APPENDIX I:
MODEL CONTRACT

STATE OF ILLINOIS

CONTRACT

between the

DEPARTMENT OF HEALTHCARE
AND FAMILY SERVICES

and

_____

for

< HEALTH PLAN PLACEHOLDER>

2018-24-001

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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 _____ (Contractor), which certifies that it is a Managed Care Organization (MCO) and whose principal office is located at _____.

RECITALS

WHEREAS, Contractor is: 1) a Health Maintenance Organization (HMO) operating pursuant to a certificate of authority issued by the Illinois Department of Financial and Professional Regulation; OR 2) 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).

1. ARTICLE I: DEFINITIONS AND ACRONYMS

<Intentionally left blank – See RFP Appendix II for complete list of definitions, abbreviations and acronyms.>

2. 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," respectively.

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 section 1.1.22.

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, caretaker 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, caretaker 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.

2.3 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 the 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 healthcare). 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 abuse, 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.** 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, and data reporting 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 healthcare.

2.3.1.11 **Integrated Health Homes Program Manager.** The IHH program manager shall be a full-time position that oversees the IHH program and ensures IHH program alignment with Department requirements, Provider education and oversight, and general management of the IHH program.

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 RN, 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 RN, a Physician, or a 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.

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, who assists 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 and twenty (120) days after the start date of operations, or until all administrative roles are fully staffed, whichever is later.

2.3.1.18 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 as 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 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 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.

2.3.3 **Training.** Contractor must clear each newly hired staff member through an industry-standard background check before such staff member assumes duties with Contractor. Contractor shall provide timely, relevant training that will help staff members competently perform their duties, and targeted training to individual staff members as necessary.

2.4 CERTIFICATE OF AUTHORITY

If organized as a HMO, Contractor must obtain and maintain during the term of this Contract a valid certificate of authority as a 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 a 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 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 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, IPoCs, 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 its 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. During the credentialing and re-credentialing process, Contractor will 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 delegated 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 subgoals shall be as follows:

2.9.1.1 eleven percent (11%) for minority-owned businesses;

2.9.1.2 seven percent (7%) for female-owned businesses; and

2.9.1.3 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.

3. ARTICLE III: ELIGIBILITY

3.1 DETERMINATION OF ELIGIBILITY

The Department has the exclusive right to determine an individual's eligibility for the HFS Medical Program and eligibility to become an Enrollee. Such determination shall be final and is not subject to review or appeal by Contractor. Nothing in this 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.

4. 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 healthcare 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 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 will immediately 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 voluntarily 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 and section 4.4.2 will have an opportunity to choose a MCO. These Potential Enrollees will have a thirty (30) day voluntary enrollment period before they are enrolled by automatic assignment to a MCO. All such Enrollees will have a ninety (90) day change period after assignment to select another MCO as provided in section 4.10.1. A Potential Enrollee will have the opportunity to select a PCP when choosing a MCO. On a daily basis, the ICES will inform Contractor of the Prospective Enrollees who have voluntarily chosen Contractor and the PCPs that were selected. 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 a MCO will be automatically assigned 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(c)(6), residence, family member assignments, geography, and cost. In no event will assignments or enrollments exceed the capacity of a 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 re-evaluate 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 the 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 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

Newborns and infants who are added to the Case of an adult Enrollee who is the Head of Case and enrolled with Contractor are enrolled as follows:

4.6.1 When an Enrollee gives birth and the newborn is added to the Case before the newborn is forty-five (45) days old, the newborn is automatically enrolled with Contractor. Contractor shall provide coverage of the newborn Enrollee retroactively to the date of birth.

4.6.2 When an Enrollee gives birth and the infant Potential Enrollee is added to the Case when the infant Potential Enrollee is over forty-five (45) days old but less than one (1) year old, the infant Potential Enrollee is automatically enrolled with Contractor. Enrollment shall be prospective as provided in section 4.7.

4.7 EFFECTIVE ENROLLMENT DATE

If an 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 as designated by the Department 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, 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 thirty (30) day period in which to change MCOs in which the Enrollee is enrolled. No later than forty (40) 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 thirty (30) day deadline for doing so. If the Enrollee selects a different Health Plan 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 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 PCP or other 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, or; 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.

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 whose HFS Medical Program coverage is reinstated within two (2) calendar months, 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 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, as provided in sections 4.10.3 and 4.14.5, takes effect.

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). Contractor shall not take an Adverse Benefit Determination in connection with an Enrollee who attempts to exercise, or is exercising, his or her Appeal or Grievance rights. Any attempts to seek to terminate enrollment in violation of this section 4.14.5 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 Healthcare, and specialty services that is adequate for the anticipated number of Enrollees in the Contracting Area, 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 in the Contracting Area.

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 auto-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 twenty-four (24)–hour telephone number to confirm eligibility for benefits and authorization for services; and

4.16.1.4 the name and phone number of the Enrollee's PCP.

4.16.2 Contractor shall send the identification cards no later than five (5) Business Days after receipt of the 834 Audit File. 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 an entire geographic area as set forth in Attachment II.

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, email, 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 Unless Prior Approval is provided by the Department, 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.

4.18 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 RESTRICTION

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

4.19.1.1 the Department indicates the Enrollee was included in the Department's Recipient Restriction Program 3pursuant 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 restriction must receive Prior Approval and shall include the right of the Enrollee to file a Grievance or Appeal.

5. 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 provide, or arrange to have provided, to all Enrollees the services described in 89 Ill. Adm. Code, Part 140, 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, 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 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 the Chicago Department of Public Health and its clinics, and 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 are three (3) Service Packages, 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 identified as excluded services pursuant to section 5.4 and those included in Service Package II (see Attachment I).

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. Department will provide contractor one hundred eighty (180) days' notice, in writing, before requiring the provision of these services.

5.2.2 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.

5.2.3 Contractor shall implement any behavioral-service plan developed by DHS Contractors for an Enrollee who is a class member under the Williams consent decree unless the Enrollee and the Enrollee's Williams Provider consent to a modification of such plan. Contractor is responsible for payment of services under such plan only to the extent the services are Covered Services. The 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.

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

5.2.4.1 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).

5.2.4.2 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).

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

5.2.4.4 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:

5.2.4.4.1 At a rate negotiated between Contractor and the IHCP; or

5.2.4.4.2 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

5.2.4.4.3 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.

5.2.4.5 Contractor shall not impose any co-payment on Enrollees identified as Indian for a Covered Service received from an IHCP or any Medicaid Provider.

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

5.2.4.7 An Enrollee identified as an Indian is exempt from all cost sharing if the Enrollee has ever received a referral from an IHCP.

5.2.4.8 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.

5.2.4.9 Contractor shall permit any Indian Enrollee who is eligible to receive Covered Services from a 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.

5.2.4.10 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 5.2.4.3 if:

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

5.2.4.10.2 If 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).

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

5.3 PHARMACY FORMULARY

5.3.1 Contractor shall cover as a preferred drug:

5.3.1.1 All drugs listed on the Department's Preferred Drug List (PDL). Found at this link: https://www.illinois.gov/hfs/SiteCollectionDocuments/pdl.pdf; and,

5.3.1.2 All drugs for which the Department has entered into a State supplemental rebate agreement with the manufacturer whether or not the drug is listed on the Department's PDL.

5.3.2 The Department will make available to the Contractor the Department's PDL as well as a list of all drugs for which a State supplemental rebate agreement exists that is not contained on the Department's PDL.

5.3.3 Contractor shall submit an attestation of its adherence to the Department's PDL at or before the Effective Date of the contract and annually thereafter.

5.3.4 The Contractor including the Contractor's Pharmacy Benefit Manager (PBM) or their Subcontractors is prohibited from negotiating any rebates with drug manufacturers for drugs listed on the Department's PDL and all drugs for which the Department has entered into a State supplemental rebate agreement with the manufacturer. If the Contractor, its PBM or other subcontractors have an existing rebate agreement with a manufacturer all covered outpatient drug claims for Medicaid participants for which the Department is obtaining State supplemental rebate must be exempt from such rebate agreements. This 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 list of manufacturers that participate in the federal Medicaid drug rebate program, which the Contractor or its Subcontractors may only negotiate with and accept rebates from in relation to non-drug items as per this section 5.3.4.

5.3.5 Contractor may determine its own utilization controls, including therapy and prior authorization, unless otherwise prohibited under this Contract or by the Department's PDL, to ensure appropriate utilization. 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.

5.3.6 Contractor's electronic and print formularies shall display the following:

5.3.6.1 Brand and generic medications covered;

5.3.6.2 If medication if preferred or non-preferred and each terms definition;

5.3.6.3 Each medications tier and the definition of each tier;

5.3.6.4 Utilization controls, including step therapy, prior approval, dosage limits, gender or age restrictions, quantity limits, and other policies;

5.3.6.5 Cost sharing;

5.3.6.6 Glossary of key terms and explanation of utilization controls and cost sharing;

5.3.6.7 A key for all utilization controls visible on every page in which specific medication coverage is displayed;

5.3.6.8 Directions to obtain more information if a medication is not covered or listed in the formulary;

5.3.6.9 An email and toll free number to which an individual can report inaccuracies in the formulary; and,

5.3.6.10 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.

5.3.7 The Department shall send a pharmacy formulary template for the contractor to complete annually.

5.3.8 Contractor shall publish formulary on their program website and make the formulary easily understandable and publicly accessible without a password, user name or personality identifiable information.

5.3.9 Contractor shall provide printed formularies upon request.

5.3.10 Upon reports of formulary inaccuracies, Contractor must investigate and make correction to the data displayed. Data correction shall be completed within three business days.

5.3.11 Contractor shall attest to the Department on a quarterly basis that they are making updates to the pharmacy formulary within three business days after investigation of reported inaccuracies.

5.3.12 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.

5.3.13 For outpatient drugs not identified in section 5.3.12, Contractor shall collect information on the total number of units of each dosage form and strength

and package size by National Drug Code of each covered outpatient drug dispensed to Enrollees.

5.3.14 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 National Drug Code of each covered outpatient drug identified in section 5.3.13 dispensed to Enrollees.

5.3.15 Contractor shall establish and maintain a process for resolving disputes over generic drug maximum allowable costs (MAC), 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 date, 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 average 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.

5.3.16 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 and all nonformulary 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 DHFS quarterly, and assist in data collection and reporting to the Department of data necessary to complete the Federal CMS DUR annual report.

5.4 EXCLUDED SERVICES

The following services are not Covered Services under Service Package I or Service Package II:

5.4.1 services that are provided in a State facility operated as a psychiatric hospital as a result of a forensic commitment;

5.4.2 services that are provided through a local education agency (LEA);

5.4.3 services that are experimental or investigational in nature;

5.4.4 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;

5.4.5 services that are provided without a required Referral or prior authorization as set forth in Contractor's Provider handbook;

5.4.6 medical and surgical services that are provided solely for cosmetic purposes;

5.4.7 diagnostic and therapeutic procedures related to infertility or sterility;

5.4.8 early-intervention services, including Case management, provided pursuant to the Early Intervention Service System Act;

5.4.9 services funded through the Juvenile Rehabilitation Services Medicaid Matching Fund;

5.4.10 services or items furnished for the purpose of causing, or for the purpose of assisting in causing, the death of an Enrollee, such as by assisted suicide, euthanasia, or mercy killing, except as otherwise permitted by P. L. 105-12, Section 3(b), which is incorporated by Section 1903(i)(l6) of the Social Security Act; and

5.4.11 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.

5.5 LIMITATIONS ON COVERED SERVICES

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

5.5.1 Contractor may provide termination of pregnancy only as allowed by applicable State and federal law (42 CFR §441, Subpart E). 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 Contractor chooses to exercise this right, Contractor must promptly notify the Department in writing of its intent to exercise its right of conscience. Such notification shall contain the 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:

5.6.2.1 to Potential Enrollees, prior to enrollment;

5.6.2.2 to Prospective Enrollees, during enrollment; and

5.6.2.3 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 an Enrollee can obtain information from the Department regarding those Covered Services subject to this section 5.6.

5.7 PROVIDER NETWORK

5.7.1 **Network Providers.** Contractor shall establish, maintain, and monitor a Provider Network, including hospitals, PCPs, 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 During the first year of this Contract for all Contracting Areas, Contractor shall enter into a contract with any willing and

qualified Provider in the Contracting Area that renders Nursing Facility and waiver services, as set forth in Attachment I, so long as the Provider agrees to Contractor's rate 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, after the first year of this Contract, 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: 1) such standards have been in effect for at minimum one (1) year, and 2) 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 by acting upon the team's credentialing applications in accordance with generally applicable standards, to permit qualified members of the team to write medication and lab orders, to access Enrollees in order 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 a 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 were receiving 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

5.7.1.4.10 Physical Therapy

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

5.7.1.5.1 Environmental accessibility adaptations—home. Contractor will 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 will 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 will enter into contracts that meet the requirements of 89 Ill. Admin. Code 240.235 with at least one (1) Provider operating a PERS within a Contracting Area.

5.7.1.5.4 If Contractor is unable to contact an Enrollee in a 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 that the Enrollee no longer be in a HCBS Waiver.

5.7.1.6 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.

5.7.1.7 Upon the implementation by the Department of Section 1861(o)(7) of the Social Security Act by Federal CMS, Contractor will not pay for a service or item (other than an Emergency Service or item furnished in an emergency room of a hospital) for home healthcare services provided by an agency or organization, unless the agency or organization provides the State with a surety bond as specified in Section 1861(o)(7) of the Act.

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 (email 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 following such termination, to each Enrollee who was served by the terminated Provider. In this notification, Contractor will provide direction to Enrollees regarding how they may select a new Provider.

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 PCP 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 Contracting Area 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, RHCs, and CMHCs, as Network Providers. Contractor shall not refuse to contract with a FQHC, RHC, or CMHC that is willing to accept Contractor's rates and contractual requirements and meets Contractor's quality standards. Contractor shall include at least one FQHC and one RHC in its Provider Network, where available in Contractor's service area.

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 make best efforts to 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.

5.7.7.2 Provider agreements shall require that Network Providers submit benefit expense claim data, as defined in 7.11.6.2, for all Covered Services provided to Enrollees.

5.7.8 **Integrated health homes.** Contractor must adhere to and implement all aspects of the IHH program designed and approved by the Department. Where requirements of the Department's IHH program overlap with the

requirements of this Contract, the IHH requirements will be prioritized.

5.7.9 **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 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 condition and needs.

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

5.7.11 **Care coordination for High-Needs Children.** Contractor shall ensure that the provision of care coordination for High-Needs Children is compliant with Attachment XXII. Nothing in this section 5.7.11 and Attachment XXII is intended to limit the children's mental health and care coordination services that are Covered Services. High-Needs Children will be determined eligible for services under Attachment XXII based on stratification criteria defined and approved by the Department. Contractor must enroll Child in high-needs services upon notification from the Department that an Enrollee meets eligibility criteria. A Child's family are also eligible for Medicaid services related to the necessary care of the Child.

5.7.12 **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 geographic area set forth in Attachment II. Contractor shall reimburse the University of Illinois and 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. Contractor shall reimburse Southern Illinois University for Physician services at no less than its rate as determined by the Medicaid-approved reimbursement methodologies. Contractor shall not limit equal access to such Providers.

5.7.13 **Special Needs Children.** Contractor shall contract with the University of Illinois, Division of Specialized Care for Children (DSCC), to provide care coordination services to those Enrollees enrolled in the Medically Fragile, Technology Dependent (MFTD) Waiver or the Nursing and Personal Care Services (NPCS) program. The Department may designate other entities with which Contractor may contract for providing such services.

5.8 ACCESS-TO-CARE STANDARDS

5.8.1 **Network adequacy standards**. Contractor's Provider Network must include all necessary Provider types, including PCPs, 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 in section 5.2. For each Provider type, Contractor must provide access to at least ninety percent (90%) of Enrollees within the service 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 PCP or specialty care 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 *PCP access*: Contractor shall ensure an Enrollee has access to at least two (2) PCPs 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) PCP within a sixty (60)–mile radius of or sixty (60)–minute drive from his or her residence.

5.8.1.1.2 *Behavioral Health service 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 his or her 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 his or her 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 his or her 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 his or her 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 his or her 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 his or her 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. 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 of 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.

5.8.4 **After hours.** PCPs 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 health care 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 **PCP-to-Enrollee ratio.** Contractor's maximum PCP panel size shall be as set

forth below. If Contractor does not satisfy the PCP requirements set forth below, Contractor may demonstrate compliance with these requirements by demonstrating that Contractor's full-time-equivalent PCP ratios exceed ninety percent (90%) of the requirements set forth below, and that Covered Services are being provided in the Contracting Area 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 PCP 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 PCP 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 provide the necessary documentation, reporting, and analyses, in the format and frequency required by the Department, to establish and demonstrate compliance with 42 CFR part 438, subpart K regarding parity in mental health and substance use disorder benefits.

5.9 PROVIDER CREDENTIALING AND RE-CREDENTIALING

5.9.1 **Credentialing and re-credentialing.** Contractor shall credential Providers in accordance with NCQA credentialing standards as well as applicable HFS, DHS, IDoA, Illinois Department of Insurance, and federal requirements. Re-credentialing shall occur every three (3) years. At re-credentialing and on a continuing basis, Contractor shall verify minimum credentialing requirements and monitor Enrollee Complaints and Appeals, quality-of-care and quality-of-service events, and medical record review. Contractor shall document its process for credentialing and re-credentialing Providers.

5.9.2 **Credentialing of primary care and specialty Providers**. All PCPs, WHCPs, and specialists who agree to be Network Providers must be credentialed by Contractor. Contractor shall not assign Enrollees to a PCP or WHCP until such Provider has been fully credentialed. Contractor must notify the Department when the credentialing process is complete and provide the results of the process.

5.9.3 **Delegated credentialing.** Contractor may subcontract all or part of its credentialing functions when the subcontractor, such as a Provider organization, maintains a formal credentialing program in compliance with Contractor, NCQA, the Department, and applicable regulatory agency

standards. Contractor shall remain responsible for Provider credentialing and re-credentialing.

5.9.4 **Verification of qualifications of Providers of Covered Services under HCBS Waivers.** 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. Contractor is not required to credential Providers of Covered Services under HCBS Waivers.

5.9.5 **Department Credentials Verification Organization (CVO).** The Department may require Contractor to delegate credentialing services to a CVO identified by the Department. The Department shall provide at least ninety (90) days' notice, in writing, of this change. The Department retains the right to define the scope of services required to be provided by such a CVO.

5.9.6 **Uniform credentialing.** Notwithstanding section 5.9.1, the Department reserves the right to provide an alternative credentialing solution for participation in the HFS Medical Program. The Department shall notify the Contractor in writing ninety at least (90) days prior to the implementation of any such solution.

5.10 PROVIDER 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 **Integrated health homes.** Contractor shall educate Network Providers about the IHH model, the importance of using it to integrate all aspects of each Enrollee's care, and how to become an IHH, including educating Network Providers about resources, support, and incentives, both financial and nonfinancial, available for becoming an IHH and receiving applicable recognition.

5.10.3 **Cultural Competency.** Contractor will provide Cultural Competence requirements at orientation, training sessions, and updates as needed.

5.10.4 **Provider manual.** The Provider manual shall be a comprehensive online reference tool for Providers and staff regarding administrative, prior authorization, and Referral processes; claims and Encounter submission processes; and plan benefits. The Provider manual shall also address topics

such as clinical practice guidelines, availability and access standards, Care Management programs, and Enrollee rights.

5.10.5 **Provider portal.** After six (6) months' notice, in writing, from the Department, the Contractor shall establish and maintain a secure Provider Web Portal which shall include population health, quality, utilization and claims information for PCP Enrollee populations. 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 available to Enrollees and Providers via Contractor's Web portal.

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 in 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 to any individual Enrollee or from Department notification within three (3) days after notification by the Department.

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.

5.11 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 system.** 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.

5.12 CARE MANAGEMENT

5.12.1 Contractor shall offer Care Management to Enrollees based upon each Enrollee's individual risk level. In addition to the stratified risk groups, Contractor shall offer Care Management to all pregnant Enrollees, Enrollees with high needs (including all High-needs Children and Dual-Eligible Adults), and Enrollees who receive Covered Services under a HCBS Waiver.

