

Contract

Between

**United States Department of Health and Human Services
Centers for Medicare & Medicaid Services**

In Partnership with

**State of Illinois
Department of Healthcare and Family Services**

and

[PLAN NAME]

Effective: January 1, 2018

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This Contract, effective made on November 5, 2013, and amended by addendum effective March 31, 2015, and amended and restated effective September 14, 2016, is hereby amended and restated effective January 1, 2018, between the Department of Health and Human Services, acting by and through the Centers for Medicare & Medicaid Services (CMS), the State of Illinois, acting by and through the Department of Healthcare and Family Services (Department) and [PLAN NAME] (the Contractor). The Contractor's principal place of business is [PLAN ADDRESS].

WHEREAS, CMS is an agency of the United States, Department of Health and Human Services, responsible for the administration of the Medicare, Medicaid, and State Children's Health Insurance Programs under Title XVIII, Title IX, Title XIX, and Title XXI of the Social Security Act;

WHEREAS, the Department is the Illinois agency responsible for operating a program of medical assistance under 42 U.S.C. § 1396 et seq., 305 ILCS 5/5-1 et seq. and 215 ILCS 106/1 et seq., designed to pay for medical services for eligible individuals;

WHEREAS, the Contractor is in the business of providing medical services, and CMS and the Department desire to purchase such services from the Contractor;

WHEREAS, the Contractor agrees to furnish these services in accordance with the terms and conditions of this Contract and in compliance with all federal and State laws and regulations;

WHEREAS, this Contract replaces in its entirety, the Contract entered into by CMS, the Department, and [PLAN NAME] (Contractor) executed November 5, 2013 and re-executed September 14, 2016, provided, however, that any duties, obligations, responsibilities, or requirements that are imposed upon the Contractor in this revised Contract but that were not imposed upon the Contractor previously under this Contract or under applicable laws or regulations, shall be effective January 1, 2018.

NOW, THEREFORE, in consideration of the mutual promises set forth in this Contract, the Parties agree as follows:

1. Definition of Terms

- 1.1 820 Payment File – the electronic Health Insurance Portability and Accountability Act of 1996 (HIPAA) transaction that Contractor retrieves from the Department that identifies each Enrollee for whom payment was made by the Department to the Contractor.
- 1.2 834 Daily File – The electronic HIPAA transaction that the Contractor retrieves from the Department each day that reflects changes in enrollment subsequent to the previous 834 Enrollment File.
- 1.3 834 Enrollment File – The electronic HIPAA transaction that Contractor retrieves monthly from the Department that reflects its Enrollees for the following calendar month.
- 1.4 Abuse – (i) A manner of operation that results in excessive or unreasonable costs to the Federal or State health care programs, generally used in conjunction with Fraud; or (ii) the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish (42 C.F.R. § 488.301), generally used in conjunction with Neglect.
- 1.5 Activities of Daily Living (ADL) – Activities such as eating, bathing, grooming, dressing, transferring and continence.
- 1.6 Administrative Allowance – The portion of the Capitation, paid and allocated by the Department, for the administrative cost of the Contract attributable to the Medicaid component of the Contract.
- 1.7 Advance Directive – An individual’s written directive or instruction, such as a power of attorney for health care or a living will, recognized under state law (whether statutory or as recognized by the courts of the state), for the provision of that individual’s health care if the individual is unable to make his or her health care wishes known.
- 1.8 Advanced Practice Nurse (APN) – A Provider of medical and preventive services, including Certified Nurse Midwives, Certified Family Nurse Practitioners and Certified Pediatric Nurse Practitioners, who is licensed as an APN, holds a valid license in Illinois, is legally authorized under statute or rule to provide services, is a Provider, and has a contract with the Contractor.
- 1.9 Adverse Benefit Determination -- (i) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a Covered Service; (ii) the reduction, suspension, or termination of a previously authorized service; (iii) the denial, in whole or in part, of payment for a service; (iv) the failure to provide services in a timely manner, as defined by the State; (v) the failure of the Contractor to act within the required timeframes for the standard resolution of Grievances and Appeals; (vi) for a resident of a rural area with only one Demonstration Plan, the denial of an Enrollee’s request to obtain services outside of the network; or (vii) the denial of an Enrollee’s request to dispute a financial liability.
- 1.10 Affiliate – Any individual, firm, corporation (including, without limitation, service corporation and professional corporation), partnership (including, without limitation, general partnership, limited partnership and limited liability partnership), limited liability company, joint venture, business trust,

association or other contractor that now or in the future directly or indirectly controls, is controlled by, or is under common control with the Contractor.

- 1.11 Affiliated – Associated with the Contractor for the purpose of providing health care services under the Contract for the Medicare-Medicaid Alignment Initiative (MMAI) pursuant to a written contract or agreement, including, but not limited to, a contracted Provider and network Provider, including such Provider of only those services available under one or more Home and Community-Based Services (HCBS) Waivers. Affiliated Providers, however, shall not include a Provider who has an agreement or contract with a Demonstration Plan for the provision of limited services (e.g., a single case out of network agreement (single case agreement)).
- 1.12 Anniversary Date – The annual date of an Enrollee’s initial enrollment in the Demonstration Plan. For example, if an Enrollee’s enrollment in an Demonstration Plan became effective on October 1, 2014, the Anniversary Date with that Demonstration Plan would be each October 1 thereafter.
- 1.13 Appeal – An Enrollee’s request for formal review of an Adverse Benefit Determination of the Contractor in accordance with Section 2.12 of the Contract.
- 1.14 Business Day -- Monday through Friday, including State holidays except for New Year’s Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day and Christmas Day.
- 1.15 Business Enterprise Program Act for Minorities, Females and Persons with Disabilities (BEP) - The State law, 30 ILCS 575, that establishes a goal for contracting with businesses that have been certified as owned and controlled by individuals who are minority, female or who have disabilities.
- 1.16 Capitation – The reimbursement arrangement in which a fixed rate of payment per Enrollee per month is made, regardless of whether the Enrollee receives Covered Services in that month, to the Contractor for the performance of all of the Contractor’s duties and responsibilities pursuant to the Contract.
- 1.17 Capitated Financial Alignment Initiative (“the Demonstration” or “Medicare-Medicaid Alignment Initiative (MMAI)”) – A model where a State, CMS, and a health plan enter into a three-way contract, and the health plan receives a prospective blended payment to provide comprehensive, coordinated care.
- 1.18 Capitation Rate – The sum of the monthly Capitation payments for (reflecting coverage of Medicare Parts A & B services, Medicare Part D services, and Medicaid services, pursuant to Appendix A of this Contract) including the application of risk adjustment methodologies, as described in Section 4.2.4. Total Capitation Rate Revenue will be calculated as if all Contractors had received the full quality withhold payment.
- 1.19 Care Coordinator – An employee or delegated subcontractor of the Demonstration Plan who provides Care Management, and together with an Enrollee and care team, establishes a Care Plan for the Enrollee and, through interaction with network Providers, ensures the Enrollee receives necessary services.
- 1.20 Care Management – Services that assist Enrollees in gaining access to needed services, including medical, social, educational and other services, regardless of the funding source for the services. Care Management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the

options and services (both Medicare and Medicaid) required to meet an Enrollee's needs across the continuum of care.

- 1.21 Centers for Medicare & Medicaid Services (CMS) – The federal agency under the Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
- 1.22 Certified Local Health Department – An agency of local government authorized under 77 Ill. Adm. Code Part 600 to develop and administer programs and services that are aimed at maintaining a healthy community.
- 1.23 Change of Control – Any transaction or combination of transactions resulting in: (i) the change in ownership of a contractor; (ii) the sale or transfer of fifty percent (50%) or more of the beneficial ownership of a contractor; or (iii) the divestiture, in whole or in part, of the business unit or division of a Party that is obligated to provide the products and services set forth in this Contract.
- 1.24 Chronic Health Condition – A health condition with an anticipated duration of at least twelve (12) months.
- 1.25 Cognitive Disabilities – A disability that may cover a wide range of needs and abilities that vary for each specific individual. Conditions range from individuals having a serious mental impairment caused by Alzheimer's disease, bipolar disorder or medications to non-organic disorders such as dyslexia, attention deficit disorder, poor literacy or problems understanding information. At a basic level, these disabilities affect the mental process of knowledge, including aspects such as awareness, perception, reasoning, and judgment.
- 1.26 Colbert Contractor – The contractor having a contract with the Department to implement the consent decree entered in *Colbert v. Quinn*, No. 07 C 4737 (N.D. Ill.) (Colbert consent decree).
- 1.27 Complaint – Any Complaint or dispute, other than one that constitutes an organization determination under 42 C.F.R. § 422.566, expressing dissatisfaction with any aspect of the Contractor's or Provider's operations, activities, or behavior, regardless of whether remedial action is requested. 42 C.F.R. § 422.561. Possible subjects for Complaints include, but are not limited to, a concern related to the health, safety or well-being of an Enrollee, quality of care or services provided, aspects of interpersonal relationships such as rudeness of a Primary Care Provider or employee of Contractor, or failure to respect the Enrollee's rights. Complaints may be received via a phone call, letter or personal contact from a Participant, Enrollee, family member, Enrollee representative or any other interested individual expressing a concern related to the health, safety or well-being of an Enrollee. See also "Grievance."
- 1.28 Computer Aided Real-time Translation (CART) – The instant translation of spoken word into text performed by a CART reporter using a stenotype machine, notebook computer and real-time software.
- 1.29 Confidential Information – Any material, data, or information disclosed by any Party to another Party that, pursuant to agreement of the Parties or a Party's grant of a proper request for confidentiality, is not generally known by or disclosed to the public or to Third Parties including, without limitation: (i) all materials, know-how, processes, trade secrets, manuals, confidential reports, services rendered by CMS,

the State, financial, technical and operational information, and other matters relating to the operation of a Party's business; (ii) all information and materials relating to Third Party contractors of CMS or the State that have provided any part of CMS' or the State's information or communications infrastructure to CMS or the State; (iii) software; and (iv) any other information that the Parties agree should be kept confidential.

- 1.30 Consumer Assessment of Healthcare Providers and Systems (CAHPS) – The survey developed by the program funded by the U.S. Agency for Healthcare Research and Quality that works closely with a consortium of public and private organizations. The CAHPS program develops and supports the use of a comprehensive and evolving family of standardized surveys that ask consumers and patients to report on and evaluate their experience with ambulatory and facility level care.
- 1.31 Contract – The participation agreement that CMS and the Department have with a Contractor, for the terms and conditions pursuant to which a Contractor may participate in this Demonstration.
- 1.32 Contract Management Team (CMT) – A group of CMS and Department representatives responsible for overseeing the contract management functions outlined in Section 2.2.2 of the Contract.
- 1.33 Contract Operational Start Date – The first date on which any enrollment into the Contractor's Demonstration Plan is effective.
- 1.34 Contractor – A Managed Care Organization (MCO) approved by CMS and the Department that enters into a Contract with CMS and the Department in accordance with and to meet the purposes specified in this Contract.
- 1.35 Covered Services – The set of services required to be provided by the Contractor.
- 1.36 Demonstration – The program, administered by CMS and the Department for providing integrated care to Medicare-Medicaid Enrollees that is the subject of this Contract.
- 1.37 Demonstration Plan – A Managed Care Organization that enters into a three-way Contract with CMS and the Department to provide Covered Services and any chosen flexible benefits and be accountable for providing integrated care to Medicare-Medicaid Enrollees.
- 1.38 Determination of Need (DON) – The tool used by the Department or the Department's authorized representative to determine eligibility (level of care) for Nursing Facility (NF) and HCBS Waivers for individuals with disabilities, HIV/AIDS, brain injury, supportive living and the elderly. This assessment includes scoring for a mini-mental state examination (MMSE), functional impairment and unmet need for care in fifteen (15) areas including Activities of Daily Living and Instrumental Activities of Daily Living. The final score is calculated by adding the results of the MMSE, the level of impairment and the unmet need for care scores. In order to be eligible for NF or HCBS Waiver services, an individual must receive at least fifteen (15) points on functional impairment section and a minimum total score of twenty-nine (29) points.

- 1.39 Developmental Disability(ies) (DD) — A disability that (i) is attributable to a diagnosis of mental retardation or related condition such as cerebral palsy or epilepsy, (ii) manifests before the age of twenty-two (22) and is likely to continue indefinitely, (iii) results in impairment of general intellectual functioning or adaptive behavior, and (iv) results in substantial functional limitations in three (3) or more areas of major life activities, such as self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living.
- 1.40 DHHS — The United States Department of Health and Human Services.
- 1.41 DHS — The Illinois Department of Human Services, and any successor agency.
- 1.42 DHS-DASA — The Division of Alcohol and Substance Abuse within DHS that operates treatment services for alcoholism & addiction through an extensive treatment Provider network throughout the State. <http://www.dhs.state.il.us/page.aspx?item=29725>
- 1.43 DHS-DDD — The Division of Developmental Disabilities within DHS that operates programs for individuals with Developmental Disabilities.
- 1.44 DHS-DMH — The Division of Mental Health within DHS that is the State mental health authority.
- 1.45 DHS-DRS — The Division of Rehabilitation Services within DHS that operates the home services programs for individuals with disabilities (Persons with Disabilities HCBS Waiver), brain injury (Persons with Brain Injury HCBS Waiver) and HIV/AIDS (Persons with HIV/AIDS HCBS Waiver).
- 1.46 Disease Management Program — A program that employs a set of interventions designed to improve the health of individuals, especially those with Chronic Health Conditions. Disease Management Program services include: (i) a population identification process; (ii) use and promotion of evidence-based guidelines; (iii) use of collaborative practice models to include Physician and support service Providers; (iv) Enrollee self-management education (includes primary prevention, behavioral modification, and compliance surveillance); (v) Care Management; (vi) process and outcome measurement, evaluation and management; and (vii) routine reporting/feedback loop (includes communication with the Enrollee, Physician, ancillary Providers and practice profiling). A Disease Management Program may be a part of a Care Management program.
- 1.47 DoA — The Illinois Department on Aging, and any successor agency, that operates the HCBS Waiver for the elderly (Persons who are Elderly HCBS Waiver).
- 1.48 DPH — The Illinois Department of Public Health, and any successor agency, that is the State survey agency responsible for promoting the health of the people of Illinois through the prevention and control of disease and injury, and conducting the activities related to licensure and certification of NF's and ICF/DD facilities.
- 1.49 Effective Enrollment Date — The date on which an Enrollee becomes a member of the Contractor's Demonstration Plan.

- 1.50 Emergency Medical Condition — A medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to, severe pain (including severe pain, psychiatric disturbances and/or symptoms of substance abuse(s)) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part or, with respect to a pregnant woman who is having contractions, (a) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (b) that transfer may pose a threat to the health or safety of the woman or the unborn child.
- 1.51 Emergency Services — Inpatient and outpatient services covered under this Contract that are furnished by a Provider qualified to furnish such services and that are needed to evaluate or stabilize an Enrollee's Emergency Medical Condition.
- 1.52 Encounter — An individual service or procedure provided to an Enrollee that would result in a claim if the service or procedure were to be reimbursed as Fee-For-Service (FFS) under the HFS Medical Program.
- 1.53 Encounter Data — The record of an Enrollee receiving any item(s) or service(s) provided through Medicaid or Medicare under a prepaid, capitated, or any other risk basis payment methodology submitted to CMS and the Department. This record must incorporate HIPAA security, privacy, and transaction standards and be submitted in the ASC X12N 837 format or any successor format.
- 1.54 Enrollee — Any Medicare-Medicaid eligible individual who is enrolled with a Contractor. "Enrollee" shall include the guardian where the Enrollee is an adult for whom a guardian has been named; provided, however, that the Contractor is not obligated to cover services for any individual who is not enrolled as an Enrollee with the Contractor.
- 1.55 Enrollee Care Plan — An Enrollee-centered, goal-oriented, culturally relevant, and logical, written plan of care with a Person-Centered Service Plan component, if necessary, that assures that the Enrollee receives, to the extent applicable, medical, medically-related, social, behavioral, and necessary Covered Services in a supportive, effective, efficient, timely and cost-effective manner that emphasizes prevention and continuity of care.
- 1.56 Enrollee Communications — Materials designed to communicate plan benefits, policies, processes and/or enrollee rights to Enrollees. This includes pre-enrollment, post-enrollment, and operational materials.
- 1.57 External Quality Review Organization (EQRO) — An organization contracted with the Department that meets the competence and independence requirements set forth in 42 C.F.R. § 438.354, and performs external quality review (EQR) and EQR-related activities as set forth in 42 C.F.R. § 438.358.
- 1.58 Family Planning (FP) — A full spectrum of Family Planning options (all FDA-approved birth control methods) and reproductive health services appropriately provided within the Provider's scope of practice and competence. The Family Planning and reproductive health services are defined as those services offered, arranged, or furnished for the purpose of preventing an unintended pregnancy, or to improve maternal health and birth outcomes.

- 1.59 Federally-Qualified Health Center (FQHC) – An entity that has been determined by CMS to satisfy the criteria set forth in 42 U.S.C. § 1396d(a)(2)(C) and meets the requirements of 89 IL Admin Code 140.461(d).
- 1.60 Fee-For-Service (FFS) – The method of paying Providers for each Encounter or service rendered.
- 1.61 First Tier, Downstream and Related Entity – An individual or entity that enters into a written arrangement with the Contractor, acceptable to CMS and the Department, to provide administrative or health care services of the Contractor under this Contract.
- 1.62 Fraud – Knowing and willful deception, or a reckless disregard of the facts, with the intent to receive an unauthorized benefit. Includes any act that constitutes fraud under federal or state law.
- 1.63 Grievance – Any Complaint or dispute, other than one that constitutes an organization determination under 42 C.F.R. § 422.566 or Adverse Benefit Determination under 42 C.F.R. § 400, expressing dissatisfaction with any aspect of the Contractor’s or Provider’s operations, activities, or behavior, regardless of whether remedial action is requested pursuant to 42 C.F.R. § 422.561. (Possible subjects for Grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships such as rudeness of a Primary Care Provider or employee of the Contractor, or failure to respect the Enrollee’s rights, as provided for in Appendix B of this Contract).
- 1.64 Group Practice – A group of Primary Care Providers (PCPs) who share a practice or are affiliated and provide direct medical or other services to Enrollees of any PCP within that practice.
- 1.65 Habilitation – An effort directed toward the alleviation of a disability or toward increasing an individual’s level of physical, mental, social or economic functioning. Habilitation may include, but is not limited to, diagnosis, evaluation, medical services, residential care, day care, special living arrangements, training, education, sheltered employment, protective services, counseling and other services.
- 1.66 Health Care Acquired Conditions (HCACs) – Conditions occurring in an inpatient hospital setting, which Medicare designates as hospital-acquired conditions HACs) pursuant to § 1886 (d)(4)(D)(iv) of the Social Security Act (SSA) (as described in § 1886(d)(D)(ii) and (iv) of the SSA), with the exception of deep vein thrombosis (DVT/pulmonary embolism (PE)) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients.
- 1.67 Healthcare Effectiveness Data and Information Set (HEDIS) – Tool developed and maintained by the National Committee for Quality Assurance that is used by health plans to measure performance on dimensions of care and service in order to maintain and/or improve quality.
- 1.68 Health Maintenance Organization (HMO) – A health maintenance organization as defined in the Health Maintenance Organization Act (215 ILCS 125/1-1 et seq.).
- 1.69 HFS – The Illinois Department of Healthcare and Family Services and any successor agency. In this Contract, HFS may also be referred to as “Agency” or “the Department”. HFS includes any Person with which it may have a contract, or otherwise designate, to perform a HFS function under this Contract.

- 1.70 HFS Medical Program – The (i) Illinois Medical Assistance Program administered under Article V of the Illinois Public Aid Code (305 ILCS 5/5-1 et seq.) or its successor program, and Title XIX (42 U.S.C. § 1396 et seq.) and XXI (42 U.S.C. § 1397aa et seq.) of the Social Security Act, and Section 12-4.35 of the Illinois Public Aid Code (305 ILCS 5/12-435); and (ii) the State Children’s Health Insurance Program administered under 215 ILCS 106 and Title XXI of the SSA (42 U.S.C. § 1397aa et seq.).
- 1.71 Health Outcomes Survey (HOS) – Beneficiary survey used by CMS to gather valid and reliable health status data in Medicare managed care for use in quality improvement activities, plan accountability, public reporting, and improving health.
- 1.72 Health Plan Management System (HPMS) – A system that supports contract management for Medicare health plans and prescription drug plans and supports data and information exchanges between CMS and health plans. Current and prospective Medicare health plans submit applications, information about Provider Networks, plan benefit packages, formularies, and other information via HPMS.
- 1.73 Home and Community-Based Services (HCBS) Waivers – Waivers under Section 1915(c) of the SSA that allow the State to cover home and community services and provide programs that are designed to meet the unique needs of individuals with disabilities who qualify for the level of care provided in an institution but who, with special services, may remain in their homes and communities.
- 1.74 Homemaker Service – General non-medical support by supervised and trained homemakers to assist Participants with their ADL and Instrumental Activities of Daily Living (IADL).
- 1.75 Hospitalist – A Physician who is part of a coordinated group working together, whose professional focus is the general medical care of hospitalized Enrollees in an acute care facility and whose activities include Enrollee care, communication with families, significant others, PCPs, and hospital leadership related to hospital medicine.
- 1.76 ILCS – Illinois Compiled Statutes, an unofficial version of which can be viewed at <http://www.ilga.gov/legislation/ilcs/ilcs.asp>.
- 1.77 Illinois Client Enrollment Services (CES) – The entity contracted by the Department to conduct enrollment activities for Potential Enrollees and Enrollees, including providing impartial education on health care delivery choices, providing enrollment materials, assisting with the selection of an Demonstration Plan and PCP, and processing requests to change Demonstration Plans.
- 1.78 Illinois Office of Inspector General (OIG) – The Office of Inspector General for the Department as set forth in 305 ILCS 5/12-13.1.
- 1.79 Independent Review Entity (IRE) – An outside organization that has a contract with CMS to review decisions about Medicare coverage and timely appeals decisions.
- 1.80 Indian Enrollee – An Enrollee who is an Indian (as defined at 25 USC 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 C.F.R. § 136.12.) This includes an enrollee is a member of a Federally recognized tribe; resides in an urban center and meets one or more of four criteria

including: is member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member; is an Eskimo or Aleut or other Alaska Native; is considered by the Secretary of the Interior to be an Indian for any purpose; or is determined to be an Indian under regulations issued by the Secretary; is considered by the Secretary of the Interior to be an Indian for any purpose; or is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian Health Services.

- 1.81 Indian Health Care Provider – A health care program, operated by the Indian Health Services (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603)..
- 1.82 Individual Provider (IP) – An individual co-employed by the DHS-DRS Home Services Program Enrollee and DHS who provides care to the Enrollee according to the service plan (Person-Centered Service Plan). Such individuals include, but are not limited to: Personal Assistants, certified nursing assistants, licensed practical nurses, registered nurses, physical therapists, occupational therapists, and speech therapists.
- 1.83 Institutionalization – Residency in a NF, ICF/DD or State operated facility, but does not include admission in an acute care or Rehabilitation hospital setting.
- 1.84 Instrumental Activities of Daily Living (IADL) – Managing money, meal preparation, telephoning, laundry, housework, being outside the home, routine health, special health and being alone.
- 1.85 Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ IID) – A facility for Residents who have physical, intellectual, social and emotional needs, that provides services primarily for ambulatory adults with Developmental Disabilities and addresses itself to the needs of individuals with mental disabilities or those with related conditions. Also known as Intermediate Care Facility for the Mentally Retarded (ICF/MR) or Intermediate Care Facility for the Developmentally Disabled (ICF/DD).
- 1.86 Long-Term Care (LTC) Facility or NF – (i) A facility that provides Skilled Nursing or intermediate long-term care services, whether public or private and whether organized for profit or not-for-profit, that is subject to licensure by the DPH under the Nursing Home Care Act, including a county nursing home directed and maintained under Section 5-1005 of the Counties Code; and (ii) a part of a hospital in which Skilled Nursing or intermediate long-term care services within the meaning of Title XVIII or XIX of the Social Security Act are provided.
- 1.87 Long-Term Services and Supports (LTSS) – Those Covered Services provided in a NF or as HCBS intended to help an Enrollee with a disability, or who is elderly, to meet the Enrollee’s daily needs for assistance and improve the quality of life.
- 1.88 Managed Care Organization (MCO) – An entity that meets the definition of managed care organization as defined at 42 C.F.R. § 438.2 and that has a contract with CMS and the Department to provide services in the Demonstration. It includes the Contractor and may also include other such entities with such contracts.

- 1.89 Mandated Reporting — Immediate reporting required from a mandated reporter of suspected maltreatment when the mandated reporter has reasonable cause to believe that an individual known to the mandated reporter in a professional or official capacity may be Abused or Neglected.
- 1.90 Marketing — Any written or oral communication from the Contractor or its representative that can reasonably be interpreted as intended to influence a Participant to enroll, not to enroll, or to disenroll from a health care delivery system.
- 1.91 Marketing Materials — Materials produced in any medium, by or on behalf of the Contractor or its representative that can reasonably be interpreted as intended to market to Potential Enrollees. Marketing Materials includes Written Materials and oral presentations.
- 1.92 Marketing, Outreach, and Enrollee Communications — Any informational materials targeted to Enrollees that are consistent with the definition of marketing materials at 42 C.F.R. § 422.2260.
- 1.93 MEDI - The Medical Electronic Data Interchange (MEDI) system is a system maintained by HFS that provides health plans and Providers the ability to verify a patient’s Medicaid eligibility.
- 1.94 Medicaid Program or Medicaid — The program under Title XIX of the SSA that provides medical benefits to eligible individuals, including certain people with low incomes.
- 1.95 Medically Necessary Services — Services, supplies, or medicines that are appropriate, reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y, covered by the Department, and meet the standards of good medical practice in the medical community, as determined by the Provider in accordance with the Demonstration Plan’s guidelines, policies and procedures based on applicable standards of care and, as approved by CMS or the Department if necessary, for the diagnosis and treatment of a covered illness or injury, for the prevention of future disease, to assist in the Enrollee’s ability to attain, maintain or regain functional capacity, or to achieve age-appropriate growth. Notwithstanding this definition, Plans will provide coverage in accordance with the more favorable of the current Medicare and Department coverage rules, as outlined in Illinois and Federal rules and coverage guidelines. See **Appendix A**.
- 1.96 Medicare-Medicaid Alignment Initiative (MMAI) – The Illinois name for the Capitated Financial Alignment Initiative.
- 1.97 Medicare-Medicaid Coordination Office — Formally the Federal Coordinated Health Care Office, established by Section 2602 of the Affordable Care Act (ACA).
- 1.98 Medicare-Medicaid Enrollee — For the purposes of this Demonstration, individuals who are entitled to or enrolled in Medicare Part A, and Medicare Parts B, eligible to enroll in Medicare Part D, and receive full Medicaid benefits under the State Plan, and otherwise meet eligibility criteria for the Demonstration.
- 1.99 Medicare — Title XVIII of the Social Security Act, the federal health insurance program for people age 65 or older, people under 65 with certain disabilities, and people with End Stage Renal Disease (ESRD) or

Amyotrophic Lateral Sclerosis. Medicare Part A provides coverage of inpatient hospital services and services of other institutional Providers, such as Skilled Nursing Facilities and home health agencies. Medicare Part B provides supplementary medical insurance that covers Physician services, outpatient services, some home health care, durable medical equipment, and laboratory services and supplies, generally for the diagnosis and treatment of illness or injury. Medicare Part C provides Medicare beneficiaries with the option of receiving Part A and Part B services through a private health plan. Medicare Part D provides outpatient prescription drug benefits.

- 1.100 Medicare Advantage — The Medicare managed care options that are authorized under Title XVIII as specified at Part C and 42 C.F.R. § 422.
- 1.101 Money Follows the Person (MFP) –Money Follows the Person is federal demonstration grant project that supports state long term care rebalancing by assisting eligible individuals to move from long-term care facilities (nursing homes) and Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DD) to community settings. Illinois’ MFP project, Pathways to Community Living program, provides individuals choices about where they can live, as well as assistance with community supports and services. In Illinois, the HFS is the lead agency in this initiative, working in partnership with the DHS, the Department on Aging, and the Illinois Housing Development Authority. The Pathways to Community Living program is available to individuals currently residing in long-term care facilities (nursing homes) and ICF/DD who are over age 65, or to individuals with physical disabilities, or developmental disabilities, or mental illness.
- 1.102 National Committee for Quality Assurance (NCQA) — A private 501(c)(3) not-for-profit organization that is dedicated to improving health care quality and that has a process for providing accreditation, certification and recognition, e.g., health plan accreditation.
- 1.103 National Council for Prescription Drug Program (NCPDP) — The electronic HIPAA transaction that the Contractor transfers to the Department that identifies health care claims for pharmacy claims and Encounters.
- 1.104 Neglect — A failure (i) to notify the appropriate health care professional, (ii) to provide or arrange necessary services to avoid physical or psychological harm to a Resident, or (iii) to terminate the residency of a Participant whose needs can no longer be met, causing an avoidable decline in function. Neglect may be either passive (non-malicious) or willful.
- 1.105 Negotiated Risk — The process by which an Enrollee, or his or her representative, may negotiate and document with Providers what risks each is willing to assume in the provision of Medically Necessary Covered Services and the Enrollee’s living environment, and by which the Enrollee is informed of the risks of these decisions and of the potential consequences of assuming these risks.
- 1.106 Occupational Therapy — A medically prescribed service identified in the Enrollee Care Plan that is designed to increase independent functioning through adaptation of the tasks and environment, and that is provided by a licensed occupational therapist who meets Illinois licensure standards.
<http://www.idfpr.com/dpr/WHO/ot.asp>.

- 1.107 Ombudsman — The entity designated by the State, and independent of the Department, that advocates and investigate on behalf of Enrollees to safeguard due process and to serve as an early and consistent means of identifying systematic problems with the Demonstration as provided for in State administrative rules and in accordance with the Older Americans Act of 1965.
- 1.108 Party/Parties — The State, through the Department, CMS and the Contractor.
- 1.109 Passive Enrollment — An enrollment process through which an eligible individual is enrolled by the Department into a Contractor’s plan following a minimum 60-day advance notification that includes the opportunity to make another enrollment decision prior to the effective date of the enrollment.
- 1.110 Performance Improvement Project – An ongoing program for improvement that focuses on clinical and nonclinical areas, and that involves (i) measurement of performance using objective quality indicators, (ii) implementation of system interventions to achieve improvement in quality, (iii) evaluation of the effectiveness of the interventions, and (iv) planning and initiation of activities for increasing or sustaining improvement.
- 1.111 Performance Measure — A quantifiable measure to assess how well an organization carries out a specific function or process.
- 1.112 Person — Any individual, corporation, proprietorship, firm, partnership, trust, association, governmental authority, contractor, or other legal entity whatsoever, whether acting in an individual, fiduciary, or other capacity.
- 1.113 Person Centered Service Plan — A personalized plan generated from the Enrollee’s DON, or other assessment tool adopted by the State, that meets the Enrollee’s specific HCBS Waiver needs.
- 1.114 Person-Centered Service Plan Care Coordinator – The individual who has primary responsibility for implementation and oversight of the Enrollee’s Person-Centered Service Plan.
- 1.115 Personal Assistant — An individual who provides Personal Care to a Participant when it has been determined by the care manager that the Participant has the ability to supervise the Personal Assistant.
- 1.116 Personal Care — Assistance with meals, dressing, movement, bathing or other personal needs or maintenance or general supervision and oversight of the physical and mental well-being of a Participant
- 1.117 Personal Emergency Response System (PERS) — An electronic device that enables a Participant who is at high risk of Institutionalization to secure help in an emergency.
- 1.118 Physical Therapy — A medically-prescribed service that is provided by a licensed physical therapist and identified in the Enrollee Care Plan that utilizes a variety of methods to enhance an Enrollee’s physical strength, agility and physical capacity for ADL.
- 1.119 Physician — An individual licensed to practice medicine in all its branches in Illinois under the Medical Practice Act of 1987 or any such similar statute of the state in which the individual practices medicine.

- 1.120 Post-Stabilization Services — Medically Necessary Non-Emergency Services furnished to an Enrollee after the Enrollee is Stabilized following an Emergency Medical Condition, in order to maintain such Stabilization, or, under the circumstances described in 42 C.F.R. § 438.114 to improve or resolve the Enrollee's condition.
- 1.121 Potential Enrollee — An individual who is eligible for Passive Enrollment in to the Demonstration, but is not yet an Enrollee of a Demonstration Plan. Potential Enrollee includes individuals within the Service Area who, pursuant to federal law, have the option to enroll with a Demonstration Plan, but are not eligible for Passive Enrollment.
- 1.122 Prevalent Languages — Spanish and other languages, as determined by the Department. Such a language exists 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 such households speak a language other than English, as determined by the Department according to published Census Bureau data).
- 1.123 Primary Care Provider (PCP) -- A Provider, including a Women's Health Care Provider (WHCP), who within the Provider's scope of practice and in accordance with State certification requirements or State licensure requirements, is responsible for providing all preventive and primary care services to his or her assigned Enrollees in the Demonstration Plan.
- 1.124 Prior Approval -- Review and written approval by the Department and CMS of any Contractor materials or actions, as set forth in the Contract, including but not limited to, subcontracts, intended courses of conduct, or procedures or protocols, that the Contractor must obtain before such materials are used or such actions are executed, implemented or followed.
- 1.125 Privacy — Requirements established in HIPAA, and implementing regulations, as well as relevant Illinois privacy laws.
- 1.126 Program of All-Inclusive Care for the Elderly (PACE) — A comprehensive service delivery and financing model that integrates medical and LTSS under dual Capitation agreements with Medicare and Medicaid. The PACE program is limited to individuals age 55 and over who meet the skilled-nursing-facility level of care criteria and reside in a PACE service area.
- 1.127 Prospective Enrollee — A Potential Enrollee who has begun the process of enrollment with the Contractor but whose coverage with the Contractor has not yet begun.
- 1.128 Protected Health Information (PHI) — Except as otherwise provided in HIPAA, which shall govern the definition of PHI, information created or received from or on behalf of a Covered Contractor as defined in 45 C.F.R. § 160.103, that relates to (i) the provision of health care to an individual; (ii) the past, present or future physical or mental health or condition of an individual; or (iii) the past, present or future payment for the provision of health care to an individual. PHI includes demographic information that identifies the individual or that there is a reasonable basis to believe can be used to identify the individual. PHI is the information transmitted or held in any form or medium.

- 1.129 Provider — A Person enrolled with CMS to provide Medicare Covered Services, or issued a provider identification number by the Department to provide Medicaid Covered Services, to an Enrollee. The Contractor is not a Provider.
- 1.130 Provider Type 36 – The State Provider registration category for community mental health centers (CMHC). Providers must be registered with the Medicaid Assistance Program as Provider Type 36 Mental Health Services Provider to be eligible for reimbursement of CMHC services.
- 1.131 Quality Assessment and Performance Improvement (QAPI) — The program required by 42 C.F.R. § 438.330, in which Demonstration Plans are required to have an ongoing quality assessment and performance improvement program for the services furnished to Enrollees, that: (i) assesses the quality of care and identifies potential areas for improvement, ideally based on solid data and focused on high volume/high risk procedures or other services that promise to substantially improve quality of care, using current practice guidelines and professional practice standards when comparing to the care provided; and (ii) corrects or improves processes of care and clinic operations in a way that is expected to improve overall quality.
- 1.132 Quality Assurance (QA) — A formal set of activities to review, monitor and improve the quality of services by a Provider or Demonstration Plan, including quality assessment, ongoing quality improvement and corrective actions to remedy any deficiencies identified in the quality of direct Enrollee, administrative and support services.
- 1.133 Quality Assurance Plan (QAP) — A written document developed by the Contractor in consultation with its QAP Committee and Medical Director that details the annual program goals and measurable objectives, utilization review activities, access and other performance measures that are to be monitored with ongoing Physician profiling and focus on quality improvement.
- 1.134 Quality Assurance Plan (QAP) Committee — A committee established by the Contractor, with the approval of CMS and the Department, that consists of a cross representation of all types of Providers, including PCPs, specialists, dentists and long term care representatives from the Contractor’s network and throughout the entire Service Area and that, at the request of CMS or the Department, shall include CMS and the Department staff in an advisory capacity.
- 1.135 Quality Assurance Program — The Contractor’s overarching mission, vision and values, which, through its goals, objectives and processes committed in writing in the QAP, are demonstrated through continuous improvement and monitoring of medical care, Enrollee safety, behavioral health services, and the delivery of services to Enrollees, including ongoing assessment of program standards to determine the quality and appropriateness of care, Care Management and coordination. It is implemented through the integration, coordination of services, and resource allocation throughout the organization, its partners, Providers, other entities delegated to provide services to Enrollees, and the extended community involved with Enrollees.
- 1.136 Quality Improvement Organization (QIO) — An organization designated by CMS as set forth in Section 1152 of the SSA and 42 C.F.R. § 476, that provides Quality Assurance, quality studies and inpatient

utilization review for the Department in the FFS program and Quality Assurance and quality studies for the Department in the HCBS setting.

- 1.137 Quality Improvement System for Managed Care (QISMC) – A quality assessment and improvement strategy to strengthen an Demonstration Plan’s efforts to protect and improve the health and satisfaction of Enrollees.
- 1.138 Readiness Review – The evaluation of each Contractor’s ability to comply with the Demonstration requirements, including but not limited to, the ability to quickly and accurately process claims and enrollment information, accept and transition new Enrollees, and provide adequate access to all Medicare and Medicaid-covered Medically Necessary Services. CMS and the Department use the results to inform its decision of whether the Contractor is ready to begin marketing and accepting enrollment under the Demonstration. At a minimum, each Readiness Review includes a desk review and potentially a site visit to the prospective Contractor’s headquarters.
- 1.139 Referral – An authorization provided by a PCP to enable an Enrollee to seek medical care from another Provider.
- 1.140 Rehabilitation – The process of restoration of skills to an individual who has had an illness or injury so as to regain maximum self-sufficiency and function in a normal or as near normal manner as possible in therapeutic, social, physical, behavioral and vocational areas.
- 1.141 Resident – An Enrollee who is living in a facility and whose facility services are eligible for Medicaid and Medicare payment.
- 1.142 Respite – Services that provide the needed level of care and supportive services to enable the Enrollee to remain in the community, or home-like environment, while periodically relieving a non-paid family member or other caregiver of care-giving responsibilities.
- 1.143 Rural Health Clinic (RHC) – A Provider that has been designated by the Public Health Service, DHHS, or the Governor of the State of Illinois, and approved by the Public Health Service, in accordance with the Rural Health Clinics Act (Public Law 95-210) as a RHC.
- 1.144 Serious Mental Illness – An emotional or behavioral functioning so impaired as to interfere with the individual’s capacity to remain in the community without supportive treatment.
- 1.145 Service Area – The specific geographical area of Illinois designated in the CMS HPMS, and as referenced in **Appendix I**, for which the Contractor agrees to provide Covered Services to all Enrollees who select or are passively enrolled with the Contractor.
- 1.146 Service Authorization Request – A request by an Enrollee or by a Provider on behalf of an Enrollee for the provision of a Covered Service.
- 1.147 Site – Any contracted Provider through which the Contractor arranges the provision of primary care to Enrollees.

- 1.148 Skilled Nursing — Nursing services provided within the scope of the Illinois Nurse Practice Act by registered nurses, licensed practical nurses, or vocational nurses licensed to practice in the State.
- 1.149 Skilled Nursing Facility (SNF) — A group care facility that provides Skilled Nursing care, continuous Skilled Nursing observations, restorative nursing and other services under professional direction with frequent medical supervision, during the post-acute phase of illness or during reoccurrences of symptoms in long-term illness.
- 1.150 SNFist — A Physician or APN licensed under the Illinois Nurse Practice Act who is part of an organized system of care, meaning a coordinated group working together, whose entire professional focus is the general medical care of individuals residing in a NF and whose activities include Enrollee care oversight, communication with families, significant others, PCPs, and NF administration.
- 1.151 Speech Therapy — A medically-prescribed speech or language-based service that is provided by a licensed speech therapist and identified in the Enrollee Care Plan, and that is used to evaluate or improve an Enrollee's ability to communicate.
- 1.152 Spend-down — The policy that allows an individual to qualify for the Medicaid Program by incurring medical expenses at least equal to the amount by which his or her income or assets exceed eligibility limits. It operates similarly to deductibles in private insurance in that the Spend-down amount represents medical expenses the individual is responsible to pay.
- 1.153 Stabilization or Stabilized — The term “to stabilize” means, with respect to an Emergency Medical Condition (1) to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, (2) with respect to an Emergency Medical Condition to deliver (including the placenta) that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to an Emergency Medical Condition), that the woman has delivered (including the placenta).
- 1.154 State — The State of Illinois, as represented through any State agency, department, board, or commission.
- 1.155 State Operated Hospital - State Operated Hospital (SOH) means a hospital operated, owned, and managed by the Department of Human Services, Division of Mental Health that serves adults with serious mental illness who require inpatient psychiatric treatment.
- 1.156 State Plan — The Illinois Medicaid State Plan filed with Federal CMS, in compliance with Title XIX of the SSA.
- 1.157 Supportive Living Facility (SLF) — A residential apartment-style (assisted living) setting in Illinois that is (i) certified by the Department to provide or coordinate flexible Personal Care services, twenty-four (24) hour supervision and assistance (scheduled and unscheduled), activities, and health related services with a service program and physical environment designed to minimize the need for Residents to move within or from the setting to accommodate changing needs and preferences; (ii) has an organizational mission,

service programs and physical environment designed to maximize Residents' dignity, autonomy, privacy and independence; (iii) encourages family and community involvement; and, (iv) administered by HFS under the Supportive Living Program HCBS Waiver.

