification of each Enrollee for whom payment is being made and the rate cell that the Enrollee is in. Contractor shall retrieve this file electronically.

7.3 PAYMENT FILE RECONCILIATION

7.3.1 Within thirty (30) days after the 820 Payment File is made available, Contractor shall notify the Department of any discrepancies, and Contractor and the Department will work together to resolve the discrepancies. Discrepancies include the following:

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

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

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

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

7.4 RISK ADJUSTMENT

7.4.1 Capitation rates under this Contract, excluding the portion attributable to supplemental payments and other fees not retained by the MCOs, will be risk-adjusted by each population category against the other full-risk MCOs providing Covered Services to the same population category within the same rate-setting region. The population categories that will be risk-adjusted are adults and Children eligible under Title XIX and Title XXI; Affordable Care Act expansion-eligible adults; Medicaid-eligible older adults; adults with disabilities who are not eligible for Medicare; Dual-Eligible Adults receiving LTSS, excluding those receiving partial benefits or enrolled in the Illinois Medicare-Medicaid Alignment Initiative (MMAI); and Special-Needs Children, excluding Children in the care of DCFS. Beneficiaries under the age of two (2) will not be risk-adjusted. Capitation rates calculated under this Contract will be adjusted in accordance with publicly available risk-adjustment software. For calendar years prior to 2020, risk adjustment will be performed on a semiannual basis. Effective with the calendar year 2020 rating period, capitation rates will be risk adjusted at least annually. For an Enrollee's individual claims data to be the basis for a risk adjustment score hereunder, such Enrollee must have been enrolled in the HFS Medical Program (i.e., either managed care or Fee-For-Service) for at least six (6) full months during the time period from which claims data are used to calculate the adjustment. In the event an Enrollee has not been enrolled in the HFS Medical Program for at least six (6) full months, then such Enrollee shall receive a risk score equal to Contractor's average risk score. The risk scores shall be established for each MCO across all rate cells. As necessary, the risk scores will be established

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

7.4.2 Initial Risk Adjustment Period. The Initial Risk Adjustment Period shall be the first six (6)-month period, beginning either January or July, during which Contractor receives its initial enrollment under this Contract. The risk scores for the Initial Risk Adjustment Period will be calculated using Contractor's enrollment as of the first month following the month in which mandatory enrollment in the Contracting Area is completed and will be based on a weighted average of the number of months each Enrollee is enrolled with the specific MCO. The claims data to be used for such calculations shall be the Department's FFS claims data for claims with dates of service from the most recent twelve (12)-month period that the Department determines is reasonably complete. To the extent an Enrollee was enrolled with another Contractor during the most recent twelve (12)-month period that the Department determines is reasonably complete, the encounters accepted by the Department during the period shall be used in addition to the aforementioned FFS claims data.

7.4.2.1 The Department shall provide written notification to Contractor of Contractor's initial risk adjustment factor, along with sufficient detail supporting the calculations. Contractor shall have thirty (30) days after the date the Department sent such notice to review the calculations and detail provided and to submit questions, if any, to the Department regarding the same. No modification to Contractor's Capitation payment may be made during such thirty (30)-day review period. If during the review period Contractor disputes the risk-adjustment factor, the Department shall agree to meet with Contractor within a reasonable time frame to achieve a good-faith resolution of the disputed matter. Modifications to Contractor's Capitation payment

resulting from the application of the risk adjustment factor, if any, shall be effective retroactively to the first month of initial enrollment and prospectively to the end of the Initial Risk Adjustment Period. All risk scores shall be budget-neutral to the Department or normalized to a 1.0000 value between the MCOs.

- 7.4.3 For every six (6)-month period thereafter through calendar year 2019, Enrollee risk scores shall be recalculated using Enrollee claims or Encounter Data, as applicable, from a prior twelve (12)-month period. Effective with the calendar year 2020 rating period, capitation rates will be risk adjusted at least annually. The Department shall provide written notification to Contractor of Contractor's risk adjustment factor, along with sufficient detail supporting the calculations. Contractor shall have thirty (30) days after the date the Department sent such notice to review the calculations and detail provided and to submit questions, if any, to the Department regarding the same. No modification to Contractor's Capitation payment may be made during such thirty (30)-day review period. If during the review period Contractor disputes the risk adjustment factor, the Department shall agree to meet with Contractor within a reasonable timeframe to achieve a good faith resolution of the disputed matter. Modifications to Contractor's Capitation payment resulting from the application of the applicable risk adjustment factor, if any, shall be effective for the duration of the applicable adjustment period, effective as of the first day thereof. All risk scores shall be budget-neutral to the Department or normalized to a 1.0000 value between the MCOs.

7.5 ACTUARIALLY SOUND RATE REPRESENTATION

The Department represents that actuarially sound Capitation rates were developed by the Department's contracted actuarial firm and that Capitation rates paid hereunder are actuarially sound. The Capitation rates provided under this Contract are "actuarially sound" for purposes of 42 CFR 438.4(a), according to the following criteria:

- 7.5.1 The Capitation rates provide for all reasonable, appropriate, and attainable costs that are required under terms of the Contract and for the operation of the managed Health Plan for the time period and population covered under the terms of the Contract, and such Capitation rates were developed in accordance with the requirements under 42 CFR 438.4(b).
- 7.5.2 To ensure compliance with generally accepted actuarial practices and regulatory requirements, the Department's contracted actuarial firm referred to published guidance from the American Academy of Actuaries (AAA), the Actuarial Standards Board (ASB), the Centers for Medicare and Medicaid Services (CMS), and federal regulations. Specifically, the following will be referenced during rate development:

7.5.2.1 Actuarial standards of practice (ASOP) applicable to Medicaid managed

care rate setting which have been enacted as of the Capitation rate certification date, including ASOP 1 (Introductory Actuarial Standard of Practice); ASOP 5 (Incurred Health and Disability Claims); ASOP 23 (Data Quality); ASOP 25 (Credibility Procedures); ASOP 41 (Actuarial Communications); ASOP 45 (The Use of Health Status Based Risk Adjustment Methodologies); and ASOP 49 (Medicaid Managed Care Capitation Rate Development and Certification).

7.5.2.2 Actuarial soundness and rate development requirements in the Medicaid and CHIP Managed Care Final Rule (CMS 2390-F) for the provisions effective as of the rate certification effective date.

7.5.2.3 The most recent Medicaid Managed Care Rate Development Guide published by CMS.

7.5.2.4 Throughout this document and consistent with the requirements under 42 CFR 438.4(a), the term “actuarially sound” will be defined as in ASOP 49:

7.5.2.4.1 “Medicaid capitation rates are ‘actuarially sound’ if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates, and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include expected reinsurance and governmental stop-loss cash flows, governmental risk-adjustment cash flows, and investment income. For purposes of this definition, costs include expected health benefits; health benefit settlement expenses; administrative expenses; the cost of capital, and government-mandated assessments, fees, and taxes.”

7.5.3 The actuarial certification was signed by an individual of the Department’s contracted actuarial firm meeting the qualification standards established by the American Academy of Actuaries, and following the practice standards established by the Actuarial Standards Board that certify that the Capitation rates meet the standards in 42 CFR §438.4 and 42 CFR §438.5.

7.6 NEW COVERED SERVICES

The financial impact of any Covered Services added to Contractor’s responsibilities under this Contract will be evaluated from an actuarial perspective by the Department, and rates will be adjusted accordingly to reflect the changes made by the Department. The Department shall provide written notice to Contractor of such new Covered Services. Any adjustment to the Capitation rates herein as a result of such new Covered Services shall include:

- 7.6.1 an explanation of the new Covered Services;
- 7.6.2 the amount of any adjustment to the Capitation rates herein as a result of such new Covered Services; and
- 7.6.3 the methodology for any such adjustment.

7.7 ADJUSTMENTS

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

7.8 COPAYMENTS

Contractor may charge copayments to Enrollees, but in no instance may the copayment for a type of service exceed the Department's FFS copayment policy then in effect. Any copayment requirement must comply with the restrictions in Sections 1916 and 1916A of the Social Security Act. If Contractor desires to charge such copayments, Contractor shall provide written notice to the Department before charging such copayments. Such written notice to the Department shall include a copy of the policy Contractor intends to distribute to its Network Providers or Subcontractors. This policy must set forth the amount, manner, and circumstances in which copayments may be charged. Such policy is subject to the Prior Approval of the Department. In the event Contractor wishes to make a change in its copayment policy, it shall provide at least sixty (60) days' prior written notice, subject to the Department's Prior Approval, to Enrollees. Contractor shall be responsible for promptly refunding to an Enrollee any copayment that, at the sole discretion of the Department, has been inappropriately collected for Covered Services.

7.9 PAY FOR PERFORMANCE (P4P)

- 7.9.1 The Department shall apply a withhold, defined as a withhold arrangement under 42 CFR 438.6(a), percentage of total Capitation rates each month. The withheld amount will be one percent (1%) in the first measurement year, one-and-one-half percent (1.5%) in the second measurement year, and two percent (2%) in the third and subsequent measurement years. Contractor may earn a percentage of the aggregate withhold from all MCOs based on its performance with respect to a Department-determined combination of: (i)

quality metrics set forth in Attachment XI; (ii) operational and implementation metrics as defined and published on the Department's website. The Department and Contractor will agree to the measures through a counter-signed letter annually. The letter will include any weighting assigned to quality, operational or implementation metrics as it relates to the withhold. In response to the COVID-19 public health emergency, the P4P withhold arrangement as described in this Section 7.9 for the second measurement year (calendar year 2020) is restructured as set forth in Section 7.9.7.

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

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

7.9.2 The Department will determine the portion of the Withhold to be allocated to each P4P metric. If Contractor reaches the target goal on a P4P metric, Contractor will earn the withheld portion of the Withhold assigned to that P4P metric. Department retention of Contractor's Capitation payment for the purposes of funding the Withhold shall commence with the Capitation payment of the first measurement year as defined in section 7.9.1.

7.9.3 Collection of data and calculation of Contractor's performance against the P4P metrics will be in accordance with national HEDIS® timelines and specifications. In the event any P4P metrics are not HEDIS® but are distinct measures established by the Department (HEDIS®-like), then the methodology for calculating such metrics shall be detailed in a separate document sent to Contractor. Contractor must obtain an independent validation of its HEDIS® and HEDIS®-like results by an NCQA-certified auditor, with such results submitted to the Department within thirty (30) days after Contractor's receipt of its audited results. Upon receipt of Contractor's certified results, the Department shall compare Contractor's performance against the P4P metrics and Encounter Data received and accepted by the Department. If the Department approves Contractor's submitted results and a Withhold payment to Contractor is due, then such payment shall be made within sixty (60) days after approval of the calculations for payment by Contractor and the Department. If there is a discrepancy, the Department shall notify Contractor, in writing within thirty (30) days after receiving Contractor's results, that a discrepancy exists and further investigation is needed. Any significant discrepancies between Contractor's audited results and the Encounter Data received by the Department, or any audit of the measures by the Department, will be resolved in a manner mutually agreeable to the Parties following good-faith negotiations before the Department will distribute any payments earned by Contractor. Once resolution of any discrepancy is agreed upon by the Parties, the Department shall initiate such

payment within thirty (30) days after such agreement. Contractor's audited results will be used to determine eligibility for payments under this section 7.9.

7.9.4 Effective for HEDIS® 2020 (measurement year January 1, 2019, through December 31, 2019), the performance goals for the P4P measures set forth in Attachment XI, Table 1, "Healthcare and quality of life performance measures," will be negotiated and established through countersigned letters.

7.9.5 Effective for HEDIS® 2020 (measurement year January 1, 2019, through December 31, 2019), the Department will provide the P4P measures and target goals prior to the beginning of the measurement year. If any coding or data specifications are modified and a Party has a reasonable basis to believe that the modification will have an impact on a payment, then the Parties will negotiate, and the resolution will be memorialized through countersigned letters.

7.9.6 The Department retains the right to use quality, operational, or any other source of metrics or performance goals to design an MCO incentive payments program. The Department shall provide Contractor with ninety (90) days' notice, in writing, of the implementation of such a program.

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

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

7.9.7 **Calendar Year 2020 P4P.** The Department will include the amounts normally withheld pursuant to section 7.9 in Contractor's monthly capitation payments for the months of June 2020 through September 2020, and, to the extent initially withheld for the months of January 2020 through May 2020, release those withheld amounts to Contractor. In the place of the quality metrics normally used for earning the withhold under this section, Contractor shall propose initiatives that reinvest the January 2020 through September 2020 released P4P funds in a manner that serves the best interests of their Enrollees and Providers. These initiatives may be based on traditional quality metrics, or, may be based on providing assistance to Enrollees through addressing social determinants of health or other needs during the COVID-19 public health emergency and providing assistance to Providers to maintain access to services during the COVID-19 public health emergency. To be paid the released P4P funds, Contractor's proposal must receive Prior Approval. Contractor shall have the opportunity to adjust its proposal, in writing, and request Department approval on a monthly basis. Contractor shall report monthly on progress towards the proposed reinvestment initiatives on a template approved by the Department. The Department reserves the right to recoup released P4P funds in an amount proportional to the extent Contractor fails to allocate P4P funds as

outlined in Contractor's Department-approved proposal, as determined by the Department. For funds withheld the last calendar year quarter, the Department will distribute to Contractor its withhold amount upon confirmation that Contractor has fulfilled its Department-approved proposal. To the extent Contractor does not earn its final withhold amount or has released withhold money recouped, these funds will be, at the option of the Department, distributed in one of the following ways:

7.9.7.1 the funds will be distributed equally to MCOs that fulfilled their Department-approved proposals; or

7.9.7.2 the funds will be allocated toward the P4P metrics originally agreed to by the Department and each MCO for calendar year 2020 and distributed based on performance with respect to those metrics as previously contemplated under this Contract.

7.10 MEDICAL LOSS RATIO GUARANTEE

7.10.1 Contractor shall calculate, and report to the Department, a medical loss ratio (MLR) for each calendar year (MLR reporting year), consistent with MLR standards in 42 CFR 438.8(a). The MLR calculation shall be determined as set forth below; however, the Department may adopt NAIC reporting standards and protocols after giving written notice to Contractor.

7.10.2 For calendar years (MLR reporting years) 2018 through 2021, the minimum MLR is 85 percent (85%). Effective with calendar year (MLR reporting year) 2022, the minimum MLR is 88 percent (88%). The Department retains the right to adjust the minimum MLR in adherence to 42 CFS §438.8.

7.10.3 MLR calculations.

7.10.3.1 Contractor shall calculate the MLR for each Coverage Year as the ratio of the numerator (as defined in accordance with 42 CFR 438.8(e)) to the denominator (as defined in accordance with 42 CFR 438.8(f)) with nine (9) months claims run out; and

7.10.3.2 For the purpose of an MLR remittance as described in section 7.10.8, Contractor shall calculate the MLR for each Coverage Year as the ratio of the numerator (as defined in accordance with 42 CFR 438.8(e)) to the denominator (as defined in accordance with 42 CFR 438.8(f)) with eighteen (18) months of claims run out.

7.10.4 For each MLR calculation, Contractor shall:

7.10.4.1 include each of Contractor's expenses under only one (1) type of expense, unless a portion of the expense fits under the definition of, or criteria for, one (1) type of expense and the remainder fits into a

different type of expense, in which case the expense must be prorated between types of expenses; and

7.10.4.2 report expenditures that benefit multiple contracts or populations, or contracts other than those being reported, on pro rata basis.

7.10.5 For each MLR calculation, Contractor shall:

7.10.5.1 base expense allocation on a generally accepted accounting method that is expected to yield the most accurate results;

7.10.5.2 apportion shared expenses, including expenses under the terms of a management contract, pro rata to the contract incurring the expense; and

7.10.5.3 ensure that those expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities.

7.10.6 **Credibility Adjustment.** For each MLR calculation:

7.10.6.1 Contractor may add a credibility adjustment, in accordance with 42 CFR 438.8(h), to a calculated MLR if the MLR reporting year experience is partially credible.

7.10.6.2 Contractor shall add the credibility adjustment, if any, to the reported MLR calculation before calculating any remittances, if required.

7.10.6.3 Contractor may not add a credibility adjustment to a calculated MLR if the Coverage Year experience is fully credible.

7.10.6.4 If Contractor's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards.

7.10.7 The Contract specifies that the MCP will aggregate data for all Medicaid eligibility groups covered under the contract with the State unless the State requires separate reporting and a separate MLR calculation for specific populations. [42 CFR 438.8(i)]

7.10.8 Contractor shall refund to the State, for each Coverage Year, an amount equal to the difference between the calculated MLR and the minimum MLR multiplied by the Coverage Year revenue based on the MLR calculation prepared in accordance with section 7.10.3.2.

7.10.9 For each MLR calculation, Contractor shall submit an MLR report, in a format specified by the Department that includes, for each MLR reporting Year:

- 7.10.9.1 total incurred claims;
- 7.10.9.2 expenditures on quality-improving activities;
- 7.10.9.3 expenditures related to activities compliant with program integrity requirements;
- 7.10.9.4 non-claims costs;
- 7.10.9.5 premium revenue, which, for purposes of the MLR calculation, will consist of the Capitation payments, as adjusted pursuant to section 7.4, due from the Department for services provided during the Coverage Year, including withheld amounts earned and paid pursuant to section 7.9.1;
- 7.10.9.6 taxes;
- 7.10.9.7 licensing fees;
- 7.10.9.8 regulatory fees;
- 7.10.9.9 methodology(ies) for allocation of expenditures;
- 7.10.9.10 any credibility adjustment applied;
- 7.10.9.11 the calculated MLR;
- 7.10.9.12 any remittance owed to the State, if applicable;
- 7.10.9.13 a comparison of the information reported with the audited financial report;
- 7.10.9.14 a description of the aggregation method used to calculate total incurred claims; and
- 7.10.9.15 the number of Enrollee months.

7.10.10 **Data submission.** Contractor shall submit to the Department, in the form and manner prescribed by the Department, the data described in section 7.10.9. Benefit expense claims must be submitted as required under this Contract. For each MLR reporting year, Contractor must submit to the Department all data and information specified (including format) in 42 CFR §438.8(k) and by 43 CFR §438.242. Contractor must attest to the accuracy of all data, including benefit expense claims, and of the MLR calculation.

7.10.10.1 Contractor shall submit the MLR calculation described in section 7.10.3.1 within twelve (12) months of the end of the MLR reporting year.

7.10.10.2 Contractor shall submit the MLR calculation described in section 7.10.3.2 within twenty-one (21) months of the end of the MLR reporting year.

7.10.11 For each MLR calculation, Contractor shall require any Third-Party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to Contractor within one hundred eighty (180) days after the end of the MLR reporting year or within thirty (30) days after a request by Contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.

7.10.12 In any instance where the Department makes a retroactive change to the Capitation payments for a Coverage Year(s) and the MLR report(s) for that MLR reporting year(s) has already been submitted to the Department, Contractor shall:

7.10.12.1 recalculate the MLR for all MLR reporting years affected by the change; and

7.10.12.2 submit a new MLR report meeting the applicable requirements of this Contract.

7.11 COST REPORT REQUIREMENTS

7.11.1 Contractor shall complete annual and quarterly cost report templates to assist the Department in monitoring emerging utilization and cost data for each category of the populations enrolled with MCOs. Additionally, the completed cost report templates will be used in evaluation of Contractor's encounter data submissions. The cost report template shall contain reporting of MCO eligibility, revenue, medical expenses, medical expense adjustments, estimated unpaid claim liability, quality improvement expenses, operating expenses, and MCO assessments and taxes. The Department reserves the right to modify the cost report templates to collect additional information.

7.11.2 **Reporting timeline and process.** Contractor will submit a draft of each cost report to the Department by the submission deadlines stated in section 7.11.2.

7.11.2.1 The Department will review the draft cost report and provide Contractor with written observations that require either a response from Contractor addressing the issue or providing further explanation regarding the issue, or an adjustment for Contractor to make in the final cost report regarding the issue.

7.11.2.2 Contractor shall provide a written response via electronic communication to each draft observation in the final cost report.

7.11.2.3 Contractor shall have fourteen (14) days after receiving the

draft report observations to submit the final cost report. If the Department provides the draft cost report observations to Contractor fewer than fourteen (14) days prior to the final submission deadline, the final submission deadline will be extended to allow for there to be fourteen (14) days between the receipt by Contractor of the draft cost report observations and the final cost report submission.

COST REPORT	DRAFT SUBMISSION DEADLINE	FINAL SUBMISSION DEADLINE	DATES OF SERVICE	PAID THROUGH
Q1 2018	April 29, 2018	May 29, 2018	Jan-Mar 2018	Mar 31, 2018
Q2 2018	July 29, 2018	August 29, 2018	Jan-Jun 2018	Jun 30, 2018
Q3 2018	Oct 31, 2018	November 30, 2018	Jan-Sep 2018	Sep 30, 2018
Q4 2018	Jan 30, 2019	February 28, 2019	Jan-Dec 2018	Dec 31, 2018
ANNUAL 2018	May 15, 2019	June 15, 2019	Jan-Dec 2018	Mar 31, 2019

7.11.2.4 For contract years following the 2018 calendar year, submission deadlines and reporting parameters will be adjusted twelve (12) months forward.

7.11.3 **Reporting instructions and template.** The Department will provide reporting instructions and templates at least ninety (90) days prior to the first quarter cost report submission deadline each calendar year.

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

7.11.5 Reporting detail.

7.11.5.1 *Eligibility.* Contractor shall provide requested eligibility information in a format specified by the Department for data fields including:

- 7.11.5.1.1 managed care population;
- 7.11.5.1.2 rate cell;
- 7.11.5.1.3 region;
- 7.11.5.1.4 eligibility month; and
- 7.11.5.1.5 Enrollee count.

7.11.5.2 *Benefit expenses.* Contractor shall provide requested benefit

expense information in a format specified by the Department for data fields including:

- 7.11.5.2.1 managed care population;
- 7.11.5.2.2 rate cell;
- 7.11.5.2.3 region;
- 7.11.5.2.4 service category;
- 7.11.5.2.5 incurred month;
- 7.11.5.2.6 sub-capitation (Y/N);
- 7.11.5.2.7 admissions (inpatient services only);
- 7.11.5.2.8 units; and
- 7.11.5.2.9 paid amount.

7.11.5.3 *Nonbenefit expense and medical expense adjustments.* Contractor shall provide requested non-benefit expense and medical expense adjustments in a format specified by the Department for data fields including:

- 7.11.5.3.1 expense type;
- 7.11.5.3.2 managed care population;
- 7.11.5.3.3 rate cell;
- 7.11.5.3.4 region;
- 7.11.5.3.5 incurred month; and
- 7.11.5.3.6 paid amount.

7.11.5.4 *Lag triangle.* Contractor shall provide lag triangle information in a format specified by the Department for data fields including:

- 7.11.5.4.1 managed care population;
- 7.11.5.4.2 rate cell;
- 7.11.5.4.3 high-level service category;
- 7.11.5.4.4 incurred month (minimum twenty-four [24] months prior);
- 7.11.5.4.5 paid month (minimum twenty-four [24] months prior);

7.11.5.4.6 units; and

7.11.5.4.7 paid amount.

7.11.6 Additional annual cost report requirements. For the annual cost report submissions in each calendar year, Contractor shall provide a reconciliation of its audited financial statement to the annual cost report in a format specified by the Department. Contractor shall have the reconciliation reviewed and certified by an independent auditor or by an executive officer of Contractor.

7.11.7 Medical loss ratio (MLR) calculation. Contractor shall calculate and report an MLR in accordance with 42 CFR §438.8. Contractor will identify and include any material IBNP claims and non-finalized provider payments in this calculation. The medical loss ratio shall be expressed as a percentage rounded to the second decimal point. The Department will review Contractor's rates and the Department will make the final determination of the MLR for the year.

7.11.8 Coverage Year. The Coverage Year shall be the calendar year. The MLR calculation shall be prepared using all data available from the Coverage Year, including IBNP expenses during the run-out months for benefit expense (excluding sub-capitation paid during the run-out months).

7.12 DENIAL OF PAYMENT SANCTION BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES

The Department shall deny payments otherwise provided for under this Contract for new Enrollees when, and for so long as, payment for those Enrollees is denied by Federal CMS under 42 CFR §438.726.

7.13 HOLD HARMLESS

Contractor shall indemnify and hold the Department harmless from any and all claims, Complaints, or causes of action that arise as a result of: (i) Contractor's failure to pay any Provider for rendering Covered Services to Enrollees, or failure to pay any Subcontractor, either on a timely basis or at all, regardless of the reason; or, any dispute arising between Contractor and a Provider or Subcontractor; provided, however, the preceding provision will not affect any obligation that the Department may have to pay for services that are not Covered Services under this Contract, but that are eligible for payment by the Department. Contractor warrants that Enrollees will not be liable for any of Contractor's debts if Contractor becomes insolvent or subject to insolvency proceedings as set forth in 215 ILCS 125/1-1 *et seq.*

7.14 PAYMENT IN FULL

Acceptance of payment of the rates specified in this Article VII for any Enrollee is payment in full for all Covered Services provided to that Enrollee, except to the

extent Contractor charges such Enrollee a copayment as permitted in this Contract.

7.15 PROMPT PAYMENT

Payments, including late charges, will be paid in accordance with the State Prompt Payment Act (30 ILCS 540) and rules (74 Ill. Adm. Code 900).

7.16 SANCTIONS

7.16.1 The Department may impose civil money penalties, late fees, performance penalties (collectively, “monetary sanction”), and other sanctions, on Contractor for Contractor’s failure to substantially comply with the terms of this Contract. Monetary sanctions imposed pursuant to this section 7.16 may be collected by deducting the amount of the monetary sanction from any payments due to Contractor or by demanding immediate payment by Contractor. The Department, at its sole discretion, may establish an installment payment plan for payment of any monetary sanction. The determination of the amount of any monetary sanction shall be at the sole discretion of the Department, within the ranges set forth below. Self-reporting by Contractor will be taken into consideration in determining the amount of any monetary sanction. The Department shall not impose any monetary sanction where the noncompliance is directly caused by the Department’s action or failure to act or where a *force majeure* delays performance by Contractor. The Department, in its sole discretion, may waive the imposition of a monetary sanction for failures that it judges to be minor or insignificant. Upon determination of substantial noncompliance, the Department shall give written notice to Contractor describing the noncompliance, the opportunity to cure the noncompliance at the discretion of the Department, or where a cure is not otherwise disallowed under this Contract, and the monetary sanction that the Department will impose hereunder. The Department may disallow an opportunity to cure when noncompliance is willful, egregious, persistent, part of a pattern of noncompliance, or incapable of being cured, or when a cure is otherwise not allowed under this Contract. The Department reserves the right to terminate this Contract as provided in Article VIII of this Contract in addition to, or in lieu of, imposing one or more monetary sanctions. At the end of each subsequent period of thirty (30) days in which no demonstrated progress is made toward compliance, the Department may, without further notice, impose additional performance penalties of equal amount. The State reserves the right to amend these sanctions and sanction amounts at any time, with sixty (60) days’ notice provided to Contractor. Where a sanction references an enrollment hold, at the discretion of the Department this may be either one or both of the following:

- 7.16.1.1 a suspension of enrollment by automatic assignment for Potential Enrollees; or

7.16.1.2 a suspension of enrollment for Potential Enrollees.

7.16.2 **Failure to report or submit standard required reports.** If Contractor fails to submit any report or other material required by this Contract to be submitted to the Department, other than Encounter Data, by the date due, the Department may, at its sole discretion and without further notice, impose a late fee of up to US \$50,000 for the late report. The date due will be either the date imposed by the Department or the date agreed to by the Department at Contractor's request. At the end of each subsequent due date for which the specific report is not submitted, the Department may, without further notice, impose an additional late fee equal to the amount of the original late fee.

7.16.3 **Failure to submit ad hoc reports.** If Contractor fails to submit any ad hoc report in an accurate, complete, and timely manner, as provided in section 5.28.1.3, then the Department may, at its sole discretion and without notice, impose a monetary sanction of up to US \$50,000. The Department may also, without further notice, impose an additional monetary sanction until an accurate and complete response is submitted.

7.16.4 **Failure to submit cost report data.** If Contractor fails to submit cost report data in a timely or accurate manner, the Department may, without further notice, impose one or more of the following:

7.16.4.1 Failure to submit draft cost report by required submission deadline: \$10,000 penalty per Business Day.

7.16.4.2 Failure to submit final cost report by required submission deadline: \$10,000 penalty per Business Day.

7.16.4.3 Failure to address or respond to draft observations, as provided in section 7.11.2, in final cost report submission:

7.16.4.3.1 First instance: written warning;

7.16.4.3.2 Second instance: US \$50,000 penalty;

7.16.4.3.3 Additional instances: US \$100,000 penalty per submission.

7.16.4.4 Change in prior period aggregate expenses (excluding additional months of paid claims), revenue, or eligibility of more than 10% in subsequent quarterly or cost report submission, unless a result of a Department data issue or programmatic variance.

7.16.4.4.1 First instance: written warning;

7.16.4.4.2 Second instance: US \$50,000 penalty;

7.16.4.4.3 Additional instances: US \$100,000 penalty per

submission.

7.16.4.5 There will be no limit on sanctions associated with cost report submissions for each calendar year period. For sections 0 and 0, a written warning will be provided upon the first instance in each separate calendar year.

7.16.5 Failure to comply with BEP requirements. If the Department determines that Contractor has not met, and has not made good-faith efforts to meet, the goals for BEP subcontracting established in section 2.9, or has provided false or misleading information or statements concerning compliance, certification status, eligibility of certified Contractors, its good-faith efforts to meet the BEP goal, or any other material fact or representation, the Department may, without further notice:

7.16.5.1 impose a performance penalty of up to US \$100,000; or

7.16.5.2 withhold payment to Contractor in an amount equal to the difference between the BEP goal and the amount of money paid to BEP-certified subcontractors during the State Fiscal Year.

The Department may withhold whichever is the larger amount.

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

7.16.6.1 impose a monetary penalty of up to US \$100,000;

7.16.6.1.1 impose a monetary penalty of up to US \$100,000 for each unmet standard, beginning with the calendar year 2022 third quarter EUM data;

7.16.6.2 impose an enrollment hold on Contractor; or

7.16.6.3 impose both.

7.16.7 Failure to submit quality and Performance Measures. If the Department determines that Contractor has not accurately conducted and submitted quality and Performance Measures as required in Attachment XI, and the

Department reasonably determines the failure warrants imposing a late fee, the Department may, without further notice, impose a late fee of up to US \$50,000 for each measure not accurately conducted or submitted.

7.16.8 Failure to participate in the Performance Improvement Project. If the Department determines that Contractor has not fully participated in the PIP, the Department may impose a performance penalty of up to US \$100,000. At the end of each subsequent period of thirty (30) days in which no demonstrated progress is made toward full compliance, the Department may, without further notice, impose an additional performance penalty of up to US \$100,000.

7.16.9 Failure to demonstrate improvement in areas of deficiencies. If the Department determines that Contractor has not made significant progress in monitoring or carrying out its QAP, implementing quality improvement plan or demonstrating improvement in areas of deficiencies, as identified in its HEDIS® results, quality monitoring, or PIP, the Department will provide notice to Contractor that Contractor shall be required to develop a formal Corrective Action Plan (CAP) to remedy the Breach of Contract.

7.16.9.1 Contractor shall submit a CAP within thirty (30) days after the date of notification by the Department. Contractor's CAP will be evaluated by the Department to determine whether it satisfactorily addresses the actions needed to correct the deficiencies. If Contractor's CAP is unsatisfactory, the Department will indicate the sections requiring revision and any necessary additions, and request that another CAP be submitted by Contractor, unless otherwise specified, within thirty (30) days after receipt of the Department's second notice. If Contractor's second CAP is unsatisfactory, the Department may declare a material Breach.