5.12.2 **Provision of Care Management.** Contractor shall offer Care Management through a Care Coordinator who participates in an interdisciplinary care team for all medical, behavioral-health, and Covered Services under service packages I and II, including 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. Contractor shall ensure that the Care Management services required by this Contract are provided to all Enrollees in NFs. These services may be provided by Nursing Facility Care Coordinators and supplemented by Contractor to fulfil the requirements of this Contract.

5.12.2.1 If Contractor enters into any contract with any entity that also administers the 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 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 discharge planning for hospital and institutional stays.

5.12.3 **Care Coordinators.** Each Enrollee identified as requiring Care Management, and any other Enrollee who agrees or wishes to receive Care Management, will be assigned a Care Coordinator. Contractor must provide Enrollee information on how to contact their designated person or entity primarily responsible for coordinating services.

5.12.3.1 **Qualifications.** Care Coordinators who serve Enrollees within the IDoA Persons Who are Elderly HCBS Waiver, DHS-DRS Persons with a Brain Injury HCBS Waiver, DHS-DRS Persons with HIV/AIDS HCBS Waiver, or DHS-DRS Persons with Disabilities HCBS Waiver must meet the applicable qualifications set forth in Attachment XVI.

5.12.3.2 **Training requirements.** Care Coordinators who serve Enrollees within the IDoA Persons Who are Elderly HCBS Waiver, DHS-DRS Persons with a Brain Injury HCBS Waiver, DHS-DRS Persons with HIV/AIDS HCBS Waiver, DHS-DRS Persons with Disabilities HCBS Waiver, or HFS Supportive Living Program HCBS Waiver must meet the applicable training requirements set forth in Attachment XVI.

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 (template) and will provide that tool to the Department. This tool will include behavioral-health risk, and administer it 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 that it is administered within sixty (60) days after enrollment. Contractor shall notify the appropriate PCPs 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 encourage PCPs to conduct outreach to their Enrollees and to schedule visits.

5.13.1.2 **Predictive modeling.** Contractor shall utilize claims and CCCD 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 tool 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. Enrollees shall be assigned to one (1) of three (3) levels:

Risk Category	Description
Level 1	Includes low- or no-risk Enrollees to whom Contractor provides, at a minimum, prevention and wellness messaging and condition-specific education materials.
Level 2	Includes moderate-risk Enrollees for whom Contractor provides problem-solving interventions.
Level 3	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. All Special-Needs Children are categorized as Level 3.

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

	Minimum percentages of Enrollees	
Population	**Level 2 and 3 (combined moderate and high risk)**	**Level 3 (high-risk)**
Families and children population	N/A	2%
ACA expansion population	N/A	2%
Special-Needs Children (SSI, Disabled, receiving services from DSCC)	N/A	100%
Seniors or Persons with Disabilities	20%	5%
Dual-Eligible Adults	90%	20%

5.13.2 **Outreach.** Contractor shall use its best efforts to locate all Enrollees who are identified through risk stratification as being high risk or moderate risk. Where appropriate, community-based organizations should be used to locate and engage such Enrollees.

5.13.3 **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.

5.13.4 **Self-directed care.** Contractor will encourage Providers to support Enrollees in directing their own care and developing an IPoC. This will include giving PCPs a copy of the IPoC.

5.13.5 **Health risk assessment.** Contractor shall use its best efforts to complete a health risk assessment for:

5.13.5.1 *All Level 3 (high-risk) Enrollees:* The assessment will be conducted, in-person or over the phone, and an IPoC will be developed within ninety (90) days after enrollment. For any Child in Level 3, the health risk assessment will be applied as per Attachment XXII.

5.13.5.2 *Enrollees receiving HCBS Waiver Services or residing in NFs as of their Effective Enrollment Date with Contractor:* The health risk assessment must be face-to-face and completed within ninety (90) days after the Effective Enrollment Date.

5.13.5.3 Enrollees receiving HCBS Waiver services or residing in NFs as of

the Effective Enrollment Date, who were enrolled in another MCO, but are transitioning to Contractor's Health Plan: The health risk assessment relating to those Covered Services must be face-to-face and completed within the first 90-days after the Effective Enrollment Date.

5.13.5.4 *Enrollees transitioning to NFs:* The health risk assessment relating to those Covered Services must be face-to-face and completed within the first ninety (90) days after the Effective Enrollment Date.

5.13.5.5 *Enrollees deemed newly eligible for HCBS Waiver Services:* The health risk assessment must be face-to-face and completed within fifteen (15) days after Contractor is notified that the Enrollee is determined eligible for HCBS waiver services.

5.14 INTERDISCIPLINARY CARE TEAM

5.14.1 Contractor will support an interdisciplinary care team (ICT) for all pregnant Enrollees, Enrollees with high needs (including all High-Needs Children and Dual-Eligible Adults), and Enrollees who receive Covered Services under a HCBS Waiver. The ICT will ensure the integration of the Enrollee's medical, behavioral-health, and, if appropriate, Service Package II care 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; supporting IHHs; 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;

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; and

5.14.3.7 ensuring that the Enrollee's IPoC is communicated to the appropriate Person when the Enrollee changes Providers, Contractor, or setting, and as provided in section 5.18.1.

5.15 INDIVIDUALIZED PLANS OF CARE/SERVICE PLANS

5.15.1 The ICT will develop a comprehensive, person-centered IPoC for Enrollees stratified as Level 3 (high risk) and Enrollees in a HCBS Waiver. The IPoC must be developed within ninety (90) days after enrollment. Enrollees should be engaged 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. 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 of the all 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; and,

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 a HCBS Waiver service plan for Enrollees receiving HCBS Waiver services. Contractor shall develop the service plan as follows:

5.15.1.5.1 Contractor shall ensure that the service plan is developed within fifteen (15) days after Contractor is notified that the Enrollee is determined eligible for HCBS Waiver services. Contractor is responsible for

actual HCBS Waiver service planning, including the development, implementation, and monitoring of the service plan, and updating the service plan when an Enrollee's needs change. The service plan Care Coordinator will lead HCBS Waiver service planning through coordination with the Enrollee and the ICT.

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 comprehensive needs 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 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 comprehensive needs 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.

5.15.1.5.4 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 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.

5.15.2 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 risk assessment 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 a risk 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 comprehensive needs assessment.

5.15.4 The Enrollee or their 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.

5.16 Individual Plan of Care reassessment

Contractor will analyze predictive-modeling reports and other surveillance data of all Enrollees monthly to identify risk level changes. As risk levels change, reassessments will be completed as necessary and IPoCs updated. Contractor will 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 reassessment annually for each Enrollee who has an IPoC. In addition, Contractor will conduct a face-to-face reassessment for Enrollees receiving HCBS Waiver services or residing in NFs each time there is a significant change in the Enrollee's condition or an Enrollee requests reassessment. Contractor will provide updated IPoCs to Providers that are involved in providing Covered Services to Enrollee within no more than five (5) Business Days.

5.17 Caseload requirements

5.17.1 Contractor shall assign each Enrollee identified as requiring Care Management and who agrees, and any other Enrollee who requests to receive Care Management, to an ICT with a Care Coordinator as provided in section 5.12.3. Care Coordinators responsible for 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 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 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:

5.17.2.2.1 For Enrollees in the Persons with Brain Injury Waiver or the Persons with HIV/AIDS Waiver, the caseloads shall not exceed 30:1.

5.17.2.2.2 For High-Needs Children, Contractor will adhere to the caseload requirements outlined in Attachment XXII.

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 HCBS Waiver: 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 Supportive living program: 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).** The Money Follows the Person program is set to end in Illinois on December 31, 2017, and Contractor will assume 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.

5.19 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. Non-Network Providers and specialists providing an ongoing course of treatment will be offered single case agreements to continue to care for that Enrollee beyond the transition period if the Enrollee remains outside the network or until a qualified Network Provider is available.

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 the Enrollee is assigned to an IHH that is capable of serving the Enrollee's needs appropriately;

5.19.1.2.2 a health screening and a comprehensive assessment,

if necessary, are complete;

5.19.1.2.3 Contractor consulted with the new IHH and determined that the IHH is accessible and competent and that it can appropriately meet the Enrollee's needs;

5.19.1.2.4 a transition-of-care plan is in place (to be updated and agreed to with the new PCP, as necessary); and

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

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

5.19.3 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 **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.

5.19.6 **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.

5.19.7 **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 seventy-two (72) hours after receiving the request for authorization from a Provider, with a possible extension of up to seventy-two (72) additional hours, 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.

5.19.7.1 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.

5.19.7.2 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 **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 Approval 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 residence 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 or IHH.

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.** 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 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 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 Center.** Contractor shall enter into a contract with any willing and qualified community mental health center (Medicaid Provider Type 36) 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 community mental health centers that meet such standards, provided that each the contracting Provider is informed of any such additional standards no later than ninety (90) days after the start of its contract and that the Department has given Prior Approval. Any such standards that are not established within ninety (90) days after the start of the contract with the community mental health center must be in effect for one (1) year before Contractor may terminate a contract of a Provider based on a failure to meet such standards.

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.

5.21 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 that 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 4.18;

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 provide 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 within thirty (30) days after Contractor receives notice of the Enrollee's enrollment and 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

5.21.4 **Communications with Prospective Enrollees, Potential Enrollees, and Enrollees**. The requirements outlined in this section 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 staff from in and around the Contracting Area 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-grade reading level and easily understood by individuals with sixth-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 certifies that 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.

5.21.5 **Enrollee handbook.** Contractor shall submit an Enrollee handbook to the Department for Prior Approval before the first enrollment, when revised, and upon the Department's request. Contractor shall not be required to submit format changes for Prior Approval, provided there is no change in the information conveyed. 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. Contractor must include terms defined by the Department as provided in42 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.

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 they 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.

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 preferred drug list 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 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 approval 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 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. 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 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 preauthorization 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 a 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 Adverse Benefit Determination 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 at 1-866-800-1409 (voice) and 1-800-206-1327 (TTY).

5.23.1.7 Reports regarding Enrollees in NFs must be made to the Department of Public Health's nursing home complaint hotline at 1-800-252-4343.

5.23.1.8 Reports regarding Enrollees aged 18 to 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 at 1-800-368-1463 (voice and TTY).

5.23.1.9 Reports regarding Enrollees in SLFs must be made to the Department of Healthcare and Family Services' SLF complaint hotline at 1-844-528-8444.

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. Contractor must inform DCFS of any and all such incidents that are reported.

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

Contractor shall not employ, subcontract with, or affiliate itself with or otherwise accept any excluded Person, as defined in section9.1.33, into its network.

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 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 or IHH 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 other than loss of Medicaid eligibility.

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

5.27.2.1 maintain claims processing and retrieval systems that 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 of all Enrollee Encounter Data that the Department is required to report to CMS under 42 CFR §438.818;

5.27.3.4 Specifications for submitting 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.

5.28 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 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

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

5.28.1.2 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, or having received Prior Approval from, the Department. 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 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 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.

5.29 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 Grievance-resolution system. 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 a 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 7.16.17 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 four (4) consecutive months.

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 of receiving the claim, and shall pay the non-Network Provider within thirty (30) days after receiving such information. 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 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. 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.

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 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, as defined in Attachment IV.

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 Contractor shall establish a complaint and resolution system for Providers that includes a Provider dispute process. Contractor shall provide a substantive response intended to resolve a complaint received through the Department's Provider complaint portal on the Department's website within two (2) Business Days if the complaint is categorized as urgent and within fifteen (15) Business Days if it is not categorized as urgent.

5.29.7 Contractor shall require that Providers agree to the reporting requirements in 42 CFR §447.26(d) as a condition of receiving payment from Contractor. Contractor shall report identified Provider-preventable conditions to the Department as required in Attachment XIII. Contractor shall not pay a Provider for Provider-preventable conditions that are identified in the State Plan. Contractor, however, is not prohibited from paying a Provider for such Provider-preventable conditions that existed prior to the initiation of treatment for an Enrollee with a Provider-preventable condition by that Provider.

5.30 GRIEVANCE AND APPEAL SYSTEM

Contractor shall have a formally structured Grievance 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, caretaker 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 notice of action that generates such Appeal. If the Enrollee does not request an expedited Appeal pursuant to 42 CFR §438.410, Contractor must require the Enrollee to follow an oral Appeal with a written, signed 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, caretaker 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 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 notice of action, 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 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 and Supportive Living Program HCBS Waiver Enrollee at each annual reassessment to determine each Enrollee's perception of the quality of life.

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 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).

5.32.3 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 a 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 a 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 FRAUD, WASTE, AND ABUSE PROCEDURES

5.35.1 Contractor shall have an affirmative duty to report to the OIG in a timely way, as provided in section 9.1.29, suspected Fraud, Waste, Abuse, or financial misconduct in the HFS Medical Program by Enrollees, Providers, Contractor's employees, or Department employees. Contractor shall:

5.35.1.1 have a designated Special Investigations Unit (SIU) to oversee Fraud, Waste and Abuse investigations.

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

5.35.1.3 develop and document in writing policies, procedures and standards of conduct that articulate Contractor's commitment to comply with all applicable requirements under this Contract and all applicable Federal and State requirements, including 42 CFR §438 Part H.

5.35.1.4 form a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing Contractor's compliance program and its compliance with the Contract.

5.35.1.5 appoint a single individual to serve as liaison to the Department regarding the reporting of suspected Fraud, Waste, Abuse, or financial misconduct.

5.35.1.6 require that any of Contractor's personnel, Network Providers, or Subcontractors who identify suspected Fraud, Waste, Abuse, or financial misconduct shall immediately make a report to Contractor's liaison.

5.35.1.7 require that Contractor's liaison shall provide notice of any suspected Fraud, Waste, Abuse, or financial misconduct to the OIG within three (3) days after receiving such report.

5.35.1.8 submit a quarterly report to the Department that includes all instances of suspected Fraud, Waste, Abuse, and financial misconduct, and certify that the report contains all such instances or that there was no suspected Fraud, Waste, Abuse, or misconduct during that quarter. The inclusion of an instance of suspected Fraud, Waste, or Abuse on a quarterly report shall be considered timely if the report of suspected Fraud, Waste, Abuse, or financial misconduct is made to Contractor's liaison as soon as Contractor knew or should have known, as determined by the Department, of the suspected Fraud, Waste, Abuse, or financial misconduct, and the newly included instance, with the required certification is received within thirty (30) days after the end of the quarter.

5.35.1.9 Contractor shall ensure that all its personnel, Network Providers, and Subcontractors receive notice of, and are educated on, these procedures, and shall require adherence to them.

5.35.2 Contractor shall not conduct any investigation of suspected Fraud, Waste, Abuse, or financial misconduct of Department personnel, but shall report all incidents immediately to the OIG.

5.35.3 Contractor may conduct investigations of suspected Fraud, Waste, Abuse, or financial misconduct of its personnel, Providers, Subcontractors, or Enrollees only to the extent necessary to determine whether reporting to the OIG is required, or when Contractor has received the express concurrence of the OIG. If Contractor's investigation discloses potential criminal acts, Contractor shall immediately notify the OIG.

5.35.4 Contractor shall cooperate with all OIG investigations of suspected Fraud, Waste, Abuse, or financial misconduct. Nothing in this section 5.35 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.

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 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 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 Contractor's delegated subcontractors, regular monitoring of Enrollee Complaints, documentation of issues, and development of a Corrective Action Plan, 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. 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. Contractor shall establish, through its FLC, a Care Coordination model that is person- and family-centric, and a mechanism for providing Contractor with a direct HFS Medical Program beneficiary feedback loop. The FLC shall not be used to review the needs of individual Enrollees.

5.40.8.1 The FLC shall be co-chaired by a young adult, or the parent or guardian of a young adult, with lived experience within public child-serving systems (e.g., mental health, welfare, education) and a member of Contractor's leadership team who has the authority to speak to program design and issues.

5.40.8.2 The FLC membership shall be comprised of, at a minimum of 51%, Enrollees or parents/guardians of Enrollees from across the Coverage Area who have lived experience with the public child-serving systems.

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.

5.40.9.2 Contractor may initially designate the 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 at least one Enrollee or parent/guardian of an Enrollee from each geographic area, as set forth in Attachment II, in the Coverage 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 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.

6. 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.

7. 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 his or her 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 the Enrollee meets all requirements of 42 CFR §438.6(e).

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

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.

7.4 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 MMAI; Special-Needs Children, including those Medicaid-eligible under SSI, a disability category of eligibility, or receiving services from DSCC; and children in the care and children formerly in the care of DCFS. Beneficiaries under the age of two (2) will not be risk-adjusted. Capitation rates calculated under this Contract will be adjusted in accordance with publicly-available risk-adjustment software. Risk adjustment will be performed on a semiannual basis. For an Enrollee's individual claims data to be the basis for a risk adjustment score hereunder, such Enrollee must have been enrolled in the HFS Medical Program (i.e., either managed care or Fee-For-Service) for at least six (6) full months during the time period from which claims data are used to calculate the adjustment. In the event an Enrollee has not been enrolled in the HFS Medical Program for at least six (6) full months, then such Enrollee shall receive a risk score equal to Contractor's average risk score. The risk scores shall be established for each MCO across all rate cells. As necessary, the risk scores will be established using a credibility formula for each MCO. The credibility formula to be used will be determined by an independent actuary. All diagnosis codes submitted by Contractor shall be included in calculations of risk scoring irrespective of placement of such diagnosis codes in the Encounter Data records. Diagnosis codes from claims or encounters that included a lab and radiology procedure or revenue code on any line, with the exception of those associated with an inpatient hospital claim, will not be collected for the risk-adjustment analysis. It is assumed that these diagnosis codes could be for testing purposes and may not definitively indicate a beneficiary's disease condition. Encounter records may not be supplemented by medical record data. Diagnosis codes may only be recorded by the Provider at the time of the creation of the medical record and may not be retroactively adjusted except to correct errors. A significant change in risk scores by 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 Fee-For-Service 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 Fee-For-Service claims data.

7.4.2.1 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, Enrollee risk scores shall be recalculated using Enrollee claims or Encounter Data, as applicable, from a prior twelve (12) month period. The Department shall provide written notification to Contractor of Contractor's risk adjustment factor, along with sufficient detail supporting the calculations. 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 IPoC 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 7.5.3 "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."

7.5.4 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. 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, rate changes in accordance with updates to Attachment IV, or other miscellaneous adjustments provided for herein. Adjustments shall be retroactive no more than eighteen (18) months. Adjustments can go beyond 18 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 Withhold based on its performance with respect a Department-determined combination of: (i) quality metrics set forth in Attachment XI; (ii) operational metrics set for in Attachment XI; and, (iii) achievement of implementation goals as set forth in Attachment XI. If Contractor, for the full calendar year immediately preceding the Effective Date, had a contract with the Department to provide medical services to individuals covered by the HFS Medical Program, then quality metrics will be applied upon the Effective Date, unless the Department provides written notice of a later date. If Contractor, for the full calendar year immediately preceding the Effective Date, did not have a contract with the Department to provide medical services to individuals covered by the HFS Medical Program, then quality metrics will be applied on January 1 of the year following the first calendar year under this Contract

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 the 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 table1-A, First Reporting Period, 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 of performance goals to design a MCO incentive payments program. The Department shall provide Contractor with ninety (90) days' notice, in writing, of the implementation of such a program.

7.10 MEDICAL LOSS RATIO GUARANTEE

7.10.1 Contractor has a minimum medical loss ratio of eighty-five percent (85%). If the medical loss ratio calculated as set forth below is less than the minimum medical loss ratio, Contractor shall refund to the State an amount equal to the difference between the calculated medical loss ratio and the minimum medical loss ratio (expressed as a percentage) multiplied by the Coverage Year revenue. The Department retains the right to adjust the minimum medical loss ratio in adherence to 42 CFS §438.8. The Contractor shall prepare a medical loss ratio calculation that shall summarize Contractor's medical loss ratio for Enrollees under this Contract for each Coverage Year. The initial Coverage Year shall include the period from the Effective Date through December 31, 2018. The medical loss ratio 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 **Revenue.** The revenue used in the medical loss ratio 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.