- 1.158 Third Party — Any Person other than CMS, the Department, the Contractor, or any of the Contractor's Affiliates.
- 1.159 Urgent Care — Medical services required promptly to prevent impairment of health due to symptoms that do not constitute an Emergency Medical Condition, but that are the result of an unforeseen illness, injury, or condition for which medical services are immediately required. Urgent Care is appropriately provided in a clinic, Physician's office, or in a hospital emergency department if a clinic or Physician's office is inaccessible. Urgent Care does not include primary care services or services provided to treat an Emergency Medical Condition.
- 1.160 Utilization Management — A comprehensive approach and planned activities for evaluating the appropriateness, need and efficiency of services, procedures and facilities according to established criteria or guidelines under the provisions of the Demonstration. Utilization Management typically includes new activities or decisions based upon the analysis of care, and describes proactive procedures, including discharge planning, concurrent planning, pre-certification and clinical case appeals. It also covers proactive processes, such as concurrent clinical reviews and peer reviews, as well as Appeals introduced by the Provider, payer or Enrollee.
- 1.161 Wellness Programs — Comprehensive services designed to promote and maintain the good health (Wellness) of an Enrollee.
- 1.162 Williams Provider — The mental health Provider having a contract with the Mental Health Division of DHS to implement the consent decree entered in *Williams v. Quinn*, No. 05 C 4673 (N.D. Ill.) (Williams consent decree).
- 1.163 Women's Health Care Provider (WHCP) — A Physician or other health care Provider, who within the Provider's scope of practice and in accordance with State certification requirements or State licensure requirements, specializes by certification or training in obstetrics, gynecology or family practice.
- 1.164 Written Materials — Materials regarding choice of Demonstration Plan, selecting a PCP or WHCP, Enrollee Handbooks, Basic Information as set forth in Section 2.14, and any information or notices distributed by the Contractor or required to be distributed to Potential Enrollees, Prospective Enrollees or Enrollees by CMS and the Department or regulations promulgated from time to time under 42 C.F.R. §§ 438 and 422.111, 422.2260 et. seq., 423.120(b) and (c), 423.128, and 423.2260 et. seq.; and the Medicare Marketing Guidelines.

2 Section 2. Contractor Responsibilities

Through the Medicare-Medicaid Alignment Initiative (MMAI), CMS and the Department will work in partnership to offer Medicare-Medicaid Enrollees the option of enrolling in a Contractor's Demonstration Plan, which consists of a comprehensive network of health and social service Providers. The Contractor will deliver and coordinate all components of Medicare and Medicaid Covered Services for Enrollees.

2.1 Compliance and Program Integrity:

The Contractor must, to the satisfaction of CMS and the Department:

- 2.1.1 Comply with all provisions set forth in this Contract;
- 2.1.2 Maintain during the term of this Contract a valid Certificate of Authority as a Health Maintenance Organization under 215 ILCS 125/1-1, et seq. The Contractor shall provide proof of Certificate of Authority upon request.
- 2.1.3 Comply with all applicable provisions of federal and State laws, regulations, guidance, waivers, and Demonstration terms and conditions, including the implementation of a compliance plan. The Contractor must comply with the Medicare Advantage requirements in Part C of Title XVIII, and 42 C.F.R. Part 422 and Part 423, except to the extent that variances from these requirements are provided in the MOU signed by CMS and the Department for this initiative.
- 2.1.4 Comply with Other Laws. No obligation imposed herein on the Contractor shall relieve the Contractor of any other obligation imposed by law or regulation, including, but not limited to, 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), and regulations promulgated by the Illinois Department of Financial and Professional Regulation, the Illinois Department of Public Health or CMS. The Department and CMS shall report to the appropriate agency any information it receives that indicates a violation of a law or regulation. The Department or CMS will inform the Contractor of any such report unless the appropriate agency to which the Department or CMS has reported requests that the Department or CMS not inform the Contractor.
- 2.1.5 Comply with all aspects of the joint Readiness Review.
- 2.1.6 Comply with all applicable administrative bulletins issued by the Department, DHS and DoA.
- 2.1.7 Program Integrity. The Contractor shall adopt and implement an effective compliance program to prevent, detect and correct Fraud, Waste, and Abuse consistent with 42 C.F.R. Part 420, et seq, 42 C.F.R. § 422.503, and 42 C.F.R. §§ 438.600-610, 42 C.F.R. Part 455. The compliance program must, at a minimum, include written policies, procedures, and standards of conduct that:

- 2.1.7.1 Articulate the Contractor's commitment to comply with all applicable Federal and State standards, including but not limited to;
 - 2.1.7.1.1 Fraud detection and investigation;
 - 2.1.7.1.2 Procedures to guard against Fraud and Abuse;
 - 2.1.7.1.3 Prohibitions on certain relationships as required by 42 C.F.R. § 438.610;
 - 2.1.7.1.4 Obligation to suspend payments to Providers;
 - 2.1.7.1.5 Disclosure of ownership and control of Contractor;
 - 2.1.7.1.6 Disclosure of business transactions;
 - 2.1.7.1.7 Disclosure of information on persons convicted of health care crimes; and
 - 2.1.7.1.8 Reporting Adverse Benefit Determinations taken for Fraud, integrity, and quality;
- 2.1.7.2 Describe compliance expectations as embodied in the Contractor's standards of conduct;
- 2.1.7.3 Implement the operation of the compliance program;
- 2.1.7.4 Provide guidance to employees and others on dealing with potential compliance issues;
- 2.1.7.5 Identify how to communicate compliance issues to appropriate compliance personnel;
- 2.1.7.6 Provide False Claims Education for all employees and First Tier, Downstream, and Related Entities as required in 42 U.S.C § 1396(a)(68);
- 2.1.7.7 Describe how potential compliance issues are investigated and resolved by the Contractor; and
- 2.1.7.8 Include a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including but not limited to reporting potential issues, investigating issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials.
- 2.1.8 Accreditation Requirements. Pursuant to 305 ILCS 5/5-30 (a) and (h), any Demonstration Plan serving at least five thousand (5,000) seniors, or, people with disabilities, or, fifteen thousand (15,000) individuals in other populations covered by the Medical Assistance Program that have been receiving full-risk capitation for at least one (1) year are considered eligible for accreditation and shall be accredited by the NCQA within two (2) years after the date it was eligible for accreditation. Contractor's failure to achieve accreditation may result in the termination of the Contract.

2.2 Contract Management and Readiness Review Requirements

2.2.1 Contract Readiness Review Requirement

2.2.1.1 CMS and the Department or their designee, will conduct a Readiness Review of each Contractor, which must be completed successfully, as determined by CMS and the Department, prior to the Contract Operational Start Date.

2.2.1.2 CMS and the Department Readiness Review Responsibilities: CMS and the Department will conduct a Readiness Review of each Contractor that will include, at a minimum, one on-site review. This review shall be conducted prior to marketing to and enrollment of Potential Enrollees into the Contractor's Demonstration Plan. CMS and the Department will conduct the Readiness Review to verify the Contractor's assurances that the Contractor is ready and able to meet its obligations under the Contract.

2.2.1.2.1 The scope of the Readiness Review will include, but is not limited to, a review of the following elements:

2.2.1.2.1.1 Network Provider composition and access, in accordance with Section 2.7;

2.2.1.2.1.2 Staffing, including key management positions and functions directly impacting Enrollees (e.g., adequacy of Enrollee Services staffing), in accordance with Sections 2.2.3.3, 2.5, and 2.10;

2.2.1.2.1.3 Capabilities of First Tier, Downstream, and Related Entities, in accordance with Section 2.7.2.2 and Appendix C;

2.2.1.2.1.4 Care Coordination capabilities, in accordance with Section 2.5;

2.2.1.2.1.5 Enrollee services capabilities (materials, processes and infrastructure, e.g., call center capabilities), in accordance with Section 2.10;

2.2.1.2.1.6 Comprehensiveness of quality management/ quality improvement and Utilization Management strategies, in accordance with Section 2.13 and Appendix D;

2.2.1.2.1.7 Internal Grievance and Appeal policies and procedures, in accordance with Section 2.12;

- 2.2.1.2.1.8 Fraud and Abuse and program integrity, in accordance with Section 2.1.7;
- 2.2.1.2.1.9 Financial solvency, in accordance with Section 2.15.1; and
- 2.2.1.2.1.10 Information systems, including claims payment system performance, interfacing and reporting capabilities and validity testing of Encounter Data, in accordance with Section 2.16 and Section 2.17, including IT testing and security assurances.

2.2.1.2.2 No individual shall be enrolled into the Contractor’s Demonstration Plan unless and until CMS and the Department determine that the Contractor is ready and able to perform its obligations under the Contract as demonstrated during the Readiness Review.

2.2.1.2.3 CMS and the Department or their designee will identify to the Contractor all areas where the Contractor is not ready and able to meet its obligations under the Contract and provide an opportunity for the Contractor to correct such areas to remedy all deficiencies prior to the start of marketing.

2.2.1.2.4 CMS or the Department may, in its discretion, postpone the date the Contractor may start marketing or the Contract Operational Start Date if the Contractor fails to satisfy all Readiness Review requirements. If, for any reason, the Contractor does not fully satisfy to CMS or the Department that it is ready and able to perform its obligations under the Contract prior to the start of marketing or the Contract Operational Start Date, and CMS or the Department does not agree to postpone the Contract Operational Start Date, or extend the date for full compliance with the applicable Contract requirement, then CMS or the Department may terminate the Contract pursuant to Section 5.5 of this Contract.

2.2.1.3 Contractor Readiness Review Responsibilities

2.2.1.3.1 Demonstrate to CMS and the Department’s satisfaction that the Contractor is ready and able to meet all Contract requirements identified in the Readiness Review prior to the Contractor engaging in marketing of its Demonstration product, and prior to the Contract Operational Start Date.

2.2.1.3.2 Provide CMS and the Department with the corrected materials requested by the Readiness Review.

2.2.2 Contract Management

- 2.2.2.1 The Contractor must employ a qualified individual to serve as the Compliance Officer of its Demonstration Plan and this Contract. The Compliance Officer must be primarily dedicated to the Contractor's Demonstration Plan, hold a senior management position in the Contractor's organization, and be authorized and empowered to represent the Contractor in all matters pertaining to the Contractor's Demonstration Plan. The Compliance Officer must act as liaison between the Contractor, CMS, and the Department, and has responsibilities that include, but are not limited to, the following:
- 2.2.2.1.1 Ensure the Contractor's compliance with the terms of the Contract, including securing and coordinating resources necessary for such compliance;
 - 2.2.2.1.2 Implement all action plans, strategies, and timelines, including but not limited to those described in the Contractor's response to the Request for Proposal (RFP) and approved by CMS and the Department;
 - 2.2.2.1.3 Oversee all activities by the Contractor and its First Tier, Downstream and Related Entities, including but not limited to coordinating with the Contractor's quality management director, medical director, and behavioral health clinician;
 - 2.2.2.1.4 Ensure that Enrollees receive written notice of any significant change in the manner in which Covered Services are rendered to Enrollees at least thirty (30) days before the intended effective date of the change;
 - 2.2.2.1.5 Receive and respond to all inquiries and requests made by CMS and the Department in time frames and formats reasonably acceptable to the Parties;
 - 2.2.2.1.6 Meet with representatives of CMS or the Department, or both, on a periodic or as-needed basis and resolve issues that arise;
 - 2.2.2.1.7 Ensure the availability to CMS and the Department upon either's request, of those members of the Contractor's staff who have appropriate expertise in administration, operations, finance, management information systems, claims processing and payment, clinical service provision, quality management, Enrollee services, Utilization Management, Provider Network management, and Benefit Coordination;
 - 2.2.2.1.8 Coordinate requests and activities among the Contractor, all First Tier, Downstream, and Related Entities, CMS, and the Department;
 - 2.2.2.1.9 Make best efforts to promptly resolve any issues related to the Contract identified by the Contractor, CMS, or the Department; and
 - 2.2.2.1.10 Meet with CMS and the Department at the time and place requested by CMS and the Department, if CMS or the Department, or both, determine that the Contractor is not in compliance with the requirements of the Contract.

2.2.3 Organizational Structure

- 2.2.3.1 The Contractor shall establish and maintain the interdepartmental structures and processes to support the operation and management of its MMAI line of business in a manner that fosters integration of physical health, behavioral health, and LTSS service provisions. The provision of all services shall be based on prevailing clinical knowledge and the study of data on the efficacy of treatment, when such data is available.
- 2.2.3.2 On an annual, and an ad hoc basis, when changes occur, or as directed by the Department or CMS, the Contractor shall submit to the CMT an overall organizational chart that includes senior and mid-level managers for the organization.
- 2.2.3.3 For key management positions, including, but not limited to, the Contractor's chief executive officer, if applicable, chief medical officer/medical director, pharmacy director, quality management coordinator, utilization management coordinator, care coordination/Disease Management Program manager, community liaison, chief financial officer, chief operating officer, claims director, management information system (MIS) director, compliance officer of the Demonstration Plan, and key contact, the Contractor shall immediately, but no later than five (5) Business Days after such position becomes vacant notify the Department and notify Department when the position is filled and by whom.

2.3 Enrollment Activities

2.3.1 Enrollment Generally.

- 2.3.1.1 Illinois Client Enrollment Services. All enrollment and disenrollment-related transactions, including enrollment from one Demonstration Plan to a different Demonstration Plan, will be processed through the Illinois Client Enrollment Services (CES).
- 2.3.1.2 Initial Program Implementation. The Department, through the CES, will begin opt-in enrollment prior to the initiation of Passive Enrollment. During this opt-in period, Medicare-Medicaid Enrollees eligible for the Demonstration may choose to enroll into a particular Demonstration Plan. The first Effective Enrollment Date for this initial opt-in period is scheduled for no earlier than February 1, 2014. Eligible Medicare-Medicaid Beneficiaries who do not select a Demonstration Plan or who do not opt out of the Demonstration during the opt-in enrollment period will be assigned to a Demonstration Plan during Passive Enrollment.
- 2.3.1.3 Passive Enrollment Phase-In. The Department will conduct monthly Passive Enrollments to assign eligible Medicare-Medicaid Beneficiaries who do not select a Demonstration Plan and who do not opt out of the Demonstration, to a

Demonstration Plan. Individuals who opt out of the Demonstration will not be included in Passive Enrollment for the remainder of the Demonstration. Passive Enrollment to the Contractor will begin no sooner than May 1, 2014. This Passive Enrollment phase-in period will not exceed 5,000 Eligible Beneficiaries per month in the Greater Chicago Region and 3,000 Eligible Beneficiaries per month in the Central Illinois region, and will occur over at least a six (6) month period. CMS and the Department, upon agreement of both parties, may adjust the volume and spacing of Passive Enrollment periods, and will consider input from the Contractor in making any such adjustments.

- 2.3.1.4 Eligible Beneficiary Passive Enrollment Notice. The CES will provide notice of Passive Enrollments at least sixty (60) days prior to the effective dates to Eligible Beneficiaries, and will accept opt-out requests prior to the Effective Date of Enrollment. The CES will develop and apply an intelligent assignment algorithm, to the extent approved by CMS. CMS will provide Illinois with historical Medicare data for the development of the algorithm. The algorithm will consider Eligible Beneficiaries' previous managed care enrollment and historic Provider utilization, including Medicare Providers and service utilization, to assign Eligible Beneficiaries to a Demonstration Plan. CMS and the Department may stop Passive Enrollment to Contractor if the Contractor does not meet reporting requirements necessary to maintain Passive Enrollment as set forth by CMS and the Department.
- 2.3.1.5 Passive Enrollments and Disenrollments. Passive Enrollments and disenrollments will be processed through the CES. The Department or CES will submit Passive Enrollment transactions, sixty (60) days in advance of the Effective Date of Enrollment, to the CMS Medicare Advantage Prescription Drug (MARx) enrollment system directly or via a Third Party CMS designates to receive such transactions, and the Department and CES will receive notification on the next day. The Contractor will then receive Enrollment and disenrollment transactions from CMS', the Department's and CES' systems. The Contractor will also use the Third Party CMS designates to submit additional enrollment-related information to MARx, and receive files from CMS.
- 2.3.1.6 Effective Date of Enrollment. If an enrollment, which includes a transfer to a different Demonstration Plan, is entered by the CES and 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 CES enters an enrollment 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. The cut-off-date is the eighteenth (18th) of each month.

- 2.3.1.7 The Contractor will be responsible for providing Covered Services to Enrollees from the Effective Date of Enrollment in Contractor's health plan. Contractor shall not be responsible for medical expenses incurred prior to the effective date of such enrollment. However, the Contractor shall still provide coordination of care per Section 2.6.10 prior to the Effective Date of Enrollment.
- 2.3.1.8 The Contractor must have a mechanism for receiving timely information about all enrollments in the Contractor's Demonstration Plan, including the Effective Date of Enrollment, from CMS, the Department's and CES' systems.
- 2.3.1.9 The Contractor shall accept for enrollment all Medicare-Medicaid Beneficiaries, as described in Section 3.2 of the Contract, in the order in which they are referred by the Department, without restriction, except that the Contractor shall notify the Department of any third party liability in accordance with Section 5.1.12. The Contractor shall accept for enrollment all Medicare-Medicaid Beneficiaries identified by the Department at any time without regard to income status, physical or mental condition, age, gender, sexual orientation, religion, creed, race, color, physical or mental disability, national origin, ancestry, pre-existing conditions, expected health status, or need for health care services.
- 2.3.1.10 Enrollee Welcome Packet. The Contractor must provide enrollees who self-select into the demonstration the welcome packet for receipt no later than ten (10) calendar days from receipt of CMS confirmation of enrollment or by the last day of the month prior to the effective date, whichever occurs later. For Passive Enrollments, the Contractor shall provide the welcome packet for receipt no later than thirty (30) days prior to the effective date. The packet shall include all Basic Information as set forth in Section 2.14.4.1.
- 2.3.1.11 The number of Enrollees enrolled with Contractor will be limited to a level that will not exceed Contractor's physical and professional capacity, as reasonably determined by CMS and the Department in consultation with the Contractor.
- 2.3.1.12 The Department and CMS, through the CMT, will review documentation provided by Contractor that sets forth Contractor's physical and professional capacity: (i) before the first enrollment and as regularly provided subsequently; (ii) when Contractor requests a review and the Department agrees to such review; (iii) when there is a change in Covered Services, categories of Potential Enrollees, Service Area or Capitation that can reasonably be expected to impact Contractor's capacity; (iv) when there is a Change of Control, or a sale or transfer of Contractor; and, (v) when the Department determines that Contractor's operating or financial performance reasonably indicates a lack of Provider or administrative capacity. Such documentation must demonstrate that Contractor offers an appropriate range of preventive, primary care and specialty services that is adequate for the anticipated number of Enrollees in the Service Area and that Contractor maintains

a network of Affiliated Providers that is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of Enrollees in the Service Area. In the event the Department reasonably finds that Contractor has failed to restore Provider and administrative capacity, the CMT may freeze Passive Enrollment during the implementation phase or take other corrective actions.

2.3.1.13 Adjustments to the volume of Passive Enrollment based on the capacity of the Contractor will be subject to any capacity determinations including but not limited to those documented in the CMS and Department final readiness review report and ongoing monitoring by CMS and the Department.

2.3.1.14 Upon receipt of instruction by the Department, the CES may not process new enrollments within six (6) months (or less) before the end date of the Demonstration, unless the Demonstration is extended. CMS and the Department, upon agreement of both parties, may adjust the volume and spacing of Passive Enrollment periods, and will consider input from the Contractor in making any such adjustments.

2.3.1.15 The Contractor may, via the CMT, request a capacity limit pursuant to 42 C.F.R. § 422.60. For the purposes of this Demonstration, CMS and the Department will consider a number of factors, including financial stability and network adequacy, in the determination of a capacity limit.

2.3.2 Disenrollment

2.3.2.1 The Contractor shall have a mechanism for receiving timely information about all disenrollments from the Contractor's Demonstration Plan, including the effective date of disenrollment, from CMS and the Department's and CES' systems. Enrollees can elect to disenroll from the Demonstration Plan or the Demonstration at any time and enroll in another Medicare-Medicaid Demonstration Plan, a Medicare Advantage plan, PACE, or may elect to receive services through Medicare FFS and a prescription drug plan and to receive Medicaid services in accordance with the State Plan and any waiver programs. Disenrollments received by the CES or received by CMS, or the CMS contractor, by the last calendar day of the month will be effective on the first calendar day of the following month.

2.3.2.2 The Contractor shall cease providing Covered Services to an Enrollee upon the effective date of disenrollment.

2.3.2.3 The Contractor shall notify the Department of any individual who is no longer eligible to remain enrolled in the Demonstration Plan per CMS Medicare-Medicaid Plan Enrollment and Disenrollment Guidance, in order for the Department to disenroll the individual. This includes where an Enrollee remains out of the

Service Area or for whom residence in the Demonstration Plan Service Area cannot be confirmed for more than six (6) consecutive months.

- 2.3.2.4 The Department and CMS shall terminate an Enrollee's coverage upon any of the occurrences specified in the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance, including but not limited to the following:
 - 2.3.2.4.1 Upon the Enrollee's death. This disenrollment is effective the first day of the calendar month following the month of death. Termination may be retroactive to the month in which the Enrollee dies;
 - 2.3.2.4.2 When an Enrollee elects to change Demonstration Plans. The effective date of disenrollment is the first day of the month after the month in which the disenrollment request was received;
 - 2.3.2.4.3 When an Enrollee requests a new Medicare plan through 1-800-Medicare;
 - 2.3.2.4.4 When an Enrollee elects to receive his or her Medicare services through Medicare FFS and a separate Medicare prescription drug plan;
 - 2.3.2.4.5 When an Enrollee remains out of the Service Area, or for whom residence in the plan Service Area cannot be confirmed, for more than six consecutive months;
 - 2.3.2.4.6 When an Enrollee no longer resides in the Service Area. If an Enrollee is to be disenrolled at the request of the Contractor under the provisions of this Section, the Contractor must first provide documentation satisfactory to the Department that the Enrollee no longer resides in the Service Area. Termination of coverage shall take effect consistent with the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance;
 - 2.3.2.4.7 When the Department or CMS determines that an Enrollee has other significant insurance coverage or is placed in Spend-down status. The Department shall notify the Contractor of such disenrollment on the 834 Daily File. This notification shall include the effective date of termination; and
 - 2.3.2.4.8 When CMS or the Department is made aware that an Enrollee is incarcerated in any county jail, Illinois Department of Corrections facility, another state's correctional facility, or federal penal institution.
 - 2.3.2.4.9 The termination or expiration of this Contract terminates coverage for all Enrollees with the 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.

2.3.2.4.10 Contractor shall not interfere with the Enrollee's right to disenroll through threat, intimidation, pressure, or otherwise;

2.3.2.5 The 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, uncooperative or disruptive behavior resulting from such Enrollee's special needs (except to the extent such Enrollee's continued enrollment with the Contractor seriously impairs the Contractor's ability to furnish Covered Services to the Enrollee or other Enrollees as defined in Section 2.3.2.6.1 below), or 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 2.3.2 will be considered a breach of this Contract.

2.3.2.6 Discretionary Involuntary Disenrollment: 42 C.F.R. § 422.74 and Sections 40.3 and 40.4 of the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance provide instructions to the Contractor on discretionary involuntary disenrollment. This Contract and other guidance provide procedural and substantive requirements the Contractor, the Department, and CMS must follow prior to involuntarily disenrolling an Enrollee. If all of the procedural requirements are met, the Department and CMS will decide whether to approve or deny each request for involuntary disenrollment based on an assessment of whether the particular facts associated with each request satisfy the substantive evidentiary requirements. Bases for Discretionary Involuntary Disenrollment:

2.3.2.6.1 Disruptive conduct: When the Enrollee engages in conduct or behavior that seriously impairs the Contractor's ability to furnish Covered Items and Services to either this Enrollee or other Enrollees and provided the Contractor made and documented reasonable efforts to resolve the problems presented by the Enrollee.

2.3.2.6.1.1 Procedural requirements:

2.3.2.6.1.1.1 The Contractor's request must be in writing and include all of the supporting documentation outlined in the evidentiary requirements.

2.3.2.6.1.1.2 The process requires three (3) written notices. The Contractor must include in the request submitted to the Department and CMS evidence that the first two (2) notices have already been sent to the Enrollee. The notices are:

2.3.2.6.1.1.2.1 Advance notice to inform the Enrollee that the consequences of continued disruptive behavior will be disenrollment. The advance notice must include a clear and thorough explanation of the

disruptive conduct and its impact on the Contractor's ability to provide services, examples of the types of reasonable accommodations the Contractor has already offered the Grievance procedures, and an explanation of the availability of other accommodations. If the disruptive behavior ceases after the Enrollee receives notice and then later resumes, the Contractor must begin the process again. This includes sending another advance notice.

2.3.2.6.1.1.2.2 Notice of intent to request the Department and CMS' permission to disenroll the Enrollee; and

2.3.2.6.1.1.2.3 A planned action notice advising that CMS and the Department have approved the Contractor's request. This notice is not a procedural prerequisite for approval and should not be sent under any circumstances prior to the receipt of express written approval and a disenrollment transaction from CMS and the Department.

2.3.2.6.1.1.3 The Contractor must provide information about the Enrollee, including age, diagnosis, mental status, functional status, a description of his or her social support systems, and any other relevant information.

2.3.2.6.1.1.4 The submission must include statements from providers describing their experiences with the Enrollee (or refusal in writing, to provide such statements); and

2.3.2.6.1.1.5 Any information provided by the Enrollee. The Enrollee can provide any information he/she wishes.

2.3.2.6.1.1.6 If the Contractor is requesting the ability to decline future Enrollments for this individual, the Contractor must include this request explicitly in the submission.

2.3.2.6.1.1.7 Prior to approval, the complete request must be reviewed by the Department and CMS including representatives from the Center for Medicare and must include staff with appropriate clinical or medical expertise.

2.3.2.6.2 Evidentiary standards; At a minimum, the supporting documentation must demonstrate the following to the satisfaction of both the Department and CMS staff with appropriate clinical or medical expertise:

2.3.2.6.2.1.1 The Enrollee is presently engaging in a pattern of disruptive conduct that is seriously impairing the Contractor's ability to furnish Covered Items and Services to the Enrollee and/or other Enrollees.

2.3.2.6.2.1.2 The Contractor took reasonable efforts to address the disruptive conduct including at a minimum:

2.3.2.6.2.1.2.1 Documentation of no fewer than three (3) separate and distinct attempts to understand and address the Enrollee's underlying interests and needs reflected in his/her disruptive conduct and

provide reasonable accommodations as defined by the Americans with Disabilities Act including those for individuals with mental and/or cognitive conditions. An accommodation is reasonable if it is efficacious in providing equal access to services and proportional to costs. The Department and CMS will determine whether the reasonable accommodations offered are sufficient;

2.3.2.6.2.1.2.2 A documented provision of information to the individual of his or her right to use the Contractor's Grievance procedures; and

2.3.2.6.2.1.2.3 The Contractor provided the Enrollee with a reasonable opportunity to cease his/her disruptive conduct.

2.3.2.6.2.1.3 The Contractor must provide evidence that the Enrollee's behavior is not related to the use, or lack of use, of medical services.

2.3.2.6.2.1.4 The Contractor may also provide evidence of other extenuating circumstances that demonstrate the Enrollee's disruptive conduct.

2.3.2.6.2.2 Limitations: The Contractor shall not seek to terminate Enrollment because of any of the following:

2.3.2.6.2.2.1 The Enrollee's uncooperative or disruptive behavior resulting from such Enrollee's special needs unless treating Providers explicitly document their belief that there are no reasonable accommodations the Contractor could provide that would address the disruptive conduct.

2.3.2.6.2.2.2 The Enrollee exercises the option to make treatment decisions with which the Contractor or any health care professionals associated with the Contractor disagree, including the option of declining treatment and/or diagnostic testing.

2.3.2.6.2.2.3 An adverse change in an Enrollee's health status or because of the Enrollee's utilization of Covered Items and Services.

2.3.2.6.2.2.4 The Enrollee's mental capacity is, has, or may become diminished.

2.3.2.6.3 Fraud or abuse: When the Enrollee provides fraudulent information on an Enrollment form or the Enrollee willfully misuses or permits another person to misuse the Enrollee's ID card.

2.3.2.6.3.1 The Contractor may submit a request that an Enrollee be involuntarily disenrolled if an Enrollee knowingly provides, on the election form, fraudulent information that materially affects the individual's eligibility to enroll in the Contractor; or if the Enrollee intentionally permits others to use his or her Enrollment card to obtain services under the Contractor.

- 2.3.2.6.3.2 Prior to submission, the Contractor must have and provide to CMS/Department credible evidence substantiating the allegation that the Enrollee knowingly provided fraudulent information or intentionally permitted others to use his or her card.
 - 2.3.2.6.3.3 The Contractor must immediately notify the CMT so that the Enrollment broker and the HHS Office of the Inspector General may initiate an investigation of the alleged fraud and/or abuse.
 - 2.3.2.6.3.4 The Contractor must provide notice to the individual prior to submission of the request outlining the intent to request disenrollment with an explanation of the basis of the Contractor's decision and information on the Enrollee's access to Grievance procedures and a fair hearing.
- 2.3.2.6.4 Necessary consent or release: When the Enrollee knowingly fails to complete and submit any necessary consent or release allowing the Contractor and/or Providers to access necessary health care and service information for the purpose of compliance with the care delivery system requirements in Section 2.5 of this Contract.
- 2.3.2.6.4.1 The Contractor may request that an Enrollee be involuntarily disenrolled if the Enrollee knowingly fails to complete and submit any necessary consent or release allowing the Contractor and/or Providers to access necessary health care and service information for the purpose of compliance with the care delivery system requirements in Section 2.5 of this Contract.
 - 2.3.2.6.4.2 The Contractor must provide notice to the Beneficiary prior to submission of the request outlining the intent to request disenrollment with an explanation of the basis of the Contractor's decision and information on the Enrollee's access to Grievance procedures and a fair hearing.
- 2.3.2.7 The Contractor must transfer Enrollee record information promptly to the new Provider upon written request signed by the disenrolled Enrollee.
- 2.3.2.8 If the Enrollee transfers to another Demonstration Plan, with the Enrollee's written consent, and in accordance with applicable laws and regulations, the Contractor must promptly transfer current DON (or other assessment tool adopted by the Department) information to the new Demonstration Plan.

- 2.3.2.9 The Contractor must notify the Department if the Contractor becomes aware that an Enrollee has comprehensive insurance other than Medicare or Medicaid.

2.4 Covered Services

- 2.4.1 The Contractor must authorize, arrange, integrate, and coordinate the provision of all Covered Services for its Enrollees (See Covered Services in Appendix A). Covered Services must be available to all Enrollees twenty-four (24) hours a day, seven (7) days a week, as authorized by the Contractor. Covered Services will be managed and coordinated by the Contractor through the Interdisciplinary Care Team (ICT) (see Section 2.5.2.1). Covered Services shall be provided in the amount, duration and scope as set forth in 89 Ill. Adm. Code, Part 140 and 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 as to 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. The Contractor shall not refer Enrollees to publicly supported health care entities to receive Covered Services for which the Contractor receives payment from the Department, unless such entities are Affiliated Providers with the Contractor. Such publicly supported health care entities include, but are not limited to, Chicago Department of Public Health and its clinics, Cook County Bureau of Health Services, and Certified Local Health Departments.
- 2.4.2 The Contractor must provide the full range of Covered Services. If either Medicare or Medicaid provides more expansive services than the other program does for a particular condition, type of illness, or diagnosis, the Contractor must provide the most expansive set of services required by either program. The Contractor may not limit or deny services to Enrollees based on Medicare or Medicaid providing a more limited range of services than the other program.

2.5 Care Delivery Model

- 2.5.1 The Contractor shall abide by the care delivery model described within this Contract and is not required to submit a model of care to CMS or HFS unless otherwise requested.
- 2.5.2 Care Management. The Contractor shall offer Care Management services to all Enrollees to ensure effective linkages and coordination between the medical home and other Providers and services and to coordinate the full range of medical and social supports, as needed. All Enrollees will be assigned a Care Coordinator and will have access to an Interdisciplinary Care Team (ICT).
- 2.5.3 Provision of Care Management.
- 2.5.3.1 Requirements for an Interdisciplinary Care Team. Every Enrollee shall have access to and input in the development of an ICT led by a Care Coordinator. The ICT will be person-centered, built on the Enrollee's specific preferences and needs and with his or her input, delivering services with transparency, individualization, respect, linguistic and cultural competence, and dignity. ICT's will:

- 2.5.3.1.1 Be led by a Care Coordinator who is accountable for coordination of all benefits and services the Enrollee may need. Care Coordinators will have prescribed caseload limits that vary based on risk-level (see Section 2.6.2). Where the Care Coordinator is not also the Person-Centered Service Plan Coordinator, the Person-Centered Service Plan Coordinator will be incorporated into the ICT;
- 2.5.3.1.2 Support Providers in medical homes, assist in assuring integration of services and coordination of care across the spectrum of the healthcare system, and help provide Care Management for Enrollees;
- 2.5.3.1.3 Assure appropriate and efficient care transitions, including, but not limited to, discharge planning;
- 2.5.3.1.4 Assess the physical, social, and behavioral risks and needs of each Enrollee;
- 2.5.3.1.5 Provide medication management;
- 2.5.3.1.6 Provide Enrollee health education on complex clinical conditions and Wellness Programs;
- 2.5.3.1.7 Assure integration of primary, specialty, behavioral health, long-term support services (LTSS), and referrals to community-based resources, as appropriate;
- 2.5.3.1.8 Maintain frequent contact with the Enrollee through various methods, including face-to-face visits, email, and telephone, as appropriate to the Enrollee's needs and risk-level, or upon the Enrollee's request;
- 2.5.3.1.9 Assist in the development of a person-centered Care Plan within ninety (90) days after enrollment;
- 2.5.3.1.10 Assist in the implementation and monitoring of the Care Plan; and
- 2.5.3.1.11 Cooperate with, collaborate with, and allow access of its Enrollees to the Ombudsman.
- 2.5.3.2 Interdisciplinary Care Team Training: Members of the ICT must be trained on the following topics: person-centered planning processes, cultural and disability competencies, the Ombudsman program, compliance with the Americans with Disabilities Act (ADA), and independent living and recovery.
- 2.5.3.3 Care Coordinator Responsibilities: The Care Coordinator will lead the ICT and will be responsible for leading the provision of Care Management services, as determined by an Enrollee's needs and preferences.

2.5.3.4 Care Coordinator Qualifications:

2.5.3.4.1 Care Coordinators who serve Enrollees within the DoA 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 Appendix K. Care Coordinators for all other Enrollees must have the appropriate qualifications to address the needs of Enrollees.

2.5.3.5 Care Coordinator Training Requirements:

2.5.3.5.1 Care Coordinators who serve Enrollees within the DoA 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 Appendix K. Care Coordinators for all other Enrollees must have the appropriate training to address the needs of Enrollees

2.5.3.6 Care Coordination Assignment and Change Request.

2.5.3.6.1 The Contractor shall assign every Enrollee to a Care Coordinator with the appropriate experience and qualifications based on an Enrollee's assigned risk level and individual needs (e.g., communication, cognitive, or other barriers).

2.5.3.6.2 The Contractor must have a process to ensure that an Enrollee or caregiver is able to request a change in his or her Care Coordinator.

2.5.3.7 Care Coordinator Caseloads. The Contractor must include a sufficient number of Care Coordinators with the background and training to serve low, moderate, and high-risk Enrollees, based on an analysis of the population to be served in accordance with Section 2.6.2. Care Coordinators responsible for Enrollees with varying risk levels shall have their overall caseload weighted and a blended overall caseload limit set, taking into account the location of the Enrollee. The maximum weighted caseload for a Care Coordinator is 600 with low risk weighted as one (1), moderate risk weighted as four (4), and high risk weighted as eight (8). CMS and the Department may review existing caseloads at any time and require a change in methodology or an Enrollee's assignment to a caseload.

2.5.3.7.1 Caseload Standards. Caseloads of Care Coordinators shall not exceed the following standards on average during the calendar year:

2.5.3.7.1.1	High Risk Enrollees. Enrollees identified as needing intensive Care Management services – 1:75
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- 2.5.3.7.1.2 Moderate Risk Enrollees. Enrollees identified as needing supportive Care Management services – 1:150
- 2.5.3.7.1.3 Low-Risk Enrollees. Enrollees identified as needing prevention and Wellness Programs – 1:600
- 2.5.3.7.1.4 For Enrollees in the Persons with Brain Injury waiver or the Persons with HIV/ AIDS waiver, the caseloads shall not exceed 1:30.

2.5.3.7.2 Care Coordinator Contact Standards. Care Coordinators shall maintain contact with Enrollees as frequently as appropriate. Care Coordinators who provide Care Management to High Risk Enrollees, who are not receiving HCBS Waiver services, shall have contact with such Enrollees at least once every ninety (90) days unless less frequent contact is requested by the Enrollee Care Coordinators providing Care Management to Enrollees receiving HCBS Waiver services shall maintain contact as follows, but in no case less often than required by the HCBS Waiver, or other applicable Medicaid requirements, then in effect:

- 2.5.3.7.2.1 Persons who are Elderly Waiver: The Care Coordinator shall have a face-to-face contact with the Enrollee in the Enrollee's home not less often than once every ninety (90) days.
- 2.5.3.7.2.2 Persons with Brain Injury: The Care Coordinator shall have contact with the Enrollee in Enrollee's home not less often than one (1) time per month.
- 2.5.3.7.2.3 Persons with HIV/ AIDS: The Care Coordinator shall contact the Enrollee at least one time each month by telephone, and not fewer than one (1) face-to-face contact every other month. The Care Coordinator shall contact the Enrollee more frequently upon the Enrollee's request.
- 2.5.3.7.2.4 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.
- 2.5.3.7.2.5 Supportive Living Program: The Care Coordinator shall contact the Enrollee at least one (1) time per year.

2.5.3.8 Coordination Tools. The Contractor shall have in place the following technology to assist with Care Coordination and Provider/Enrollee Communication:

2.5.3.8.1 Enrollee Profile. The Contractor shall use technology and processes that effectively integrate data from the Contractor's sources to profile, measure and monitor Enrollee Profiles. Profiles will include demographics, eligibility data, claims data, pharmacy data, assessment results, authorizations and Care Coordinator assignments.

2.5.3.8.2 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 Enrollee Care Plans, maintain Enrollee Care Plans, and identify Enrollees' needs.

2.5.3.8.3 Predictive Modeling. The Contractor shall utilize claims and care coordination claims database (CCCD) data and have a predictive modeling and health risk stratification engine that the Contractor will use to proactively identify high-risk Enrollees, identify high risk conditions needing immediate care management, and monitor gaps in care.

2.5.4 Transition of Care.

2.5.4.1 Transition of Care Process. The Contractor will manage transition of care and continuity of care for new Enrollees, Enrollees moving from an institutional setting to a community living arrangement, and Enrollees moving from a hospital back to the Enrollee's home or NF. The Contractor's process for facilitating continuity of care will include:

2.5.4.1.1 Identification of Enrollees needing transition of care.

2.5.4.1.2 Communication with entities involved in Enrollees' transition.

2.5.4.1.3 Making accommodations so that all community supports, including housing, are in place prior to the Enrollee's move and that Providers are fully knowledgeable and prepared to support the Enrollee, including interface and coordination with and among social supports, clinical services and LTSS.

2.5.4.1.4 Environmental adaptations and equipment and technology the Enrollee needs for a successful care setting transition.

2.5.4.1.5 Stabilization and provision of uninterrupted access to Covered Services for the Enrollee.

2.5.4.1.6 Assessment of Enrollees' ongoing care needs.

2.5.4.1.7 Monitoring of continuity and quality of care, and services provided.

2.5.4.1.8 Medication reconciliation.

2.5.4.2 Transition of Care Plan. The Contractor shall, initially, and as revised, submit to the CMT, for the CMT's review and Prior Approval, a transition of care plan that shall include transition of care policies and procedures and a staffing model designed to achieve a seamless, efficient transition with minimal impact to an Enrollee's care.

2.5.4.3 Transition of Care Team. The Contractor shall have an interdisciplinary transition of care team to design and implement the transition of care plan and provide oversight and management of all transition of care processes. The transition of care team may be part of the ICT. The transition of care team will consist of skilled personnel with extensive knowledge and experience transitioning Enrollees with special health care needs.

2.5.4.4 Transition of Enrollees. The Contractor will identify new Enrollees who require transition services by using a variety of sources, including, but not limited to:

2.5.4.4.1 Use of predictive modeling;

2.5.4.4.2 Review of Enrollee Information from current Providers;

2.5.4.4.3 Identification of an Enrollee's current placement as a guide for addressing needs; and

2.5.4.4.4 Health Risk Screenings for Enrollees.

2.5.4.5 Outreach. The Contractor's ICT will interact with Enrollees needing transition of care in order to assess the Enrollees' service needs, identify Enrollees' current Providers, and identify gaps in care. The ICT shall coordinate the provision of Medically Necessary Covered Services.

2.5.4.6 Money Follows the Person. Contractor shall use the MFP web referral form for Enrollees residing in NFs who are interested in returning to a community based setting. The web referral form is available at <https://mfp.hfs.illinois.gov/mfpreferral.aspx>. This provision will no longer apply in the event that this grant project ends during the duration of this contract.

2.5.4.6.1 Contractor shall follow MFP program processes, procedures, and coordination requirements provided by the Department.

2.5.4.6.1.1 Contractor shall coordinate with the Department, DOA, and DHS and their community based provider

agencies and contractors working to transition individuals through the MFP program, including but not limited to Care Coordination Units, Center's for Independent Living, Aging and Disability Resource Centers, Community Mental Health Centers, and the University of Illinois at Chicago College of Nursing.