7.16.9.2 Within ninety (90) days after Contractor has submitted an acceptable CAP, Contractor must demonstrate progress toward improvement. The Department, or its designee, may review Contractor's progress through an on-site or off-site process. Thereafter, Contractor must show improvement for each ninety (90)-day period until Contractor is compliant with the applicable requirements of this Contract.

7.16.9.3 If Contractor does not submit a satisfactory CAP within the required timeframes or show the necessary improvements, the Department, without further notice, may impose a performance penalty of US \$50,000 for each thirty (30)-day period thereafter.

7.16.9.4 The CAP must be submitted with the signature of Contractor's chief executive officer and is subject to approval by the Department. The CAP must include the following:

- 7.16.9.4.1 the specific problems that require corrective action;
- 7.16.9.4.2 the type of corrective action to be taken for improvement of each specific problem;
- 7.16.9.4.3 the goals of the corrective action;
- 7.16.9.4.4 the timetable and work plan for action;
- 7.16.9.4.5 the identified changes in processes, structure, and internal and external education;
- 7.16.9.4.6 the type of follow-up monitoring, evaluation, and improvement; and
- 7.16.9.4.7 the identified improvements and enhancements of existing outreach and care-management activities, if applicable.

7.16.10 **Imposition of prohibited charges.** If the Department determines that Contractor has imposed a charge on an Enrollee that is prohibited, or otherwise not allowed, under the Medicaid program, the Department may impose a civil money penalty of up to US \$25,000.

7.16.11 **Misrepresentation or falsification of information.** If the Department determines that Contractor has misrepresented or falsified information furnished to a Potential Enrollee, Enrollee, or Provider, the Department may impose a civil money penalty of US \$10,000 to US \$25,000 for each determination. If the Department determines that Contractor has misrepresented or falsified information furnished to the Department or Federal CMS, the Department may impose a civil money penalty of up to US \$100,000 for each determination.

7.16.12 **Failure to comply with the Physician incentive plan requirements.** If the Department determines that Contractor has failed to comply with the Physician incentive plan requirements of section 5.24, the Department may impose a civil money penalty of up to US \$25,000 for each determination.

7.16.13 **Failure to meet access and Provider ratio standards.** If the Department determines that Contractor has not met the Provider-to-Enrollee access standards established in section 5.8, the Department will send Contractor a notice of noncompliance. If Contractor has not met these requirements by the end of the thirty (30)-day period following the notice, the Department may, without further notice:

- 7.16.13.1 impose a performance penalty of up to US \$50,000;
- 7.16.13.2 impose an enrollment hold on Contractor; or

- 7.16.13.3 impose both.
- 7.16.14 **Failure to provide Covered Services.** If the Department determines that Contractor has substantially failed to provide, or arrange to provide, a Medically Necessary service that Contractor is required to provide under law or this Contract, the Department may:
 - 7.16.4.1 impose a civil money penalty of US \$50,000 for each determination, or
 - 7.16.4.2 impose an enrollment hold on Contractor, or
 - 7.16.4.3 impose both.
- 7.16.15 **Discrimination related to preexisting conditions or medical history.** If the Department determines that discrimination has occurred in relation to an Enrollee's preexisting condition or medical history indicating a probable need for substantial medical services in the future, the Department may:
 - 7.16.15.1 impose a civil money penalty of up to US \$50,000 for each determination; or
 - 7.16.15.2 impose an enrollment hold on Contractor; or
 - 7.16.15.3 impose both.
 - 7.16.15.4 For each beneficiary not enrolled because of a discriminatory practice, the Department may impose a civil money penalty of up to US \$15,000.
- 7.16.16 **Pattern of Marketing failures.** If the Department determines that there is Marketing Misconduct or a pattern of Marketing failures, the Department may:
 - 7.16.16.1 impose a civil money penalty of up to US \$25,000 for each determination; or
 - 7.16.16.2 impose an enrollment hold on Contractor; or
 - 7.16.16.3 impose both.
- 7.16.17 **Failure to develop a written proposal intended to resolve a disputed claim and within required timeframe.** If the Department determines that Contractor fails to develop a written proposal addressing a Provider's disputed claim that has been submitted to the Department's Provider complaint portal within the timeframes delineated in the Department's policies and procedures, or, if the Department determines a

timely written proposal is demonstrably inadequate such that resolution is improbable, the Department may:

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

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

7.16.7.3 impose an enrollment hold on Contractor; or

7.16.7.4 impose both.

7.16.18 **Other failures.** If the Department determines that Contractor is in substantial noncompliance with any material terms of this Contract, or any State or federal laws affecting Contractor's conduct under this Contract, that are not specifically enunciated in this article VII but for which the Department reasonably determines imposing a performance penalty or other sanction is warranted, the Department, may:

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

7.16.18.2 impose an enrollment hold on Contractor; or

7.16.18.3 impose both.

7.17 RETENTION OF PAYMENTS

In addition to the assessment of monetary sanctions:

7.17.1 Pursuant to 44 Ill. Admin. Code 1.2065(c), the Department may deduct from whatever is owed Contractor on this or any other contract an amount sufficient to compensate the State for any damage resulting from termination or rescission.

7.17.2 If any failure of Contractor to meet any requirement of this Contract results in the withholding of federal funds from the State, the Department may withhold and retain an equivalent amount from payments to Contractor until such federal funds are released, in whole or in part, to the State, at which time the Department will release to Contractor an amount equivalent to the amount of federal funds received by the State.

7.18 DEDUCTIONS FROM PAYMENTS

Any payment to Contractor may be reduced or suspended when a provision of this Contract requires a payment or refund to the Department or an adjustment of a payment to Contractor.

7.19 COMPUTATIONAL ERROR

The Department reserves the right to correct any mathematical or computational error in payment subtotals or total contractual obligation. The Department will notify Contractor of any such corrections.

7.20 NOTICE FOR RETENTIONS AND DEDUCTIONS

Prior to making an adjustment pursuant to sections 7.17, 7.18, or 7.19, except for routine systematic adjustments, the Department will provide Contractor with a notice and explanation of the adjustment. Contractor may provide written objections regarding the adjustment to the Department within fifteen (15) days after the Department sends the notice. No adjustment will be made until the Department responds in writing to the objections or, if no timely objections are made, on or after the sixteenth (16th) day after sending the notice.

7.21 NON-CONTRACTUAL RECOVERIES

If the Department requires Contractor to recover established overpayments made to a Subcontractor or Network Provider by the Department for performance or nonperformance of activities not governed by this Contract, Contractor shall immediately notify the Department of any amount recovered, and, as agreed to by the Parties:

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

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

7.22 MATERNITY RISK POOL.

Pursuant to the retrospective maternity risk pool described in the applicable calendar year HealthChoice Illinois rate certification, Contractor shall participate in the risk pool arrangement on a calendar year basis. The risk pool is applicable to the non-disabled children and adults and Affordable Care Act Adult populations. Maternity services benefit costs and related non-benefit costs will be calculated for applicable rate cells by region. The aggregate amount of the risk pool will be determined by actual Enrollee months in the applicable rate cells and documented per Enrollee per month maternity-related expenses included in the respective rate cells. Risk pool amounts will be distributed based on maternal deliveries by Enrollees as documented by MCO-submitted inpatient maternity admission Encounter Data through six (6) months following the end of the given calendar year. The Department will distribute funds among the MCOs by region and population. The distribution of funds will be budget-neutral to the Department for each calendar year. The Department will provide Contractor written notice of the risk pool results

that contains sufficient documentation to support the calculations. Contractor shall have thirty (30) days to review the written notice and to submit questions, if any, to the Department. In the event Contractor disputes the risk pool results within the thirty (30) day review period, the Department will meet with Contractor within a reasonable time frame to achieve a good-faith resolution of the disputed matter.

7.23 COMMUNITY TRANSITIONS INITIATIVE INCENTIVE ARRANGEMENT

The Department shall make incentive payments to Contractor, in accordance with 42 CFR 438.6, for the Community Transitions Initiative discussed in section 5.18.6 consistent with the following:

7.23.1 Incentive Payments for Successful Community Transitions. Effective March 1, 2022: (1) the Department will pay Contractor an incentive payment for each successful transition, approved by the Department or its designee, of an Enrollee from an institutional setting to the community in the amount of \$5,000 for Colbert and Williams class members, and (2) the Department will not pay Contractor an incentive payment for community transitions for non-class members that initiate on or after March 1, 2022.

7.23.1.1 To be considered a successful community transition, the Enrollee must continuously reside in the community setting for a minimum of six (6) months after the date of transition.

7.23.1.2 The Department will pay Contractor an additional incentive payment of \$500 upon an Enrollee's community transition anniversary date when the Enrollee has continued to reside continuously in the community. Contractor may earn this incentive payment, for each transitioned Enrollee, up to a maximum of three such annual payments. Enrollees who have not resided continuously in the community are not eligible for any subsequent incentive payments.

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

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

7.23.3.1 In the event Contractor achieves the annual minimum performance target for successful community transitions of Colbert and Williams class members, the Department will pay Contractor an additional \$500 incentive payment for each Colbert and Williams class member's successful community transition that occurred within the calendar year.

7.23.3.2 In the event Contractor fails to meet the annual minimum performance target for successful community transitions of Colbert and Williams class members, the Department will implement a performance penalty as described in section 7.16.18 in the amount of \$5,000 for each community transition that fails to meet Contractor's established minimum performance target.

7.24 CY2020 RISK CORRIDOR

The Department shall utilize, for all Enrollees, a risk corridor mechanism that allows Contractor to operate with the understanding that if there are excessive losses or profits as a result of the COVID-19 public health emergency's impact on utilization of Covered Services, the mechanism ensures that Contractor will share the risk of such deviations to a certain degree with the Department.

7.24.1 For the purpose of this risk corridor calculation, benefit expenses include Covered Services and approved in-lieu-of services, as well as non-Covered Services and Provider-based care coordination services approved by the Department as part of Contractor's reinvestment proposal to address needs resulting from the COVID-19 public health emergency. Benefit expenses exclude healthcare quality improvement expenses as defined in 42 CFR 438.8(e)(2). Benefit expenses include incurred but not yet paid expenses, as reported by Contractor within a timeframe and format provided by the Department.

7.24.2 The risk corridor settlement will be calculated for Contractor across all HealthChoice Illinois populations and rating regions combined. The risk corridor ratio is calculated as actual benefit expenses divided by the target benefit expense amount for Contractor.

7.24.3 In the event Contractor's risk corridor ratio is greater than 101%, the Department shall reimburse Contractor the target amount multiplied by:

7.24.3.1 50.0% multiplied by [risk corridor ratio less 101.0%], if the risk corridor ratio is less than or equal to 104.0%; or

7.24.3.2 1.5% plus [risk corridor ratio less 104.0%], if the risk corridor ratio exceeds 104.0%.

7.24.4 In the event Contractor's risk corridor ratio is less than 99.0%, the Department shall make a recoupment from Contractor of the target amount multiplied by:

7.24.4.1 50.0% multiplied by [99.0% less risk corridor ratio], if the risk corridor ratio is greater than or equal to 96.0%; or

7.24.4.2 1.5% plus [96.0% less risk corridor ratio], if the risk corridor is less than 96.0%.

7.24.5 The risk corridor will be calculated using values reported consistent with the medical loss ratio (MLR) reporting. The payment or recoupment amount will be an adjustment to the denominator of the MLR for the calculation of the calendar year 2020 MLR.

7.25 CY2021 RISK CORRIDOR

The Department shall utilize for calendar year 2021, for all Enrollees, a risk corridor mechanism that allows Contractor to operate with the understanding that if there are excessive losses or profits as a result of the COVID-19 public health emergency's impact on utilization of Covered Services, the mechanism ensures that Contractor will share the risk of such deviations to a certain degree with the Department.

7.25.1 For the purpose of this risk corridor calculation, benefit expenses include Covered Services and approved in-lieu-of services, as well as non-Covered Services and Provider-based care coordination services approved by the Department as part of Contractor's reinvestment proposal to address needs resulting from the COVID-19 public health emergency. Benefit expenses exclude healthcare quality improvement expenses as defined in 42 CFR 438.8(e)(2). Benefit expenses include incurred but not yet paid expenses, as reported by Contractor within a timeframe and format provided by the Department.

7.25.2 The risk corridor settlement will be calculated for Contractor across all HealthChoice Illinois populations and rating regions combined. The risk corridor ratio is calculated as actual benefit expenses divided by the target benefit expense amount for Contractor.

7.25.3 In the event Contractor's risk corridor ratio is greater than 103%, the Department shall reimburse Contractor the target amount multiplied by:

7.25.3.1 50.0% multiplied by [risk corridor ratio less 103.0%], if the risk corridor ratio is less than or equal to 105.0%; or

7.25.3.2 1.0% plus [risk corridor ratio less 105.0%], if the risk corridor ratio exceeds 105.0%.

7.25.4 In the event Contractor's risk corridor ratio is less than 97.0%, the Department shall make a recoupment from Contractor of the target amount multiplied by:

7.25.4.1 50.0% multiplied by [97.0% less risk corridor ratio], if the risk corridor ratio is greater than or equal to 95.0%; or

7.25.4.2 1.0% plus [95.0% less risk corridor ratio], if the risk corridor is less than 95.0%.

7.25.5 The risk corridor will be calculated using values reported consistent with the medical loss ratio (MLR) reporting. The payment or recoupment amount will be an adjustment to the denominator of the MLR for the calculation of the calendar year 2021 MLR.

7.26 REIMBURSEMENT FOR EMERGENCY GROUND AMBULANCE SERVICE

For dates of service on or after January 1, 2020 and continuing through March 31, 2021, Contractor shall reimburse for emergency ground ambulance services (current procedural terminology (CPT) codes A0427 and A0429), including affiliated mileage and oxygen, at the FFS Medicaid Program fee schedule rates as provided by the Department, inclusive of Government Emergency Medical Transportation (GEMT) rates. These services are outside of Contractor's risk-based Capitation payments and shall be paid on behalf of the Department by Contractor as an Administrative Services Organization. The Department shall reimburse Contractor on a quarterly basis the actual paid amounts expended by Contractor based on encounter claims accepted by the Department during the quarter, or, other quarterly documentation mutually agreed to by the Parties, plus a \$35,000 per quarter administrative fee. Accrued payments are due to Contractor thirty (30) days after execution of this Contract amendment; subsequent payments are due within thirty (30) days of the end of a quarter. State Prompt Payment Act (30 ILCS 540) requirements apply to these payments.

7.27 VALUE-BASED PAYMENTS (VBP)

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

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

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

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

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

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

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

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

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

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

7.27.2 Annual VBP Plan Submission. Contractor shall annually update and submit a VBP Plan by May 1 of each calendar year using a template provided by the

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

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

7.28 AUDITED FINANCIAL REPORTS

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

ARTICLE VIII: TERM, RENEWAL, AND TERMINATION

8.1 TERM OF THIS CONTRACT

This Contract shall take effect on the Effective Date and shall continue for a period of four (4) years.

8.2 RENEWAL

8.2.1 If the Contract is renewed, the renewal shall be subject to the same terms and conditions as the Contract unless otherwise stated. The Contract may not renew automatically, nor may the Contract renew solely at Contractor's option. The Department reserves the right to renew for a total of four (4) years in any of the following manners or combination thereof:

8.2.1 8.2.1.1 one renewal covering the entire renewal allowance;

8.2.2 8.2.1.2 individual one-year renewals up to and including the entire renewal allowance; and/or

8.2.3 8.2.1.3 any combination of single- and multi-year renewals up to and including the entire renewal allowance.

8.2.2 Term of Contract Renewal.

Effective January 1, 2022, this Contract is renewed, in accordance with and subject to the requirements of section 8.2, for a single renewal term of four (4) years.

8.3 CONTINUING DUTIES IN THE EVENT OF TERMINATION

Upon termination of this Contract, the Parties are obligated to perform those duties that survive under this Contract. Such duties include payment to Network or non-Network Providers, including resolution of aged unpaid claims; completion of Enrollee satisfaction surveys; cooperation with medical records review; all reports for periods of operation, including Encounter Data; retention of records; and preservation of confidentiality and security of PHI. Termination of this Contract does not eliminate Contractor's responsibility to the Department for overpayments, which the Department determines in a subsequent audit may have been made to Contractor, nor does it eliminate any responsibility the Department may have for underpayments to Contractor. Contractor warrants that if this Contract is terminated, Contractor shall promptly supply all information in its possession or that may be reasonably obtained that is necessary for the orderly transition of Enrollees and completion of all Contract responsibilities. Contractor must, for a period of time

specified by the Department, provide all reasonable transition assistance requested by the Department.

8.4 IMMEDIATE TERMINATION FOR CAUSE

In addition to any other termination rights under this Contract, the Department may terminate this Contract, in whole or in part, immediately upon notice to Contractor if it is determined that the actions, or failure to act, of Contractor or its agents, employees, or Subcontractors have caused, or reasonably could cause, jeopardy to health, safety, or property. This Contract may be terminated immediately if the Department determines that Contractor fails to meet any of the applicable requirements established by 89 Ill. Admin. Code Part 143.

8.5 TERMINATION FOR CAUSE

In addition to any other termination rights under this Contract, if Contractor fails to perform to the Department's satisfaction any material requirement of this Contract or is in violation of a material provision of this Contract, the Department shall provide written notice to Contractor requesting that the Breach or noncompliance be remedied within the period of time specified in the Department's written notice, which shall be no fewer than sixty (60) days. If the Breach or noncompliance is not remedied by that date, the Department may: (i) immediately terminate the Contract without additional written notice; or, (ii) enforce the terms and conditions of the Contract. In either event, the Department may also seek any available legal or equitable remedies and damages.

8.6 SOCIAL SECURITY ACT

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

8.7 TEMPORARY MANAGEMENT

While one (1) or more agencies of the State have the authority and retain the power under 42 CFR §438.702 to impose temporary management upon Contractor for repeated violations of the Contract, the Department may exercise its option to terminate the Contract prior to imposition of temporary management. This does not

preclude other State agencies from exercising such power at their discretion.

8.8 TERMINATION FOR CONVENIENCE

Following ninety (90) days' written notice, the Department may terminate this Contract in whole or in part without the payment of any penalty or incurring any further obligation to Contractor. In no event will the Department or State be liable to Contractor for any compensation for services not rendered or outside the scope of this Contract. Following one-hundred eighty (180) days' written notice, Contractor may terminate this Contract in whole or in part without the payment of any penalty or incurring any further obligation to the Department.

8.9 OTHER TERMINATION RIGHTS

- 8.9.1 This Contract may be terminated immediately or upon notice by the Department, at its sole discretion, in the event of the following:
- 8.9.1.1 material failure of Contractor to maintain the representations, warranties, and applicable certifications set forth in section 9.2;
 - 8.9.1.2 failure of Contractor to maintain general liability insurance coverage, as provided in section 9.2;
 - 8.9.1.3 commencement of any case or proceeding by or against Contractor seeking a decree or order with respect to the other Party under the United States Bankruptcy Code or any other applicable bankruptcy or similar law, including, without limitation, laws governing liquidation and receivership, provided such proceeding is not dismissed within ninety (90) days after its commencement;
 - 8.9.1.4 material misrepresentation or falsification of any information provided by Contractor in the course of dealings between the Parties;
 - 8.9.1.5 action by Contractor to sell, transfer, dissolve, merge, or liquidate its business;
 - 8.9.1.6 failure of the Parties to negotiate an amendment necessary for statutory or regulatory compliance as provided in this Contract;
 - 8.9.1.7 funds for this Contract become unavailable as set forth in section 9.1.1; or
 - 8.9.1.8 the Department does not receive Federal CMS approval of this Contract, in which event the Department shall provide at least thirty (30) days' prior written notice to Contractor.
- 8.9.2 The effective date of any termination under this section 8.9 shall be the earliest date that is at least thirty (30) days following the date the notice is

sent and occurs on the last day of a calendar month. Neither Party shall be relieved of its obligations under this Contract, including the Department's obligation to pay Contractor, for the period from the date of the first enrollment through the effective termination date.

8.10 AUTOMATIC TERMINATION

This Contract shall automatically terminate on a date set by the Department upon the conviction of a felony of Contractor, or a Person with Ownership or a Controlling Interest in Contractor.

8.11 REIMBURSEMENT IN THE EVENT OF TERMINATION

In the event of termination of this Contract, Contractor shall be responsible and liable for payment to Providers for any and all claims for Covered Services rendered to Enrollees prior to the effective termination date.

8.12 TERMINATION BY CONTRACTOR

If the Department fails to pay Contractor the entire Capitation due under section 7.1 for three (3) consecutive months, Contractor may provide written notice to the Department that Contractor wishes to terminate the Contract. If none of the Capitation attributable to those three (3) consecutive months has been paid at the time the notice is sent, and at least thirty-three percent (33%) of such Capitation is not paid within three (3) days after such notice is received by the Department, or the Parties do not otherwise agree, the Contract will terminate at 11:59 p.m. on the last day of the calendar month immediately following the month in which the notice is sent.

ARTICLE IX: GENERAL TERMS

9.1 STANDARD BUSINESS TERMS AND CONDITIONS

- 9.1.1 **Availability of appropriations; sufficiency of funds.** This Contract is contingent upon and subject to the availability of sufficient funds. The Department may terminate or suspend this Contract, in whole or in part, without advance notice and without penalty or further payment being required, if: (i) sufficient funds for this Agreement have not been appropriated or otherwise made available to the Department by the State or the Federal funding source; (ii) the Governor or the Department reserves funds; or (iii) the Governor or the Department determines that funds will not or may not be available for payment. The Department shall provide notice, in writing, to Contractor of any such funding failure and its election to terminate or suspend this Contract as soon as practicable. Any suspension or termination pursuant to this Section will be effective upon the date of the written notice unless otherwise indicated.
- 9.1.2 **Audit/retention of records.** Unless otherwise required by this Contract, Contractor and its Subcontractors shall maintain books and records relating to the performance of the Contract or any Subcontract and necessary-to-support amounts charged to the State under the Contract or subcontract. Books and records, including information stored in databases or other computer systems, shall be maintained by Contractor for a period of three (3) years from the later of the date of final payment under the Contract or completion of the Contract, and by a Subcontractor for a period of three (3) years from the later of the date of final payment under the Subcontract or completion of the Subcontract. If federal funds are used to pay Contract costs, Contractor and its Subcontractors must retain the books and records for ten (10) years. Books and records required to be maintained under this section 9.1 shall be available for review or audit by representatives of the Department, the auditor general, the executive inspector general, the Chief Procurement Officer, State of Illinois internal auditors, or other governmental entities with monitoring authority upon reasonable notice and during normal business hours. Contractor and its Subcontractors shall cooperate fully with any such audit and with any investigation conducted by any of these entities. Failure to maintain the books and records required by this section 9.1.2 shall establish a presumption in favor of the State for the recovery of any funds paid by the State under the Contract for which adequate books and records are not available to support the purported disbursement. Contractor or its Subcontractors shall not impose a charge for audit or examination of Contractor's books and records.
- 9.1.3 **Time is of the essence.** Time is of the essence with respect to Contractor's performance of this Contract. Unless otherwise directed by the Department,

Contractor shall continue to perform its obligations while any dispute concerning the Contract is being resolved.

- 9.1.4 **No waiver of rights.** Except as specifically waived in writing, failure by a Party to exercise or enforce a right does not waive that Party's right to exercise or enforce that or other rights in the future.
- 9.1.5 **Force majeure.** Failure by either Party to perform its duties and obligations will be excused by unforeseeable circumstances beyond its reasonable control and not due to its negligence, including acts of nature, acts of terrorism, riots, labor disputes, fire, flood, explosion, and governmental prohibition. The non-declaring Party may cancel the Contract without penalty if performance does not resume within thirty (30) days after the declaration.
- 9.1.6 **Confidential Information.** It is understood that each Party to this Contract, including its agents and Subcontractors, may have or gain access to Confidential Information or data owned or maintained by the other Party in the course of carrying out its responsibilities under this Contract. Contractor shall presume that all information received from the State or to which it gains access pursuant to this Contract is confidential. Contractor's information (excluding information regarding rates paid by Contractor to its Providers and Subcontractors), unless clearly marked as confidential and exempt from disclosure under the Illinois Freedom of Information Act, shall be considered public. No confidential data collected, maintained, or used in the course of performance of the Contract shall be disseminated except as authorized by law and with the written consent of the disclosing Party, either during the term of the Contract or thereafter, or as otherwise set forth in this Contract. The receiving Party must return any and all data collected, maintained, created, or used in the course of the performance of the duties of this Contract, in whatever form they are maintained, promptly at the end of the term of this Contract, or earlier at the request of the disclosing Party, or notify the disclosing Party in writing of the data's destruction. The foregoing obligations shall not apply to confidential data or information that:
- 9.1.6.1 are lawfully in the receiving Party's possession prior to its acquisition from the disclosing Party;
 - 9.1.6.2 are received in good faith from a Third Party not subject to any confidentiality obligation to the disclosing Party;
 - 9.1.6.3 are now, or become, publicly known through no Breach of confidentiality obligation by the receiving Party; or
 - 9.1.6.4 are independently developed by the receiving Party without the use or benefit of the disclosing Party's Confidential Information.
- 9.1.7 **Use and ownership.** Excluding all materials, information, processes, and programs that are owned by or proprietary to Contractor or that are licensed

to Contractor by a Third Party, including any modifications or enhancements thereto, all work performed or supplies created by Contractor under this Contract, whether written documents or data, goods, or deliverables of any kind, shall be deemed work-for-hire under copyright law and all intellectual property and other laws, and the State is granted sole and exclusive ownership to all such work, unless otherwise agreed in writing. Contractor hereby assigns to the State all right, title, and interest in and to such work including any related intellectual-property rights, and waives any and all claims that Contractor may have to such work including any so-called moral rights in connection with the work. Contractor acknowledges that the State may use the work product for any purpose. Confidential data or information contained in such work shall be subject to confidentiality provisions of this Contract.

9.1.8 Indemnification and liability. Contractor shall indemnify and hold harmless the State and its agencies, officers, employees, agents, and volunteers from any and all costs, demands, expenses, losses, claims, damages, liabilities, settlements, and judgments, including in-house and contracted attorneys' fees and expenses, arising out of: (i) any Breach or violation by Contractor of any of its certifications, representations, warranties, covenants, or agreements; (ii) any actual or alleged death or injury to any individual, damage to any property, or any other damage or loss claimed to result in whole or in part from Contractor's negligent performance; or, (iii) any act, activity, or omission of Contractor or any of its employees, representatives, Subcontractors, or agents. Neither Party shall be liable for incidental, special, consequential, or punitive damages.

9.1.9 Insurance. Contractor shall, at all times during the term of this Contract and any renewals thereof, maintain and provide a certificate of insurance naming the State as additional insured for all required bonds and insurance. Certificates may not be modified or canceled until at least thirty (30) days' notice has been provided to the State. Contractor shall provide: (i) general commercial liability occurrence form in amount of US \$1,000,000 per occurrence (combined single-limit bodily injury and property damage) and US \$2,000,000 annual aggregate; (ii) auto liability, including hired auto and unowned auto (combined single-limit bodily injury and property damage) in amount of US \$1,000,000 per occurrence; and, worker's compensation insurance in amount required by law. Insurance shall not limit Contractor's obligation to indemnify, defend, or settle any claims. In lieu of the foregoing, Contractor may have a program, acceptable to the State, that provides the coverage and the coverage amounts set forth herein.

9.1.10 Independent Contractor. Contractor shall act as an independent Contractor and not an agent or employee of, or joint venture with, the State. All payments by the State shall be made on that basis.

9.1.11 Solicitation and employment. Contractor shall give notice immediately to

the Department's ethics officer if Contractor solicits or intends to solicit State employees to perform any work under this Contract.

- 9.1.12 **Compliance with the law.** Contractor and its employees, agents, and Subcontractors shall comply with all applicable federal, State, and local laws, rules, ordinances, regulations, orders, federal circulars, and license and permit requirements in the performance of this Contract. Contractor shall be compliant with applicable tax requirements and shall be current in payment of such taxes. Contractor shall obtain, at its own expense, all licenses and permissions necessary for the performance of this Contract.
- 9.1.13 **Background check.** Whenever the State deems it reasonably necessary for security reasons, the State may conduct, at its expense, criminal and driver-history background checks of Contractor's and its Subcontractor's officers, employees, or agents. Contractor or the Subcontractor shall reassign immediately any such individual who, in the opinion of the State, does not pass the background checks. At minimum, the Department will require background checks be conducted for Contractor's and Subcontractor's key personnel positions outlined in section 2.3, along with any individual in an Enrollee-facing, a Provider-facing, or a financial role.
- 9.1.14 **Applicable law.** This Contract shall be construed in accordance with, and is subject to, the laws and rules of the State of Illinois. The applicable provisions of the Department of Human Rights' equal-opportunity requirements (44 Ill. Adm. Code 750) are incorporated by reference. Any claim against the State arising out of this Contract must be filed exclusively with the Illinois Court of Claims (705 ILCS 505/1). The State shall not enter into binding arbitration to resolve any Contract dispute. The State does not waive sovereign immunity by entering into this Contract. The applicable provisions of the official text of cited statutes are incorporated by reference. In compliance with the Illinois and federal constitutions, the Illinois Human Rights Act, the US Civil Rights Act, and Section 504 of the federal Rehabilitation Act and other applicable laws and rules, the State does not unlawfully discriminate in employment, contracts, or any other activity.
- 9.1.15 **Anti-trust assignment.** If Contractor does not pursue any claim or cause of action it has arising under federal or State antitrust laws relating to the subject matter of the Contract, then upon request of the Illinois attorney general, Contractor shall assign to the State rights, title, and interest in and to the claim or cause of action.
- 9.1.16 **Contractual authority.** The agency that signs for the State shall be the only State entity responsible for performance and payment under the Contract.
- 9.1.17 **Notices.** Notices and other communications provided for herein shall be given in writing by first-class, registered, or certified mail, return receipt requested; by receipted hand delivery; by courier (UPS, Federal Express, or

other similar and reliable carrier); or by e-mail, fax, or other electronic means, showing the date and time of successful receipt as provided in sections 2.1.12 and 2.1.13. Except as otherwise provided herein, notices shall be sent to the Contract monitors set forth in Attachment XV using the contact information in Attachment XV. By giving notice, either Party may change the Contract monitor or the Contract monitor's contact information.

9.1.18 Modifications and survival. Amendments, modifications, and waivers must be in writing and signed by authorized representatives of the Parties. Any provision of this Contract officially declared void, unenforceable, or against public policy shall be ignored, and the remaining provisions shall be interpreted, as far as possible, to give effect to the Parties' intent. All provisions, including those set forth in section 8.3, that by their nature would be expected to survive, shall survive termination.

9.1.19 Performance record/suspension. Upon request of the State, Contractor shall meet to discuss performance or provide Contract performance updates to help ensure proper performance of the Contract. The State may consider Contractor's performance under this Contract and compliance with law and rule to determine whether to continue the Contract or suspend Contractor from doing future business with the State for a specified period of time, or to determine whether Contractor can be considered responsible on specific future contracting opportunities.

9.1.20 Freedom of Information Act. This Contract and all related public records maintained by, provided to, or required to be provided to the State are subject to FOIA notwithstanding any provision to the contrary that may be found in this Contract. If the Department receives a request for a record relating to Contractor under this Contract, Contractor's provision of services, or the arranging of the provision of services under this Contract, the Department shall provide notice to Contractor as soon as practicable. Within the period available under FOIA, Contractor may identify those records, or portions thereof, that it in good faith believes to be exempt from production and the justification for such exemption. The Department shall make good-faith efforts to notify Contractor regarding a request for a record that has been the subject of a previous request under FOIA.