7.10.3 **Benefit expense.** The benefit expense shall be determined using the following data:

7.10.3.1 **Paid claims.** Paid claims shall be included in benefit expense. The Department shall use benefit expense claims for all dates of service during the Coverage Year and accepted by the Department within nine (9) months after the end of the Coverage Year. Benefit expense claims covered by sub-capitation contracts shall be priced at Contractor's FFS rate for Covered Services. If Contractor does not have a published fee schedule for a Covered Service, the price on the sub-capitated service may not exceed one-hundred-ten percent (110%) of the Department rates as provided in Attachment IV.

7.10.3.2 **Incurred-but-not-paid (IBNP) claims**. IBNP claims, as determined by the Department's actuary based on benefit expense claims and made available for review by Contractor, shall be included in benefit expense.

7.10.3.3 **Provider value-based and incentive payments.** Value-based and incentive payments to Network Providers shall be included in benefit expense so long as they are paid within nine (9) months after the end of the Coverage Year for Performance Measures recorded during the Coverage Year, provided the payments are made pursuant to agreements in place at the start of the measurement period under which the benchmarks triggering payments and the methodology for determining payments amounts are clearly set forth. Litigation reserves and payments in settlement of claims disputes, excluding legal fees, shall be included in benefit expense. Such amounts shall be recorded by Contractor for the Coverage Year.

7.10.3.4 **Care coordination expense.** That portion of the personnel costs for Care Coordinators whose primary duty is direct Enrollee contact that is attributable to this Contract shall be included as a benefit expense. That portion of the personnel costs for Contractor's medical director that is attributable to this Contract shall be included as a benefit expense. Payments to delegated care coordination entities shall be included as benefit expenses.

7.10.3.5 **Other benefit expense**. Any service provided directly to an Enrollee that is not capable of being sent as a benefit expense

claim because of an appropriate code or similar issue may be sent to the Department on a report identifying the Enrollee, the service, and the cost. Such costs can, at the discretion of the Department, be included in benefit expense.

7.10.4 **Data submission.** Within ten (10) months after the end of each Coverage Year, Contractor shall submit to the Department, in the form and manner prescribed by the Department, the data described in sections 7.10.3.3, 7.10.3.4, and 7.10.3.5. 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

7.11 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

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

7.11.4 **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.

7.11.5 **Submission certification.** An executive officer of Contractor shall attest to the accuracy and completeness of each quarterly and annual cost report submission provided to the Department.

7.11.6 Reporting detail.

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

7.11.6.1.1 Managed care population

7.11.6.1.2 Rate cell

7.11.6.1.3 Region

7.11.6.1.4 Eligibility month

7.11.6.1.5 Enrollee count

7.11.6.2 **Benefit expenses.** Contractor shall provide requested benefit expense information in a format specified by the Department for data fields including:

7.11.6.2.1 Managed care population

7.11.6.2.2 Rate cell

7.11.6.2.3 Region

7.11.6.2.4 Service category

7.11.6.2.5 Incurred month

7.11.6.2.6 Sub-Capitation (Y / N)

7.11.6.2.7 Admissions (inpatient services only)

7.11.6.2.8 Units

7.11.6.2.9 Paid amount

7.11.6.3 **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:

7.11.6.3.1 Expense type

7.11.6.3.2 Managed care population

7.11.6.3.3 Rate cell

7.11.6.3.4 Region

7.11.6.3.5 Incurred month

7.11.6.3.6 Paid amount

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

7.11.6.4.1 Managed care population

7.11.6.4.2 Rate cell

7.11.6.4.3 High-level service category

7.11.6.4.4 Incurred month (minimum twenty-four [24] months prior)

7.11.6.4.5 Paid month (minimum twenty-four [24] months prior)

7.11.6.4.6 Units

7.11.6.4.7 Paid Amount

7.11.7 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.

7.11.8 **Medical loss ratio (MLR) calculation**. Within thirty (30) days following the nine (9) month claims run-out period following the Coverage Year, 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.

7.11.9 **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 and nine (9) months of run-out 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. 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 the Contractors 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 7.16.4.3 and 7.16.4.4, 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 $25,000; 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 Attachment XXIII, for each evaluation period. If Contractor does not meet the standards by the evaluation date as set forth in Attachment XXIII, the Department, without further notice, may:

7.16.6.1 impose a quarterly monetary penalty of up to US $100,000;

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.

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 US $50,000.

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:

7.16.14.1 impose a civil money penalty of US $50,000 for each determination, or

7.16.14.2 impose an enrollment hold on Contractor, or

7.16.14.3 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 **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:

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

7.16.17.2 impose an enrollment hold on Contractor, or

7.16.17.3 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 RECOVERIES FROM PROVIDERS

If the Department requires Contractor to recover established overpayments made to a 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 will immediately provide the amount recovered to the Department; or

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

8. 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

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 one renewal covering the entire renewal allowance

8.2.2 individual one-year renewals up to and including the entire renewal allowance

8.2.3 any combination of single- and multi-year renewals up to and including the entire renewal allowance

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; 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.

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 Enrollees of the hearing and its purpose and inform them that they 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 the Contractor for any compensation for services not rendered or outside the scope of this Contract. Following one-hundred eighty (180) days' written notice, and only if

Contractor and Department are unable to come to an agreement regarding rates, 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 sections 7.9 or 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 33 percent 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.

9. 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 9.1shall 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 9.1.2shall 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 Subcontractors' 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 his or her 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, and Executive Orders 11246 and 11375.

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 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 which 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 obligations Contractor has as a governmental body, news releases, publications, presentations, technical papers, or other information disseminated to the public pertaining to this Contract or the services or project to which it relates shall be in coordination with the Department. The Parties shall work in good faith to resolve any differences they may have regarding a public disclosure.

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

9.1.32.1 requiring current or prospective employees, contractors, or 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 DHS-OIG List of Excluded Individuals/Entities (LEIE), the excluded parties list system maintained by the US General Services Administration, and 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 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 last ten (10) years.

9.1.34 Contractor shall terminate its relations with any employee, Contractor, or subcontractor immediately upon learning that such employee, Contractor, or subcontractor 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 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; and

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; and

9.1.35.3 Report the violation to the Secretary of the United States Department of Health and Human Services; and

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 **Coordination of benefits for Enrollees.** Money that Contractor receives as a result of Third-Party liability collection activities may be retained by Contractor to the extent, as permitted by law, Contractor has paid any claim or incurred any expense. Upon the Department's verification that an Enrollee has Third-Party coverage for major medical benefits, the Department shall disenroll such Enrollee from Contractor. Contractor shall be notified of the disenrollment on the 834 Daily File. 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.

9.1.39 **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 *Colbert v. Quinn*, No. 07 C 4735 (N.D. Ill.), and W *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.

9.2 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 9.2and is under a continuing obligation to remain in compliance and report any noncompliance. This section 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 9.2is 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.

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 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-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 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 subawards 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 and within thirty-five (35) days after a change 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 9.2.34.1, 9.2.34.2, 9.2.34.3, and 9.2.34.4.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.

ATTACHMENTS

I. Service Package II Covered Services
II. Geographic areas and Potential Enrollees
III. <Intentionally left blank>
IV. Rate sheet *<Intentionally left blank>*
V. State of Illinois Drug Free Workplace
VI. HIPAA Requirements
VII. Addendum to BEP Requirements *<Intentionally left blank>*
VIII. *<Intentionally left blank>*
IX. <Intentionally left blank>
X. *<Intentionally left blank>*
XI. Quality Assurance
XII. Utilization Review and Peer Review
XIII. Required deliverables, submission, and reports
XIV. Data security 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 Incidents
XVIII. Illinois Department of Aging Elder Abuse and Neglect Program
XIX. Illinois Department of Healthcare and Family Services Incident Reporting for Supportive Living Facilities
XX. Personal Assistant payment policy
XXI. Required minimum standards of care
XXII. High-Needs Children minimum standards of care
XXIII. Illinois Medicaid Health Plan Encounter Utilization Monitoring (EUM) requirements

Attachment I
Service Package II Covered Services

Service	DoA	DHS-DRS			DSCC	HFS			
	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury	Children who are Medically Fragile, Technology Dependent	Supportive Living Facility	Definition	Standards	HFS Fee-For-Service Service Limits
Adult Day Service	x	x	x	x			Adult day service is the direct care and supervision of adults aged 60 and over 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 units of transportation shall be provided per MFP Enrollee in a 24 hour period, and shall not include trips to a Physician, shopping, or other miscellaneous trips.

Service	DoA	DHS-DRS			DSCC	HFS			
	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury	Children who are Medically Fragile, Technology Dependent	Supportive Living Facility	Definition	Standards	HFS Fee-For-Service Service Limits
Environmental Accessibility Adaptations-Home		x	x	x	x		Those physical adaptations to the home, required by the Enrollee Care Plan, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require Institutionalization. Excluded are those adaptations or improvements to the home that are of general utility and are not of direct remedial benefit to the Enrollee. **DSCC** Vehicle modifications (wheelchair lifts and tie downs) are also provided under environmental modifications.	**DRS:** 89 Il.Adm.Code 686.608 **DSCC:** DSCC Home Care Manual, 53.20.30, (Rev.9/01) &53.43 (Rev.9/01)	**DRS** The cost of environmental modification, when amortized over a 12 month period and added to all other monthly service costs, may not exceed the service cost maximum. **DSCC** All environmental modifications will be limited in scope to the minimum necessary to meet the Enrollee's medical needs.

Service	DoA	DHS-DRS			DSCC	HFS			
	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury	Children who are Medically Fragile, Technology Dependent	Supportive Living Facility	Definition	Standards	HFS Fee-For-Service Service Limits
Supported Employment				x			Supported employment services consist of intensive, ongoing supports that enable Enrollees, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need 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 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 determination of need assessment conducted by the case manager and the service cost maximum determined by the DON.

Service	DoA	DHS-DRS			DSCC	HFS			
	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury	Children who are Medically Fragile, Technology Dependent	Supportive Living Facility	Definition	Standards	HFS Fee-For-Service Service Limits
Nursing, Intermittent		x	x	x			Nursing services that are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or a licensed practical nurse, licensed to practice in the State. Nursing through the HCBS Waiver focuses on long term habilitative needs rather than short-term acute restorative needs. HCBS Waiver intermittent nursing services are in addition to any Medicaid State Plan nursing services for which the Enrollee may qualify.	**DRS:** Home Health Agency: 210 ILCS 55 Licensed Practical Nurse: 225 ILCS 65 Registered Nurse: 225 ILCS 65	The amount, duration, and scope of services are based on the determination of need assessment conducted by the case manager and the service cost maximum determined by the DON score. All HCBS Waiver clinical services require a prescription from a Physician. The duration and/or frequency of these services are dependent on continued authorization of the Physician, and relevance to the Enrollee's service plan.
Nursing,Skilled (RN and LPN)		x	x	x			Service provided by an individual that meets Illinois licensure standards for nursing services and provides shift nursing services.	**DRS:**Home Health Agency: 210 ILCS 55 Licensed Practical Nurse: 225 ILCS 65 Registered Nurse: 225 ILCS 65	**DRS**The amount, duration, and scope of services is based on the service plan and is included in the service cost maximum/monthly cost limit. This service will not be duplicative of other services in the HCBS Waiver.
Occupational Therapy		x	x	x			Service provided by a licensed occupational therapist that meets Illinois standards. Services are in addition to any Medicaid State Plan services for which the Enrollee may qualify. Occupational therapy through the HCBS Waiver focuses on long term habilitative needs rather than short-term acute restorative needs.	**DRS:** Occupational Therapist: 225 ILCS 75 Home Health Agency: 210 ILCS 55	**DRS** All HCBS Waiver clinical services require a prescription from a Physician. The duration and/or frequency of these services are dependent on continued authorization of the Physician, and relevance to the Enrollee's service plan. The amount, duration, and scope of services is based on the service plan and is included in the service cost maximum

Service	DoA	DHS-DRS			DSCC	HFS			
	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury	Children who are Medically Fragile, Technology Dependent	Supportive Living Facility	Definition	Standards	HFS Fee-For-Service Service Limits
Physical Therapy		x	x	x			Service provided by a licensed physical therapist that meets Illinois standards. Services are in addition to any Medicaid State Plan services for which the Enrollee may qualify. Physical Therapy through the HCBS Waiver focuses on long term habilitative needs rather than short-term acute restorative needs.	**DRS:** Physical Therapist 225 ILCS 90 Home Health Agency: 210 ILCS 55	**DRS** All HCBS Waiver clinical services require a prescription from a Physician. The duration and/or frequency of these services are dependent on continued authorization of the Physician, and relevance to the Enrollee's service plan. The amount, duration, and scope of services is based on the service plan and is included in the service cost maximum.
Speech Therapy		x	x	x			Service provided by a licensed speech therapist that meets Illinois standards. Services are in addition to any Medicaid State Plan services for which the Enrollee may qualify. Speech Therapy through the HCBS Waiver focuses on long term habilitation needs rather than short-term acute restorative needs.	**DRS:** Speech Therapist 225 ILCS 110 Home Health Agency: 210 ILCS 55	**DRS**All HCBS Waiver clinical services require a prescription from a Physician. The duration and/or frequency of these services are dependent on continued authorization of the Physician, and relevance to the Enrollee's service plan. The amount, duration, and scope of services is based on the service plan and is included in the service cost maximum.

Service	DoA	DHS-DRS			DSCC	HFS			
	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury	Children who are Medically Fragile, Technology Dependent	Supportive Living Facility	Definition	Standards	HFS Fee-For-Service Service Limits
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 work force or participate in a transitional sheltered workshop within one 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 determination of need assessment conducted by the case manager and the service cost maximum determined by the DON score.All prevocational services will be reflected in the Enrollee Care Plan as directed to habilitative, rather than explicit employment, objectives.
Habilitation-Day				x			**BI** Day habilitation assists with the acquisition, retention, or improvement in self-help, socialization, and adaptive skills which takes place in a non-residential setting, separate from the home or facility which the individual resides. The focus is to enable the individual to attain or maintain his or her maximum functional level. Day habilitation shall be coordinated with any physical, occupational, or speech therapies listed in the Enrollee Care Plan. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.	**BI** 59 Il.Adm.Code 119 **IL Admin Code 686.1200**	**BI** The amount, duration, and scope of services are based on the determination of need assessment conducted by the case manager and the service cost maximum determined by the DON score. This service shall be furnished 4 or more hours per day on a regularly scheduled basis, for 1 or more days per week unless provided as an adjunct to other day activities included in the Enrollee Care Plan.
Placement Maintenance Counseling					x		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 his or her judgment that it is necessary to maintain the child in the home placement.	Licensed Clinical Social Worker 225 ILCS 20 Medicaid Rehabilitation Option 59 Il.Adm.Code 132 Licensed Clinical Psychologist 225 ILCS 15	Services will require pr-authorization by HFS and will be limited to a maximum of twelve sessions per calendar year.

Service	DoA	DHS-DRS			DSCC	HFS			
	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury	Children who are Medically Fragile, Technology Dependent	Supportive Living Facility	Definition	Standards	HFS Fee-For-Service Service Limits
Medically Supervised Day Care					x		This service offers the necessary technological support and nursing care provided in a licensed medical day care setting as a developmentally appropriate adjunct to full time care in the home. Medically supervised day care serves to normalize the child's environment and provide an opportunity for interaction with other children who have similar medical needs.	Licensed Day Care Facility 89 Il.Adm.Code 407 Health Care Center 77 Il.Adm.Code 260	This service cannot exceed more than 12 hours per day, five days per week.
Homemaker	x	x	x	x			Homemaker service is defined as general non-medical 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. (a.k.a. In home care)	**DOA:** 89 Il.Adm.Code 240 **DRS:** 89 Il. Adm. Code 686.200	**DOA, DRS:** The amount, duration, and scope of services are based on the determination of need assessment conducted by the case manager and the service cost maximum determined by the DON score.
Home Delivered Meals		x	x	x			Prepared food brought to the client's residence that may consist of a heated luncheon meal and/or a dinner meal which can be refrigerated and eaten later. This service is designed primarily for the client who cannot prepare his/her own meals but is able to feed him/herself.	89 Il. Adm. Code 686.500	The amount, duration, and scope of services is based on the determination of need assessment conducted by the case manager and the service cost maximum. This service will be provided as described in the service plan and will not duplicate any other services.

Service	DoA	DHS-DRS			DSCC	HFS			
	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury	Children who are Medically Fragile, Technology Dependent	Supportive Living Facility	Definition	Standards	HFS Fee-For-Service Service Limits
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 determination of need 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 person'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			DSCC	HFS			
	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury	Children who are Medically Fragile, Technology Dependent	Supportive Living Facility	Definition	Standards	HFS Fee-For-Service Service Limits
Respite		x	x	x	x		**DRS** Respite services provide relief for unpaid family or primary care givers, who are currently meeting all service needs of the Enrollee. Services are limited to Individual Provider, homemaker, nurse, adult day care, and provided to a consumer to provide his or her activities of daily living during the periods of time it is necessary for the family or primary care giver to be absent. **DSCC** Respite care services allow for the needed level of care and supportive services to enable the Enrollee to remain in the community, or home-like environment, while periodically relieving the family of care-giving responsibilities. These services will be provided in the Enrollee'ss home or in a Children's Community-Based Health Care Center Model, licensed by the Illinois Department of Public Health.	Adult Day Care 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:** Health Care Center 77 Il.Adm.Code 260 Nursing Agency: Meet DSCC nursing agency requirements-DSCC Home Care Manual, 53.09	**DRS** The amount, duration, and scope of services is based on the determination of need assessment conducted by the case manager and the service cost maximum determined by the DON score **DSCC** Respite care services will be limited to a maximum of 14 days or 336 hour annual limit. Exceptions may be made on an individual basis based on extraordinary circumstances.
Nurse Training					x		This service provides child specific training for nurses, under an approved nursing agency, in the use of new or unique prescribed equipment, or special care needs of the child.	DSCC Nursing agency requirements-DSCC Home Care Manual, 53.09.	This service cannot exceed the maximum of four hours per nurse, per HCBS Waiver year.
Family Training					x		Training for the families of Enrollees served on this HCBS Waiver. Training includes instruction about treatment regimens and use of equipment specified in the Enrollee Care Plan and shall include updates as necessary to safely maintain the Enrollee at home. It may also include training such as Cardiopulmonary Resuscitation (CPR).	Nursing Agency: Meet DSCC nursing agency requirements-DSCC Home Care Manual, 53.09 Service Agency: Qualify to provide the service.	All Family Training must be included in the Enrollee Care Plan.

Service	DoA	DHS-DRS			DSCC	HFS			
	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury	Children who are Medically Fragile, Technology Dependent	Supportive Living Facility	Definition	Standards	HFS Fee-For-Service Service Limits
Specialized Medical Equipment and Supplies		x	x	x	x		Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the Enrollee Care Plan, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. All items shall meet applicable standards of manufacture, design and installation.	**DRS:** 68 Il. Adm. Code 1253 Pharmacies 225.ILCS.85 Medical Supplies 225.ILCS.51 **DSCC:** 225.ILCS.51 If not licensed under 225 ILCS 51, must be accredited by the Joint Commission on Accreditation of Healthcare Organizations, or other accrediting organization. Meet DSCC Home Medical Equipment requirements for the HCBS Waiver. A Medicaid enrolled pharmacy or durable medical equipment provider that provides items not available from a DSCC approved home medical equipment (HME) provider,(such as special formula).	Items reimbursed with HCBS Waiver funds shall be in addition to any medical equipment and supplies furnished under the State Plan and shall exclude those items, which are not of direct medical or remedial benefit to the individual. **DSCC:** Medical supplies, equipment and appliances are provided only on the prescription of the PCP as specified in the Enrollee Care Plan.