2.5.4.6.2 Contractor shall provide an incentive payment to MFP community based providers under contract with DOA and DHS when they transition a Demonstration Plan Enrollee through the MFP program that remains in the community at the specified intervals as follows:

- 2.5.4.6.2.1 Contractor shall provide a thousand dollar (\$1,000) incentive payment to the MFP Provider that is the lead transition coordinator on the case for each Enrollee who transitions to the community and remains in the community for ninety (90) consecutive days;
- 2.5.4.6.2.2 Contractor shall provide a thousand dollar (\$1,000) incentive payment to the MFP provider that is the lead transition coordinator on the case for each Enrollee who transitions to the community and remains in the community for three hundred and sixty five (365) consecutive days;
- 2.5.4.6.2.3 If an Enrollee changes the Enrollee's Demonstration Plan during either of the periods set for in Section 2.5.3.6.2.1 or Section 2.5.3.6.2.2, the Demonstration Plan in which the Enrollee is enrolled with at the conclusion of either such period is responsible for making the incentive payment to the MFP provider;
- 2.5.4.6.2.4 A provider may be paid both bonuses detailed above if the requirements are met; and
- 2.5.4.6.2.5 Incentive payments in this section are paid for active enrollees in a Medicaid managed care plan. No incentive payment will be made for disenrolled members including those whose enrollment ended due to death prior to the requisite 90 and 365 day periods, respectively. If an MFP person is re-institutionalized for rehabilitation stays for periods of less than 30 days will not be disenrolled from the MFP program.

2.5.4.6.3 Contractor shall continue to meet all other responsibilities outlined in this Contract for their Enrollees when the MFP period ends after three hundred and sixty five (365) consecutive days in the community.

- 2.5.5 Pre-existing Conditions. Upon the Effective Date of Enrollment, the 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 the Contractor. The 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. The Contractor shall evaluate the appropriateness of integrated Care Management and education for each Enrollee who it determines to have a pre-existing condition.
- 2.5.6 Hospitalist Program. If the Contractor proposed to use a Hospitalist program in its response to the Request for Proposal number 2013-24-003 or number 2013-24-004, then the Contractor shall operate a Hospitalist program as it proposed and as incorporated as a part of this Contract pursuant to Section 5.6.1.5.
- 2.5.7 SNFist Program. The Contractor shall provide SNFist services, either through direct employment or a sub-contractual relationship. The SNFist program shall provide intensive clinical management of Enrollees in NFs. The Contractor shall implement one of the following for each Enrollee in a NF:
- 2.5.7.1 When appropriate or necessary, the ICT will include an additional facility-based Provider (Physician or nurse practitioner) who will deliver care in identified NFs.
- 2.5.7.2 For all other Enrollees, Care Management through the SNFist program shall be performed by either telephonic or field-based Registered Nurses or licensed clinical social workers who will work within each assigned NF to provide Care Management and care coordination activities.
- 2.5.8 Health Promotion and Wellness Activities
- 2.5.8.1 Enrollee Health Education. The Contractor will offer an expansive set of health education programs, including such programs through Care Coordinators that use comprehensive outreach and communication methods to effectively educate Enrollees, and their families and other caregivers, about health and self-care and how to access plan benefits and supports.
- 2.5.8.2 Collaborative Education Development and Oversight. The Contractor's Medical Management Department and Medical Director shall be responsible for development, maintenance and oversight of Enrollee health education programs.

- 2.5.8.3 Health Education Outreach. The Contractor will identify regional community health education opportunities, improve outreach and communication with Enrollees and community-based organization members, and actively promote healthy lifestyles such as disease prevention and health promotion.
- 2.5.8.4 Flu Prevention Program. The 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.
- 2.5.8.5 Education through Care Coordinators. The 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 preventative care, to help resolve those barriers, if any, and to educate Enrollees on the appropriate use of emergency room services and the Enrollees' medical homes.

2.6 Comprehensive Assessments and Individualized Care Plan

- 2.6.1 Identifying Need for Care Management. The 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, but not be limited to, the following:
 - 2.6.1.1 Health Risk Screening. The Contractor shall have a health risk screening, and make its best efforts to administer the health risk screening and, if needed, a behavioral health risk assessment to all new Enrollees within sixty (60) days after enrollment, and will collect information about the Enrollee's medical, psychosocial, functional, and cognitive needs, and medical and behavioral health (including substance abuse) history. The 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. The Contractor shall notify PCPs of enrollment of any new Enrollee who has not completed a health risk screening within the time period set forth above and whom the Contractor has been unable to contact. The Contractor shall encourage PCPs to conduct outreach to their Enrollees and to schedule visits.
 - 2.6.1.2 Predictive Modeling (upon availability of Enrollee claims data). The Contractor shall have a predictive modeling and health risk stratification engine that the Contractor will use to proactively identify high-risk Enrollees and monitor gaps in care.
 - 2.6.1.3 Surveillance Data. The Contractor shall identify Enrollees through Referrals, transition information, service authorizations, alerts, memos, results of the DON

(or other assessment tool adopted by the Department), and from families, caregivers, Providers, community organizations and Contractor personnel.

- 2.6.2 Stratification. Based upon an analysis of the information gathered through the process in Section 2.6.1, the Contractor shall stratify all Enrollees identified for its Care Management program to determine the appropriate level of intervention. Enrollees shall be assigned to one (1) of three (3) levels:
- 2.6.2.1 Low or no risk – The Contractor provides prevention and Wellness messaging and condition-specific education materials.
 - 2.6.2.2 Moderate risk – The Contractor provides problem-solving interventions. Contractor shall assign no less than twenty percent (20%) of its Enrollees to moderate risk and high risk levels combined.
 - 2.6.2.3 High risk – The Contractor provides intensive Care Management for reasons such as ameliorating past ineffective health care or addressing lack of social support. The Contractor shall assign no less than five percent (5%) of its Enrollees to this level.
- 2.6.3 Health Risk Assessment. The Contractor shall have a risk assessment and make its best efforts to complete a health risk assessment, by following the procedures outlined in this section, within ninety (90) days after the Effective Enrollment Date for Enrollees stratified as high or moderate risk, except as follows:
- 2.6.3.1 For those Enrollees receiving HCBS Waiver services or residing in a NF as of the Effective Enrollment Date, the health risk assessment must be face-to-face and completed within one hundred eighty (180) days of the Effective Enrollment Date.
 - 2.6.3.2 For those Enrollees switching from another Medicaid MCO to the Contractor's Demonstration Plan who are receiving HCBS services or residing in NFs as of their Effective Enrollment Date, the health risk assessment must be face-to-face and completed within ninety (90) days after the Effective Enrollment Date.
 - 2.6.3.3 For those Enrollees transitioning to NFs as of the Effective Enrollment Date, the health risk assessment must be face-to-face and completed within ninety (90) days after the Effective Enrollment Date.
 - 2.6.3.4 For those Enrollees deemed newly eligible for HCBS services, the health risk assessment must be face-to-face and completed within fifteen (15) days after the Demonstration Plan is notified that the Enrollee is determined eligible for HCBS services.

- 2.6.3.5 An Enrollee may choose to decline a health risk assessment. Should that occur, the Contractor will not continue to contact the Enrollee for a health risk assessment unless a reassessment is needed as provided in 2.6.5.
 - 2.6.3.5.1 To comply with Sections 2.6.3, 2.6.4, 2.6.5, and 2.6.6 of this Contract, the Contractor must document its attempts to reach Enrollees and the modes of communication attempted.
 - 2.6.3.5.2 The Contractor shall attempt to reach the Enrollee at least five (5) times within the first sixty (60) days after the Effective Enrollment Date. Attempts must be on different days of the week and at different times during the day, including times outside of standard work hours.
 - 2.6.3.5.3 The Contractor shall use community resources where possible to identify and engage Enrollees.
- 2.6.4 Individualized Enrollee Care Plans/ Person-Centered Service Plans. Following stratification under Section 2.6.2, the Contractor shall assign an ICT, with a Care Coordinator, to the Enrollee; and, the ICT, in conjunction with the Enrollee, will develop a comprehensive person-centered Enrollee Care Plan for all Enrollees. The Enrollee Care Plan must be developed within ninety (90) days after the Effective Enrollment Date, except in the following instances:
 - 2.6.4.1 For Enrollees new to the Demonstration Plan receiving HCBS Waiver services or residing in NFs as of the Effective Enrollment Date, the Enrollee Care Plan must be developed within one hundred eighty (180) days after the Effective Enrollment Date. For those Enrollees, any existing Enrollee Care Plan will remain in effect for a transition period spanning at least one hundred eighty (180) days, unless that period is changed with the input and consent of the Enrollee after completion of a health risk assessment.
 - 2.6.4.2 For Enrollees switching from another MCO to the Contractor's Demonstration Plan who are receiving HCBS Waiver services or residing in NFs as of their Effective Enrollment Date, the Enrollee Care Plan must be developed within ninety (90) days after the Effective Enrollment Date. For those Enrollees, any existing Enrollee Care Plan will remain in effect for a transition period spanning at least ninety (90) days, unless that period is changed with the input and consent of the Enrollee after completion of a health risk assessment.
 - 2.6.4.3 For Enrollees transitioning to NFs, the Enrollee Care Plan must be developed within ninety (90) days after the Effective Enrollment Date. For those Enrollees, any existing Enrollee Care Plan will remain in effect for a transition period spanning at least ninety (90) days, unless that period is changed with the input and consent of the Enrollee after completion of a health risk assessment.

- 2.6.4.4 For Enrollees deemed newly eligible for HCBS Waiver services, the Enrollee Care Plan must be developed within fifteen (15) days after the Demonstration Plan is notified that the Enrollee is determined eligible for HCBS Waiver services.
- 2.6.4.5 Every Enrollee must have an Enrollee Care Plan, unless the Enrollee refuses and such refusal is documented. The Enrollee Care Plan must:
 - 2.6.4.5.1 Incorporate an Enrollee's medical, behavioral health, LTSS, social, and functional needs (including those functional needs identified on the DON or other assessment tool that is adopted by the Department for HCBS Waiver Enrollees);
 - 2.6.4.5.2 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;
 - 2.6.4.5.3 Include, in the development, implementation, and ongoing assessment of the Enrollee Care Plan, an opportunity for Enrollee participation and an opportunity for input from the PCP, other Providers, a legal representative, and the Enrollee's family and caregiver if appropriate;
 - 2.6.4.5.4 Identify and evaluate risks associated with the Enrollee's care. Factors considered include, but are not limited to, 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. The Contractor shall incorporate the results of the risk assessment into the Enrollee Care Plan. Enrollee Care Plans that include Negotiated Risks shall be submitted to the Contractor's medical director for review. Negotiated Risks shall not allow or create a risk for other Residents in a group setting; and
 - 2.6.4.5.5 Include, as appropriate, the following elements:
 - 2.6.4.5.5.1 The Enrollee's personal or cultural preferences, such as types or amounts of services;
 - 2.6.4.5.5.2 The Enrollee's preference of Providers and any preferred characteristics, such as gender or language;
 - 2.6.4.5.5.3 The Enrollee's living arrangements;
 - 2.6.4.5.5.4 Covered Services and non-Covered Services to address each identified need, provided that the Contractor shall not be required to pay for non-Covered Services;

- 2.6.4.5.5.5 Actions and interventions necessary to achieve the Enrollee's objectives;
 - 2.6.4.5.5.6 Follow-up and evaluation;
 - 2.6.4.5.5.7 Collaborative approaches to be used;
 - 2.6.4.5.5.8 Desired outcome and goals, both clinical and non-clinical;
 - 2.6.4.5.5.9 Barriers or obstacles;
 - 2.6.4.5.5.10 Responsible parties;
 - 2.6.4.5.5.11 Standing Referrals;
 - 2.6.4.5.5.12 Community resources;
 - 2.6.4.5.5.13 Informal supports;
 - 2.6.4.5.5.14 Timeframes for completing actions;
 - 2.6.4.5.5.15 Status of the Enrollee's goals;
 - 2.6.4.5.5.16 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;
 - 2.6.4.5.5.17 Back-up plan arrangements for critical services;
 - 2.6.4.5.5.18 Crisis plans for an Enrollee with behavioral health condition(s); and,
 - 2.6.4.5.5.19 Wellness Program plans.
- 2.6.4.5.6 Include a HCBS Waiver service plan (Person-Centered Service Plan) for Enrollees receiving HCBS Waiver services. The Contractor shall develop the Person-Centered Service Plan as follows:
- 2.6.4.5.6.1 For an Enrollee who is not receiving HCBS Waiver services, the Contractor shall ensure that the Person-Centered Service Plan is developed within fifteen (15) days after the Contractor is notified that the Enrollee is determined eligible for HCBS Waiver services. The

Contractor is responsible for actual HCBS Waiver service planning, including the development, implementation, and monitoring of the Person-Centered Service Plan, and updating the Person-Centered Service Plan when an Enrollee's needs change. The Person-Centered Service Plan Care Coordinator will lead HCBS Waiver service planning through coordination with the Enrollee and the ICT.

2.6.4.5.6.2

For an Enrollee who is receiving HCBS Waiver services at the time of this assignment, the Contractor will use the Enrollee's existing Person-Centered Service Plan, and that Person-Centered Service Plan will remain in effect for at least a one hundred eighty (180)-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 in the Enrollee's home. The Person-Centered Service Plan will be transmitted to the Contractor prior to the effective date of enrollment. The Person-Centered 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.

2.6.4.5.6.3

In addition to Section 2.6.4.5.6.2, for an Enrollee who is receiving HCBS Waiver services and was enrolled in another MCO, but is enrolling in and transitioning to the Contractor's Demonstration Plan the Enrollee's existing Person-Centered Service Plan will remain in effect for at least ninety (90) days unless changed with the input and consent of the Enrollee. For such Enrollees transitioning from the Contractor to a new Demonstration Plan, the Contractor shall provide the Person Centered Service Plan to the new Demonstration Plan within fifteen (15) days.

2.6.4.5.6.4

For an Enrollee who is receiving HCBS Waiver services through the Contractor and ceases to be eligible for Contractor services, but continues to be eligible for HCBS Waiver or equivalent home care services, the Contractor will deliver the Enrollee's existing Person-Centered Service Plan to the applicable State agency

within fifteen (15) days after new coverage information is reflected in MEDI.

- 2.6.5 Enrollee Care Plan Reassessment. The 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 Care Plans and interventions updated. The Contractor will review Enrollee Care Plans and intervention of Enrollees at high-risk at least every thirty (30) days, and Enrollees at moderate-risk at least every ninety (90) days, and conduct reassessments as necessary based upon such reviews. At a minimum, the Contractor shall conduct a reassessment annually for each Enrollee. In addition, the 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.
- 2.6.6 Enrollee Engagement and Education. The 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. The Contractor shall solicit input from Enrollees and other stakeholders to help develop strategies to increase motivation for enhanced independent and healthy living.
- 2.6.7 Self-directed Care. The Contractor will support the Enrollee in actively participating in the development of the Enrollee Care Plan. The Contractor will also encourage Providers to support Enrollees in directing their own care and Enrollee Care Plan development. This will include giving PCPs a copy of the Enrollee Care Plan.
- 2.6.8 Williams Service Plans. The 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. The Contractor is responsible for payment of services under such plan only to the extent the services are Covered Services. The Department, or its designee, will provide the Contractor with a timely copy of any such plan. To the extent that Covered Services in such plan would not have been paid by the Contractor due to the Contractor's utilization controls, the Contractor is not obligated to pay until the Contractor has received a copy of the plan.
- 2.6.9 Colbert Service Plans. The Contractor shall implement any service plan developed by the Department's contractors for an Enrollee who is a class member under the Colbert consent decree unless the Enrollee and the Enrollee's Colbert Contractor consent to a modification of such plan. The Contractor is responsible for payment of services under such plan only to the extent the services are Covered Services. The Department, or its designee, will provide the Contractor with a timely copy of any such plan. To the extent that Covered Services in such plan would not have been paid by the Contractor due to the Contractor's utilization controls, the Contractor is not obligated to pay until the Contractor has received a copy of the plan.

- 2.6.10 Continuity of Care. The Contractor must develop policies and procedures to ensure continuity of care for all Enrollees upon initial enrollment, as follows:
- 2.6.10.1 The Contractor must offer an initial one hundred eighty (180)-day transition period for Enrollees new to the Demonstration in which Enrollees may maintain a current course of treatment with a Provider who is currently out of the Contractor's network. The Contractor must offer a ninety (90)-day transition period for Enrollees switching from another MCO to the Contractor. The one hundred eighty (180)-day and ninety (90)-day transition periods are applicable to all Providers, including behavioral health Providers and Providers of LTSS. Out-of-network PCPs 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 they remain outside the network or until a qualified Affiliated Provider is available.
- 2.6.10.2 The Contractor may choose to transition Enrollees to a network PCP during the transition period only if:
- 2.6.10.2.1 The Enrollee is assigned to a medical home that is capable of serving the Enrollee's needs appropriately;
- 2.6.10.2.2 A health screening and a comprehensive assessment, if necessary, is complete;
- 2.6.10.2.3 The Contractor consulted with the new medical home and determined that the medical home is accessible, competent, and can appropriately meet the Enrollee's needs;
- 2.6.10.2.4 A transition of care plan is in place (to be updated and agreed to with the new PCP, as necessary); and
- 2.6.10.2.5 The Enrollee agrees to the transition prior to the expiration of the transition period.
- 2.6.10.3 The Contractor may choose to transition Enrollees to a network specialist or LTSS Provider during the transition period only if:
- 2.6.10.3.1 A health screening and a comprehensive assessment, if necessary, is complete;
- 2.6.10.3.2 A transition of care plan is in place (to be updated and agreed to with the new Provider, as necessary); and
- 2.6.10.3.3 The Enrollee agrees to the transition prior to the expiration of the transition period.

- 2.6.10.4 Except as provided in Appendix A, all prior approvals for non-Part D drugs, therapies, or other services existing in Medicare or Medicaid at the time of enrollment will be honored for one hundred eighty (180) days after enrollment and will not be terminated at the end of one hundred eighty (180) days without advance notice to the Enrollee and transition to other services, if needed.2.6.10.5 Out of Network Reimbursement Rules.
- 2.6.10.5 Out-of-Network Payment Rules
- 2.6.10.5.1 For reimbursement of emergent or Urgent Care, as defined by 42 C.F.R. § 424.101 and 42 C.F.R. § 405.400 respectively, the Health Care Professional is required to accept as payment in full by the Contractor the amounts that the Health Care Professional could collect for that service if the beneficiary were enrolled in original Medicare or Medicaid FFS. However, the Contractor is not required to reimburse the Health Care Professional more than the Health Care Professional's charge for that service. The original Medicare reimbursement amounts for providers of services (as defined by section 1861(u) of the Act) do not include payments under 42 C.F.R. §§ 412.105(g) and 413.76. A section 1861(u) provider of services may be paid an amount that is less than the amount it could receive if the beneficiary were enrolled in original Medicare or Medicaid FFS if the provider expressly notifies the Contractor in writing that it is billing an amount less than such amount. Enrollees maintain balance billing protections.
- 2.6.10.5.2 Contractors may authorize other out-of-network services to promote access to and continuity of care. For services that are part of the traditional Medicare benefit package, prevailing Medicare Advantage policy will apply, under which Contractors shall pay non-contracted Providers at least the lesser of the provider's charges or the amount that the providers could collect for that service if the beneficiary were enrolled in original Medicare,(less any payments under 42 C.F.R. §§ 412.105(g) and 413.76 for section 1861(u) providers), regardless of the setting and type of care for authorized out-of-network services.
- 2.6.10.6 If an Enrollee is receiving any service that would not otherwise be covered by the Contractor after the continuity of care period, the Contractor must notify the Enrollee prior to the end of the continuity of care period, according to the requirements at 42 C.F.R. § 438.404 and 42 C.F.R. § 422.568. The Enrollee shall be entitled to all Appeal rights, including aid pending Appeal, if applicable, as outlined in Section 2.12 of this Contract.
- 2.6.10.7 The Contractor must provide an appropriate transition process for Enrollees who are prescribed Part D drugs that are not on its formulary (including drugs that are on the Contractor's formulary but require prior authorization or step therapy

under the Contractor's utilization management rules). This transition process must be consistent with the requirements at 42 C.F.R. § 423.120(b)(3).

- 2.6.10.8 Contractor shall provide for the transition of services in accordance with Section 25 of the Managed Care and Patients Rights Act (215 ILCS 134/25).
- 2.6.10.9 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.
- 2.6.10.10 Continuity of Care for NF residents. When a resident in a NF first transitions to the Contractor from the fee-for-service system or from another plan, the Contractor shall honor the existing Enrollee Care Plan and any necessary changes to that Enrollee Care Plan until it has completed a comprehensive assessment and new Enrollee Care Plan, to the extent such services are covered benefits under the Contract, which shall be consistent with the requirements of the Resident Assessment Instrument (RAI) Manual.
 - 2.6.10.10.1 When an Enrollee is moving from a community setting to a NF, and the Contractor is properly notified of the proposed admission by a network NF, and the Contractor fails to participate in developing an Enrollee Care Plan within the time frames required by NF regulations and this Contract, the Contractor must honor an Enrollee Care Plan developed by the NF until the Contractor has completed a comprehensive assessment and a new Enrollee Care Plan to the extent such services are covered benefits under the contract, consistent with the requirements of the RAI Manual.
 - 2.6.10.10.2 A NF shall have the ability to refuse admission of an Enrollee for whom care is required that the NF determines is outside the scope of its license and healthcare capabilities.

2.7 Provider Network

2.7.1 General.

- 2.7.1.1 The Contractor must demonstrate annually that it has an adequate network, as approved by CMS and the Department, to ensure adequate access to medical, behavioral health, pharmacy, community-based services, and long-term services and supports Providers that are appropriate for and proficient in addressing the

needs of the enrolled population, including physical, communication, and geographic access. The Contractor must maintain a Provider Network sufficient to provide all Enrollees with access to the full range of Covered Services, including behavioral health services, other specialty services, and all other services required in 42 C.F.R. §§422.112, 423.120, and 438.206 and under this Contract (see Covered Services in Appendix A). The Contractor must notify the CMT of any significant Provider Network changes immediately, but no later than five (5) days after becoming aware or should become aware of an issue, including a change in the Contractor's network of Affiliated Providers that renders the Contractor unable to provide one (1) or more Covered Services within the access to care standards set forth in Section 2.8.2, with the goal of providing notice to the CMT at least sixty (60) days prior to the effective date of any such change.

- 2.7.1.2 The Contractor must comply with the requirements specified in 42 C.F.R. §§ 422.504, 423.505, 438.214, which include selection and retention of Providers, credentialing and re-credentialing requirements, and nondiscrimination against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment.
- 2.7.1.3 The Contractor may not employ or contract with Providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act, and implementing regulations at 42 C.F.R. Part 1001 et seq. Federal financial participation (FFP) is not available for any amounts paid to the Contractor if the Contractor could be excluded from participation in Medicare or Medicaid under section 1128(b)(8)(B) of the Social Security Act or for any of the reasons listed in 42 C.F.R. § 431.55(h).
- 2.7.1.4 The Contractor shall establish, maintain and monitor a network that is sufficient to provide adequate access to all Covered Services under the Contract including the appropriate range of preventive, primary care and specialty service, taking into consideration:
 - 2.7.1.4.1 The anticipated number of Enrollees;
 - 2.7.1.4.2 The expected utilization of services, in light of the characteristics and health care needs of the Contractor's Enrollees;
 - 2.7.1.4.3 The number and types of Providers required to furnish the Covered Services;
 - 2.7.1.4.4 The number of Affiliated Providers who are not accepting new patients; and
 - 2.7.1.4.5 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.

- 2.7.1.5 The Contractor must make reasonable efforts to contact out-of-network Providers, including Providers and prescribers that are providing services to Enrollees during the initial continuity of care period, and provide them with information on becoming Affiliated Providers.
- 2.7.1.6 The Contractor shall ensure that its Network Providers are responsive to the linguistic, cultural, ethnic, racial, religious, age, gender and other unique needs of any minority, homeless person, disabled individuals, or other special population served by the Contractor, including the capacity to communicate with Enrollees in languages other than English, when necessary, as well as those who are deaf, hard-of-hearing or blind.
- 2.7.1.7 The Contractor shall educate Providers through a variety of means including, but not limited to, Provider Alerts or similar written issuances, about their legal obligations under State and Federal law to communicate with individuals with limited English proficiency, including the provision of interpreter services, and the resources available to help Providers comply with those obligations. All such written communications shall be subject to review at the Department's and CMS' discretion.
- 2.7.1.8 The Contractor shall ensure that multilingual Network Providers and, to the extent that such capacity exists within the Contractor's Service Area, all Network Providers, understand and comply with their obligations under State or Federal law to assist Enrollees with skilled medical interpreters and the resources that are available to assist Network Providers to meet these obligations.
- 2.7.1.9 The Contractor shall ensure that Network Providers and interpreters or translators are available for those who are deaf or hearing-impaired within the Contractor's Service Area.
- 2.7.1.10 The Contractor shall not include in its Provider Contracts any provision that directly or indirectly prohibits, through incentives or other means, limits or discourages Network Providers from participating as Network or non-network Providers in any Provider network other than the Contractor's Provider Network.
- 2.7.1.11 The Contractor shall not establish selection policies and procedures for Providers that discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment.
- 2.7.1.12 The Contractor shall ensure that the Provider Network provides female Enrollees with direct access to a women's health specialist, including an obstetrician or gynecologist, within the Provider Network for Covered Services necessary to provide women's routine and preventive health care services. This shall include

contracting with, and offering to female Enrollees, women's health specialists as PCPs.

2.7.1.12.1 If the Contractor operates in the Counties of Cook, Lake, Kane, DuPage, Will, or Kankakee, it must demonstrate that it has a contract with the Indian Health Care Provider or provide documentation that the Indian Health Care Provider refused.

2.7.1.13 The Contractor shall ensure that its Network Providers have a strong understanding of disability culture and LTSS.

2.7.1.14 At the Enrollee's request, the Contractor shall provide for a second opinion from a qualified health care professional within the Provider Network, or arrange for the Enrollee to obtain one outside the Provider Network, at no cost to the Enrollee.

2.7.1.15 If the Contractor declines to include individuals or groups of Providers in its Provider Network, the Contractor must give the affected Providers written notice of the reason for its decision.

2.7.1.16 The Contractor shall use best efforts to contact out-of-network Providers, including, within the first 180 days or 90 days after the enrollment of an Enrollee in the Contractor's plan, such Providers that are providing services to Enrollees during the initial continuity of care period, and provide them with information on becoming Affiliated Providers. If the Provider does not become an Affiliated Provider, or if the Enrollee does not select a new Affiliated Provider by the end of the 180-day or 90-day period, the Contractor shall choose an Affiliated Provider for the Enrollee.

2.7.1.17 The Contractor must also offer single-case out-of-network agreements to Providers to treat the Enrollee until a qualified Affiliated Provider is available.

2.7.1.18 The Contractor must permit any Indian Enrollee eligible to receive services from an Indian Health Care Provider to choose an Indian Health Care Provider as his or her PCP, if the Indian Health Care Provider Contractor has a PCP in its network that has capacity to provide such services regardless of whether the Indian Health Care Provider is in or out of network.

The Contractor must permit an out-of-network Indian Health Care Provider to refer an Indian Enrollee to a network Provider without requiring an Indian Enrollee to obtain a referral from an in-network Provider.

2.7.1.19 The Contractor may not pay for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room or hospital):

2.7.1.19.1 Furnished under the Contract by any individual or entity during any period when the individual or entity is excluded from participation under Titles V, XVIII, XIX, or XX pursuant to section 1128, 1128A, 1156, or 1842(j)(2);

2.7.1.19.2 Furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, XIX, or XX pursuant to section 1128, 1128A, 1156, or 1842(j)(2) and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person);

2.7.1.19.3 Furnished by an individual or entity to whom the Department has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the Department determines there is good cause not to suspend such payments;

2.7.1.20 The Contractor may not pay for an item or service with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.

2.7.1.21

2.7.2 Provider Qualifications and Performance

2.7.2.1 Primary Care Qualifications: For purposes of establishing the Provider network, and consistent with Section 2.8.8, a PCP must be one of the following:

2.7.2.1.1 A Primary Care Physician that is:

2.7.2.1.1.1 Licensed by the State of Illinois;

2.7.2.1.1.2 Specialized in Family Practice, Internal Medicine, General Practice, OB/GYN, or Geriatrics; and

2.7.2.1.1.3 In good standing with the Medicare and Medicaid programs.

2.7.2.1.2 A Physician extender who is:

2.7.2.1.2.1 A Nurse Practitioner licensed by the State of Illinois; or

2.7.2.1.2.2 A Physician Assistant who is licensed by the Illinois Department of Financial & Professional Regulation.

2.7.2.2 Subcontracting Requirements

- 2.7.2.2.1 The Contractor remains fully responsible for meeting all of the terms and requirements of the Contract regardless of whether the Contractor subcontracts for performance of any Contract responsibility. The Contractor shall require each First Tier, Downstream or Related Entity to meet all terms and requirements of the Contract that are applicable to such First Tier, Downstream or Related Entity. No subcontract will operate to relieve the Contractor of its legal responsibilities under the Contract.
- 2.7.2.2.2 The Contractor is responsible for the satisfactory performance and adequate oversight of its First Tier, Downstream and Related Entities. First Tier, Downstream and Related Entities are required to meet the same federal and State financial and program reporting requirements as the Contractor. The Contractor is required to evaluate any potential First Tier, Downstream or Related Entity prior to delegation, pursuant to 42 C.F.R. § 438.230. Additional information about subcontracting requirements is contained in Appendix C.
- 2.7.2.2.3 The Contractor must establish contracts and other written agreements between the Contractor and First Tier, Downstream and Related Entities for Covered Services not delivered directly by the Contractor or its employees.
- 2.7.2.2.4 Contract only with qualified or licensed Providers who continually meet federal and State requirements, as applicable, and the qualifications contained in Appendix C.

2.7.3 Non-Payment and Reporting of Provider Preventable Conditions

- 2.7.3.1 The Contractor agrees to take such action as is necessary in order for the Department to comply with and implement all Federal and State laws, regulations, policy guidance, and Illinois policies and procedures relating to the identification, reporting, and non-payment of Provider preventable conditions, including 42 U.S.C. § 1396b-1 and regulations promulgated thereunder.
- 2.7.3.2 As a condition of payment, the Contractor shall develop and implement policies and procedures for the identification, reporting, and non-payment of Provider Preventable Conditions. Such policies and procedures shall be consistent with federal law and regulation, including but not limited to 42 C.F.R. § 434.6(a)(12), 42 C.F.R. § 438.3(g), and 42 C.F.R. § 447.26, and guidance and be consistent with the Department's policies, procedures, and guidance on Provider Preventable Conditions. The Contractor's policies and procedures shall also be consistent with the following:
 - 2.7.3.2.1 The Contractor shall not pay a Provider for a Provider Preventable Condition.
 - 2.7.3.2.2 The Contractor shall require, as a condition of payment from the Contractor, that all Providers comply with reporting requirements on Provider

Preventable Conditions as described at 42 C.F.R. § 447.26(d) and as may be specified by the Contractor and/or the Department.

2.7.3.2.3 The Contractor shall not impose any reduction in payment for a Provider-Preventable Condition when the condition defined as a Provider-Preventable Condition for a particular Enrollee existed prior to the Provider's initiation of treatment for that Enrollee.

2.7.3.2.4 A Contractor may limit reductions in Provider payments to the extent that the following apply:

2.7.3.2.4.1 The identified Provider-Preventable Condition would otherwise result in an increase in payment.

2.7.3.2.4.2 The Contractor can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the Provider-Preventable Condition.

2.7.3.2.5 The Contractor shall ensure that its non-payment for Provider-Preventable Conditions does not prevent Enrollee access to services.

2.7.4 Provider Education and Training

2.7.4.1 Provider Education. Prior to any enrollment of Enrollees under this Contract and thereafter, the Contractor shall conduct Affiliated Provider education regarding the Contractor's policies and procedures as well as the Demonstration.

2.7.4.2 The Contractor must inform its Provider Network about the procedures and timeframes for Enrollee Grievances and Enrollee Appeals, per 42 C.F.R. § 438.414.

2.7.4.3 Provider Orientation. The Contractor shall conduct orientation sessions for Affiliated Providers and their office staff on the Demonstration.

2.7.4.4 Medical Home. The Contractor shall educate Affiliated Providers about the medical home model, the importance of using it to integrate all aspects of each Enrollee's care, and how to become a medical home, including educating Affiliated Providers about resources, support, and incentives, both financial and non-financial, available for becoming a medical home and receiving applicable recognition such as NCQA certification.

2.7.4.5 Cultural Competency. The Contractor will provide the cultural competency requirements at orientation, training sessions, and updates as needed. This will also include Americans with Disabilities Act (ADA) compliance, accessibility, and accommodations as required in Section 2.9.1.6.

- 2.7.4.6 Provider Manual. The Provider Manual shall be a comprehensive online reference tool for the Provider and staff regarding, but not limited to, 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, including Enrollees rights not to be balanced billed. The Contractor must include in the Provider Manual a provision explaining that the Plan may not limit a Provider's communication with Enrollees as provided in Section 2.8.1.2.2.
- 2.7.4.7 Provider and Pharmacy Directory. The Contractor shall make its Provider and Pharmacy Directory available to Providers via the Contractor's web-portal.
- 2.7.4.8 Provider-based Health Education for Enrollees. The Contractor shall encourage PCPs to provide health education to Enrollees. The 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.
- 2.7.4.9 Health, Safety and Welfare Education. As part of its Provider education, the Contractor shall include information related to identifying, preventing and reporting Abuse, Neglect, exploitation, and critical incidents.
- 2.7.4.10 DHS HCBS Waiver Provider Education. The Contractor shall distribute Provider packets, which the Department or its designee will provide, to Enrollees and educate each Enrollee regarding the Enrollee's responsibility to provide the Provider packets to all Individual Providers, including 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. The 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.

2.8 Network Management

2.8.1 General Requirements

- 2.8.1.1 The Contractor shall develop and implement a strategy to manage the Provider Network with a focus on access to services for Enrollees, quality, consistent practice patterns, Independent Living Philosophy, Cultural Competence, and the integration and cost effectiveness. The management strategy shall address all Providers. Such strategy shall include at a minimum:

- 2.8.1.1.1 Conducting on-site visits to Network Providers for quality management and quality improvement purposes, and for assessing meaningful compliance with ADA requirements; and
- 2.8.1.1.2 Ensuring that its Provider Network is adequate to assure access to all Covered Services, and that all Providers are appropriately credentialed, maintain current licenses, and have appropriate locations to provide the Covered Services.
- 2.8.1.2 Affiliated Provider Enrollment. Contractor shall assure that all Affiliated Providers that provide Medicare Covered Services are enrolled as Medicare providers in order to submit claims for reimbursement or otherwise participate in the Medicare Program. Contractor shall assure that all Affiliated Providers, including out-of-State Affiliated Providers that provide Medicaid Covered Services 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.
 - 2.8.1.2.1 Contractor shall make a good faith effort to give written notice of nonrenewal or termination of a Provider as soon as practicable, but in no event later than (15) days after issuance of a termination notice by the Contractor to a provider, or receipt of a termination notice from a Provider, to each Enrollee who was served by the Provider that terminated. In this notification, Contractor will provide direction to the Enrollee regarding how the Enrollee may select a new Provider.
 - 2.8.1.2.2 Contractor shall give at least sixty (60) written notice in advance of its nonrenewal or termination effective date of a Provider to the Provider and to each Enrollee served by the Provider consistent with 42 C.F.R. § 422.111(e). The notice shall include a name and address to which the Provider or an Enrollee may direct comments and concerns regarding the nonrenewal or termination. In the notification to the Enrollee, Contractor will provide direction regarding how the Enrollee may select a new Provider.
 - 2.8.1.2.3 The Contractor shall not limit or prohibit Provider-Based Marketing Activities or Provider Affiliation Information addressed by §§ 70.11.1 and 70.11.2 of the Medicare Marketing Guidelines. The Contractor shall not prohibit a Provider from informing Enrollees of the Provider's affiliation or change in affiliation.
- 2.8.1.3 Non-Affiliated Providers. It is understood that in some instances Enrollees will require specialty care not available from an Affiliated Provider and that Contractor will arrange that such services be provided by a non-Affiliated Provider. In such event, Contractor will promptly negotiate an agreement ("Single Case

Agreement”) with a non-Affiliated Provider to treat the Enrollee until a qualified Affiliated Provider is available. Contractor shall make best efforts to have any non-Affiliated Provider billing for services be enrolled in the Medicare Program or HFS Medical Program, as appropriate and in the same manner as Affiliated Providers under Section 2.8.1.2, prior to paying a claim.

- 2.8.1.4 Access to Provider Locations. Provider locations shall be accessible for Enrollees with disabilities. Contractor shall collect sufficient information from Providers to assess compliance with the ADA. As necessary to serve Enrollees, Provider locations where Enrollees receive services shall be ADA compliant. In addition, Contractor shall include within its network Provider locations that are able to accommodate the unique needs of Enrollees.
- 2.8.1.5 The Contractor shall operate a toll-free pharmacy technical help call center or make available call support to respond to inquiries from pharmacies and Providers regarding the beneficiary’s prescription drug benefit; inquiries may pertain to operational areas such as claims processing, benefit coverage, claims submission, and claims payment. This requirement can be accommodated through the use of on-call staff pharmacists or by contracting with the Contractor’s pharmacy benefit manager during non-business hours as long as the individual answering the call is able to address the call at that time. The call center must operate or be available during the entire period in which the Contractor’s network pharmacies in its plans’ Service Areas are open, (e.g., Contractors whose pharmacy networks include twenty-four (24) hour pharmacies must operate their pharmacy technical help call centers twenty-four (24) hours a day as well). The pharmacy technical help call center must meet the following operating standards:
 - 2.8.1.5.1 Average hold time must not exceed two (2) minutes, with the average hold time defined as the time spent on hold by the caller following the interactive voice response (IVR) system, touch tone response system, or recorded greeting and before reaching a live person.
 - 2.8.1.5.2 Eighty (80) percent of incoming calls answered within thirty (30) seconds.
 - 2.8.1.5.3 Disconnect rate of all incoming calls not to exceed five (5) percent.

2.8.2 Proximity Access Standards

The Contractor must demonstrate annually that its Provider Network meets the stricter of the following standards:

- 2.8.2.1 For Medicare medical Providers and facilities, time, distance and minimum number standards updated annually on the CMS website (<http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and->

Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html);

2.8.2.2 For Medicare pharmacy providers, time, distance and minimum number as required in Appendix E, Article II, Section I and 42 C.F.R. §423.120; or

2.8.2.3 Within the following State Specific Standards:

2.8.2.3.1 NF and Supportive Living Facility Standards. Unless the Department approves an exception, for the first twelve months of the Demonstration (February 1, 2014 – January 31, 2015), the Contractor is required to offer contracts to all NFs and Supportive Living Facilities (SLFs) in the service area that render such Covered Services so long as such Provider meets all applicable State and federal requirements for participation in the Medicaid Program and meets the qualifications of the applicable HCBS waiver. For NF services covered under the traditional Medicaid benefit, the contract offered by the Contractor to the NFs and SLF must provide for payment that equates to at least the Medicaid payment level in Illinois FFS Medicaid. Nothing in this provision shall preclude Contractor and NFs or SLF from agreeing to alternate payment arrangements.

2.8.2.3.1.1 For NFs, the Contractor shall ensure that at least two NFs are within a fifteen (15) mile or thirty (30) minute radius from the Enrollee's ZIP code of residence within each county of the Service Area, provided that each NF meets all applicable State and federal requirements for participation in the Medicaid and Medicare Programs. Notwithstanding the foregoing, the Contractor may offer an Enrollee only one NF with the Prior Approval of CMS and the Department.

2.8.2.3.1.2 *Quality Standards.* For NFs and SLFs, after the first twelve months of the Demonstration, the Contractor may establish quality standards and may contract with only those Providers that meet such standards, provided that all of the contracting Providers are informed of any such quality standards no later than ninety (90) days after the start of the Demonstration and that the Department and CMS has given Prior Approval of the quality standards. Any such quality standards that are not established within ninety (90) days after the start of the Demonstration must be in effect for twelve (12) months before the Contractor may terminate a contract of a Provider based on a

failure to meet such quality standards. The Department and CMS may grant exceptions to these contracting requirements for reasons other than failure to meet the quality standards.

2.8.2.3.1.2.1 The Contractor must transition Enrollees, or have a plan to transition Enrollees, to new Providers prior to terminating the contracts.

2.8.2.3.2 Waiver Providers. For Providers of each of the Covered Services listed below under a HCBS waiver, within each county in the Service Area, the Contractor must maintain a network with a set of Providers that provided at least eighty percent (80%) of the FFS services during calendar year (CY) 2012. For counties where there is more than one Provider of Covered Services, the Contractor must maintain a network that includes at least two of such Providers, even if one served more than eighty percent (80%) of the current HCBS Waiver participants. HCBS services subject to this standard include:

- 2.8.2.3.2.1 Adult Day Care;
- 2.8.2.3.2.2 Homemaker;
- 2.8.2.3.2.3 Day Habilitation (offered for participants in the Persons with a Brain Injury (BI) HCBS waiver);
- 2.8.2.3.2.4 Supported Employment (BI waiver);
- 2.8.2.3.2.5 Home Delivered Meals;
- 2.8.2.3.2.6 Home Health Aides;
- 2.8.2.3.2.7 Nursing Services;
- 2.8.2.3.2.8 Occupational Therapy;
- 2.8.2.3.2.9 Speech Therapy; and
- 2.8.2.3.2.10 Physical Therapy.

2.8.2.3.3 The following requirements apply for the remaining HCBS Waiver services:

- 2.8.2.3.3.1 Environmental Modifications: the Contractor will be monitored to ensure that necessary environmental modifications are made within ninety (90) days after the Contractor becomes aware of the need or from when the Contractor should have been aware and the Contractor shall ensure compliance with Ill. Admin. Code 686.640.