9.1.21 Confidentiality of program-recipient information. Contractor shall ensure that all information, records, data, and data elements pertaining to applicants for and recipients of public assistance, or to Providers, facilities, and associations, shall be protected from unauthorized disclosure by Contractor and Contractor's employees, by Contractor's corporate Affiliates and their employees, and by Contractor's Subcontractors and their employees, pursuant to 305 ILCS 5/11-9, 11-10, and 11-12; 42 USC 654(26); 42 CFR §431, Subpart F; and 45 CFR §160 and 45 CFR §164, Subparts A and E. To the extent that Contractor, in the course of performing the Contract, serves as a business associate of the Department, as "business associate" is defined in the

HIPAA Privacy Rule (45 CFR §160.103), Contractor shall assist the Department in responding to the client as provided in the HIPAA Privacy Rule, and shall maintain for a period of six (6) years any records relevant to an individual's eligibility for services under the DHFS Medical Program.

9.1.22 **Nondiscrimination.** Contractor shall abide by all federal and State laws, regulations, and orders that prohibit discrimination because of race, color, religion, sex, sexual orientation, gender identity, national origin, ancestry, age, or physical or mental disability, including the Federal Civil Rights Act of 1964, the Americans with Disabilities Act of 1990, the Federal Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, the Illinois Human Rights Act, Executive Orders 11246 and 11375, and 42 CFR 438.3(d)(4).

9.1.22.1 Contractor further agrees to take affirmative action to ensure that no unlawful discrimination is committed in any manner, including the delivery of services under this Contract.

9.1.22.2 Contractor will not discriminate against Potential Enrollees, Prospective Enrollees, or Enrollees on the basis of health status or need for health services.

9.1.22.3 Contractor may not discriminate against any Provider who is acting within the scope of his/her licensure solely on the basis of that licensure or certification.

9.1.22.4 Contractor will provide each Provider or group of Providers whom it declines to include in its network written notice of the reason for its decision.

9.1.22.5 Contractor shall not discriminate against Providers that serve high-risk populations or that specialize in conditions that require costly treatment.

9.1.22.6 Nothing in sections 9.1.22.3, 9.1.22.4, or 9.1.22.5 may be construed to require Contractor to contract with Providers beyond the number necessary to meet the needs of its Enrollees; preclude Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or preclude Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to Enrollees.

9.1.23 **Child support.** Contractor shall ensure its employees who provide services under this contract are compliant with child support payments pursuant to a court or administrative order of this or any other State. Contractor will not be considered out of compliance with the requirements of this section 9.1.23 if,

upon request by the Department, Contractor provides:

- 9.1.23.1 proof of payment of past-due amounts in full;
- 9.1.23.2 proof that the alleged obligation of past-due amounts is being contested through appropriate court or administrative proceedings and Contractor provides proof of the pendency of such proceedings; or
- 9.1.23.3 proof of entry into payment arrangements acceptable to the appropriate State agency.

9.1.24 **Notice of change in circumstances.** In the event Contractor, Contractor's parent, or a related corporate entity becomes a party to any litigation, investigation, or transaction that may reasonably be considered to have a material impact on Contractor's ability to perform under this Contract, Contractor will immediately notify the Department in writing.

9.1.25 **Performance of services and duties.** Contractor shall perform all services and other duties as set forth in this Contract in accordance with, and subject to, applicable Administrative Rules and Department policies including rules and regulations that may be issued or promulgated from time to time during the term of this Contract. Contractor shall be provided copies of such upon Contractor's written request.

9.1.26 **Consultation.** Contractor shall promptly furnish the Department with copies of all correspondence and all documents prepared in connection with the services rendered under this Contract.

9.1.27 **Employee handbook.** Contractor shall require that its employees and Subcontractors who provide services under this Contract at a location controlled by the Department, or any other State agency, abide by applicable provisions of the Department's Employee Handbook.

9.1.28 **Disputes between Contractor and Third Parties.** Any dispute between Contractor and any Third Party, including any Subcontractor, shall be solely between such Third Party and Contractor, and the Department shall be held harmless by Contractor. Contractor agrees to assume all risk of loss and to indemnify and hold the Department and its officers, agents, and employees harmless from and against any and all liabilities, demands, claims, suits, losses, damages, causes of Adverse Benefit Determination, fines, or judgments, including costs, attorneys' and witnesses' fees, and expenses incident thereto, for Contractor's failure to pay any Subcontractor, either timely or at all, regardless of the reason.

9.1.29 **Fraud, Waste, Abuse, and financial misconduct.** In accordance with section 5.35, Contractor shall report in writing to the OIG any suspected Fraud, Waste, Abuse, or financial misconduct associated with any service or function provided for under this Contract by any parties directly or indirectly affiliated

with this Contract, including Contractor's staff, Contractor's Subcontractors, the Department's employees, and the Department's Contractors. Contractor shall make this report within three (3) days after first suspecting Fraud, Waste, Abuse, or financial misconduct. Contractor shall not conduct any investigation of the suspected Fraud, Abuse, or financial misconduct without the express concurrence of the OIG; the foregoing notwithstanding, Contractor may conduct and continue investigations necessary to determine whether reporting is required under this section 9.1.29. Contractor must report the results of such an investigation to the OIG. Contractor shall cooperate with all investigations of suspected Fraud, Waste, Abuse, or financial misconduct reported pursuant to this paragraph. Contractor shall require adherence with these requirements in any contracts it enters into with Subcontractors. Nothing in this section 9.1.29 precludes Contractor or Subcontractors from establishing measures to maintain quality of services and control costs that are consistent with their usual business practices, conducting themselves in accordance with their respective legal or contractual obligations, or taking internal personnel-related actions.

9.1.30 **Gifts.** Contractor must comply with all applicable State and federal statutes related to gifts. Contractor and Contractor's principals, employees, and Subcontractors are prohibited from giving gifts to Department employees, and from giving gifts to, or accepting gifts from, any Person who has a contemporaneous contract with the Department involving duties or obligations related to this Contract.

9.1.31 **Media relations and public information.** Subject to any disclosure obligations of Contractor under applicable law, rule, or regulation, including any open meeting and freedom of information obligations Contractor has as a governmental body, all information to be disseminated to the media or general public, such as news releases, responses to media inquiries, proactive media outreach, publications, presentations, technical papers, or other information pertaining to this Contract or the Illinois Medicaid Program shall be in coordination with and requires Prior Approval by the Department. The Parties shall work in good faith to resolve any differences they may have regarding a public disclosure to the media or general public. Contractor shall submit items to the Department for Prior Approval: (1) as soon as practicable when responding to a media inquiry, and (2) no later than two (2) Business Days in advance of public dissemination when communicating proactively.

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

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

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

9.1.33 For purposes under section 9.1 of this Contract, "excluded individual/entity" shall mean a Person who:

9.1.33.1 under Section 1128 of the Social Security Act, is or has been terminated, barred, suspended, or otherwise excluded from participation in, or as the result of a settlement agreement has voluntarily withdrawn from participation in, any program under federal law, including any program under Titles IV, XVIII, XIX, XX, or XXI of the Social Security Act;

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

9.1.33.3 has been convicted of a criminal offense related to the provision of items or services to a federal, State, or local government entity within the past ten (10) years.

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

9.1.35 **Termination for Breach of HIPAA requirements.** Contractor shall comply with the terms of the HIPAA requirements set forth in Attachment VI. Upon the Department's learning of a material Breach of the terms of the HIPAA requirements, the Department may take any or all of the following actions:

9.1.35.1 immediately terminate the Contract;

9.1.35.2 provide Contractor with an opportunity to cure the Breach or end the violation, and terminate the Contract if Contractor does not cure the Breach or end the violation within the time specified by the Department;

9.1.35.3 report the violation to the Secretary of the United States Department of Health and Human Services; and/or

9.1.35.4 require Contractor to pay all costs associated with the Breach, including costs of notifying all individuals affected by the Breach, costs associated with mitigating the Breach, and all fines and penalties.

9.1.36 **Retention of HIPAA records.** Contractor shall maintain, for a minimum of six (6) years, documentation of the protected health information disclosed by

Contractor, and all requests from individuals for access to records or amendment of records in accordance with 45 CFR §164.530(j).

9.1.37 **Sale or transfer.** Contractor shall provide the Department with the earliest possible advance notice of any sale or transfer of Contractor's business. The Department has the right to terminate this Contract upon notification of such sale or transfer.

9.1.38 **Third-Party liability (TPL)**

9.1.38.1 Contractor shall report any and all Third-Party liability collections it makes with Contractor's Encounter Data. Contractor shall report to the Department those Enrollees who Contractor discovers to have any Third-Party health insurance coverage.

9.1.38.2 Contractor shall assure that the Medicaid program is the payer of last resort for all Covered Services in accordance with federal regulations. Contractor shall exercise full assignment rights as applicable, shall actively seek and identify third party resources and shall be responsible for making every reasonable effort to determine the liability of Third Parties to pay for services rendered to Enrollees under this contract and to cost avoid (deny) and/or recover any such liability from the third party.

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

9.1.38.4 Contractor shall develop and implement policies and procedures to meet its obligations regarding TPL. Contractor shall designate a TPL Benefit Coordinator who shall serve as a contact person for Benefit Coordination issues related to this Contract and shall designate one or more recoveries specialist(s), whose function shall be to investigate and process all transactions related to the identification of TPL.

9.1.38.5 Clients determined by the Department to have high-level comprehensive TPL will be disenrolled from the Contractor prospectively. A client with non-comprehensive TPL that is not otherwise excluded is a Potential Enrollee.

- 9.1.38.6 Contractor shall provide all TPL data to any Provider having a claim denied by Contractor based upon TPL. This information shall be provided by the Contractor to the Provider at the time of claim denial.
- 9.1.38.7 If TPL exists for part or all of the services reimbursed by Contractor, Contractor shall make reasonable efforts to recover from the TPL sources the value of these services. Contractor may retain amounts it receives through Third-Party liability (TPL) collection activities up to the amount of claims paid or expenses incurred by Contractor, as permitted by law.
- 9.1.38.8 If TPL exists for part or all of the services provided to an Enrollee by a subcontractor or Provider, and the Third Party will make payment within a reasonable time, the Contractor may pay the subcontractor or Provider only the amount, if any, by which the allowable claim exceeds the amount of the TPL.
- 9.1.38.9 Contractor shall deny payment on a claim that has been denied by a Third Party payer when the reason for denial is the Provider or enrollee's failure to follow prescribed procedures, including prior authorization and timely filing.
- 9.1.38.10 Medicaid cost sharing and patient liability responsibilities, such as patient credit amounts for nursing facilities, shall not be considered TPL.
- 9.1.38.11 Contractor shall provide the Department any verified Third Party resource information in a format and media described by the Department and shall cooperate in any manner necessary, as requested by the Department, with Department cost recovery attempts.
- 9.1.38.12 Contractor shall implement procedures to determine if an Enrollee has other health insurance besides Medicaid, and identify other health insurance that may be obtained by an Enrollee using, at a minimum, the following sources: The 834 Daily File; Claims Activity, including diagnosis and trauma code editing to identify potential TPL or subrogation claims; Point of Service Investigation (Customer Service, Member Services and Utilization Management); and Any self-reported TPL information by an Enrollee.
- 9.1.38.13 If the Contractor also offers commercial policies or other Medicaid or Medicare products, the Contractor shall perform a data match within their own product enrollee lists. Contractor must ensure match includes an exact match on, at a minimum, name and date of birth. If an Enrollee is found to also be enrolled in the Contractor's other product, the Enrollee's information shall be sent to the Department. The Department shall verify the Enrollee's enrollment

and eligibility status and disenroll the Enrollee as appropriate.

9.1.38.14 The Department shall be solely responsible for estate recovery activities and shall retain any and all funds recovered through these activities.

9.1.39 **Subrogation.** If an Enrollee is injured by an act or omission of a Third Party, Contractor shall have the right to pursue subrogation and recover reimbursement from the Third Party for all Covered Services that Contractor provided to the Enrollee in exchange for the Capitation paid hereunder.

9.1.40 **Consent decrees.** Contractor shall consult and cooperate with the State in meeting any obligations the State may have under any consent decree, including the consent decrees entered in *Colbert v. Quinn*, No. 07 C 4735 (N.D. Ill.), and *Williams v. Quinn*, No. 05 C 4673 (N.D. Ill.). Contractor shall modify its business practices, as required by the State, in performing under the Contract in order for the State to comply with such consent decrees and, if necessary, enter into any amendments to the Contract. If compliance with section 9.1.40 necessitates the expenditure of additional material resources, then the Department will address adjustments of the Capitation rates as set forth in section 7.7.

9.1.41 **Loss of legal authority.** Should any part of the scope of work under this Contract relate to a State program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which federal CMS has withdrawn federal authority, or which is the subject of legislative repeal) Contractor must do no work on that part after the effective date of the loss of program authority. The Department must adjust payment of Capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. If Contractor works on a program or activity no longer authorized after the date the legal authority for the work ends, Contractor will not be paid for that work. If the Department paid Contractor in advance to work on a no-longer-authorized program or activity and under the terms of this Contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to the Department. However, if Contractor worked on a program or activity prior to the date the legal authority ended for that program or activity, and the Department included the cost of performing that work in its payments to Contractor, Contractor may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

9.2 CERTIFICATIONS

9.2.1 **General.** Contractor acknowledges and agrees that compliance with this section 9.2 and each subsection thereof is a material requirement and condition of this Contract, including renewals. By executing this Contract, Contractor certifies compliance, as applicable, with this section 9.2 and is under a continuing obligation to remain in compliance and report any noncompliance. This section 9.2 applies to Subcontractors used on this Contract. Contractor shall include these standard certifications in any subcontract used in the performance of the Contract using the standard subcontractor certification form provided by the State. If this Contract extends over multiple State Fiscal Years, including the initial term and all renewals, Contractor and its Subcontractors shall confirm compliance with this section 9.2 in the manner and format determined by the State by the date specified by the State and in no event later than July 1 of each year that this Contract remains in effect. If the Parties determine that any certification in this section 9.2 is not applicable to this Contract, it may be stricken without affecting the remaining subsections.

9.2.1.1 As part of each certification, Contractor acknowledges and agrees that if Contractor or its Subcontractors provide false information, or fail to be or remain in compliance with the standard certification requirements, one (1) or more of the sanctions listed below will apply. Identifying a sanction or failing to identify a sanction in relation to any of the specific certifications does not waive imposition of other sanctions or preclude application of sanctions not specifically identified. The following sanctions will apply:

9.2.1.1.1 the Contract may be void by operation of law;

9.2.1.1.2 the State may void the Contract; and

9.2.1.1.3 Contractor and its Subcontractors may be subject to one or more of the following: suspension, debarment, denial of payment, civil fine, or criminal penalty.

9.2.2 Contractor certifies that it and its employees will comply with applicable provisions of the US Civil Rights Act, Section 504 of the Federal Rehabilitation Act, the Americans with Disabilities Act (42 U.S.C. § 12101 *et seq.*) and applicable rules in performance under this Contract.

9.2.3 Contractor certifies that it is not in default on an educational loan (5 ILCS 385/3). This applies to individuals, sole proprietorships, partnerships, and individuals as members of LLCs.

9.2.4 Contractor (if an individual, sole proprietor, or partner, or an individual as member of a LLC) certifies that it has not received:

- 9.2.4.1 an early-retirement incentive prior to 1993 under Section 14-108.3 or 16-133.3 of the Illinois Pension Code, 40 ILCS 5/14-108.3 and 40 ILCS 5/16-133.3; or
- 9.2.4.2 an early-retirement incentive on or after 2002 under Section 14-108.3 or 16-133.3 of the Illinois Pension Code, 40 ILCS 5/14-108.3 and 40 ILCS 5/16-133, (30 ILCS 105/15a).
- 9.2.5 Contractor certifies that it is a properly formed and existing legal entity and, as applicable, has obtained an assumed-name certificate from the appropriate authority; or has registered to conduct business in Illinois and is in good standing with the Illinois secretary of state.
- 9.2.6 To the extent there was an incumbent Contractor providing the services covered by this Contract and the employees of that Contractor that provide those services are covered by a collective-bargaining agreement, Contractor certifies: (i) that it will offer to assume the collective-bargaining obligations of the prior employer, including any existing collective-bargaining agreement with the bargaining representative of any existing collective-bargaining unit or units performing substantially similar work to the services covered by the Contract subject to its bid or offer; and, (ii) that it shall offer employment to all employees currently employed in any existing bargaining unit performing substantially similar work that will be performed under this Contract (30 ILCS 500/25-80). This does not apply to heating, air conditioning, plumbing, and electrical service contracts. There is no incumbent Contractor contracted with the State that is providing the services covered by this Contract.
- 9.2.7 Contractor certifies that it has not been convicted of bribing or attempting to bribe an officer or employee of the State or any other state, nor has Contractor made an admission of guilt of such conduct that is a matter of record (30 ILCS 500/50-5).
- 9.2.8 If Contractor has been convicted of a felony, Contractor certifies at least five (5) years have passed after the date of completion of the sentence for such felony, unless no Person held responsible by a prosecutor's office for the facts upon which the conviction was based continues to have any involvement with the business (30 ILCS 500/50-10).
- 9.2.9 If Contractor or any officer, director, partner, or other managerial agent of Contractor has been convicted of a felony under the Sarbanes-Oxley Act of 2002, or a Class 3 or Class 2 felony under the Illinois Securities Law of 1953, Contractor certifies that at least five (5) years have passed since the date of the conviction. Contractor further certifies that it is not barred from being awarded a contract and acknowledges that the State shall declare the Contract void if this certification is false (30 ILCS 500/50-10.5).
- 9.2.10 Contractor certifies that it is not barred from having a contract with the State based on violating the prohibition on providing assistance to the State in

identifying a need for a contract (except as part of a public request for information process) or by reviewing, drafting, or preparing a solicitation or similar documents for the State (30 ILCS 500/50-10.5e).

- 9.2.11 Contractor certifies that it and its Affiliates are not delinquent in the payment of any debt to the State (or if delinquent has entered into a deferred-payment plan to pay the debt), and Contractor and its Affiliates acknowledge the State may declare the Contract void if this certification is false (30 ILCS 500/50-11) or if Contractor or an Affiliate later becomes delinquent and has not entered into a deferred-payment plan to pay off the debt (30 ILCS 500/50-60).
- 9.2.12 Contractor certifies that it and all Affiliates shall collect and remit Illinois use tax on all sales of tangible personal property into the State in accordance with provisions of the Illinois Use Tax Act (30 ILCS 500/50-12), and acknowledges that failure to comply can result in the Contract being declared void.
- 9.2.13 Contractor certifies that it has not been found by a court or the Pollution Control Board to have committed a willful or knowing violation of the Environmental Protection Act within the last five (5) years, and is therefore not barred from being awarded a contract (30 ILCS 500/50-14).
- 9.2.14 Contractor certifies that it has not paid any money or valuable thing to induce any person to refrain from bidding on a State contract, nor has Contractor accepted any money or other valuable thing, or acted upon the promise of same, for not bidding on a State contract (30 ILCS 500/50-25).
- 9.2.15 Contractor certifies that it is not in violation of the “revolving door” section of the Illinois Procurement Code (30 ILCS 500/50-30).
- 9.2.16 Contractor certifies that it has not retained a person to attempt to influence the outcome of a procurement decision for compensation contingent in whole or in part upon the decision or procurement (30 ILCS 500/50-38).
- 9.2.17 Contractor certifies that it will report to the Illinois attorney general and the chief procurement officer any suspected collusion or other anti-competitive practice among any bidders, offerors, Contractors, proposers, or employees of the State (30 ILCS 500/50-40, 50-45, 50-50).
- 9.2.18 In accordance with the Steel Products Procurement Act, Contractor certifies that steel products used or supplied in the performance of a contract for public works shall be manufactured or produced in the United States, unless the executive head of the procuring agency grants an exception (30 ILCS 565).
- 9.2.19 If Contractor employs twenty-five (25) or more employees and this Contract is worth more than US \$5,000, Contractor certifies that it will provide a drug-free workplace pursuant to the Drug-Free Workplace Act (30 ILCS 580).
- 9.2.20 Contractor certifies that neither Contractor nor any substantially owned

Affiliate is participating or shall participate in an international boycott in violation of the US Export Administration Act of 1979 or the applicable regulations of the US Department of Commerce. This applies to contracts that exceed US \$10,000 (30 ILCS 582).

- 9.2.21 Contractor certifies that it has not been convicted of the offense of bid rigging or bid rotating or any similar offense of any state or of the United States (720 ILCS 5/33E-3, E-4).
- 9.2.22 Contractor certifies that it complies with the Illinois Department of Human Rights Act and rules applicable to public contracts, including equal employment opportunity, refraining from unlawful discrimination, and having written sexual harassment policies (775 ILCS 5/2-105).
- 9.2.23 Contractor certifies that it does not pay dues, or reimburse or subsidize payments by its employees for any dues or fees, to any “discriminatory club” (775 ILCS 25/2).
- 9.2.24 Contractor certifies that it complies with the State Prohibition of Goods from the Forced Labor Act, and certifies that no foreign-made equipment, materials, or supplies furnished to the State under the Contract have been or will be produced in whole or in part by forced labor or indentured labor under penal sanction (30 ILCS 583).
- 9.2.25 Contractor certifies that no foreign-made equipment, materials, or supplies furnished to the State under this Contract have been produced in whole or in part by the labor of any child under the age of twelve (12) (30 ILCS 584).
- 9.2.26 Contractor certifies that it is not in violation of Section 50-14.5 of the Illinois Procurement Code (30 ILCS 500/50-14.5), which states: “Owners of residential buildings who have committed a willful or knowing violation of the Lead Poisoning Prevention Act (410 ILCS 45) are prohibited from doing business with the State until the violation is mitigated.”
- 9.2.27 Contractor warrants and certifies that it and, to the best of its knowledge, its subcontractors have complied and will comply with Executive Order No. 1 (2007). The order generally prohibits Contractors and subcontractors from hiring the then-serving governor’s family members to lobby procurement activities of the State, or any other unit of government in Illinois including local governments, if that procurement may result in a contract valued at more than US \$25,000. This prohibition also applies to hiring for that same purpose any former State employee who had procurement authority at any time during the one (1)-year period preceding the procurement-lobbying activity.
- 9.2.28 Contractor certifies that information technology, including electronic information, software, systems, and equipment, developed or provided under this Contract, will comply with the applicable requirements of the Illinois

Information Technology Accessibility Act Standards as published at www.dhs.state.il.us/iitaa (30 ILCS 587).

9.2.29 **Nonexclusion.** Contractor certifies that it is not currently barred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal or State department or agency, and is not currently barred or suspended from contracting with the State under Section 50-35(f), 50-35(g), or 50-65 of the Illinois Procurement Code, 30 ILCS 500/1-1 *et seq.*

9.2.29.1 If at any time during the term of this Contract, Contractor becomes barred, suspended, or excluded from participation in this transaction, Contractor shall, within thirty (30) days after becoming barred, suspended, or excluded, provide to the Department a written description of each offense causing the exclusion, the date(s) of the offense, the action(s) causing the offense(s), any penalty assessed or sentence imposed, and the date any penalty was paid or sentence complete.

9.2.30 **Conflict of interest.** In addition to any other provision in this Contract governing conflicts of interest, Contractor certifies that neither Contractor nor any party directly or indirectly affiliated with Contractor, including Contractor's officers, directors, employees, and subcontractors, and the officers, directors, and employees of Contractor's subcontractors, shall have or acquire any conflict of interest in performance of this Contract.

9.2.30.1 For purposes of this section 9.2.30, "conflict of interest" shall mean an interest of Contractor, or any entity described above, that may be direct or indirect, professional, personal, financial, or beneficial in nature; that, at the sole discretion of the Department, compromises, appears to compromise, or gives the appearance of impropriety with regard to Contractor's duties and responsibilities under this Contract. This term shall include potential conflicts of interest. A conflict of interest may exist even if no unethical or improper act results from it, or may arise where Contractor becomes a party to any litigation, investigation, or transaction that materially affects Contractor's ability to perform under this Contract. Any situation in which Contractor's role under the Contract competes with Contractor's professional or personal role may give rise to an appearance of impropriety. Any conduct that would lead a reasonable individual, knowing all the circumstances, to a conclusion that bias may exist or that improper conduct may occur, or that gives the appearance of the existence of bias or improper conduct, is a conflict of interest.

9.2.30.2 Contractor shall disclose in writing any conflicts of interest to the Department no later than seven (7) days after learning of the conflict of interest. The Department may initiate any inquiry as to the

existence of a conflict of interest. Contractor shall cooperate with all inquiries initiated pursuant to this section 9.2.30. Contractor shall have an opportunity to discuss the conflict of interest with the Department and suggest a remedy under this section 9.2.30.

9.2.30.3 Notwithstanding any other provisions in this Contract, the Department shall, at its sole discretion, determine whether a conflict of interest exists or whether Contractor failed to make any required disclosure. This determination shall not be subject to appeal by Contractor. If the Department concludes that a conflict of interest exists, or that Contractor failed to disclose any conflict of interest, the Department may impose one or more remedies, as set forth below.

9.2.30.4 The appropriate remedy for a conflict of interest shall be determined at the sole discretion of the Department and shall not be subject to appeal by Contractor. Available remedies shall include the elimination of the conflict of interest or the nonrenewal or termination of the Contract.

9.2.31 **Clean Air Act and Clean Water Act.** Contractor certifies that it is compliant with all applicable standards, orders, or regulations issued pursuant to the federal Clean Air Act (42 U.S.C. 7401 *et seq.*) and the federal Water Pollution Control Act (33 U.S.C. 1251 *et seq.*). Violations shall be reported to the DHHS and the appropriate regional office of the United States Environmental Protection Agency.

9.2.32 **Lobbying.** Contractor certifies that, to the best of its knowledge and belief, no federally appropriated funds have been paid or will be paid by or on behalf of Contractor to any Person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal loan or grant, or the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

9.2.32.1 If any funds other than federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with this federal contract, grant, loan, or cooperative agreement, Contractor shall complete and submit Standard Form LLL, "Disclosure Forms to Report Lobbying," in accordance with its instructions. Such form is to be obtained at Contractor's request from the Department's Bureau of Fiscal Operations.

9.2.32.2 Contractor shall require that the language of this certification be included in the award document for sub-awards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

9.2.32.3 This certification is a material representation of fact upon which reliance was placed when this contract was executed. Submission of this certification is a prerequisite for making or entering into the transaction imposed by Section 1352, Title 31, US Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than US \$10,000 and not more than US \$100,000 for each such failure.

9.2.33 **Drug-free workplace certification.** Contractor certifies that it has accurately completed the certification on Attachment V.

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

9.2.34.1 the name, federal employer identification number, and address of each Person with Ownership or a Controlling Interest in Contractor; for individuals, include home address, work address, date of birth, Social Security number, and gender;

9.2.34.2 whether any of the individuals so identified are related to another so identified as the individual's spouse, child, brother, sister, or parent;

9.2.34.3 the name of any Person with Ownership or a Controlling Interest in Contractor who also is a Person with Ownership or a Controlling Interest in another MCO that has a contract with the Department to furnish services under the DHFS Medical Program, and the name or names of the other MCO;

9.2.34.4 the name and address of any Person with Ownership or a Controlling Interest in Contractor or an agent or employee of Contractor who has been convicted of a criminal offense related to the involvement of that Person with Ownership or a Controlling Interest in any program under federal law, including any program under Titles XVIII, XIX, XX, or XXI of the Social Security Act, since the inception of such programs;

9.2.34.5 whether any Person identified in sections 0, 0, 0, and 0 is currently terminated, suspended, barred, or otherwise excluded from

participation in, or has voluntarily withdrawn from as the result of a settlement agreement, any program under federal law including any program under Titles XVIII, XIX, XX, or XXI of the Social Security Act, or has within the past five (5) years been reinstated to participation in any program under federal law including any program under Titles XVIII, XIX, XX, or XXI of the Social Security Act and prior to said reinstatement had been terminated, suspended, barred, or otherwise excluded from participation in, or has voluntarily withdrawn from, as the result to a settlement agreement, such programs; and

9.2.34.6 whether the medical director of the plan is a Person with Ownership or a Controlling Interest.

9.2.35 Contractor certifies it is a “covered entity” as defined at 45 CFR 160.103.

IN WITNESS WHEREOF, the Department and Contractor hereby execute and deliver this Contract, #2018-24-001 **[MCO]**, effective as of the Effective Date. This Contract may be executed in one or more counterparts, each of which shall be considered to be one and the same agreement, binding on all Parties hereto, notwithstanding that all Parties are not signatories to the same counterpart. Duplicated signatures, signatures transmitted via facsimile, or signatures contained in a Portable Document Format (PDF) document shall be deemed original for all purposes.

CONTRACTOR

STATE OF ILLINOIS

[MCO]

Department of Healthcare and Family Services

By: _____
Authorized Representative

By: _____
Director

Printed Name

Title

Date: _____

Date: _____

Address: _____

Address: _____

201 South Grand Avenue East

Springfield, IL 62763-0002

FEIN: _____

Phone: 217-782-1200

Phone: _____

Fax: _____

Fax: 217-524-7979

E-mail: _____

E-mail: HFS.Director@illinois.gov

ATTACHMENTS

- I. Service Package II Covered Services and MLTSS Covered Services
- II. Contracting Areas and Potential Enrollees
- III. *<Intentionally left blank>*
- IV. Rate Sheet
- V. State of Illinois Drug-free Workplace Certification
- VI. HIPAA Requirements
 - A. Exhibit A: Notification of Unauthorized Access, Use, or Disclosure
- VII. Addendum to BEP Requirements *<Intentionally left blank>*
- VIII. Taxpayer Identification Number
- IX. Disclosures of Conflicts of Interest
- X. Public Act 95-971
- XI. Quality Assurance
 - A. Table 1: Healthcare and Quality of Life Performance Measures
 - B. Table 2: Service Package II HCBS Waiver Performance Measures
- XII. Utilization Review and Peer Review
- XIII. Required Deliverables, Submission, and Reports
- XIV. Data Security and Connectivity Specifications
- XV. Contract Monitors
- XVI. Qualifications and Training Requirements of Certain Care Coordinators and Other Care Professionals
- XVII. Illinois Department of Human Services, Division of Rehabilitative Services, Critical Incident Definitions
- XVIII. Illinois Department on Aging Elder Abuse and Neglect Program
- XIX. Illinois Department of Healthcare and Family Services Incident Reporting for Supportive Living Facilities
- XX. Individual Provider Payment Policy
- XXI. Required Minimum Standards of Care
- XXII. High-Needs Children Care Coordination Requirements
- XXIII. *<Intentionally left blank>*
- XXIV. Requirements Specific To DCFS Youth in Care Enrollees
- XXV. 42 CFR 438.6(c) State-Directed Payment (SDP) Descriptions

ADDENDUM #1 - IMMIGRANT ADULTS & IMMIGRANT SENIORS POPULATIONS

ATTACHMENT I: SERVICE PACKAGE II COVERED SERVICES AND MLTSS 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.	DOA: 89 Il.Adm.Code 240.1505-1590 Contract with DoA, Contract requirements, DRS: 89 Il.Adm.Code 686.100	DOA, DRS The amount, duration, and scope of services is based on the service plan and is included in the service cost maximum/monthly cost limit. This service will not be duplicative of other services in the HCBS Waiver.
Adult Day Service Transportation	x	x	x	x				DOA: 89 Il.Adm.Code 240.1505-1590 DRS: 89 Il.Adm.Code 686.100	No more than two (2) units of transportation shall be provided per MFP Enrollee in a twenty-four (24)-hour period, and shall not include trips to a Physician, shopping, or other miscellaneous trips.
Environmental Accessibility Adaptations-- Home		x	x	x			Those physical adaptations to the home, required by the Enrollee Care Plan, which are necessary to ensure the health, welfare, and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require Institutionalization. Excluded are those adaptations or improvements to the home that are of general utility and are not of direct remedial benefit to the Enrollee.	DRS: 89 Il.Adm.Code 686.608 DSCC: DSCC Home Care Manual, 53.20.30, (Rev.9/01) &53.43 (Rev.9/01)	DRS: The cost of environmental modification, when amortized over a twelve (12)-month period and added to all other monthly service costs, may not exceed the service cost maximum.