Service	DoA	DHS-DRS			DSCC	HFS			
	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury	Children who are Medically Fragile, Technology Dependent	Supportive Living Facility	Definition	Standards	HFS Fee-For-Service Service Limits
Behavioral Services (M.A. and PH.D)				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 determination of need 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 65 years of age or older and persons with physical disabilities between 22 and 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 apartment 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 24 hours a day	Supportive Living Facilities 89 Il. Adm.Code 146 SupPart B	SLFs are reimbursed through a global rate which includes the following Covered Services: • Nursing Services • Personal Care • Medication administration, oversight and assistance in self-administration • Laundry • Housekeeping • Maintenance • Social and recreational programming • Ancillary Services • 24 Hour Response/Security staff • Health Promotion and Exercise • Emergency call System • Daily Checks • Quality Assurance Plan • Management of Resident Funds, if applicable

Attachment II
Geographic Area and Potential Enrollees

Geographic Area	There are nineteen (19) Urban Areas in Illinois and eighty-three (83) Rural Areas. Urban Area counties are highlighted in **bold** below. **Proposal Option A:** Adams, Alexander, Bond, Boone, Brown, Bureau, Calhoun, Carroll, Cass, **Champaign**, Christian, Clark, Clay, Clinton, Coles, **Cook**, Crawford, Cumberland, **DeKalb**, De Witt, 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 **Proposal Option B: Cook County** http://www.icahn.org/files/Rural_Health_Clinic/Rural_urban_counties.pdf
Potential Enrollees	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 a HCBS waiver; Special Needs Children, defined as Medicaid-eligible enrollees under the age of 21 who are covered under Supplemental Security Income (SSI), a disability category of eligibility, or are receiving services from the Division of Specialized Care for Children (DSCC); and children formerly under the care of Department of Children and Family Services (DCFS) who have opted out of the DCFS specific managed care program. Members excluded from the scope of this Contract are as follows: • Participants enrolled in SCHIP Premium Level 2; • 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; • DCFS Youth in Care children; • Participants only eligible with a Spend-down; • All Presumptive Eligibility categories; • Participants enrolled in partial/limited benefits programs; and, • Participants with Comprehensive Third Party Insurance.

Attachment III

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Attachment IV
Rate Sheet

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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.

_____	2015-XX-XXX _____
Signature of Authorized Representative	Contract ID Number
_____	_____
Printed Name and Title	Date

Attachment VI:
HIPAA Requirements

A. Definitions. Capitalized terms used in this Attachment shall have the following meanings:

1. "Designated Record Set" shall have the same meaning as set forth in 45 CFR Section 164.501.
2. "Individual" shall have the same meaning as set forth in 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).
3. "Protected Health Information" or "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.
4. "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.
5. "Required by law" shall have the same meaning as set forth in 45 CFR Section 164.103.
6. "Services" shall mean the duties or obligations described in the Contract to be performed by Contractor for the Department.
7. "Contractor" shall mean [insert name of contracting party].
8. "Department" shall mean the Illinois Department of Healthcare and Family Services (HFS).
9. "Breach" shall have the same meaning as set forth in 45 CFR 164.402.
10. "Unsecured PHI" shall have the same meaning as set forth in 45 CFR 164.402.
11. "HIPAA Rules" shall mean the "HIPAA Administrative Simplification," 45 CFR Parts 160, 162, and 164, and shall include any amendments thereto.
12. "Contract" shall mean the [Contract, Grant, Agreement, etc.] between HFS and [insert contracting party][insert HFS Tracking Number].
13. All other terms used herein shall have the meaning ascribed to them in the HIPAA Rules.

B. Contractor's Obligations and Activities. Contractor shall:

1. Not use or disclose PHI other than as permitted or required by the Contract, this Attachment, or as permitted or required by law; and
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; and
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; and
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; and
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; and

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; and
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 HITECH Act; and
8. To the extent the 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); and
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 United States Department of Health and Human Services, Contractor's internal practices, books, and records, including policies and procedures and 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; and
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; and
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; and
12. Refrain from exchanging PHI with any entity which the Contractor knows has a pattern of activity or practice that constitutes a material breach or violation of HIPAA; and
13. Encrypt PHI in transit and at rest; and
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.

C. Contractor's Permitted Uses and Disclosures.

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.
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.
3. Contractor shall make uses and disclosures and requests for PHI consistent with the "minimum necessary" standard set forth in 45 CFR Section 164.502(b).
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.
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).

D. Provisions for the Department to Inform Contractor of Privacy Practices and Restrictions.

1. The Department shall notify Contractor of any limitation contained in the the Department's notice of privacy practices to the extent that such limitation may affect Contractor's use or disclosure of PHI.
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.

E. Term and Termination.

1. Effective Date. This Attachment shall be effective as of the execution of the Contract.
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.
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:
    a. 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 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
    b. If destruction of the PHI is not feasible, Contractor shall 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.
4. Survival. The obligations of Contractor under this Attachment shall survive the termination of the Contract or this Attachment.

F. The Department's Obligations. The Department shall:

1. Provide Contractor with access to the Department's Notice of Privacy Practices (http://www.hfs.illinois.gov/assets/hfs3806.pdf); and
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; and
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
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.

G. Breach.

1. Breach Notification. If Contractor discovers a Breach of Unsecured PHI as defined in 45 CFR 164.402, within 10 calendar days after the 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.

a. 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.

b. Contractor shall be deemed to have become aware of the Breach of Unsecured PHI as of the first 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, that is an employee, officer or other agent of Contractor.

c. Contractor shall notify the Department by completing and submitting the Notification of Unauthorized Access, Use, or Disclosure (Exhibit A).

d. The Department and the 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.

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.

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 12 months provided to Individuals, and any litigation costs, fines, penalties or judgments resulting from the Breach.

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, Attachment or 45 CFR Section 164 Subparts D and E.

H. 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.

I. Miscellaneous.

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.

2. Interpretation. Any ambiguity in this Attachment shall be interpreted to permit compliance with the HIPAA Rules.

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 - 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. In accordance with the Contract, notice must occur immediately.

Notice shall be provided to: <contact name>; and

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 No.:

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 the 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/have been taken to investigate the unauthorized access, use, or disclosure, mitigate losses, and protect against any further incidents?
Number of Individuals Impacted. If over 500, identify whether individuals live in multiple states.

Submitted by:

Signature: _____ **Date:** _____

Printed Name and Title: _____

Attachment VII
Addendum to BEP Requirements

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Attachment VIII

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Attachment IX

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Attachment X

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Attachment XI
Quality Assurance

1. Contractor shall establish procedures such that Contractor shall be able to demonstrate that it has an ongoing fully implemented Quality Assurance 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)), and the regulations promulgated pursuant to the Balanced Budget Act of 1997 (42 CFR 438.200 et seq.). These regulations require that Contractor have an ongoing fully implemented Quality Assurance Program for health services that:

a. Incorporates widely accepted practice guidelines that meet nationally-recognized standards and are distributed to Network Providers, as appropriate, and to Enrollees and Potential Enrollees, upon request, and:

   i. Are based on valid and reliable clinical evidence;

   ii. Consider the needs of Enrollees;

   iii. Are adopted in consultation with Network Providers; and

   iv. Are reviewed and updated periodically as appropriate.

b. Monitors the health care services Contractor provides, including assessing the appropriateness and quality of care;

c. Stresses health outcomes and monitors Enrollee risks status and improvement in health outcomes;

d. Provides a comprehensive program of Care Coordination, Care Management, and Disease Management, with needed outreach to assure appropriate care utilization and community referrals;

e. Describes its use of Care Coordination Claims Data (CCCD) files for risk stratification, risk management, Care Coordination and case management of enrollees or other uses;

f. Provides review by Physicians and other health professionals of the process followed in the provision of health services;

f. Includes fraud control provisions;

g. Establishes and monitors access standards;

h. 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;

i. 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;

j. Describes its implementation process for reducing unnecessary emergency room utilization and inpatient services, including (thirty) 30-day readmissions;

k. Describes its process for obtaining clinical results, findings, including emergency room and inpatient care, pharmacy information, lab results, feedback from other care providers, etc., to provide such data and information to the PCP or specialist, or others, as determined appropriate, on a real-time basis;

l. 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.

m. Details its processes for establishing medical homes and the coordination between the PCP and Behavioral Health provider, specialists and PCP, or specialists and Behavioral Health providers;

n. 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; and

o. Describes its processes for addressing Abuse and Neglect and unusual incidents in the community setting.

p. Detail any compensation structure, incentives, pay-for-performance programs, value purchasing strategies, and other mechanisms utilized to promote the goals of Integrated Health Homes and accountable, coordinated care;

q. 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 abuse resources) and outreach documents (e.g., about chronic conditions) using evidence based guidelines and best practice strategies;

r. Describes its process for developing, implementing and evaluating transition care plans for children transitioning to adulthood;

s. Provides for systematic activities to monitor and evaluate the dental services and Behavioral Health services rendered;

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 and Disease Management). This written description must meet federal and State requirements, as outlined below:

a. Goals and objectives — The written description shall contain a detailed set of Quality Assurance objectives that are developed annually and include a workplan and timetable for implementation and accomplishment.

b. 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.

c. 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, and home care), and types of services (e.g., preventive, primary, specialty care, Behavioral Health, dental, pharmacy, and 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.

d. 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 workplan 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.

e. 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.

f. Focus on health outcomes — The QAP methodology shall address health outcomes; a complete description of the methodology shall be fully documented and provided to Department.

g. 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.

h. Enrollee and advocate input --- The QAP shall detail its operational and management plan for including Enrollee and advocate input into its QAP processes.

3. Contractor shall provide the Department with the QAP written guidelines which delineate the QA process, specifying:
   a. Clinical areas to be monitored:
      i. 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.
      ii. 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.

iii. 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.

iv. At a minimum, the following areas shall be monitored:

a) For all populations:

1. Emergency room utilization.
2. Inpatient hospitalization.
3. Thirty (30)-day readmission rate.
4. Assistance to Enrollees accessing services outside the Covered Services, such as housing, social service agencies and senior centers.
5. Health education provided.
6. Coordination of primary and specialty care.
7. Coordination of care, Care Management, Disease Management, and other activities.
8. Individualized Plan of Care (IPoC).
9. Utilization of dental benefits.
10. Utilization of family planning services.
11. Preventive health care for enrollees (e.g., annual health history and physical exam; mammography; Papanicolaou test, immunizations).
12. PCP or Behavioral Health follow-up after emergency room or inpatient hospitalization.
13. Utilization of Behavioral Health services.

b.) For pregnant women:

1. Timeliness and frequency of prenatal visits; postpartum care rate.
2. Provision of American Congress of Obstetricians and Gynecologists (ACOG) recommended prenatal screening tests.
3 Birth outcomes.
4. Birth intervals.
5. Early Elective Delivery (EED) policies of contracted hospitals of delivery.
6. Development of reproductive life plans.
7. Utilization of 17P.
8. Referral to the Perinatal Centers, as appropriate.
9. Length of hospitalization for the mother.
10. Utilization of post-partum family planning services, including LARC
11. Length of newborn hospital stay for the infant.
12. Assistance to Enrollees in finding an appropriate PCP/Pediatrician for the infant.

c.) For children ages birth through twenty (20):

1. Number of preventive and well-child visits appropriate for age.
2. Immunization status.
3. Lead screenings conducted (measured using HEDIS Lead Screening in Children (LSC) measure, or other department approved measure), and blood-level status.
4. Objective developmental screenings conducted (measured using SDEV measure or other department-approved measure).
5. Number of hospitalizations.
6. Length of hospitalizations.
7. Medical management for a limited number of medically complicate conditions as agreed to by Contractor and Department.

d) For 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 co-morbidities).

1. Appropriate treatment, follow-up care, and coordination of care, for all Enrollees.
2. Identification of Enrollees with special health care 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.
3. Care coordination, Care Management, Disease Management, and Chronic Health Conditions action plan, as appropriate.

e) For Behavioral Health:

1. Behavioral Health network adequate to serve the Behavioral Health care needs of Enrollees, including mental health and substance abuse services sufficient to provide care within the community in which the Enrollee resides.
2. Assistance sufficient to access Behavioral Health services, including but not limited to transportation and escort services.
3. Enrollee access to timely Behavioral Health services.
4. An IPoC or Service Plan and provision of appropriate level of care.
5. Coordination of care between Providers of medical and Behavioral Health services to assure follow-up and continuity of care.
6. Involvement of the PCP in aftercare.
7. Enrollee satisfaction with access to and quality of Behavioral Health services
8. Mental health outpatient and inpatient utilization, and follow up.
9. Chemical dependency outpatient and inpatient utilization, and follow up.

f) For Enrollees in Nursing Facilities and Enrollees receiving HCBS Wavier services:

1. Maintenance in, or movement to, community living.
2. Number of hospitalizations and length of hospital stay.
3. Falls resulting in hospitalization.
4. Behavior resulting in injury to self or others.
5. Enrollee non-compliance of services.
6. Medical errors resulting in hospitalizations.
7. Occurrences of pressure ulcers, unintended weight loss, and infections.

b. 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:

i. Contractor shall identify and use quality indicators that are objective, measurable, and based on current knowledge and clinical experience.

ii. Contractor shall document that methods and frequency of data collected are appropriate and sufficient to detect the need for a program change.

iii. 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.

c. 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.

   i. Multi-disciplinary teams shall be used, where indicated, to analyze and address systems issues.

   ii. Clinical and related service areas requiring improvement shall be identified and documented, and a corrective action plan shall be developed and monitored.

d. Conduct Performance Improvement Projects (PIPs)/Quality Improvement Projects (QIPs) ---- PIPs/QIPs (42 C.F.R. 438.240 (1)(d)), 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.

e. 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:

   i. Specification of the types of problems requiring remedial or corrective action;

   ii. Specification of the person(s) or entity responsible for making the final determinations regarding quality problems;

   iii. Specific actions to be taken;

   iv. A provision for feedback to appropriate health professionals, providers and staff;

   v. The schedule and accountability for implementing corrective actions;

   vi. The approach to modifying the corrective action if improvements do not occur; and

vii. Procedures for notifying a PCP group that a particular Physician is no longer eligible to provide services to Enrollees.

f. 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.

g. Evaluation of Continuity and Effectiveness of the QAP:

i. 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).

ii. 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:

a) QA/UR/PR Plan with overview of goal areas;
b) Major Initiatives to comply with the State Quality Strategy,
c) Quality Improvement and work plan monitoring;
d) Contractor Network Access and Availability and Service Improvements, including access and utilization of dental services;
e) Cultural Competency;
f) Fraud, Waste and Abuse Monitoring;
g) Population Profile;
h) Improvements in Care Coordination/Care Management and Clinical Services/Programs;
i) Effectiveness of Care Coordination Model of Care;
j) Effectiveness of Quality Program Structure;
k) Summary of monitoring conducted under Section 3-IV including issues or barriers addressed or pending remediation;
l) Comprehensive Quality Improvement Work Plans;
m) Chronic Conditions;
n) Behavioral Health (includes mental health and substance abuse services);
o) Dental care;
p) Discussion of Health Education Program;
q) Member Satisfaction;
r) Enrollee Safety;
s) Fraud, waste and abuse and privacy and security; and
t) Delegation.

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:

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

b. 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.

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

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

e. Program Modification — Upon receipt of regular written reports from the QAP Committee delineating actions taken and improvements made, the Governing Body shall 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.

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:

a. Regular Meetings — The QAP Committee shall meet on a regular basis with specified frequency to oversee QAP activities. This frequency shall be sufficient to demonstrate that the structure/committee is following-up on all findings and required actions, but in no case shall such meetings be held less frequently than quarterly. A copy of the meeting summaries/minutes shall be submitted to the Department no later than thirty (30) days after the close of the quarterly reporting period.

b. Established Parameters for Operating — The role, structure and function of the QAP Committee shall be specified.

c. Documentation — There shall be records kept documenting the QAP Committee's activities, findings, recommendations and actions.

d. 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.

e. Membership — There shall be meaningful participation in the QAP Committee by the Medical Director, practicing physicians, senior leadership and other appropriate personnel.

f. Enrollee Advisory and Community Stakeholder Committee – 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.

6. There shall be a designated Quality Management Coordinator as set forth in Section 2.3.3. Contractor's Medical Director shall have substantial involvement in QA activities and shall be responsible for the required reports.

   a. 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.

   b. Provider Participation in the QAP

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

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

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

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:

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

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

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

   d. There shall be evidence of continuous and ongoing evaluation and oversight of delegated activities, including approval of quality improvement plans and regular specified reports, as well as a formal review of such activities. Oversight of delegated activities 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.

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

f. If Contractor 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 the Contractor.

8. The QAP shall contain provisions to assure that Network Providers, are qualified to perform their services and are credentialed by Contractor. Recredentialing shall occur at least once every three (3) years. Contractor's written policies shall include procedures for selection and retention of Physicians and other Providers.

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:

   a. Asthma;
   b. Congestive Heart Failure (CHF);
   c. Coronary Artery Disease (CAD);
   d. Chronic Obstructive Pulmonary Disease (COPD);
   e. Diabetes;
   f. Adult Preventive Care;
   g. EPSDT for children birth through age 20;
   h. Smoking Cessation;
   i. Behavioral Health (mental health and substance use) screening, assessment, and treatment, including medication management and PCP follow-up;
   j. Psychotropic medication management;
   k. Clinical Pharmacy Medication Review;

l. Coordination of community support and services for Enrollees in HCBS Waivers;
m. Dental services;
n. Pharmacy services;
o. Community reintegration and support;
p. Long-term Care (LTC) residential coordination of services;
q. Prenatal, obstetrical, postpartum and reproductive health care; and
r. Other conditions and services as deemed by the Contractor and/or the Department.

10. Contractor shall put a basic system in place which promotes continuity of Care Management. Contractor shall provide documentation on:

    a. Monitoring the quality of care across all services and all treatment modalities.

    b. Studies, reports, protocols, standards, worksheets, minutes, or such other documentation as may be appropriate, concerning its QA activities and corrective actions and make such documentation available to the Department upon request.

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.

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

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

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

        i. Network changes.

        ii. Benefits redesign.

        iii. Medical management systems (e.g., pre-certification).

        v. Practice feedback to Physicians.

        vi. Other services, such as dental, vision, pharmacy etc.

        vii. Member services.

        viii. Care Management, Disease Management.

        ix. Enrollee education.

    d. 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.

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.

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 health care 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 (1) verifying the accuracy and timeliness of reported data; (2) screening the data for completeness, logic, and consistency; and (3) 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.

14. Contractor shall perform and report the Healthcare and Quality of Life Performance Measures identified in Attachment XI, Table 1 Families and Children Population (FHP/ACA) and Seniors and Persons with Disabilities (ICP) Population – Quality 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.

15. Contractor shall perform and report the performance measures in Table 2 – 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.