- 2.8.2.3.3.2 Personal Assistants: The Department is not dictating a network adequacy requirement, as Personal Assistants are hired at the discretion and choice of the Enrollee. The Contractor is required, however, to assist Enrollees in locating potential Personal Assistants as necessary.
 - 2.8.2.3.3.3 Personal Emergency Response System: the Contractor must contract with at least two Providers that serve the Service Area.
 - 2.8.2.4 Contractor shall enter into a contract with any willing and qualified community mental health center (Medicaid Provider Type 36) in the Service Area so long as the Provider agrees to the 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 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.
- 2.8.3 Family Planning Provider Network. Subject to Appendix A hereof, the Contractor shall cover Family Planning services for all Enrollees whether the Family Planning services are provided by an Affiliated or non-Affiliated Provider.
 - 2.8.3.1 Contractor agrees to abide by 42 C.F.R. § 438.206.
- 2.8.4 Safety Net Providers. The Contractor will prioritize recruiting safety net Providers, such as FQHCs and Community Mental Health Centers (CMHC), as Affiliated Providers. The Contractor shall not refuse to contract with an FQHC, RHC or CMHC that is willing to accept the Contractor's standard rates and contractual requirements and meets the Contractor's quality standards.
- 2.8.5 Medical Homes. The Contractor's Affiliated Provider network shall include Providers that act as medical homes, with a focus on FQHCs, CMHCs and multi-specialty PCP-centered medical groups and private practice PCP offices. An Enrollee may choose from among the available medical homes. Medical homes shall be patient-centered medical homes that provide and coordinate high quality, planned, family-centered health promotion; Wellness Programs; acute illness care; and Chronic Health Condition management. Medical homes shall provide all PCP services and be supported by Integrated Care Teams and Health Information Technology. The Contractor will support medical homes and the integration of behavioral and physical health care by providing embedded Care Coordinators, as appropriate, onsite at FQHCs, CMHCs and high volume Providers that agree to this approach. The Contractor is required to have a process

in place to facilitate medical homes advancing towards NCQA certification and is required to provide financial incentives to Providers that achieve NCQA medical home certification.

- 2.8.6 Appointments. The 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. Enrollees with more serious problems not deemed Emergency Medical Conditions shall be triaged and, if necessary or appropriate, immediately referred for urgent Medically Necessary care or provided with an appointment within one (1) Business Day after the request. Enrollees with problems or complaints that are not deemed serious shall be seen within three (3) weeks from the date of request for such care. Initial prenatal visits without expressed problems shall be made available within two (2) weeks after a request for an Enrollee in her first trimester, within one (1) week for an Enrollee in her second trimester, and within three (3) days for an Enrollee in her third trimester. Affiliated Providers shall offer hours of operation that are no less than the hours of operation offered to individuals who are not Enrollees.
- 2.8.7 The Contractor will monitor Providers regularly to determine compliance with the timely access requirements
- 2.8.8 The Contractor will take corrective action if it, or its Providers, fail to comply with timely access requirements.
- 2.8.9 PCP Selection and Assignment.
 - 2.8.9.1 Choice of Primary Care Provider. The Contractor shall afford to each Enrollee a choice of PCP, which may be, where appropriate, a WHCP.
 - 2.8.9.2 Specialists as PCPs. The Contractor shall offer pregnant Enrollees and Enrollees with Chronic Health Conditions, disabilities, or special health care needs the option of choosing a specialist to be their PCP or medical home. Such Enrollees or their Providers may request a specialist as a PCP at any time. The Contractor shall contact the Enrollee promptly after the request to determine whether the Enrollee needs a specialist as a PCP. The 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 PCP or medical home.
 - 2.8.9.3 Homebound. If an Enrollee is homebound or has significant mobility limitations, the Contractor shall provide access to primary care through home visits by the PCP to support the Enrollee's ability to live as independently as possible in the community.
- 2.8.10 Provider Credentialing, Recredentialing, and Board Certification
 - 2.8.10.1 Credentialing and Re-credentialing. The Contractor shall credential Providers, except as provided in Section 2.8.8.4, in accordance with NCQA credentialing

standards as well as applicable HFS, DHS, DoA, Illinois Department of Insurance and federal requirements. Re-credentialing shall occur every three (3) years. At re-credentialing and on a continuing basis, the Contractor shall verify minimum credentialing requirements and monitor Enrollee Complaints and Appeals, quality of care and quality of service events, and medical record review.

2.8.10.1.1 Credentialing of Primary Care Providers. All PCPs, WHCPs, and specialists who agree to be PCPs must be credentialed by the Contractor. If the Contractor utilizes a single-tiered credentialing process, the Contractor shall not assign Enrollees to a PCP or WHCP until such Provider has been fully credentialed.

2.8.10.1.2 Delegated Credentialing. The Contractor may subcontract or delegate all or part of its credentialing functions when the First Tier or Downstream Entity, such as a Provider organization, maintains a formal credentialing program in compliance with the Contractor, NCQA, CMS, the Department and applicable regulatory standards. The Contractor shall remain responsible for delegated Provider credentialing and re-credentialing except where Providers are enrolled in the IMPACT system, as noted below in 2.8.10.2..

2.8.10.2 Medicaid Uniform Provider Credentialing and Re-credentialing. In accordance with 42 C.F.R. § 438.214, Provider enrollment in the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system constitutes Illinois' Medicaid managed care uniform credentialing and re-credentialing process. To participate in the Contractor's Provider network, the Contractor must verify that Provider is enrolled in IMPACT.

To the extent the Contractor is using Provider enrollment in the IMPACT system to constitute the credentialing and re-credentialing process for the credentialing of a Provider, the requirements of 42 C.F.R. §422.504(i)(4)(iv) are waived; the Contractor must comply with 42 C.F.R. §422.504(i)(4)(iv) for credentialing of all Providers not enrolled in the IMPACT system.

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

2.8.10.2.2 The 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 the Contractor with a weekly Department extract file containing the list of such approved and authorized Providers.

2.8.10.2.3 The Contractor is prohibited from requiring Providers who only offer Medicaid-covered services under this Contract to undergo additional credentialing processes that are not a part of this Contract.

2.8.11 FQHCs and RHCs Reimbursements

2.8.11.1 The Contractor shall ensure that its payments to FQHCs and RHCs for services to Enrollees are no less than the sum of:

2.8.11.1.1 The level and amount of payment that the plan would make for such services if the services had been furnished by an entity providing similar services that was not a FQHC or RHC, and

2.8.11.1.2 The difference between eighty percent (80%) of the Medicare FFS rate for that FQHC or RHC and the Medicaid PPS amount for that FQHC or RHC, where the Medicaid PPS amount exceeds eighty percent (80%) of the Medicare rate.

2.8.12 Primary Care Payment Rates

2.9 Enrollee Access to Services

2.9.1 General. The Contractor must provide services to Enrollees as follows:

2.9.1.1 Authorize, arrange, coordinate and ensure the provision of all Medically Necessary Covered Services to Enrollees as specified in Section 2.4 and Appendix A, in accordance with the requirements of the Contract, including:

2.9.1.1.1 Meeting State standards for timely access to care and services, taking into account the requirements of Section 2.8.2 of this Contract and 42 C.F.R. § 438.206(c);

2.9.1.1.2 Offering hours of operation that are no less than the hours of operation offered to commercial beneficiaries or comparable to Medicaid fee-for-service, if the Provider serves only Medicaid beneficiaries;

2.9.1.1.3 Making services available twenty- four (24) hours a day, seven (7) days a week, when medically necessary; and

2.9.1.1.4 Establishing mechanisms to ensure compliance by Providers,

2.9.1.2 Offer adequate choice and availability of primary, specialty, acute care, behavioral health and long term services and support Providers that meet CMS and the Department standards as provided in Section 2.8.2;

2.9.1.3 At all times, cover the appropriate level of service for all Emergency Services and non-Emergency Services in an appropriate setting.

- 2.9.1.4 The Contractor shall provide a mechanism for an Enrollee to obtain a second opinion from a qualified Provider, whether Affiliated or non-Affiliated, at no cost to the Enrollee. The Contractor will assist in coordinating obtaining any second opinion from a non-Affiliated Provider.
- 2.9.1.5 Offer adequate choice and availability of Providers as follows:
 - 2.9.1.5.1 PCP to Enrollee Ratio. The Contractor's maximum PCP panel size shall be six hundred (600) Enrollees. If Contractor does not satisfy the PCP requirements set forth above, the Contractor may demonstrate compliance with these requirements by demonstrating that (i) the Contractor's full time equivalent PCP ratios exceed ninety percent (90%) of the requirements set forth above, and (ii) that Covered Services are being provided in the Service Area in a manner what is timely and otherwise satisfactory. The Contractor shall comply with § 1932(b)(97) of the Social Security Act.
- 2.9.1.6 Reasonably accommodate Enrollees and ensure that the programs and services are as accessible (including physical and geographic access) to an individual with disabilities as they are to an individual without disabilities. The Contractor and its Network Providers must comply with the ADA (28 C.F.R. § 35.130) and § 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794) and maintain capacity to deliver services in a manner that accommodates the needs of its Enrollees. The Contractor shall have written policies and procedures to assure compliance, including ensuring that physical, communication, and programmatic barriers do not inhibit individuals with disabilities from obtaining all Covered Services from the Contractor by:
 - 2.9.1.6.1 Providing flexibility in scheduling to accommodate the needs of the Enrollees;
 - 2.9.1.6.2 Providing interpreters or translators for Enrollees who are Deaf or hard of hearing, visually impaired, and those who do not speak English;
 - 2.9.1.6.3 Ensuring that individuals with disabilities are provided with reasonable accommodations to ensure effective communication, including auxiliary aids and services. Reasonable accommodations will depend on the particular needs of the individual and include but are not limited to:
 - 2.9.1.6.3.1 Providing large print (at least 16-point font) versions of all Written Materials to individuals with visual impairments;
 - 2.9.1.6.3.2 Ensuring that all Written Materials are available in formats compatible with optical recognition software;

- 2.9.1.6.3.3 Reading notices and other Written Materials to individuals upon request;
- 2.9.1.6.3.4 Assisting individuals in filling out forms over the telephone;
- 2.9.1.6.3.5 Ensuring effective communication to and from individuals with disabilities through email, telephone, and other electronic means;
- 2.9.1.6.3.6 Making available services such as TTY, computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified interpreters for the deaf and hard of hearing; and
- 2.9.1.6.3.7 Individualized assistance.
- 2.9.1.6.4 Ensuring safe and appropriate physical access to buildings, services and equipment;
- 2.9.1.6.5 Demonstrating compliance with the ADA by surveying Providers or site review of facilities for both physical and programmatic accessibility, documenting any deficiencies in compliance and monitoring correction of deficiencies; and
- 2.9.1.6.6 Identifying to CMS and the Department the individual, and the job title, in its organization who is responsible for ADA compliance related to this Demonstration. The Demonstration Plan must also establish and execute a work plan to achieve and maintain ADA compliance.
- 2.9.1.7 If the Contractor's network is unable to provide necessary medical services covered under the Contract to a particular Enrollee, the Contractor must adequately and timely cover these services out of network for the Enrollee, for as long as the Contractor is unable to provide them. The Contractor must ensure that cost to the Enrollee is no greater than it would be if the services were furnished within the network;
- 2.9.1.8 When a PCP or any medical, behavioral health or long-term services and supports Provider is terminated from the Contractor's plan or leaves the network for any reason, the Contractor must make a good faith effort to give written notification of termination of such Provider, within fifteen (15) days after receipt or issuance of the termination notice, to each Enrollee who received his or her care from, or was seen on a regular basis by, the terminated PCP or any other medical, behavioral or long-term services and supports Provider. For terminations of PCPs, the

Contractor must also report the termination to the Department and provide assistance to the Enrollee in selecting a new PCP within fifteen (15) calendar days. For Enrollees who are receiving treatment for a chronic or ongoing medical condition or long-term services and supports, the Contractor shall ensure that there is no disruption in services provided to the Enrollee; and

- 2.9.1.9 When the Food and Drug Administration (FDA) determines a drug to be unsafe, the Contractor will remove it from the formulary immediately. The Contractor must make a good faith effort to give written notification of removal of this drug from the formulary and the reason for its removal, within five (5) days after the removal, to each Enrollee with a current or previous prescription for the drug.

2.9.2 Availability of Services

- 2.9.2.1 After Hours. PCPs and specialty Provider contracts shall provide coverage for their respective practices twenty-four (24) hours a day, seven (7) days a week and have a published after hours telephone number; voicemail alone after hours is not acceptable.

2.9.3 Services Not Subject to Prior Approval

- 2.9.3.1 The Contractor will assure coverage of Emergency Medical Conditions and Urgent Care services. The Contractor must not require prior approval for the following services:
 - 2.9.3.1.1 Any services for Emergency Medical Conditions as defined in 42 C.F.R 422.113(b)(1) and 438.114(a), which includes emergency behavioral health care;
 - 2.9.3.1.2 Urgent Care sought outside of the Service Area;
 - 2.9.3.1.3 Urgent Care under unusual or extraordinary circumstances provided in the Service Area when the contracted Provider is unavailable or inaccessible;
 - 2.9.3.1.4 Family planning services; and
 - 2.9.3.1.5 Out-of-area renal dialysis services.

2.9.4 Authorization of Services. The Contractor shall authorize services as follows:

- 2.9.4.1 For the processing of requests for initial and continuing authorizations of Covered Services, the Contractor shall:
 - 2.9.4.1.1 Have in place and follow written policies and procedures;
 - 2.9.4.1.2 Have in place procedures to allow Enrollees to initiate requests for provisions of services;

- 2.9.4.1.3 Have in effect mechanisms to ensure the consistent application of review criteria for authorization decisions; and
- 2.9.4.1.4 Consult with the requesting Provider when appropriate.
- 2.9.4.2 The Contractor shall ensure that a Physician and a behavioral health Provider are available twenty-four (24) hours a day seven (7) days a week, three-hundred sixty-five (365) days a year for timely authorization of Medically Necessary services, including NF services, and to coordinate transfer of Stabilized Enrollees in the emergency department, if necessary. The Contractor's Medical Necessity guidelines must, at a minimum, be no more restrictive than Medicare standards for acute services and prescription drugs and Medicaid standards for LTSS.
- 2.9.4.3 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 health care professional who has appropriate clinical expertise in treating the Enrollee's medical condition, performing the procedure, or providing the treatment. Behavioral health services denials must be rendered by board-certified or board-eligible psychiatrists or by a clinician licensed with the same or similar specialty as the behavioral health services being denied, except in cases of denials of service for psychological testing, which shall be rendered by a qualified psychologist.
- 2.9.4.4 The Contractor shall ensure that all behavioral health authorization and Utilization Management activities are in compliance with 42 U.S.C. § 1396u-2(b)(8). The Contractor must comply with the requirements for demonstrating parity for both cost sharing (co-payments) and treatment limitations between mental health and substance use disorder and medical/surgical inpatient, outpatient and pharmacy benefits.
- 2.9.4.5 The Contractor must notify the requesting Provider, either orally or in writing, and give the Enrollee written notice of any decision by the Contractor to deny a Service Authorization Request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements of Section 2.4, and must:
 - 2.9.4.5.1 Be produced in a manner, format, and language that can be easily understood;
 - 2.9.4.5.2 Be made available in Prevalent Languages, upon request; and
 - 2.9.4.5.3 Include information, in the most commonly used languages about how to request language assistance services and Alternative Formats. Alternative Formats shall include materials which can be understood by persons with limited English proficiency.

2.9.4.6 The Contractor must make authorization decisions in the following timeframes and provide notice that meet the timing requirements set forth in 42 C.F.R. § 438.404 and 305 ILCS 5/5F-32:

2.9.4.6.1 Unless limited by Section 2.9.4.6.4, for standard authorization decisions, provide notice as expeditiously as the Enrollee's health condition requires and no later than fourteen (14) calendar days after receipt of the request for service, with a possible extension not to exceed fourteen (14) additional calendar days. Such extension shall only be allowed if:

2.9.4.6.1.1 The Enrollee or the Provider requests an extension, or

2.9.4.6.1.2 The Contractor can justify (to the satisfaction of the Department and CMS upon request) that:

2.9.4.6.1.2.1 The extension is in the Enrollee's interest; and

2.9.4.6.1.2.2 There is a need for additional information where:

2.9.4.6.1.2.2.1 There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received;

2.9.4.6.1.2.2.2 Such outstanding information is reasonably expected to be received within fourteen (14) calendar days; and

2.9.4.6.1.2.3. The Contractor provides the Enrollee with notice of the reason for the extension and informs the Enrollee of the right to file an Expedited Grievance if the Enrollee disagrees with the decision to extend the Service Authorization Notice timeframe.

2.9.4.6.2 Unless limited by Section 2.9.4.6.4, for expedited service authorization decisions, where the Provider indicates or the Contractor determines that following the standard timeframe in Section 2.9.4.6.1 could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make a decision and provide notice as expeditiously as the Enrollee's health condition requires and no later than seventy-two (72) hours after receipt of the request for service, with a possible extension not to exceed fourteen (14) additional calendar days. Such extension shall only be allowed if:

2.9.4.6.2.1 The Enrollee or the Provider requests an extension; or

2.9.4.6.2.2 The Contractor can justify (to the Department and CMS upon request) that:

2.9.4.6.2.3 The extension is in the Enrollee's interest; and

2.9.4.6.2.4 There is a need for additional information where:

2.9.4.6.2.4.1 There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and

2.9.4.6.2.4.2 Such outstanding information is reasonably expected to be received within fourteen (14) calendar days.

2.9.4.6.3 In accordance with 42 C.F.R. §§ 438.3(i) and 422.208, compensation to individuals or entities that conduct Utilization Management activities for the Demonstration Plan must not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Enrollee.

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

2.9.5 Quality Assurance, Utilization Review and Peer Review.

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

2.9.5.2 The Contractor shall ensure Affiliated labs are capable of reporting lab values to the Contractor directly. The Contractor shall use the electronic lab values to calculate HEDIS® performance measures.

2.9.5.3 The Contractor shall adopt practice guidelines that meet, at a minimum, the following criteria:

2.9.5.3.1 The clinical guidelines shall rely on credible scientific evidence published in peer reviewed medical literature generally recognized by the medical community. To the extent applicable, the guidelines shall take into account Physician specialty society recommendations and the views of Physicians practicing in relevant clinical areas and other relevant factors;

2.9.5.3.2 Consider the needs of the Enrollees;

- 2.9.5.3.3 Are adopted in consultation with Affiliated Providers;
- 2.9.5.3.4 Are reviewed and updated periodically, as appropriate; and
- 2.9.5.3.5 Are available to all affected Affiliated Providers, non-Affiliated Providers, Enrollees and Potential Enrollees.
- 2.9.5.4 The Contractor shall have a Utilization Review Program that includes a utilization review plan, a utilization review committee that meets quarterly and appropriate mechanisms covering preauthorization and review requirements.
- 2.9.5.5 The Contractor shall establish and maintain a Peer Review Program approved by the Department to review the quality of care being offered by the Contractor and its employees, First Tier, Downstream, and Related Entities, and Affiliated Providers.
- 2.9.5.6 The Contractor shall comply with the QA standards outlined in Section 2.13.
- 2.9.5.7 The Contractor shall comply with the utilization review standards and peer review standards attached hereto as Appendix D.
- 2.9.5.8 The Contractor shall conduct a program of ongoing review that evaluates the effectiveness of its QA and performance improvement strategies designed in accordance with the terms of Section 2.13.
- 2.9.5.9 The 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.
- 2.9.5.10 The Contractor shall ensure that decisions governed by its practice guidelines are made consistently with those practice guidelines.
- 2.9.6 Critical Incidents and Other HCBS Required Reporting
 - 2.9.6.1 The Contractor shall comply with critical incident reporting requirements of the DHS-DRS, DoA, and HFS HCBS Waivers for incidents and events that do not rise to the level of Abuse, Neglect or exploitation. Such reportable incidents include, but are not limited to, the incidents identified in Appendix L, M, and N for the appropriate HCBS Waivers.
 - 2.9.6.2 The Contractor shall comply with HCBS Waiver reporting requirements to assure compliance with Federal Waiver Assurances for Health Safety, and Welfare, and other Federal requirements as set forth in the approved HCBS Waivers. The 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 for all HCBS programs.
- 2.9.6.3 The Contractor shall train all of the Contractor's employees, Affiliated Providers, Affiliates, and First Tier, Downstream and Related Entities that have interaction with Enrollees or Enrollee's Care Plan to recognize potential concerns related to Abuse, Neglect and exploitation, and 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 the Contractor, its Affiliated Providers, Affiliates or First Tier, Downstream, or Related Entities.
 - 2.9.6.4 The 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 Contractor's responsibilities. Training sessions will be customized to the target audience. Training will include general indicators of Abuse, Neglect and exploitation and the timeframe requirements for reporting suspected Abuse, Neglect and exploitation.
 - 2.9.6.5 Reports regarding Enrollees who are disabled adults age eighteen (18) through fifty-nine (59), who are residing in the community, are to be made to the Illinois Adult Protective Services Unit of DoA at 1-866-800-1409 (voice) and 1-888-206-1327 (TTY).
 - 2.9.6.6 Reports regarding Enrollees who are age sixty (60) or older, who reside in the community, are to be made to the Illinois Adult Protective Services Unit of DoA at 1-866-800-1409 (voice) and 1-888-206-1327 (TTY).
 - 2.9.6.7 Reports regarding Enrollees in NFs must be made to the DPH's Nursing Home Complaint Hotline at 1-800-252-4343.
 - 2.9.6.8 Reports regarding Enrollees in SLFs must be made to the Department's SLF Complaint Hotline at 1-800-226-0768.
 - 2.9.6.9 The Contractor shall provide the Department, upon request, with its protocols for reporting suspected Abuse, Neglect and exploitation and other critical incidents that are reportable.
 - 2.9.6.10 The 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 or exploitation, or a critical incident, is reported.
 - 2.9.6.11 Critical Incident Reporting

- 2.9.6.11.1 The 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 the Contractor and, when required or otherwise appropriate, to the investigating authority.
- 2.9.6.11.2 The 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.
- 2.9.6.11.3 The Contractor shall have systems in place to report, monitor, track, and resolve critical incidents concerning restraints and restrictive interventions.
 - 2.9.6.11.3.1 The Contractor shall make reasonable efforts to detect unauthorized use of restraint or seclusion. The Contractor shall require that events involving the use of restraint or seclusion are reported to the 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.
 - 2.9.6.11.3.2 The Contractor shall make reasonable efforts to detect unauthorized use of restrictive interventions. The Contractor shall require that events involving the use of restrictive interventions are reported to the Contractor as a reportable incident, and reported to the investigating authority if it rises to the level of Abuse, Neglect or exploitation.

2.9.7 Health, Safety and Welfare Monitoring

- 2.9.7.1 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, but not limited to, 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.
- 2.9.7.2 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.

2.9.8 Emergency, Out-of-Service Area Elective Care, Post-Stabilization Care Coverage, and State Operated Hospitals.

2.9.8.1 Emergency Services

- 2.9.8.1.1 The Contractor's Provider network must ensure access to 24-hour Emergency Services for all Enrollees, whether they reside in institutions or in the community. The Contractor must cover and pay for any services obtained for Emergency Medical Conditions in accordance with 42 C.F.R. § 438.114(c).
- 2.9.8.1.2 The Contractor shall cover and pay for Emergency Services regardless of whether the Provider that furnishes the services has a contract with the Contractor. Out-of-network payment policies are described at Section 2.6.10.5. The Contractor shall ensure that the Enrollee is not billed for the difference, if any, between such rate and the non-Affiliated Provider's charges.
- 2.9.8.1.3 The Contractor shall cover Emergency Services provided to Enrollees who are temporarily away from their residence and outside the Service Area to the extent that the Enrollees would be entitled to the Emergency Services if they still were within the Service Area.
- 2.9.8.1.4 The Contractor shall not deny payment for treatment for an Emergency Medical Condition or cases in which prudent layperson, who possesses an average knowledge of health and medicine, reasonably thought that the absence of immediate medical attention would result in the following: (1) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) Serious impairment to bodily functions; or (3) Serious dysfunction of any bodily organ or part; when the absence of immediate medical attention would not have resulted in placing the individual in serious jeopardy, pursuant to 42 C.F.R. § 438.114.
- 2.9.8.1.5 The Contractor shall not deny payment for Emergency Services in cases which the Contractor's representative instructed the Enrollee to seek Emergency Services.
- 2.9.8.1.6 The Contractor shall not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.
- 2.9.8.1.7 The Contractor shall require Providers to notify the Enrollee's PCP of an Enrollee's screening and treatment, but may not refuse to cover Emergency Services based on their failure to do so.
- 2.9.8.1.8 An Enrollee who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

2.9.8.1.9 The attending emergency Physician, or the Provider actually treating the Enrollee, is responsible for determining when the Enrollee is Stabilized for transfer or discharge, and that determination is binding on the Contractor if:

2.9.8.1.9.1 Such transfer or discharge order is consistent with generally accepted principles of professional medical practice; and

2.9.8.1.9.2 Is a Covered Service under the Contract.

2.9.8.1.10 The Contractor shall provide ongoing education to Enrollees regarding the appropriate use of Emergency Services. The 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 medical home.

2.9.8.1.11 The Contractor shall not impose any requirements for prior approval of Emergency Services.

2.9.8.1.12 The Contractor shall have no obligation to cover medical services provided on an emergency basis that are not Covered Services under this Contract.

2.9.8.2 Elective Care

2.9.8.2.1 Elective care or care required as a result of circumstances that could reasonably have been foreseen prior to the Enrollee's departure from the Service Area is not covered. Unexpected hospitalization due to complications of pregnancy shall be covered. Routine delivery at term outside the Service Area, however, shall not be covered if the Enrollee is outside the Service Area against medical advice unless the Enrollee is outside of the Service Area due to circumstances beyond her control. The Contractor must educate the Enrollee regarding the medical and financial implications of leaving the Service Area and the importance of staying near the treating Provider throughout the last month of pregnancy.

2.9.8.3 Post-Stabilization Services

2.9.8.3.1 The Contractor shall cover and pay for Post-Stabilization Care Services in accordance with 42 C.F.R. § 438.114(e), 42 C.F.R. § 422.113(c). Contractor shall cover Post-Stabilization Services provided by an Affiliated or non-Affiliated Provider in any of the following situations: (i) the Contractor authorized such services; (ii) such services were administered to maintain the Enrollee's Stabilized condition within one (1) hour after a request to the Contractor for authorization of further Post-Stabilization Services; or (iii) the Contractor does not respond to a request to authorize further Post-Stabilization Services within one (1) hour, the Contractor could not be contacted, or the Contractor and the treating Provider cannot reach an agreement concerning the Enrollee's care and an Affiliated Provider is unavailable

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

2.9.8.4 State Operated Hospitals (SOH)

2.9.8.4.1 When covered by Medicaid, Contractor shall provide inpatient psychiatric care to a SOH for an Enrollee admitted under civil status, at Medicaid established rates, whether that SOH is an Affiliated or non-Affiliated Provider. Payment shall be made for all days utilized as determined by DHS-DMH and is not subject to the utilization review determinations or admission authorization standards of Contractor.

2.9.9 Emergency Medical Treatment and Labor Act (EMTALA)

2.9.9.1 The Contractor and Providers shall comply with EMTALA, which, in part, requires:

2.9.9.1.1 Qualified hospital medical personnel to provide appropriate medical screening examinations to any individual who "comes to the emergency department," as defined in 42 C.F.R. § 489.24(b); and,

2.9.9.1.2 As applicable, to provide individuals stabilizing treatment or, if the hospital lacks the capability or capacity to provide stabilizing treatment, appropriate transfers.

2.9.9.1.3 The Contractor's contracts with its Providers must clearly state the Provider's EMTALA obligations and must not create any conflicts with hospital actions required to comply with EMTALA.

2.10 Enrollee Services

2.10.1 Enrollee Service Representatives (ESRs). The Contractor must employ ESRs trained to answer inquiries and concerns from Enrollees and Potential Enrollees, consistent with the requirements of 42 C.F.R. §§ 422.111(h) and 423.128(d) as well as the following requirements:

2.10.1.1 Be trained to answer Enrollee inquiries and concerns from Enrollees and Prospective Enrollees;

2.10.1.2 Be trained in the use of those services required pursuant to Section 2.9.1.6.3.6.

2.10.1.3 Be capable of speaking directly with, or arranging for an interpreter to speak with, Enrollees in their primary language, including American Sign Language, or through an alternative language device or telephone translation service;

2.10.1.4 Inform callers that interpreter services are free;

- 2.10.1.5 Be knowledgeable about the Illinois Medicaid program, Medicare, and the terms of the Contract, including the Covered Services listed in Appendix A;
- 2.10.1.6 Be available to Enrollees to discuss and provide assistance with resolving Enrollee Complaints;
- 2.10.1.7 Have access to the Contractor's Enrollee database, the Contractor's Enrollee handbook, and an electronic Provider and Pharmacy directory;
- 2.10.1.8 Maintain the availability of services, such as TTY services, computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified interpreters and other services for Deaf and hard of hearing Enrollees;
- 2.10.1.9 Demonstrate sensitivity to culture, including Disability Culture and the independent living philosophy;
- 2.10.1.10 Provide assistance to Enrollees with cognitive impairments; for example, provide Written Materials in simple, clear language at a reading level of 6.0 and below, and individualized guidance from ESRs to ensure materials are understood;
- 2.10.1.11 Provide reasonable accommodations needed to assure effective communication and provide Enrollees with a means to identify their disability to the Demonstration Plan;
- 2.10.1.12 Maintain employment standards and requirements (e.g., education, training, and experience) for Enrollee services department staff and provide a sufficient number of staff to meet defined performance objectives; and
- 2.10.1.13 Ensure that ESRs make available to Enrollees and Potential Enrollees, upon request, information concerning the following:
 - 2.10.1.13.1 The identity, locations, qualifications, and availability of Providers;
 - 2.10.1.13.2 Enrollees' rights and responsibilities;
 - 2.10.1.13.3 The procedures available to an Enrollee and Provider(s) to challenge or Appeal the failure of the Demonstration Plan to provide a Covered Service and to Appeal any Adverse Benefit Determinations (denials);
 - 2.10.1.13.4 How to access oral interpretation services and Written Materials in Prevalent Languages and Alternative Formats;
 - 2.10.1.13.5 Information on all Covered Services and other available services or resources (e.g., State agency services) either directly or through Referral or authorization;

- 2.10.1.13.6 The procedures for an Enrollee to change plans or to opt out of the Demonstration; and
 - 2.10.1.13.7 Additional information that may be required by Enrollees and Potential Enrollees to understand the requirements and benefits of the Demonstration Plan.
- 2.10.2 Enrollee Service Telephone Responsiveness.
- 2.10.2.1 The Contractor must operate a call center during normal business hours, seven (7) days a week, consistent with the required Marketing Guidelines and the Medicare-Medicaid marketing guidance. ESRs must be available Monday through Friday, during normal business hours, consistent with the required Marketing Guidelines and the Medicare-Medicaid marketing guidance. The Contractor may use alternative call center technologies on Saturdays, Sundays, and Federal holidays.
 - 2.10.2.2 The Contractor's ESR's must answer eighty percent (80%) of all Enrollee telephone calls within thirty (30) seconds or less. The Contractor must limit average hold time to two (2) minutes, with the average hold time defined as the time spent on hold by the caller following the interactive voice response (IVR) system, touch tone response system, or recorded greeting and before reaching a live person. The Contractor must limit the disconnect rate of all incoming calls to five percent (5%). The Contractor must have a process to measure the time from which the telephone is answered to the point at which an Enrollee reaches an ESR capable of responding to the Enrollee's question in a manner that is sensitive to the Enrollee's language and cultural needs.
- 2.10.3 Coverage Determinations and Appeals Call Center Requirements
- 2.10.3.1 The Contractor must operate a toll-free call center with live customer service representatives available to respond to Providers or Enrollees for information related to requests for coverage under Medicare or Medicaid, and Medicare and Medicaid Appeals (including requests for Medicare exceptions and prior authorizations). The Contractor shall provide immediate access to requests for Medicare and Medicaid covered benefits and services, including Medicare coverage determinations and redeterminations, via its toll-free call centers. The call centers must operate during normal business hours specified in the Medicare Marketing Guidelines and the Medicare-Medicaid guidance. The Contractor must accept requests for Medicare or Medicaid coverage, including Medicare coverage determinations / redeterminations, outside of normal business hours, but is not required to have live customer service representatives available to accept such requests outside normal business hours. Voicemail may be used outside of normal business hours provided the message:
 - 2.10.3.1.1 Indicates that the mailbox is secure;

- 2.10.3.1.2 Lists the information that must be provided so the case can be worked (e.g., Provider identification, Enrollee identification, type of request (coverage determination or Appeal), Physician support for an exception request, and whether the Enrollee is making an expedited or standard request);
 - 2.10.3.1.3 For coverage determination calls (including exceptions requests) related to Part D, articulates and follows a process for resolution within twenty-four (24) hours after the call for expedited requests and seventy-two (72) hours for standard requests; and
 - 2.10.3.1.4 For Appeals calls related to Part D, articulates the process information needed and provide for a resolution within seventy-two (72) hours for expedited Appeal requests and seven (7) calendar days for standard Appeal requests.
- 2.10.4 Provider Accessibility and Nurse Support Line:
- 2.10.4.1 The Contractor shall require PCPs and specialty Provider contracts to provide coverage for their respective practices twenty-four (24) hours a day, seven (7) days a week and have a published after hours telephone number; voicemail alone after hours is not acceptable.
 - 2.10.4.2 The Contractor shall establish a toll-free advice line, available twenty-four (24) hours a day, seven (7) days a week, through which Enrollees may obtain medical guidance and support from a nurse. The Contractor shall ensure that the nurses staffing the nurse advice line will be able to obtain Physician support and advice by contacting the Contractor's Medical Director if needed.
- 2.10.5 Member Relationship Management System. The Contractor shall have a system dedicated to the management of information about Enrollees, specifically designed to collect Enrollee-related data and processing workflow needs in health care administration. The system shall have, at a minimum, three (3) core integrated components:
- 2.10.5.1 Member demographics tracking and information;
 - 2.10.5.2 Means to automate, manage, track and report on the 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
 - 2.10.5.3 Technology for use for inbound Enrollee contact and query management.
- 2.10.6 Enrollee Portal. Contractor shall have and maintain a secure Enrollee website that shall comply with, at a minimum 42 CFR § 422.111(h) and 42 CFR § 423.128(d) and shall include, at a minimum, the following functions or capabilities:

- 2.10.6.1 Information about Contractor;
- 2.10.6.2 “Contact Us” information;
- 2.10.6.3 Local health events and news;
- 2.10.6.4 Provider search of the Provider directory under Section 2.7.4.6;
- 2.10.6.5 Access to the Enrollee’s Care Plan;
- 2.10.6.6 Access to the Enrollee’s care gaps; and
- 2.10.6.7 Access to health education materials.

2.11 Enrollee Grievance

2.11.1 Grievance Filing.

- 2.11.1.1 Internal Grievance Filing. An Enrollee, or an authorized representative, may file an Internal Enrollee Grievance at any time with the Contractor or its Providers by calling or writing to the Contractor or Provider. If the internal Enrollee Grievance is filed with a Provider, the Contractor must require the Provider to forward it to the Contractor. The Enrollee may file the Grievance at any time as allowed in 42 C.F.R. § 438.402(c)(2)(i).
- 2.11.1.2 External Grievance Filing. The Contractor shall inform Enrollees that they may file an external Grievance through 1-800 Medicare. The Contractor must display a link to the electronic Grievance form on the Medicare.gov Internet Web site on the Contractor’s main Web page. The Contractor must inform Enrollees of the email address, postal address or toll-free telephone number where an Enrollee Grievance may be filed.
- 2.11.1.3 External Grievances filed with the Department shall be forwarded to the Contract Management Team and entered into the CMS Complaints tracking module, which will be accessible to the Contractor.

2.11.2 Internal Grievance Administration Process

- 2.11.2.1 The Contractor must have a formally structured Grievance system, consistent with 215 ILCS 134/45, 42 CFR § 422 Subpart M, 42 C.F.R. § 431 Subpart E and 42 C.F.R. § 438 Subpart F, in place for addressing Enrollee Grievances, including Grievances regarding reasonable accommodations and access to services under the ADA. The Contractor must maintain written records of all Grievance activities, and notify CMS and the Department of all internal Enrollee Grievances. The Contractor must also submit to the Department, in the format required by the Department, a quarterly report summarizing all Grievances heard by the Grievance Committee

and the responses to and disposition of those Grievances. The Contractor must submit its Grievance procedures to the Department for Prior Approval. The system must meet the following standards:

- 2.11.2.1.1 Timely acknowledgement of receipt of each Enrollee Grievance;
- 2.11.2.1.2 Timely review of each Enrollee Grievance;
- 2.11.2.1.3 Informal attempt by Contractor to resolve all Grievances;
- 2.11.2.1.4 Establishing a Grievance and Appeals Committee that meets, at minimum, on a quarterly basis;
- 2.11.2.1.5 Providing the Enrollee with a form and instructions on how the Enrollee may appoint an authorized representative to represent the Enrollee throughout the Grievance process;
- 2.11.2.1.6 Response, electronically, orally or in writing, to each Enrollee Grievance within a reasonable time, but no later than thirty (30) days after the Contractor receives the Grievance; and
- 2.11.2.1.7 Expedited response, orally or in writing, within twenty-four (24) hours after the Contractor receives the Grievance to each Enrollee Grievance whenever the Contractor extends the Appeals timeframe (see Section 2.12 below) or the Contractor refuses to grant a request for an expedited Appeal; and
- 2.11.2.1.8 Availability to Enrollees of information about Enrollee Grievances and Appeals, including reasonable assistance in completing any forms or other procedural steps, which shall include interpreter services and toll-free numbers with TTY/TDD and interpreter capability.
- 2.11.2.1.9 Ensure that decision makers on grievances were not involved in previous levels of review or decision-making and are health care professionals with clinical expertise in treating the enrollee's condition or disease if any of the following apply:
 - 2.11.2.1.9.1 A grievance regarding denial of expedited resolutions of an appeal.
 - 2.11.2.1.9.2 Any grievance involving clinical issues.

2.12 Enrollee Appeals

- 2.12.1 General. All Contractors shall utilize and all Enrollees may access the existing Part D Appeals Process, as described in Appendix E. Consistent with existing rules, Part D Appeals will be automatically forwarded to the CMS Medicare IIRE if the Contractor misses the applicable

adjudication timeframe. The CMS Independent Review Entity is contracted by CMS. The Contractor must maintain written records of all Appeal activities, and notify CMS and the Department of all internal Appeals.

2.12.2 Integrated/Unified Non-Part D Appeals Process Overview:

2.12.2.1 Notice of Adverse Benefit Determination – In accordance with 42 C.F.R. §§ 422.568 and 438.404, the Contractor must give the Enrollee written notice of any Adverse Benefit Determination. Such notice shall be provided at least ten (10) days in advance of the date of its action, in accordance with 42 C.F.R. § 438.404. An Enrollee, or a Provider or an authorized representative acting on behalf of an Enrollee and with the Enrollee's written consent, may appeal the Contractor's decision to deny, terminate, suspend, or reduce services. In accordance with 42 C.F.R. §§ 422.574 and 438.402, an Enrollee or Provider acting on behalf of an Enrollee and with the Enrollee's consent may also appeal the Contractor's delay in providing or arranging for a Covered Service.

2.12.2.2 The Contractor's Appeal procedures must: (i) be submitted to the CMT in writing for Prior Approval by CMS and the Department; (ii) provide for resolution with the timeframes specified herein; and (iii) assure the participation of individuals with authority to require corrective action. Appeals procedures must be consistent with 42 CFR § 422.560 et seq., 42 CFR § 431.200 et seq, and 42 CFR § 438.400 et seq. The Contractor must have a committee in place for reviewing Appeals made by Enrollees. The Contractor shall review its Appeal procedures at least annually for the purpose of amending such procedures when necessary. The Contractor shall amend its procedures only upon receiving Prior Approval from the Department.

2.12.3 Medicare A & B Service Appeals

2.12.3.1 Process: All initial Appeal requests will be filed with the Contractor in accordance with applicable laws and regulations (Level One Appeal). If the Contractor does not decide fully in the Enrollee's favor within the relevant timeframe, the Contractor shall automatically forward the case file regarding Medicare services to the IRE for a new and impartial review. If the Contractor or the Enrollee disagrees with the IRE's decision, further levels of Appeal are available, including a hearing before an Administrative Law Judge, a review by the Departmental Appeals Board, and judicial review. The Contractor must comply with any requests for information or participation from such further Appeal entities.

2.12.3.2 Timeframes: An Enrollee may file an oral or written Appeal with the Contractor within sixty (60) calendar days following the date of the notice of Adverse Benefit Determination that generates such Appeal.

2.12.3.2.1 Unless an Enrollee requests an expedited Appeal, for Level One Appeals filed with the Contractor, the Contractor shall render its decision on the Appeal within fifteen (15) Business Days after submission of the Appeal. The Contractor may extend this timeframe for up to fourteen (14) calendar days if the Enrollee requests an extension or if the Contractor desires additional information and/or documents and is able to establish that the delay is in the interest of the Enrollee. The Contractor must provide the Enrollee with written notice of the reason for the extension and inform the Enrollee of the right to file a grievance if they disagree with the delay. If an Enrollee requests an expedited Appeal, the Contractor shall notify the Enrollee, within twenty-four (24) hours after the submission of the Appeal, of all information from the Enrollee that the Contractor requires to evaluate the expedited Appeal. The Contractor shall render a decision on an expedited Appeal within twenty-four (24) hours after receipt of the required information.

2.12.3.2.1.1 In a non-emergency situation, notwithstanding any provisions in State law to the contrary, in the event a NF resident's Physician orders a service, treatment, or test that is not approved by the Contractor, the Enrollee, or the Physician or other Provider acting on behalf of the Enrollee, may utilize a Level One expedited Appeal to the Contractor, as defined in 2.12.3.2.1. Non-emergency situations not meeting the criteria for expedited Appeals set forth in 42 C.F.R. § 422.570 shall proceed as standard Appeals beyond Level One for Medicare services, as specified in Section 2.12.3.2.2.