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			
Supported Employment				x			Supported employment services consist of intensive, ongoing supports that enable an Enrollee for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of the Enrollee's disabilities, needs supports, to perform in a regular work setting. It may include assisting the Enrollee to locate a job or develop a job on behalf of the Enrollee, and is conducted in a variety of settings; including work sites where persons without disabilities are employed.	DHS: 89 Il.Adm.Code 530 89 Il.Admin.Code 686.1400	BI: When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by Enrollees receiving HCBS Waiver services as a result of their disabilities and will not include payment for the supervisory activities rendered as a normal part of the business setting. The amount, duration, and scope of services are based on the determination of need (DON) assessment conducted by the case manager and the service cost maximum determined by the DON score.
Home Health Aide		x	x	x			Service provided by an individual that meets Illinois licensure standards for a Certified Nursing Assistant (CNA) and provides services as defined in 42C.F.R. 440.70, with the exception that limitations on the amount, duration, and scope of such services imposed by the State's approved Medicaid State Plan shall not be applicable.	DRS: Individual: 210 ILCS 45/3-206 Agency: 210 ILCS 55	Services provided are in addition to any services provided through the State Plan. The amount, duration, and scope of services are based on the DON assessment conducted by the case manager and the service cost maximum determined by the DON.

Service	DoA	DHS-DRS				HFS	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			
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 habilitative needs rather than short-term acute restorative needs. HCBS Waiver intermittent nursing services are in addition to any Medicaid State Plan nursing services for which the Enrollee may qualify.</p>	<p>DRS: Home Health Agency: 210 ILCS 55 Licensed Practical Nurse: 225 ILCS 65 Registered nurse: 225 ILCS 65</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>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: 210 ILCS 55 Licensed Practical nurse: 225 ILCS 65 Registered nurse: 225 ILCS 65</p>	<p>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>
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 habilitative needs rather than short-term acute restorative needs.</p>	<p>DRS: Occupational Therapist: 225 ILCS 75 Home Health Agency: 210 ILCS 55</p>	<p>DRS: 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>

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			
Physical Therapy		x	x	x			Service provided by a licensed physical therapist that meets Illinois standards. Services are in addition to any Medicaid State Plan services for which the Enrollee may qualify. Physical Therapy through the HCBS Waiver focuses on long-term habilitative needs rather than short-term acute restorative needs.	DRS: Physical Therapist 225 ILCS 90 Home Health Agency: 210 ILCS 55	DRS: All HCBS Waiver clinical services require a prescription from a Physician. The duration and/or frequency of these services are dependent on continued authorization of the Physician, and relevance to the Enrollee's service plan. The amount, duration, and scope of services is based on the service plan and is included in the service cost maximum.
Speech Therapy		x	x	x			Service provided by a licensed speech therapist that meets Illinois standards. Services are in addition to any Medicaid State Plan services for which the Enrollee may qualify. Speech Therapy through the HCBS Waiver focuses on long-term habilitation needs rather than short-term acute restorative needs.	DRS: Speech Therapist 225 ILCS 110 Home Health Agency: 210 ILCS 55	DRS: All HCBS Waiver clinical services require a prescription from a Physician. The duration and/or frequency of these services are dependent on continued authorization of the Physician, and relevance to the Enrollee's service plan. The amount, duration, and scope of services is based on the service plan and is included in the service cost maximum.
Prevocational Services				x			Prevocational services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. This can include teaching concepts such as compliance, attendance, task completion, problem solving, and safety. Prevocational services are provided to persons expected to be able to join the general workforce or participate in a transitional sheltered workshop within one (1) year (excluding supported employment programs).	89 Il.Adm.Code 530 89 il Admin Code 686.1300	The amount, duration, and scope of services are based on the DON assessment conducted by the case manager and the service cost maximum determined by the DON score. All prevocational services will be reflected in the Enrollee Care Plan as directed to habilitative, rather than explicit employment objectives.

Service	DoA	DHS-DRS				HFS	Definition	Standards	HFS Fee-For-Service Service Limits
	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury		Supportive Living Facility			
Habilitation-Day				x			<p>BI: Day habilitation assists with the acquisition, retention, or improvement in self-help, socialization, and adaptive skills, which takes place in a nonresidential setting, separate from the home or facility in which the individual resides. The focus is to enable the individual to attain or maintain his or her maximum functional level. Day habilitation shall be coordinated with any physical, occupational, or speech therapies listed in the Enrollee Care Plan. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.</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. 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>
Placement Maintenance Counseling							<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>Licensed Clinical Social Worker 225 ILCS 20 Medicaid Rehabilitation Option 59 Il.Adm.Code 132 Licensed Clinical Psychologist 225 ILCS 15</p>	<p>Services will require preauthorization by HFS and will be limited to a maximum of twelve (12) sessions per calendar year.</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: 89 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	DoA	DHS-DRS				HFS	Definition	Standards	HFS Fee-For-Service Service Limits
	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury		Supportive Living Facility			
Home Delivered Meals		x	x	x			Prepared food brought to the client's residence that may consist of a heated luncheon meal and/or a dinner meal which can be refrigerated and eaten later. This service is designed primarily for the client who cannot prepare his/her own meals but is able to feed him/herself.	89 Il. Adm. Code 686.500	The amount, duration, and scope of services is based on the determination of need assessment conducted by the case manager and the service cost maximum. This service will be provided as described in the service plan and will not duplicate any other services.
Individual Provider (contingent upon compliance with collective bargaining agreement and accompanying side letter between SEIU and the State.)		x	x	x			Individual Providers provide assistance with eating, bathing, personal hygiene, and other activities of daily living in the home and at work (if applicable). When specified in the Enrollee Care Plan, this service may also include such housekeeping chores as bed making, dusting, vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the consumer, rather than the consumer's family. Personal Care Providers must meet State standards for this service. The Individual Provider is the employee of the consumer. The State acts as fiscal agent for the Enrollee.	89 Il. Adm. Code 686.10	The amount, duration, and scope of services is based on the DON assessment conducted by the case manager and the service cost maximum as determined by the DON score. These services may include assistance with preparation of meals, but does not include the cost of the meals themselves. Personal Care will only be provided when it has been determined by the case manager that the consumer has the ability to supervise the Personal Care Provider and the service is not otherwise covered.
Personal Emergency Response System (PERS)	x	x	x	x			PERS is an electronic device that enables certain individuals at high risk of Institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the individual's phone and programmed to signal a response center once a "help" button is activated. Trained professionals staff the response center.	DOA: Standards for Emergency Home Response 89 Il. Adm. Code 240 DRS: 89 Il. Adm. Code 686.300	PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

Service	DoA	DHS-DRS				HFS	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			
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 Dare 89 Il. Adm.Code 686.100 Home health aide 210 ILCS 45/3-206 RN/LPN 225 ILCS 65 Home health agency: 210 ILCS 55 Homemaker 89 Il. Adm.Code 686.200 PA 89 Il. Adm.Code 686.10 DSCC: Healthcare center 77 Il. Adm.Code 260 Nursing agency: Meet DSCC nursing agency requirements-DSCC Home Care Manual, 53.09</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	Definition	Standards	HFS Fee-For-Service Service Limits
	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury		Supportive Living Facility			
Specialized Medical Equipment and Supplies		x	x	x			<p>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> <p>DRS: 68 Il. Adm. Code 1253 Pharmacies 225.ILCS.85 Medical Supplies 225.ILCS.51 DSCC: 225.ILCS.51 If not licensed under 225 ILCS 51, must be accredited by the Joint Commission on Accreditation of Healthcare Organizations, or other accrediting organization.</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>	

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			
Behavioral Services (MA and PhD)				x			Behavioral Services provide remedial therapies to decrease maladaptive behaviors and/or to enhance the cognitive functioning of the recipient. These services are designed to assist Enrollees in managing their behavior and cognitive functioning and to enhance their capacity for independent living.	Speech Therapist 225 ILCS 110/ Social Worker 225 ILCS 20/ Clinical Psychologist 225 ILCS 15/ Licensed Counselor 225 ILCS 107/ 89 IL Admin Code 686.1100	The amount, duration, and scope of services are based on the DON assessment conducted by the case manager and the service cost maximum determined by the DON score. The services are based on a clinical recommendation and are not covered under the State Plan.
Assisted Living						x	The Supportive Living Program serves as an alternative to Nursing Facility (NF) placement, providing an option for seniors sixty-five (65) years of age or older and persons with physical disabilities between twenty-two (22) and sixty-four (64) years of age who require assistance with activities of daily living, but not the full medical model available through a Nursing Facility. Enrollees reside in their own private apartments with kitchen or kitchenette, private bath, individual heating and cooling system, and lockable entrance. Supportive Living Facilities (SLFs) are required to meet the scheduled and unscheduled needs of Residents twenty-four (24) hours a day.	Supportive Living Facilities 89 IL Adm.Code 146 SupPart B	SLFs are reimbursed through a global rate, which includes the following Covered Services: <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

MLTSS COVERED SERVICES

Category of service	Definition	MLTSS coverage
001	Physician Services	EXCLUDED
002	Dental Services	EXCLUDED
003	Optometric Services	EXCLUDED
004	Podiatric Services	EXCLUDED
005	Chiropractic Services	EXCLUDED
006	Physicians Psychiatric Services	EXCLUDED
007	Development Therapy, Orientation and Mobility Services (Waivers)	EXCLUDED
008	DSCC Counseling/Fragile Children	EXCLUDED
009	DCFS Rehab Option Services	EXCLUDED
010	Nursing service	EXCLUDED
011	Physical Therapy Services	EXCLUDED
012	Occupational Therapy Services	EXCLUDED
013	Speech Therapy/Pathology Services	EXCLUDED
014	Audiology Services	EXCLUDED
015	Sitter Services	EXCLUDED
016	Home Health Aides	EXCLUDED
017	Anesthesia Services	EXCLUDED
018	Midwife Services	EXCLUDED
019	Genetic Counseling	EXCLUDED
020	Inpatient Hospital Services (General)	EXCLUDED
021	Inpatient Hospital Services (Psychiatric)	EXCLUDED
022	Inpatient Hospital Services (Physical Rehabilitation)	EXCLUDED
023	Inpatient Hospital Services (ESRD)	EXCLUDED
024	Outpatient Services (General)	EXCLUDED
025	Outpatient Services (ESRD)	EXCLUDED
026	General Clinic Services	EXCLUDED
027	Psychiatric Clinic Services (Type 'A')	EXCLUDED
028	Psychiatric Clinic Services (Type 'B')	EXCLUDED
029	Clinic Services (Physical Rehabilitation)	EXCLUDED
030	Healthy Kids Services	EXCLUDED
031	Early Intervention Services	EXCLUDED
032	Environmental modifications (waiver)	EXCLUDED
033	Mental Health Clinic Option Services	EXCLUDED
034	Mental Health Rehab Option Services	COVERED SERVICE
035	Alcohol and Substance Abuse Rehab. Services	COVERED SERVICE
036	Juvenile Rehabilitation	EXCLUDED
037	Skilled Care - Hospital Residing	EXCLUDED
038	Exceptional Care	COVERED SERVICE
039	DD/MI Non-Acute Care - Hospital Residing	EXCLUDED
040	Pharmacy Services (Drug and OTC)	EXCLUDED
041	Medical equipment/prosthetic devices	EXCLUDED
042	Family planning service	EXCLUDED
043	Clinical Laboratory Services	EXCLUDED
044	Portable X-Ray Services	EXCLUDED
045	Optical Supplies	EXCLUDED

046	Psychiatric Drugs	EXCLUDED
047	Targeted case management service (mental health)	COVERED SERVICE
048	Medical Supplies	EXCLUDED
049	DCFS Targeted Case Management Services	EXCLUDED
050	Emergency Ambulance Transportation	EXCLUDED
051	Non-Emergency Ambulance Transportation	COVERED SERVICE
052	Medicar Transportation	COVERED SERVICE
053	Taxicab Services	COVERED SERVICE
054	Service Car	COVERED SERVICE
055	Auto transportation (private)	COVERED SERVICE
056	Other Transportation	COVERED SERVICE
057	Nurse Practitioners Services	EXCLUDED
058	Social work service	COVERED SERVICE
059	Psychologist service	COVERED SERVICE
060 *	Home Care [*Hospice room and board (revenue code D0658) is covered]	EXCLUDED *
061	General Inpatient	EXCLUDED
062	Continuous Care Nursing	EXCLUDED
063	Respite Care	EXCLUDED
064	Other Behavioral Health Services	COVERED SERVICE
065	LTC Full Medicare Coverage	EXCLUDED
066	Home Health Services	EXCLUDED
067	All Kids application agent (valid on provider file only)	EXCLUDED
068	Targeted case management service (early intervention)	EXCLUDED
069	Subacute Care Program	EXCLUDED
070	LTC - Skilled	COVERED SERVICE
071	LTC - Intermediate	COVERED SERVICE
072	LTC--NF skilled (partial Medicare coverage)	EXCLUDED
073	LTC--ICF/MR	EXCLUDED
074	LTC--ICF/MR skilled pediatric	EXCLUDED
075	LTC - MI Recipient age 21-64	COVERED
076	LTC - Specialized Living Center - Intermediate MR	EXCLUDED
077	SOPF--MI recipient over 64 years of age	COVERED
078	SOPF--MI recipient under 22 years of age	COVERED
079	SOPF--MI recipient non-matchable	COVERED
080	Rehabilitation option service (special LEA service)	EXCLUDED
081	Capitation Services	EXCLUDED
082	LTC--Developmental training (level I)	EXCLUDED
083	LTC--Developmental training (level II)	EXCLUDED
084	LTC--Developmental training (level III)	EXCLUDED
085	LTC - Recipient 22-64 in IMD not MI or MR	COVERED SERVICE
086	LTC SLF Dementia Care	COVERED SERVICE
087	LTC - Supportive Living Facility (Waivers)	COVERED SERVICE
088	Licensed Clinical Professional Counselor (LCPC)	COVERED SERVICE
089	LTC - MR Recipient - Inappropriately Placed	EXCLUDED
090	Case Management	EXCLUDED
091	Homemaker	COVERED SERVICE
092	Agency Providers RN, LPN, CNA and Therapies	COVERED SERVICE
093	Individual Providers PA, RN, LPN, CNA and Therapies	COVERED SERVICE
094	Adult Day Health	COVERED SERVICE
095	Habilitation Services	COVERED SERVICE

096	Respite Care	COVERED SERVICE
097	Other HCFA Approved Services	COVERED SERVICE
098	Electronic Home Response/EHR Installation (MARS), MPE Certification (Provider), Automated Medication Dispenser	COVERED SERVICE
099	Transplants	EXCLUDED
100	Genetic counseling	EXCLUDED
102	Fluoride varnish	EXCLUDED
106	Methadone Medication Assistance	COVERED SERVICE
117	Medical Assisted Transport	COVERED SERVICE

ATTACHMENT II: CONTRACTING AREAS AND POTENTIAL ENROLLEES

<p>Contracting Areas</p>	<p>There are nineteen (19) Urban Areas in Illinois and eighty-three (83) Rural Areas. Urban Area counties are highlighted in bold below.</p> <p>Statewide: Adams, Alexander, Bond, Boone, Brown, Bureau, Calhoun, Carroll, Cass, Champaign, Christian, Clark, Clay, Clinton, Coles, Cook, Crawford, Cumberland, DeKalb, DeWitt, Douglas, Dupage, Edgar, Edwards, Effingham, Fayette, Ford, Franklin, Fulton, Gallatin, Greene, Grundy, Hamilton, Hancock, Hardin, Henderson, Henry, Iroquois, Jackson, Jasper, Jefferson, Jersey, Jo Daviess, Johnson, Kane, Kankakee, Kendall, Knox, Lake, LaSalle, Lawrence, Lee, Livingston, Logan, Macon, Macoupin, Madison, Marion, Marshall, Mason, Massac, McDonough, McHenry, McLean, Menard, Mercer, Monroe, Montgomery, Morgan, Moultrie, Ogle, Peoria, Perry, Piatt, Pike, Pope, Pulaski, Putnam, Randolph, Richland, Rock Island, Saline, Sangamon, Schuyler, Scott, Shelby, St. Clair, Stark, Stephenson, Tazewell, Union, Vermilion, Wabash, Warren, Washington, Wayne, White, Whiteside, Will, Williamson, Winnebago, Woodford</p> <p>http://www.icaahn.org/files/Rural_Health_Clinic/Rural_urban_counties.pdf</p>
<p>Potential Enrollees</p>	<p>Potential Enrollees include: families and children eligible for Medicaid through Title XIX or Title XXI (Children’s Health Insurance Program); Affordable Care Act expansion Medicaid-eligible adults; Medicaid-eligible adults with disabilities who are not eligible for Medicare; Medicaid-eligible older adults who are not eligible for Medicare; Dual-Eligible Adults receiving long-term services and supports (LTSS) in an institutional care setting or through an HCBS waiver; and Special Needs Children. Members excluded from the scope of this Contract are as follows:</p> <ul style="list-style-type: none"> • Dual-Eligible Adults enrolled in MMAI; • Dual-Eligible Adults not receiving nursing facility or waiver services; • Participants who are American Indian/Alaskan Natives unless they voluntarily enroll in an MCO; • Premium Level 2, effective January 1, 2018 through September 30, 2022; • Participants only eligible with a Spend-Down; • All Presumptive Eligibility categories; • Participants who are incarcerated in a county jail, Illinois Department of Corrections facility, or federal penal institution; • Participants in a hospital receiving inpatient psychiatric services as a result of a forensic commitment; • Participants enrolled in partial/limited benefits programs; and, • Participants with comprehensive third-party insurance.

ATTACHMENT III

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Attachment IV Rate Sheet

[MCO NAME HERE]

Rate Cell Regions	Region 1 – Northwestern Illinois Region 2 – Central Illinois Region 3 – Southern Illinois Region 4 – Cook County Region 5 – Collar Counties
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Affordable Care Act (ACA) Expansion Adults Rates Effective January 1, 2018 through December 31, 2018

ACA Adults	Region 1 Rate	Region 2 Rate	Region 3 Rate	Region 4 Rate	Region 5 Rate
Female 19-24 Years Old					
Male 19-24 Years Old					
Female 25-34 Years Old					
Male 25-34 Years Old					
Female 35-44 Years Old					
Male 35-44 Years Old					
Female 45-54 Years Old					
Male 45-54 Years Old					
Female 55-64 Years Old					
Male 55-64 Years Old					

Non-Disabled Children and Adults (NDCA) Rates Effective January 1, 2018 through December 31, 2018

NDCA	Region 1 Rate	Region 2 Rate	Region 3 Rate	Region 4 Rate	Region 5 Rate
0 thru 3 months					
4 thru 23 months					
2 thru 5 Years Old					
6 thru 13 Years Old					
14 thru 20 Years Old-Female					
14 thru 20 Years Old-Male					

21thru 44 Years Old-Female					
21 thru 44 Years Old-Male					
45+Years Old(Male&Female)					

**Special Needs Children (SNC)
Rates Effective January 1, 2018 through December 31, 2018**

SNC	Region 1 Rate	Region 2 Rate	Region 3 Rate	Region 4 Rate	Region 5 Rate

**Disabled Adults (DA) - Service Package I (SPI)
Rates Effective January 1, 2018 through December 31, 2018**

DA-SPI	Region 1 Rate	Region 2 Rate	Region 3 Rate	Region 4 Rate	Region 5 Rate
Community Residents					
HCBS DD Waiver					
ICFDD					
Nursing Facility					
HCBS Other Waivers					
State Operated Facility					

**Disabled Adults (DA) - Service Package II (SPII)
Rates Effective January 1, 2018 through December 31, 2018**

DA-SPII - Blended	Region 1 Rate	Region 2 Rate	Region 3 Rate	Region 4 Rate	Region 5 Rate

**Managed Long Term Services and Supports (MLTSS)
Rates Effective January 1, 2018 through December 31, 2018**

MLTSS	Region 1 Rate	Region 2 Rate	Region 3 Rate	Region 4 Rate	Region 5 Rate
21 thru 64 Years Old					
65+ Years Old					

**State Only IMD*
Rates Effective January 1, 2018 through December 31, 2018**

State Only IMD	Region 1 Rate	Region 2 Rate	Region 3 Rate	Region 4 Rate	Region 5 Rate

ATTACHMENT V: STATE OF ILLINOIS DRUG-FREE WORKPLACE CERTIFICATION

Contractor certifies that it will not engage in the unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance in the performance of the Agreement.

This business or corporation has twenty-five (25) or more employees, and Contractor certifies and agrees that it will provide a drug-free workplace by:

- A) Publishing a statement:
 - 1) Notifying employees that the unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance, including cannabis, is prohibited in the grantee's or Contractor's workplace.
 - 2) Specifying the actions that will be taken against employees for violations of such prohibition.
 - 3) Notifying the employees that, as a condition of employment on such contract, the employee will:
 - a) abide by the terms of the statement; and
 - b) notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five (5) days after such conviction.

- B) Establishing a drug free awareness program to inform employees about:
 - 1) the dangers of drug abuse in the workplace;
 - 2) Contractor's policy of maintaining a drug-free workplace;
 - 3) any available drug counseling, rehabilitation, and employee-assistance programs; and
 - 4) the penalties that may be imposed upon an employee for drug violations.

- C) Providing a copy of the statement required by subparagraph (a) to each employee engaged in the performance of the contract or grant and to post the statement in a prominent place in the workplace.

- D) Notifying the contracting or granting agency within ten (10) days after receiving notice under part (B) or paragraph (3) of subsection (a) above from an employee or otherwise receiving actual notice of such conviction.

- E) Imposing a sanction on, or requiring the satisfactory participation in, a drug-abuse assistance or rehabilitation program by any employee who is so convicted, as required by section 5 of the Drug Free Workplace Act, 1992 Illinois Compiled Statute, 30 ILCS 580/5.

- F) Assisting employees in selecting a course of action in the event drug counseling, treatment, and rehabilitation is required and indicating that a trained referral team is in place.

- G) Making a good faith effort to continue to maintain a drug free workplace through implementation of the Drug Free Workplace Act, 1992 Illinois Compiled Statute, 30 ILCS 580/1 *et seq.*

THE UNDERSIGNED AFFIRMS, UNDER PENALTIES OF PERJURY, THAT HE OR SHE IS AUTHORIZED TO EXECUTE THIS CERTIFICATION ON BEHALF OF CONTRACTOR.

Signature of authorized representative

2018-24-001

Contract ID number

Printed name and title

Date

ATTACHMENT VI: HIPAA REQUIREMENTS

1.1 DEFINITIONS

Capitalized terms used in this Attachment shall have the following meanings:

- 1.1.1 **Breach** shall have the same meaning as set forth in 45 CFR 164.402.
- 1.1.2 **Contract** shall mean the Contract between the Department and [MCO NAME HERE] [2018-24-001].
- 1.1.3 **Contractor** shall mean [MCO NAME HERE].
- 1.1.4 **Department** shall mean the Illinois Department of Healthcare and Family Services (HFS).
- 1.1.5 **Designated Record Set** shall have the same meaning as set forth in 45 CFR Section 164.501.
- 1.1.6 **HIPAA Rules** shall mean the “HIPAA Administrative Simplification,” 45 CFR Parts 160, 162, and 164, and shall include any amendments thereto.
- 1.1.7 **Individual** shall have the same meaning as set forth in 45 CFR Section 160.103, and shall include a person who qualifies as a personal representative in accordance with 45 CFR Section 164.502(g).
- 1.1.8 **Privacy Rule** shall mean the Standards for Privacy of Individually Identifiable Health Information set forth in 45 CFR Part 160 Subpart A and 45 CFR Part 164 subparts A and E.
- 1.1.9 **Protected Health Information (PHI)** shall have the same meaning as set forth in 45 CFR Section 160.103, and is limited to the information received from the Department, or created, maintained, or received by Contractor on behalf of the Department, in connection with Contractor’s performance of the Services.
- 1.1.10 **Required by Law** shall have the same meaning as set forth in 45 CFR Section 164.103.
- 1.1.11 **Services** shall mean the duties or obligations described in the Contract to be performed by Contractor for the Department.
- 1.1.12 **Unsecured PHI** shall have the same meaning as set forth in 45 CFR 164.402.

All other terms used herein shall have the meaning ascribed to them in the HIPAA Rules.

1.2 CONTRACTOR’S OBLIGATIONS AND ACTIVITIES

Contractor shall:

- 1.2.1 not use or disclose PHI other than as permitted or required by the Contract, by this Attachment, or as permitted or Required by Law;
- 1.2.2 use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to PHI, to prevent use or disclosure of PHI other than as provided for by the Contract or this Attachment;
- 1.2.3 report to the Department any use or disclosure of PHI of which Contractor becomes aware that is not provided for by the Contract or this Attachment, including Breaches of unsecured PHI and security incidents. A report of a Breach to the Department does not alter Contractor's responsibility to notify the affected Individuals;
- 1.2.4 in accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any Subcontractors that create, receive, maintain, or transmit PHI on behalf of Contractor agree to the same restrictions, conditions, and requirements that apply to Contractor with respect to such information;
- 1.2.5 ensure that any agents, including a subcontractor, to whom Contractor provides PHI received from the Department or created or received by Contractor on behalf of the Department in connection with its performance of the Services agree to restrictions and conditions at least as stringent as those that apply to Contractor under this Attachment with respect to such information;
- 1.2.6 to the extent Contractor maintains PHI in a Designated Record Set, make such PHI available to the Department for amendment, and incorporate any amendments to such PHI that the Department directs;
- 1.2.7 provide to the Department or to an Individual, in a time and manner specified by the Department, information collected in accordance with the terms of the Contract to permit the Department to respond to a request by the Individual for an accounting of disclosures of PHI in accordance with 45 CFR Section 164.528. In the event that Contractor in connection with the Services uses or maintains an electronic health record of PHI of or about an Individual, Contractor will make an accounting of disclosures of such PHI in accordance with Section 13405(c) of the Health Information Technology for Economic and Clinical Health (HITECH) Act;
- 1.2.8 to the extent Contractor is to carry out one or more of the Department's obligation(s) under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to "Covered Entity" in the performance of such obligation(s);
- 1.2.9 for purposes of allowing determination of the Department's compliance with the Privacy Rule, make available to the Department and to the Secretary of the DHHS Contractor's internal practices, books, and records, including policies and procedures regarding PHI, that relate to the use and disclosure of PHI received from the Department or created or received by Contractor on behalf of the Department;
- 1.2.10 mitigate, to the extent practicable, any harmful effect of a use or disclosure of PHI by

Contractor in violation of the requirements of the Contract or this Attachment;

- 1.2.11 to the extent possible, limit the use, disclosure, or request of PHI to the minimum necessary to perform or fulfill a specific function required, contemplated, or permitted under the Contract;
- 1.2.12 refrain from exchanging PHI with any entity that Contractor knows has a pattern of activity or practice that constitutes a material Breach or violation of HIPAA;
- 1.2.13 encrypt PHI in transit and at rest; and
- 1.2.14 adopt internal procedures for reporting Breaches and for mitigating potential damages associated with a Breach of Unsecured PHI and with uses and disclosures in violation of this Attachment.

1.3 CONTRACTOR'S PERMITTED USES AND DISCLOSURES.

- 1.3.1 Contractor may use or disclose PHI only to perform Services for, or on behalf of, the Department, and only provided that such use or disclosure would not violate the Privacy Rule.
- 1.3.2 Contractor may disclose PHI for the proper management and administration of Contractor, provided that the disclosures are Required by Law or Contractor obtains reasonable assurances from the person or entity to whom the PHI is disclosed that the PHI will remain confidential and will be used or further disclosed only as Required by Law or for the purpose for which it was disclosed to the person or entity. Contractor shall require the person or entity to which the PHI was disclosed to notify Contractor of any Breach of the confidentiality of the PHI of which the person is or becomes aware.
- 1.3.3 Contractor shall make uses, disclosures, and requests for PHI consistent with the "minimum necessary" standard set forth in 45 CFR Section 164.502(b).
- 1.3.4 Contractor may not use or disclose PHI in a manner that, if done by the Department, would violate Subpart E of 45 CFR Part 164.
- 1.3.5 Contractor may use PHI to report violations of law to appropriate federal and state authorities, consistent with 45 CFR Section 164.502(j)(1).

1.4 PROVISIONS FOR THE DEPARTMENT TO INFORM CONTRACTOR OF PRIVACY PRACTICES AND RESTRICTIONS.

- 1.4.1 The Department shall notify Contractor of any limitation contained in the Department's notice of privacy practices to the extent that such limitation may affect Contractor's use or disclosure of PHI.
- 1.4.2 The Department shall notify Contractor of any restriction on the use or disclosure of PHI that the Department has agreed to or is required to abide by under 45 CFR

164.522, to the extent that such restriction may affect Contractor's use or disclosure of PHI.

1.5 TERM AND TERMINATION

1.5.1 **Effective date.** This Attachment shall be effective as of the execution of the Contract.

1.5.2 **Termination for cause.** The Contract may be terminated by the Department if the Department determines Contractor has violated a material term of the Contract or this Attachment and Contractor has not cured the Breach or ended the violation within the time specified by the Department.

1.5.3 **Obligations of Contractor upon termination.** Upon termination of the Contract for any reason, Contractor shall, with respect to PHI received from the Department, or created, maintained, or received by Contractor on behalf of the Department:

destroy all PHI maintained in any form. Contractor must perform this destruction in a manner no less restrictive than that set forth in the requirements for "Purge" contained in the National Institute for Standards and Technology (NIST) Special Publication 800-88, Appendix A: "Minimum Sanitization Recommendation for Media Containing Data." Contractor must certify in writing the method used to destroy the PHI, including the date and time of data destruction. The Department reserves the right to verify that the PHI has been properly destroyed pursuant to this Attachment; and

if destruction of the PHI is not feasible, extend the protections of the Contract and this Attachment to the PHI and limit further uses and disclosures to those purposes that make the return or destruction of the PHI unfeasible. This provision shall apply equally to PHI that is in the possession of any subcontractor or agent of Contractor.

1.5.4 **Survival.** The obligations of Contractor under this Attachment shall survive the termination of the Contract or this Attachment.

1.6 THE DEPARTMENT'S OBLIGATIONS

The Department shall:

1.6.1 provide Contractor with access to the Department's Notice of Privacy Practices (<http://www.hfs.illinois.gov/assets/hfs3806.pdf>);

1.6.2 notify Contractor of any change in or revocation of permission by an Individual to use or disclose PHI, to the extent that such change or revocation may affect Contractor's permitted or required uses and disclosures of PHI;

1.6.3 notify Contractor of any restriction to the use or disclosure of PHI to which the Department has agreed in accordance with 45 CFR Section 164.522, to the extent that such restriction may affect Contractor's use or disclosure of PHI; and

- 1.6.4 not require Contractor to use or disclose PHI in any manner that would be impermissible for the Department to use or disclose PHI under the Privacy Rule, HIPAA, the HITECH Act, or any applicable federal or state law or regulation for the Department to use or disclose.