16. Contractor shall monitor other Performance Measures as required by the federal Centers for Medicare and Medicaid Services (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	ICP Reports	FHP/ACA Reports
AAP	Adults' Access to Preventive/ Ambulatory Health Services	Percentage of member's age ≥20 years that had an ambulatory or preventive care visit during the measure year.	Admin	Yes	Yes
AMB	Ambulatory Care	Two Rates Reported, per 1,000 member months	Admin	Yes	Yes
	1) Outpatient visits				
	2) ED visits				
PPC	Prenatal and Postpartum Care	Two rates reported	Hybrid / Admin	Yes	Yes
	1) Timeliness of prenatal care	Percentage of deliveries with a prenatal care visit in the first trimester or within 42 days of enrollment			
	2) Postpartum Care	Percentage of deliveries with a postpartum visit on or between 21 and 56 days after delivery.			
IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Two rates reported. Members with a new episode of alcohol or other drug (AOD) dependence who received indicated services.	Admin	Yes	Yes
	1) Initiation of AOD Treatment				
	2) Engagement of AOD Treatment				
W15	Well-Child Visits in the First 15 Months of Life (W15)	Percentage of members who turned 15 months old during the measure year and who had 0-6+ well-child visits with a PCP during the first 15 months of life.	Hybrid / Admin	N/A	Yes
W34	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)	Percentage of members 3-6 years of age who had one or more well-child visits with a PCP during the measure year.	Hybrid / Admin	N/A	Yes
ABA	Adult BMI Assessment	Percentage of members 18-74 years of age who had an outpatient visit and who had their body mass index (BMI) documented during the measurement year or the year prior to the measurement year.	Hybrid / Admin	Yes	Yes
BCS	Breast Cancer Screening	Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer during the measurement year or prior 18 months.	Admin	Yes	Yes
CCS	Cervical Cancer Screening	The percentage of women 21–65 years of age who were screened for cervical cancer using either of the following criteria:	Hybrid / Admin	Yes	Yes

Acronym	Performance Measure	Further Description	Reporting Methodology	ICP Reports	FHP/ACA Reports
		• Women age 24-65 who had a Pap test in the measurement year or the two years prior • Women age 35-65 who had a Pap test and an HPV test on the same date of service in the measurement year or the four years prior.			
CHL	Chlamydia Screening for Women	Percentage of women age 16-24 who were identified as sexually active and who had at least one test for Chlamydia during the measure year.	Admin	Yes	Yes
CBP	Controlling High Blood Pressure	Percentage of members 18-85 years if age who had a diagnosis of hypertension and who's BP was adequately controlled during the measurement year.	Hybrid	Yes	Yes
CIS	Childhood Immunization Status	Percentage of children who had the indicated vaccinations by their 2nd Birthday. (report rate for each vaccine and combos 2-10)	Hybrid / Admin	N/A	Yes
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents 1) BMI percentile documentation 2) Counseling for nutrition 3) Counseling for physical activity	Percentage of members 3-17 years of age who had an outpatient visit including BMI percentile, Counseling for nutrition and Counseling for physical activity.	Hybrid / Admin	N/A	Yes
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 13th birthday.	Hybrid / Admin	N/A	Yes
CDC	Comprehensive Diabetes Care (CDC) 1) Hemoglobin A1c (HbA1c) testing 2) Eye exam (retinal) performed 3) Medical attention for nephropathy	Percentage of members18-75 years of age with diabetes (type 1 and type 2) who had the following during the measurement year	Hybrid / Admin	Yes	Yes
SPD	Statin therapy for Patients With Diabetes	Percentage of members 40-75 years of age with diabetes and who do not have clinical atherosclerotic cardiovascular disease who met the following:	Admin	Yes	Yes

Acronym	Performance Measure	Further Description	Reporting Methodology	ICP Reports	FHP/ACA Reports
	1) Received Statin Therapy	Were dispensed a statin medication during measurement year			
	2) Statin Adherence 80%	Remained on statin for 80% of treatment period			
MPM	Annual Monitoring for Patients on Persistent Medications	Percentage of members ≥18 years who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent (ACE/ARB, digoxin, diuretics) and at least one therapeutic monitoring event for the therapeutic agent in the measure year.	Admin	Yes	Yes
MMA	Medication Management for People with Asthma	Percentage of member's age 5-64 years with persistent asthma who were dispensed appropriate medications.	Admin	Yes	Yes
	1) Remained on medication for at least 50% of treatment period.				
	2) Remained on medication for at least 75% of treatment period.				
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.	Admin	N/A	Yes
FUH	Follow-Up After Hospitalization for Mental Illness	Percentage of discharges for member's hospitalized for treatment of selected mental health disorders that had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates reported:	Admin	Yes	Yes
	1) Follow-up within 7 days of discharge				
	2) Follow-up within 30 days of discharge				

N/A - indicates measure is not applicable to the indicated population

Table 2 to Attachment XI
Service Package II HCBS Waiver Performance Measures

PM #	Waiver Performance Measures	Resp 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 C- Qualified Providers								
Subassurance C **The State implements its policies and procedures for verifying that training is provided in accordance with state requirements and the approved waiver**								
26C	*# and % of enrolled non-licensed/non-certified waiver service providers (Personal Assistants) who meet waiver provider qualifications.* N: # of enrolled waiver service providers reviewed who meet waiver provider qualifications. D: Total # of enrolled waiver service providers reviewed.	EQRO/ MCO	Annually and Ongoing	Representa tive Sample	MCO	Quarterly and Annually	MCO Reports	Obtain document; Training for MCO case managers. Change provider; remove from MMIS; disenroll from plan, Remediation within 60 days.
29C	*# and % of case managers 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.

PM #	Waiver Performance Measures	Resp 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 D- Service Plan Development								
<u>Subassurance A</u> **Service plans address all participants' assessed needs (including health and safety factors) and personal goals, either by the provision of waiver services or through other means**								
31D	*# and % of MCO participants' care plans/service plans that address all personal goals identified by the assessment.* N: # of MCO care plans/service plans reviewed that address all personal goals identified by the assessment. ---------- D: Total # of MCO care plans/service plans reviewed.	EQRO /MCO	Quarterly and Ongoing	Representa tive 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 MCO will provide training of case managers. Remediation must be completed within 60 days.
32D	*# and % of MCO participants' care plans/service plans that address all participant needs identified by the assessment.* N: # of MCO care plans/service plans reviewed that address all participant needs identified by the assessment. ---------- D: Total # of MCO care plans/service plans reviewed.	EQRO /MCO	Quarterly and Ongoing	Representa tive 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 MCO will provide training of case managers. Remediation must be completed within 60 days.

PM #	Waiver Performance Measures	Resp 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
33D	*# and % of MCO participants' care plans/service plans that address risks identified in the assessment.* N: # of MCO care plans/service plans reviewed that address risks identified in the assessment. ---------- D: Total # of MCO care plans/service plans reviewed.	EQRO /MCO	Quarterly and Ongoing	Representa tive 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 MCO will provide training of case managers. Remediation must be completed within 60 days.
34D	*# and % of MCO survey respondents in the sample who reported they receive services they need when they need them.* N: # of MCO survey respondents who reported they receive services when needed. ---------- D: # of MCO survey respondents in the sample.	MCO	Annually	CAHPS Guidelines (BI, HIV, PD)	MA/MCO	Quarterly and Annually	CAHPS Survey (BI, HIV, PD)	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. Patterns of negative responses, including anonymous survey responses, will be
			Quarterly and Annually	100% (Elderly)			POSM Survey question A.2. (Elderly)	

PM #	Waiver Performance Measures	Resp 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
								used to identify need for system improvement.
<u>Subassurance B</u> **The State monitors service plan development in accordance with its policies and procedures**								
35D	*# and % of MCO participants' care plans/service plans that were signed and dated by the waiver participant and the case manager.* N: # of MCO care plans/service plans that were signed by the waiver participant and the case manager. ---------- D: Total # of MCO care plans/service plans reviewed.	EQRO /MCO	Quarterly and Ongoing	Representa tive Sample	MA/MCO	Quarterly and Annually	MCO Reports; EQRO Reviews	If plans are not signed by appropriate parties, the MA will require the plans be signed, with a review of the plan with the participant when indicated. The MCO may also provide training in both cases. Remediation must be completed within 60 days.

PM #	Waiver Performance Measures	Resp 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
36D	*# and % of MCO participants who received contact by their case manager every 12 months for Persons with Disabilities and Elderly; monthly for BI and HIV, with a bi-monthly contact being face-face for HIV, in an effort to monitor service provision and to address potential gaps in service delivery.* 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 HIV; with a bi-monthly contact being face-to-face, for HIV. ---------- D: Total # of MCO participants reviewed.	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 MCO will provide training of case managers. Remediation must be completed within 60 days.
<u>Subassurance C</u> **Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs**								
37D	*# and % of MCO waiver participants who have their care plan/service plan updated every 12 months for Persons with Disabilities, HIV and Elderly; every 6 months for BI.*	EQRO /MCO	Quarterly and Ongoing	Representative Sample	MA/MCO	Quarterly and Annually	MCO Reports; EQRO Reviews	If service plans are untimely, the MA will require completion of overdue service

PM #	Waiver Performance Measures	Resp 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
	N: # of MCO waiver participants reviewed who have their care plan/service plan updated every 12 months for Persons with Disabilities, HIV and Elderly; every 6 months for BI. ---------- D: Total # of MCO waiver participants with care plan/service plan due during the period reviewed.							plans and justification from the case manager. In both cases the MCO may also provide training of case managers. Remediation within 60 days.
38D	*# and % of MCO waiver participants that received updates to care plans/service plans when participants needs changed.* N: # of MCO waiver participants reviewed that received updates to care plans/service plans when participants' needs changed. ---------- D: Total # of MCO waiver participants identified whose needs changed.	EQRO /MCO	Quarterly and Ongoing	Subset of Representative Sample	MCO	Quarterly and Annually	MCO Reports; EQRO Reviews	If plans do not address required items, the MA will require that the plans be corrected and provide training of case managers. Remediation must be completed within 60 days.
<u>Subassurance D</u> **Services are delivered in accordance with the service plan, including type, scope, amount, duration, and frequency specified in the service plan**								

PM #	Waiver Performance Measures	Resp 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
39D	*# and % of MCO participants who received services in the type, scope, amount, duration, and frequency as specified in the care plan/service plan.* N: # of MCO participants reviewed who received services as specified in the care plan/service plan. ---------- D: Total # of MCO participants reviewed.	EQRO /MCO	Quarterly and Ongoing	Representa tive 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.

PM #	Waiver Performance Measures	Resp 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
40D	*# and % of MCO survey respondents in the sample who reported the receipt of all services listed in the plan of care.* N: # of MCO survey respondents who reported the receipt of all services listed in the plan of care. ---------- D: # of MCO survey respondents in the sample.	MCO	Annually	CAHPS Guidelines	MA/MCO	Quarterly and Annually	CAHPS Survey	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
<u>Subassurance E</u> Participants are afforded choice between/among waiver services and providers.								
41D	*# and % of MCO participants records with the most recent plan of care indicating the participant had choice between/among services and providers.*	EQRO /MCO	Quarterly and Ongoing	Representa tive Sample	MA/MCO	Quarterly and Annually	MCO Reports; EQRO Reviews	The MCO will assure that choice was provided as shown by the correction of

PM #	Waiver Performance Measures	Resp 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
	N:# of MCO participant records reviewed with a signed POC that indicates participant had choice between services and providers. ---------- D:Total # of MCO participant records reviewed.							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								
<u>Subassurance A</u> The State demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.								
42G	*# and % of participants who received information from the MCO about how and to whom to report abuse, neglect, exploitation at the time of assessment/reassessment.* 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. ----------	EQRO /MCO	Quarterly and Ongoing	Represent-ative Sample	MA/MCO	Quarterly and Annually	MCO Reports; EQRO Reviews	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,

PM #	Waiver Performance Measures	Resp 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
	D: Total # of MCO participant records reviewed.							including evidence of steps taken to educate the customer. Remediation must be completed within 30 days.
43G	*# and % of participants' substantiated incidents that were reported by the Investigative Authority to the MCO and resolved within recommended timelines.* N: # of substantiated incidents reported to the MCO that were resolved within recommended timelines. ---------- D: Total # of substantiated incidents reported to the MCO.	MCO	Quarterly and Ongoing	100%	MCO	Quarterly and Annually	MCO Reports	The MCO will follow up all outstanding Investigative Authority referrals and Unusual Incident Reports. Changes in customers' service plans will be made when needed. Remediation must be completed within 30 days.
44G	*# and % of participants' substantiated cases of abuse, neglect or exploitation received from the Investigative Authority*	MCO	Quarterly and Ongoing	100%	MCO	Quarterly and Annually	MCO Reports	The MCO will implement the Investigative Authority recommenda-

PM #	Waiver Performance Measures	Resp 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
	where the MCO implemented the recommendations. N: # of substantiated cases of abuse, neglect or exploitation received from where the MCO implemented the recommendations. ---------- D: Total # of substantiated cases of abuse, neglect or exploitation received by the MCO.							tions 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.
45G	*# and % of participants' deaths as a result of substantiated case of abuse, neglect or exploitation where appropriate follow-up actions were implemented by the MCO.* N:# of deaths as a result of a substantiated case of A/N/E where appropriate follow-up actions were implemented by the MCO. ---------- D:Total # of MCO deaths as a result of a substantiated case of A/N/E.	MCO	Quarterly and Ongoing	100%	MA/MCO	Quarterly and Annually	MCO Reports	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.

PM #	Waiver Performance Measures	Resp 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
Subassurance B The State demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.								
46G	*# and % of participants for whom identified critical incidents other than A/N/E were reviewed and corrective measures were appropriately taken by the MCO.* N:# of participants for whom identified critical incidents other than A/N/E were reviewed and corrective measures were appropriately taken by the MCO. ---------- D:Total # of MCO participants for whom identified critical incidents were reviewed.	MCO	Quarterly and Ongoing	100%	MCO	Quarterly and Annually	MCO Reports	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.
Subassurance C The State policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.								
47G	*# And % of restraint applications, seclusion, or other restrictive interventions where appropriate intervention by the MCO occurred.* N: # of restraint applications,	MCO	Quarterly and Ongoing	100%	MA/MCO	Quarterly and Annually	MCO Reports	Restraint applications, seclusion, or other restrictive interventions will be reviewed by

PM #	Waiver Performance Measures	Resp 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
	seclusion, or other restrictive interventions where appropriate intervention by the MCO occurred. ---------- D: Total # of MCO restraint applications, seclusion, or other restrictive intervention.							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.
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.								
48G	*# and % of participant survey respondents who reported to the 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. ---------- D: Total # of MCO participant satisfaction survey respondents.	MCO	Annually	CAHPS Guidelines (BI, HIV, PD)	MA/MCO	Annually	CAHPS Survey (BI, HIV, PD)	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
			Quarterly and Annually	100% (Elderly)			POSM Survey Ques. E.1.a (Elderly)	

PM #	Waiver Performance Measures	Resp 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
								survey responses will be used to identify need for system improvement.
49G	*# and % of MCO participants who have personal assistant or other independently employed services whose care plan/service plan included back up plans.* N: # of MCO participants reviewed who have personal assistant or other independently employed services whose care plan/service plan included back up plans. ---------- D: Total MCO participants reviewed who have personal assistant or other independently employed services.	MCO	Quarterly and Ongoing	Representa tive 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.
Appendix I- Financial Accountability								
Subassurance A 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								

PM #	Waiver Performance Measures	Resp 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
50I	*# and % of payments that were paid for participants who were enrolled in the waiver on the date the service was delivered.* N: # of MCO payments made for participants who were enrolled in the waiver on the date the service was delivered. ---------- D: Total # of MCO payments.	MCO	Quarterly and Annually	100%	MCO	Semi-Annually	Encounter Data	The MA will adjust the federal claim for services provided by the MCO prior to the customers' waiver enrollment. Remediation must be completed within 30 days.
51I	*# and % of payments there were paid for services that were specified in the participant's service plan.* N: # of MCO payments made that are specified in the participant's service plan. ---------- D: Total # of MCO payments.	MCO	Quarterly and Annually	Non-Representative Sample	MCO	Semi-Annually	MCO Reports	The MCO will determine whether the service was authorized. If authorized, the MCO will revise customer service plan; If not authorized, the MA will void the federal claims that were not consistent with service plans. Remediation must be completed within 30 days.

PM #	Waiver Performance Measures	Resp 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
<u>Subassurance B</u> The State provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.								
52l	*# and % of payments that were paid using the correct rate as specified in the waiver application.* N: # of MCO payments using the correct rate as specified in the waiver application. ---------- D: Total # of MCO payments.	MCO	Quarterly and Annually	100%	MA and MCO	Semi-Annually	Encounter Data	The MA will require the MCO to recoup the overpayment or repay at correct rate. Remediation must be completed within 30 days.

Attachment XII
Utilization Review/Peer Review

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.

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:

    a. 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.

    b. Scope — The program shall have mechanisms to detect under-utilization as well as over-utilization.

    c. Preauthorization and concurrent review requirements — For organizations with preauthorization and concurrent review programs:

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

        ii. Utilize practice guidelines that have been adopted, pursuant to Attachment XI.

        iii. 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;

        iv. Efforts shall be made to obtain all necessary information, including pertinent clinical information, and consultation with the treating Provider, as appropriate;

        v. 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;

vi. There shall be written well-publicized and readily available Appeal mechanisms for both Providers and Enrollees;

vii. 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;

viii. There shall be mechanisms to evaluate the effects of the program using data on Enrollee satisfaction, Provider satisfaction or other appropriate measures;

ix. If Contractor delegates responsibility for utilization management, it shall have mechanisms to ensure that these standards are met by the subcontractor.

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.

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:

   a. 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:

      i. A regular schedule for review;

      ii. A system to evaluate the process and methods by which care is given; and

      iii. A medical record review process.

   b. 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.

   c. 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.

   d. 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.

e. Contractor shall participate in the annual collaborative PIPS/QIPs, as mutually agreed upon and directed by the Department.

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.

6. The Department may request that peer review be initiated on specific Providers.

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.

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

Name of Report/Submission	Frequency	HFS Prior Approval	Report Description and Requirements
			and correct file length. To be accepted by the Department, the format of the file must be correct. 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 name. The acceptable error rate of claims processing edits of the Encounter Data provided by Contractor shall be determined by the Department. Once an acceptable error rate has been achieved, as determined by the Department, Contractor shall be instructed that the testing phase is complete and that data must be sent in production. **Production.** Once Contractor's testing of data specified above is completed, Contractor will be certified for production. Once certified for production, Contractor shall continue to submit Encounter Date in accordance with these requirements. The Department will continue to review the Encounter Data for correct format and quality. Contractor shall submit as many files as necessary, in a time frame agreed upon by the Department and Contractor, to ensure all Encounter Data are current. Records that fail the edits described above will be returned to Contractor for correction. Corrected Encounter Data must be returned to the Department for reprocessing. **Electronic Data Certification.** In a format determined by the Department, Contractor shall certify by the 5th day of each month that all electronic data submitted during the previous calendar month is accurate, complete and true.

Name of Report/Submission	Frequency	HFS Prior Approval	Report Description and Requirements
Disclosure Statement	Initially, annually, on request and as changes occur	No	Contractor shall submit disclosure statements as specified in 42 CFR, Part 455.
Report of Transactions with Parties of Interest	Annually	No	Contractor shall report all "transactions" with a "party of interest" (as such terms are defined in Section 1903(m)(4)(A) of the Social Security Act and SMM 2087.6(A-B)), as required by Section 1903(m)(4)(A) of the Social Security Act.
Adjudicated Claims Inventory Summary	Monthly, no later than fifteen (15) days after the close of the reporting month	No	Contractor shall report the number of claims Contractor adjudicated by claim type, in-network and out-of-network break out, and the number of days the claims took to process.
Compliance Certification	Annually, no later than July 1	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.

Name of Report/Submission	Frequency	HFS Prior Approval	Report Description and Requirements
Provider Directory	Initially and as changes occur	Yes	Contractor shall submit separate Provider Directories that are on Contractor's website for Prior Approval. For example, the Provider Directory shall include only those Providers that provide Covered Services to FHP population. Provider updates shall not be required to be submitted for Prior Approval.
Fraud and Abuse			
Fraud and Abuse Referral	Immediately upon notification or knowledge of suspected Fraud and Abuse	N/A	Contractor shall report all suspected Fraud and Abuse to the Department as required in Article V and Article IX of this Contract. Contractor shall provide a preliminary investigation report as each occurrence is identified.
Fraud and Abuse Report	Quarterly	No	Contractor shall provide a summary report of referrals made and program integrity activities conducted in the previous quarter.
Recipient Verification Procedure	Initially, annually and as revised	Yes	Contractor shall submit Contractor's plan for verifying with Enrollees whether services billed by Providers were received, as required by 42 CFR 455.20, for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in information conveyed. This does not need to be provided to the Department separately by population.
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.