2.12.3.2.2 If the Level One Appeal is not fully in favor of the Enrollee, the Contractor must auto-forward the Appeal to the IRE. For standard Appeals, the IRE will send the Enrollee and the Contractor a letter with its decision within thirty (30) calendar days after it receives the case from the Contractor, or at the end of up to a fourteen (14) calendar day extension, and a payment decision within sixty (60) calendar days. For expedited Appeals, the IRE will send the Enrollee and the Contractor a letter with its decision within seventy-two (72) hours after it receives the case from the Contractor or at the end of up to a fourteen (14) calendar day extension.

2.12.3.2.3 If the IRE decides in the Enrollee's favor and reverses the Contractor's decision, the Contractor must authorize the service under dispute as expeditiously as the Enrollee's health condition requires, but no later than seventy-two (72) hours from the date the Contractor receives the notice reversing the decision. Generally, the Contractor must provide the services under dispute as expeditiously as the enrollee's health condition requires, but no later than fourteen (14) calendar days from the date it receives notice that the IRE reversed the determination.

2.12.3.3 Continuation of Benefits Pending an Appeal: The Contractor must provide continuing benefits for all previously approved non-Part D benefits that are being

terminated or modified pending the Contractor's internal Appeal process. This means that such benefits will continue to be provided by Providers to Enrollees and that the Contractors must continue to pay Providers for providing such services or benefits pending an internal Appeal.

2.12.4 Medicaid Appeals

2.12.4.1 Process: An Appeal may be submitted orally or in writing. If the Enrollee does not request an expedited Appeal pursuant to 42 C.F.R. §438.410, the Contractor may require the Enrollee to follow an oral Appeal with a written, signed Appeal. All Appeals shall be registered initially with the Contractor and, if the Contractor's decision is adverse to the Enrollee, the Enrollee may file an appeal for a Fair Hearing with the State as provided in this Section 2.12.4. The Contractor shall timely acknowledge receipt of each Enrollee Appeal.

2.12.4.1.1 An Enrollee may appoint any authorized representative, including, but not limited to, a guardian, caregiver relative, or Provider, to represent the Enrollee throughout the Appeal process. The Contractor shall provide a form and instructions on how an Enrollee may appoint a representative. The Contractor shall consider the Enrollee, the Enrollee's authorized representative, or the representative of the Enrollee's estate as parties to the Appeal. The Contractor shall provide such parties a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The Contractor shall allow such parties an opportunity, before and during the Appeal process, to examine the Enrollee's case file, including medical records and any other documents and records.

2.12.4.1.1.1 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 C.F.R. § 438.410(b).

2.12.4.1.2 The 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.

2.12.4.1.3 The Contractor shall ensure that decision makers on Appeals were not involved in previous levels of review or decision-making and are health care professionals with clinical expertise in treating the enrollee's condition or disease if any of the following apply:

2.12.4.1.3.1 A denial of an Appeal based on lack of medical necessity;

2.12.4.1.3.2 Any Appeal involving clinical issues.

2.12.4.2 Timeframes: An Enrollee may file an oral or written Appeal with the Contractor within sixty (60) calendar days following the date of the notice of Adverse Benefit Determination that generates such Appeal.

2.12.4.2.1 For Level One Appeals filed with the Contractor, if the Enrollee does not request an expedited Appeal pursuant to 42 C.F.R. § 438.410, the Contractor may require the Enrollee to follow an oral Appeal with a written, signed Appeal. The Contractor shall render its decision on the Appeal within fifteen (15) Business Days after submission of the Appeal. In the case of oral appeals, the Contractor shall render its decision on the Appeal within fifteen (15) Business Days after the receipt of the oral appeal. The Contractor may extend this timeframe for up to fourteen (14) calendar days if the Enrollee requests an extension, or if the 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. The Contractor must make reasonable efforts to provide the Enrollee with prompt oral notice of the delay; and within two (2) calendar days must provide written notice of the reason for the extension and inform the Enrollee of the right to file a grievance if the Enrollee disagrees with the delay.

2.12.4.2.2 If an Enrollee requests an expedited Appeal pursuant to 42 C.F.R. § 438.410, the Contractor shall notify the Enrollee, within 24 hours after the submission of the Appeal, of all information from the Enrollee that the Contractor requires to evaluate the expedited Appeal. The Contractor shall also inform the Enrollee of the limited time available for the Enrollee to present evidence, and allegations of fact or law, in person as well as in writing. The Contractor shall render a decision on an expedited Appeal within twenty-four (24) hours after receipt of the required information and shall make reasonable efforts to provide oral notice. If the Contractor denies the expedited Appeal, the Contractor shall ensure that it complies with the procedures in 42 C.F.R. § 438.410(c), including providing the Enrollee with prompt oral notice of the denial and a written notice within two (2) calendar days. The Contractor may extend this timeframe for up to fourteen (14) calendar days if the Enrollee requests an extension, or if the 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. The Contractor must make reasonable efforts to provide the Enrollee with prompt oral notice of the delay; and within two (2) calendar days must provide written notice of the reason for the extension and inform the Enrollee of the right to file a grievance if the Enrollee disagrees with the delay. The Contractor must ensure that no punitive action is taken against a Provider that either requests an expedited Appeal or that supports an Enrollee's expedited Appeal. If the Enrollee does not request an expedited Appeal, the Contractor shall render a decision within fifteen (15) business days after receipt of the Appeal and shall provide the Enrollee with written notice of the resolution pursuant to 42 CFR § 438.408, and 2.12.4.2.4 below.

- 2.12.4.2.2.1 In a non-emergency situation, notwithstanding any provisions in State law to the contrary in the event a NF resident's Physician orders a service, treatment, or test that is not approved by the Contractor, the Enrollee, or the Physician or other Provider acting on behalf of the Enrollee, may utilize a Level One expedited Appeal to the Contractor, as defined in 2.12.4.2.2. Non-emergency situations shall proceed as standard appeals beyond Level One.
- 2.12.4.2.3 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) calendar days after the date of the Contractor's decision notice.
- 2.12.4.2.4 The Contractor shall provide written notice to the Enrollee of the final decision of the Appeal, which shall include:
 - 2.12.4.2.4.1. Results of the Appeals;
 - 2.12.4.2.4.2. Date of the Appeal resolution;
 - 2.12.4.2.4.3. Right to request and how to request a State Fair Hearing;
 - 2.12.4.2.4.4. Right to continued benefits pending a State Fair Hearing, and how to request continued benefits;
 - 2.12.4.2.4.5. Notice that the Enrollee may be liable for the cost of any continued benefits if the Contractor's action is upheld at the State Fair hearing.
- 2.12.4.2.5 Except for a denial of HCBS Waiver services, which may not be reviewed by an external independent entity, the Contractor shall have procedures allowing an Enrollee, within thirty (30) calendar days after the date of the Contractor's decision notice, to request an external independent review of both standard and expedited Appeals that are not resolved wholly in favor of the Enrollee by the Contractor.
- 2.12.4.2.6 If an Appeal is filed with the State Fair Hearing system, the Contractor will participate in the pre-hearing process, including, but not limited to, 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 the Contractor.
- 2.12.4.3 Continuation of Benefits Pending an Appeal: If an Enrollee files an Appeal within ten (10) calendar days after the date of a notice of Adverse Benefit Determination from the Contractor and the Enrollee requests that the disputed Covered Services be continued pending the Appeal, then the Contractor must continue the Enrollee's benefits during the Appeal process. This includes continuing benefits in a case where the authorization for such disputed Covered Services expires or

authorization limits for such Covered Services are met. Pursuant to 42 C.F.R. § 438.420, if the final resolution of the Appeal is adverse to the Enrollee, the Contractor may recover the cost of the services that were furnished to the Enrollee. If the Contractor or the State Fair Hearing Officer reverses a decision to deny, limit or delay Covered Services, and those services were not furnished while the Appeal was pending, the Contractor must authorize or provide the disputed services as expeditiously as the Enrollee's health condition requires. If the Contractor or the State Hearing Officer reverses a decision to deny authorization of Covered Services, and the Enrollee received the disputed services while the Appeal was pending, the Contractor must pay for those services in accordance with State rules and policy.

2.12.5 Medicare A & B/Medicaid Appeals (Overlap Services and Items)

- 2.12.5.1 Process: For services and items in which Medicare and Medicaid overlap (including Home Health, Durable Medical Equipment and skilled therapies), all initial Appeal requests will be filed with the Contractor in accordance with applicable laws and regulations. If the resolution following the Contractor's Appeal process is not wholly in favor of the Enrollee, the Appeal related to these services will be forwarded to the IRE by the Contractor. If the resolution of the IRE is not wholly in favor of the Enrollee, the Enrollee or authorized representative may then request further levels of Appeal, including a State Fair Hearing or Administrative Law Judge.
- 2.12.5.2 Timelines: Like Medicare and Medicaid benefits, an Enrollee may file an oral or written Appeal with the Contractor within sixty (60) calendar days following the date of the notice of Adverse Benefit Determination that generates such Appeal for his or her overlapping benefits.
 - 2.12.5.2.1 For Level One Appeals filed with the Contractor, if the Enrollee does not request an expedited Appeal pursuant to 42 C.F.R. § 438.410, the Contractor shall render its decision on the Appeal within fifteen (15) Business Days after submission of the Appeal. The Contractor may extend this timeframe for up to fourteen (14) calendar days if the Enrollee requests an extension, or if the 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.
 - 2.12.5.2.2 If an Enrollee requests an expedited Appeal pursuant to 42 C.F.R. § 438.410, the Contractor shall notify the Enrollee, within twenty-four (24) hours after the submission of the Appeal, of all information from the Enrollee that the Contractor requires to evaluate the expedited Appeal. The Contractor shall render a decision on an expedited Appeal within twenty-four (24) hours after receipt of the required information. If the Enrollee does not request an expedited Appeal, the Contractor shall render a decision within fifteen (15) business days after receipt of the Appeal

and shall provide the Enrollee with written notice of the resolution pursuant to 42 CFR § 438.408.

2.12.5.2.2.1

In a non-emergency situation, notwithstanding any provisions in State law to the contrary, in the event a NF resident's Physician orders a service, treatment, or test that is not approved by the Contractor, the Enrollee, or the Physician or other Provider acting on behalf of the Enrollee, may utilize a Level One expedited Appeal to the Contractor, as defined in 2.12.5.2.2. Non-emergency situations not meeting the criteria for expedited Appeals set forth in 42 C.F.R. § 422.570 shall proceed as standard Appeals beyond Level One, as specified in Section 2.12.3.2.2.

2.12.5.2.3 If the Level One Appeal is not fully in favor of the Enrollee, the Contractor must auto-forward the Appeal to the IRE. For standard Appeals, the IRE will send the Enrollee and the Contractor a letter with its decision within thirty (30) calendar days after it receives the Appeal file from the Contractor, or at the end of up to a fourteen (14) calendar day extension, and a payment decision within sixty (60) calendar days. For expedited Appeals, the IRE will send the Enrollee and the Contractor a letter with its decision within 72 hours after it receives the Appeal file from the Contractor or at the end of up to a fourteen (14) calendar day extension.

2.12.5.2.4 If the IRE decides in the Enrollee's favor, whether in whole or in part, the Contractor must authorize the service under dispute as expeditiously as the Enrollee's health condition requires, but no later than 72 hours from the date the Contractor receives the notice of the decision.

2.12.5.2.5 If the IRE's decision is not wholly in favor of the Enrollee, the Contractor must send a notice to the Enrollee informing him or her of his or her rights to file an Appeal with either the State Fair Hearing system within thirty (30) calendar days after the date of the Contractor's decision notice or Administrative Law Judge, or both, at the choice of the Enrollee.

2.12.5.2.6 If an Appeal is filed with the State Fair Hearing system, the Department will issue Final Administrative Decisions for Standard Appeals within ninety (90) calendar days after the Enrollee filed the Appeal with the Contractor, not including the number of days the Contractor took to auto-forward to the IRE or the number of days the Enrollee took to file for a State Fair Hearing, and Final Administrative Decisions for Expedited Appeals will be issued within three (3) business days after the filing of an Appeal with the State Fair Hearing Agency. The Contractor will participate in the pre-hearing process, including, but not limited to, 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 the Contractor.

2.12.5.2.7 If the Enrollee seeks review of the Administrative Law Judge's decision, the review of Medicare is to the Departmental Appeals Board and any further review is to federal court, and the review of Medicaid, pursuant to the State Administrative Review Law (735 ILCS 5/3-101 et seq.), is to State circuit court. Any review of the Final Administrative Decision issued by the Department is to State circuit court pursuant to the State Administrative Review Law (735 ILCS 5/3-101 et seq.). The Contractor must comply with any requests for information or participation from such further Appeal entities. Any determination in favor of the Enrollee will require payment by the Contractor for the service or item in question.

2.12.5.3 Continuation of Benefits Pending an Appeal: The Contractor must provide continuing benefits for all previously approved non-Part D benefits that are being terminated or modified pending the Contractor's internal Appeal process. If the Contractor does not decide fully in the Enrollee's favor within the relevant timeframe, the Contractor must continue providing benefits for all previously approved non-Part D benefits that are being terminated or modified through the IRE review. If the resolution of the IRE is not wholly in favor of the Enrollee, services will be required to be provided and paid for pending resolution of the State Fair Hearing Appeal process, if the Enrollee files an Appeal with the State Fair Hearing Agency within ten (10) calendar days of the notice of disposition from the IRE.

2.12.6 Integrated Notice - Enrollees will be notified of all applicable Demonstration Medicare and Medicaid Appeal rights through a single notice. The form and content of the notice must be prior approved by CMS and the Department. The Contractor shall notify the Enrollee of its decision at least ten (10) days in advance of the date of its Adverse Benefit Determination. The Contractor must give notice of Adverse Benefit Determination on the day of the action when the action is a denial of payment

2.12.6.1 The notice must explain:

2.12.6.1.1 The action the Contractor intends to take;

2.12.6.1.2 The reasons for the action;

2.12.6.1.3 The citation to the regulations supporting such action;

2.12.6.1.4 The Enrollee's or the Provider's right to file an Appeal;

2.12.6.1.5 Procedures for exercising the Enrollee's rights to Appeal;

2.12.6.1.6 Circumstances under which expedited resolution is available and how to request it; and

2.12.6.1.7 If applicable, the Enrollee's rights to have benefits continue pending the resolution of the Appeal, and the circumstances under which the Enrollee may be required to pay the costs of these services.

2.12.6.2 The notice must use easily understood language and format, be available in alternative formats, and in an appropriate manner that takes into consideration those with special needs. All Enrollees and Potential Enrollees must be informed that information is available in alternative formats and how to access those formats.

2.12.6.3 The notice must be translated for the individuals who speak Prevalent Languages.

2.12.6.4 The notice must include language clarifying that oral interpretation is available for all languages and how to access it.

2.12.7 Hospital Discharge Appeals

2.12.7.1 The Contractor must comply with the hospital discharge Appeal requirements at 42 C.F.R. §§ 422.620-422.622

2.12.8 Other Medicare QIO Appeals

2.12.8.1 The Contractor must comply with the termination of services Appeal requirements for individuals receiving services from a comprehensive outpatient rehabilitation facility, skilled NF, or home health agency at 42 C.F.R. §§ 422.624 and 422.626.

2.13 Quality Assurance Program

2.13.1 QA Program Structure Generally. The Contractor shall maintain a well-defined QA organizational and program structure that supports the application of the principles of Continuous Quality Improvement (CQI) to all aspects of the Contractor's service delivery system. The QA program must be communicated in a manner that is accessible and understandable to internal and external individuals and entities, as appropriate. The Contractor's QA organizational and program structure shall comply with all applicable provisions of 42 C.F.R. § 438, including Subpart E, Quality Assessment and Performance Improvement, 42 C.F.R. § 422, Subpart D Quality Improvement, and shall meet the quality management and improvement criteria described in the most current NCQA Health Plan Accreditation Requirements. Specifically, the Contractor shall establish procedures such that the Contractor shall be able to demonstrate that it meets the requirements of the HMO Federal qualification regulations (42 C.F.R. § 417.106), the Medicare HMO/CMP regulations (42 C.F.R. § 417.418(c)), and the regulations promulgated pursuant to the Balanced Budget Act of 1997 (42

C.F.R. § 438.200 et seq.). These regulations require that the Contractor have an ongoing fully implemented Quality Assurance Program for health services that:

- 2.13.1.1 Incorporates widely accepted practice guidelines that meet the criteria referenced above, and are distributed to Affiliated Providers, as appropriate, and to Enrollees and Potential Enrollees, upon request, and:
 - 2.13.1.1.1 Are based on valid and reliable clinical evidence;
 - 2.13.1.1.2 Consider the needs of Enrollees, including assessing the quality and appropriateness of care furnished to Enrollees with special needs;
 - 2.13.1.1.3 Are adopted in consultation with Affiliated Providers; and
 - 2.13.1.1.4 Are reviewed and updated periodically as appropriate.
- 2.13.1.2 Monitors the health care services the Contractor provides, including assessing the appropriateness and quality of care;
- 2.13.1.3 Stresses health outcomes and monitors Enrollee risks status and improvement in health outcomes;
- 2.13.1.4 Provides a comprehensive program of care coordination, Care Management, and Disease Management, with needed outreach to assure appropriate care utilization and community referrals;
- 2.13.1.5 Provides review by Physicians and other health professionals of the process followed in the provision of health services;
- 2.13.1.6 Includes fraud control provisions;
- 2.13.1.7 Establishes and monitors access standards;
- 2.13.1.8 Uses systematic data collection of performance and Enrollee results, provides interpretation of these data to its Affiliated Providers- (including, without limitation, Enrollee-specific and aggregate data provided by CMS and the Department), and institutes needed changes;
- 2.13.1.9 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 there was a delay in providing, or a failure to provide, Covered Services that should have been provided;
- 2.13.1.10 Describes its implementation process for reducing unnecessary emergency room utilization, inpatient services, including thirty (30)-day readmissions;

- 2.13.1.11 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, specialist, care coordinator, or others, as determined appropriate, on a real-time basis;
- 2.13.1.12 Describes its process to assure follow up services after inpatient care for behavioral health, with a behavioral health provider, follow up after inpatient medical care, including delivery care, to assure women have access to contraception and postpartum care, with a PCP or specialist, or follow up following an emergency room visit.
- 2.13.1.13 Details its processes for establishing patient-centered medical homes and the coordination between the PCP and behavioral health Provider, specialists and PCP, or specialists and behavioral health Providers;
- 2.13.1.14 Details its processes for determining and facilitating Enrollees needing nursing home, SLF or ICF level of care, or to live in the community with HCBS supports;
- 2.13.1.15 Describes its processes for addressing Abuse and Neglect and unusual incidents in the community setting;
- 2.13.1.16 Details its compensation structure, incentives, pay-for-performance programs, value purchasing strategies, and other mechanisms utilized to promote the goals of medical homes and accountable, integrated care;
- 2.13.1.17 Describes its health education procedures and materials for Enrollees; processes for training, monitoring, and holding Providers accountable for health education; and oversight of Provider requirements to coordinate care and provide health education topics (e.g., 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; and
- 2.13.1.18 Provides for systematic activities to monitor and evaluate the dental services rendered.
- 2.13.1.19 Applies the principles of CQI to all aspects of the Contractor's service delivery system through ongoing analysis, evaluation and systematic enhancements based on:
 - 2.13.1.19.1 Quantitative and qualitative data collection and data-driven decision-making;
 - 2.13.1.19.2 Up-to-date evidence-based practice guidelines and explicit criteria developed by recognized sources or appropriately certified professionals or, where evidence-based practice guidelines do not exist, consensus of professionals in the field;

2.13.1.19.3 Feedback provided by Enrollees and Providers in the design, planning, and implementation of its CQI activities; and

2.13.1.19.4 Issues identified by the Contractor, the Department or CMS; and

2.13.1.20 Ensure that the quality improvement (QI) requirements of this Contract are applied to the delivery of primary and specialty health care services, behavioral health Services and LTSS.

2.13.2 Quality Assurance Plan

2.13.2.1 The Contractor shall provide to CMS and the Department a written description of its Quality Assurance Plan (QAP) for the provision of clinical services (e.g., medical, medically related services, care coordination, Care Management, Disease Management, and behavioral health services). This written description must meet federal and State requirements:

2.13.2.1.1 Goals and objectives — The written description shall contain a detailed set of QA objectives that are developed annually and include a workplan and timetable for implementation and accomplishment. The annual workplan shall include the following components or other components as directed by the Department and CMS:

2.13.2.1.1.1 Planned clinical and non-clinical initiatives;

2.13.2.1.1.2 The objectives for planned clinical and non-clinical initiatives using specific, measurable, achievable, realistic and time-limited (SMART) taxonomy;

2.13.2.1.1.3 The short and long term time frames within which each clinical and non-clinical initiative's objectives are to be achieved;

2.13.2.1.1.4 The individual(s) responsible for each clinical and non-clinical initiative;

2.13.2.1.1.5 Any issues identified by the Contractor, the Department, CMS, Enrollees, or Providers, and how those issues are tracked and resolved over time;

2.13.2.1.1.6 Program review process for formal evaluations that address the impact and effectiveness of clinical and non-clinical initiatives at least annually; and

2.13.2.1.1.7 Process for correcting deficiencies.

2.13.2.1.2 Scope — The scope of the QAP shall be comprehensive, addressing both the quality of clinical care and the quality of non-clinical aspects of service, such as and including: availability, accessibility, coordination, and continuity of care. The scope of the QAP should include activities for Primary, Specialty, and Behavioral Health Services, and LTSS that reflect utilization across the network and include all of the activities in this Section 2.13 of this Contract and, in addition, the following elements:

- 2.13.2.1.2.1 A process to utilize HEDIS, Consumer Assessment of Healthcare Providers and Services (CAHPS), Participant Outcomes and Status Measures (POSM), as applicable, the Health Outcomes Survey (HOS) and other measurement results in designing QI activities;
- 2.13.2.1.2.2 A medical record review process for monitoring Provider Network compliance with policies and procedures, specifications and appropriateness of care. Such process shall include the sampling method used which shall be proportionate to utilization by service type. The Contractor shall submit its process for medical record reviews and the results of its medical record reviews to the Department and CMS;
- 2.13.2.1.2.3 A process to measure Network Providers and Enrollees, at least annually, regarding their satisfaction with the Contractor's Plan. The Contractor shall submit a survey plan to the Department for Prior Approval and shall submit the results of the survey to the Department and CMS;
- 2.13.2.1.2.4 A process to measure clinical reviewer consistency in applying Clinical Criteria to Utilization Management activities, using inter-rater reliability measures; and
- 2.13.2.1.2.5 A process for including Enrollees and their families in Quality Management activities, as evidenced by participation in consumer advisory boards.

2.13.2.1.3 Methodology — The QAP methodology shall provide for review of the entire range of care provided, by assuring that all demographic groups, care settings, (e.g., inpatient, ambulatory, and home care), and types of services (e.g., preventive, primary, specialty care, behavioral health, dental and ancillary services) are included in the scope of the review. Documentation of the monitoring and evaluation plan shall be provided to CMS and the Department.

- 2.13.2.1.4 Activities — The written description shall specify quality of care studies and other activities to be undertaken over a prescribed period of time, and methodologies and organizational arrangements to be used to accomplish them. Individuals responsible for the studies and other activities shall be clearly identified in the written workplan and shall be appropriately skilled or trained to undertake such tasks. The written description shall provide for continuous performance measurement of the activities, including tracking of issues over time.
- 2.13.2.1.5 Provider review — The written description shall document how Physicians and other health professionals will be involved in reviewing quality of care and the provision of health services and how feedback to health professionals and the Contractor staff regarding performance and Enrollee results will be provided.
- 2.13.2.1.6 Focus on health outcomes — The QAP methodology shall address health outcomes; a complete description of the methodology shall be fully documented and provided to CMS and the Department.
- 2.13.2.1.7 Systematic process of quality assessment and improvement — The QAP shall objectively and systematically monitor and evaluate the quality, appropriateness of, and timely access to, care and service to Enrollees, and pursue opportunities for improvement on an ongoing basis. Documentation of the monitoring activities and evaluation plan shall be provided to CMS and the Department.
- 2.13.2.1.8 Enrollee and advocate input --- The QAP shall detail its operational and management plan for including Enrollee and advocate input into its QAP processes.
- 2.13.2.2 The Contractor shall provide CMS and the Department with the QAP written guidelines which delineate the QA process, specifying:
- 2.13.2.2.1 Clinical areas to be monitored:
- 2.13.2.2.1.1 The monitoring and evaluation of clinical care shall reflect the population served by the Contractor in terms of age groups, disease categories, and special risk status, and shall include quality improvement initiatives, as determined appropriate by the Contractor or as required by CMS and the Department.
 - 2.13.2.2.1.2 The QAP shall, at a minimum, monitor and evaluate care and services in certain priority clinical areas of interest specified by CMS and the Department, based on the needs of Enrollees.
 - 2.13.2.2.1.3 At its discretion or as required by CMS and the Department, the Contractor's QAP must monitor and evaluate other

important aspects of care and service, including coordination with community resources.

2.13.2.2.1.4 At a minimum, the following areas shall be monitored:

2.13.2.2.1.4.1 For all populations:

2.13.2.2.1.4.1.1 Emergency room utilization.

2.13.2.2.1.4.1.2 Inpatient hospitalization.

2.13.2.2.1.4.1.3 Thirty (30)-day readmission rate.

2.13.2.2.1.4.1.4 Assistance to Enrollees accessing services outside the Covered Services, such as housing, social service agencies, senior center.

2.13.2.2.1.4.1.5 Health education provided.

2.13.2.2.1.4.1.6 Coordination of primary and specialty care.

2.13.2.2.1.4.1.7 Coordination of care, Care Management, Disease Management, and other activities.

2.13.2.2.1.4.1.8 Individualized Enrollee Care Plan.

2.13.2.2.1.4.1.9 Access to dental benefits.

2.13.2.2.1.4.1.10 Preventive health care for adults (e.g., annual health history and physical exam; mammography; Papanicolaou test ("Pap test"), immunizations).

2.13.2.2.1.4.1.11 PCP or behavioral health follow-up after emergency room or inpatient hospitalization.

2.13.2.2.1.4.1.12 Utilization of behavioral health benefits.

2.13.2.2.1.4.2 For Chronic Health Conditions (such conditions specifically including, without limitation, diabetes, asthma, CHF, CAD, COPD, Behavioral Health, including those with one or more co-morbidities) and appropriate treatment, follow-up care, and coordination of care, Care Management and Disease Management for all Enrollees.

2.13.2.2.1.4.2.1 Identification of Enrollees with special health care needs and processes in place to assure adequate,

ongoing risk assessments, treatment plans 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.

2.13.2.2.1.4.2.2 Care coordination, Care Management, Disease Management, and Chronic Health Conditions action plan, as appropriate.

2.13.2.2.1.4.3 For behavioral health:

2.13.2.2.1.4.3.1 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.

2.13.2.2.1.4.3.2 Assistance sufficient to access behavioral health services, including transportation and escort services.

2.13.2.2.1.4.3.3 Enrollee access to timely behavioral health services.

2.13.2.2.1.4.3.4 An Enrollee Care Plan or treatment and provision of appropriate level of care;

2.13.2.2.1.4.3.5 Coordination of care between Providers of medical and behavioral health services to assure follow-up and continuity of care

2.13.2.2.1.4.3.6 Involvement of the PCP in aftercare.

2.13.2.2.1.4.3.7 Enrollee satisfaction with access to and quality of behavioral health services

2.13.2.2.1.4.3.8 Mental health outpatient and inpatient utilization, and follow up.

2.13.2.2.1.4.3.9 Chemical dependency outpatient and inpatient utilization, and follow up.

2.13.2.2.1.4.4 For pregnant women:

2.13.2.2.1.4.4.1 Timeliness and frequency of prenatal visits.

2.13.2.2.1.4.4.2 Provision of the Illinois Prenatal Care Quality Tool developed by the Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Act, and referral and consultation recommendations for high risk women based on the American Congress of Obstetricians and Gynecologists (ACOG) and the Illinois Perinatal Code.

2.13.2.2.1.4.4.3 Birth outcomes.

2.13.2.2.1.4.4.4 Referral to the Perinatal Centers, as appropriate.

2.13.2.2.1.4.4.5 Length of hospitalization for the mother.

2.13.2.2.1.4.4.6 Length of newborn hospital stay for the infant.

2.13.2.2.1.4.4.7 Assist the Enrollee in finding an appropriate PCP for the infant.

2.13.2.2.1.4.5 For Enrollees in NFs and Enrollees receiving HCBS Waiver services:

2.13.2.2.1.4.5.1 Maintenance in, or movement to, community living.

2.13.2.2.1.4.5.2 Number of hospitalizations and length of hospital stay.

2.13.2.2.1.4.5.3 Falls resulting in hospitalizations.

2.13.2.2.1.4.5.4 Behavior resulting in injury to self or others.

2.13.2.2.1.4.5.5 Enrollee non-compliance of services.

2.13.2.2.1.4.5.6 Medical errors resulting in hospitalizations.

2.13.2.2.1.4.5.7 Occurrences of pressure ulcers, weight loss, and infections.

2.13.3 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:

- 2.13.3.1.1 The Contractor shall utilize quality indicators as provided in this Contract, as well as other quality measures identified by the Contractor, that are objective, measurable, and based on current knowledge and clinical experience.
- 2.13.3.1.2 The Contractor shall document that methods and frequency of data collected are appropriate and sufficient to detect the need for a program change.
- 2.13.3.1.3 For the priority clinical areas specified by CMS and the Department, the Contractor shall monitor and evaluate quality of care through studies which address, but are not limited to, the quality indicators also specified by CMS and the Department.
- 2.13.3.2 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.
 - 2.13.3.2.1 Multi-disciplinary teams shall be used, where indicated, to analyze and address delivery systems issues.
 - 2.13.3.2.2 Clinical and related service areas requiring improvement shall be identified and documented, and a corrective action plan shall be developed and monitored.
- 2.13.3.3 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 the Contractor to CMS and the Department on a timely basis. Written remedial or corrective action procedures shall include:
 - 2.13.3.3.1 Specification of the types of problems requiring remedial or corrective action;
 - 2.13.3.3.2 Specification of the person(s) or entity responsible for making the final determinations regarding quality problems;
 - 2.13.3.3.3 Specific actions to be taken;
 - 2.13.3.3.4 A provision for feedback to appropriate health professionals, Providers and staff;
 - 2.13.3.3.5 The schedule and accountability for implementing corrective actions;
 - 2.13.3.3.6 The approach to modifying the corrective action if improvements do not occur; and

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

2.13.4 Assessment of Effectiveness of Corrective Actions — The Contractor shall monitor and evaluate corrective actions taken to assure that appropriate changes have been made. The Contractor shall assure follow-up on identified issues to ensure that actions for improvement have been effective and provide documentation of the same.

2.13.5 Evaluation of Continuity and Effectiveness of the QAP:

2.13.5.1.1 At least annually, the Contractor shall conduct a regular examination of the scope and content of the QAP (42 C.F.R. § 438.330 (c)(i), (ii), and (iii)) 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 QA, Utilization Review (UR) and Peer Review (PR).

2.13.5.1.2 At the end of each year, a written report on the QAP shall be prepared by the Contractor and submitted to CMS and 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:

- 2.13.5.1.2.1 QA/UR/PR Plan with overview of goal areas;
- 2.13.5.1.2.2 Major Initiatives to comply with the Department's Quality Assessment and Performance Improvement Strategy;
- 2.13.5.1.2.3 Quality Improvement and work plan monitoring;
- 2.13.5.1.2.4 Provider Network Access and Availability and Service Improvements, including access, utilization of dental services, and Provider satisfaction;
- 2.13.5.1.2.5 Cultural Competency;
- 2.13.5.1.2.6 Fraud and Abuse Monitoring;
- 2.13.5.1.2.7 Population Profile;
- 2.13.5.1.2.8 Improvements in Care Management and Clinical Services/Programs;
- 2.13.5.1.2.9 Findings on Initiatives and Quality Reviews;
- 2.13.5.1.2.10 Effectiveness of Quality Program Structure;

- 2.13.5.1.2.11 Comprehensive Quality Improvement Work Plans;
 - 2.13.5.1.2.12 Chronic Conditions;
 - 2.13.5.1.2.13 Behavioral Health (includes mental health and substance abuse services);
 - 2.13.5.1.2.14 Discussion of Health Education Program;
 - 2.13.5.1.2.15 Member Satisfaction;
 - 2.13.5.1.2.16 Enrollee Safety;
 - 2.13.5.1.2.17 Fraud, Waste and Abuse and Privacy and Security;
 - 2.13.5.1.2.18 Delegation; and
 - 2.13.5.1.2.19 ADA Compliance/Monitoring.
- 2.13.5.2 QAP Committee. The Contractor shall have a QAP Committee. The Contractor shall have a governing body to which the QA Committee shall be held accountable (“Governing Body”). The Governing Body of the 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 the 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:
- 2.13.5.3 Oversight of QAP – The Contractor shall document through meeting minutes that the Governing Body has approved the overall Quality Assurance Program and an annual QAP.
- 2.13.5.4 Oversight Entity – The Governing Body 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.
- 2.13.5.5 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.
- 2.13.5.6 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.

2.13.5.7 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 the 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.

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

2.13.6.1 Regular Meetings — The QAP Committee shall meet on a regular basis with specified frequency to oversee QAP activities. This frequency shall be sufficient to demonstrate that the structure/committee is following-up on all findings and required actions, but in no case shall such meetings be held less frequently than quarterly. A copy of the minutes shall be submitted to the Department as needed, and within ten (10) Business Days after the Department's request.

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

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

2.13.6.4 Accountability — The QAP Committee shall be accountable to the Governing Body and report to it on a scheduled basis on activities, findings, recommendations and actions.

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

2.13.6.6 Consumer Advisory Committee and Community Stakeholder Committee - There shall be a Consumer Advisory Committee and Community Stakeholder Committee that will provide feedback to the QAP Committee on the Plan's performance from Enrollee and community perspectives that meet at least quarterly throughout the Demonstration. These committees 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 racial or ethnic disparities, that may impact community groups; and offer guidance on reviewing Enrollee materials and effective approaches for reaching enrollees. The Consumer Advisory Committee will be comprised of randomly selected Enrollees, family members and other caregivers that reflect the diversity of the Demonstration population. The Community Stakeholder Committee will be comprised of local representation from key community stakeholders such as churches, advocacy groups, and other community-based organizations. The Contractor will educate Enrollees and community stakeholders about these committees through materials such as handbooks, newsletters, websites and communication events.

2.13.7 The Contractor's Medical Director shall have substantial involvement in QA activities.

2.13.7.1 Adequate Resources — The QAP shall have sufficient material resources, and staff with the necessary education, experience, and training, to effectively carry out its specified activities.

2.13.7.2 Provider Participation in the QAP:

2.13.7.2.1 Affiliated Physicians and other Affiliated Providers shall be kept informed about the written QAP.

2.13.7.2.2 The Contractor shall include in all agreements with Affiliated Provider and Subcontractors a requirement securing cooperation with the QAP.

2.13.7.2.3 Contracts shall specify that Affiliated Providers and Subcontractors will allow access to the medical records of its Enrollees to the Contractor.

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

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

2.13.8.2 The 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.

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

- 2.13.8.4 There shall be evidence of continuous and ongoing evaluation and oversight of delegated activities, including approval of quality improvement plans and regular specified reports, as well as a formal review of such activities. Oversight of delegated activities must include no less than an annual audit, analyses of required reports and Encounter Data, a review of Enrollee complaints, grievances, Provider complaints and appeals, and quality of care concerns raised through Encounter Data, monitoring activities, or other venues. Outcomes of the annual audit shall be submitted to CMS and the Department as part of the QA/UR/PR Annual Report.
- 2.13.8.5 The 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.
- 2.13.8.6 If the Contractor or subcontractor identifies areas requiring improvement, the 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 the Contractor to prevent such deficiencies from reoccurring. Evidence of ongoing monitoring of the delegated activities sufficient to assure corrective action shall be provided to CMS and the Department through quarterly or annual reporting.
- 2.13.9 The QAP shall contain provisions to assure that Affiliated Physicians and other Affiliated Providers, are qualified to perform their services and are credentialed by the Contractor. Recredentialing shall occur at least once every three (3) years. The Contractor's written policies shall include procedures for selection and retention of Physicians and other Providers.
- 2.13.10 All services provided by or arranged to be provided by the Contractor shall be in accordance with 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, or as otherwise required by the Department or CMS, and shall be adopted by the Contractor's QAP Committee with sources referenced and guidelines documented in Contractor's QAP. The 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. The Contractor shall provide ongoing education to Affiliated Providers on required clinical guideline application and provide ongoing monitoring to assure that its Affiliated Providers are utilizing them. At a minimum, clinical practice guidelines and best practice standards of care shall be adopted by the Contractor for the following conditions and services:
- 2.13.10.1 Asthma;

- 2.13.10.2 Congestive Heart Failure (CHF);
- 2.13.10.3 Coronary Artery Disease (CAD);
- 2.13.10.4 Chronic Obstructive Pulmonary Disease (COPD);
- 2.13.10.5 Diabetes;
- 2.13.10.6 Adult Preventive Care;
- 2.13.10.7 Prenatal, Postpartum and Interconceptual Care;
- 2.13.10.8 Smoking Cessation;
- 2.13.10.9 Behavioral Health (mental health and substance abuse) screening, assessment, and treatment, including medication management and PCP follow-up;
- 2.13.10.10 Psychotropic medication management;
- 2.13.10.11 Clinical Pharmacy Medication Review;
- 2.13.10.12 Coordination of community support and services for Enrollees in HCBS Waivers;
- 2.13.10.13 Community reintegration and support; and
- 2.13.10.14 Long-term Care (LTC) residential coordination of services.
- 2.13.11 The Contractor shall put a basic system in place which promotes continuity of Care Management. The Contractor shall provide documentation on:
 - 2.13.11.1 Monitoring the quality of care across all services and all treatment modalities and transitions of care; and
 - 2.13.11.2 Studies, reports, protocols, standards, worksheets, minutes, or such other documentation as may be appropriate, concerning its QA activities and corrective actions and make such documentation available to CMS and the Department upon request.
- 2.13.12 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. The Contractor shall document coordination of QA activities and other management activities.
 - 2.13.12.1 QA information shall be used in recredentialing, recontracting and annual performance evaluations.

- 2.13.12.2 QA activities shall be coordinated with other performance monitoring activities, including utilization management, risk management, and resolution and monitoring of Enrollee complaints and grievances.
- 2.13.12.3 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.
 - 2.13.12.3.1 QA information shall be used in recredentialing, re-contracting and annual performance evaluations.
 - 2.13.12.3.2 QA activities shall be coordinated with other performance monitoring activities, including utilization management, risk management, and resolution and monitoring of Enrollee complaints and grievances.
 - 2.13.12.3.3 There shall be documented evidence that management decisions of the Contractor are reflective of QA activities and findings in the following areas:
 - 2.13.12.3.4 Network changes;
 - 2.13.12.3.5 Benefits redesign;
 - 2.13.12.3.6 Medical management systems (e.g., pre-certification);
 - 2.13.12.3.7 Practice feedback to and from Physicians;
 - 2.13.12.3.8 Other services, such as dental, vision, etc.;
 - 2.13.12.3.9 Member services;
 - 2.13.12.3.10 Care Management and Disease Management; and
 - 2.13.12.3.11 Enrollee education.
- 2.13.13 Compliance.
 - 2.13.13.1 In the aggregate, without reference to individual Physicians or Enrollee identifying information, all Quality Assurance findings, conclusions, recommendations, actions taken, results or other documentation relative to QA shall be reported to CMS and the Department on a quarterly basis or as requested by CMS and the Department. CMS and the Department shall be notified of any Provider or Subcontractor who ceases to be an Affiliated Provider or Subcontractor for a quality of care issue.

- 2.13.13.2 The Contractor shall, at the direction of CMS and the Department, cooperate with the external, independent quality review process conducted at least annually by the EQRO. Such review process shall include, at a minimum, reviews of the quality outcomes, timeliness of, and access to, Covered Services. The 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 the Contractor following the EQRO's findings.
- 2.13.13.3 The 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 the Contractor's Affiliated 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 (b)(2). The 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. The Contractor shall have in effect a program consistent with the utilization control requirements of 42 C.F.R. Part 456. This program will include, when required by the regulations, written plans of care and certifications of need of care.
- 2.13.13.4 The Contractor shall perform and report the quality and utilization measures required by CMS and the Department. The Contractor shall not modify the reporting specifications methodology prescribed by CMS and the Department without first obtaining CMS and the Department's written approval. The Contractor must obtain an independent validation of its findings by a recognized entity, e.g., NCQA-certified auditor, as approved by CMS and the Department. CMS and the Department's External Quality Review Organization will perform an independent validation of at least a sample of the Contractor's findings.
- 2.13.13.5 The Contractor shall monitor other performance measures not specifically stated in this Contract that are required by CMS. CMS and the Department will use its best efforts to notify the Contractor of new CMS requirements.
- 2.13.13.6 The Contractor shall perform and report the HCBS Waiver Performance Measures. The Contractor shall not modify the reporting specifications methodology prescribed by CMS and the Department without first obtaining CMS and the Department's written approval.

2.13.14 Performance Measurement

- 2.13.14.1 Performance Measurement. The Contractor shall engage in performance measurement and Performance Improvement Projects, designed to achieve, through ongoing measurement and intervention, significant improvements, sustained over time, in a clinical care and non-clinical care processes, outcomes and Enrollee experience. The Contractor's QAP must include a health information system to collect, analyze, and report quality performance data as described in 42 C.F.R. §§ 422.516(a) and 422.152, 423.514, and 438.242(a) and (b), and 330.