1.7 BREACH

- 1.7.1 **Breach notification.** If Contractor discovers a Breach of Unsecured PHI as defined in 45 CFR 164.402, within ten (10) calendar days after Contractor first becomes aware of the incident Contractor shall notify the Department, except where a law-enforcement official determines that a notification would impede a criminal investigation or cause damage to national security.

Contractor shall notify the Department within the above time frame even if Contractor has not conclusively determined that the incident constitutes a Breach of Unsecured PHI.

Contractor shall be deemed to have become aware of the Breach of Unsecured PHI as of the first (1st) day on which such Breach of Unsecured PHI is known or reasonably should have been known to any person, other than the person or entity committing the Breach of Unsecured PHI, who is an employee, officer, or other agent of Contractor.

Contractor shall notify the Department by completing and submitting Exhibit A to this Attachment, "Notification of unauthorized access, use, or disclosure."

The Department and Contractor will cooperate in investigating whether a Breach has occurred and deciding how to provide Breach notifications to Individuals, the federal Health and Human Services' Office for Civil Rights, and potentially the media.

- 1.7.2 **Notification duty.** Contractor shall provide notification to the Individuals whose PHI was Breached, unless the Department agrees to assume the notification and any associated costs. Contractor shall coordinate with the Department to draft a notice to inform Individuals about the Breach.
- 1.7.3 **Costs.** Unless the Department agrees to assume the costs of providing Breach notifications to affected Individuals who are Required by Law to receive such notifications, Contractor shall pay directly or reimburse the Department for all reasonable and direct out-of-pocket costs, including, but not limited to, credit monitoring services for not less than twelve (12) months provided to Individuals, and any litigation costs, fines, penalties, or judgments resulting from the Breach.
- 1.7.4 **Indemnification for Breach.** Contractor shall indemnify the Department for costs associated with any incident involving the acquisition, access, use, or disclosure of Unsecured PHI in a manner not permitted under this Contract, this Attachment, or 45 CFR Section 164 Subparts D and E.

1.8 **THIRD-PARTY BENEFICIARY**

Nothing contained in this Attachment is intended to confer upon any person other than the Parties hereto any rights, benefits, or remedies of any kind or character whatsoever, whether in contract, statute, tort (such as negligence), or otherwise, and no person shall be deemed a Third-Party beneficiary under or by reason of this Attachment.

1.9 **MISCELLANEOUS**

- 1.9.1 **Amendment.** The Parties may amend this Attachment from time to time as necessary for compliance with the requirements of the HIPAA Rules and any other applicable law.
- 1.9.2 **Interpretation.** Any ambiguity in this Attachment shall be interpreted to permit compliance with the HIPAA Rules.
- 1.9.3 **No Agency.** The Parties do not intend, nor does this Contract or Attachment create, an agency relationship between the Department and Contractor.

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

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

Notice shall be provided to:

- 1) Contract Administrator Bureau Chief – Bureau of Managed Care in compliance with the Notice Requirements of the Underlying Agreement, at:
Illinois Department of Healthcare and Family Services
Attn: Bureau Chief – Bureau of Managed Care
Bloom Building, 3rd Floor
201 South Grand Avenue East
Springfield, Illinois 62763

- 2) HFS Privacy Officer, in compliance with the Notice Requirements of the Underlying Agreement at:
Illinois Department of Healthcare and Family Services
Attn: Privacy Officer
Bloom Building, 3rd Floor
201 South Grand Avenue East
Springfield, Illinois 62763
HFS.Privacy.Officer@illinois.gov

Information to be submitted by Contractor:

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

NOTIFICATION:

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

Date of Discovery:
Detailed Description:

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

Submitted by:

Signature: _____ Date: _____

Printed name and title: _____

ATTACHMENT VII: ADDENDUM TO BEP REQUIREMENTS

<Intentionally left blank>

ATTACHMENT VIII: TAXPAYER IDENTIFICATION NUMBER

I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. Person (including a U.S. resident alien).
 - *If you are an individual, enter your name and SSN as it appears on your Social Security Card.*
 - *If you are a sole proprietor, enter the owner's name on the name line followed by the name of the business and the owner's SSN or EIN.*
 - *If you are a single-member LLC that is disregarded as an entity separate from its owner, enter the owner's name on the name line and the d/b/a on the business name line and enter the owner's SSN or EIN.*
 - *If the LLC is a corporation or partnership, enter the entity's business name and EIN and for corporations, attach IRS acceptance letter (CP261 or CP277).*
 - *For all other entities, enter the name of the entity as used to apply for the entity's EIN and the EIN.*

Name: _____

Business Name: _____

Taxpayer Identification Number:

Social Security Number _____

or

Employer Identification Number _____

Legal Status (*check one*):

- | | |
|---|--|
| <input type="checkbox"/> Individual | <input type="checkbox"/> Governmental |
| <input type="checkbox"/> Sole Proprietor | <input type="checkbox"/> Nonresident alien |
| <input type="checkbox"/> Partnership | <input type="checkbox"/> Estate or trust |
| <input type="checkbox"/> Legal Services Corporation | <input type="checkbox"/> Pharmacy (Non-Corp.) |
| <input type="checkbox"/> Tax-exempt | <input type="checkbox"/> Pharmacy/Funeral Home/
Cemetery(Corp.) |

Corporation providing or billing medical and/or health care services (select applicable tax classification)

- D = disregarded entity
- C = corporation
- Limited Liability Company
- P = partnership

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

Signature: _____ **Date:** _____

ATTACHMENT IX: DISCLOSURES OF CONFLICTS OF INTEREST

Instructions: Contractor shall disclose financial interests, potential conflicts of interest and contract information identified in Sections 1, 2 and 3 below as a condition of receiving this Contract. Failure to fully disclose shall render the Contract voidable by the Department. There are five sections to this form and each must be completed to meet full disclosure requirements. The requested disclosures are a continuing obligation and must be promptly supplemented for accuracy throughout the term of the Contract. Contractor must submit these disclosures on an annual basis.

A publicly traded entity may submit its 10K disclosure in satisfaction of the disclosure requirements set forth in Section 1 below. If a Contractor submits a 10K, however, it must still must complete Sections 2, 3, 4 and 5 and submit the disclosure form.

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

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

Name of Contractor: _____

D/B/A (if used): _____

Name of any Parent Organization: _____

Section 1. Disclosure of Financial Interest in Contractor. Contractor must complete one of subsections (a), (b) or (c) below.

- (a) If Contractor is a publicly traded corporation subject to SEC reporting requirements, Contractor shall submit its 10K disclosure (include proxy if referenced in 10k). The SEC 20f or 40f, supplemented with the names of those owning in excess of 5% and up to the ownership percentages disclosed in those submissions, may be accepted as being substantially equivalent to a 10K disclosure.

Check here if submitting a 10k , 20f , or 40f .

OR

- (b) If Contractor is a privately held corporation with more than 400 shareholders, Contractor may submit the information identified in 17 CFR 229.401 and list the names of any person or entity holding any ownership share in excess of 5%.

OR

(c) If Contractor is an individual, sole proprietorship, partnership or any other entity not qualified to use subsections (a) or (b), Contractor shall complete (i) and (ii) below as appropriate.

i. For each individual having any of the following financial interests in Contractor (or its parent), please mark each that apply and show the applicable name and address. Use a separate form for each individual.

Name: _____

Address: _____

1. Do you have an ownership share of greater than 5% of the offering entity or parent entity?

Yes No

2. Do you have an ownership share of less than 5%, but which has a value greater than \$106,447.20?

Yes No

3. Do you receive more than \$106,447.20 of the offering entity's or parent entity's distributive income? (Note: Distributive income is, for these purposes, any type of distribution of profits. An annual salary is not distributive income.)

Yes No

4. Do you receive greater than 5% of the offering entity's or parent entity's total distributive income, but which is less than \$106,447.20?

Yes No

5. If you responded yes to any of questions 1 - 4 above, please provide either the percentage or dollar amount of your ownership or distributive share of income: _____. For partnerships with more than 50 partners, the percentage share of ownership of each individual identified above may be shown in the following ranges (dollar value fields must also be completed when applicable):

0.5% or less: ____; >0.5 to 1.0%: ____; >1.0 to 2.0%: ____;
>2.0 to 3.0 %: ____; > 3.0 to 4.0% ____%; >4.0 to 5.0% ____; and
in additional 1% increments as appropriate: ____%

6. If you responded yes to any of the questions 1 - 4 above, please check the appropriate type of ownership/distributable income share:

Sole Proprietorship Stock Partnership

Other (explain): _____

ii. With regard to each individual identified in (i), above, indicate whether any of the following potential conflict of interest relationships apply. Use a separate form for each individual. If the answer to any question is "Yes," please describe each situation (label with appropriate number). If no individual has been identified above, mark not applicable (N/A) here: _____

1. State employment, currently or in the previous three years, including contractual employment of services directly with the individuals identified in Section 1 in their individual capacity unrelated to Contractor's contract.
Yes No
2. State employment of spouse, father, mother, son, or daughter, including contractual employment for services in the previous two years.
Yes No
3. Elective status; the holding of elective office of the State of Illinois, the government of the United States, any unit of local government authorized by the Constitution of the State of Illinois or the statutes of the State of Illinois currently or in the previous three years.
Yes No
4. Relationship to anyone holding elective office currently or in the previous two years; spouse, father, mother, son, or daughter.
Yes No
5. Appointive office; the holding of any appointive government office of the State of Illinois, the United States of America, or any unit of local government authorized by the Constitution of the State of Illinois or the statutes of the State of Illinois, which office entitles the holder to compensation in excess of expenses incurred in the discharge of that office currently or in the previous three years.
Yes No
6. Relationship to anyone holding appointive office currently or in the previous two years; spouse, father, mother, son, or daughter.
Yes No
7. Employment, currently or in the previous three years, as or by any registered lobbyist of the State government.
Yes No

8. Relationship to anyone who is or was a registered lobbyist in the previous two years; spouse, father, mother, son, or daughter.
Yes No
9. Compensated employment, currently or in the previous three years, by any registered election or re-election committee registered with the Secretary of State or any county clerk in the State of Illinois, or any political action committee registered with either the Secretary of State or the Federal Board of Elections.
Yes No
10. Relationship to anyone; spouse, father, mother, son, or daughter; who is or was a compensated employee in the last two years of any registered election or reelection committee registered with the Secretary of State or any county clerk in the State of Illinois, or any political action committee registered with either the Secretary of State or the Federal Board of Elections.
Yes No

Section 2: Conflicts of Interest

- (a) Prohibition. Pursuant to 30 ILCS 500/50-13(a), it is unlawful for any person holding an elective office in this State, holding a seat in the General Assembly, or appointed to or employed in any of the offices or agencies of State government and who receives compensation for such employment in excess of 60% of the salary of the Governor of the State of Illinois [\$106,447.20], or who is an officer or employee of the Capital Development Board or the Illinois Toll Highway Authority, or who is the spouse or minor child of any such person, to have or acquire any contract, or any direct pecuniary interest in any contract for any services, materials, or supplies, that will be wholly or partially satisfied by the payment of funds appropriated by the General Assembly of the State of Illinois.
- (b) Interests. Pursuant to 30 ILCS 500/50-13(b), it is unlawful for any firm, partnership, association, or corporation, in which any person listed in subsection (a) is entitled to receive (i) more than 7½% of the total distributable income or (ii) an amount in excess of the salary of the Governor (\$177,412.00), to have or acquire any such contract or direct pecuniary interest therein.
- (c) Combined interests. Pursuant to 30 ILCS 500/50-13(c), it is unlawful for any firm, partnership, association, or corporation, in which any person listed in subsection (a) together with his or her spouse or minor children is entitled to receive (i) more than 15%, in the aggregate, of the total distributable income or (ii) an amount in excess of two times the salary of the Governor [\$354,824.00], to have or acquire any such contract or direct pecuniary interest therein.

Contractor has (check one):

No Conflicts Of Interest
Potential Conflict of Interest

If checked, name each conflicted individual, the nature of the conflict, and the name of the State agency that is associated directly or indirectly with the conflicted individual.

Section 3: Debarment/Legal Proceeding Disclosure. Each person identified in Sections 1, 2 and 3 must each identify any of the following that occurred within the previous 10 years:

Debarment from contracting with any governmental entity	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Professional licensure discipline	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Bankruptcies	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Adverse civil judgments and administrative findings	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Criminal felony convictions	Yes <input type="checkbox"/>	No <input type="checkbox"/>

If any of the above is checked "Yes", please describe the nature of the debarment or legal proceeding. The State reserves the right to request more information for further clarification.

Section 4: Disclosure of Business Operations with Iran. Contractor shall disclose whether it, or any of its corporate parents or subsidiaries, within the 24 months prior to the submission of Contractor's response to the Solicitation, had business operations that involved contracts with or provision of supplies or services to the Government of Iran, companies in which the Government of Iran has any direct or indirect equity share, consortiums or projects commissioned by the Government of Iran and:

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

OR

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

Check one of the following items, and disclose as necessary.

There are no business operations that must be disclosed.

The following business operations are disclosed:

Section 5: Current and Pending Contracts.

Contractor has any contracts, pending contracts, bids, proposals or other ongoing procurement relationships with units of State of Illinois government:

Yes No

If "Yes", please identify each contract, pending contract, bid, proposal or other ongoing procurement relationship by stating the agency name and other descriptive information such as bid number, project title, purchase order number or contract reference number:

Section 6: Representative Lobbyist or Other Agent.

Is Contractor represented by or does Contractor employ a lobbyist or other agent who is not identified under Sections 1 and 2 and who has communicated, is communicating, or may communicate with any State officer or employee concerning this Contract?

Yes No

If "Yes":

1. State the name and address of each agent or lobbyist:

2. Describe the costs, fees, compensation or reimbursements paid for assistance to obtain this Contract:

3. Contractor certifies that none of these costs will be billed to the State. Contractor must file this information with the Secretary of State.

The information contained on this Attachment is submitted on behalf of:

Signature of Authorized Representative

Name and Title of Authorized Representative

Date: _____

ATTACHMENT X: PUBLIC ACT 95-971

Contractor certifies that it has read, understands, and is in compliance with the registration requirements of the Elections Code (10 ILCS 5/9-35) and the restrictions on making political contributions and related requirements of the Illinois Procurement Code (30 ILCS 500/20-160 and 50-37). Contractor will not make a political contribution that will violate these requirements. These requirements are effective for the duration of the term of office of the incumbent Governor or for a period of two (2) years after the end of the Contract term, whichever is longer.

In accordance with Section 20-160 of the Illinois Procurement Code, Contractor certifies as applicable:

- Contractor is not required to register as a business entity with the State Board of Elections,
or
- Contractor has registered **and has attached a copy** of the official certificate of registration as issued by the State Board of Elections. As a registered business entity, Contractor acknowledges a continuing duty to update the registration as required by the Act.

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;

1.1.1.7 includes fraud control provisions;

1.1.1.8 establishes and monitors access standards;

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;

1.1.1.10 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;

1.1.1.11 describes its implementation process for reducing unnecessary emergency room utilization and inpatient services, including thirty (30)-day readmissions;

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;

1.1.1.13 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;

1.1.1.14 details its process for determining and facilitating Enrollees needing nursing home, supportive living facility (SLF), or ICF/DD level of care, or to live in the community with HCBS supports;

1.1.1.15 describes its processes for addressing Abuse and Neglect and unusual incidents in the community setting;

1.1.1.16 details any compensation structure, incentives, pay-for-performance (P4P) programs, value-purchasing

strategies, and other mechanisms utilized to promote the goals of accountable, coordinated care;

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;

1.1.1.18 describes its process for developing, implementing, and evaluating care plans for children transitioning to adulthood; and

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 upon request.

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	Reporting methodology	Source
AAP	Adults' Access to Preventive/Ambulatory Health Services	Percentage of member's 20 years and older who had an ambulatory or preventive care visit during the measure year. (Report 3 age ranges and total)	Admin [P4P measure]	HEDIS
AMB	Ambulatory Care	This measure summarizes utilization of ambulatory care in the following categories: <ul style="list-style-type: none"> • Outpatient Visits • ED Visits. (Reported per 1,000 member months, on 9 age ranges and total)	Admin	HEDIS
PPC	Prenatal and Postpartum Care	Percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care. <ul style="list-style-type: none"> • <i>Timeliness of Prenatal Care.</i> Percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date or within 42 days of enrollment in the organization. • <i>Postpartum Care.</i> Percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery. 	Hybrid / Admin [P4P measure]	HEDIS
IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Percentage of adolescents and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following. <ul style="list-style-type: none"> • Initiation of AOD Treatment. Percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. • Engagement of AOD Treatment. Percentage of members who initiated treatment and who had 	Admin	HEDIS

Acronym	Performance measure	Further description	Reporting methodology	Source
		two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.		
W30	Well-Child Visits in the First 30 Months of Life	The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported: 1. Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits. 2. Well-Child Visits for Age 15 Months–30 Months. Children who turned 30 months old during the measurement year: Two or more well-child visits.	Admin [P4R measure]	HEDIS
WCV	Child and Adolescent Well-Care Visits	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.	Admin [P4R measure]	HEDIS
ADV	Annual Dental Visit	Percentage of members 2-20 years of age who had at least one dental visit during the measurement year. (Report 6 age ranges and total)	Admin	HEDIS
BCS	Breast Cancer Screening	Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.	Admin [P4P measure]	HEDIS
CCS	Cervical Cancer Screening	Percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria: • Women age 21-64 who had a cervical cytology performed every 3 years. • Women age 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.	Hybrid / Admin [P4P measure]	HEDIS
CHL	Chlamydia Screening in Women	Percentage of women age 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measure year.	Admin	HEDIS

Acronym	Performance measure	Further description	Reporting methodology	Source
CBP	Controlling High Blood Pressure	Percentage of members 18-85 years of age who had a diagnosis of hypertension and who's BP was adequately controlled during the measurement year based on the following criteria: <ul style="list-style-type: none"> • Members 18-59 years of age whose BP was <140/90mm Hg. • Members 60-85 years of age with a diagnosis of diabetes whose BP was <140/90mm Hg. • Members 60-85 years of age without a diagnosis of diabetes whose BP was <150/90mm Hg. 	Hybrid [P4P measure]	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.	Hybrid / Admin [P4P measure – Combo 3 P4R measure – Combo 10]	HEDIS
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	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. 	Hybrid / Admin	HEDIS
IMA	Immunizations for Adolescents	Percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine and all required doses of the Human Papillomavirus (HPV) vaccine by their 13 th birthday. This measure calculates a rate for each vaccine and two combination rates.	Hybrid / Admin	HEDIS
CDC	Comprehensive Diabetes Care	Percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following: <ul style="list-style-type: none"> • Hemoglobin A1c (HbA1c) testing. • HbA1c poor control (>9.0%) • HbA1c control (<8.0%) 	Hybrid / Admin	HEDIS

Acronym	Performance measure	Further description	Reporting methodology	Source
		<ul style="list-style-type: none"> • Eye exam (retinal) performed. • BP control (< 140/90 mm Hg). 		
SPD	Statin Therapy for Patients With Diabetes	Percentage of members 40-75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria. Two rates are reported: 1) <i>Received Statin Therapy</i> . Members who were dispensed at least one statin medication of any intensity during measurement year. 2) <i>Statin Adherence 80%</i> . Members who remained on a statin medication of any intensity for at least 80% of the treatment period	Admin	HEDIS
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	Percentage of children and adolescents 1-17 years of age who had two or more antipsychotic prescriptions and had metabolic testing. (Report three age stratifications and total)	Admin	HEDIS
FUH	Follow-Up After Hospitalization for Mental Illness – 30 days and 7 days follow-up	Percentage of discharges for member's 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported: 1) Percentage of discharges for which the member received follow-up within 30 days of discharge. 2) Percentage of discharges for which the member received follow-up within 7 days of discharge.	Admin [P4P measure]	HEDIS
MPT	Mental Health Utilization	The number and percentage of members receiving the following mental health services during the measurement year: any service, inpatient, intensive outpatient or partial hospitalization, outpatient, or ED	Admin	HEDIS
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	Percentage of ED visits for which enrollees 13 years and older with a principal diagnosis of alcohol or other drug abuse or dependence received follow-up within 30 days of the ED visit (31 total days) and within 7 days of the ED visit (8 total days).	Admin [P4P measure]	HEDIS

Acronym	Performance measure	Further description	Reporting methodology	Source
		(Effective for measure year 2020, reporting year 2021)		
FUI	Follow-Up After High-Intensity Care for Substance Use Disorder	Percentage of visits or discharges for which enrollees 13 years and older received follow-up for substance use disorder within the 30 days after the visit or discharge and within the 7 days after the visit or discharge. (Effective for measure year 2020, reporting year 2021)	Admin [P4R measure]	HEDIS
FUM	Follow-Up After Emergency Department Visit for Mental Illness	Percentage of ED visits for which enrollees 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm received follow-up within 30 days of the ED visit (31 total days) and within 7 days of the ED visit (8 total days). (Effective for measure year 2020, reporting year 2021)	Admin [P4P measure]	HEDIS
POD	Pharmacotherapy for Opioid Use Disorder	The percentage of new opioid use disorder (OUD) pharmacotherapy events with OUD pharmacotherapy for 180 or more days among enrollees age 16 and older with a diagnosis of OUD. (Effective for measure year 2020, reporting year 2021)	Admin [P4R measure]	HEDIS
HIV	HIV Viral Load Suppression	Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/ml at last viral load test during the measurement year.	Admin [P4R measure]	NQF #2082
HIV	Gap in HIV Medical Visits	Percentage of patients, regardless of age, with a diagnosis of HIV who did not have a medical visit in the last 6 months of the measurement year.	Admin [P4R measure]	NQF #2079
HIV	Prescription of HIV Antiretroviral Therapy	Percentage of patients, regardless of age, with a diagnosis of HIV prescribed antiretroviral therapy ¹ for the treatment of HIV infection during the measurement year.	Admin [P4R measure]	NQF #2083

Acronym	Performance measure	Further description	Reporting methodology	Source
LTSS-CPU	LTSS Comprehensive Care Plan Update	The percentage of long-term services and supports (LTSS) organization members 18 years of age and older who have documentation of a comprehensive LTSS care plan in a specified timeframe that includes core elements. The following rates are reported: 1. Care Plan with Core Elements Documented. Members who had a comprehensive LTSS care plan with nine core elements documented within 120 days of enrollment (for new members) or during the measurement year (for established members). 2. Care Plan with Supplemental Elements Documented. Members who had a comprehensive LTSS care plan with nine core elements and at least four supplemental elements documented within 120 days of enrollment (for new members) or during the measurement year (for established members).	LTSS Case Management Record Review [P4R measure]	HEDIS
LTSS	Successful Transition after Long-Term Care Stay	The proportion of long-term institutional facility stays among MLTSS plan members age 18 and older, which result in successful transitions to the community (community residence for 60 or more days). This measure is reported as an observed rate and a risk-adjusted rate.	Admin [P4R measure]	NQF #9999
CBH	Mobile Crisis Response Services that Result in Hospitalization		Admin [P4R measure]	Non-HEDIS – State Defined
CBH	Visits to the ER for BH services that Result in Hospitalization		Admin [P4R measure]	Non-HEDIS – State Defined
CBH	Overall Number and Length of BH Hospitalizations		Admin [P4R measure]	Non-HEDIS – State Defined
CBH	Number of Repeat BH Hospitalizations		Admin [P4R measure]	Non-HEDIS – State Defined

TABLE 2 TO ATTACHMENT XI: SERVICE PACKAGE II HCBS WAIVER PERFORMANCE MEASURES

PM #	Waiver performance measures	Responsible for data collection	Frequency of data collection/generation	Sampling approach	Responsible party for data aggregation and analysis	Frequency of data aggregation and Analysis	Data source	Remediation
Appendix A - Administrative Authority								
1	<p># and % of individual non-compliance findings regarding waiver providers without a Medicaid provider agreement on file at MA that were remediated within 30 days by MCO</p> <p>-----</p> <p>-</p> <p>N: # of findings of non-compliance regarding waiver providers without a MPA on file at the MA that were remediated within 30 days by the MCO.</p> <p>-----</p> <p>-</p> <p>D: Total # of findings of non-compliant waiver providers without an MPA on file.</p>	MCO	Quarterly and Ongoing	100%	MA/MCO	Quarterly and Annually	MCO Reports	<p>The MCO will work with providers and the OA to obtain Medicaid provider agreements. If not qualified, the provider is dis-enrolled and the MCO provides participant with other available providers. The MCO trains case managers, if needed. If remediation not completed within 60 days, the MCO reviews procedures and submits a plan of correction to MA. The MA follows up to completion.</p>

2	<p># and % of waiver service providers utilized by MCO that are an enrolled Medicaid provider</p> <p>-----</p> <p>N: # of enrolled certified waiver service providers utilized by the MCO that continue to meet applicable certification requirements.</p> <p>-----</p> <p>-</p> <p>D: Total # of enrolled certified waiver service providers.</p>	MCO	Quarterly and Annually	100%	MA/MCO	Quarterly and Annually	MCO Reports	<p>Upon discovery of non-compliance, the MCO is notified to change the provider. The MCO will work with providers and the OA to become an enrolled Medicaid provider. Training for MCO case managers. Remediation within 60 days.</p>
Appendix B - Level of Care								
<u>Subassurance A</u> - An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.								
3	<p># and % of new waiver applicants who have required initial level of care assessment (DON) prior to admission</p> <p>-----</p> <p>N: # of new waiver applicants who have required initial level of care assessment (DON) prior to</p>	MCO	Ongoing	100%	MA/MCO	Monthly, Annually and Ongoing	MCO Event Reports	<p>When it is discovered that an annual level of care assessment has not been completed for a waiver participant, the LOC assessment is completed. If a person is found to be ineligible for waiver services during an annual level of care assessment, he/she is notified in writing by the Medicaid agency and</p>

	admission. ----- - D: Total # of new waiver applicants requiring initial level of care evaluation.							provided appeal rights. Supportive Living Facility staff would assist the person with relocation assistance to another program or setting of the individual's choice.
Subassurance B - The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.								
4	# and % of waiver participants' data reviewed to ensure agreement with approved projected waiver capacity ----- - N: Total participant enrollment data reviewed for each quarter. ----- - D: Annual projected total enrollment data for the waiver year.	MCO	Quarterly and Ongoing	100%	MA	Quarterly and Ongoing	MCO Enrollment Reports	MA will report data to federal CMS on a quarterly basis. Increase in projected capacity will be requested if necessary based on client service population methodology.
Appendix C - Qualified Providers								
Subassurance A - The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.								

5	<p># and % of individual non-compliance findings regarding provider qualifications that were remediated within 60 days by MCO</p> <p>-----</p> <p>-</p> <p>N: # of individual findings regarding provider qualifications non-compliance that were remediated within 60 days by the MCO.</p> <p>-----</p> <p>-</p> <p>D: Total # of individual findings regarding provider qualifications non-compliance.</p>	MCO	Quarterly and Annually	100%	MA/ MCO	Quarterly and Annually	MCO Reports	<p>The MCO obtains provider qualifications documentation. The MCO will work with providers and the OA to obtain documentation. If not qualified, the provider is dis-enrolled and the MCO provides participant with other available providers. MCO trains case managers, if needed. Remediation must be completed within 60 days, the MCO reviews procedures and submits a plan of correction to the MA. The MA follows-up to completion.</p>
6	<p># and % of MCOs that initially meet contract requirements prior to furnishing waiver services</p> <p>-----</p> <p>-</p> <p>N: # of MCOs who initially meet contract qualifications prior to furnishing services.</p> <p>-----</p> <p>D: Total # of MCOs</p>	EQRO	Quarterly and Annually	100%	EQRO	Quarterly and Annually	EQRO Reviews	<p>The MCO will be notified by the MA of lacking documentation. Receipt of documentation to meet contract requirements or unable to contract. Remediation within 60 days.</p>

	furnishing waiver services.							
7	# and % of MCOs that continue to meet contract qualification requirements ----- N: # of contracted MCOs who continue to maintain contract qualification requirements. ----- - D: Total # of contracted MCOs.	EQRO	Quarterly and Annually	100%	EQRO	Quarterly and Annually	EQRO Reviews	Remove as a MCO in MMIS and require the documentation be submitted to meet contract requirements. Change of MCO for enrolled wavier participants; Remediation within 60 days.
Subassurance C - The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.								
8	# and % of MCOs that offer training as required by policy ----- - N: # of MCOs that offered training as required by policy. -----	MCO	Quarterly and Annually	100%	MA/ MCO	Quarterly and Annually	MCO Reports	If a MCO was found to not have completed staff training as required, remediation would occur within 60 days in the form of training being completed. Medicaid agency staff would follow up to verify the required

	D: Total number of MCOs reviewed.							training had been completed.
9	# and % of MCO case managers (new, existing, previously inactive) who meet waiver provider training requirements ----- N: # of MCO case managers reviewed who meet waiver provider training requirements. ----- D: Total # of MCO case managers reviewed.	EQRO/ MCO	Quarterly and Annually	100%	MA/ MCO	Quarterly and Annually	MCO Reports	Completion of case manager training; Moratorium of new waiver cases to non-certified MCO case managers. Remediation within 60 days.
Appendix D - Service Plan								
<u>Subassurance A</u> - Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.								
10	# and % of MCO waiver participants' service plans that address all personal goals identified by the assessment	EQRO/MCO	Quarterly and Ongoing	Representative Sample	MA/ MCO	Quarterly and Annually	MCO Reports: EQRO Reviews	If plans do not address required items, the MA will require the plans be corrected and will provide training of case managers.

	<p>-----</p> <p>N: # of MCO service plans reviewed that address all personal goals identified by the assessment.</p> <p>-----</p> <p>D: Total # of MCO service plans reviewed.</p>							Remediation must be completed within 60 days.
11	<p># and % of MCO waiver participants' service plans that address all participant needs identified by the assessment</p> <p>-----</p> <p>N: # of MCO service plans reviewed that address all participant needs identified by the assessment.</p> <p>-----</p> <p>D: Total # of MCO service plans reviewed.</p>	EQRO/MCO	Quarterly and Ongoing	Representative Sample	MA/MCO	Quarterly and Annually	MCO Reports: EQRO Reviews	If plans do not address required items, the MA will require the plans be corrected and will provide training of case managers. Remediation must be completed within 60 days.
12	<p># and % of MCO participants' service plans that address all health and safety risk factors identified in the assessment</p> <p>-----</p> <p>N: # of MCO service plans reviewed that address risks</p>	EQRO/MCO	Quarterly and Ongoing	Representative Sample	MA/MCO	Quarterly and Annually	MCO Reports: EQRO Reviews	If plans do not address required items, the MA will require the plans be corrected and will provide training of case managers. Remediation must be completed within 60 days.