Name of Report/Submission	Frequency	HFS Prior Approval	Report Description and Requirements
Marketing			
Marketing Gifts and Incentives	Initially and within ten (10) Business Days after the Department's request	Yes	Contractor shall submit all plans to distribute gifts and incentives, as well as description of gifts and incentives, for Prior Approval.
Marketing Materials	Initially and as revised	Yes	Contractor shall submit all Marketing Materials for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed.
Marketing Plans and Procedures	Initially and as revised	Yes	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			
PCP, Hospital, and Affiliated Specialist File (CEB Provider File)	No less often than weekly	Yes	Contractor shall submit to the Department or its designee, in a format and medium designated by the Department, an electronic file of Contractor's PCPs, Hospitals and Affiliated Specialists. The PCPs must include, but not limited to, the following information: • Provider name, Provider number, office address, and telephone number; • Type of specialty (e.g., family practitioner, internist, oncologist, etc.), subspecialty if applicable, and treatment age ranges; • Identification of Group Practice, if applicable; • Geographic service area, if limited; • Areas of board-certification, if applicable; • Language(s) spoken by Provider and office staff; • Office hours and days of operation; • Special services offered to the deaf or hearing impaired (i.e., sign language, TDD/TTY, etc.); • Wheelchair accessibility status (e.g., parking, ramps, elevators, automatic doors, personal transfer assistance, etc.); • PCP indicator; • PCP gender and panel status (open or closed); and • PCP hospital affiliations, including information about where the PCP has admitting privileges or admitting arrangements and delivery privileges (as appropriate).
Provider Site Closures/Terminations	As each occurs	No	Contractor shall submit Provider Site Closures/termination reports, in a format and medium designated by the Department.

ACA Primary Physician Services Reimbursement Requirement	No later than ninety (90) days after the receipt of each supplemental payment from the Department	No	Contractor shall provide to the Department documentation of the additional amounts paid to qualifying Physicians and APNs in accordance with Section 5.25.6 of the Contract.
Provider Grievance-Resolution System and Procedures	Initially and as revised	Yes	Contact 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 Grievances, Appeals and Resolutions – Summary Report	Quarterly	No	Contractor shall submit a summary of the Grievances and Appeals filed by Providers. Reporting shall include total Provider Grievances and Appeals per/1,000 Enrollees. The report shall include a summary count of any such Provider Grievances or Appeals received during the reporting period including those that go through fair hearings and external independent reviews. Contractor shall report on Covered Services and include Appeals and Grievances outcomes and the levels at which the Grievances or Appeals were resolved, and whether the Appeals were upheld or overturned.
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	Quarterly	No	Contractor shall submit a summary of the Grievances and Appeals filed by Enrollees, organized by categories of quality of care, access to care, medical necessity reviews, transportation, Long Term Services and Supports (LTSS), and "Other" issues. Reporting shall include total Grievances and Appeals per/1,000 Enrollees. The report shall include a summary count of any such Grievances or Appeals received during the reporting period including those that go through fair hearings and external independent reviews. Contractor shall report on Covered Services and include Appeals and Grievances outcomes and the levels at which the Grievances or Appeals were resolved, and whether the Appeals were upheld or overturned. Contractor shall provide this report for each population for which it provides Covered Services. Contractor shall also report Grievances and Appeals separately for the categories of: Nursing Facility Services; Persons who are Elderly; Assisted Living, Supportive Living Program; Persons with Physical Disabilities; Persons with HIV/AIDS; and Persons with Brain Injury. The report shall only include Grievances and Appeals related specifically to LTC and Waiver services and providers.
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	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.

QA/UR/PR Committee Meeting Minutes	As needed, and within ten (10) Business Days after the Department's request	No	Contractor shall submit the minutes of its QA/UR/PR Committee meetings.
QA/UR/PR and Health Education Plans	Initially and as revised	Yes	Contractor shall submit the Quality Assurance, Utilization Review, Peer Review and Health Education Plans 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, activities and performance data that differ among care coordination programs.
Conditions Report	As needed, and within ten (10) Business Days after the Department's request	No	Contractor shall submit the aggregate count of the primary health conditions of its Enrollees and their associated risk levels. These reports may be generated utilizing Contractor's unique internal algorithms and systems to determine primary conditions and risk level of Enrollees.
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 Management/ Disease Management Summary Report	Monthly	No	Contractor shall track Enrollees based on enrollment date and show the data points of initial screenings completed, comprehensive assessments completed, Enrollee care plans completed, opt outs (Enrollees who declined Care Management), and attempting to locate. Contractor shall report separately for the categories of: Families and Children; Persons with Developmental Disabilities; Persons with Disabilities; Persons with Brain Injury; Persons with HIV/AIDS; Persons who are Elderly; Assisted Living, Supportive Living Program; LTC; Behavioral Health (by primary diagnoses, including Substance Abuse); ACA Adult; and High Needs Children. Contractor shall also report on all Enrollees who are assigned to Contractor's Care Management and Disease Management interventions, including a count of those who are risk-stratified, in process of stratification, attempting to locate, opt out of care management, and the percentage of Enrollees at each level. Contractor shall provide summary data for each of the categories listed above.
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	Quarterly	No	Contractor shall submit a summary report that shows Enrollee outreach for each level of stratification. Enrollees' risk levels will be determined by which level they are in the end of the quarter. Contractor shall report separately for the categories of: Persons with Disabilities; Persons with Brain Injury; Persons with HIV/AIDS; Persons who are Elderly; LTC; and Assisted Living, Supportive Living Program.

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

Critical Incidents – Detail Report	Monthly	No	Contractor shall submit a detailed report on Critical Incidents providing Enrollee name, Enrollee Medicaid number, incident summary, date received, source, incident date, date referred, referral entity, date resolved, and resolution summary, grouped in the following categories: Abuse; Neglect; Exploitation; and Other. Contractor shall report Critical Incidents for each of the following: Nursing Facility Services; HCBS Waiver for Persons who are Elderly; HCBS Waiver for Assisted Living, Supportive Living Program; HCBS Waiver for Persons with Physical Disabilities; HCBS Waiver for Persons with HIV/AIDS; and HCBS Waiver for Persons with Brain Injury.
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; and, HCBS Waiver for Persons with Brain Injury. This report shall only include Critical Incidents specifically related to Enrollees receiving Long-Term Services and Supports (LTSS).
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 health care 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 (CSHCN) 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 CSHCN.
Provider-preventable Conditions Report	Quarterly	No	Contractor shall report provider-preventable conditions that are identified in the State Plan to the Department.

Utilization Review			
Utilization Management Report	Monthly	No	Contractor shall submit an analysis of Inpatient and Emergency Services utilization. Inpatient services shall be based on inpatient days and be categorized as follows: Utilization for total Inpatient, Medical/Surgical, Rehabilitation, Mental Health including Substance Abuse, Emergency Services, and Outpatient visits. Data will be based on utilization per 1,000 Enrollees and Total utilization. Reporting for Inpatient, Emergency Services, and Outpatient visits utilization shall be divided into separate worksheets for LTC, HCBS Waiver for Persons with Developmental Disabilities, HCBS Waiver for Persons with Disabilities, HCBS Wavier for Persons with Brain Injury, HCBS Waiver for Persons with HIV/AIDS, HCBS Waiver for Persons who are Elderly, HCBS Waiver for Assisted Living, Supportive Living Program, and total population as defined by Department standards.
Pharmacy			
Pharmacy Rebate Report	Quarterly	N/A	Contractor shall submit a report that sets forth the pharmaceutical rebates received by it or its Pharmacy Benefit Manager (PBM) from pharmaceutical manufacturers or labelers for the drug utilization covered under this Contract. Rebates include all revenue or credits from manufacturers or labelers that is paid or credited as a result of formulary placement or that is paid or credited based on the volume of drugs sold.
Pharmacy Monitoring Report	Monthly	No	Contractor shall submit pharmacy data utilization reports based on total utilization, claims summaries, cost summaries and cost per claim.

Psychotropic Review Report	Monthly	No	Contractor shall submit a summary report of Enrollees' Psychotropic medication utilization and the prescribing patterns of Providers. The report must include information on the following criteria: use of 5 or more psychotropics for 60 or more days, use of 2 or more ADHD medications for 60 or more days, use of 3 or more antidepressants for 60 or more days, use of 5 or more drugs for bipolar disorder (mood stabilizers, atypical antipsychotics, antidepressants) for 60 or more days, use of 2 or more SSRIs for 60 or more days, use of 2 or more antipsychotics for 60 or more days, use of 2 or more atypical antipsychotics for 60 or more days, and use of 2 or more benzodiazepine or benzodiazepine hypnotics for 60 or more days.
Drug Utilization Review Report	Quarterly	No	Contractor shall report its prospective and retrospective Drug Utilization Review activities to the Department.
Outpatient Drug Utilization Report	Quarterly	No	Contractor shall report to the Department, 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 National Drug Code of each covered outpatient drug identified in Section 5.2.5.4.1 dispensed to Enrollees.
Subcontracts and Provider Agreements			
Executed Subcontracts	Initially and as revised	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 as revised	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.
Business Enterprise Program Act for Minorities, Females and Persons with Disabilities			
BEP Report	Quarterly & Annually	N/A	Contractor shall submit the information required in Section 2.9 of the Contract.

Attachment XIV
Data Security and Connectivity Specifications

10. **DATA SECURITY:** FOR ALL INFORMATION SYSTEMS THAT TRANSMIT, STORE, OR ACCESS PROTECTED HEALTH INFORMATION:

1. Contractor shall:

a. Establish an information security program in accordance with the FISMA (Federal Information Security Management Act), 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.

b. Assess, review, and evaluate the information systems based upon security categorization and classification in accordance with Federal Information Processing Standards (FIPS) Publication 199 Standards for Security Categorization of Federal Information and Information Systems and FIPS Publication 200, Minimum Security Requirements for Federal Information and Information Systems. Additional guidance on defining the information type can be obtained from NIST SP 800-60 Revision 1 Volume I and II.

c. Select the baseline controls described in FIPS 200 and NIST SP 800-53 to develop a System Security Plan (SSP). Contractor must develop a SSP, in accordance with 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.

d. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the system and the information processed that it creates, receives, maintains, or transmits based on NIST SP 800-66 Revision 1, An Introductory Resource Guide for Implementing the Health Insurance Portability and Accountability Act (HIPAA) Security Rule.

e. Perform continuous monitoring of the system in compliance with NIST SP 800-137.

f. Implement four specifications with the Access Controls, Unique User Identification (Required), 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 Rule.

g. Implement audit controls that allow Contractor to adhere to policy and procedures developed to comply with the required implementation specification at 45 CFR §164.308(a)(1)(ii)(D) for Information System Activity Review.

h. Implement policies and procedures to protect electronic protected health information from improper alteration or destruction. Integrity is defined in the 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.

2. SYSTEM SECURITY PLAN:

A. THE SSP DEVELOPED BY CONTRACTOR SHALL INCLUDING THE FOLLOWING:

i. The requirements traceability matrix (RTM) cross-referenced to the specific system design function that meets each requirement related to system security;

ii. 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;

iii. A description of the process Contractor will use to report security breach incidents, regardless of severity or loss of actual data, to HFS within 4 hours;

iv. A description of measures to secure data and software;

v. A description of how data are encrypted in transit and in storage;

vi. A description of physical and equipment security measures;

vii. A description of personnel security;

viii. A description of software used for security;

ix. A description of the user roles and the access capabilities of each role;

x. A description of how users are assigned certain roles;

xi. An identification of the staff responsible for controlling the system security;

xii. A description of contingency security procedures during a disaster recovery event;

xiii. A description of how Contractor works with HFS to conduct an annual security review;

xiv. Password security; and

xv. Audit trails for all data access.

B. 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.

3. Contractor will be responsible for all costs associated with identity theft resulting from a security breach.

11. CONNECTIVITY SPECIFICATIONS

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 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.

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 pubic assigned IP ranges from Contractor (No RFC-1918 addresses).

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.
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.
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.
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

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Attachment XVI

Qualifications and Training Requirements of Certain Care Coordinators

A. Qualifications of Certain Care Coordinators

Persons who are Elderly Waiver

Care Coordinators must meet one (1) of the four (4) following requirements:

1. RN licensed in Illinois
2. Bachelor's degree in nursing, social sciences, social work, or related field
3. LPN with one (1) year experience in conducting comprehensive assessments and provision of formal service for the elderly
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

Persons with Disabilities Waiver

Care Coordinators must meet one (1) of the nine (9) following requirements:

1. Registered Nurse (RN)
2. Licensed Clinical Social Worker (LCSW)
3. Licensed Marriage and Family Therapist (LMFT)
4. Licensed Clinical Professional Counselor (LCPC)
5. Licensed Professional Counselor (LPC)
6. PhD
7. Doctorate in Psychology (PsyD)
8. Bachelor or Master's Degree prepared in human services related field
9. Licensed Practical Nurse (LPN)

Persons with Brain Injury Waiver

Care Coordinators must meet one (1) of the seven (7) following requirements:

1. Registered Nurse (RN) licensed in Illinois
2. Certified or Licensed social worker
3. Unlicensed social worker: minimum of bachelor's degree in social work, social sciences or counseling
4. Vocational specialist: certified rehabilitation counselor or at least three (3) years' experience working with people with disabilities
5. Licensed Clinical Professional Counselor (LCPC)
6. Licensed Professional Counselor (LPC)
7. Certified Case Manager (CCM)

Persons with HIV/AIDS Waiver

Care Coordinators must meet one (1) of the three (3) following requirements:

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.
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).

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 Waiver have experience working with:
   - Addictive and dysfunctional family systems
   - Racial and ethnic minorities
   - Homosexuals and bisexuals
   - Persons with AIDS, and
   - Substance abusers

Children with High Needs

1. Care Coordinators must meet the following requirements:
   a) Bachelor's degree in nursing, social sciences, social work, or related field
   b) One (1) year of supervised clinical experience in a human services field
2. Care Coordinator Supervisors must meet the following requirements:
   a) Master's degree in nursing, social sciences, social work, or related field
   b) No fewer than three (3) years of supervised experience in a human services field
3. All Care Coordinators, Care Coordination Supervisors, and the Clinical Director shall be certified in the IM-CANS within thirty (30) days after the start of their performance of Care Coordination duties and activities under this Contract. All such staff shall be re-certified annually and a Care Coordinator shall not be assigned any Enrollees until the Care Coordinator is certified in the IM-CANS.
4. Contractor must employee at least one (1) certified trainer in IM-CANS

B. Qualifications for other Health Care Professional roles

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 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 year of experience in a mental health setting; an individual with a high school diploma or GED and a minimum of five 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 years of supervised clinical experience under a QMHP in a mental health setting.

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 year of clinical experience in a mental health setting or master's degree in psychiatric nursing; an occupation therapist licensed pursuant to the Illinois Occupational Therapy Practice Act [225 ILCS 75] with at least one 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 1) successfully completed a practicum or internship that includes 1,000 hours, or 2) one year of clinical experience under the supervision of a LPHA.

C. Training Requirements of Certain Care Coordinators

Care Coordinators for HCBS Waiver Enrollees shall receive a minimum of 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:

Persons who are Elderly Waiver

- Aging related subjects

Persons with Brain Injury Waiver

- Training relevant to the provision of services to persons with brain injuries.

Persons with HIV/AIDS Waiver

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

Supportive Living Program Waiver

- Training on the following subjects: resident rights; prevention and notification of Abuse, Neglect, and exploitation; behavioral intervention, techniques for working with the elderly and persons with disabilities; and, disability sensitivity training.

High Needs Children

- All Care Coordinators must attend the Introduction to Wraparound and Engagement trainings offered by an NWIC-certified trainer and any follow-up training modules developed and made available by the State.
- All Supervisors overseeing Care Coordinators assigned to Intensive/Intervention tier Enrollees must be certified as Wraparound coaches by a State-identified and approved entity.

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 instance where the arrest, charge, or conviction has a risk or potential risk upon the Enrollee's health and safety should be reported.
Provider arrested, charged with or convicted of a crime	In instance where the arrest, charge, or conviction has a risk or potential risk upon the Enrollee's health and safety should 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 their 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 should be reported. In some cases, persons with SMI are not allowed to possess firearms and this should 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 abuse 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 should 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 a 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 60 and to adults with disabilities age 18-59 who may be victims of abuse as prescribed below:

- **Physical Abuse** means causing the inflictions of physical pain or injury to an older person.
- **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.
- **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.
- **Confinement** means restraining or isolating, without legal authority, an older person for other than medical reasons ordered by a physician.
- **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, or 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 health care services provided or not provided by licensed health care professionals.
- **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 exposes that person to the risk of physical, mental, or emotions harm because of such denial; except with respect to medical care or treatment when the dependent person has expressed an intent to forego such medical care or treatment and has the capacity to understand the consequences.
- **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

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:

- Abuse or suspected abuse of any nature by anyone, including another resident, staff, volunteer, family, friend, etc.
- Allegations of theft when a resident chooses to involve local law enforcement.
- Elopement of residents/missing residents.
- Any crime that occurs on facility property.
- 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.
- Physical injury suffered by residents during a mechanical failure or force of nature.
- Loss of electrical power in excess of an hour.
- Evacuation of residents for any reason.

Attachment XX
Individual Provider Payment Policy

The 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 co-employers of the Individual Provider. DHS-DRS, as the co-employer, shall be responsible for making payment, and for the performance of related payroll and employment functions, for the Individual 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 the 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 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 the Contractor is obligated to pay. The 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 the Contractor reasonably demonstrates materially increase the 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 co-employer of the Individual Providers working under the Home Services Program under Section 3 of the Disabled Persons Rehabilitation Act (5 ILCS 315). Nothing in this Contract shall diminish the effect of the collective bargaining agreement covering Individual Providers' employment.

Attachment XXI
Required minimum standards of care

1. Scope
Contractor shall provide or arrange to provide to all Enrollees Covered Services at locations serving the Contracting Area that assure availability and accessibility to Enrollees.

2. Implementation
Contractor will implement written and verbal methods to notify and inform Enrollees of the need for and benefits of health screenings and physical examinations. Contractor will provide or arrange to provide all such examinations to all 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, promulgated by leading academic and national clinical organizations, and shall be adopted by Contractor's Quality Assessment and Performance (QAP) Committee with sources referenced and guidelines documented in Contractor's QAP. 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:

a. **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 are eligible to receive screening services inclusive of a comprehensive health history, developmental history (including assessment of both physical and mental health development), a comprehensive unclothed physical exam, laboratory tests (including blood lead level assessment) and health education; vision services; dental services; hearing services; other necessary health care, diagnostic services, treatment and other measures to ameliorate defects, physical and mental illnesses and conditions identified; and appropriate childhood immunizations at intervals as specified by the 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*, including future revisions.

   i. Contractor shall employ strategies to ensure that Child Enrollees receive comprehensive child health services, 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 care for acute and Chronic Health Condition care needs.

ii. Any condition discovered during the screening examination or screening test requiring further diagnostic study 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.

iii. Annually, inform Enrollees about the EPSDT program.

iv. Provide information about the EPSDT program to families who are newly enrolled with the plan. Use a combination of written and oral methods. For newly enrolled families provide information generally within 60 days following the date of the new enrollment with the plan.

v. Inform pregnant women about the availability of EPSDT services for children under age 21 (including children eligible as newborns).

vi. Assist pregnant women or legal guardians to enroll infants in Medicaid and to identify a primary care provider for the infant. It is suggested that plans use HFS Form4691 as an educational tool, but plans may use other means, including direct assistance, to help pregnant women or legal guardians enroll the infant in Medicaid.

b. **Preventive medicine schedule (services to Enrollees age twenty-one [21] years or older).** The following preventive medicine services and age schedule is the minimum acceptable range and scope of required services for the average-risk patient. These guidelines do not supplant clinical judgment of the alternative schedule for adult preventive medicine services as long as such schedule is based upon recognized guidelines such as those recommended by the current United States Preventive Service Task Force.

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 (21) to the age of sixty-four (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 need 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. With each health history and physical

examination, screening, counseling, and immunization should be provided in accordance with national medical organizations' guidelines.

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:

- Initial and interval history;
- Height and weight measurement for body mass index (BMI);
- Blood pressure;
- Nutrition and physical activity assessment and counseling;
- Alcohol, tobacco, substance abuse, intimate partner violence, and depression screening and counseling; and
- Health promotion and anticipatory guidance.