Measurement and improvement projects shall be conducted in accordance with requirements in the Memorandum of Understanding between CMS and the Department of February 22, 2013 (MOU), Figure 7-1 Core Quality Measures, and as described in this Contract and shall include, but are not limited to:

- 2.13.14.1.1 All HEDIS, HOS and CAHPS data, as well as all other measures listed in Figure 7-1 Core Quality Measures of the MOU referenced above (Figure 7-1). HEDIS, HOS and CAHPS must be reported consistent with Medicare requirements. All existing Part D metrics will be collected as well. Additional details, including technical specifications, will be provided in annual guidance for the upcoming reporting year.
- 2.13.14.1.2 The Contractor shall collect annual data and contribute to all Demonstration QI-related processes, as directed by the Department and CMS, as follows:
- 2.13.14.1.2.1 Collect and submit to the Department, CMS and/or CMS' contractors, in a timely manner, data for the measures listed in Figure 7-1;
 - 2.13.14.1.2.2 Contribute to all applicable Department and CMS data quality assurance processes, which shall include, but not be limited to, responding, in a timely manner, to data quality inadequacies identified by the Department and rectifying those inadequacies, as directed by the Department;
 - 2.13.14.1.2.3 Contribute to the Department and CMS data regarding the individual and aggregate performance of Illinois Medicaid contracted plans with respect to the noted measures; and
 - 2.13.14.1.2.4 Contribute to the Department processes culminating in the publication of any additional technical or other reports by the Department related to the noted measures.
 - 2.13.14.1.2.5 The Contractor shall demonstrate how it will utilize results of the measures listed in **Figure 7-1** in designing QI initiatives.

2.13.14.2 Enrollee Experience Surveys

2.13.14.2.1 The Contractor shall conduct Enrollee experience survey activities, as directed by the Department and/or CMS, disclose the survey results to the Department and CMS, and disclose the survey results to Enrollees upon request, as follows:

- 2.13.14.2.1.1 Conduct, as directed by the Department and CMS, an annual CAHPS survey, including the Persons with Mobility Impairment Supplemental Questions, using an approved CAHPS vendor;
- 2.13.14.2.1.2 Conduct, as directed by the Department, the POSM survey for Enrollees in the Elderly Waiver (Community Care Program (CCP)) HCBS Waiver. This shall require that individuals conducting such survey are appropriately and comprehensively trained, culturally competent, and knowledgeable of the population being surveyed;
- 2.13.14.2.1.3 Contribute, as directed by the Department and CMS, to data quality assurance processes, including responding, in a timely manner, to data quality inadequacies identified by the Department and CMS and rectifying those inadequacies, as directed by the Department and CMS; and
- 2.13.14.2.1.4 The Contractor shall demonstrate best efforts to utilize member experience survey results in designing QI initiatives.

2.13.15 Quality Improvement Project Requirements.

2.13.15.1 The Contractor shall implement and adhere to all processes relating to the quality improvement project (QIP) requirements, as directed by the Department and CMS, as follows:

- 2.13.15.1.1 In accordance with 42 C.F.R. §§ 438.330(d) and 422.152 (d), measure data using objective quality indicators; and collect information and data in accordance with QIP requirement specifications for its Enrollees; using the format and submission guidelines specified by the Department and CMS in annual guidance provided for the upcoming contract year;
- 2.13.15.1.2 Implement the quality improvement project requirements, in a culturally competent manner, to achieve objectives as specified in Section 2.13 above;
- 2.13.15.1.3 Evaluate the effectiveness of quality improvement interventions;

- 2.13.15.1.4 Plan and initiate processes to sustain achievements and continue improvements;
- 2.13.15.1.5 Submit to the Department and CMS, comprehensive written reports, using the format, submission guidelines and frequency specified by the Department and CMS. Such reports shall include information regarding progress on QIP goals and objectives, barriers encountered and new knowledge gained. As directed by the Department and CMS, the Contractor shall present this information to the Department and CMS at the end of the quality improvement project cycle as determined by the Department and CMS; and
- 2.13.15.1.6 In accordance with 42 C.F.R. § 422.152 (c), develop a chronic care improvement program (CCIP) and establish criteria for participation in the program. The CCIP must be relevant to and target the Contractor's plan population. Although the Contractor has the flexibility to choose the design of their CCIPs, the Department and CMS may require them to address specific topic areas.
- 2.13.16 CMS-Specified Performance Measurement and Performance Improvement Projects
 - 2.13.16.1 The Contractor shall conduct additional performance measurement or performance improvement projects (PIPs) if mandated by CMS pursuant to 42 C.F.R. § 438.330(a)(2).
- 2.13.17 The Contractor shall assess the risks from external and internal sources to identify and analyze the relevant risks to the achievement of objectives. A mechanism shall be employed to identify and evaluate key exposures or vulnerabilities and establish plans for mitigating overall risks to the Enrollee, the Department and the Contractor. The Contractor is responsible for conducting (at least annually) a risk assessment of events that occur or could occur that impact the vulnerability of the Enrollee, the Department and the Contractor. The impact of the risk shall be measurable or definable. Definable terms are measurable common measurement units (e.g., dollars, ratios in areas of health and safety).
 - 2.13.17.1 The risk assessment shall include input from staff throughout the Contractor's organization seeking input given the objectives about processes, resources and solutions.
 - 2.13.17.2 The Contractor's Quality Assurance Program shall list how the impact can best be measured and a description of the controls in place to manage risk and the effectiveness of those controls.
 - 2.13.17.3 Contractor's Quality Assurance Program shall perform and report the risk assessment outcomes and improvement in the committee minutes.
- 2.13.18 External Quality Review (EQR) Activities

- 2.13.18.1 The Contractor shall take all steps necessary to support the EQRO contracted by the Department and the QIO to conduct EQR Activities, in accordance with 42 C.F.R. § 438.358 and 42 C.F.R. § 422.153. EQR Activities shall include, but are not limited to:
 - 2.13.18.1.1 Annual validation of performance measures reported to the Department, as directed by Department, or calculated by Department;
 - 2.13.18.1.2 Annual validation of performance improvement projects required by Department and CMS; and
 - 2.13.18.1.3 At least once every three years, review of compliance with standards mandated by 42 C.F.R. Part 438, Subpart E, and at the direction of Department, regarding access, structure and operations, and quality of care and services furnished to Enrollees.
- 2.13.18.2 The Contractor shall take all steps necessary to support the EQRO and QIO in conducting EQR Activities including, but not limited to:
 - 2.13.18.2.1 Designating a qualified individual to serve as Project Director for each EQR Activity who shall, at a minimum:
 - 2.13.18.2.1.1 Oversee and be accountable for compliance with all aspects of the EQR activity;
 - 2.13.18.2.1.2 Coordinate with staff responsible for aspects of the EQR activity and ensure that staff respond to requests by the EQRO, QIO, Department and/or CMS staff in a timely manner;
 - 2.13.18.2.1.3 Serve as the liaison to the EQRO, QIO Department and CMS and answer questions or coordinate responses to questions from the EQRO, QIO, CMS and Department in a timely manner; and
 - 2.13.18.2.1.4 Ensure timely access to information systems, data, and other resources, as necessary for the EQRO and/or QIO to perform the EQR Activity and as requested by the EQRO, QIO, CMS or Department.
 - 2.13.18.2.2 Maintaining data and other documentation necessary for completion of EQR Activities specified above. The Contractor shall maintain such documentation for a minimum of seven years;

- 2.13.18.2.3 Reviewing the EQRO's draft EQR report and offering comments and documentation to support the correction of any factual errors or omissions, in a timely manner, to the EQRO or Department;
- 2.13.18.2.4 Participating in ICO-specific and cross-ICO meetings relating to the EQR process, EQR findings, and/or EQR trainings with the EQRO and Department;
- 2.13.18.2.5 Implementing actions, as directed by Department and/or CMS, to address recommendations for quality improvement made by the EQRO or QIO, and sharing outcomes and results of such activities with the EQRO or QIO, Department, and CMS in subsequent years; and
- 2.13.18.2.6 Participating in any other activities deemed necessary by the EQRO and/or QIO and approved by Department and CMS, including but not limited to the existing QIO responsibilities for when the an Enrollee appeals a Contractor's termination of pre-authorized coverage of an inpatient hospital admission or SNF, Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) services.

2.14 Marketing, Outreach, and Enrollee Communications Standards

2.14.1 General Marketing, Outreach, and Enrollee Communications Requirements

- 2.14.1.1 The Contractor is subject to rules governing marketing and Enrollee Communications as specified under section 1851(h) of the Social Security Act; 42 C.F.R. §§ 422.111, 422.2260 et seq., 423.120(b) and (c), 423.128, 423.2260 et seq., and 438.10; and the Medicare Marketing Guidelines , with the following exceptions or modifications:
 - 2.14.1.1.1 The Contractor must refer Enrollees and Potential Enrollees who inquire about the Demonstration eligibility or enrollment to CES, although the Contractor may provide Enrollees and Potential Enrollees with information about the Contractor's Demonstration Plan and its benefits prior to referring a request regarding eligibility or enrollment to the CES;
 - 2.14.1.1.2 The Contractor must make available to CMS and the Department, upon request, current schedules of all educational events conducted by the Contractor to provide information to Enrollees or Potential Enrollees;

- 2.14.1.1.3 The Contractor must convene all educational and marketing events at sites within the Contractor's Service Area that are physically accessible to all Enrollees or Potential Enrollees, including persons with disabilities and persons using public transportation.
- 2.14.1.1.4 The Contractor may not offer financial or other incentives, including private insurance, to induce Potential Enrollees to enroll with the Contractor; and, the Contractor may not offer financial or other incentives, including private insurance, to induce Enrollees or Potential Enrollees to refer a friend, neighbor, or other person to enroll with the Contractor;
- 2.14.1.1.5 The Contractor may not directly or indirectly conduct door-to-door, telephone, or other unsolicited contacts; and
- 2.14.1.1.6 The Contractor may not use any Marketing, Outreach, or Enrollee Communications materials that contain any assertion or statement (whether written or oral) that:
 - 2.14.1.1.6.1 The Enrollee or Potential Enrollee must enroll with the Contractor in order to obtain benefits or in order not to lose benefits;
 - 2.14.1.1.6.2 The Contractor is endorsed by CMS, the Department, Medicare, Medicaid, the Federal government, Illinois, or similar entity.

- 2.14.2 The Contractor's Marketing, Outreach, and Enrollee Communications materials must be:
 - 2.14.2.1 Made available in alternative formats, upon request and as needed, to assure effective communication for blind and vision-impaired Enrollees;
 - 2.14.2.2 Provided in a manner, format and language that may be easily understood by persons with limited English proficiency, or for those with Developmental Disabilities or cognitive impairments;
 - 2.14.2.3 Translated into Prevalent Languages for all read vital materials, as specified in the Medicare-Medicaid marketing guidance and annual guidance to Contractors on specific translation requirements for their service areas;
 - 2.14.2.4 Sent in Spanish to members whose primary language is known to be Spanish, if the materials are pre-enrollment or enrollment materials;
 - 2.14.2.5 As applicable, mailed with non-English language taglines that alert Enrollees with limited English proficiency to the availability of language assistance service, free of charge, and how those services can be obtained, consistent with the requirements

- of 45 C.F.R. Part 92. Distributed to the Contractor's entire Service Area as specified in **Appendix I** of this Contract; and
- 2.14.2.6 As applicable, mailed with a non-discrimination notice or statement consistent with the requirements of 45 C.F.R. Part 92.
 - 2.14.3 Submission, Review, and Approval of Marketing, Outreach, and Enrollee Communications Materials
 - 2.14.3.1 The Contractor must receive Prior Approval of all marketing and Enrollee Communications materials in categories of materials that CMS and the Department require to be prospectively reviewed. Contractor materials may be designated as eligible for the File & Use process, as described in 42 C.F.R. §§ 422.2262(b) and 423.2262(b), and will therefore be exempt from prospective review and approval by both CMS and the Department. CMS and the Department may agree to defer to one or the other Party for review of certain types of marketing and Enrollee Communications, as agreed in advance by both parties. The Contractor must submit all materials that are consistent with the definition of marketing materials at 42 C.F.R. § 422.2260, whether prospectively reviewed or not, via the CMS HPMS Marketing Module.
 - 2.14.3.2 CMS and the Department may conduct additional types of review of the Contractor's Marketing, Outreach, and Enrollee Communications activities, including, but not limited to:
 - 2.14.3.2.1 Review of on-site marketing facilities, products, and activities during regularly scheduled Contract compliance monitoring visits.
 - 2.14.3.2.2 Random review of actual Marketing, Outreach, and Enrollee Communications pieces as they are used in the marketplace.
 - 2.14.3.2.3 "For cause" review of materials and activities when complaints are made by any source, and CMS or the Department determines it is appropriate to investigate.
 - 2.14.3.2.4 "Secret shopper" activities where CMS or the Department request the Contractor's Written Materials.
 - 2.14.3.3 Beginning of Marketing, Outreach and Enrollee Communications Activity
 - 2.14.3.3.1 The Contractor may not begin Marketing, Outreach, and Enrollee Communications activities to new Potential Enrollees or Enrollees more than 90 days prior to the effective date of enrollment for the following Contract year.
 - 2.14.4 Requirements for Dissemination of Marketing, Outreach, and Enrollee Communications Materials

- 2.14.4.1 Consistent with the timelines specified in the Medicare-Medicaid marketing guidance, the Contractor must provide new Enrollees with the following materials which must also be provided annually thereafter:
 - 2.14.4.1.1 An Evidence of Coverage (EOC)/Member Handbook document that is consistent with the requirements at 42 C.F.R. §§ 438.10, 422.111, and 423.128; that includes information about all Covered Services, as outlined below; and, that uses the model document developed by CMS and the Department:
 - 2.14.4.1.1.1 Enrollee rights (see Appendix B);
 - 2.14.4.1.1.2 An explanation of the process by which clinical information, including diagnostic and medication information, may be available to key caregivers;
 - 2.14.4.1.1.3 How to request and obtain a copy of the Enrollee's medical records, and to request that they be amended or corrected;
 - 2.14.4.1.1.4 How to obtain access to specialty, behavioral health, pharmacy and long-term services and supports Providers;
 - 2.14.4.1.1.5 How to obtain services and prescription drugs for Emergency Medical Conditions and Urgent Care in and out of the Provider Network and in and out of the Service Area; including:
 - 2.14.4.1.1.5.1 What constitutes Emergency Medical Condition, Emergency Services, and Post-Stabilization Services, with reference to the definitions in 42 C.F.R. §§ 422.113 and 438.114(a);
 - 2.14.4.1.1.5.2 The fact that prior authorization is not required for Emergency Services;
 - 2.14.4.1.1.5.3 The process and procedures for obtaining Emergency Services, including the use of the 911 telephone system or its local equivalent;
 - 2.14.4.1.1.5.4 The locations of any emergency settings and other locations at which Providers and hospitals furnish Emergency Services and Post-Stabilization Services covered under the Contract;
 - 2.14.4.1.1.5.5 That the Enrollee has a right to use any hospital or other setting for emergency care; and

- 2.14.4.1.1.5.6 The Post-Stabilization Care Services rules at 42 C.F.R. § 422.113(c).
- 2.14.4.1.1.6 Information about Advance Directives (at a minimum those required in 42 C.F.R. §§ 489.102, 422.128, and 438.3(j)), including Enrollee rights under the law of the Illinois, which information shall be updated to reflect any changes in state law as soon as possible, but no later than ninety (90) days after the effective date of changes; the Contractor's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of Advance Directives as a matter of conscience; that complaints concerning noncompliance with the Advance Directive requirements may be filed with the Contractor; designating a health care proxy, and other mechanisms for ensuring that future medical decisions are made according to the desire of the Enrollee;
- 2.14.4.1.1.7 How to obtain assistance from ESRs;
- 2.14.4.1.1.8 How to file Grievances and Internal and External Appeals, including:
 - 2.14.4.1.1.8.1 Grievance, Appeal and fair hearing procedures and timeframes;
 - 2.14.4.1.1.8.2 Toll free numbers that the Enrollee can use to file a Grievance or an Appeal by phone; and
 - 2.14.4.1.1.8.3 A statement that when requested by the Enrollee, benefits will continue at the plan level for all benefits and, if the Enrollee files an appeal or a request for State fair hearing within the timeframes specified for filing, the Enrollee may be required to pay to the Contractor the cost of services furnished while the Appeal is pending if the final decision is adverse to the Enrollee; and
- 2.14.4.1.1.9 How the Enrollee can identify who the Enrollee wants to receive written notices of denials, terminations, and reductions;
- 2.14.4.1.1.10 How to obtain assistance with the Appeals processes through the ESR and other assistance mechanisms as the

Department or CMS may identify, including an Ombudsperson;

- 2.14.4.1.1.11 The extent to which, and how, Enrollees may obtain benefits, including Family Planning services, from out-of-network Providers;
- 2.14.4.1.1.12 How and where to access any benefits that are available under the State Plan or HCBS Waivers, but that are not covered under the Contract, including any cost sharing, and how transportation is provided;
- 2.14.4.1.1.13 How to change Providers; and
- 2.14.4.1.1.14 How to disenroll voluntarily.

2.14.4.1.2 A Summary of Benefits (SB) that contains a concise description of the important aspects of enrolling in the Contractor's plan, as well as the benefits offered under the Contractor's plan, including any cost sharing, applicable conditions and limitations, and any other conditions associated with receipt or use of benefits, and uses the model document developed by CMS and the Department. The SB must provide sufficient detail to ensure that Enrollees understand the benefits to which they are entitled. For new Enrollees, the SB is required only for individuals enrolled through Passive Enrollment. For current Enrollees, the SB must be sent with the Annual Notice of Change (ANOC) as described in the Medicare-Medicaid marketing guidance.

2.14.4.1.3 A combined Provider and Pharmacy Directory that is consistent with the requirements in Section 2.14.5, or a distinct and separate notice on how to access this information online and how to request a hard copy, as specified in Section 2.14.5, Chapter 4 of the Medicare Managed Care Manual, and the Medicare-Medicaid marketing guidance.

2.14.4.1.4 A single identification (ID) card for accessing all Covered Services under the Demonstration Plan that uses the model document developed by CMS and the Department;

2.14.4.1.5 A comprehensive, integrated formulary that includes prescription drugs and over-the-counter products required to be covered by Medicare Part D and the Department's outpatient prescription drug benefit and that uses the model document developed by CMS and the Department, or a distinct and separate notice on how to access this information online and how to request a hard copy, as specified in the Medicare Marketing Guidelines and the Medicare-Medicaid marketing guidance.

2.14.4.1.6 The procedures for an Enrollee to change Demonstration Plans or to opt out of the Demonstration.

2.14.4.1.7 Enrollee rights as specified in Appendix B.

2.14.4.2 Welcome Calls. The Contractor will conduct “Welcome Calls” to each new Enrollee within thirty (30) days after the effective date of enrollment. For those new Enrollees who the Contractor successfully contacts, the Contractor will provide health education and 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.

2.14.4.3 The Contractor must provide Enrollees the following materials on an ongoing basis:

2.14.4.3.1 An ANOC that summarizes all major changes to the Contractor’s covered benefits from one Contract year to the next, and that uses the model document developed by CMS and the Department;

2.14.4.3.2 As needed to replace old versions or upon an Enrollee’s request, a single ID card for accessing all Covered Services provided by the Contractor.

2.14.4.4 The Contractor must provide all Medicare Part D required notices, with the exception of the creditable coverage and late enrollment penalty notices required under Chapter 4 of the Prescription Drug Benefit Manual, and the Low Income subsidy (LIS) Rider required under Chapter 13 of the Prescription Drug Benefit Manual.

2.14.4.5 Consistent with the requirement at 42 C.F.R. § 423.120(b)(5), the Contractor must provide Enrollees with at least sixty (60) days advance notice regarding changes to the comprehensive, integrated formulary.

2.14.4.6 The Contractor must provide Enrollees with notice of any change that the State defines as significant in the information specified in 42 C.F.R. § 438.10(g) at least thirty (30) days before the intended effective date of the change.

2.14.4.7 The Contractor must ensure that all information provided to Enrollees and Potential Enrollees (and families or caregivers when appropriate) is provided in a manner and format that is easily understood and that is:

2.14.4.7.1 Made available in large print (at least sixteen (16) point font) to Enrollees as an alternative format, upon request;

2.14.4.7.2 For vital materials, available in Prevalent Languages, as provided for in the Medicare-Medicaid marketing guidance;

- 2.14.4.7.3 Written with cultural sensitivity and at a sixth grade reading level; and
- 2.14.4.7.4 Available in alternative formats, according to the needs of Enrollees and Potential Enrollees, including Braille, oral interpretation services in non-English languages, as specified in Section 2.14.2 of this Contract; audiotope; American Sign Language video clips, and other alternative media, as requested.
- 2.14.4.8. The Contractor will provide information to Beneficiaries on Physician Incentive Plans upon the Beneficiary's request, pursuant to 42 C.F.R. § 438.10(f)(3).
- 2.14.5 Provider and Pharmacy Network Directory.
 - 2.14.5.1 Maintenance and Distributions. The Contractor must:
 - 2.14.5.1.1 Maintain a combined Provider and Pharmacy Directory that uses the model document developed by CMS and the Department;
 - 2.14.5.1.2 Provide either a copy or a distinct and separate notice on how to access this information online and how to request a hard copy, as specified in Chapter 4 of the Medicare Managed Care Manual and the Medicare-Medicaid marketing guidance, to all new Enrollees at the time of enrollment and annually thereafter to continuing Enrollees;
 - 2.14.5.1.3 Provide an email address and toll-free phone/TTY for enrollees to report any mistakes found in the Provider and Pharmacy Directory;
 - 2.14.5.1.4 When there is a significant change to the network, the Contractor must provide notice to Enrollees, as specified in Chapter 4 of the Medicare Managed Care Manual and the Medicare-Medicaid marketing guidance;
 - 2.14.5.1.5 The Contractor must ensure an up-to-date copy is available on the Contractor's website, consistent with the requirements at 42 C.F.R. §§ 422.111(h) and 423.128(d) and the Medicare Marketing Guidelines. The directory must be available online in a searchable and machine readable file and format, and the directory must be publicly accessible without the necessity of providing a password, a username, or personally identifiable information;
 - 2.14.5.1.6 Include written and oral offers of such Provider and Pharmacy Directory in its outreach and orientation sessions for new Enrollees.
 - 2.14.5.2 Content of Provider and Pharmacy Directory. The Provider and Pharmacy Directory must include, at a minimum, the following information for all Providers in the Contractor's Provider Network:
 - 2.14.5.2.1 The names, addresses, and telephone numbers of all current network Providers, and the total number of each type of Provider, consistent with 42 C.F.R. § 422.111(h);

- 2.14.5.2.2 As applicable, Network Providers with training in and experience treating, including Providers with expertise in treating the Demonstration population;
- 2.14.5.2.3 For Network Providers, that are health care professionals or non-facility based and for facilities and facility-based Network Providers, office hours, including the names of any Network Provider sites open after 5:00 p.m. (CST) weekdays and on weekends;
- 2.14.5.2.4 As applicable, whether the health care professional or non-facility based Network Provider has completed cultural competence training;
- 2.14.5.2.5 For Network Providers that are health care professionals or non-facility based and, as applicable, for facilities and facility-based Network Providers, licensing information, such as license number or National Provider Identifier;
- 2.14.5.2.6 Whether the Network Provider has specific accommodations for people with physical disabilities, such as wide entry, wheelchair access, accessible exam rooms and tables, lifts, scales, bathrooms and stalls, grab bars, or other accessible equipment;
- 2.14.5.2.7 Whether the Provider is accepting new patients as of the date of publication of the directory;
- 2.14.5.2.8 Whether the Network Provider is on a public transportation route;
- 2.14.5.2.9 Any languages other than English, including ASL, spoken by Network Providers or offered by skilled medical interpreters at the Provider's site;
- 2.14.5.2.10 For behavioral health Providers, training in and experience treating trauma, child welfare, and substance use;
- 2.14.5.2.11 As applicable, whether the network Provider has access to language line interpreters; and
- 2.14.5.2.12 A description of the roles of the PCP and ICT and the process by which Enrollees select and change PCPs.
- 2.14.5.2.13 The directory must include, at a minimum, the following information for all pharmacies in the Contractor's pharmacy network:
 - 2.14.5.2.13.1 The names, addresses, office hours, and telephone numbers of all current Network Providers and pharmacies; and

2.14.5.2.13.2

Instructions for the Enrollee to the contact the Enrollee's toll free Enrollee Services telephone line (as described in Section 2.10.1) for assistance in finding a convenient pharmacy.

2.15 Financial Requirements

2.15.1 General

2.15.1.1 The Contractor, at all times, shall be in compliance with all financial requirements of the Health Maintenance Organization Act (215 ILCS 125/1 et seq.), all rules promulgated thereunder, and 42 C.F.R. § 438.116.

2.15.2 Other Financial Requirements

2.15.2.1 The Contractor shall pay for DHS-DRS HCBS Waiver services provided by Individual Providers, including Personal Assistants, by making payment to the Department. 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 Provider. 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 Department 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 Department 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 pursuant to Section 2.15.2.2. 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 and to the extent such increased costs would exist absent the Demonstration, the Department will address adjustments of the Capitation rates as set forth in Section 4.4.3. The Department shall not negotiate contract rates with SEIU that are applicable only to the Demonstration. 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.

2.15.2.2 The Contractor shall pay all Providers of HCBS Waiver services at a rate no less than the State Medicaid rate for such Covered Services.

2.15.2.2.1 The 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. In the event that any other HCBS Waiver becomes subject to a duly promulgated State rule that includes a similar enhanced rate, the Contractor shall pay the affected Provider agencies at a rate that includes such enhanced rate.

2.15.2.2.2 The Contractor shall not discriminate against Providers of HCBS Waiver services that offer health insurance to their in-home services workers.

2.15.2.3 The Contractor shall pay all Providers that are NFs owned by a county that has an intergovernmental agreement with the Department at a rate no less than the Department pays such a NF according to the approved State Plan. The Contractor shall not discriminate against such NFs based upon the rate required by this Section 2.15.2.3.

2.16 Data Submissions, Reporting Requirements, and Surveys

2.16.1 General Requirements for Data. The Contractor must provide and require its First Tier, Downstream and Related Entities to provide:

2.16.1.1 All information CMS and the Department require under the Contract related to the performance of the Contractor's responsibilities, including non-medical information for the purposes of research and evaluation;

2.16.1.2 Any information CMS and the Department require to comply with all applicable federal or State laws and regulations; and

2.16.1.3 Any information CMS or the Department require for external rapid cycle evaluation, including, but not limited to, program expenditures, service utilization rates, rebalancing from institutional to community settings, Enrollee satisfaction, Enrollee Complaints and Appeals and enrollment/disenrollment rates.

2.16.2 General Reporting Requirements. The Contractor must:

2.16.2.1 Submit to the Department applicable Illinois reporting requirements;

2.16.2.2 Submit to CMS applicable reporting requirements in compliance with 42 C.F.R. §§ 422.516, 423.514, and 42 C.F.R. §§ 438.604 and 438.606; for the data required to be

submitted under 42 C.F.R. § 438.604, certify pursuant to requirements specified in 42 C.F.R. § 438.606.

- 2.16.2.3 Submit to the Department all applicable Demonstration reporting requirements;
- 2.16.2.4 Submit to CMS and the Department all required reports and data in accordance with the specifications, templates and time frames described in this Contract, unless otherwise directed or agreed to by CMS and the Department;
- 2.16.2.5 Report HEDIS, HOS, and CAHPS data, as well as measures related to long-term services and supports. HEDIS, HOS, and CAHPS measures will be reported consistent with Medicare requirements for HEDIS, plus additional Medicaid measures required by the Department. All existing Part D metrics will be collected as well. Such measures shall include a combined set of core measures that the Contractor must report to CMS and the Department;
- 2.16.2.6 Pursuant to 42 C.F.R. § 438.3(g), comply with any reporting requirements on Provider Preventable Conditions in the form and frequency as may be specified by the Department; and
- 2.16.2.7 Submit at the request of CMS or the Department additional ad hoc or periodic reports or analyses of data related to the Contract.

2.16.3 Information Management and Information Systems

2.16.3.1 General. The Contractor shall:

2.16.3.1.1 Maintain Information Systems (Systems) that will enable the Contractor to meet all of the Department's requirements as outlined in this Contract. The Contractor's Systems shall be able to support current Department requirements, and any future IT architecture or program changes. Such requirements include, but are not limited to, the following State standards:

2.16.3.1.1.1 The Illinois Unified Process Methodology User Guide;

2.16.3.1.1.2 The User Experience and Style Guide Version 2.0;

2.16.3.1.1.3 Information Technology Architecture Version 2.0; and

2.16.3.1.1.4 Enterprise Web Accessibility Standards 2.0.

2.16.3.1.2 Ensure a secure, HIPAA-compliant exchange of Member information between the Contractor and the Department and any other entity deemed appropriate by the Department. Such files shall be transmitted to the Department through secure FTP, HTS, or a similar secure data exchange as determined by the Department;

- 2.16.3.1.3 Develop and maintain a website that is accurate and up-to-date, and that is designed in a way that enables Enrollees and Providers to quickly and easily locate all relevant information. If directed by the Department, establish appropriate links on the Contractor's website that direct users back to the Department's website portal;
- 2.16.3.1.4 The Contractor shall cooperate with the Department in its efforts to verify the accuracy of all Contractor data submissions to the Department; and
- 2.16.3.1.5 Actively participate in any Illinois Systems Workgroup, as directed by the Department. The Workgroup shall meet in the location and on a schedule determined by the Department.

2.16.3.2 Design Requirements

- 2.16.3.2.1 The Contractor shall comply with the Department's requirements, policies, and standards in the design and maintenance of its Systems in order to successfully meet the requirements of this Contract.
- 2.16.3.2.2 The Contractor's Systems shall interface with the Department's Legacy Medicaid Management Information System (MMIS), the Department's MMIS system, the Illinois Virtual Gateway, and other Illinois IT architecture.
- 2.16.3.2.3 The Contractor shall have adequate resources to support the MMIS interfaces. The Contractor shall demonstrate the capability to successfully receive interface files, which include, but are not limited to:

- 2.16.3.2.3.1 Provider Extract File
- 2.16.3.2.3.2 HIPAA 834 Daily File;
- 2.16.3.2.3.3 HIPAA 834 Audit File;
- 2.16.3.2.3.4 HIPAA 820 File;
- 2.16.3.2.3.5 834 Transaction Error File;
- 2.16.3.2.3.6 Provider Error File;
- 2.16.3.2.3.7 Claims Files;
- 2.16.3.2.3.8 Prior Approval Files;
- 2.16.3.2.3.9 NCPDP Response File;
- 2.16.3.2.3.10 LTC Patient Credit File; and

2.16.3.2.3.11 Remittance Advice File.

2.16.3.2.4 The Contractor shall conform to HIPAA compliant standards for data management and information exchange.

2.16.3.2.5 The Contractor shall have controls to maintain information integrity.

2.16.3.2.6 The Contractor shall maintain appropriate internal processes to determine the validity and completeness of data submitted to Illinois.

2.16.3.3 System Exchange of Encounter Data

2.16.3.3.1 The Contractor's Systems shall generate and transmit Encounter Data files according to the specifications outlined Section 2.17 of this Contract, as updated from time-to-time; and

2.16.3.3.2 The Contractor shall maintain processes to ensure the validity, accuracy and completeness of the Encounter Data in accordance with the standards specified Section 2.17.

2.16.4 Accepting and Processing Assessment Data

2.16.4.1 System Access Management and Information Accessibility Requirements

2.16.4.1.1 The Contractor shall make all Systems and system information available to authorized CMS, Department and other agency staff as determined by CMS or the Department to evaluate the quality and effectiveness of the Contractor's data and Systems.

2.16.4.1.2 The Contractor is prohibited from sharing or publishing CMS or Department data and information without prior written consent from CMS or the Department.

2.16.4.2 System Availability and Performance Requirements

2.16.5 The Contractor shall ensure that its Enrollee and Provider web portal functions and phone-based functions are available to Enrollees and Providers twenty-four (24) hours a day, seven (7) days a week.

2.16.6 The Contractor shall draft an alternative plan that describes access to Enrollee and Provider information in the event of system failure. Such plan shall be contained in the Contractor's Continuity of Operations Plan (COOP) and shall be updated annually and submitted to the Department upon request. In the event of system failure or unavailability, the Contractor shall notify the Department upon discovery and implement the COOP immediately.

2.16.7 The Contractor shall preserve the integrity of Enrollee-sensitive data that reside in both live and archived environments.

2.17 Encounter Reporting

- 2.17.1 The Contractor must meet any diagnosis and/or encounter reporting requirements that are in place for Medicare Advantage plans, as may be updated from time to time. Furthermore, the Contractor's Systems shall generate and transmit Encounter Data files to CMS according to additional specifications as shall be provided by CMS or the Department and updated from time to time. The Contractor shall maintain processes to ensure the validity, accuracy and completeness of the Encounter Data in accordance with the standards specified in this section. CMS and the Department will provide technical assistance to the Contractor for developing the capacity to meet encounter reporting requirements.
- 2.17.2 Requirements. The Contractor shall:
- 2.17.2.1 Collect and maintain one hundred percent (100%) Encounter Data for all Covered Services provided to Enrollees, including from any subcapitated sources. Such data must be able to be linked to the Department's eligibility data;
 - 2.17.2.2 Participate in site visits and other reviews and assessments by CMS and the Department, or its designee, for the purpose of evaluating the Contractor's collection and maintenance of Encounter Data;
 - 2.17.2.3 Upon request by CMS, the Department, or their designee, provide medical records of Enrollees and a report from administrative databases of the Encounters of such Enrollees in order to conduct validation assessments. Such validation assessments may be conducted annually;
 - 2.17.2.4 Produce Encounter Data according to the specifications, format, and mode of transfer reasonably established by CMS, the Department, or their designee, in consultation with the Contractor. Such Encounter Data shall include elements and level of detail determined necessary by CMS and the Department. As directed by CMS and the Department, such Encounter Data shall also include the National Provider Identifier (NPI) of the ordering and referring physicians and professionals and any National Drug Code (NDC);
 - 2.17.2.5 Provide Encounter Data to CMS and the Department on a monthly basis or within time frames specified by CMS and the Department in consultation with the Contractor, including at a frequency determined necessary by CMS and the Department to comply with any and all applicable statutes, rules, regulations and guidance;
 - 2.17.2.6 Submit Encounter Data that is at a minimum standard for completeness and accuracy as defined by CMS. The Contractor must also correct and resubmit denied encounters as necessary; and

- 2.17.2.7 If CMS, the Department, or the Contractor, determines at any time that the Contractor's Encounter Data is not in accordance with the standards identified by CMS, the Contractor shall:
- 2.17.2.7.1 Notify CMS and the Department, prior to Encounter Data submission, that the data is not complete or accurate, and provide an action plan and timeline for resolution;
 - 2.17.2.7.2 Submit for CMS and the Department approval, within a time frame established by CMS and the Department, which shall in no event exceed thirty (30) days from the day the Contractor identifies or is notified that it is not in compliance with the Encounter Data requirements, a corrective action plan to implement improvements or enhancements to bring the accuracy and/or completeness to an acceptable level;
 - 2.17.2.7.3 Implement the CMS and the Department -approved corrective action plan within a time frame approved by CMS and the Department, which shall in no event exceed 30 days from the date that the Contractor submits the corrective action plan to CMS and the Department for approval; and
 - 2.17.2.7.4 Participate in a validation study to be performed by CMS, the Department, and/or their designee, following the end of a twelve-month period after the implementation of the corrective action plan to assess whether the Encounter Data is complete and accurate. The Contractor may be financially liable for such validation study.
- 2.17.2.8 Report as a voided claim in the monthly Encounter Data submission any claims that the Contractor pays, and then later determines should not have paid.

2.17.3 Failure to Submit Encounter Data to the Department. 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. The Department shall also review on a quarterly basis the Encounter Data submitted per the requirements set forth at Section 2.17.2.5 in accordance with the Illinois Medicaid Health Plan Encounter Utilization Monitoring (EUM) Requirements provided by the Department. If Contractor does not meet the standards by the evaluation date as set forth in EUM Requirements, the Department and CMS, may impose sanctions, which may include monetary penalties as described in Section 5.3.14 or ceasing passive enrollment to the Contractor as described in Section 3.2.2.7.2.

2.18 BEP Goals.

- 2.18.1 Contractor shall meet the BEP subcontracting goals set by the Department. The Department shall notify the Contractor of the goal at least ninety (90) days prior to February 1, 2014, and prior to the start of each subsequent State fiscal year, which begins on July 1 of each calendar year. The goal will be set as percentages of the Administrative Allowance, multiplied by the anticipated Enrollee months during the State fiscal year. Changes to the BEP subcontracting

goal may be made without amendment to the Contract if agreed to in writing by the Department and the Contractor. The percentages for the goals shall be twenty percent (20%) of the Administrative Allowance.

- 2.18.2 Prior to the start of each State fiscal year, the Contractor shall submit a BEP Utilization Plan for such State fiscal year, as a required report to the Department in a format specified by the Department, and such report being incorporated as a part of this Contract, sufficient to demonstrate compliance with the goals set by the Department for such State fiscal year. The first BEP Utilization Plan shall be due on December 1, 2013, and on June 1 prior to the start of each subsequent State fiscal Year. The Contractor shall provide the Department with a quarterly report regarding the Contractor's status of meeting the goal. The Contractor shall maintain a record of all relevant data with respect to the utilization of BEP certified subcontractors, including, but not limited to, 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, the Contractor shall grant full access to these records to any Authorized Person. The Department shall have the right to obtain from the Contractor any additional data reasonably related or necessary to verify any representations by the Contractor. A determination by the Department that the Contractor has not made a good faith effort to comply with goals set by the Department may result in a sanction under Section 5.3.14.12.

3 CMS and Department Responsibilities

3.1 Contract Management

- 3.1.1 Administration. Contract Management.

CMS and the Department will:

- 3.1.1.1 Designate a Contract Management Team that will include at least one representative from CMS and at least one contract manager from the Department authorized and empowered to represent CMS and the Department about all aspects of the Contract. Generally, the CMS part of the team will include the State Lead from the Medicare Medicaid Coordination Office (MMCO), Regional Office lead from the Consortium for Medicaid and Children's Health Operations (CMCHO), and an Account Manager from the Consortium for Health Plan Operations (CMHPO). The CMS representatives and the Department representatives will act as liaisons among the Contractor and CMS and the Department for the duration of the Contract. The Contract Management Team will:
- 3.1.1.1.1 Monitor compliance with the terms of the Contract, including, but not limited to, issuance of joint notices of non-compliance and enforcement;

- 3.1.1.1.2 Coordinate periodic audits and surveys of the Contractor;
- 3.1.1.1.3 Receive and respond to complaints;
- 3.1.1.1.4 Conduct regular meetings with the Contractor;
- 3.1.1.1.5 Coordinate requests for assistance from the Contractor and assign CMS and Department staff with appropriate expertise to provide technical assistance to the Contractor;
- 3.1.1.1.6 Make best efforts to resolve any issues applicable to the Contract identified by the Contractor, CMS, or the Department; and
- 3.1.1.1.7 Inform the Contractor of any discretionary action by CMS or the Department under the provisions of the Contract;
- 3.1.1.1.8 Coordinate review of marketing materials and procedures; and
- 3.1.1.1.9 Coordinate review of Grievance and Appeals data, procedures,
- 3.1.1.2 Review, approve, and monitor the Contractor's Outreach and orientation materials and procedures;
- 3.1.1.3 Review, approve, and monitor the Contractor's Complaint and Appeals procedures;
- 3.1.1.4 Monitor compliance with all applicable rules and requirements, and issue compliance notices, as appropriate;
- 3.1.1.5 Apply one or more of the sanctions provided in Section 5.3.14 including termination of the Contract in accordance with Section 5.5, if CMS and the Department determine that the Contractor is in violation of any of the terms of the Contract stated herein;
- 3.1.1.6 Conduct site visits as determined necessary by CMS and the Department to verify the accuracy of reported data; and
- 3.1.1.7 Coordinate the Contractor's external quality reviews conducted by the external quality review organization.

3.1.2 Performance Evaluation

CMS and the Department will, at their discretion:

- 3.1.2.1 Evaluate, through inspection or other means, the Contractor's compliance with the terms of this Contract, including but not limited to the reporting requirements in

Sections 2.16 and 2.17, and the quality, appropriateness, and timeliness of services performed by the Contractor and its Provider Network. CMS and the Department will provide the Contractor with the written results of these evaluations;

- 3.1.2.2 Conduct periodic audits of the Contractor, including, but not limited to, an annual independent external review and an annual site visit;
- 3.1.2.3 Conduct annual Enrollee surveys and provide the Contractor with written results of such surveys; and
- 3.1.2.4 Meet with the Contractor at least semi-annually to assess the Contractor's performance.

3.2 Enrollment and Disenrollment Systems

3.2.1 CMS and the Department will maintain systems to provide:

- 3.2.1.1 Enrollment and disenrollment information to the Contractor; and
- 3.2.1.2 Continuous verification of eligibility status.