	<p>identified in the assessment.</p> <p>-----</p> <p>D: Total # of MCO service plans reviewed.</p>							
13	<p># and % of MCO survey respondents in the sample who reported they receive services when they need them</p> <p>-----</p> <p>N: # of MCO survey respondents who reported they receive services when needed.</p> <p>-----</p> <p>D: # of MCO survey respondents in the sample.</p>	MCO	Quarterly and Annually	Representative Sample (Elderly)	MA/MCO	Quarterly and Annually	POSM	<p>If identifying information is available for individual surveys the MCO case managers will follow up on non-favorable surveys. Resolution or remediation will be based on the nature of the concern. Anonymous survey responses will be used to identify need for system improvement.</p>
		MCO	Annually	CAHPS Guidelines (BI, HIV, PD)			CAHPS Survey	
<p>Subassurance B - The State monitors service plan development in accordance with its policies and procedures.</p>								

14	<p># and % of service plans that were implemented pre-authorization by MCO with remediation within 60 days</p> <p>-----</p> <p>-</p> <p>N: # of service plans that were implemented pre-authorization by MCO with remediation within 60 days.</p> <p>-----</p> <p>D: Total # of service plans reviewed by MCO that were implemented pre-authorization.</p>	MCO	Quarterly and Ongoing	100%	MA/MCO	Quarterly and Annually	MCO Reports	<p>The MCO provides training to case managers and authorizes service plans if appropriate. If remediation not completed within 60 days, the MCO reviews procedures and submits a plan of correction to MA. The MA follows-up to completion.</p>
15	<p># and % of MCO participants' service plans that were signed and dated by the waiver participant (or representative) and the case manager</p> <p>-----</p> <p>N: # of MCO service plans that were signed by the waiver participant and the case manager.</p> <p>-----</p> <p>D: Total # of MCO</p>	EQRO/MCO	Quarterly and Ongoing	Representative Sample	MA/MCO	Quarterly and Annually	MCO Reports; EQRO Reviews	<p>If plans are not signed by appropriate parties, the MA will require the plans be corrected. The MCO may also provide training in both cases. Remediation must be completed within 60 days.</p>

	service plans reviewed.							
16	<p># and % of MCO participants who received at least required contact by their case manager in effort to monitor svc provision & to address potential gaps in svc delivery (ELD, PD-annual; BI-monthly; HIV/AIDS-1/month, with 1 face to face bimonthly)</p> <p>-----</p> <p>N: # of MCO participants reviewed who received contact by their case manager every 12 months for Persons with Disabilities and Elderly; monthly for BI; and 3 times a month, with 1 contact being face-to-face, for HIV.</p> <p>-----</p>	EQRO/MCO	Quarterly and Ongoing	Representative Sample	MA/MCO	Quarterly and Annually	MCO Reports: EQRO Reviews	If participants do not receive the required contact by case manager, the MA will require the participant be contacted and provide training of case managers. Remediation must be completed within 60 days.

	D: Total # of MCO participants reviewed.							
17	<p># and % of MCO participants who have PAs or other independently employed services whose service plan included back up plans</p> <p>-----</p> <p>N: # of MCO participants reviewed who have personal assistant or other independently employed services whose service plan included back up plans.</p> <p>-----</p> <p>D: Total MCO participants reviewed who have personal assistant or other</p>	MCO	Quarterly and Ongoing	Representative Sample	MCO	Quarterly and Annually	EQRO Reviews	The MCO would develop and implement PA back up plans and revisions to customers' service plans. Timeline for remediation would be within 30 days.

	independently employed services.							
Subassurance C - Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.								
18	<p># and % of MCO participants who have their Service Plan updated in a timely manner (ELD, HIV/AIDS, PD- 12 months; BI- 6 months)</p> <p>-----</p> <p>N: # of MCO waiver participants reviewed who have their service plan updated every 12 months for Persons with Disabilities and Elderly; every 6 months for BI and HIV.</p> <p>-----</p> <p>D: Total # of MCO waiver participants with service plan due during the period reviewed.</p>	EQRO/MCO	Quarterly and Ongoing	Representative Sample	MA/MCO	Quarterly and Annually	MCO Reports: EQRO Reviews	<p>If service plans are untimely, MA will require completion of overdue service plans and justification from case manager. If service plans are not updated when there is documentation that a participant's needs changed, the MCO will require an update. In both cases the MCO may also provide training of case managers. Remediation within 60 days.</p>

19	# and % of overdue Service Plan renewals that were remediated within 30 days by the MCO (ELD, HIV/AIDS, PD- 12 months; BI- 6 months)	MCO	Quarterly and Ongoing	100%	MA/MCO	Quarterly and Annually	MCO Reports	The OA/MCO conducts timely completion of the overdue Support Plans and renewals. The OA/MCO may also provide training for case managers. If remediation not completed within 30 days, the OA/MCO reviews procedures and submits a plan of correction to MA. The MA follows-up to completion.
20	<p># and % of MCO waiver participants that received updates to service plans when participants' needs changed</p> <p>-----</p> <p>-</p> <p>N: # of MCO waiver participants reviewed that received updates to care plans/service plans when participants' needs changed.</p> <p>-----</p> <p>D: Total # of MCO waiver participants identified whose needs changed.</p>	EQRO/MCO	Quarterly and Ongoing	Subset of Representative Sample	MCO	Quarterly and Annually	MCO Reports: EQRO Reviews	If plans do not address required items, MCO will require that plans be corrected and provide training of case managers. Remediation must be completed within 60 days.

Subassurance D - Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.								
21	<p># and % of MCO participants who received services in the type, scope, amount, duration, and frequency as specified in the service plan</p> <p>-----</p> <p>N: # of MCO participants reviewed who received services as specified in the care plan/service plan.</p> <p>-----</p> <p>D: Total # of MCO participants reviewed.</p>	EQRO/MCO	Quarterly and Ongoing	Representative Sample	MA/MCO	Quarterly and Annually	MCO Reports: EQRO Reviews	If a participant does not receive services as specified in the service plan, the MCO will determine if a correction or adjustment of service plan, services authorized, or services vouchered is needed. If not, services will be implemented as authorized. The MCO may also provide training to case managers. If the issue appears to be fraudulent, it will be reported by the MA to fraud control. Remediation must be completed within 60 days.
22	<p># and % of MCO survey respondents in the sample who reported the receipt of all services listed in the plan of care</p> <p>-----</p> <p>N: # of MCO survey respondents who reported the receipt of all services listed in the plan of care.</p> <p>-----</p> <p>D: # of MCO survey</p>	EQRO	Quarterly and Ongoing	Representative Sample (Elderly)	MA/MCO	Quarterly and Annually	POSM	If identifying information is available for individual surveys the MCO case managers will follow up on non-favorable surveys. Resolution or remediation will be based on the nature of the concern. Anonymous survey responses will be used to identify need for system improvement.
		MCO	Annually	CAHPS Guidelines (BI, HIV, PD)	MA/MCO	Quarterly and Annually	CAHPS Survey	

	respondents in the sample.							
Subassurance E - Participants are afforded choice: Between/among waiver services and providers.								
23	<p># and % of MCO participant records with most recent POC indicating participant had choice between waiver services/institutional care and between/among services and providers</p> <p>-----</p> <p>- N:# of MCO participant records reviewed with a signed POC that indicates participant had choice between services and providers.</p> <p>-----</p> <p>D:Total # of MCO participant records reviewed.</p>	EQRO/MCO	Quarterly and Ongoing	Representative Sample	MA/MCO	Quarterly and Annually	MCO Reports: EQRO Reviews	The MCO will assure that choice was provided as shown by the correction of documentation to indicate customer choice. The MCO may also provide training to case managers. Remediation must be completed within 60 days.

Appendix G - Participant Safeguards

Subassurance A - The State demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.

24	<p># and % of participants who received information from MCO about how and to whom to report abuse, neglect and exploitation at time of assessment/reassessment</p> <p>-----</p> <p>-</p> <p>N: # of participant records reviewed where the participant received information from the MCO about how and to whom to report abuse, neglect exploitation at the time of assessment/reassessment.</p> <p>-----</p> <p>D: Total # of MCO participant records reviewed.</p>	EQRO/MCO	Quarterly and Ongoing	Representative Sample	MA/MCO	Quarterly and Annually	MCO Reports: EQRO Reviews	<p>The MCO will assure that customers know how to report abuse, neglect or exploitation. This will be demonstrated by correction of case work documentation reflecting customers awareness, including evidence of steps taken to educate the customer. Remediation must be completed within 30 days.</p>

25	<p># and % of medication errors for participants documented and reported to the Department</p> <p>-----</p> <p>N: # of medication error reports documented and reported to the Department.</p> <p>-----</p> <p>D: Total # of incidents of medication errors requiring documenting and reporting to the Department.</p>	MCO	Quarterly and Ongoing	100%	MA/MCO	Annually and Ongoing	MCO Reports	<p>If it was discovered a Medication Error Report requiring submission to the MA had not been sent, the SLF would need to complete a report (if not previously done) and send it. MA staff would review the report form for completeness and accuracy to verify remediation.</p>
26	<p># and % of participants' APS substantiated incidents that were reported to MCO and resolved within recommended APS timelines</p> <p>-----</p> <p>N: # of APS substantiated incidents reported to the MCO that were resolved within recommended OIG timelines.</p> <p>-----</p>	MCO	Quarterly and Ongoing	100%	MCO	Quarterly and Annually	MCO Reports	<p>The MCO will follow up all outstanding DHS-OIG referrals and Unusual Incident Reports. Changes in customers' service plans will be made when needed. Remediation must be completed within 30 days.</p>

	D: Total # of APS substantiated incidents reported to the MCO.							
27	<p># and % of participants' substantiated cases of A/N/E where MCO implemented APS recommendations within waiver-specified or regulatory timeframes</p> <p>-----</p> <p>N: # of substantiated cases of abuse, neglect or exploitation received from APS where the MCO implemented the APS recommendations.</p> <p>-----</p> <p>D: Total # of substantiated cases of abuse, neglect or exploitation received by the MCO from APS.</p>	MCO	Quarterly and Ongoing	100%	MCO	Quarterly and Annually	MCO Reports	The MCO will implement the DHS-OIG recommendations for substantiated cases of abuse, neglect or exploitation. Changes in customers' service plans will be made when needed. Remediation must be completed within 30 days.

28	<p># and % of participants' deaths as a result of substantiated case of A/N/E where appropriate follow-up actions were implemented by MCO</p> <p>-----</p> <p>N:# of deaths as a result of a substantiated case of A/N/E where appropriate follow-up actions were implemented by the MCO.</p> <p>-----</p> <p>D:Total # of MCO deaths as a result of a substantiated case of A/N/E.</p>	MCO	Quarterly and Ongoing	100%	MA/MCO	Quarterly and Annually	MCO Reports	<p>The cause of death/circumstances would be reviewed by the MCO and need for training or other remediation; including sanction or termination of provider, would be determined based on circumstances and identified trends and patterns.</p>
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<p>29</p>	<p># and % of participants for whom identified critical incidents other than A/N/E were reviewed and corrective measures were appropriately taken by MCO</p> <p>-----</p> <p>-</p> <p>N:# of participants for whom identified critical incidents other than A/N/E were reviewed and corrective measures were appropriately taken by the MCO.</p> <p>-----</p> <p>D:Total # of MCO participants for whom identified critical incidents were reviewed.</p>	<p>MCO</p>	<p>Quarterly and Ongoing</p>	<p>100%</p>	<p>MA/MCO</p>	<p>Quarterly and Annually</p>	<p>MCO Reports</p>	<p>The MCO will follow up on identified critical incidents, other than A/N/E, to ensure information was reviewed and corrective measures were appropriately taken. Resolution or remediation will be based on the nature of the concern. Survey responses will be used to identify need for system improvement.</p>
<p>Subassurance C - The State policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusions) are followed.</p>								

30	<p># and % of waiver participants who are free from seclusion or restraints</p> <p>-----</p> <p>-</p> <p>N: # of waiver participants who are free from seclusion or restraints.</p> <p>-----</p> <p>-</p> <p>D: Total # of waiver participants reviewed.</p>	MCO	Quarterly	100%	MA/MCO	Quarterly, Annually and Ongoing	MCO Reports	<p>If a participant was found to be in/have been in restraints or seclusion, the SLF would need to immediately discontinue the practice. MA staff would verify the participant was not in restraints or seclusion in order to document remediation. In addition to the issuance of findings of non-compliance summarized below, the MA may also issue an Immediate Jeopardy, as outlined earlier in this section, if the participant was identified to be in immediate danger.</p>
31	<p># and % of restraint applications, seclusion or other restrictive interventions where appropriate intervention by MCO occurred in accordance with waiver and within waiver prescribed timeframes</p> <p>-----</p> <p>N:# of restraint applications, seclusion, or other restrictive interventions where</p>	MCO	Quarterly and Ongoing	100%	MA/MCO	Quarterly and Annually	MCO Reports	<p>Restraint applications, seclusion, or other restrictive interventions will be reviewed by the MCO. The need for training or other remediation; including sanction or termination of provider, would be determined based on circumstances and identified trends and patterns.</p>

	appropriate intervention by the MCO occurred. ----- D: Total # of MCO restraint applications, seclusion, or other restrictive intervention.							
Subassurance D - The State establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.								
32	# and % of participant survey respondents who reported to MCO of being treated well by direct support staff ----- N: # of participant satisfaction survey respondents who reported to the MCO of being treated well by direct support staff.	EQRO	Quarterly	Representative Sample (Elderly)	MA/MCO	Quarterly and Annually	POSM	If identifying information is available for individual surveys the MCO case managers will follow up on non-favorable surveys. Resolution or remediation will be based on the nature of the concern. Anonymous survey responses will be used to identify need for system improvement.
	D: Total # of MCO participant satisfaction survey respondents.	MCO	Annually	CAHPS Guidelines (BI, HIV, PD)			CAHPS Survey	

33	<p># and % of HSP Individual Provider evaluations returned reporting satisfaction as stated in the approved waiver ----- - N: # of HSP Individual Provider evaluations completed that report satisfaction as stated in the approved waiver. ----- D: Total # of Individual Provider evaluations completed.</p>	MCO	Annually	CAHPS Guidelines (PD)	MA/MCO	Annually	CAHPS Survey	<p>If identifying information is available for individual surveys the MCO case managers will follow up on non-favorable surveys. Resolution or remediation will be based on the nature of the concern. Anonymous survey responses will be used to identify need for system improvement.</p>
34	<p># and % of participants who received information from MCO regarding universal precautions ----- - N: # of participant records reviewed where there is a signed document that shows the participant received information from the OA and MCO about universal precautions.</p>	MCO	MCO	Annually	CAHPS Guidelines (PD)	MA/MCO	Annually	<p>If identifying information is available for individual surveys the MCO case managers will follow up on non-favorable surveys. Resolution or remediation will be based on the nature of the concern. Anonymous survey responses will be used to identify need for system improvement.</p>

	----- - D: Total # of OA and MCO participant records reviewed.							
35	# and % of MCO in-home service providers who have policy addressing participant back up plans ----- - N: # of participant records reviewed where there is a signed document that shows the participant received information from the OA and MCO about universal precautions. ----- - D: Total # of OA and MCO participant records reviewed.	MCO	Quarterly and Ongoing	Representative Sample	MA/MCO	Quarterly and Annually	MCO Reports	The MCO would require a plan of correction from the case manager to include participant's service plan revisions addressing the backup plan. The plan may require case manager training. Timeline for remediation would be within 30 days.
Appendix I - Financial Accountability								
<u>Subassurance A</u> - The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.								

36	<p># and % of payments that were paid for participants who were enrolled in the waiver on the date the service was delivered</p> <p>-----</p> <p>-</p> <p>N: # of payments made by Medicaid Agency to waiver providers and MCOs for individuals enrolled in the Medicaid waiver.</p> <p>-----</p> <p>-</p> <p>D: Total number of waiver provider and MCO payment records reviewed.</p>	MCO	Semi-Annually	100%	MA/MCO	Semi-Annually	MCO Encounter Data	<p>The MA will require the OA to void the federal claim for services provided prior to the customers' waiver enrollment. Remediation must be completed within 30 days. HFS will adjust the federal claim for services provided by the MCO prior to the customers' waiver enrollment. Remediation must be completed within 30 days.</p>
37	<p># and % of payments there were paid for services that were specified in the participant's service plan</p> <p>-----</p> <p>-</p> <p>N: # of payments made to the OA and MCO that are specified in the participant's service plan.</p>	MCO	Semi-Annually	Non-Representative Sample	MA/MCO	Semi-Annually	MCO Encounter Data	<p>The OA/MCO will determine whether the service was authorized. If authorized, the OA/MCO will revise customer service plan; If not authorized, the OA/MA will void the federal claims that were not consistent with service plans. Remediation must be completed within 30 days.</p>

	----- - D: Total # of OA and MCO payments.							
Subassurance B - The State provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.								
38	# and % of payments that were paid using the correct rate as specified in the waiver application ----- N: # of waiver provider and MCO payments made for waiver services using the correct reimbursement rate. ----- - D: Total number of waiver provider and MCO payment records reviewed.	MCO	Quarterly and Annually	100%	MA/MCO	Annually	MCO Encounter Data	The MA will require that the OA either recoup the overpayment or repay at correct rate. Remediation must be completed within 30 days.

39	<p># and % of rates consistent with the approved rate methodology over the five year waiver cycle</p> <p>-----</p> <p>-</p> <p>N: # of rates consistent with approved rate methodology for the five year waiver cycle.</p> <p>-----</p> <p>D: # of approved rates.</p>	MCO	Quarterly and Annually	100%	MA/MCO	Annually	MCO Encounter Data	<p>The MA will require the OA to either recoup the overpayment or repay at correct rate. If necessary, will also adjust the federal claim. Remediation must be completed within 30 days. The MA will require the MCO to recoup the overpayment or repay at correct rate. Remediation must be completed within 30 days.</p>
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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 XIII: REQUIRED DELIVERABLES, SUBMISSIONS, AND REPORTING

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

Failure to submit required deliverables, submissions and reports outlined in this section will be grounds for the imposition of sanctions as described in 7.16.

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

Name of report/submission	Frequency	HFS Prior Approval	Report description and requirements
			<p>composition; and correct file length. To be accepted by the Department, the format of the file must be correct.</p> <p>Once the format is correct, the Department shall then perform the second level of review. This second review shall be for standard claims processing edits. These edits shall include, but are not limited to, the following: correct Provider numbers; valid Enrollee numbers; valid procedure and diagnosis codes; and cross checks to assure Provider and Enrollee numbers match their names. The acceptable error rate of claims processing edits of the Encounter Data provided by Contractor shall be determined by the Department. Once an acceptable error rate has been achieved, as determined by the Department, Contractor shall be instructed that the testing phase is complete and that data must be sent in production.</p> <p>Production. Once Contractor’s testing of data specified above is completed, Contractor will be certified for production. Once certified for production, Contractor shall continue to submit Encounter Data in accordance with these requirements. The Department will continue to review the Encounter Data for correct format and quality. Contractor shall submit as many files as necessary, in a time frame agreed upon by the Department and Contractor, to ensure all Encounter Data are current.</p> <p>Records that fail the edits described above will be returned to Contractor for correction. Corrected Encounter Data must be returned to the Department for reprocessing.</p> <p>Electronic data certification. In a format determined by the Department, Contractor shall certify by the 5th day of each month that all electronic data submitted during the previous calendar month are accurate, complete and true.</p>
Disclosure statement	Initially, annually, on request, and as changes occur	No	Contractor shall submit disclosure statements as specified in 42 CFR, Part 455.

Name of report/submission	Frequency	HFS Prior Approval	Report description and requirements
Report of transactions with Parties of Interest	Annually	No	Contractor shall report all “transactions” with a “party of interest” (as such terms are defined in Section 1903(m)(4)(A) of the Social Security Act and SMM 2087.6(A-B)), as required by Section 1903(m)(4)(A) of the Social Security Act.
Adjudicated claims inventory summary	Frequency as provided in the MCO MPR Guidelines	No	Reporting will follow the MCO Performance Reporting (MPR) Guidelines.
Compliance certification	Annually, no later than July 31	No	Contractor shall submit a Certification confirming that Contractor and its subcontractors are in compliance with Section 9.2 and each subsection thereof.
Enrollee Materials			
Certificate of Coverage, Description of Coverage, and any changes or amendments	Initially and as revised	Yes	Contractor shall submit the Certificate of Coverage and Description of Coverage for Prior Approval that comply with the Managed Care Reform and Patient Rights Act (215 ILCS 134) and the Illinois Administrative Code, Title 50, Chapter 1, Subchapter kkk, Part 5421.
Enrollee Handbook	Initially and as revised	Yes	Contractor shall submit an Enrollee Handbook for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed.
Identification Card	Initially and as revised	Yes	Contractor shall submit the Enrollee identification card for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed.
Provider Directory Attestation	Monthly	No	Contractor shall submit an attestation that they have met the provider directory requirements in 305 ILCS 5/5-30.3(b)(1) and 305 ILCS 5/5 30.1(f)(2).
Fraud and Abuse			

Name of report/submission	Frequency	HFS Prior Approval	Report description and requirements
Fraud and Abuse Referral	Immediately upon notification or knowledge of suspected Fraud and Abuse	N/A	Contractor shall report all suspected Fraud and Abuse to the Department as required in Article V and Article IX of this Contract. Contractor shall provide a preliminary investigation report as each occurrence is identified.
Fraud and Abuse Report	Quarterly	No	Contractor shall provide a summary report of referrals made and program integrity activities conducted in the previous quarter.
Recipient Verification Procedure	Initially, annually and as revised	Yes	Contractor shall submit Contractor's plan for verifying with Enrollees whether services billed by Providers were received, as required by 42 CFR 455.20, for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in information conveyed. This does not need to be provided to the Department separately by population.
Recipient Verification Results	Annually and within ten (10) Business Days after the Department's request	No	Contractor shall submit a summary of the results of the Recipient Verification Procedure.
Fraud and Abuse Compliance Plan	Initially and annually	Yes	Per 42 CFR 438.608, Contractor shall submit its compliance plan designed to guard against Fraud and Abuse to the Department for Prior Approval. This does not need to be provided to the Department separately by population.
Marketing			
Marketing Gifts and Incentives	Initially and as revised	Yes	Contractor shall submit all plans to distribute gifts and incentives, as well as description of gifts and incentives, for Prior Approval.
Marketing Materials	Initially and as revised	Yes	Contractor shall submit all Marketing Materials for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed.

Name of report/submission	Frequency	HFS Prior Approval	Report description and requirements
Marketing, Outreach and Education Plan	Annually	Yes	As described in Section 4.17.5, Contractor shall submit descriptions of proposed Marketing concepts, strategies, and procedures for Prior Approval.
Community Outreach Events	Monthly, by the last day of the reporting month	No	Contractor shall submit to the Department a list of all previously approved community outreach events that occurred during the submission month. The report must include the Event name, date, time, address/location, county, audience type, estimated number of attendees and date of Department approval.

Provider Network			
Primary care Provider, Hospital, and Affiliated Specialist File (CEB Provider File)	No less often than weekly	Yes	<p>Contractor shall submit to the Department or its designee, in a format and medium designated by the Department, an electronic file of Contractor's PCPs, Hospitals and Affiliated Specialists. The primary care Providers must include, but not limited to, the following information:</p> <ul style="list-style-type: none"> • Provider name, Provider number, office address, and telephone number; • Type of specialty (e.g., family practitioner, internist, oncologist, etc.), subspecialty if applicable, and treatment age ranges; • Identification of Group Practice, if applicable; • Geographic service area, if limited; • Areas of board-certification, if applicable; • Language(s) spoken by Provider and office staff; • Office hours and days of operation; • Special services offered to the deaf or hearing impaired (i.e., sign language, TDD/TTY, etc.); • Wheelchair accessibility status (e.g., parking, ramps, elevators, automatic doors, personal transfer assistance, etc.); • PCP indicator; • Primary care Provider gender and panel status (open or closed); and • Primary care Provider hospital affiliations, including information about where the primary care Provider has admitting privileges or admitting arrangements and delivery privileges (as appropriate).
Provider Terminations	As each occurs	No	Contractor shall submit Provider termination reports, in a format and medium designated by the Department.
Provider Grievance-Resolution System and Procedures	Initially and as revised	Yes	Contractor shall submit details of its Provider Grievance-resolution system and related procedures for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed.

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

Care Management and Disease Management Program Descriptions	Initially and as revised	Yes	Contractor shall submit the descriptions of its Care Management and Disease Management programs for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed. Contractor shall identify all areas in its CM/DM program that differ among care coordination programs.
Care Coordination effectiveness Summary Report	Frequency as provided in the MCO MPR Guidelines	No	Reporting will follow the MCO Performance Reporting (MPR) Guidelines
Care Gap Plan	Annually	No	Contractor shall submit its plan for ensuring provision of services missed by Enrollees, including, but not limited to, annual preventive exams, immunizations, women's healthcare, PAP and missed services for Chronic Health Conditions and Behavioral Health follow-up. Contractor may submit one plan that includes all care coordination programs in which it participates; however, Contractor must clearly identify program-specific activities.
Outreach Summary Report	Frequency as provided in the MCO MPR Guidelines	No	Reporting will follow the MCO Performance Reporting (MPR) Guidelines
Prior Authorization Report	Frequency as provided in the MCO MPR Guidelines	No	Reporting will follow the MCO Performance Reporting (MPR) Guidelines
Quality Performance Reporting	Quarterly	No	Contractor shall submit a report that is based on the Performance Measures required by this Contract, and that may include HEDIS® measures, modified HEDIS® measures, and State defined measures. This report shall include, as requested by the Department, the numerator, denominator and rate for each measure and will display information in a manner that includes trending data, based on previous quality indicators.
Processes and Procedures to Receive Reports of Critical Incidents	Initially and as revised	Yes	Contractor shall submit Critical Incident Processes and Procedures for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed. Contractor may submit one set of processes and procedures that includes all care coordination programs in which it participates; however, Contractor shall identify all areas that differ among care coordination programs.

Critical Incidents – Detail Report	Monthly	No	Contractor shall submit a detailed report on Critical Incidents providing Enrollee name, Enrollee Medicaid number, incident summary, date received, source, incident date, date referred, referral entity, date resolved, and resolution summary, grouped in the following categories: Abuse; Neglect; Exploitation; and Other. Contractor shall report Critical Incidents for each of the following: Nursing Facility Services; HCBS Waiver for Persons who are Elderly; HCBS Waiver for Assisted Living, Supportive Living Program; HCBS Waiver for Persons with Physical Disabilities; HCBS Waiver for Persons with HIV/AIDS; HCBS Waiver for Persons with Brain Injury; ACA Expansion Adults; Non-Disabled Children; Non-Disabled Adults; Special Needs Children; and IMD Residents.
Critical Incidents – Summary Report	Quarterly	No	Contractor shall submit a summary report on Critical Incidents that includes the total Critical Incidents and the total Critical Incidents referred. Contractor shall submit a summary count of Critical Incidents in the following categories: Abuse, Neglect, Exploitation, and Other. Contractor shall report Critical Incidents separately for each of the following: Nursing Facility Services; HCBS Waiver for Persons who are Elderly; HCBS Waiver for Assisted Living, Supportive Living Program; HCBS Waiver for Persons with Physical Disabilities; HCBS Waiver for Persons with HIV/AIDS; HCBS Waiver for Persons with Brain Injury; ACA Expansion Adults; Non-Disabled Children; Non-Disabled Adults; Special Needs Children; and IMD Residents.
Transition of Care Plan	Initially and as revised	Yes	Contractor shall submit its Transition of Care Plan to the Department for review and Prior Approval. The Transition of Care Plan shall include policies and procedures and a staffing model designed to achieve a seamless, efficient transition with minimal impact to an Enrollee’s care. Contractor may submit one plan that includes all care coordination programs in which it participates; however, Contractor shall identify all areas that differ among care coordination programs.

Cultural Competence Plan	At least two (2) weeks prior to the Department's Readiness Review	No	Contractor shall submit its Cultural Competence Plan that addresses the challenges of meeting the healthcare needs of Enrollees. Contractor's Cultural Competence Plan shall contain, at a minimum, the provisions listed in Section 2.7.2 of the Contract. Contractor may submit one plan that includes all care coordination programs in which it participates; however, Contractor shall identify all areas that differ among care coordination programs.
Executive Summary	Quarterly	No	Contractor shall submit an Executive Summary that summarizes the data within the reports submitted to the Department for that quarter (including monthly and quarterly reports). The Executive Summary shall contain, at a minimum, an analysis of the reports submitted during the quarter, an explanation of the data submitted, and highlights from the reports.
Children with Special Health Care Needs (CSHN) Plan	Initially and as revised	No	Contractor shall submit the Children with Special Health Care Needs Plan to conduct timely identification and screening, comprehensive assessments, and appropriate case management services for any CSHN.
Provider-preventable Conditions Report	Quarterly	No	Contractor shall report provider-preventable conditions that are identified in the State Plan to the Department.
Utilization Review			
Utilization Management Report	Frequency as provided in the MCO MPR Guidelines	No	Reporting will follow the MCO Performance Reporting (MPR) Guidelines
Pharmacy			
Drug Utilization Review Report	Annual	No	Contractor shall report its prospective and retrospective Drug Utilization Review activities to the Department.

Subcontracts and Provider agreements			
Executed Subcontracts	Within ten (10) Business Days after the Department's request	N/A	Contractor shall submit copies of each executed subcontract relating to an arrangement for the provision of Covered Services, but not those subcontracts for the direct provision of Covered Services. For example, a subcontract with a behavioral health or dental administrator shall be submitted to the Department, but an agreement with a therapist or dentist providing direct care to an Enrollee need not be submitted unless otherwise required or requested by the Department.
Executed Provider Agreements	Within ten (10) Business Days after the Department's request	N/A	Contractor shall submit copies of executed Provider agreements to the Department upon request.
Model Subcontracts and Provider Agreements	Initially and annually	N/A	Contractor shall submit copies of model subcontracts and Provider agreements related to Covered Services, assignment of risk and data reporting functions, inclusive of all proposed schedules or exhibits, intended to be used therewith. Contractor shall provide the Department with any substantial revisions to, or deviations from, these model subcontracts and Provider agreements.
Value-Based Payment Arrangements	Annually	N/A	As described in Section 7.27, Contractor shall report on its progress towards enrolling its providers in arrangements that incentivize value based care. Contractor shall submit description of each model, as well number of providers, number of members, and total spend, with a breakdown of upside-only versus upside and downside risk arrangements for each. Breakdown outlined above shall be reported by region.
Business Enterprise Program Act for Minorities, Females and Persons with Disabilities			
BEP Report	Quarterly and annually	N/A	Contractor shall submit the information required in Section 2.9 of the Contract.

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 XV: CONTRACT MONITORS

For the Department:

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

Telephone: 217-752-7478

Fax: 217-524-7535

E-mail:

For Contractor:

Contact Person:

Contact Title:

Address:

Telephone:

E-mail:

Fax:

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 Who are Elderly Waiver. Care Coordinators must meet one (1) of the four (4) following requirements:

1.1.1.1 Registered nurse (RN) licensed in Illinois

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

1.1.1.3 Licensed practical nurse (LPN) with one (1) year experience in conducting comprehensive assessments and provision of formal service for the elderly

1.1.1.4 One (1) year of satisfactory program experience may replace one year of college education, at least four (4) years of experience replacing baccalaureate degree

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

1.1.2.1 Registered Nurse (RN)

1.1.2.2 Licensed clinical social worker (LCSW)

1.1.2.3 Licensed marriage and family therapist (LMFT)

1.1.2.4 Licensed clinical professional counselor (LCPC)

1.1.2.5 Licensed professional counselor (LPC)

1.1.2.6 Doctorate of Philosophy (PhD)

1.1.2.7 Doctorate in psychology (PsyD)

1.1.2.8 Bachelor or master's degree prepared in human-services related field

1.1.2.9 Licensed practical nurse (LPN)

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

1.1.3.1 Registered nurse (RN) licensed in Illinois

1.1.3.2 Certified or licensed social worker

- 1.1.3.3 Unlicensed social worker: minimum of bachelor's degree in social work, social sciences, or counseling
- 1.1.3.4 Vocational specialist: certified rehabilitation counselor or at least three (3) years' experience working with people with disabilities
- 1.1.3.5 Licensed clinical professional counselor (LCPC)
- 1.1.3.6 Licensed professional counselor (LPC)
- 1.1.3.7 Certified case manager (CCM)

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

- 1.1.4.1 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.
- 1.1.4.2 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).
- 1.1.4.3 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:

- 1.1.4.4 Addictive and dysfunctional family systems
- 1.1.4.5 Racial and ethnic minorities
- 1.1.4.6 Homosexuals and bisexuals
- 1.1.4.7 Persons with AIDS, and
- 1.1.4.8 Substance abusers

1.1.5 High-Needs and Special Needs Children.

- 1.1.5.1 Care Coordinators must meet the following requirements:
 - 1.1.5.1.1 Bachelor's degree in nursing, social sciences, social work, or related field
 - 1.1.5.1.2 One (1) year of supervised clinical experience in a human-services field

1.1.5.2 Care Coordinator supervisors must meet the following requirements:

- 1.1.5.2.1 Master's degree in nursing, social sciences, social work, or related field
- 1.1.5.2.2 No fewer than three (3) years of supervised experience in a human-services field
- 1.1.5.3 Contractor must employ at least one (1) certified trainer in IM-CANS.