Any known condition or condition discovered during the complete health history and physical examination requiring further Medically Necessary diagnostic study or treatment must be provided if within the scope of Covered Services.

i. The following are cancer screenings for healthy adults with recommended age and intervals:

   A. Cervical cancer: Women age twenty-one to twenty-nine (21–29) should have cytology (pap smear) every three (3) years. For women age thirty to sixty-five (30–65), extended screening to every five years (5) is appropriate after three (3) satisfactory normal cytology results and a negative human papillomavirus (HPV) test. Women over age sixty-five (65) with adequate screening or women of any age who have had a hysterectomy with removal of the cervix for benign reasons and without a history of high-grade lesion or at low risk for cervical cancer do not need screening. The HPV vaccine series should also be offered for those up to age twenty-six (26) years old, if not already immunized.

   B. Breast cancer: Women age forty to forty-nine (40–49) are recommended to have biennial mammogram screenings, and annual screenings begin at age fifty (50). Clinical breast exams are recommended every one (1) to three (3) years from twenty to forty (20–40) years old and annually thereafter. Breast self-awareness to recognize changes should be discussed from age twenty (20). Women with a family history of breast, ovarian, tubal, or peritoneal cancer should be offered the gene mutation screening for BRCA 1 and BRCA2. Subsequent positive testing should be offered genetic counseling. Women who are at increased risk for breast cancer should be counseled and offered risk-reducing medication such as

selective estrogen response modulators.

C. Colorectal cancer: Men and women are recommended to have a colonoscopy at age fifty (50) and again every ten (10) years OR fecal occult blood test (FOBT) every three (3) years with flexible sigmoidoscopy every five (5) years OR annual FOBT until age seventy-five (75) years.

D. Prostate cancer: There is no recommendation to screen for prostate cancer with prostate-specific antigen (PSA) testing for the asymptomatic, low-risk man. Along the same line, performance of a digital rectal exam (DRE) is at the discretion of the Provider and after informed discussion with the patient. Screening with both PSA and DRE may be considered at age forty (40) for those of African American ancestry or those with a first-degree relative diagnosed at younger than sixty-five (65) years of age.

E. Skin cancer: There are no specific age or interval recommendations, but general preventive exams should include examination of the skin with attention to those with family history of skin cancer or considerable exposure to sun and sunburns. Fair-skinned men and women age sixty-five (65) and older or people with atypical moles or greater than fifty (50) moles may be at greater risk for melanoma.

ii. The following are recommended other screenings with age and intervals:

A. Diabetes mellitus type two: Screening should start at age forty-five (45) at three (3)–year intervals for the Enrollee with normal weight and no other risk factors. For those with first-degree relatives with diabetes mellitus, clinical signs and symptoms consistent with glucose intolerance, or sustained blood pressure greater than 135/80, screening may begin earlier. Fasting plasma glucose is the preferred screening method, however the two (2)–hour oral glucose tolerance test (OGTT) or a hemoglobin A1c test are both also considered appropriate.

B. Lipid disorder: Cholesterol screening for men and women should begin at thirty-five (35) years old and recur at five (5)–year intervals. For men and women at risk of coronary artery disease (CAD) screening should start at twenty (20) years old. Higher risk of coronary artery disease may include family history of CAD, obesity, hypertension, diabetes, and current tobacco use.

C. Osteoporosis: Women age sixty-five (65) or older are recommended to be screened for bone mineral density with dual energy x-ray absorptiometry. For those with one risk factor or a fracture risk equivalent to a sixty-five (65)-year-old white woman, screening may begin earlier. An interval of two (2) years is usually sufficient for clinical changes. Increased risk factor may include certain ethnicities, very low BMI, history of fractures, tobacco use, limited exercise, and other chronic

diseases.

D. Sexually transmitted infections: See "Family Planning and reproductive health care" section herein.

E. Tuberculosis: Annual tuberculin (Mantoux) skin testing should be performed on all at-risk Enrollees. Those at risk may include men and women with signs and symptoms of tuberculosis, those who have had recent contact with someone diagnosed with tuberculosis, those with occupational or living hazard of close quarters, recent immigrants from county with high prevalence of tuberculosis, those who use illicit drugs, those with a compromised immune system, and healthcare workers.

iii. The following are recommended immunizations by age and interval for both male and female Enrollees, unless contraindicated:

A. Influenza: One (1) dose annually.

B. Tetanus/Diphtheria (Tdap/Td): One (1) Tdap and one (1) Td booster every ten (10) years.

C. Varicella: One (1) series of two (2) doses for all adults without previous evidence of immunity.

D. Human Papilloma Virus (HPV): One (1) series of three (3) doses for men and women age twenty-six (26) or younger.

E. Shingles (zoster): One (1) dose at sixty (60) years of age or older.

F. Hepatitis A and B: Combined Hepatitis A and Hepatitis B immunizations as one (1) series of three (3) doses; OR one (1) series of two (2) Hepatitis A immunization doses; OR one (1) series of three (3) Hepatitis B immunization doses, provided at any age for any Enrollee requesting protection.

c. **Family Planning and reproductive health care.** Contractor shall ensure that the full spectrum of Family Planning options and reproductive health services are appropriately provided within the Provider's scope of practice and competence. The 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. The Contractor must follow nationally recognized standards of care and guidelines for sexual and reproductive health, such as those established by the Centers for Disease Control and Prevention (CDC) or the American Congress of Obstetricians and Gynecologists (ACOG) and comply with the requirements of the Affordable Care Act.

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 most effective methods first, specifically long-acting reversible contraception (LARC). Enrollees have the freedom to choose the preferred birth control method that is most appropriate for them.

Contractor shall provide the following Family Planning and reproductive health services:

i. A reproductive life plan, which may include a preconception care risk assessment (see HFS Form 27, Preconception Screening Checklist) and preconception and interconception care discussions.

ii. Education and counseling on all contraceptive methods, with emphasis on presenting the most effective methods first, specifically LARC methods such as intrauterine devices (IUDs) and the implantable rod.

iii. Contraceptive methods must also include over-the-counter and prescription emergency contraception, including the provision of the copper IUD for emergency contraception.

iv. Permanent methods of birth control, including tubal ligation, transcervical sterilization, and vasectomy.

v. Basic infertility counseling, consisting of medical/sexual history review and fertility awareness education. Infertility medications and procedures are not Covered Services.

vi. Reproductive health exam, with pelvic exam decoupled from the provision of contraception.

vii. Sexually transmitted infection (STI) screenings. Sexually active enrollees under age twenty-six (26) should be screened annually for chlamydia and gonorrhea. Enrollees under age twenty-six (26) should be screened for chlamydia and gonorrhea if presenting in clinical settings with a high prevalence of STIs such as STD clinics, adolescent health centers, and Family Planning clinics. For all Enrollees who are age twenty-six (26) or older, screening should be based on risk factors such as symptoms, new partners, multiple partners, or recent history of another STI. For all Enrollees, syphilis screening is recommended if he or she is infected with another STI or has risk factors such as men having sex with men, recent incarceration, IV drug use, or commercial sex workers. The CDC recommends a one-time screening for Hepatitis C for all Enrollees born from 1945 to 1965 regardless of risk factors. Blanket screening for Hepatitis C is not recommended because testing low-risk individuals may increase the risk of false positives.

viii. Universal HIV testing, counseling, and screening.

ix. Testing and treatment for genital and related infections and other

pathological conditions.

x. Lab test or screening necessary for Family Planning and reproductive health services.

xi. Cervical cancer screening, management, and early and ongoing treatment.

xii. Vaccines for preventable reproductive health related conditions such as HPV and Hepatitis B.

xiii. Mammography referral and BRCA genetic counseling and testing.

xiv. Maternity care.

Contractor shall provide evidence-based care for pregnant Enrollees. At a minimum, Contractor shall provide the following services:

A. A comprehensive prenatal evaluation and care in accordance with the latest standards as recommended by ACOG or the American Academy of Family Physicians (AAFP), including ongoing risk assessment and development of an Individualized Plan of Care (IPoC) that takes into consideration the medical, psychosocial, cultural/linguistic, and educational needs of the Enrollee and her family.

B. Contractor shall have systems and protocols in place to handle regular appointments; entry into early prenatal care appointments; after-hours care with emergency appointment slots; a seamless process for transmitting prenatal records to the delivering facility; and a Provider Network for mental health, social services, and specialty care referrals. 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 be able to provide equally high-quality obstetrical care to special populations such as adolescents, homeless women, and women with developmental or intellectual disabilities.

C. The specific areas to be addressed regarding the provision of prenatal care include but are not limited to the following items:

- Risk counseling for STI/HIV, intimate partner violence, teratogen exposure, substance use and abuse and potential for preterm delivery screenings, and education on use of 17P, if appropriate.

- Screening for, diagnosing, and treating depression before, during, and after pregnancy with any number of tested screening tools (refer to the *Handbook for Providers of Healthy Kids Services* for a list of approved screening tools).

- Health maintenance promotion, including nutrition, exercise, dental

care, immunizations, management of current Chronic Health Conditions, over-the-counter and prescription medication, breastfeeding counseling and recommendations, appropriate weight gain in pregnancy, obesity counseling, managing signs and symptoms of common pregnancy ailments, and referral to breastfeeding, childbirth classes, and maternity education tools, platforms and materials such as text4baby. The influenza vaccine should be offered to all pregnant women during influenza season regardless of gestational age. Tdap should be provided regardless of prior interval of Td or Tdap.

- Routine laboratory screening and physical exam, which includes dating by ultrasound for accurate gestational age. Every prenatal exam at minimum should include blood pressure check, fetal growth assessment, and fetal heart rate check. In the absence of patient symptoms and/or suspicion for preeclampsia, renal disease, or urinary tract infection, a urine analysis and culture is only required at the initial visit. Routine laboratory screening should include the following: blood type, Rh type, antibody, CBC (routine screening for anemia), rubella, hepatitis B, syphilis/gonorrhea/chlamydia/HIV, varicella, diabetes, and, to applicable populations, tuberculosis.

- Genetic screening should be counseled and offered depending on the Enrollee's age, medical/family history, and ethnic background.

- Visits approximate 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, breastfeeding encouragement, postpartum Family Planning including LARC or permanent sterilization with informed consent done prior to labor and delivery, circumcision, newborn provider care, car seat, SIDS, the importance of waiting at least thirty-nine (39) weeks to deliver, referral to parenting classes and WIC, and transition of maternal healthcare after the postpartum visit. Contractor shall have protocols in place to facilitate the continuum of care after the obstetric period.

D. Contractor shall require all Providers to identify high-risk pregnancies in a timely manner and arrange for a maternal fetal medicine specialist or transfer to Level III perinatal facilities in accordance with ACOG guidelines and the Illinois Perinatal Act requirements for referral and/or transfer of women with a high-risk pregnancy. Risk-appropriate care shall be ongoing during the perinatal period. Contractor shall provide a plan to the Department on how it will ensure that maternity care is received at the appropriate perinatal facility for the level of risk associated with each pregnancy.

- Contractor shall require hospitals of delivery to provide immediate postpartum LARC prior to hospital discharge for women who indicate a desire for this service.

E. Contractor shall require that all contracted hospitals have a hard-stop policy to reduce early elective delivery (EED)Contractor shall provide evidence-based postpartum care for Enrollees. At a minimum, Contractor shall provide and document the following services:

- Immediate and subsequent 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 such as text4baby, and WIC.

- 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.

- Contractor must continue to engage the Enrollee in health promotion and Chronic Health Condition maintenance by supporting the postpartum mother with seamless referrals to avoid interruption of care.

- 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 follow closely Enrollees who delivered and who are at risk of or diagnosed with diabetes, hypertension, heart disease, depression, substance use, obesity, or renal disease.

- Contractor shall provide or arrange for interconception care management services for these high-risk women for twenty-four (24) months following delivery.

xv. **Well-woman exam.** Contractor shall provide evidence-based annual preventive well-woman care to female Enrollees. This care shall consist of preconception and interconception care and reproductive life planning.

A. At a minimum, Contractor shall provide and document an annual exam

that includes screening, counseling, evaluation, education, and immunizations based on age. The examination may vary but at minimum should include the following: routine vital signs, BMI, palpation of abdominal and inguinal lymph nodes, and visual inspection of breast and genitals. The components of the exam are based on Enrollee's age, medical history, symptoms and provider findings.

B. Exams shall include age-appropriate discussions and anticipatory guidance related to reproductive health issues. Education shall include, but not be limited, to Chronic Health Condition management. breastfeeding reinforcement, reproductive life planning, and emphasis on the most effective method of Family Planning, specifically IUDs or the implant.

C. Appropriate referrals should be made to support services including WIC, interconception core management, and parenting classes.

D. A routine pelvic exam is not required for Enrollees younger than age twenty-one (21) unless there is a clinical indication. A pelvic examination is an appropriate component of a comprehensive evaluation of any Enrollee who reports or exhibits symptoms suggestive of female genital tract, pelvic, urologic, or rectal problems.

E. Cervical cytology screening every three (3) years from age twenty-one (21) regardless of sexual debut and every three to five (3–5) years after twenty-nine (29) years of age.

F. Annual clinical breast examination for women age forty (40) years and older, and every one to three (1–3) years for women age twenty to thirty-nine (20–39).

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

d. **Complex and serious medical conditions.**

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

A. Timely identification of Enrollees with complex and serious medical conditions.

B. Assessment of such conditions and identification of appropriate medical procedures for monitoring or treating them.

C. A Chronic Care Action Plan that is symptom-based and developed in conjunction with the Enrollee. A copy of this Chronic Care Action Plan shall be provided to the Enrollee.

ii. Contractor shall have procedures in place to identify Enrollees with special health care needs to identify any ongoing special conditions that require a course of treatment or regular care monitoring. Appropriate health care professionals shall make these assessments. Such procedures must be delineated in Contractor's QAP, 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).

iii. Contractor shall have a mechanism in place to allow Enrollees with special health care needs as defined by Contractor to have direct access to a specialist as appropriate for each Enrollee's condition and identified needs.

e. **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, and school systems. Such cooperation may include performing annual physical examinations for school and the sharing of information (with the consent of the Enrollee).

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

i. Coordinating services and sharing information with existing FCM/BBO providers for its Enrollees;

ii. Developing internal policies, procedures, and protocols for the organization and its provider network for use with FCM/BBO Providers serving Enrollees; and

iii. Conducting periodic meetings with FCM/BBO Providers performing problem resolution and handling of Grievances and issues, including policy review and technical assistance.

Attachment XXII
High-Needs Children care coordination requirements

1. ATTACHMENT XXII CONSTRUCTION

Contractor acknowledges that for the purposes of this Attachment XXII:

a. "Enrollee" shall be defined as an individual under the age of twenty-one (21) who is enrolled with Contractor and stratified as Level 3 as preset forth in section 5.13.3.1 of the model Contract.

b. "Child" shall include Medicaid-eligible individuals age twenty (20) or younger who is admitted to a qualifying inpatient psychiatric institution as defined by the Federal Medicaid "Psych Under 21" Option (42 CFR 440.160). Individuals who qualifying for the Psych Under 21 definition of "Child" shall remain "Children" until they are discharged from the institution, or they reach their twenty-second (22nd) birthday, whichever comes first.

2. COMPLIANCE WITH THE CHILDREN'S MENTAL HEALTH ACT

Contractor shall ensure that all Enrollees potentially requiring psychiatric inpatient hospitalization, acute care, or subacute care (in a Psychiatric Residential Treatment Facility) 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/l et seq.).

3. HIGH-NEEDS CHILDREN PROGRAM DESIGN

a. Contractor acknowledges that the State is committed to a child's physical health and Behavioral Health, as well as family support that is based upon the values and principles of this program design, and Contractor agrees to design its delivery systems consistently with these values and principles.

b. **Family and Child–Driven Care Plan.**

   i. Contractor shall establish a Family and Child–Driven Care Plan, which shall have as its primary responsibility the establishing of a Care Coordination model that is person- and family-centric. Contractor shall submit its initial Family and Child–Driven Care Plan under this Attachment XXII, section 3, ninety (90) days prior to the Effective Enrollment Date of the first Enrollee for review and approval by the

Department. Contractor shall thereafter annually update its Family and Child–Driven Care Plan no later than the anniversary of the Effective Date and submit it to the Department for review and approval. The Family and Child–Driven Care Plan shall, at a minimum:

ii. Address how Contractor will promote and ensure family and Enrollee input across the state of Illinois (including all 102 counties);

iii. State the annual goals, objectives, and activities Contractor will complete related to family and youth driven care; and

iv. Establish the role of the regional Family Leadership Council (FLC) in the Family and Child–Driven Care Plan.

A. Contractor shall ensure that the FLC reviews and provides official comment on the Family and Child–Driven Care Plan prior to Contractor submitting the Family and Child–Driven Care Plan for review and approval by the Department.

c. Stakeholder Councils.

i. The FLC shall be established within ninety (90) days after the High-Needs Children population is brought into managed care under the scope of this Contract, a FLC to create opportunities to engage families directly regarding issues in Children's Behavioral Health. Contractor shall establish, through its FLC, a Care Coordination model that is person- and family-centric, and a mechanism for providing Contractor with a direct HFS Medical Program beneficiary feedback loop. The FLC shall not be used to review the needs of each individual Enrollee.

A. The FLC shall be co-chaired by a young adult, or the parent or guardian of a young adult, with lived experience within public child-serving systems (e.g., mental health, welfare, and education) and a member of Contractor's leadership team with the authority to speak to program design and issues.

B. Contractor shall ensure that the FLC membership is comprised of, at a minimum of 51%, Enrollees or parents/guardians of Enrollees from across the Coverage Area who have lived experience with the public child-serving systems.

ii. Contractor shall ensure High-Needs Children are a component of the broader managed care Community Stakeholder Council, under section 50.40.9 of the model Contract.

4. CARE COORDINATION MODEL AND ACTIVITIES

a. Care Coordination model.

i. No later than the Effective Date, Contractor shall establish and implement a tiered Care Coordination model for High-Needs Children. Contractor shall conduct Care Coordination activities in compliance with the requirements of this Attachment XXII, section 4, and on a frequency as defined in a timeline defined by the Department. The Department reserves the sole right to define the Care Coordination model (e.g., Integrated Health Homes or a similar model) for each tier of Care Coordination and may alter the Care Coordination model at any time, with thirty (30) days advance written notice to Contractor.

ii. Contractor shall establish and implement all necessary policies and procedures to facilitate the necessary events associated with each tier to ensure compliance with the Department's established Care Coordination model, through Integrated Health Homes or a similar model. Contractor shall ensure that its policies and procedures are inspired by the High Fidelity Wraparound Model, as defined by the National Wraparound Implementation Center (NWIC), for all Enrollees stratified to the highest need tier. The High Fidelity Wraparound Model of care will provide for time-limited services, with such time-frame determined by the Department.

b. **IM-CANS Assessment and Enrollee Stratification.**

i. Contractor shall use the Illinois Medicaid Child and Adolescent Needs and Strengths (IM-CANS) Assessment, as defined or selected by the Department, for identifying needs and strengths of all Enrollees requiring High-Needs Children health services.

A. The stratification model for High-Needs Children will be defined by the Department.

B. Contractor shall stratify Enrollees requiring High-Needs Children services and establish service plans consistent with the identified level of strengths and needs of each such Enrollee and the Enrollee's family.

C. Contractor shall identify the highest need Enrollees requiring High-Needs Children services and provide their services using intensive-Care Coordination through a quality wraparound treatment approach.