3.2.2 Illinois Client Enrollment Services (CES)

The Department shall have responsibility to:

- 3.2.2.1 Develop generic materials to assist Potential Enrollees in choosing whether to enroll in the Demonstration. Said materials shall present the Contractor's Demonstration Plan in an unbiased manner to Potential Enrollees. The Department may collaborate with the Contractor in developing Demonstration Plan-specific materials;
- 3.2.2.2 Present the Contractor's Demonstration Plan in an unbiased manner to Potential Enrollees and Enrollees seeking to transfer from one Demonstration Plan to another. Such presentation(s) shall ensure that Potential Enrollees and such Enrollees are informed prior to enrollment of the following:
 - 3.2.2.2.1 The rights and responsibilities of participation in the Demonstration;
 - 3.2.2.2.2 The nature of the Contractor's care delivery system, including, but not limited to, the Provider Network; and
 - 3.2.2.2.3 Orientation and other Enrollee services made available by the Contractor.
- 3.2.2.3 Enroll, disenroll, and process transfer requests of Enrollees in the Contractor's Demonstration Plan, including completion of the Department's enrollment and disenrollment forms;

- 3.2.2.4 Ensure that Enrollees are informed at the time of enrollment or transfer of their right to terminate their enrollment voluntarily at any time, unless otherwise provided by federal law or waiver;
- 3.2.2.5 Be knowledgeable about the Contractor's policies, services, and procedures; and
- 3.2.2.6 At its discretion, develop and implement processes and standards to measure and improve the performance of the CES staff. The Department shall monitor the performance of the CES.
- 3.2.2.7 Perform the auto-assignment of Enrollees to Demonstration Plans in accordance with the terms below.
 - 3.2.2.7.1 Schedule of Auto-Assignment.
 - 3.2.2.7.1.1 Passive Enrollment will be phased in over a six (6) month period. Passive Enrollment into a Demonstration Plan will not exceed 5,000 Eligible Enrollees in the Greater Chicago area and 3,000 Eligible Enrollees in Central Illinois per month.
 - 3.2.2.7.1.2 Enrollees will receive no fewer than sixty (60) days notice prior to the effective date of enrollment, and will have the opportunity to opt out up until the last day of the month prior to the effective date of Enrollment.
 - 3.2.2.7.2 On a daily basis, the CES will inform the Contractor of individuals who have been enrolled with the Contractor by Passive Enrollment and the PCPs and Sites that were assigned. During the first twelve (12) month period of this Contract, the algorithm will attempt to equalize enrollment in all Demonstration Plans, taking into account both Enrollees who actively selected a Demonstration Plan and those who are passively enrolled. Thereafter, Passive Enrollment will occur systematically and randomly by algorithm in order to approximate equal distribution, subject to the capacity of each Demonstration Plan. The Department reserves the right to re-evaluate and modify the Passive Enrollment algorithm at any time for any reason after the first twelve (12) month period of this Contract, and may provide that Passive Enrollment will be based on the Contractor's performance on quality measures.
 - 3.2.2.7.3 Enrollment of Beneficiaries in Medicare Advantage by Auto-Assignment. Beneficiaries who do not opt out of the Demonstration, and who are enrolled in a Medicare Advantage plan that is operated by the same parent organization that operates a Demonstration Plan, will be eligible for Passive Enrollment into the parent organization's Demonstration Plan effective May 1, 2014. Eligible beneficiaries enrolled in a Medicare Advantage plan that is operated by a parent organization that is not offering a Demonstration Plan may enroll into the

Demonstration if they elect to disenroll from their current Medicare Advantage plan.

4 Payment and Financial Provisions

4.1 General Financial Provisions

4.1.1 Capitation Payments

4.1.1.1 CMS and the Department will each contribute to the total Capitation payment. CMS and the Department will each make monthly payments to the Contractor for their respective portion of the capitated rate, in accordance with the rates of payment and payment provisions set forth in Section 4.1.1.3 and subject to all applicable Federal and State laws, regulations, rules, billing instructions, and bulletins, as amended. The Contractor will receive three monthly payments for each Enrollee: one (1) amount from CMS reflecting coverage of Medicare Parts A/B services (Medicare Parts A/B Component), one amount from CMS reflecting coverage Medicare Part D services (Medicare Part D Component), and a third amount from the Department reflecting coverage of Medicaid services (Medicaid Component).

4.1.1.2 The Medicare Parts A/B Component will be risk adjusted using the Medicare Advantage CMS-HCC model and CMS-HCC ESRD model, except as specified in Section 4.2.4. The Part D direct subsidy portion of the Medicare Part D Component will be risk adjusted using the Part D RxHCC model. The Medicaid Component will utilize the rate cell methodology described in Section 4.2.1.

4.1.1.3 CMS and the Department will provide the Contractor with a rate report, to be signed by all Parties, on an annual basis for the upcoming calendar year.

4.1.1.4 On a regular basis, CMS will provide the Department with the Contractor--level payment information in the Medicare Plan Payment Report. The use of such information by the Department will be limited to financial monitoring, performing financial audits, and related activities, unless otherwise agreed to by CMS and the Contractor. On a regular basis, the Department will also provide to CMS Contractor plan-level payment information including the Medicaid Capitation Payments.

4.1.2 Demonstration Year Dates

Capitation Rate updates will take place on January 1st of each calendar year, however savings percentages and quality withhold percentages (see Sections 4.2.3.1 and 4.4.4) will be applied based on Demonstration Years, as follows:

Demonstration Year	Calendar Dates
1	February 1, 2014 - December 31, 2015
2	January 1, 2016 - December 31, 2016
3	January 1, 2017 - December 31, 2017
4	January 1, 2018 - December 31, 2018
5	January 1, 2019 - December 31, 2019

4.2 Capitated Rate Structure

4.2.1 Underlying Rate Structure for the Medicaid Component

- 4.2.1.1 The Department shall pay the Contractor on a Capitation basis (the Medicaid Component), based on the rate cell of the Enrollee, 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. An Enrollee's rate cell will be determined by the Enrollee's residential status (e.g., NF Resident, HCBS Waiver) as of the first day of the month. The Department will use its eligibility system to determine an Enrollee's rate cell. Delays in changes to an Enrollee's residential status being reflected in the Department's eligibility system, will cause adjustments to past Capitation payments to be made.
- 4.2.1.2 The rate cells for the Medicaid Component are stratified by age (21-64 and 65+), geographic service area (Greater Chicago and Central Illinois), and setting-of-care as follows:
- 4.2.1.2.1 NF. The NF rate cell will be paid for Enrollees residing in a NF on the first of the month in which the payment is made.
- 4.2.1.2.2 Waiver. The Waiver rate cell will be paid for Enrollees enrolled in a qualifying HCBS Waiver as of the first of the month in which the payment is made.
- 4.2.1.2.3 Community. The Community rate cell will be paid for Enrollees who do not meet the State's nursing home level of care criteria and do not reside in a NF or qualify for an HCBS Waiver.
- 4.2.1.2.4 The Department shall pay the Contractor a separate, State-funded-only monthly Capitation payment for an Enrollee who is residing in an Institution for Mental Diseases on the first day of the month (this rate cell is for IMD stays of more than 15 days in a calendar month and is state-funded only).
- 4.2.1.3 Selection factors will be used to account for variances that may arise if the enrolled population mix is vastly different than the experience used for rate setting. The Department will develop selection factors by stratifying the membership in the

base experience based on rate cell and enrollment period, and applying selection adjustments to LTSS and acute services.

4.2.1.4 820 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. The Contractor shall retrieve this file electronically.

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

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

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

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

4.2.2 Underlying Rate Structure for Medicare Component of the Capitation Rate

4.2.2.1 Medicare will pay the Contractor a monthly capitation amount for the Medicare Parts A/B services (the Medicare A/B Component), risk adjusted using the Medicare Advantage CMS-HCC Model and the CMS-HCC ESRD Model, except as specified in Section 4.2.4. Medicare will also pay the Contractor a monthly capitation amount for Medicare Part D services, risk adjusted using the Part D RxHCC Model (the Medicare Part D Component).

4.2.2.2 Medicare A/B Baseline

4.2.2.2.1 The Medicare baseline spending for Parts A/B services are a blend of the Medicare Fee For Service (FFS) standardized county rates and the Medicare Advantage projected payment rates for each year, weighted by the proportion of the target population projected to otherwise be in each program in the absence of the Demonstration. The FFS county rates will generally reflect amounts published with the April Medicare Advantage Final Rate Announcement, adjusted to fully incorporate more current hospital wage index and physician geographic practice cost index information; in this Demonstration, this adjustment will be fully applied to the FFS county rates in 2014, but the adjustment will otherwise use the same methodologies and timelines used to make the analogous adjustments in Medicare Advantage. CMS may also further adjust the Medicare FFS standardized county

rates as necessary to calculate accurate payment rates for the Demonstration. To the extent that the published FFS county rates do not conform with current law in effect for Medicare during an applicable payment month, and to the extent that such nonconformance would have a significant fiscal impact on the Demonstration, CMS will update the baseline (and therefore the corresponding payment rate) to calculate and apply an accurate payment rate for such month. Such update may take place retroactively, as needed.

- 4.2.2.2.2 Separate baselines will exist for Enrollees meeting the Medicare ESRD criteria. For Enrollees with ESRD in the dialysis or transplant status phases, the Medicare Parts A/B baseline will be the ESRD dialysis state rate. For Enrollees in the functioning graft status phase, the Medicare Parts A/B baseline will be the Medicare Advantage 3.5% bonus county rate (benchmark) for the applicable county as of January 2015 (for CY 2014 the baseline was the 3-star county rate).
- 4.2.2.2.3 Both baseline spending and payment rates under the Demonstration for Medicare Parts A/B services will be calculated as PMPM standardized amounts for each county participating in the Demonstration for each year. Enrollee risk scores will be applied to the standardized payment rates at the time of payment.
- 4.2.2.2.4 The Medicare A/B Component will be updated annually consistent with annual Fee-for-Service (FFS) estimates and Medicare Advantage rates released each year with the annual rate announcement.
- 4.2.2.2.5 If an Enrollee elects to receive the Medicare hospice benefit, the Enrollee may remain in the Demonstration Plan, but will obtain the hospice service through the Medicare FFS benefit and the Demonstration Plan would no longer receive the Medicare Parts A/B Component for that Enrollee as described in this section. Medicare hospice services and hospice drugs and all other Original Medicare services would be paid for under Medicare FFS. Demonstration Plans and providers of hospice services would be required to coordinate these services with the rest of the Enrollee's care. The Demonstration Plan would continue to receive the Medicare Part D Component for all non-hospice covered drugs. Election of hospice services does not change the Medicaid Component.
- 4.2.2.2.6 For Enrollees electing hospice services while residents of a NF, the Medicaid payment to the hospice provider for the "room and board" component will be the responsibility of the Demonstration Plan.
- 4.2.2.3 Medicare Part D
 - 4.2.2.3.1 The Medicare Part D Component is comprised of the Part D direct subsidy set at the Part D national average monthly bid amount (NAMBA) for the calendar year, as well as CMS-estimated average monthly prospective payment amount for the low

income cost-sharing subsidy and Federal reinsurance amounts; these payments will be reconciled after the end of each payment year in the same manner as for all Part D sponsors.

- 4.2.2.3.2 The monthly Medicare Part D Component for an Enrollee can be calculated by multiplying the Part D NAMBA by the RxHCC risk score assigned to the individual, and then adding to this the estimated average monthly prospective payment amount for the low income cost-sharing subsidy and Federal reinsurance amounts.

4.2.3 Aggregate Savings Percentages

- 4.2.3.1 Aggregate savings percentages will be applied equally, as follows, to the baseline spending amounts for the Medicare Parts A/B Component and Medicaid components of the capitated rate herein.

- 4.2.3.1.1 Demonstration Year 1: 1%

- 4.2.3.1.2 Demonstration Year 2: 3%

- 4.2.3.1.3 Demonstration Year 3: 5%

- 4.2.3.1.4 Demonstration Year 4: 5%

- 4.2.3.1.5 Demonstration Year 5: 5%

- 4.2.3.2 Except as otherwise specified, rate updates will take place on January 1st of each calendar year.

- 4.2.3.3 Savings percentages will not be applied to the Part D component of the rate. CMS will monitor Part D costs closely on an ongoing basis. Any material change in Part D costs relative to the baseline may be factored into future year savings percentages.

4.2.4 Risk Adjustment Methodology.

- 4.2.4.1 Medicare Parts A/B: The Medicare Parts A/B Component will be risk adjusted based on the risk profile of each Enrollee. Except as specified in Section 4.2.4.2, the existing Medicare Advantage CMS-HCC and CMS-HCC ESRD risk adjustment methodology will be used for the Demonstration.

4.2.4.2 Coding Intensity Adjustment Factor

- 4.2.4.2.1 In calendar year 2014, CMS will calculate and apply a coding intensity adjustment reflective of all Demonstration Enrollees except as indicated in Section 4.2.4.2.3. This will apply the prevailing Medicare Advantage coding intensity adjustment proportional to the anticipated proportion of Demonstration Enrollees in 2014 with

Medicare Advantage experience in 2013. Operationally CMS will still apply the full prevailing Medicare Advantage coding intensity adjustment factor to the risk scores but will increase the Medicare A/B Component for non-ESRD beneficiaries and beneficiaries with an ESRD status of functioning graft, to offset this.

4.2.4.2.2 In CY 2015, CMS will apply an appropriate coding intensity adjustment reflective of all Demonstration Enrollees; this will apply the prevailing Medicare Advantage coding intensity adjustment proportional to the anticipated proportion of Demonstration enrollees in CY 2015 with prior Medicare Advantage experience and/or Demonstration experience based on the Demonstration's enrollment phase-in as of September 30, 2014.

4.2.4.2.3 After calendar year 2015, CMS will apply the prevailing Medicare Advantage coding intensity adjustment to all Demonstration Enrollees.

4.2.4.2.4 The coding intensity adjustment factor will not be applied during the Demonstration to risk scores for Enrollees with an ESRD status of dialysis or transplant, consistent with Medicare Advantage policy.

4.2.4.3 Medicare Part D: The Medicare Part D national average bid amount will be risk adjusted in accordance with existing Part D RxHCC methodology. The estimated average monthly prospective payment amount for the low income cost-sharing subsidy and Federal reinsurance amounts will not be risk adjusted.

4.2.4.4 Medicaid: The Medicaid Component uses the rate cell methodology described in Section 4.2.1, which is sufficient to risk adjust Medicaid Covered Services.

4.3 Medical Loss Ratio (MLR)

4.3.1 Medical Loss Ratio Guarantee: The Contractor has a Target Medical Loss Ratio of eighty-five percent (85%). If the Medical Loss Ratio calculated as set forth below is less than the Target Medical Loss Ratio, the Contractor shall refund to the Department and CMS an amount equal to the difference between the calculated Medical Loss Ratio and the Target Medical Loss Ratio (expressed as a percentage) multiplied by the Coverage Year Revenue. The Department and CMS shall calculate a Medical Loss Ratio for Enrollees under this Contract for each Coverage Year, and shall provide to the Contractor the amount to be refunded, if any, to the Department and CMS respectively. Any refunded amounts will be distributed back to the Medicaid and Medicare programs, with the amount to each payor based on the proportion between the Medicare and Medicaid Components. At the option of CMS and the Department, separately, any amount to be refunded may be recovered either by requiring the Contractor to make a payment or by an offset to future Capitation payment. The Medical Loss Ratio Calculation shall be determined as set forth below; however, the Department and CMS may adopt NAIC reporting standards and protocols after giving written notice to the Contractor.

- 4.3.1.1 The MLR will be based on 42 C.F.R. §§ 422.2400 et seq. and §§ 423.2400 et seq., except that the numerator in the MLR calculation will include:
- 4.3.1.1.1 All Covered Services required in the Demonstration under Section 2.4 and Appendix A;
 - 4.3.1.1.2 Any services purchased in lieu of more costly Covered Services and consistent with the objectives of the MMAI;
 - 4.3.1.1.3 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;
 - 4.3.1.1.4 Other Benefit Expense. Any service provided directly to an Enrollee not capable of being sent as Encounter Data to the Department due to there not being appropriate codes or similar issues may be sent to the Department on a report identifying the Enrollee, the service and the cost. Such costs will be included in Benefit Expense; and
 - 4.3.1.1.5 To the extent not already so adjusted by 42 C.F.R. §§ 422.2400 et seq. and §§ 423.2400 et seq., when the Contractor has a subcapitated payment to an Affiliate, only the actual payments to Providers, rather than the full subcapitated payment.
- 4.3.1.2 The revenue used in the Medical Loss Ratio calculation will consist of the total Capitation rate revenue, due from the Department and CMS for services during the Coverage Year. Revenue will include amounts withheld pursuant to Section 4.4.4, regardless of whether the Contractor actually receives the amount in Section 4.4.4.
- 4.3.1.3 Data Submission. The Contractor shall submit to the Department and CMS, in the form and manner prescribed by the Department and CMS, the necessary data to calculate and verify the Medical Loss Ratio within nineteen (19) months after the end of the Coverage Year. Such data shall include eighteen (18) months of claims run-out.
- 4.3.1.4 Medical Loss Ratio Calculation. Within ninety (90) days following the eighteen month claims runout period, the Department and CMS shall calculate the Medical Loss Ratio in a timely manner by dividing the Benefit Expense by the Revenue. The Medical Loss Ratio shall be expressed as a percentage rounded to the second decimal point. The Contractor shall have sixty (60) days to review the Medical Loss Ratio Calculation. Each Party shall have the right to review all data and methodologies used to calculate the Medical Loss Ratio.

4.3.1.5 Coverage Year. The Coverage Year shall be the demonstration year. The Medical Loss Ratio Calculation shall be prepared using all data available from the Coverage Year, including IBNP and eighteen (18) months of run-out for Benefit Expense.

4.3.2 Medicaid Medical Loss Ratio (MLR). If at any point for Medicaid rating periods beginning on or after July 1, 2017, the joint MLR covering both Medicare and Medicaid, as described above in 4.3.1, ceases, the Contractor is required to calculate and report their MLR experience for Medicaid, consistent with the requirements at 42 CFR 42 C.F.R. §438.4, §438.5, §438.8 and §438.74.

4.4 Payment Terms

4.4.1 CMS will make monthly, prospective Capitation payments to the Contractor. The Department will make monthly Capitation payments to the Contractor. The Medicare Parts A/B Component will be the product of the Enrollee's CMS-HCC risk score multiplied by the relevant standard county payment rate (or the ESRD dialysis state rate or the Medicare Advantage 3-star county rate by the HCC ESRD risk score, as applicable). The Medicare Part D Component will be the product of the Enrollee's RxHCC risk score multiplied by the Part D NAMBA, with the addition of the estimated average monthly prospective payment amount for the low income cost-sharing subsidy and Federal reinsurance amounts. The Medicaid Component for each rate cell will be the product of the number of Enrollees in each category multiplied by the payment rate for that rate cell.

4.4.2 Timing of Capitation Payments

4.4.2.1 Enrollments

4.4.2.2 CMS and the Department will make monthly per member per month Capitation payments to the Contractor. The PMPM Capitation payment for a particular month will reflect payment for the Enrollees with effective enrollment into the Contractor's Demonstration Plan as of the first day of that month, as described in Section 2.3.1.

4.4.2.3 Disenrollments

4.4.2.4 The final per member per month Capitation payment made by CMS and the Department to the Contractor for each Enrollee will be for the month in which the disenrollment was submitted, the Enrollee loses eligibility, or the Enrollee dies (see Section 2.3.2).

4.4.2.5 Timing of Medicaid Component of the Rate

- 4.4.2.6 Capitation paid by the Department for the Medicaid Component is due to the Contractor by the fifteenth (15th) day of the service month. Payments due from the Department, including late charges, will be paid in accordance with the State Prompt Payment Act (30 ILCS 540) and rules (74 Ill. Admin. Code 900) when applicable. Collection of underlying amounts owed plus interest shall be the Contractor's sole financial remedy against the Department for late payments by the State. Payment terms contained on the Contractor's invoices shall have no force and effect.
- 4.4.2.7 Adjustments in amounts paid by the Department due to lags in the eligibility system are described in Section 4.2.1.

4.4.3 Modifications to Capitation Rates

CMS and the Department will jointly notify the Contractor in advance and in writing as soon as practicable, but in no event less than thirty (30) days prior to processing the change to the Capitation rate, of any proposed changes to the Capitation rates, and the Contractor shall accept such changes as payment in full as described in Section 4.7. Any mid-year rate changes would be articulated in a rate report, subject to the signature requirement in Section 4.1.1.3.

- 4.4.3.1 Rates will be updated using a similar process for each calendar year. Subject to Section 4.4.3.2, changes to the Medicare and Medicaid baselines outside of the annual Medicare Advantage and Part D rate announcement and the annual Medicaid rate update will be made only if and when CMS and the Department jointly determine the change is necessary to calculate accurate payment rates for the Demonstration. Such changes may be based on the following factors: shifts in enrollment assumptions; major changes or discrepancies in Federal law and/or State policy compared to assumptions about Federal law and/or State law or policy used in the development of baseline estimates; and changes in coding intensity.
- 4.4.3.2 For changes solely affecting the Medicare program baseline, CMS will update baselines by amounts identified by the independent Office of the Actuary necessary to best effectuate accurate payment rates for each month.
- 4.4.3.3 Subject to Section 4.4.3.2, if other statutory changes enacted after the annual baseline determination and rate development process are jointly determined by CMS and the Department to have a material change in baseline estimates for any given payment year, baseline estimates and corresponding standardized payment rates shall be updated outside of the annual rate development process.
- 4.4.3.4 Changes to the savings percentages will be made if and when CMS and the Department jointly determine that changes in Part D spending have resulted in

materially higher or lower savings that need to be recouped through higher or lower savings percentages applied to the Medicare A/B baselines.

- 4.4.3.5 Any material changes in the Medicaid State plan, including pertaining to Covered Services, payment schedules and related methodologies, shall be reflected in corresponding capitation payment adjustments. Contractor will not be required to implement such changes without advance notice and corresponding adjustment in the capitation payment. In addition, to the extent other Medicaid costs are incurred absent the Demonstration, such costs shall be reflected in corresponding capitation payment adjustments.

4.4.4 Quality Withhold Policy for Medicaid and Medicare A/B Components

- 4.4.4.1 Under the Demonstration, both CMS and the Department will withhold a percentage of their respective components of the Capitation Rate, with the exception of the Part D Component amounts. The withheld amounts will be repaid subject to the Contractor's performance consistent with established quality thresholds.
- 4.4.4.2 CMS and the Department will evaluate the Contractor's performance according to the specified metrics required in order to earn back the quality withhold for a given year.
- 4.4.4.3 Whether or not the Contractor has met the quality requirements in a given year will be made public.
- 4.4.4.4 Additional details regarding the quality withholds, including the more detailed specifications, required thresholds and other information regarding the methodology is available in separate technical guidance.
- 4.4.4.5 Withhold Measures in Demonstration Year 1
- 4.4.4.6 Figure 4.1 below identifies core withhold measures for Demonstration Year 1. Together, these will be utilized as the basis for a 1% withhold.
 - 4.4.4.6.1 For Demonstration Year One, which crosses calendar years, the Contractor will be evaluated to determine whether it has met required quality withhold requirements at the end of CY 2014 and at the end of CY 2015. The determination in CY 2014 will be based solely on those measures that can appropriately be calculated based on the actual enrollment volume during CY 2014. Consistent with such evaluations, the withheld amounts will be repaid separately for each CY.

Figure 4.1: Quality Withhold Measures for Demonstration Year 1

Domain	Measure	Source	CMS Core Withhold Measure	Illinois Withhold Measure
Encounter data	Encounter data submitted accurately and completely in compliance with contract requirements.	CMS/State defined process measure	X	
Assessments	Percent of Enrollees stratified to medium or high risk with a completed comprehensive assessment within 90 days of enrollment.	CMS/State defined process measure	X	X
Beneficiary governance board	Establishment of beneficiary advisory board or inclusion of beneficiaries on governance board consistent with the Three-way Contract requirements.	CMS/State defined process measure	X	
Customer Service	Percent of best possible score the Demonstration Plan earned on how easy it is to get information and help when needed. <ul style="list-style-type: none"> In the last six months, how often did your health plan's customer service give you the information or help you needed? In the last six months, how often did your health plan's customer service treat you with courtesy and respect? In the last six months, how often were the forms for your health plan easy to fill out? 	AHRQ/CAHPS	X	
Getting Appointments and Care Quickly	Percent of best possible score the Demonstration Plan earned on how quickly members get appointments and care <ul style="list-style-type: none"> In the last six months, when you needed care right away, how often did you get care as soon as you thought you needed? In the last six months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed? In the last six months, how often did you see the person you came to see within 15 minutes of your appointment time? 	AHRQ/CAHPS	X	
Documentation of care goals	Percent of Enrollees with documented discussions of care goals	CMS/State defined process measure		X
Ensuring physical access to buildings, services and equipment	Demonstration Plan has established a work plan and identified individual in its organization who is responsible for ADA compliance related to this Demonstration	CMS/State defined process measure		X

4.4.4.7 Withhold Measures in Demonstration Years 2, 3, 4 and 5

4.4.4.7.1 The quality withhold will increase to 2% in Demonstration Year 2 and 3% in Demonstration Year 3, 4, and 5.

4.4.4.7.2 Payment will be based on performance on the quality withhold measures listed in **Figure 4.2, below.**

4.4.4.7.3 If the Contractor is unable to report at least three of the quality withhold measures listed in Figure 4.2 for a given year due to low Enrollment or inability to meet other reporting criteria, alternative measures will be used in the quality withhold analysis. Additional information about this policy is available in separate technical guidance.

Figure 4.2: Quality Withhold Measures for Demonstration Years 2, 3, 4, and 5

Domain	Measure	Source	CMS Core Withhold Measure	Illinois Withhold Measure
Encounter data	Encounter data submitted accurately and completely in compliance with contract requirements.		X	
Plan all-cause readmissions	Percent of members discharged from a hospital stay who were readmitted to a hospital within 30 days, either for the same condition as their recent hospital stay or for a different reason.	NCQA/HEDIS	X	
Annual flu vaccine	Percent of plan members who got a vaccine (flu shot) prior to flu season.	AHRQ/CAHPS	X	
Follow-up after hospitalization for mental illness	Percentage of discharges for members six years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.	NCQA/HEDIS	X	
Reducing the risk of falling	Percent of members with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year.	NCQA/HEDIS HOS	X	
Controlling blood pressure	Percentage of members 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) for members 18-59 years of age and 60-85 years of age with diagnosis of diabetes or (150/90) for members 60-85 without a diagnosis of diabetes during the measurement year.	NCQA/HEDIS	X	
Part D medication adherence for diabetes medications	Percent of plan members with a prescription for diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS	X	
Care for Older Adults (COA)	Percentage of adults 66 years and older who had each of the following during the measurement year: <ul style="list-style-type: none"> • Advance care planning • Medication review • Functional status assessment • Pain assessment 	NCQA/HEDIS		X
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	Percentage of adult members with a new episode of alcohol or other drug (AOD) dependence who received the following: <ul style="list-style-type: none"> • Initiation of AOD Treatment: The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. • Engagement of AOD Treatment: The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit. 	NCQA/HEDIS		X

Domain	Measure	Source	CMS Core Withhold Measure	Illinois Withhold Measure
Movement of Members Within Service Populations	<p>The number and percentage of members:</p> <ul style="list-style-type: none"> • In Long Term Care (LTC) on January 1 of Measure Year • In LTC on December 31 of Measure Year • Not in LTC on January 1 of Measure Year (i.e., members in Community and HCBS waivers) • Not in LTC on December 31 of Measure Year (i.e., members in Community and HCBS waivers) 	State-defined measure		X

4.4.5 American Recovery and Reinvestment Act of 2009

- 4.4.5.1 All payments to the Contractor are conditioned on compliance with the provisions below and all other applicable provisions of the American Recovery and Reinvestment Act of 2009 (ARRA).
- 4.4.5.2 The Contractor shall demonstrate that there are sufficient Indian Health Care Providers in the provider network to ensure timely access to Covered Services for Indian Enrollees who are eligible to receive services;
- 4.4.5.3 The Contractor shall make prompt payment to Indian Health Care Providers;
- 4.4.5.4 The Contractor shall pay Indian Health Care Providers, whether participating in the network or not, for covered items and services provided to Indian Enrollees who are eligible to receive services from the Indian Health Care Providers either at a negotiated rate between the Contractor and the Indian Health Care Provider, or if there is no negotiated rate, at a rate no less than the level and amount of payment that would be made if the Provider were not an Indian Health Care Provider.
- 4.4.5.5 The Contractor shall pay non-network Indian Health Care Providers that are FQHCs for the provision of services to an Indian Enrollee at a rate equal to the rate that the Contractor would pay to a network FQHC that is not an Indian Health Care Provider, including any supplemental payment from the state to make up the difference between the contract amount and what the Indian Health Care Provider would have received Medicaid Fee For Service.
- 4.4.5.6 The Contractor shall not reduce payment that is due under Medicaid to the Indian Health Care Provider through referral under contract health services for furnishing an item or service to an Indian Enrollee. The State must pay these Providers the full Medicaid payment rate for furnishing the item or service.
- 4.4.5.7 The Contractor shall not impose enrollment fees, premiums, or similar charges on Indian Enrollees regardless of payer. The Contractor must exempt from all cost sharing any Indian Enrollee who is currently receiving or has ever received an

item or service furnished by an Indian Health Care Provider or through referral under contract health services.

4.4.6 Suspension of Payments

- 4.4.6.1 The Department may suspend payments to Demonstration Plans in accordance with 42 C.F.R. § 455.23, et seq. and 130 CMR 450, et seq. as determined necessary or appropriate by Illinois.

4.5 Transitions Between Rate Cells and Risk Score Changes

- 4.5.1 Medicaid rate cell changes are addressed above under Section 4.2.
- 4.5.2 Medicare Risk Score Changes. Medicare CMS-HCC, CMS-HCC ESRD, and RxHCC risk scores will be updated consistent with prevailing Medicare Advantage regulations and processes

4.6 Reconciliation

4.6.1 Medicaid Component Reconciliation.

- 4.6.1.1 Within thirty (30) days after the 820 Payment File is made available, the Contractor shall notify the Department of any discrepancies, including Enrollees who the Contractor believes are in its Demonstration Plan and not on the 820 Payment File, Enrollees included on the 820 Payment File who the Contractor believes have not been enrolled with Contractor, and Enrollees included on the 820 Payment File who the Contractor believes are in a different rate cell. The Contractor and the Department will work together to resolve these discrepancies. Payments to the Contractor will be adjusted for retroactive disenrollment of Enrollees, changes to Enrollee information that affect the Capitation rates (e.g., eligibility classification), monetary sanctions and penalties imposed in accordance with Section 5.3.14, rate changes in accordance with Section 4.3.3, or other miscellaneous adjustments provided for herein. Adjustments shall be retroactive no more than eighteen (18) months, unless otherwise agreed to by the Contractor and the Department. Notwithstanding the foregoing, any adjustment for retroactive disenrollment of Enrollees shall not exceed two (2) months except in instances of the death of an Enrollee or when the Enrollee moves out of the State. The Department will make retroactive enrollments only in accordance with Section 2.3.1.7.

4.6.2 Medicare Capitation Reconciliation

- 4.6.2.1 Medicare capitation reconciliation will comply with prevailing Medicare Advantage and Part D regulations and processes.

4.6.2.2 Final Medicare Reconciliation and Settlement: In the event the Contractor terminates or non-renews this Contract, CMS' final settlement phase for terminating contracts applies. This final settlement phase lasts for a minimum of 18 months after the end of the calendar year in which the termination date occurs. This final settlement will include reconciliation of any demonstration-specific payments or recoupments, including those related to quality withholds, and medical loss ratios as applicable, that are outstanding at the time of termination.

4.6.3 Audits/Monitoring

4.6.3.1 CMS and the Department will conduct periodic audits to validate rate cell assignments or other coding. Audits may be conducted by a peer review organization or other entity assigned this responsibility by CMS and the Department.

4.7 Payment in Full

- 4.7.1 The Contractor must accept, as payment in full for all Covered Services, the Capitation rate(s) and the terms and conditions of payment set forth herein, except as provided in A.3 of Appendix A.
- 4.7.2 Notwithstanding any contractual provision or legal right to the contrary, the three parties to this Contract (CMS, the Department and the Contractor), for this Demonstration agree there shall be no redress against either of the other two parties, or their actuarial contractors, over the actuarial soundness of the Capitation rates.
- 4.7.3 By signing this contract, the Contractor accepts that the Capitation rate(s) offered is reasonable; that operating within this Capitation rate(s) is the sole responsibility of the Contractor; and that while data is made available by the Federal Government and the State to the Contractor, any entity participating in the Demonstration must rely on their own resource to project likely experience under the Demonstration.

5 Section 5: Additional Terms and Conditions

5.1 Administration

- 5.1.1 Notification of Administrative Changes. The Contractor must notify CMS and the Department through HPMS of all changes affecting the key functions for the delivery of care, the administration of its program, or its performance of Contract requirements. The Contractor must notify CMS and the Department in HPMS no later than thirty (30) calendar days prior to any significant change to the manner in which services are rendered to Enrollees, including but not limited to reprourement or termination of a First Tier, Downstream and Related Entity pursuant to Appendix C. The Contractor must notify CMS and the Department in HPMS of all other changes no later than five (5) Business Days prior to the effective date of such change.
- 5.1.2 Assignment. The Contractor may not assign or transfer any right or interest in this Contract to any successor entity or other entity without the prior written consent of CMS and the Department, which may be withheld for any reason or for no reason at all.
- 5.1.3 Independent Contractors:
 - 5.1.3.1 The Contractor, its employees, First Tier, Downstream and Related Entities, and any other of its agents in the performance of this Contract, shall act in an independent capacity and not as officers, agents or employees of, or joint venturers with, the federal government or State of Illinois.
 - 5.1.3.2 The Contractor must ensure it evaluates the prospective First Tier, Downstream and Related Entities' abilities to perform activities to be delegated.
- 5.1.4 Subrogation. Subject to CMS and Illinois lien and Third Party recovery rights, the Contractor must:
 - 5.1.4.1 Be subrogated and succeed to any right of recovery of an Enrollee against any person or organization, for any services, supplies, or both provided under this Contract up to the amount of the benefits provided hereunder;
 - 5.1.4.2 Require that the Enrollee pay to the Contractor all such amounts recovered by suit, settlement, or otherwise from any third person or his or her insurer to the extent of the benefits provided hereunder, up to the value of the benefits provided hereunder. The Contractor may ask the Enrollee to:
 - 5.1.4.2.1 Take such action, furnish such information and assistance, and execute such instruments as the Contractor may require to facilitate enforcement of its rights hereunder, and take no action prejudicing the rights and interest of the Contractor hereunder; and

5.1.4.2.2 Notify the Contractor hereunder and authorize the Contractor to make such investigations and take such action as the Contractor may deem appropriate to protect its rights hereunder whether or not such notice is given.

5.1.5 Prohibited Affiliations. In accordance with 42 USC §1396 u-2(d)(1), the Contractor shall not knowingly have an employment, consulting, or other agreement for the provision of items and services that are significant and material to the Contractor's obligations under this Contract with any person, or affiliate of such person, who is excluded, under federal law or regulation, from certain procurement and non-procurement activities. Further, no such person may have beneficial ownership of more than five percent of the Contractor's equity or be permitted to serve as a director, officer, or partner of the Contractor.

5.1.6 Disclosure Requirements. The Contractor must disclose to CMS and the Department information on ownership and control, business transactions, and persons convicted of crimes in accordance with 42 C.F.R. Part 455, Subpart B. The Contractor must obtain federally required disclosures from all Network Providers and applicants in accordance with 42 C.F.R. 455 Subpart B and 42 C.F.R. § 1002.3, and as specified by the Department, including but not limited to obtaining such information through Provider enrollment forms and credentialing and recredentialing packages. The Contractor must maintain such disclosed information in a manner which can be periodically searched by the Contractor for exclusions and provided to the Department in accordance with this Contract and relevant state and federal laws and regulations. In addition, the Contractor must comply with all reporting and disclosure requirements of 42 USC § 1396b(m)(4)(A) if the Contractor is not a federally qualified Health Maintenance Organization under the Public Health Service Act.

5.1.7 Physician Incentive Plans

5.1.7.1 The Contractor and its First Tier, Downstream and Related Entities must comply with all applicable requirements governing Physician incentive plans, including but not limited to such requirements appearing at 42 C.F.R. Parts 417, 422, 434, 438.3(i), and 1003. The Contractor must submit all information required to be disclosed to CMS and the Department in the manner and format specified by CMS and the Department, which, subject to Federal approval, must be consistent with the format required by CMS for Medicare contracts.

5.1.7.2 The Contractor shall be liable for any and all loss of federal financial participation (FFP) incurred by Illinois that results from the Contractor's or its subcontractors' failure to comply with the requirements governing Physician incentive plans at 42 C.F.R. Parts 417, 434 and 1003; however, the Contractor shall not be liable for any

loss of FFP under this provision that exceeds the total FFP reduction attributable to Enrollees in the Contractor's Demonstration Plan, and the Contractor shall not be liable if it can demonstrate, to the satisfaction of CMS and the Department, that it has made a good faith effort to comply with the cited requirements. Federal financial participation is not available for any amounts paid to the Contractor if the Contractor could be excluded from participation in Medicare or Medicaid under section 1128(b)(8)(B) of the Social Security Act or for any of the reasons listed in 42 C.F.R. § 431.55(h).

- 5.1.8 Physician Identifier. The Contractor must require each Physician providing Covered Services to Enrollees under this Contract to have a unique identifier in accordance with the system established under 42 U.S.C. §1320d-2(b). The Contractor must provide such unique identifier to CMS and the Department for each of its PCPs in the format and time-frame established by CMS and the Department in consultation with the Contractor.
- 5.1.9 Timely Provider Payments. The Contractor must make timely payments to Providers. The Contractor must ensure that ninety percent (90%) of payment claims from physicians who are in individual or group practice, which can be processed without obtaining additional information from the physician or from a Third Party (hereinafter "Clean Claim"), from Providers for Covered Services will be paid within thirty (30) days after the date of receipt of the claim. The Contractor must ensure that ninety-nine percent (99%) of Clean Claims from Providers for Covered Services will be paid within ninety (90) days after the date of receipt of the claim. The Contractor and its Providers may by mutual agreement, in writing, establish an alternative payment schedule provided that payment is no less timely than provided in this Section 5.1.9.
 - 5.1.9.1 The Contractor shall pay for Family Planning services, subject to Appendix A, Section A.5 hereof, rendered by a non-Affiliated Provider, for which the Contractor would pay if rendered by an Affiliated Provider, at the same rate the Department would pay for such services exclusive of disproportionate share payments and Medicaid percentage adjustments, unless a different rate was agreed upon by Contractor and the non-Affiliated Provider.
 - 5.1.9.2 The Contractor shall accept claims for non-Affiliated Providers for at least one hundred eighty (180) days after the date the services are provided. The Contractor shall not be required to pay for claims initially submitted by such non-Affiliated Providers more than one hundred eighty (180) days after the date of service.
- 5.1.10 Protection of Enrollee-Provider Communications. In accordance with 42 USC § 1396 u-2(b)(3), the 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 options for the Enrollee's condition or disease; information the Enrollee needs in order to decide among all relevant treatment options; risk, benefits and consequences of treatment or non-treatment; and/or the Enrollee's rights to participate in decisions about his or her health care, including

the right to refuse treatment and to express preferences about future treatment decisions; regardless of whether benefits for such care or treatment are provided under the Contract, if the Provider is acting within the lawful scope of practice.

5.1.11 Protecting Enrollee from Liability for Payment

The Contractor must:

5.1.11.1 In accordance with 42 C.F.R. § 438.106, not hold an Enrollee liable for:

5.1.11.1.1 Debts of the Contractor, in the event of the Contractor's insolvency;

5.1.11.1.2 Covered Services provided to the Enrollee in the event that the Contractor fails to receive payment from CMS or the Department for such services; or

5.1.11.1.3 Payments to a clinical First Tier, Downstream and Related Entity in excess of the amount that would be owed by the Enrollee if the Contractor had directly provided the services;

5.1.11.2 Not charge Enrollees coinsurance, co-payments, deductibles, financial penalties, or any other amount in full or part, for any service provided under this Contract, except as otherwise provided in Appendix A, Section A.3;

5.1.11.3 Not deny any service provided under this Contract to an Enrollee for failure or inability to pay any applicable charge;

5.1.11.4 Not deny any service provided under this Contract to an Enrollee who, prior to becoming Medicare and Medicaid eligible, incurred a bill that has not been paid; and

5.1.11.4.1 Moral or Religious Objections. The Contractor is not required to provide, reimburse for, or provide coverage of, a counseling or Referral service that would otherwise be required if the Contractor objects to the service on moral or religious grounds. If the Contractor elects not to provide, pay for, or provide coverage of, a counseling or Referral service because of an objection on moral or religious grounds, it must promptly notify the Department and CMS in writing of its intent to exercise the objection. It must furnish information about the services it does not cover as follows:

5.1.11.4.1.1 To the State;

5.1.11.4.1.2 With its application for a contract;

5.1.11.4.1.3 Whenever it adopts the policy during the term of the contract; and

- 5.1.11.4.1.4 The information provided must be:
- 5.1.11.4.1.5 Consistent with the provisions of 42 C.F.R. § 438.10;
- 5.1.11.4.1.6 Provided to Eligible Beneficiaries before and during enrollment; and
- 5.1.11.4.1.7 Provided to Enrollees within ninety (90) days after adopting the policy with respect to any particular service.

5.1.12 Third Party Liability

5.1.12.1 General Requirements

5.1.12.1.1 Coordination of Benefits. The Department shall provide the Contractor with all Third Party health insurance information on Enrollees where it has verified that Third Party health insurance exists.

5.1.12.1.2 The Department shall refer to the Contractor the Enrollee's name and pertinent information where the Department knows an Enrollee has been in an accident or had a traumatic event where a liable Third Party may exist.

5.1.12.1.3 The Contractor shall:

- 5.1.12.1.3.1 Designate a Third Party Liability (TPL) Benefit Coordinator who shall serve as a contact person for Benefit Coordination issues related to this Contract.
- 5.1.12.1.3.2 Designate one or more recoveries specialist(s), whose function shall be to investigate and process all transactions related to the identification of TPL.
- 5.1.12.1.3.3 Perform Benefit Coordination in accordance with this Section 5.1.12. The Contractor shall work with Illinois via interface transactions with the MMIS system using HIPAA standard formats to submit information with regard to TPL investigations and recoveries.