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 who are Elderly Waiver.

1.3.1.1.1 Aging related subjects

1.3.1.2 Persons with Brain Injury Waiver.

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

1.3.1.3 Persons with HIV/AIDS Waiver.

1.3.1.3.1 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)

1.3.1.4 Supportive Living Program Waiver.

1.3.1.4.1 Training on the following subjects: resident rights; prevention and notification of Abuse, Neglect, and exploitation; behavioral intervention, techniques for working with the elderly and persons with disabilities; and, disability sensitivity training

ATTACHMENT XVII: ILLINOIS DEPARTMENT OF HUMAN SERVICES, DIVISION OF REHABILITATION SERVICES, CRITICAL INCIDENT DEFINITIONS

Critical Incidents include, but are not limited to, the following:

Death, HSP Enrollee	Contractor shall report deaths of an unusual nature to HFS OIG and DHS-DRS. Criteria for reporting deaths of an unusual nature include, but are not limited to, a recent allegation of Abuse, Neglect or exploitation, or that Enrollee was receiving home health services at time of passing. Contractor shall cooperate in any investigation conducted by HFS OIG or DHS-DRS.
Death, Other parties	Events that result in significant event for Enrollee. For example, Enrollee's caregiver dies in the process of giving Enrollee bath, thereby leaving Enrollee stranded in home without care for several days. Passing of immediate family members is not necessary unless the passing creates a resulting turn events that are harmful to Enrollee.
Physical abuse of Enrollee	Non-accidental use of force that results in bodily injury, pain or impairment. Includes but not limited to being slapped, burned, cut, bruised or improperly physically restrained.
Verbal/Emotional abuse of Enrollee	Includes but is not limited to name calling, intimidation, yelling and swearing. May also include ridicule, coercion, and threats.
Sexual abuse of Enrollee	Unwanted touching, fondling, sexual threats, sexually inappropriate remarks or other sexual activity with an adult with disabilities.
Exploitation of Enrollee	The illegal use of assets or resources of an adult with disabilities. It includes, but is not limited to, misappropriation of assets or resources of the alleged victim by undue influence, by Breach of fiduciary relationship, by fraud, deception, extortion, or in any manner contrary to law.
Neglect of Enrollee	The failure of another individual to provide an adult with disabilities with, or the willful withholding from an adult with disabilities of the necessities of life including but not limited to food, clothing, shelter, or medical care
Sexual Harassment by provider	Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature that tends to create a hostile or offensive work environment.

Sexual Harassment by Enrollee	Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature that tends to create a hostile or offensive work environment.
Sexually problematic behavior	Inappropriate sexual behaviors exhibited by either the Enrollee or individual provider which impacts the work environment adversely.
Significant Medical event of Provider	A recent event to a provider that has the potential to impact upon an Enrollee's care.
Significant Medical Event of Enrollee	This includes a recent event or new diagnosis that has the potential to impact on the Enrollee's health or safety. Also included are unplanned hospitalizations or errors in medication administration by provider.
Enrollee arrested, charged with or convicted of a crime	In an instance where the arrest, charge, or conviction has a risk or potential risk upon the Enrollee's health and safety shall be reported.
Provider arrested, charged with or convicted of a crime	In an instance where the arrest, charge, or conviction has a risk or potential risk upon the Enrollee's health and safety shall be reported.
Fraudulent activities or theft on the part of the Enrollee or the Provider	Executing or attempting to execute a scheme or ploy to defraud the Home Services program, or obtaining information by means of false pretenses, deception, or misrepresentation in order to receive services from our program. Theft of Enrollee property by a provider, as well as theft of provider property by an Enrollee is included.
Self-Neglect	Individual neglects to attend to the individual's basic needs, such as personal hygiene, appropriate clothing, feeding, or tending appropriately to medical conditions.
Enrollee is missing	Enrollee is missing or whereabouts are unknown for provision of services.
Problematic possession or use of a weapon by an Enrollee.	Enrollees should never display or brandish a weapon in staff's presence. Any perceived threat through use of weapons shall be reported. In some cases, persons with SMI are not allowed to possess firearms, and this shall be documented if observed.
Enrollee displays physically aggressive behavior	Enrollee uses physical violence that results in harm or injury to the provider.
Property damage by Enrollee of \$50 or more	Enrollee causes property damage to in the amount of \$50 or more to provider property.
Suicide attempt by Enrollee	Enrollee attempts to take own life.
Suicide ideation/threat by Enrollee	An act of intended violence or injurious behavior towards self, even if the end result does not result in injury.

Suspected alcohol or substance use by Enrollee	Use of alcohol or other substances that appears compulsive and uncontrolled and is detrimental to Enrollee's health, personal relationships, safety of self and others. Social and legal status.
Seclusion of an Enrollee	Seclusion is defined as placing a person in a locked or barricaded area that prevents contact with others.
Unauthorized Restraint of an Enrollee	Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely.
Media involvement/media inquiry	Any inquiry or report/article from a media source concerning any aspect of an Enrollee's case shall be reported via an incident report. Additionally, all media requests will be forwarded to the DHS Office of Communications for response.
Threats made against DRS/HSP Staff	Threats and/or intimidation manifested in electronic, written, verbal, physical acts of violence, or other inappropriate behavior
Falsification of credentials or records	To falsify medical documents or other official papers for the expressed interest of personal gain, either monetary or otherwise.
Report against DHS/HSP employee	Deliberate and unacceptable behavior initiated by an employee of DRS against an Enrollee or provider in HSP.
Bribery or attempted bribery of an HSP Employee	Money or favor given to an HSP employee in exchange to influence the judgment or conduct of a person in a position of authority.

ATTACHMENT XVIII: ILLINOIS DEPARTMENT ON AGING ELDER ABUSE AND NEGLECT PROGRAM

The program provides services to people over the age of sixty (60) and to adults with disabilities age eighteen (18) to fifty-nine (59) who may be victims of abuse as prescribed below:

- 1.1.1 **Confinement** means restraining or isolating, without legal authority, an older person for reasons other than medical reasons ordered by a Physician.
- 1.1.2 **Emotional Abuse** means verbal assaults, threats of maltreatment, harassment, or intimidation intended to compel the older person to engage in conduct from which he or she wishes and has a right to abstain, or to refrain from conduct in which the older person wishes and has a right to engage.
- 1.1.3 **Financial Exploitation** means the misuse or withholding of an older person's resources by another person to the disadvantage of the older person or the profit or advantage of a person other than the older person.
- 1.1.4 **Physical Abuse** means causing the inflictions of physical pain or injury to an older person.
- 1.1.5 **Sexual Abuse** means touching, fondling, sexual threats, sexually inappropriate remarks, or any other sexual activity with an older person when the older person is unable to understand, unwilling to consent, threatened, or physically forced to engage in sexual activity.
- 1.1.6 **Passive Neglect** means a caregiver's failure to provide an eligible adult with the necessities of life including, but not limited to, food, clothing, shelter, and medical care. This definition does not create any new affirmative duty to provide support to eligible adults, nor shall it be construed to mean that an eligible adult is a victim of neglect because of healthcare services provided or not provided by licensed healthcare professionals.
- 1.1.7 **Willful Deprivation** means willfully denying medications, medical care, shelter, food, therapeutic devices, or other physical assistance to a person who, because of age, health, or disability, requires such assistance and thereby exposing that person to the risk of physical, mental, or emotional harm because of such denial; except with respect to medical care or treatment when the person has expressed an intent to forego such medical care or treatment and has the capacity to understand the consequences.

ATTACHMENT XIX: ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES INCIDENT REPORTING FOR SUPPORTIVE LIVING FACILITIES

Examples of incidents that must be reported to the Department include, but are not limited to the following:

- 1.1.1 Abuse or suspected Abuse of any nature by anyone, including another Resident, staff, volunteer, family, friend, etc.
- 1.1.2 Allegations of theft when a Resident chooses to involve local law enforcement.
- 1.1.3 Elopement of Residents/missing Residents
- 1.1.4 Any crime that occurs on facility property
- 1.1.5 Fire alarm activation for any reason that results in on-site response by local fire department personnel. This does *not* include fire department response that is a result of Resident cooking mishaps that only cause minimal smoke limited to a Resident's apartment and that do not result in any injuries or damage to the apartment. Examples of what do not need to be reported include, but are not limited to: burnt toast or burnt popcorn.
- 1.1.6 Physical injury suffered by Residents during a mechanical failure or force of nature
- 1.1.7 Loss of electrical power in excess of an hour
- 1.1.8 Evacuation of Residents for any reason

ATTACHMENT XX: INDIVIDUAL PROVIDER PAYMENT POLICY

Contractor shall pay for DHS-DRS HCBS Waiver services provided by Individual Providers, including Personal Assistants, by making payment to the State. DHS-DRS and the Enrollee shall remain the coemployers of the Individual Provider. DHS-DRS, as the coemployer, shall be responsible for making payment, and for the performance of related payroll and employment functions, for the Individual Providers. After the first one hundred eighty (180) days of an Enrollee's enrollment, Contractor shall be responsible to provide DHS-DRS with data, in a mutually agreed upon format, necessary to pay these bills prior to the date the bills are due to be submitted. The State will provide invoices to Contractor, in a mutually agreed upon format, within sixty (60) days after DHS-DRS has paid such invoices for Individual Providers' hours paid to Individual Providers.

The State is a party to a collective bargaining agreement with the Service Employees International Union (SEIU) covering Individual Providers, including Personal Assistants, in certain HCBS Waivers. Services provided by Individual Providers are included as a Covered Service. Wages agreed to pursuant to the collective bargaining agreement constitute the Medicaid rate for Individual Provider services, which Contractor is obligated to pay. Contractor shall have no obligation to become party to such agreement, or have any liability under such agreement, as a result of entering into this Contract. If the parties to the SEIU agreement negotiate terms that Contractor reasonably demonstrates materially increase Contractor's cost of providing, or arranging for the provision of, Covered Services or otherwise meeting its obligations under this Contract, the Department will address adjustments of the Capitation rates as set forth in Section 7.1. Nothing in this Contract shall impair or diminish DHS-DRS' status as coemployer of the Individual Providers working under the Home Services Program under Section 3 of the Disabled Persons Rehabilitation Act (5 ILCS 315). Nothing in this Contract shall diminish the effect of the collective bargaining agreement covering Individual Providers' employment.

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 uspreventativeservicestaskforce.org, under the *Recommendations* section.

The USPSTF grade definitions can be found on uspreventativeservicestaskforce.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 CHILDREN'S BEHAVIORAL HEALTH (CBH) SERVICE DELIVERY DESIGN.

1.1.1 For the purposes of this Attachment XXII:

1.1.1.1 **Care Coordination and Support Organization (CCSO)** means a provider with responsibility for delivering Mobile Crisis Response and Care Coordination to eligible Enrollees within a designated service area.

1.1.1.2 **Pathways to Success** means a program that provides an evidence-informed model of intensive Care Coordination and additional home and community-based services for Enrollees under the age of twenty-one (21) who meet eligibility criteria demonstrating complex Behavioral Health needs requiring intensive services.

1.1.2 Contractor shall design its Behavioral Health service delivery system for Children consistent with the values and principles of Systems of Care, Wraparound, and the N.B. consent decree program design. This includes a commitment to working collaboratively with the Department to ensure that Behavioral Health services are delivered in a manner that is family-driven, youth-guided, strengths-based, individualized, community-based, trauma-informed, data-driven, and culturally and linguistically competent.

1.1.3 Contractor shall adhere to and implement all aspects of the N.B. consent decree relevant to the Medicaid Managed Care Program as set forth in the N.B. consent decree dated January 16, 2018, and the N.B. implementation plan dated December 2, 2019, and any subsequent revisions, updates or related court orders, all of which shall be incorporated herein and made part of this contract and are available here: <https://www2.illinois.gov/hfs/info/legal/Pages/NBConsentDecree.aspx>.

1.1.4 Contractor shall incorporate the specific requirements of the N.B. consent decree and implementation plan into Contractor's overall Children's Behavioral Health service delivery design. Where requirements of the N.B. consent decree or implementation plan overlap with or conflict with other requirements of this Contract, the N.B. consent decree or implementation plan shall prevail.

1.1.5 **Plan for Implementing N.B. Requirements.** Contractor shall establish a plan for implementing the requirements of this Contract related to the N.B. consent decree. The plan shall include specific activities and timeframes and shall minimally address the following: Enrollee communication and education, Provider Network development and oversight, necessary system updates (e.g. claiming), Care Coordination, Utilization Management, coordination with CCSOs, and Continuity of Care. Contractor shall submit its initial plan to the Department for review and Prior Approval ninety (90) days after the effective date of this Amendment. Contractor shall thereafter annually update its plan for implementing N.B. requirements and submit it to the Department for review and Prior Approval by July 1 of each year.

- 1.1.6 **Plan for Family Driven Care.** Contractor shall establish a plan for Family Driven Care, 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 plan for Family Driven Care to the Department for review and Prior Approval ninety (90) days prior to the Effective Enrollment Date of the first Enrollee. Contractor shall thereafter annually update its plan for Family Driven Care and submit it to the Department for review and Prior Approval by no later than July 1st of each calendar year. The plan for Family Driven Care shall, at a minimum:
- 1.1.6.1 Address how Contractor will establish and maintain a service delivery system that is person and family centric and that incorporates the values and principles of Systems of Care and Wraparound;
 - 1.1.6.2 Address how Contractor will promote and ensure family and Enrollee input across all of the Contracting Area;
 - 1.1.6.3 State the annual goals, objectives, and activities Contractor will complete related to family and youth driven care; and
 - 1.1.6.4 Establish the role of the Family Leadership Council (FLC) in the plan for Family Driven Care. Contractor shall ensure that the FLC reviews and provides official comment on the plan for Family Driven Care prior to Contractor submitting the plan for Family Driven Care for review and approval by the Department at initiation and annually thereafter.
 - 1.1.6.5 Contractor is encouraged to seek technical assistance on best practices for enhancing Family Driven Care from an organization that is led by and that employs individuals with lived experience in navigating one or more child-serving systems as a caregiver or as a customer (also known as a family-run organization) or similar resource with appropriate expertise, such as the National Federation of Families or the Family Run Executive Director Leadership Association (FREDLA).

1.2 REQUIREMENTS FOR N.B. CLASS MEMBERS.

- 1.2.1 Contractor acknowledges and agrees to provide eligible Enrollees access to the Pathways to Success (Pathways) program as a core component of the Department's implementation of the N.B. consent decree. Contractor acknowledges that all Enrollees the Department determines eligible for Pathways are N.B. class members and shall provide access to services consistent with all eligibility determinations made by the Department.
- 1.2.2 Contractor agrees to meet all applicable requirements in this agreement regarding N.B. class members for any Enrollee identified by the Department as an N.B. class member, regardless of the extent to which the Enrollee participates in the Pathways program.
- 1.2.3 Contractor shall provide communication, education, and assistance to N.B. class members regarding the Pathways to Success program, their rights, service options, and applicable processes as needed to comply with the N.B. consent decree and N.B. implementation plan.
- 1.2.4 Contractor shall provide coverage of the following home and community-based services to Enrollees in the Pathways to Success program, referred to hereafter as Pathways Services: Care Coordination and Support (CCS), Respite, Intensive Home-Based (IHB), Family Peer Support, and Therapeutic Mentoring.

- 1.2.5 Contractor shall participate in a Joint Pathways Oversight Committee convened by the Department. The Joint Pathways Oversight Committee shall be responsible for monitoring and providing oversight of all components of Pathways administration and operation, including but not limited to: Provider Network development; conducting Provider audits and quality reviews; establishing standardized reporting templates and processes for Pathways Providers and N.B. class members; reviewing process and outcome reports, establishing corrective action plans, incentive strategies, or other quality improvement efforts with Providers of Pathways Services; and, providing technical assistance and support to Providers in the implementation of Pathways.
- 1.2.6 Contractor shall provide to the Department all requested reports, report methodologies, and data related to the requirements of Attachment XXII and the N.B. consent decree in a format and manner defined by the Department, and shall work collaboratively with the Department in the development of any new required reports. The Department will provide Contractor with no less than thirty (30) days written notice prior to implementing any new report requirements.
- 1.2.7 Provider Network Requirements.**
- 1.2.7.1 Contractor shall collaborate with the Department in the selection and implementation of Care Coordination and Support Organizations (CCSOs), including participating in credentialing, readiness review, and other related processes designed to ensure the capacity and capability of CCSOs to provide CCS to Enrollees in Pathways.
- 1.2.7.2 In collaboration with the Department or its designee, Contractor shall provide ongoing training, support, and technical assistance to CCSOs, CMHCs, BHCs, hospitals, PCPs, and other Behavioral Health Providers on the CBH Service Delivery System and the N.B. implementation plan.
- 1.2.7.3 Contractor shall recruit Providers of Pathways Services into Contractor's Provider Network and shall monitor its Provider Network to ensure adequate access to Medically Necessary services for Enrollees in Pathways consistent with sections 5.8.1 and 5.8.3 of this Contract. Contractor shall negotiate in good faith and enter into a Network Agreement with any willing Providers enrolled with the Department to deliver Pathways services.
- 1.2.7.4 Contractor shall negotiate in good faith and enter into a Network Agreement with all Providers enrolled for participation as a CCSO in the Medical Assistance Program and must ensure that all Enrollees in the Pathways program have access to the CCSO in their home designated service area or other geographic area determined by the Department.
- 1.2.7.5 Contractor shall require that its Network Providers of CCSOs:
- 1.2.7.5.1 Deliver CCS services consistent with all service requirements established by the Department, including but not limited to those outlined in the applicable Department Handbook; and,
- 1.2.7.5.2 Provide Contractor with a minimum of ninety (90) days advance written notice in the event the Provider is no longer willing or capable of continuing to serve as a CCSO within parts or all the Provider's designated service area (DSA).

1.2.8 Care Coordination Requirements.

- 1.2.8.1 Contractor shall stratify all Enrollees designated as N.B. class members as high-risk (level 3). Enrollees shall remain stratified as high-risk for a period of no less than one hundred-eighty (180) days after the Enrollee is no longer designated as an N.B. class member by the Department.
- 1.2.8.2 Contractor shall assist CCSOs in locating, engaging, and educating Enrollees identified as N.B. class members or as eligible for participation in Pathways using a multifaceted approach that may include, but is not limited to: direct Enrollee outreach; use of Enrollee claims and care management data; PCP engagement; CFT member engagement; and usage of Care Coordinators, Community Health Workers, Family Peer Support workers, or other community liaisons.
- 1.2.8.3 Contractor shall assign a Care Coordinator to serve as a liaison to each child and family team (CFT) established for Enrollees in Pathways, helping provide education and navigation of the Contractor's processes and requirements, including helping identify providers in Contractor's network and other resources to ensure service provision consistent with the IPoCs for Enrollees in Pathways and reduce barriers to accessing care. The assigned Care Coordinator shall attend CFT meetings as needed, based upon family preference, and as requested by the CFT.
- 1.2.9 Utilization Management Requirements.**
- 1.2.9.1 Contractor shall accept the IM+CANS established by the CCSO and the Enrollee's CFT, as applicable, as the IPoC for Enrollees who are N.B. class members.
- 1.2.9.2 Contractor shall establish Utilization Management and Prior Authorization policies and procedures, subject to Prior Approval, for N.B. class members that ensures the following:
- 1.2.9.2.1 Utilization Management staff shall base any service utilization reviews conducted on community-based Behavioral Health services for N.B. class members on the Enrollee's completed IM+CANS.
- 1.2.9.2.2 Any service authorization activity for an N.B. Class Member takes into consideration the service recommendations of the Enrollee's CFT, as applicable, and as documented on the Enrollee's IM+CANS or other related CFT documentation.
- 1.2.9.2.3 Medical necessity and service utilization standards for community-based Behavioral Health services and Pathways services are consistent with Department established standards.
- 1.2.9.3 Contractor shall not prior authorize Pathways Services in a manner more restrictive than the Department's fee-for-service system or apply any prior authorization or utilization management policies or procedures to Pathways or community-based Behavioral Health services for N.B. class members beyond those established and specifically approved by the Department.
- 1.2.9.4 Contractor shall ensure that Utilization Management staff responsible for performing service utilization reviews for N.B. class members are adequately trained in the N.B. consent decree and implementation plan requirements, IM+CANS, the Wraparound process including the role of the child and family team, and as appropriate other relevant tools and clinical assessments (e.g. functional behavioral assessments, behavioral health screening tools).

1.3 MOBILE CRISIS RESPONSE SYSTEM.

- 1.3.1 Contractor shall establish a Mobile Crisis Response (MCR) system capable of responding immediately to Enrollees experiencing a Behavioral Health Crisis and providing short-term crisis intervention and stabilization services to Enrollees post-crisis, consistent with the requirements of this section 1.3.
- 1.3.2 Contractor shall require that all Children 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.*).
- 1.3.3 Contractor acknowledges the existence of the Screening, Assessment, and Support Services (SASS) Program, cooperatively administered by DCFS, the DHS Division of Mental Health, and the Department.
- 1.3.4 Contractor shall provide Enrollees and their families with information on how and when to engage Contractor's Mobile Crisis Response (MCR) system, including how to access Contractor's Behavioral Health Crisis line and MCR providers. This information shall be included in Contractor's Member Handbook and easily accessible on Contractor's website.
- 1.3.5 **Behavioral Health Crisis Line.**
- 1.3.5.1 Contractor shall establish a dedicated Behavioral Health Crisis line for Enrollees, family members of Enrollees, or other concerned parties seeking to refer any Enrollee to Behavioral Health Crisis services.
- 1.3.5.2 Contractor shall ensure that Contractor's Crisis line does not require callers to navigate a telephonic menu to make a referral for Crisis services.
- 1.3.5.3 Contractor's Crisis line shall adjudicate crisis referrals for Enrollees in a timely and efficient manner to determine if the Enrollee meets clinical acuity for MCR services.
- 1.3.5.3.1 If the Enrollee is determined to meet clinical acuity, the Crisis line shall immediately dispatch Contractor's designated MCR provider to the location of the Enrollee in crisis.
- 1.3.5.3.2 Contractor shall establish protocols for the Crisis line to provide callers with information on how to access outpatient behavioral health services through the Contractor's behavioral health service delivery system when the Enrollee does not meet clinical acuity for MCR services.
- 1.3.5.3.3 Contractor's Behavioral Health Crisis Line protocols shall be subject to Department review and Prior Approval.
- 1.3.5.4 **Interface with the CARES.** Contractor acknowledges the existence of the Crisis and Referral Entry Service (CARES) Behavioral Health Crisis line cooperatively administered by DCFS, the DHS Division of Mental Health, and the Department.
- 1.3.5.4.1 Contractor acknowledges that the Department shall issue the CARES per call rate annually.

- 1.3.5.4.2 CARES shall adjudicate all Crisis referrals received for Contractor's Enrollees. Contractor shall reimburse CARES at the Department issued per call rate in the instance Contractor does not have an executed contract with CARES.
- 1.3.5.4.3 Contractor shall provide CARES with the details of its MCR System, including the telephone numbers needed to access its designated MCR providers.
- 1.3.5.4.4 Contractor shall accept invoices from CARES monthly and shall remit payment to CARES within forty-five (45) days after receiving an invoice.
- 1.3.5.4.5 If CARES is unable to dispatch Contractor's designated MCR provider, CARES shall dispatch the fee-for-service designated MCR provider to ensure timely Crisis response to the Enrollee.
- 1.3.5.4.6 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.

1.3.6 Mobile Crisis Response Services.

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

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

1.3.6.2.1 Within ninety (90) minutes of notification of an emergency referral. An emergency referral involves an Enrollee who presents in Behavioral Health Crisis and who requires an immediate screening and assessment to determine if they can be safely stabilized in the community.

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

1.3.6.3 Contractor shall require that its Network Providers of MCR services:

1.3.6.3.1 Deliver MCR services consistent with all service requirements established by the Department including, but not limited to, those outlined in the Department's Handbook for Providers of Community-Based Behavioral Services, such as the usage of the IM-CAT as the standardized MCR screening tool;

- 1.3.6.3.2 Provide immediate and sufficient Crisis and Stabilization services to stabilize an Enrollee in the community when at all possible and appropriate for the Enrollee; and,
- 1.3.6.3.3 Provide Enrollees and their family with contact information that may be used at any time, twenty-four (24) hours a day, to contact the Provider in moments of Behavioral Health Crisis in lieu of utilizing the CARES line.
- 1.3.6.4 If an Enrollee is screened, due to necessity, by a Non-Network Provider of MCR services, Contractor shall pay for the MCR service at the Medicaid rate.

1.3.7 Inpatient Institutional Treatment.

- 1.3.7.1 Contractor shall require its Network Providers of MCR services to facilitate the Enrollee's admission to an appropriate inpatient treatment setting, including arranging for the necessary transportation, when the Enrollee in Crisis cannot be stabilized in the community
- 1.3.7.2 Contractor shall require its Network Providers of MCR services to inform the Enrollee and their parents, guardians, or caregivers, as applicable, about all available inpatient Network Providers and any pertinent policies needed to allow the involved parties to select an appropriate inpatient institutional treatment setting.
- 1.3.7.3 Contractor shall establish policies that outline a process for Network Providers of MCR services and hospitals to escalate access to care issues to Contractor in instances when an Enrollee is experiencing a Behavioral Health Crisis. The policies shall minimally include a requirement and process for Network Providers of MCR services and hospitals to notify Contractor in the instance:
 - 1.3.7.3.1 An Enrollee requiring psychiatric inpatient hospitalization remains in an Emergency Department for a period of 24 hours or greater due to the inability to locate a hospital willing or able to admit the Enrollee; and
 - 1.3.7.3.2 An Enrollee receiving psychiatric inpatient services is identified as at significant risk of remaining at the inpatient facility after the Enrollee has been medically cleared for discharge.
- 1.3.7.4 Contractor or, when applicable, its Network Provider of CCS services working with the Enrollee, shall convene an emergency ICT for any Enrollee identified through the process outlined in Section 1.3.7.3 of this Attachment XXII that minimally includes the MCR Provider, the Enrollee's guardian, if appropriate, any community providers offering community-based services to the Enrollee, and representatives from any State Agencies offering services to the Enrollee within 48 hours of notification of the Enrollee's status.
 - 1.3.7.4.1 Contractor will continue to convene the ICT for the Enrollee until appropriate treatment services are identified and the Enrollee is transitioned to those services.
- 1.3.7.5 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.

- 1.3.7.6 Contractor shall provide and have documented procedure requirements for Network Providers regarding discharge and transition planning, consistent with the following:
- 1.3.7.6.1 Discharge and Transition planning shall begin upon admission;
 - 1.3.7.6.2 The Network Provider of MCR services shall:
 - 1.3.7.6.2.1 Participate in and take lead in coordinating staffing, discharge, and transition processes with assistance from the Enrollee's Care Coordinator, including coordinating all necessary follow-up appointments and referrals for the Enrollee upon transition back into the community. Appointments shall be established prior to discharge to ensure continuity across care providers;
 - 1.3.7.6.2.2 Notify the Enrollee's family and caregiver of key dates and events related to the admission, staffing, discharge, and transition of the Enrollee, and shall make every effort to involve the Enrollee and the Enrollee's family and caregiver in decisions related to these processes; and,
 - 1.3.7.6.2.3 Speak directly with the Enrollee at least once each week while the Enrollee is receiving inpatient services.
 - 1.3.7.6.3 The Enrollee's Care Coordinator and community-based Providers responsible for providing services upon the Enrollee's discharge shall participate in all inpatient staffings by phone, videoconference, or in person.
 - 1.3.7.6.4 Contractor shall coordinate communication of admission, pharmaceutical, and discharge data, consistent with the consents and releases secured, to the necessary Network Providers to promote Continuity of Care.
 - 1.3.7.6.5 Contractor shall include a provision in its contracts or other agreements with its hospitals and Network Providers to notify Contractor or the MCR provider, as appropriate, at least twenty-four (24) hours in advance of any discharge from inpatient hospital stays.
- 1.3.8 **Crisis Safety Plans.** Contractor shall require its Network Providers of MCR services to:
- 1.3.8.1 Create, or review and update, a Crisis Safety Plan for all Enrollees that present in Behavioral Health Crisis, in collaboration with the Enrollee and their family, consistent with the following timelines:
 - 1.3.8.1.1 Prior to the completion of crisis intervention and stabilization services necessary to stabilize an Enrollee in the community following an MCR screening;
 - 1.3.8.1.2 Prior to the Enrollee's discharge from an inpatient psychiatric hospital setting for any Enrollee admitted to such a facility. When applicable, the MCR provider shall coordinate the completion of the Crisis Safety Plan with the Enrollee's CCSO.
 - 1.3.8.2 Provide Enrollees and their families with physical copies of the Crisis Safety Plan consistent with the timelines in section 1.3.8.1 of this Attachment XXII.

- 1.3.8.3 Educate and orient the Enrollee and their family to the components of the Crisis Safety Plan, ensure that the plan is reviewed with the family regularly, and explain to the Enrollee and their family how the plan is updated as necessary.
- 1.3.8.4 Share the Crisis Safety Plan with all necessary medical professionals, including Care Coordinators and the Enrollee's CCSO, consistent with the authorizations established by consent or release.
- 1.3.9 Follow-Up After a Crisis Event.**
- 1.3.9.1 Contractor shall establish policies promoting access to and delivery of crisis stabilization and follow-up services that shall minimally include:
- 1.3.9.1.1 Policies and protocols that refer and immediately link Enrollees who have been community stabilized following a Crisis event with an urgent appointment with a mental health provider within one (1) Business Day after the Crisis event, if deemed Medically Necessary.
 - 1.3.9.1.2 Policies defining an established period post-Crisis, no less than thirty (30) days, during which Contractor shall not require prior authorization of outpatient mental health services.
 - 1.3.9.1.3 Policies requiring Network Providers to educate Enrollees who may be eligible for the State-funded Family Support Program (FSP) pursuant to 89 Ill. Adm. Code 139 about FSP to help these Enrollees access community-based services.
- 1.3.9.2 For Enrollees not receiving CCS services, Contractor shall convene an ICT meeting for Enrollees within fourteen (14) days after a Crisis event if the Enrollee is community stabilized and within fourteen (14) days after discharge if the Enrollee is hospitalized.
- 1.3.9.2.1 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.
- 1.3.9.3 Contractor shall ensure that the Enrollee has a scheduled appointment with a Behavioral Health Provider for follow-up within seven (7) days after the Enrollee's discharge from hospitalization.
- 1.3.9.4 Psychiatric Resource and Pharmacological Services.
- 1.3.9.4.1 For all Enrollees referred for MCR services, Contractor shall establish procedures and facilitate priority access to a psychiatric resource to provide consultation and medication management services, as Medically Necessary, within the following timeframes:
 - 1.3.9.4.1.1 Fourteen (14) days after an Enrollee's discharge from an inpatient psychiatric hospital setting; or,
 - 1.3.9.4.1.2 Within three (3) days after the Crisis event for an Enrollee who is community stabilized.
 - 1.3.9.4.2 Contractor shall have procedures for communicating to the Enrollee's PCP the pharmacological services performed as part of MCR service, consistent with all consents and releases.