D. Contractor shall submit its High-Needs Children services stratification approach with the Department annually.

ii. Contractor shall ensure the completion of the IM-CANS Assessment on all Enrollees within the timelines established by the Department. Contractor shall provide the Department with IM-CANS Assessment information on an ongoing basis, in a manner established by the

Department, for the purposes of stratifying Enrollees into Care Coordination tiers and monitoring the progress of such Enrollees.

iii. Contractor shall ensure that an IM-CANS Assessment is performed with Enrollees requiring High-Needs Children services at least every six (6) months.

iv. Contractor shall develop and implement procedures for ensuring the completion of the IM-CANS Assessment on a more frequent basis, as the Enrollee's situation warrants, including, but not limited to, following a crisis event.

c. **Prior authorization.** A suite of prior authorized services will be defined for each High-Needs Children tier. Contractor may define additional prior authorized services for each tier, though at minimum must match the Department's prior authorization requirements.

d. **Child and Family Teams.** Contractor shall convene and facilitate a unique Child and Family Team for each Enrollee in the higher and lower intensity tiers, per the timelines established by the Department. Contractor's Child and Family Team processes shall be consistent with the wraparound practice guidelines.

i. A Child and Family Team shall be convened with the Enrollee and family. It may include invested collateral contacts, Natural Supports (family members, neighbors, or other family-approved sources), service Providers, and other necessary individuals or entities, for the purposes of:

A. Identifying the physical health and Behavioral Health strengths and needs of the Enrollee;

B. Identifying the resources available to the Enrollee;

C. Developing, reviewing, and modifying the Individualized Plan of Care (IPoC) and Crisis Safety Plan; and

D. Care Coordination.

ii. Contractor shall ensure that its intensive-Care Coordination approach includes the utilization of a Child and Family Team, defined as a planning process in which the Enrollee, family, and Natural Supports work with treatment Providers and a dedicated Care Coordinator to identify needs and treatment approaches to address those needs. Due to the extensive efforts required to develop and facilitate a Child and Family Team, intensive Care Coordination is usually performed with low Enrollee-to-dedicated-Care-Coordinator ratios (see Attachment XXII, section 8).

iii. Contractor shall ensure that the dedicated Care Coordinator shall have the authority to authorize all noninstitutional Behavioral Health services that can be delivered without a Physician's orders in collaboration with the recommendations of the Child and Family Team and the Enrollee's IPoC.

iv. Contractor shall have policies requiring the dedicated Care Coordinator to obtain all necessary consents and releases, as well as detailing how information is shared across all treating Providers, including, but not limited to, Physicians, Community Mental Health Centers, hospitals, psychiatric resource, and other allied healthcare Providers treating the Enrollee. Such policies may exclude one (1)–time treatment events, urgent care, and emergent situations.

v. Contractor shall work with the Enrollee and his or her family to identify the most appropriate participants for the Child and Family Team. Contractor shall ensure the appropriate consents and releases are in place for each individual participating in the Child and Family Team.

vi. Contractor shall be solely responsible for facilitating the Child and Family Team process.

vii. Contractor shall provide training to Child and Family Team Care Coordinators regarding how to make treatment decisions that are efficient and effective and how to meet the needs of Enrollees while favoring service provision in the least restrictive setting that is clinically appropriate.

viii. Contractor shall schedule Child and Family Team meetings at a time and in a location that is convenient and agreeable to the Enrollee and his or her family. Contractor will seek to accommodate the schedules of all participating Child and Family Team members.

ix. If an Enrollee experiences a Crisis event, Contractor shall convene a Child and Family Team meeting for the Enrollee within fourteen (14) days of the event if the Enrollee is community stabilized and within fourteen (14) days of discharge if the Enrollee is hospitalized.

x. The Contractor shall ensure that the Enrollee has a scheduled appointment with a Behavioral Health Provider and the Enrollee’s PCP or psychiatric resource within thirty (30) days after the Enrollee’s discharge from hospitalization.

xi. When the Contractor receives notification from DCFS that an Enrollee in the Contractor’s plan has been designated a Youth at Risk, the Contractor will involve DCFS on the Enrollee’s Child and Family Team.

e. **Individual Plan of Care (IPoC).** Contractor shall require that the dedicated Care Coordinator work with the Child and Family Team to establish a single plan of care, referred to herein as Individual Plan of Care (IPoC). Contractor shall develop processes to provide each Enrollee and family with a unique, IPoC that is consistent with the principles and practices of the Department-defined Care Coordination Model. IPoCs are to be evaluated and modified on a timeline consistent with the Enrollee's stratified tier, or more frequently as the Enrollee's situation dictates. The IPoC shall be the Enrollee's standing treatment plan for all services provided by Network Providers, Behavioral Health providers, community-based Providers, and other Providers or stakeholders as required.

i. The IPoC shall include:

A. Summary of the Enrollee's screening and assessment results;

B. Services currently received by the Enrollee, including developmental health, physical health, or Behavioral Health services provided outside of managed care;

C. Covered Services that the Enrollee should receive;

D. Description of non-Covered Services that the Enrollee may benefit from;

E. Member and family goals and preferences for services;

F. Covered Services recommended for family members, where such coverage is in pursuit of the needs of the Enrollee and covered under the Enrollee's Medicaid benefits;

G. Plan for integrating care across Network Providers and all other Provider types;

H. Short- and long-term goals for the Enrollee's well-being;

I. Plan for transitioning Enrollees to adulthood for Enrollees within one (1) year of becoming an adult; and

J. Any additional information required as recommended by the Care Coordinator or PCP.

ii. The IPoC shall be based upon:

A. The strengths and needs identified by the completed IM-CANS Assessment;

B. Level of risk as identified by the Enrollee's intensity of Care Coordination tier;

C. Input from the Child and Family Team and other relevant family members and caregivers, Natural Support providers, and engaged service Providers;

D. Required elements of any applicable Waiver services plan; and

E. Goals expressed by the Enrollee and his or her family.

iii. Contractor shall engage the Enrollee, and the Enrollee's family or legal guardian, in the ongoing development, implementation, review, and evaluation of the Enrollee's IPoC.

iv. Contractor shall ensure that the IPoC includes all EPSDT services included in Attachment XXI, "Required minimum standards of care."

v. Contractor shall ensure that the IPoC includes any specialty physical health services or supports required for youth and families to address any identified high-intensity physical health needs. Contractor shall ensure that the Enrollee's PCP reviews and evaluates the initial IPoC and any revisions thereof.

vi. Contractor shall ensure that sufficient consents and releases are in place to share the IPoC with all appropriate service Providers.

vii. The IPoC may exclude one (1)–time treatment events, urgent care, and emergent situations.

f. Contractor shall use a combination of State Medicaid services, Natural Supports, resources from the community, and other services as developed in conjunction with the Department to meet the identified needs of Enrollees and the family through the IPoC and Child and Family Team processes.

g. Contractor shall ensure delivery of intensive-Care Coordination using:

i. A Special Behavioral Health MCO Liaison;

ii. A Behavioral Health Care Coordination Entity; or,

iii. Network Providers capable of providing intensive-Care Coordination.

5. DUTIES OF THE CARE COORDINATOR

a. Care Coordinators are responsible for performing Care Coordination activities with assigned Enrollees and their families. Contractor shall require Care Coordinators to be available to their assigned Enrollees and families outside of normal business hours, including weekends, and in times of Crisis, as appropriate. Contractor shall require Care Coordinators to conduct Care Coordination activities in locations convenient and comfortable for the Enrollee and his or her family, including the Enrollee's home and other

community-based settings, whenever possible. Contractor shall require that Care Coordinators work with the Nursing Care Coordinators and other members of the Child and Family Team to ensure that the Enrollee's physical healthcare and Behavioral Healthcare needs are met. Activities that Contractor shall require Care Coordinators to perform include, but are not limited to, the following:

b. Educating Enrollees and their families on the following:

   i. Contractor's Care Coordination Model, including the rights and responsibilities of Enrollees and their families;

   ii. How and when it is appropriate to contact the Care Coordinator after hours;

   iii. How and when to utilize their Crisis Safety Plan, including when to contact the Mobile Crisis Response team;

   iv. The availability of public benefits and other social services in the community (e.g., Social Security, Medicaid, housing, food, clothing);

   v. The importance of using primary care services through PCPs and participating in wellness programs; and

   vi. How to manage chronic physical health and Behavioral Health conditions, including monitoring potential side effects from prescribed psychotropic medications.

c. Assisting Enrollees in applying for and maintaining public benefits;

d. Coordinating discharge planning from acute care facilities;

e. Completing all Care Coordination activities, per the Department-defined Care Coordination Model and the High-Fidelity Wraparound Model;

f. Assisting the Enrollee and his or her family in identifying service Providers available to provide the services recommended by the Child and Family Team and included on the IPoC;

g. Communicating all necessary information to the Enrollee's PCP;

h. Coordinating and facilitating access to care for services recommended by the Child and Family Team and included on the IPoC, including making appropriate referrals and linkages and assisting with intake and application paperwork; and

i. Maintaining regular, active communication with any service Providers or other allied collateral individuals or entities involved with Enrollees and their families regarding the Enrollee's physical health and Behavioral Health needs.

6. CASELOAD STANDARDS

Caseload standards for High-Needs Children are not yet defined by the Department. At minimum, the Contractor shall meet the requirements of the Enrollees in a Level 3 risk category as per section 5.16.2 of the model Contract. Contractor must implement the Enrollee tier structure and Department-defined Care Coordination model (e.g., Integrated Health Homes or a similar model).

7. STAFFING AND TRAINING REQUIREMENTS

a. Contractor shall ensure all Care Coordinators and Care Supervisors adhere to the qualification and training requirements outlined in Attachment XVI, "Qualifications and training requirements of certain Care Coordinators."

b. Contractor shall provide annual training to all staff working with the High-Needs Children program, covering the following topics:

   i. High-Needs Children values and principles;

   ii. Cultural and linguistic competency;

   iii. Trauma-informed care; and

   iv. Mandated Reporting responsibilities.

8. MOBILE CRISIS RESPONSE SERVICES

a. Contractor acknowledges the existence of the State-funded Screening, Assessment, and Support Services (SASS) Program, cooperatively administered by the Department of Children and Family Services, the DHS Division of Mental Health, and the Department.

b. Contractor shall establish a dedicated Behavioral Health Crisis line for Enrollees, family members of Enrollees, or other concerned parties seeking to refer the Enrollee to Behavioral Health Crisis services.

   i. Contractor shall ensure that Contractor's Crisis line shall not require callers to navigate a telephonic menu in order to make a referral for crisis services.

   ii. Contractor shall ensure that the Crisis line is answered by staff who are:

      A. Capable of addressing a Behavioral Health Crisis upon direct answer;

      B. Knowledgeable and authorized to engage Contractor's Mobile Crisis Response System; and

C. Knowledgeable about Contractor's Disease Management Model for Children's Mental Health.

c. Contractor shall ensure the availability of Mobile Crisis Response Services, including a face-to-face crisis screening within ninety (90) minutes of notification, to all Enrollees experiencing a Behavioral Health Crisis.

d. Contractor shall ensure that Mobile Crisis Response Services are available every day of the year and twenty-four (24) hours per day.

e. Contractor shall inform the Enrollees and families of all Enrollees how to seek Mobile Crisis Response Services with Contractor's Network Providers.

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

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

   ii. Qualified Mental Health Professional; or

   iii. Licensed Practitioner of the Healing Arts.

g. Contractor shall require the utilization of the prevailing Illinois decision support tool, the CSPI and CSPI-EC or any State-defined successor, for all face-to-face mobile Crisis screening.

   i. Contractor shall report clinical CSPI data, in a manner defined by the Department, for all Enrollees receiving Mobile Crisis Response Services.

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

9. MOBILE CRISIS SERVICE DISPOSITION

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

   i. Contractor shall require its Network Providers responsible for providing Mobile Crisis Response Services to establish a Crisis Safety

Plan unique to the Enrollee and circumstances that includes concrete interventions and techniques that will assist in ameliorating the circumstances leading to the Crisis situation.

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

iii. Contractor shall require, in lieu of utilizing the publicly funded CARES line service (Attachment XXII, section 10 below), Network Providers responsible for providing Mobile Crisis Response Services to provide the Enrollee's family with contact information that may be used at any time, twenty-four (24) hours a day, to contact Contractor in moments of Crisis.

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

b. **Crisis Safety Plan Development.** Contractor shall require its Network Providers responsible for providing Mobile Crisis Response Services to:

i. Create a Crisis Safety Plan for all Enrollees that present in Behavioral Health Crisis, in collaboration with the Enrollee and his or her family;

ii. Provide families of Enrollees with physical copies of the Crisis Safety Plans:

A. Prior to the completion of the Crisis screening as provided in Attachment XXII, section 9(b) for any Enrollee stabilized in the community; and

B. Prior to discharge of the Enrollee from an inpatient psychiatric hospital for any Enrollee that is admitted to such a facility.

iii. Educate and orient the Enrollee's family to the components of the Crisis Safety Plan, to ensure that the plan is reviewed with the family regularly, and to detail how the plan is updated as necessary; and

iv. Share the Crisis Safety Plan with all necessary medical professionals, including Care Coordinators, consistent with the authorizations established by consent or release.

c. **Inpatient Institutional Treatment.** Contractor shall be responsible for providing Mobile Crisis Response Services to facilitate the Enrollee's admission to an appropriate inpatient institutional treatment setting when

the Enrollee in Crisis cannot be stabilized in the community.

i. Contractor shall be responsible for providing Mobile Crisis Response Services to inform the Enrollee's parents, guardian, caregivers, or residential staff about all the available service Providers and pertinent policies needed to allow the involved parties to select an appropriate inpatient institutional treatment setting.

ii. Contractor shall arrange for the necessary transportation when an Enrollee requires transportation assistance to be admitted to an appropriate inpatient institutional treatment setting. Under no circumstances should an Enrollee arrive unaccompanied at an inpatient psychiatric facility without the Mobile Crisis Response Provider or the Enrollee's family or caregiver.

iii. 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.

iv. Contractor shall provide and have documented procedures for its Network Providers regarding, discharge, and transitional planning related to an appropriate inpatient institutional treatment setting consistent with the following:

A. Planning shall begin upon admission;

B. Community-based Providers responsible for providing service upon the Enrollee's discharge shall participate in all inpatient staffing by phone, videoconference, or in person;

C. The Enrollee's Care Coordinator shall notify the Enrollee's family and caregiver of key dates and events related to the admission, staffing, discharge, and transition of the Enrollee, and he or she shall make every effort to involve the Enrollee and the Enrollee's family and caregiver in decisions related to these processes;

D. The Enrollee's Care Coordinator shall speak directly with the Enrollee at least each week;

E. The Enrollee's Care Coordinator or Network Provider shall educate and train the Enrollee's family on how to use the Crisis Safety Plans while the Enrollee is receiving inpatient institutional treatment; and

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

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

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

d. **Psychiatric Resource and Pharmacological Services.**

i. For all Enrollees referred for Mobile Crisis Response Services, Contractor shall facilitate priority access to a psychiatric resource to provide consultation and medication management within the following time frames:

A. Within fourteen (14) calendar days after an Enrollee's discharge from an inpatient psychiatric hospital admission; or

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

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

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

10. INTERFACE WITH ILLINOIS CRISIS AND REFERRAL ENTRY SERVICE (CARES)

a. Contractor acknowledges the existence of the State-funded Crisis and Referral Entry Service (CARES) cooperatively administered by the Department of Children and Family Services, the DHS Division of Mental Health, and the Department.

b. Contractor acknowledges that the Department shall issue the CARES per call rate annually.

c. Contractor shall provide CARES with the details of its Mobile Crisis

Response System, including the telephone numbers needed to access its Crisis response team.

d. If an Enrollee seeks Crisis intervention service outside of the Contractor's Mobile Crisis Response Service System and a Crisis call is routed to CARES for a Crisis referral, Contractor shall reimburse CARES at the annual CARES Per Call Rate.

   i. Contractor shall accept invoices from CARES on a monthly basis.

   ii. Contractor shall remit payment to CARES within forty-five (45) days after receiving an invoice for Crisis referral services.

e. Contractor shall have provisions in the Provider agreements of its Network Providers responsible for providing Mobile Crisis Response Services for CARES to authorize and dispatch Mobile Crisis Response Services, which shall be reimbursed by Contractor.

   i. In the event that CARES is unable to dispatch the Contractor's Mobile Crisis Response Service, CARES shall engage the SASS Program to ensure Crisis response to the Enrollee.

   ii. In the event that an Enrollee is screened, due to necessity, by a Non-Network Provider of SASS services, Contractor shall pay for the screening at the Medicaid rate.

f. 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.

11. DISCHARGE PLANNING AND TRANSITIONAL SERVICES

a. Contractor shall provide Enrollees with access to discharge planning and transitional services when being discharged from higher levels of care to lower levels or community-based services. Contractor shall work with the institution to facilitate appropriate follow-up services, including the scheduling of follow-up treatment appointments.

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

c. Contractor shall encourage the Enrollee and the Enrollee's family to contact the Enrollee's Care Coordinator whenever a biological, psychological, or social intervention is required or requested. Contractor shall ensure that the entry and exit from any level of care is managed effectively, efficiently, and, when possible and appropriate, within Contractor's Provider Network.

d. Contractor shall establish and implement procedures for Enrollees to obtain access to Non-Network Providers and to facilitate the timely provision of necessary and appropriate records to those Non-Network Providers.

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

f. Contractor shall develop, implement, and follow a procedure to confirm that a medication management review has been completed prior to discharge from higher levels of care (e.g., hospital, PRTF, residential, and Crisis respite); to confirm that PCPs are made aware of any medications that have been prescribed for Enrollees during treatment at an institutional setting; and to confirm with the Enrollees that they have the ability to get prescribed medications.

g. Contractor shall communicate directly with the Enrollee or Enrollee's family within forty-eight (48) hours after transition and shall see the Enrollee in person in the Enrollee's home, or another location as mutually agreed by the Enrollee or the Enrollee's family and Contractor, within seven (7) days after the discharge from higher levels of care (e.g., hospital, PRTF, residential, and Crisis respite).

h. Contractor shall assist the Enrollee in attending all post-discharge appointments for follow-up care. Contractor shall provide appropriate care management based on concurrent assessment for an appropriate period of time following discharge. This care management shall be a combination of Care Coordination, Mobile Crisis Response, and, when appropriate, the use of the Child and Family Team.

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

j. Upon discharge, Contractor shall monitor and manage the Enrollee's care as necessary.

Attachment XXIII
Illinois Medicaid Health Plan Encounter Utilization Monitoring (EUM) Requirements

Illinois Medicaid Health Plan Encounter Utilization Monitoring (EUM) Requirements for 2018:
General Process (Page 1 of 2)

Evaluation Period	Final date for MCO to submit encounter claims to be included in the evaluation	Final date for MCO to email EUM spend data to HFS (See #2 below)	Evaluation Date (EUM Summary Reports due-date)	Service Dates Measured (Calendar year)	Cumulative Percentage Difference between Plan Reported and Encounter Reported Service Cost PMPM (Plan/Encounter)	
					$50,000 Financial Penalty if at or below:	Auto-Assignment Shut-Off if at or below:
1						
2						
3						
4						

General Implementation Procedures:

1. The Department will inform Contractor in writing what spend data is to be included and provided. Failure to send accurate spend data by the deadline will result in both the Financial Penalty and Auto-Assignment Shut-Off to occur.

   When Medicaid spend data is sent, it must be accompanied by an attestation letter signed by Contractor's Executive Director/CEO.

2. If Contractor has more than one contract as a MCO with the Department, each contract will be measured separately and sanctions will be imposed by contract.
3. Contractor shall email all related data to the Department's designated Contract Monitor, Bhavin Shah (bhavin.shah@illinois.gov) and Paul Stieber (paul.stieber@illinois.gov).

Illinois Medicaid Health Plan Encounter Utilization Monitoring (EUM) Requirements for 2018:
Auto-Assignment Specific Process (Page 2 of 2)

Evaluation Period	HFS to communicate any Auto-Assignment Shut-Off to Client Enrollment Broker by this date:	Date Auto-Assignment Shut-Off occurs	30 Day Re-Evaluation date	Final date for MCO to submit data for 30 Day Re-Evaluation	If Auto-Assignment Re-Evaluation is positive, Auto-Assignment re-start date	If Auto-Assignment remains off, 60 Day Re-Evaluation date	Final date for MCO to submit data for 60 Day Re-Evaluation	If Auto-Assignment Re-Evaluation is positive, Auto-Assignment re-start date
1								
2								
3								
4								

Auto-Assignment Shut-Off Implementation Procedures:

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

2. Contractor shall email all related data to the Department's designated Contract Monitor, Bhavin Shah (bhavin.shah@illinois.gov) and Paul Stieber (paul.stieber@illinois.gov)