- 1.3.9.4.3 Contractor shall attempt to supplement the psychiatric resources available through its network with telepsychiatry services. Telepsychiatry services may include identifying available psychiatric resources and enhancing access outside the Coverage Area by connecting such resources to the Coverage Area or utilizing resources within the Coverage Area more efficiently by making such resources available to more rural Enrollees via electronic means. All telehealth services must be delivered consistent with any rules or requirements on telehealth established by HFS including but not limited to 89 Ill. Adm. Code 140.403.
- 1.3.10 Contractor shall make available the details of its MCR 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 MCR service model to the Department, in a format developed by the Department that includes but is not limited to a detailed report of utilization, outcomes, and hospitalization rates.

1.4 DISCHARGE PLANNING AND TRANSITIONAL SUPPORTS.

For Enrollees not receiving CCS services, Contractor shall:

- 1.4.1 provide Enrollees with access to discharge planning and transitional services when being discharged from a psychiatric institutional level of care (e.g., hospital, PRTF, residential, Crisis respite), to lower levels or community-based services. Contractor shall work with the involved parties to facilitate appropriate follow-up services, including the scheduling of follow-up treatment appointments.
- 1.4.2 require the Care Coordinator to retain accountability and responsibility for the Enrollee as the transition between levels of care occurs.
- 1.4.3 provide oversight regarding admissions and discharge dates for Enrollees. This oversight shall include facilitating the link between the institutional-based care Providers and Contractor's Care Coordinators. Contractor shall initiate follow-up care within seven (7) days after discharge from institutional levels of care and provide oversight that appropriate levels of services are being provided.
- 1.4.4 develop, implement, and follow a procedure to confirm that a medication management review has been completed prior to discharge from institutional levels of care; to confirm that PCPs are made aware of any medications that have been prescribed for Enrollees during treatment at an institutional setting; and to confirm with the Enrollees that they have the ability to get prescribed medications.
- 1.4.5 communicate directly with the Enrollee or Enrollee's family within forty-eight (48) hours after transition.
- 1.4.6 assist the Enrollee in attending all post-discharge appointments for follow-up care. Contractor shall provide appropriate Care Management based on concurrent assessment for an appropriate period of time following discharge, involving other parties (e.g. CCSO, MCR provider, DCFS caseworker) in the Care Management as necessary.

ATTACHMENT XXIII: <INTENTIONALLY LEFT BLANK>

ATTACHMENT XXIV: REQUIREMENTS SPECIFIC TO DCFS YOUTH IN CARE ENROLLEES

1.1 DEFINITIONS

- 1.1.1 **Authorized Representative** means an individual, case worker, group, entity, or other person(s) approved by DCFS Guardianship Administrator who is legally authorized to speak for or on behalf of the Enrollee and which has been communicated to Contractor through DCFS.
- 1.1.2 **Comprehensive Health Evaluation** means the evaluation that is conducted within twenty-one (21) days of DCFS temporary custody and includes: (i) an Early and Periodic Screening, Diagnostic and Treatment program (EPSDT) examination; (ii) vision, hearing, and dental screening, when appropriate; and (iii) mental health, developmental, and alcohol and substance abuse screenings, when appropriate. Resulting referrals for specialized services are made as needed.
- 1.1.3 **DCFS** means the Illinois Department of Children and Family Services.
- 1.1.4 **DCFS Authorized Agent** means DCFS staff who have been appointed and authorized by the DCFS Guardianship Administrator to officially act in the place of the DCFS Guardianship Administrator to authorize and consent to matters concerning DCFS Youth in Care.
- 1.1.5 **DCFS Caseworker** means the representative of record who has primary responsibility for a DCFS Youth in Care's child welfare case management, working with the youth and the youth's family to identify services to address issues that brought the youth into the child welfare system and providing updates to and making court appearances in the youth's Juvenile Court case. The DCFS Caseworker may be employed by DCFS or by a contracted Purchase of Service (POS) agency and may also be referred to as a "permanency worker."
- 1.1.6 **DCFS Guardianship Administrator** means that person designated by the Director of DCFS to serve as guardian of children accepted by DCFS pursuant to the Juvenile Court Act, the Children and Family Services Act, the Abused and Neglected Child Reporting Act, and the Adoption Act. The DCFS Guardianship Administrator has the legal authority to consent to certain medical and behavioral health services for DCFS Youth in Care based on the specific orders entered

in the Juvenile Court and on the specific ages of DCFS Youth in Care, in accordance with DCFS Rule 327.

- 1.1.7 **DCFS Service Plan** means a written plan on a form prescribed by DCFS that guides all individuals in the plan of child welfare intervention toward the permanency goals for DCFS Youth in Care. The DCFS Service Plan is developed by the DCFS Caseworker and other members of the Child and Family Team in accordance with DCFS Procedure 302, and indicates all services required for the child including services that are ordered by Juvenile Court.
- 1.1.8 **DCFS Youth** means both DCFS Youth in Care and Former Youth in Care who are Potential Enrollees, Prospective Enrollees or Enrollees.
- 1.1.9 **DCFS Youth in Care** means a youth who is under the legal custody or guardianship of DCFS.
- 1.1.10 **Former Youth in Care** means a youth under the age of 21 who was previously under the legal custody or guardianship of DCFS but was reunified with their biological family, was adopted, was placed in subsidized guardianship, or whose Juvenile Court case was closed and is no longer under the legal custody of DCFS.
- 1.1.11 **Health Passport** means a summary of health information for each DCFS Youth in Care that contains the youth's health history, present health care and medical conditions, if any, and available health information about the youth necessary for the youth's proper care.
- 1.1.12 **HealthWorks** means a comprehensive system of health care developed by DCFS for all Illinois children and youth in foster care that ensures they have access to quality health care, routine health care and special health care that meets their identified health care needs and provides documentation of health needs and health care information that is readily accessible to caregivers, other healthcare providers and DCFS. HealthWorks provides access to and referral for primary health care physicians, initial health screenings, comprehensive health evaluations, well-child examinations and immunizations.
- 1.1.13 **Initial Health Screening** means the medical screening that is conducted within twenty-four (24) hours of DCFS temporary custody to identify health conditions that require prompt medical attention and to consider in making substitute care placement decisions.
- 1.1.14 **Interim Medical Case Management** means medical case management services provided by a HealthWorks lead agency for a child within the first forty-five (45) days of being placed in DCFS temporary custody. Activities required

include, at a minimum, enrollment in HealthWorks, selection of a primary care physician, gathering of child and family health information, initiation of requests for prior health records, receipt of initial health screening documentation, completion of a Comprehensive Health Evaluation, ensuring provision of the Health Passport to the caregiver of the child, providing appropriate documentation and other information to the assigned permanency worker for inclusion in the DCFS Service Plan, and supporting the completion of any appropriate screening tools as necessary.

- 1.1.15 **Juvenile Court** means a court that is presiding over matters related to petitions alleging that a child or youth is abused, neglected, dependent or delinquent under the provisions of the Juvenile Court Act, 705 ILCS 405.1 et seq.
- 1.1.16 **Permanency Goal** means the desired outcome of child welfare intervention and service that is determined to be consistent with the health, safety, well-being, and best interests of the DCFS Youth in Care as defined by the Juvenile Court Act.
- 1.1.17 **Psychotropic Medication** means any medication capable of affecting the mind, emotions and behavior. This includes medications whose use for antipsychotic, antidepressant, antimanic, antianxiety, behavioral modification or behavioral management purposes is listed in AMA Drug Evaluations, latest edition, or Physician's Desk Reference, latest edition or that are administered for any of these purposes [405 ILCS 5/1-121.1]. For the purpose of this definition, medications used to induce or sustain sleep or to treat symptoms of aggression, enuresis and psychotropic medication-induced adverse effects are also included.
- 1.1.18 **Purchase of Service (POS) Agency** means a licensed child welfare agency with whom DCFS contracts to provide child welfare services to youth and families.
- 1.1.19 **Retained Behavioral Health Services** means all behavioral health services which are potentially eligible for reimbursement under Medicaid but are being paid by DCFS, as of the Comprehensive Implementation Date.
- 1.1.20 **Significant Events** are serious, sometimes traumatic occurrences that affect children and youth served by DCFS, are subject to mandatory reporting requirements, and are described in additional detail in DCFS Procedure 331.

1.2 TRANSITION FROM YOUTH IN CARE TO FORMER YOUTH IN CARE

1.2.1 At the time a DCFS Youth in Care Enrollee becomes a Former Youth in Care, the Enrollee will remain enrolled with Contractor until the Enrollee's next Open Enrollment Period.

1.3 WELCOME PACKET

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

1.4 PHARMACY REQUIREMENT

1.4.1 Contractor shall comply with the requirements of DCFS Rule and Procedure 325, including all requirements for consents and the development of a system that maintains the requirement of prior authorization from DCFS prior to the administration of any psychotropic medication and stops prescriptions for psychotropic medications from being filled at a pharmacy if no prior authorization has been received from DCFS.

1.5 [THIS SECTION INTENTIONALLY LEFT BLANK]

1.6 INTERIM MEDICAL CASE MANAGEMENT CONTRACTING REQUIREMENT

1.6.1 Contractor is responsible for the provision of Interim Medical Case Management. In the event a DCFS Youth in Care, upon enrollment with Contractor, is receiving services through a HealthWorks lead agency, Contractor shall enter into a single-case agreement with that HealthWorks lead agency to provide Interim Medical Case Management through the first forty-five (45) days of DCFS custody of the youth. The Interim Medical Case Management services shall include, at a minimum, gathering of child and family health information, initiation of requests for prior health records, receipt of twenty-four (24) hour initial health screenings, selection of primary care physician, completion of the Comprehensive Health Evaluation within twenty-one (21) days of DCFS temporary custody and provision of the Health Passport to the DCFS Youth in Care's caregivers, and supporting the completion of any appropriate screening tools as necessary.

1.7 COORDINATION AND COMMUNICATION TOOLS

1.7.1 Contractor shall have fully operational portals, and secure email, which provide the DCFS Guardianship Administrator or Authorized Agents, DCFS Caseworkers, Enrollees, and Providers access to relevant information from the Care Management system, as applicable.

1.8 RISK STRATIFICATION

1.8.1 In the event DCFS is not in agreement with the risk level determination made by Contractor for a DCFS Youth in Care Enrollee, Contractor will work collaboratively with the Department and DCFS to resolve the disagreement and ensure that the best interest and needs of the DCFS Youth in Care Enrollee are met.

1.9 INTERDISCIPLINARY CARE TEAM (ICT)

1.9.1 Contractor shall support an ICT for all DCFS Youth in Care Enrollees stratified as Level 3 (high-risk) and Level 2 (moderate-risk). Contractor shall make reasonable efforts to collaborate with the DCFS Caseworker to ensure that the ICT is coordinated with all DCFS team-based decision-making processes, such as Child and Family Team meetings; that the Care Coordinator is able to participate, as needed, in the DCFS team-based decision-making process; and, that the IPoC is updated as necessary with information or decisions made during a DCFS team-based decision-making process.

1.10 INDIVIDUALIZED PLANS OF CARE (IPOC) AND SERVICE PLANS

1.10.1 Contractor shall develop an IPoC for all DCFS Youth in Care Enrollees stratified as Level 3 (high-risk) and Level 2 (moderate-risk). Contractor shall include information from DCFS as available. The IPoC shall be coordinated and consistent with the DCFS Service Plan as follows, given that DCFS provides this information to Contractor:

1.10.1.1 The IPOC shall include all goals and services that are necessary to support the Permanency Goal established in the DCFS Service Plan, given that DCFS provides this information to Contractor.

1.10.1.2 Information from the DCFS Service Plan will be incorporated into the IPoC as available.

- 1.10.1.3 Contractor shall not have responsibility for the payment for any non-Medicaid Services included in the DCFS Service Plan. DCFS shall retain responsibility for payment for all non-Medicaid Services.
- 1.10.1.4 Contractor shall notify the DCFS Caseworker within two (2) Business Days when the IPoC is updated. The updated IPoC shall be available for the DCFS Caseworker through the Enrollee portal.

1.11 APPROVED CONTACTS FOR DCFS YOUTH IN CARE ENROLLEES

- 1.11.1 Contractor shall ensure that contact is made only with Authorized Representatives.

1.12 HEALTH, SAFETY, AND WELFARE MONITORING

- 1.12.1 Contractor shall comply with DCFS rules and procedures for reporting Significant Events.

1.13 ADDITIONAL TRAINING FOR CARE COORDINATORS

- 1.13.1 Contractor's Care Coordinators assigned to DCFS Youth in Care Enrollees 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. Contractor shall have no less than two (2) Care Coordinators who have attended the Department-sponsored DCFS managed care and child welfare training.

ATTACHMENT XXV: 42 CFR 438.6(c) State-Directed Payment (SDP) Descriptions

1.1 STATE-DIRECTED PAYMENTS

Contractor shall comply with the Department's instructions in disbursing payments pursuant to federal CMS-approved State-directed payments (SDPs) authorized under 42 CFR 438.6(c).

1.1.1 Managed Care Access Payments (MCAP)

Implemented January 1, 2018, these utilization-based State-directed payments are made to all hospitals qualifying for enhanced payments under the Medicaid State Plan; as such, Cook County Health and Hospital System Hospitals and the University of Illinois Hospital are excluded. The payments are a fixed dollar amount add-on based on inpatient admissions or days, depending on class of hospital, and outpatient claims, and are made monthly through a separate payment term outside of Contractor's Capitation payment. Payment amounts are calculated by the Department using Contractor's Encounter claims data and vary by class of hospital and the inpatient add-on for High Medicaid and General Acute Hospitals multiplied by the hospital's case mix index. The Department will provide Contractor detailed instructions on the amount to pay each hospital.

1.1.2 Large Non-State Government Hospitals

Implemented January 1, 2020, these utilization-based State-directed payments are made to Large Non-State Government Hospitals (i.e., the two Cook County Health and Hospital System (CCHHS) hospitals). The payments are an uniform percentage add-on to Contractor's rate of reimbursement for inpatient and outpatient services (percentage differs for inpatient and outpatient services) and are made monthly through a separate payment term outside of Contractor's Capitation payment. The add-on amount is the difference between Contractor's reimbursement and the Medicaid State Plan approved rate plus previous pass-through payments received by the hospital from the Department. Payment amounts are calculated by the Department using Contractor's Encounter claims data. The Department will provide Contractor detailed instructions on the amount to pay each hospital.

1.1.3 Cook County Health and Hospital System (CCHHS) Encounter Rate Clinics

Implemented January 1, 2020, these utilization-based State-directed payments are made to Encounter Rate Clinics of non-State Government Owned Providers. The payments are an add-on equal to the difference between Medicaid State Plan approved Encounter rates and Contractor's claim payments per Contractor's physician fee schedules and are made monthly through a separate payment term outside of Contractor's Capitation payment. Payment amounts are calculated by the Department using Contractor's Encounter claims data. The Department will provide Contractor detailed instructions on the amount to pay each clinic.

1.1.4 State-Owned Medical Schools Average Commercial Rate (ACR) for Physicians

Implemented January 1, 2021, these utilization-based State-directed payments are made to physicians employed by State-owned medical schools, specifically the University of Illinois and Southern Illinois University. The payments are an add-on equal to the difference between Medicaid State Plan approved average commercial rates for the medical schools and Contractor's claim payments per Contractor's physician fee schedules for each service provided at a CPT code level and are made quarterly through a separate payment term outside of Contractor's Capitation payment. Payment amounts are calculated by the Department using Contractor's Encounter claims data. The Department will provide Contractor detailed instructions on the amount to pay each medical school.

1.1.5 Hospital Transformation

Implemented January 1, 2022, these utilization-based State-directed payments are made to Department-approved hospitals participating in the delivery system transformation program. Participating classes of hospital include: Cook County Safety Net, Metro East Safety Net and Acute, Rural Safety Net and Acute, and High Medicaid and Other Acute. The payments are a fixed dollar amount add-on based on inpatient and outpatient claims and are made monthly through a separate payment term outside of Contractor's Capitation payment. Payment amounts, which vary by class of hospital, are calculated by the Department using Contractor's Encounter claims data. The Department will provide Contractor detailed instructions on the amount to pay each hospital.

1.1.6 Lurie Children's Hospital InCK Innovation Grant

Implemented January 1, 2022, these State-directed payments are made to qualifying primary care physicians (PCPs). To qualify, PCPs must opt-in and contract with Lurie Children Hospital's All Hands Health Network (AHHN) to serve as fiscal agent to administer the earned bonus. This directed payment is a quality payment alternative payment model (APM) linked to the Integrated Care for Kids (INCK) CMMI Innovation Grant that provides PCPs the ability to earn a PMPM bonus payment for achievement of specified quality metrics. Contractor shall make payments to Providers from its monthly Capitation rate, as the cost of these payments were incorporated into the Capitation rate as a rate adjustment.

1.1.7 Nursing Facilities Quality Star Rating

Implemented July 1, 2022, these utilization-based State-directed payments are made to Nursing Facilities (excluding CMS-designated special focus facilities and hospital-based nursing homes). The payments are an add-on quality bonus based on each Nursing Facility's Medicaid days and Star Rating (ratings of two (2) and above are weighted). An established quarterly pool of funding is divided by qualifying weighted days. Payments are made quarterly through a separate payment term outside of Contractor's Capitation payment. Payment amounts are calculated by the Department based on federal CMS' Nursing Facility Star Ratings. The Department will provide Contractor detailed instructions on the amount to pay each Nursing Facility.

1.1.8 Behavioral Health Assertive Community Treatment

Pursuant to federal CMS approval, the implementation date is July 1, 2022. These State-directed payments are made to Community Mental Health Centers (CMHCs) for the provision of assertive community treatment (ACT) outpatient services. The payments are uniform dollar amount increases of \$6,000 per member per year (PMPY) for Enrollees receiving a threshold amount of three hundred (300) units of service per year. Payments are made monthly through a separate payment term outside of Contractor's Capitation payment. Payment amounts are calculated by the Department using Contractor's Encounter claims data. The Department will provide Contractor detailed instructions on the amount to pay each clinic.

1.1.9 Behavioral Health Community Support Services

Pursuant to federal CMS approval, the implementation date is July 1, 2022. These State-directed payments are made to Community Mental Health Centers (CMHCs) and Behavioral Health Centers (BHCs) for the provision of community

support services (CSS) outpatient services. The payments are uniform dollar amount increases of \$4,200 per member per year (PMPY) for Enrollees receiving a threshold amount of two hundred (200) units of service per year. Payments are made monthly through a separate payment term outside of Contractor's Capitation payment. Payment amounts are calculated by the Department using Contractor's Encounter claims data. The Department will provide Contractor detailed instructions on the amount to pay each clinic.

1.1.10 Egyptian Health Department InCK Innovation Grant

Implemented January 1, 2023, these State-directed payments are made to qualifying primary care physicians (PCPs) and outpatient Behavioral Health (BH) Providers that reside and provide service in one or more of five (5) counties (Saline, Gallatin, White, Hamilton, Wayne). To qualify, PCPs and BH Providers must opt-in and contract with Egyptian Health Department to serve as fiscal agent to administer the earned bonus. This directed payment is a quality payment alternative payment model (APM) linked to the Integrated Care for Kids (INCK) CMMI Innovation Grant that provides PCPs and BH Providers the ability to earn a PMPM bonus payment for achievement of specified quality metrics. Contractor shall make payments to Providers from its monthly Capitation rate, as the cost of these payments were incorporated into the Capitation rate as a rate adjustment.

1.1.11 One-time Hospital COVID Relief Payments

Pursuant to federal CMS approval, during the first quarter of calendar year 2023, Contractor shall make one-time COVID relief payments to hospitals. The payments are a fixed dollar amount add-on based on outpatient claims and, for Safety Net Hospitals only, inpatient days, and are made through a separate payment term outside of Contractor's Capitation payment. Payment amounts are calculated by the Department using Contractor's Encounter claims data and dividing a pool of money allotted to each class of hospital by outpatient claims for High Medicaid, General Acute, Rehabilitation, Government, and Critical Access Hospitals. For Safety Net Hospitals, an additional inpatient add-on per day will be paid. A \$460 million appropriation was allocated across hospital classes based on the percentage of State-directed payments made to that class in calendar year 2022. The Department will provide Contractor detailed instructions on the amount to pay each hospital.

1.1.12 Minimum Fee Schedule SDPs

As described in Sections 5.7.13, 5.29.5, 5.29.13, and 5.29.14 of this Contract, Contractor shall make payment to the University of Illinois Hospital, Home and Community Based Waiver Services Providers, county Nursing Facilities, and critical access pharmacies at a rate no less than the Medicaid State Plan approved fee schedule. Contractor will make payments to these Providers from its monthly Capitation rate, as the cost of these payments were incorporated into the Capitation rate as a rate adjustment.

1.1.12.1 Contractor shall reimburse eligible Nursing Facilities that adopt the Department-specified pay scale and promotional path for CNAs an enhanced daily rate following the methodology in the Medicaid State Plan beginning with dates of service July 1, 2022. The Department will provide Contractor the data necessary to reimburse Nursing Facilities according to that methodology on a quarterly basis.

1.1.12.2 During the first quarter of calendar year 2023, Contractor shall make a one-time COVID relief payment to Behavioral Health Providers. A \$30 million pool appropriated by the State of Illinois General Assembly has been divided among various outpatient Behavioral Health services; the allocations will be divided by claims for those services. Services included are assertive community treatment, community support team, Crisis Intervention, family therapy, individual assessment and treatment plan, medication monitoring APN, medication monitoring physician, and Mobile Crisis Response. An additional add-on will be provided to services rendered to Youth in Care Enrollees. Providers eligible are Community Behavioral Health Centers, Behavioral Health Clinics, and independent Behavioral Health practitioners.

IMMIGRANT ADULTS & IMMIGRANT SENIORS POPULATIONS – ADDENDUM #1

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ARTICLE I: DEFINITIONS AND ACRONYMS

1.3 Additional Defined Terms Specific to the Immigrant Adults and Immigrant Seniors Populations:

- 1.3.1 **Contract Addendum Effective Date** means the date of last signature.
- 1.3.2 **Emergency Services** means services, as defined in Section 1903(v) of the Social Security Act, necessary for the treatment of an emergency medical condition that occurs suddenly and unexpectedly, is caused by injury or illness, and requires immediate medical attention to prevent serious jeopardy to the patient's health, or serious impairment to bodily functions or parts.
- 1.3.3 **Health Benefits for Immigrant Adults Program (HBIA)** means a State of Illinois program created to provide medical coverage for Immigrant Adults who are ineligible for Medicaid due to their immigration status.
- 1.3.4 **Health Benefits for Immigrant Seniors Program (HBIS)** means a State of Illinois program created to provide medical coverage for Immigrant Seniors who are ineligible for Medicaid due to their immigration status.
- 1.3.5 **Immigrant Adults** means persons between the ages of forty-two (42) and sixty-four (64) who are an Illinois resident and are either a lawful permanent resident (LPR) of the United States for less than five years (i.e., non-citizen status that does not meet the criteria for Medicaid), or an undocumented immigrant. Qualifying annual household income is the equivalent of eligibility requirement for the ACA Adult program.
- 1.3.6 **Immigrant Seniors** means persons ages sixty-five (65) or older who are an Illinois resident and are either a lawful permanent resident (LPR) of the United States for less than five years (i.e., non-citizen status that does not meet the criteria for Medicaid), or an undocumented immigrant. Qualifying annual household income and resources are the equivalent of eligibility requirements for the Assistance for Aged, Blind or Disabled (AABD) program.

1.3.7 **Implementation Date** means January 1, 2024 or a later date mutually agreed upon by the Parties documented at least sixty (60) days prior to such a later date by written notice from the Department.

ARTICLE III: ELIGIBILITY

3.3 **Eligibility Determination Process for HBIA Program & HBIS Program.**

The Department has the exclusive right to determine an individual's eligibility for the HBIA Program and the HBIS Program. Such determination shall be final and is not subject to review or appeal by Contractor. The Department maintains the right, for any reason, to limit the number of individuals enrolled into the HBIA Program or the HBIS Program. Enrollment limitation by the Department shall occur by pausing approval of applications for the HBIA Program and the HBIS Program as provided in Illinois P.A. 103-0102.

ARTICLE IV: ENROLLMENT, COVERAGE AND TERMINATION OF COVERAGE

4.1 **ENROLLMENT GENERALLY**

4.1.4 For enrollment of the Immigrant Adults and Immigrant Seniors populations on the Implementation Date, the Department shall auto-assign in accordance with Section 4.5.

4.3 **INITIAL PROGRAM IMPLEMENTATION**

4.3.1 **Immigrant Adults and Immigrant Seniors.** Beginning on the Implementation Date, enrollment of Immigrant Adults and Immigrant Seniors will be phased according to a schedule set by the Department to ensure a smooth transition and to minimize disruption of care. The Department retains the right to begin on a later date and to stagger enrollment in its sole discretion.

4.5 ENROLLMENT BY AUTOMATIC ASSIGNMENT

4.5.3 For the Immigrant Adults and Immigrant Seniors populations, automatic assignment to a qualified MCO will occur as follows:

4.5.3.1 For individuals residing outside of Cook County, automatic assignment will be based on the existing HealthChoice Illinois algorithm in accordance with Section 4.5.

4.5.3.2 For individuals residing in Cook County, automatic assignment shall be to the CountyCare HealthChoice Illinois Health Plan. During initial program implementation, individuals residing in Cook County that are on a Medicaid case with another family member enrolled in HealthChoice Illinois will be assigned to the MCO of the family member.

4.7 EFFECTIVE ENROLLMENT DATE

4.7.1 For the Immigrant Adults and Immigrant Seniors populations, enrollment shall occur as described in section 4.7, unless otherwise paused due to an enrollment cap imposed on the HBIA Program or the HBIS Program.

4.16 IDENTIFICATION CARD

4.16.1.8 copayments required by Contractor in accordance with Section 7.8.1.

ARTICLE V: DUTIES OF CONTRACTOR

5.2 COVERED SERVICES

5.2.7 **Immigrant Adults and Immigrant Seniors Service Package IV.** For the Immigrant Adults and Immigrant Seniors populations, a Service Package IV is established that includes those Covered Services in Service Package I as described in Section 5.2.1.1, other than as follows:

5.2.7.1 organ transplant procedures are limited to kidney transplants and inpatient bone marrow/stem cell transplants;

5.2.7.2 Long-Term Care/Nursing Facility services are not covered, with the exception of:

5.2.7.2.1 medically necessary rehabilitation services for non-residents at a Long-Term Care/Nursing Facility, limited to no more than ninety (90) days per episode.

5.3 PHARMACY REQUIREMENTS

5.3.4 Effective upon the Implementation Date, Contractor shall comply with the requirements of Section 5.3.2. The Department reserves the right to reevaluate and revise the requirements of Section 5.3.2 for the Immigrant Adults and Immigrant Seniors populations. The Department shall provide written notice to Contractor at least ninety (90) days before enacting any such changes specific to the Immigrant Adults and Immigrant Seniors populations.

5.13 ASSESSMENTS AND CARE PLANNING

5.13.1.4.1.1 Contractor shall stratify Immigrant Adults and Immigrant Seniors populations using the minimum requirements provided below:

	Minimum percentages of Enrollees	
Population	Level 2 and 3 (combined moderate-	Level 3 (high-risk)

	and high-risk)	
Immigrant Adults	N/A	2%
Immigrant Seniors	20%	5%

5.28 INFORMATION-REPORTING AND INFORMATION TECHNOLOGY REQUIREMENTS

5.28.1.2.1 Effective upon the Contract Addendum Effective Date, Contractor shall report data, including ad hoc report requests, in a format that provides the information with a separate breakdown for the Immigrant Adults population and for the Immigrant Seniors population.

ARTICLE VII: PAYMENT AND FUNDING

7.1 CAPITATION PAYMENT

7.1.1.1 For the Immigrant Adults and Immigrant Seniors populations, the Department shall pay Contractor on a Capitation basis, the following based on the rate cell as shown in the table below, a sum equal to the product of the approved Capitation rate and the number of individuals enrolled in that category as of the first day of that month:

**Immigrant Adults & Immigrant Seniors - Emergency Services
Rates Effective January 1, 2024 through December 31, 2024**

Immigrant Adults & Immigrant Seniors	Region 1 Rate	Region 2 Rate	Region 3 Rate	Region 4 Rate	Region 5 Rate
Immigrant Adults 42-44 female	\$78.48	\$111.38	\$224.83	\$108.69	\$85.93
Immigrant Adults 42-44 male	\$209.57	\$174.75	\$76.54	\$234.23	\$289.56
Immigrant Adults 45-64	\$123.48	\$173.79	\$164.87	\$252.46	\$191.24
Immigrant Seniors 65+	\$289.09	\$194.27	\$139.09	\$319.51	\$230.14

**Immigrant Adults & Immigrant Seniors – State-Funded Services
Rates Effective January 1, 2024 through December 31, 2024**

Immigrant Adults & Immigrant Seniors	Region 1 Rate	Region 2 Rate	Region 3 Rate	Region 4 Rate	Region 5 Rate
Immigrant Adults 42-44 female	\$848.35	\$564.36	\$662.90	\$422.07	\$477.38
Immigrant Adults 42-44 male	\$330.02	\$222.70	\$181.95	\$546.09	\$519.65
Immigrant Adults 45-64	\$597.72	\$482.93	\$544.25	\$790.17	\$704.34
Immigrant Seniors 65+	\$841.37	\$709.80	\$751.93	\$894.33	\$691.54

7.8 COPAYMENTS

7.8.1 Contractor may, for the Immigrant Adults and Immigrant Seniors populations, charge copayments or coinsurance for the following services up to but not exceeding these amounts:

- non-emergency inpatient hospitalizations: \$250 copayment
- non-emergency hospital emergency room visits: \$100 copayment
- hospital or ambulatory surgical treatment center outpatient services as set forth at 89 Ill. Admin. Code 148.140(b): 10% of the Department rate

7.8.1.1 Contractor shall notify the Department in writing no less than ninety (90) days prior to any change in its copayment policy.

7.9 PAY for PERFORMANCE (P4P)

7.9.8 For calendar year 2024, the withhold does not apply to Capitation rates for the Immigrant Adults and Immigrant Seniors populations. The Department retains the right to impose withhold P4P requirements for subsequent calendar years, when no less than one hundred-twenty (120) days advance written notice is provided by Department to Contractor.

7.10 MEDICAL LOSS RATIO GUARANTEE

7.10.13 MLR Calculations for the Immigrant Adults and Immigrant Seniors populations.

7.10.13.1 Contractor shall calculate and report to the Department a separate MLR specific to the State-funded non-emergency services Capitation payments. The terms and method of calculation will be the same as described in subsections 7.10.1 through 7.10.12.

7.10.13.2 Contractor shall include the revenue and expenses related to the Emergency Services Capitation payments, which are claimable for federal match, in the MLR described in subsections 7.10.1 through 7.10.12.