5.1.12.2 Third Party Health Insurance Information:

5.1.12.2.1 The Contractor shall implement procedures to (1) determine if an Enrollee has other health insurance except Medicare Part A and B and Medicaid, and (2) identify other health insurance that may be obtained by an Enrollee using, at a minimum, the following sources:

- 5.1.12.2.1.1 The HIPAA 834 outbound Enrollment File (for more information on this interface with MMIS and all interfaces, see Section 2.16);
- 5.1.12.2.1.2 Claims Activity;
- 5.1.12.2.1.3 Point of Service Investigation (Customer Service, Member Services and Utilization Management); and
- 5.1.12.2.1.4 Any TPL information self-reported by an Enrollee.

5.1.12.2.2 At a minimum, such procedures shall include:

- 5.1.12.2.2.1 If the Contractor also offers commercial policies or Illinois Integrated Care Program plans, the Contractor shall perform a data match within their own commercial plan and Demonstration Plan subscriber/member / Enrollee lists. If an Enrollee is found to also be enrolled in the Contractor's commercial plan or Demonstration Plan, the Enrollee's information shall be sent to the Department. The Department shall verify the Enrollee's enrollment Integrated Care Program and eligibility status. If the Department determines that the Contractor was correct, the Department will disenroll the Enrollee retroactive to the effective date of the other insurance; and
- 5.1.12.2.2.2 Reviewing claims for indications that other insurance may be active (e.g. explanation of benefit attachments or Third Party payment).

5.1.12.3 Third Party Health Insurance Cost-Avoidance, Pay and Recover Later and Recovery

5.1.12.3.1 Once an Enrollee is identified as having other health insurance, the Contractor must cost avoid claims for which another insurer may be liable, except in the case of prenatal services per 42 U.S.C. § 1396(a)(25)(E) and 42 C.F.R. § 433.139.

5.1.12.3.2 The Contractor shall perform the following activities to cost-avoid, pay and recover later, or recover claims when other health insurance coverage is available:

- 5.1.12.3.2.1 Cost-Avoidance. The Contractor shall:

- 5.1.12.3.2.1.1 On the Daily Inbound Demographic Change File provide all third party liability information on the Contractor's Enrollees;
- 5.1.12.3.2.1.2 Pend claims that are being investigated for possible third party health insurance coverage in accordance with the Department's guidelines;
- 5.1.12.3.2.1.3 Deny claims submitted by a Provider when the claim indicates the presence of other health insurance;
- 5.1.12.3.2.1.4 Instruct Providers to use the TPL Indicator Form to notify the Department of the potential existence of other health insurance coverage and to include a copy of the Enrollee's health insurance card with the TPL Indicator Form if possible; and
- 5.1.12.3.2.1.5 Distribute TPL Indicator Forms at the Contractor's Provider orientations.
- 5.1.12.3.2.2 Pay and Recover Later
 - 5.1.12.3.2.2.1 The Contractor shall take all actions necessary to comply with the requirements of 42 U.S.C. § 1396a(a)(25)(E) and 42 C.F.R. § 433.139.
- 5.1.12.3.2.3 Recovery. The Contractor shall:
 - 5.1.12.3.2.3.1 Identify claims it has paid inappropriately when primary health insurance coverage is identified. Identification will be achieved through data matching processes and claims analyses;
 - 5.1.12.3.2.3.2 Implement policies and procedures and pursue recovery of payments made where another payer is primarily liable; and
 - 5.1.12.3.2.3.3 Develop procedures and train staff to ensure that Enrollees who have comprehensive third party health insurance are identified and reported to the Department.
- 5.1.12.3.2.4 Reporting

5.1.12.3.2.4.1 Semi-annually, the Contractor shall report to the Department the following:

5.1.12.3.2.4.1.1 Other Insurance – the number of referrals sent by the Contractor on the Inbound Demographic Change File, and the number of Enrollees identified as having TPL on the monthly HIPAA 834 inbound Enrollment file;

5.1.12.3.2.4.1.2 Pay and Recover Later – the number and dollar amount of claims that were paid and recovered later consistent with the requirements of 42 U.S.C. § 1396a(a)(25)(E) and 42 C.F.R. § 433.139;

5.1.12.3.2.4.1.3 Cost avoidance – the number and dollar amount of claims that were denied by the Contractor due to the existence of other health insurance coverage on a semi-annual basis, and the dollar amount per Enrollee that was cost avoided on the denied claim; and

5.1.12.3.2.4.1.4 Recovery - Claims that were initially paid but then later recovered by the Contractor as a result of identifying coverage under another health insurance plan, on a semi-annual basis, and the dollar amount recovered per Enrollee from the other liable insurance carrier or Provider.

5.1.12.3.2.5 Accident and Trauma Identification and Recovery Identification

5.1.12.3.2.5.1 Cost Avoidance and Recovery. The Contractor shall recover or cost avoid claims where an Enrollee has been involved in an accident or lawsuit.

5.1.12.3.2.5.2 Claims Editing and Reporting. The Contractor shall utilize the following claims editing and reporting procedures to identify potential accident and/or other third party liability cases:

5.1.12.3.2.5.2.1 Claims Reporting – Specific diagnosis ranges that may indicate potential accident and casualty cases;

5.1.12.3.2.5.2.2 Provider Notification – Claims where Providers have noted accident involvement;

5.1.12.3.2.5.2.3 Patient Questionnaires – Questionnaires will be sent to Enrollees who are suspected of having suffered an injury as a result of an accident; and

5.1.12.3.2.5.2.4 Questionnaires will be based on a predetermined diagnosis code range.

5.1.12.3.2.5.3 Medical Management. The Contractor shall identify any requested medical services related to motor vehicle accidents, or work related injuries, and refer these claims to the recoveries specialist for further investigation.

5.1.12.3.2.5.4 Reporting. On a semi-annual basis, the Contractor will provide the Department with cost avoidance and recovery information on accidents and trauma cases.

5.1.13 Medicaid Drug Rebate

5.1.13.1 Non-Part D covered outpatient drugs dispensed to Enrollees shall be subject to the same rebate requirements as the Department is subject under section 1927 and that the Department shall collect such rebates from pharmaceutical manufacturers.

5.1.13.2 The Contractor shall submit to the Department, on a timely and periodic basis, information on the total number of units of each dosage form and strength and package size by National Drug Code of each non-Part D covered outpatient drug dispensed to Enrollees for which the Contractor is responsible for coverage and other data as the Department determines.

5.2 Confidentiality

5.2.1 Statutory Requirements. The Contractor understands and agrees that CMS and the Department may require specific written assurances and further agreements regarding the security and Privacy of protected health information that are deemed necessary to implement and comply with standards under the HIPAA as implemented in 45 C.F.R., parts 160 and 164. The Contractor further represents and agrees that, in the performance of the services under this Contract, it will comply with all legal obligations as a holder of personal data under 305 ILCS 5/11-9, 11-10, and 11-12. The Contractor represents that it currently has in place policies and procedures that will adequately safeguard any confidential personal data obtained or created in the course of fulfilling its obligations under this Contract in accordance with applicable State and Federal laws. The Contractor is required to design, develop, or operate a system of records on individuals, to accomplish an agency function subject to the Privacy Act of 1974, Public Law 93-579, December 31, 1974 (5 U.S.C.552a) and applicable agency regulations. Violation of the Act may involve the imposition of criminal penalties.

- 5.2.2 Personal Data. The Contractor must inform each of its employees having any involvement with personal data or other confidential information, whether with regard to design, development, operation, or maintenance of the laws and regulations relating to confidentiality.
- 5.2.3 Data Security. The Contractor must take reasonable steps to ensure the physical security of personal data or other confidential information under its control, including, but not limited to: fire protection; protection against smoke and water damage; alarm systems; locked files, guards, or other devices reasonably expected to prevent loss or unauthorized removal of manually held data; passwords, access logs, badges, or other methods reasonably expected to prevent loss or unauthorized access to electronically or mechanically held data by ensuring limited terminal access; limited access to input documents and output documents; and design provisions to limit use of Enrollee names. The Contractor must put all appropriate administrative, technical, and physical safeguards in place before the start date to protect the Privacy and security of Protected Health Information in accordance with 45 C.F.R. § 164.530(c). The Contractor must meet the security standards, requirements, and implementation specifications as set forth in the HIPAA Security Rule, 45 C.F.R. part 164, subpart C. Contractor must follow the National Institute for Standards and Technology (NIST) Guidelines for the Risk Management Framework (RMF) to establish an information security program in accordance with the Federal Information Security Management Act (FISMA).
- 5.2.4 Return of Personal Data. The Contractor must return any and all personal data, with the exception of medical records, furnished pursuant to this Contract promptly at the request of CMS or the Department in whatever form it is maintained by the Contractor. Upon the termination or completion of this Contract, the Contractor shall not use any such data or any material derived from the data for any purpose, and, where so instructed by CMS or the Department, will destroy such data or material.
- 5.2.5 Destruction of Personal Data. For any PHI received regarding an Eligible Beneficiary referred to Contractor by the Department who does not enroll in Contractor's plan, the Contractor must destroy the PHI in accordance with standards set forth in NIST Special Publication 800-88, Guidelines for Media Sanitizations, and all applicable state and federal Privacy and security laws including HIPAA and its related implementing regulations, at 45 C.F.R. Parts 160, 162, and 164, as may be amended from time to time. The Contractor shall also adhere to standards described in OMB Circular No. A-130, Appendix III-Security of Federal Automated Information Systems and NIST Federal Information Processing Standard 200 entitled "Minimum Security Requirements for Federal Information and Information Systems" while in possession of all PHI.
- 5.2.6 Research Data. The Contractor must seek and obtain prior written authorization from CMS and the Department for the use of any data pertaining to this Contract for research or any other purposes not directly related to the Contractor's performance under this Contract.

5.3 General Terms and Conditions

5.3.1 Applicable Law.

The term "applicable law," as used in this Contract, means, without limitation, all federal and State law, and the regulations, policies, procedures, and instructions of CMS and the Department all as existing now or during the term of this Contract. All applicable law is hereby incorporated into this Contract by reference.

5.3.2 Sovereign Immunity.

Nothing in this Contract will be construed to be a waiver by the Department, Illinois or CMS of its rights under the doctrine of sovereign immunity and the Eleventh Amendment to the United States Constitution. Illinois shall not enter into binding arbitration to resolve any contract dispute.

5.3.3 Advance Directives.

The Contractor shall comply with 42 C.F.R. §§ 489.102, 422.128, and 438.3(j) with its Advance Directives policies and procedures, education of staff, and provision of information to Beneficiaries.

Nothing in this Contract shall be interpreted to require an Enrollee to execute an Advance Directive or agree to orders regarding the provision of life-sustaining treatment as a condition of receipt of services under the Medicare or Medicaid program.

5.3.4 Loss of Licensure

If, at any time during the term of this Contract, the Contractor or any of its First Tier, Downstream or Related Entities incurs loss of licensure at any of the Contractor's facilities or loss of necessary Federal or State approvals, the Contractor must report such loss to CMS and the Department. Such loss may be grounds for termination of this Contract under the provisions of Section 5.5.

5.3.5 Indemnification

The Contractor shall indemnify and hold harmless CMS, the Department, the federal government, and Illinois, and their agencies, officers, employees, agents and volunteers, from and against any and all liability, loss, damage, costs, or expenses which CMS and or Illinois may sustain, incur, or be required to pay, arising out of or in connection with any negligent action, inaction, or willful misconduct of the Contractor, any person employed by the Contractor, or any of its First Tier, Downstream, or Related Entities provided that the Contractor is notified of any claims within a reasonable time from when CMS or Illinois become aware of the claim.

5.3.6 Prohibition against Discrimination

5.3.6.1 In accordance with 42 USC §1396 u-2(b)(7), the Contractor shall not discriminate with respect to participation, reimbursement, or indemnification of any Provider in the Contractor's Provider Network who is acting within the scope of the Provider's license or certification under applicable federal or State law, solely on the basis of such license or certification. This section does not prohibit the Contractor from including Providers in its Provider Network to the extent necessary to meet the needs of the Contractor's Enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the Contractor. (i) The Contractor shall abide by all Federal and state laws, regulations, and orders that prohibit discrimination because of race, color, religion, sex, national origin, ancestry, age, physical or mental disability, including, but not limited to, 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. (ii) The Contractor further agrees to take affirmative action to ensure that no unlawful discrimination is committed in any manner including, but not limited to, the delivery of services under this Contract. (iii) The Contractor will not discriminate against Potential Enrollees, Prospective Enrollees, or Enrollees on the basis of health status or need for health services. (iv) The 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. (v) Nothing in subsection (iv), above, may be construed to require the Contractor to contract with Providers beyond the number necessary to meet the needs of its Enrollees; precludes the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or precludes the Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to Enrollees.

5.3.6.2 If a Complaint or claim against the Contractor is presented to Illinois for handling discrimination complaints, the Contractor must cooperate with the investigation and disposition of such Complaint or claim.

5.3.7 Anti-Boycott Covenant. During the time this Contract is in effect, neither the Contractor nor any affiliated company, as hereafter defined, may participate in or cooperate with an international boycott, as defined in Section 999(b)(3) and (4) of the Internal Revenue Code of 1954, as amended. Pursuant to 30 ILCS 582, the Contractor certifies that neither the Contractor nor any substantially-owned affiliated company is participating or shall participate in an international boycott in violation of the provisions of the U.S. Export Administration Act of 1979 or the regulations of the U.S. Department of Commerce promulgated under that Act. Without limiting such other rights as it may have, CMS and the Department will be entitled to rescind this Contract in the event of noncompliance with

this Section 5.3.7. As used herein, an affiliated company is any business entity directly or indirectly owning at least fifty-one percent (51%) of the ownership interests of the Contractor.

- 5.3.8 Information Sharing. During the course of an Enrollee's enrollment or upon transfer or termination of enrollment, whether voluntary or involuntary, and subject to all applicable Federal and State laws, the Contractor must arrange for the transfer, at no cost to CMS, the Department, or the Enrollee, of medical information regarding such Enrollee to any subsequent Provider of medical services to such Enrollee, as may be requested by the Enrollee or such Provider or as directed by CMS or the Department, regulatory agencies of Illinois, or the United States Government. With respect to Enrollees who are in the custody of Illinois, the Contractor must provide, upon reasonable request of the State agency with custody of the Enrollee, a copy of said Enrollee's medical records in a timely manner.
- 5.3.9 Other Contracts. Nothing contained in this Contract shall be construed to prevent the Contractor from operating other comprehensive health care plans or providing health care services to persons other than those covered hereunder; provided, however, that the Contractor must provide CMS and the Department with a complete list of such plans and services, upon request. CMS and the Department will exercise discretion in disclosing information that the Contractor may consider proprietary, except as required by law. Nothing in this Contract may be construed to prevent CMS or the Department from contracting with other comprehensive health care plans, or any other Provider, in the same Service Area.
- 5.3.10 Counterparts. This Contract may be executed simultaneously in two or more counterparts, each of which will be deemed an original and all of which together will constitute one and the same instrument.
- 5.3.11 Entire Contract. This Contract constitutes the entire agreement of the Parties with respect to the subject matter hereof, including all Attachments and Appendices hereto, and supersedes all prior agreements, representations, negotiations, and undertakings not set forth or incorporated herein. The terms of this Contract will prevail notwithstanding any variances with the terms and conditions of any verbal communication subsequently occurring.
- 5.3.12 No Third Party Rights or Enforcement. No person not executing this Contract is entitled to enforce this Contract against a Party hereto regarding such Party's obligations under this Contract.
- 5.3.13 Corrective Action Plan. If, at any time, CMS or the Department reasonably determine that the Contractor is deficient in the performance of its obligations under the Contract, CMS and the Department may require the Contractor to develop and submit a corrective action plan that is designed to correct such deficiency. CMS and the Department may require modifications to the corrective action plan based on their reasonable judgment as to whether the corrective action plan will correct the deficiency. The Contractor must promptly and

diligently implement the corrective action plan, and demonstrate to CMS and the Department that the implementation of the plan was successful in correcting the problem. Failure to implement the corrective action plan may subject the Contractor to termination of the Contract by CMS and the Department or other intermediate sanctions as described in Section 5.3.14.

5.3.14 Intermediate Sanctions and Civil Monetary Penalties

5.3.14.1 In addition to termination under Section 5.5, CMS and the Department may impose any or all of the sanctions in Section 5.3.14.2 upon any of the events below; provided, however, that CMS and the Department will only impose those sanctions they determine to be reasonable and appropriate for the specific violations identified. Sanctions may be imposed in accordance with regulations that are current at the time of the sanction. Sanctions may be imposed in accordance with this section if the Contractor:

- 5.3.14.1.1 Fails substantially to provide Covered Services required to be provided under this Contract to Enrollees;
- 5.3.14.1.2 Imposes charges on Enrollees in excess of any permitted under this Contract;
- 5.3.14.1.3 Discriminates among Enrollees or individuals eligible to enroll on the basis of health status or need for health care services, race, color or national origin, or uses any policy or practice that has the effect of discriminating on the basis of race, color, or national origin;
- 5.3.14.1.4 Misrepresents or falsifies information provided to CMS, the Department, Enrollees, or its Provider Network;
- 5.3.14.1.5 Fails to comply with requirements regarding Physician incentive plans (see Section 5.1.7);
- 5.3.14.1.6 Fails to comply with federal or State statutory or regulatory requirements related to this Contract;
- 5.3.14.1.7 Violates restrictions or other requirements regarding marketing;
- 5.3.14.1.8 Fails to comply with quality management requirements consistent with Section 2.13;
- 5.3.14.1.9 Fails to comply with any corrective action plan required by CMS and the Department;
- 5.3.14.1.10 Fails to comply with financial solvency requirements;

- 5.3.14.1.11 Fails to comply with reporting requirements;
- 5.3.14.1.12 Fails to submit complete and usable encounter data; or
- 5.3.14.1.13 Fails to comply with any other requirements of this Contract.
- 5.3.14.2 Such sanctions may include:
 - 5.3.14.2.1 Intermediate sanctions and civil monetary penalties consistent with 42 C.F.R. § 422 Subpart O;
 - 5.3.14.2.2 Intermediate sanctions consistent with 42 C.F.R. § 438 Subpart I;
 - 5.3.14.2.3 Financial penalties consistent with 42 C.F.R. § 438.704;
 - 5.3.14.2.4 The appointment of temporary management to oversee the operation of the Contractor in those circumstances set forth in 42 U.S.C. § 1396 u-2(e)(2)(B);
 - 5.3.14.2.5 Suspension of enrollment (including assignment of Enrollees);
 - 5.3.14.2.6 Suspension of payment to the Contractor;
 - 5.3.14.2.7 Disenrollment of Enrollees; and
 - 5.3.14.2.8 Suspension of marketing.
 - 5.3.14.2.9 Denial of payment as set forth in 42 C.F.R. § 438.730.
- 5.3.14.3 If CMS or the Department have identified a deficiency in the performance of a First Tier, Downstream or Related Entity and the Contractor has not successfully implemented an approved corrective action plan in accordance with Section 5.3.13, CMS and the Department may:
 - 5.3.14.3.1 Require the Contractor to subcontract with a different First Tier, Downstream or Related Entity deemed satisfactory by CMS and the Department; or
 - 5.3.14.3.2 Require the Contractor to change the manner or method in which the Contractor ensures the performance of such contractual responsibility.
- 5.3.14.4 Before imposing any intermediate sanctions, the Department and CMS must give the entity timely written notice that explains the basis and nature of the sanction, and other due process protections that CMS and the Department elect to provide.
- 5.3.15 Additional Administrative Procedures. CMS and the Department may, from time to time, issue program memoranda clarifying, elaborating upon, explaining, or otherwise relating to

Contract administration and other management matters. The Contractor must comply with all such program memoranda as may be issued from time to time.

- 5.3.16 Effect of Invalidity of Clauses. If any clause or provision of this Contract is officially declared to be in conflict with any federal or State law or regulation, that clause or provision will be null and void and any such invalidity will not affect the validity of the remainder of this Contract.
- 5.3.17 Conflict of Interest. The Contractor certifies that neither the Contractor nor any First Tier, Downstream or Related Entity may, for the duration of the Contract, have any interest that will conflict, as determined by CMS and the Department, with the performance of services under the Contract. Without limiting the generality of the foregoing, CMS and the Department require that neither the Contractor nor any First Tier, Downstream, or Related Entity has any financial, legal, contractual or other business interest in any entity performing Demonstration Plan enrollment functions for the Department. The Contractor further certifies that it will comply with Section 1932(d) of the Social Security Act.
- 5.3.18 Insurance for Contractor's Employees. The Contractor must agree to maintain at the Contractor's expense all insurance required by law for its employees, including worker's compensation and unemployment compensation, and must provide CMS and the Department with certification of same upon request. The Contractor, and its professional personnel providing services to Enrollees, must obtain and maintain appropriate professional liability insurance coverage. The Contractor must, at the request of CMS or the Department, provide certification of professional liability insurance coverage.
- 5.3.19 Waiver. The Contractor, CMS, or the Department shall not be deemed to have waived any of its rights hereunder unless such waiver is in writing and signed by a duly authorized representative. No delay or omission on the part of the Contractor, CMS, or the Department in exercising any right shall operate as a waiver of such right or any other right. A waiver on any occasion shall not be construed as a bar to or waiver of any right or remedy on any future occasion. The acceptance or approval by CMS and the Department of any materials including, but not limited to, those materials submitted in relation to this Contract, does not constitute waiver of any requirements of this Contract.
- 5.3.20 Section Headings. The headings of the sections of this Contract are for convenience only and will not affect the construction hereof.
- 5.3.21 Other State Terms and Conditions
 - 5.3.21.1 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 the Contractor's and its First Tier, Downstream and Related Entities' officers, employees or agents. The Contractor or the First Tier, Downstream

- and Related Entity shall reassign immediately any such individual who, in the opinion of the State, does not pass the background checks.
- 5.3.21.2 Solicitation and Employment. The Contractor shall give notice immediately to the Department's Ethics Officer if the Contractor solicits or intends to solicit State employees to perform any work under this Contract.
- 5.3.21.3 Anti-Trust Assignment. If the 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, the Contractor shall assign to the State rights, title and interest in and to the claim or cause of action.
- 5.3.21.4 Performance Record/Suspension. Upon request of the State, the Contractor shall meet to discuss performance or provide Contract performance updates to help ensure proper performance of the Contract. The State may consider the Contractor's performance under this Contract and compliance with law and rule to determine whether to continue the Contract, suspend the Contractor from doing future business with the State for a specified period of time, or to determine whether the Contractor can be considered responsible on specific future contract opportunities.
- 5.3.21.5 Illinois 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 the Illinois Freedom of Information Act notwithstanding any provision to the contrary that may be found in this Contract. If the Department receives a request for records relating to the Contractor under this Contract, or the Contractor's provision of services, or the arranging of the provision of services, under this Contract, the Department shall provide notice to the Contractor as soon as practicable and, within the period available under FOIA, the 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 be under no obligation to notify the Contractor regarding a request for a record that has been the subject of a previous request under FOIA.
- 5.3.21.6 Child Support. The Contractor shall ensure that it is in compliance with paying, or any other obligations it may have in enforcing, child support payments pursuant to a court or administrative order of this or any other State. The Contractor will not be considered out of compliance with the requirements of this Section 5.3.21.6 if, upon request by the Department, the Contractor provides:
- 5.3.21.6.1 Proof of payment of past-due amounts in full;

5.3.21.6.2 Proof that the alleged obligation of past-due amounts is being contested through appropriate court or administrative proceedings and the Contractor provides proof of the pendency of such proceedings; or

5.3.21.6.3 Proof of entry into payment arrangements acceptable to the appropriate State agency.

5.3.21.7 Notice of Change in Circumstances. In the event the Contractor, the 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 the Contractor's ability to perform under this Contract, the Contractor will immediately notify the Department in writing.

5.3.21.8 Gifts. The Contractor and the Contractor's principals, employees and First Tier, Downstream and Related Entities 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.

5.3.21.9 Media Relations and Public Information. Subject to any disclosure obligations of the Contractor under applicable law, rule, or regulation, news releases pertaining to this Contract or the services or project to which it relates shall only be made with prior written approval by, and in coordination with, the Department. The Contractor shall not disseminate any publication, presentation, technical paper, or other information related to the Contractor's duties and obligations under this Contract unless such dissemination has received prior written approval from the Department.

5.3.22 Certifications to the State of Illinois.

General. The Contractor acknowledges and agrees that compliance with this Section 5.3.22 and each subsection thereof is a material requirement and condition of this Contract, including renewals. By executing this Contract, the Contractor certifies compliance, as applicable, with this Section and is under a continuing obligation to remain in compliance and report any non-compliance. This Section applies to First Tier, Downstream, and Related Entities used on this Contract. The 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 fiscal years, including the initial term and all renewals, the Contractor and its First Tier, Downstream, and Related Entities shall confirm compliance with this Section 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 is not applicable to this Contract it may be stricken without affecting the remaining subsections.

- 5.3.22.1 As part of each certification, the Contractor acknowledges and agrees that if the Contractor or its First Tier, Downstream, and Related Entities 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.
- 5.3.22.1.1 The Contract may be void by operation of law,
- 5.3.22.1.2 The State may void the Contract, and
- 5.3.22.1.3 The Contractor and its First Tier, Downstream, and Related Entities may be subject to one or more of the following: suspension, debarment, denial of payment, civil fine, or criminal penalty.
- 5.3.23 The Contractor certifies that it and its employees will comply with applicable provisions of the U.S. Civil Rights Act, Section 504 of the Federal Rehabilitation Act, the ADA(42 U.S.C. § 12101 et seq.) and applicable rules in performance under this Contract.
- 5.3.24 The Contractor certifies that it is a properly formed and existing legal entity (30 ILCS 500/1.15.80, 20-43); 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.
- 5.3.25 The 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 the Contractor made an admission of guilt of such conduct that is a matter of record (30 ILCS 500/50-5).
- 5.3.26 If the Contractor employs twenty-five (25) or more employees and this Contract is worth more than \$5000, Contractor certifies that it will provide a drug free workplace pursuant to the Drug Free Workplace Act (30 ILCS 580).
- 5.3.27 The Contractor certifies that neither Contractor nor any substantially owned Affiliate is participating or shall participate in an international boycott in violation of the U.S. Export Administration Act of 1979 or the applicable regulations of the U.S. Department of Commerce. This applies to contracts that exceed \$10,000 (30 ILCS 582).
- 5.3.28 The 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).
- 5.3.29 The 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).

5.3.30 The Contractor warrants and certifies that it and, to the best of its knowledge, its subcontractors have 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 over \$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.

5.3.31 Non-Exclusion:

5.3.31.1 The 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.

5.3.31.2 If at any time during the term of this Contract, the Contractor becomes barred, suspended, or excluded from participation in this transaction, the 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.

5.3.32 Lobbying:

5.3.32.1 The 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 the 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.

5.3.32.2 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, the 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 the Contractor's request from the Department's Bureau of Fiscal Operations.
- 5.3.32.3 The Contractor shall require that the language of this certification be included in the award document for sub awards at all tiers (including subcontracts, sub grants, and contracts under grants, loans, and cooperative agreements) and that all sub recipients shall certify and disclose accordingly.
- 5.3.32.4 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, U.S. Code. Any Person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.
- 5.3.32.5 The Contractor certifies that it has accurately completed the certification in Appendix J.

5.4 Record Retention, Inspection, and Audit

- 5.4.1 The Contractor must maintain books, records, documents, and other evidence of administrative, medical, and accounting procedures and practices through ten years from the end of the final Contract period or completion of audit, whichever is later, and, at a minimum, comply with 30 ILCS 500/20-65.
- 5.4.2 The Contractor must make the records maintained by the Contractor and its Provider Network, as required by CMS and the Department and other regulatory agencies, available to CMS and the Department and its agents, designees or contractors or any other authorized representatives of Illinois or the United States Government, or their designees or contractors, at such times, places, and in such manner as such entities may reasonably request for the purposes of financial or medical audits, inspections, and examinations, provided that such activities are conducted during the normal business hours of the Contractor.
- 5.4.3 The Contractor further agrees that the Secretary of the U.S. Department of Health and Human Services or his or her designee, the Governor or his or her designee, Comptroller General, and the State Auditor or his or her designee have the right at reasonable times and upon reasonable notice to examine the books, records, and other compilations of data of the Contractor and its First Tier, Downstream and Related Entities that pertain to: the ability of the Contractor to bear the risk of potential financial losses; services performed; or determinations of amounts payable.

- 5.4.4 The Contractor must make available, for the purposes of record maintenance requirements, its premises, physical facilities and equipment, records relating to its Enrollees, and any additional relevant information that CMS or the Department may require, in a manner that meets CMS and the Department's record maintenance requirements.
- 5.4.5 The Contractor must comply with the right of the U.S. Department of Health and Human Services, the Comptroller General, the Department and their designees to inspect, evaluate, and audit records through ten years from the final date of the Contract period or the completion of audit, whichever is later, in accordance with Federal and State requirements.

5.5 Termination of Contract

- 5.5.1 Termination without Prior Notice. In the event the Contractor materially fails to meet its obligations under this Contract or has otherwise violated the laws, regulations, or rules that govern the Medicare or Illinois Medicaid programs, CMS or the Department may take any or all action under this Contract, law, or equity, including but not limited to immediate termination of this Contract. CMS or the Department may terminate the Contract in accordance with regulations that are current at the time of the termination.

Without limiting the above, if CMS and the Department determine that participation of the Contractor in the Medicare or Illinois Medicaid program or in the Demonstration, may threaten or endanger the health, safety, or welfare of Enrollees or compromise the integrity of the Medicare or Illinois Medicaid program, CMS or the Department, without prior notice, may immediately terminate this Contract, suspend the Contractor from participation, withhold any future payments to the Contractor, or take any or all other actions under this Contract, law, or equity. Such action may precede enrollment of any Enrollee into any Demonstration Plan, and shall be taken upon a finding by CMS or the Department that the Contractor has not achieved and demonstrated a state of readiness that will allow for the safe and efficient provision of Medicare-Medicaid services to Enrollees.

United States law will apply to resolve any claim of breach of this Contract.

5.5.2 Termination with Prior Notice

- 5.5.2.1 CMS or the Department may terminate this Contract without cause upon no less than one hundred eighty (180) days prior written notice to the other Party specifying the termination date, unless applicable law requires otherwise. Per Section 5.7, the Contractor may choose to not renew prior to the end of each term pursuant to 42 C.F.R. § 422.506(a) except in Demonstration Year 1, in which the Contractor may choose to non renew the contract as of December 31, 2014 provided the Contractor gives notice before August 1, 2014, and may terminate the contract by mutual consent of CMS and the Department at any time pursuant to 42 C.F.R. § 422.508. In considering requests for termination under 42 C.F.R. § 422.508, CMS and the Department will consider, among other factors, financial performance and stability in granting consent for termination. Any written

communications or oral scripts developed to implement the requirements of 42 C.F.R. § 422.506(a) must be submitted to and approved by CMS and the Department prior to their use.

Pursuant to 42 C.F.R. §§ 422.506(a)(4) and 422.508(c), CMS considers Contractor termination of this Contract with prior notice as described in paragraph 5.5.B.1 to be circumstances warranting special consideration, and will not prohibit the Contractor from applying for new Medicare Advantage contracts or Service Area expansions for a period of two (2) years due to termination.

5.5.3 Termination pursuant to Social Security Act § 1115A(b)(3)(B).

5.5.4 Termination for Cause

5.5.4.1 Any Party may terminate this Agreement upon ninety (90) days' notice due to a material breach of a provision of this Contract unless CMS or the Department determines that a delay in termination would pose an imminent and serious risk to the health of the Enrollees enrolled with the Contractor or the Contractor experiences financial difficulties so severe that its ability make necessary health services available is impaired to the point of posing an imminent and serious risk to the health of its Enrollees, whereby CMS or the Department may expedite the termination.

5.5.4.2 Pre-termination Procedures. Before terminating a Contract under 42 C.F.R. § 422.510 and § 438.708, the Contractor may request a pre-termination hearing or develop and implement a corrective action plan. CMS or the Department must:

5.5.4.2.1 Give the Contractor written notice of its intent to terminate, the reason for termination, and a reasonable opportunity of at least thirty (30) calendar days to develop and implement a corrective action plan to correct the deficiencies; and/or

5.5.4.2.2 Notify the Contractor of its appeal rights as provided in 42 C.F.R. § 422 Subpart N and § 438.710.

5.5.5 Termination due to a Change in Law

5.5.5.1 In addition, CMS or the Department may terminate this Contract upon 30 days' notice due to a material change in law or appropriation, or with less or no notice if required by law.

5.5.6 Termination due to unavailability of Appropriations (30 ILCS 500/20-60); Sufficiency of Funds.

5.5.6.1 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 penalty or further payment being required, if (i) sufficient State funds have not been appropriated to the Department or sufficient federal funds have not been made available to the Department by the federal funding source, (ii) the Governor or the Department reserves appropriated funds, or (iii) the Governor or the Department determines that appropriated funds or federal funds may not be available for payment. The Department shall provide notice, in writing, to Contractor and CMS 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 no fewer than 30 (thirty) days/ notice to CMS and Contractor.

5.5.7 Continued Obligations of the Parties

- 5.5.7.1 In the event of termination, expiration, or non-renewal of this Contract, or if the Contractor otherwise withdraws from the Medicare or Illinois Medicaid programs, the Contractor shall continue to have the obligations imposed by this Contract or applicable law. These include, without limitation, the obligations to continue to provide Covered Services to each Enrollee at the time of such termination or withdrawal until the Enrollee has been disenrolled from the Contractor's Demonstration Plan. CMS and the Department will disenroll all beneficiaries by the end of the month that termination, expiration, or non-renewal of this Contract is effective.
- 5.5.7.2 In the event that this Contract is terminated, expires, or is not renewed for any reason:
 - 5.5.7.2.1 If CMS or the Department, or both, elect to terminate or not renew this Contract, CMS and the Department will be responsible for notifying all Enrollees covered under this Contract of the date of termination and the process by which those Enrollees will continue to receive care, unless the Enrollee notification is delegated to the Contractor by CMS or the Department. If the Contractor elects to terminate or not renew the Contract, the Contractor will be responsible for notifying all Enrollees and the general public, in accordance with federal and State requirements;
 - 5.5.7.2.2 The Contractor must promptly return to CMS and the Department all payments advanced to the Contractor for Enrollees after the effective date of their disenrollment; and
 - 5.5.7.2.3 The Contractor must supply to CMS and the Department all information necessary for the payment of any outstanding claims determined by CMS and the Department to be due to the Contractor, and any such claims will be paid in accordance with the terms of this Contract.

5.6 Order of Precedence

5.6.1 The following documents are incorporated into and made a part of this Contract, including all appendices:

- 5.6.1.1 Capitated Financial Alignment Application, a document issued by CMS and subject to modification each program year;
- 5.6.1.2 Memorandum of Understanding, a document between CMS and the Department Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees (February 22, 2012);
- 5.6.1.3 The Request for Proposal number 2013-24-004 or number 2013-24-004 issued by the Department, including the Department's responses to questions submitted by potential bidders; and
- 5.6.1.4 The Contractor's proposal in response to the Request for Proposal number 2013-24-004 or number 2013-24-004; and
- 5.6.1.5 Any State or Federal Requirements or Instructions released to MMPs. Examples include the annual rate report, Medicare-Medicaid marketing guidance, and Medicare-Medicaid Plan Enrollment and Disenrollment Guidance.

5.6.2 In the event of any conflict among the documents that are a part of this Contract, including all appendices, the order of priority to interpret the Contract shall be as follows:

- 5.6.2.1 The Contract terms and conditions, including all appendices;
- 5.6.2.2 Capitated Financial Alignment Application;
- 5.6.2.3 The Memorandum of Understanding between CMS and Illinois;
- 5.6.2.4 The Request for Proposal number 2013-24-004 or number 2013-24-004 issued by the Department, including the Department's responses to questions submitted by potential bidders;

The Contractor's proposal in response to the Request for Proposal number 2013-24-004 or number. 2013-24-004; and

- 5.6.2.5 Any State or Federal Requirements or Instructions released to MMPs. Examples include the annual rate report, Medicare-Medicaid marketing guidance, and Medicare-Medicaid Plan Enrollment and Disenrollment Guidance.

5.6.3 In the event of any conflict between this Contract and the MOU, the Contract shall prevail.

5.7 Contract Term

- 5.7.1 This Contract shall be in effect starting on January 1, 2018, through December 31, 2019, so long as the contractor meets all federal submission requirements and has not provided CMS and the Department with a notice of intention not to renew, pursuant to 42 C.F.R. 422.506 or Section 5.5, above, provided, however, that any duties, obligations, responsibilities, or requirements that are imposed upon the Contractor in this revised Contract but that were not imposed upon the Contractor previously under this Contract or under applicable laws or regulations, shall be effective January 1, 2018.
- 5.7.2 At the discretion of CMS and upon notice to the Parties, this Contract may be terminated, or the effectuation of the Contract Operational Start Date may be delayed, if Illinois has not received all necessary approvals from CMS or, as provided in Section 2.2.1.3 of this Contract, if the Contractor is determined not to be ready to participate in the MMAI.
- 5.7.3 Illinois may not expend Federal funds for, or award Federal funds to, the Contractor until Illinois has received all necessary approvals from CMS. Illinois may not make payments to Contractor by using Federal funds, or draw Federal Medical Assistance Payment (FMAP) funds, for any services provided, or costs incurred, by Contractor prior to the later of the approval date for any necessary State Plan and waiver authority, the Readiness Review approval, or the Contract Operational Start Date.

5.8 Amendments

The Parties agree to negotiate in good faith to cure any omissions, ambiguities, or manifest errors herein. By mutual agreement, the Parties may amend this Contract where such amendment does not violate federal or State statutory, regulatory, or waiver provisions, provided that such amendment is in writing, signed by authorized representatives of each Parties, and attached hereto.

5.9 Written Notices

Notices to the Parties as to any matter hereunder will be sufficient if given in writing and sent by certified mail, postage prepaid, or delivered in hand to:

To: Centers for Medicare and Medicaid Services
Medicare-Medicaid Coordination Office
7500 Security Boulevard, S3-13-23
Baltimore, MD 21244

To: Illinois Department of Healthcare and Family Services
Bureau of Managed Care
201 South Grand Avenue East
Springfield, IL 62763

Electronic copies to:

To:

Electronic copies to:

In Witness Whereof, CMS, the Department, and the Contractor have caused this Contract to be executed by their respective authorized officers:

[Contractor]:

(Authorized Signatory)

(Title)

(Signature)

Date

In Witness Whereof, CMS, the State of Illinois, and the Contractor have caused this Contract to be executed by their respective authorized officers:

State of Illinois:

(Authorized Signatory)

(Title)

(Signature)

(Date)

In Witness Whereof, CMS, the State of Illinois, and the Contractor have caused this Contract to be executed by their respective authorized officers:

United States Department of Health and Human Services, Centers for Medicare & Medicaid Services:

Kathryn Coleman
Director
Medicare Drug & Health Plan Contract Administration Group
Centers for Medicare & Medicaid Services
United States Department of Health and Human Services

Date

In Witness Whereof, CMS, the State of Illinois, and the Contractor have caused this Contract to be executed by their respective authorized officers:

United States Department of Health and Human Services, Centers for Medicare & Medicaid Services:

Ruth A. Hughes
Associate Regional Administrator,
Division of Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
United States Department of Health and Human Services

Date

Section 6: Appendices

APPENDIX A: COVERED SERVICES

- A.1 Medical Necessity. The Contractor shall provide services to Enrollees as follows:
- A.1.1 Authorize, arrange, coordinate, and provide to Enrollees all Medically Necessary Covered Services as specified in Section 2.4, in accordance with the requirements of the Contract.
 - A.1.2 Provide all Covered Services that are Medically Necessary, including but not limited to, those Covered Services that:
 - A.1.2.1. Prevent, diagnose, or treat health impairments;
 - A.1.2.2. Attain, maintain, or regain functional capacity.
 - A.1.3 Not arbitrarily deny or reduce the amount, duration, or scope of a required Covered Service solely because of diagnosis, type of illness, or condition of the Enrollee.
 - A.1.4 Not deny authorization for a Covered Service that the Enrollee or the Provider demonstrates is Medically Necessary.
 - A.1.5 The Contractor may place appropriate limits on a Covered Service on the basis of Medical Necessity, or for the purpose of Utilization Management, provided that the furnished services can reasonably be expected to achieve their purpose. The Contractor's Medical Necessity guidelines must, at a minimum, be:
 - A.1.5.1. Developed with input from practicing Physicians in the Demonstration Plan's Service Area;
 - A.1.5.2. Developed in accordance with standards adopted by national accreditation organizations;
 - A.1.5.3. Updated at least annually or as new treatments, applications and technologies are adopted as generally accepted professional medical practice;
 - A.1.5.4. Evidence-based, if practicable; and
 - A.1.5.5. Applied in a manner that considers the individual health care needs of the Enrollee.
 - A.1.6 The Contractor's Medical Necessity guidelines, program specifications and service components for Behavioral Health services must, at a minimum, be submitted to the Department annually for approval no later than thirty (30) days prior to the start of a new Contract Year, and no later than thirty (30) days prior to any change.
 - A.1.7 Offer and provide to all Enrollees any and all non-medical programs and services specific to Enrollees for which the Contractor has received the Department's approval.

A.2 Covered Services. The Contractor agrees to provide Enrollees access to the following Covered Services:

A.2.1 All services provided under Illinois State Plan services, excluding ICF/MR services, and those services otherwise excluded or limited in A.4 or A.5 of this Appendix A.

A.2.2 All Home and Community Based Waiver Services for individuals on the following waivers (See Addendum 1)

A.2.2.1. Persons who are Elderly;

A.2.2.2. Persons with Disabilities;

A.2.2.3. Persons with HIV/ AIDS;

A.2.2.4. Persons with Brain Injury; and

A.2.2.5. Supportive Living Facilities Waiver.

A.2.3 All services provided under Medicare Part A

A.2.4 All services provided under Medicare Part B

A.2.5 All services provided under Medicare Part D

A.2.5.1. Particular pharmacy products that are covered by Illinois and may not be covered under Medicare Part D, including:

- Drugs specified:
<http://www.illinois.gov/hfs/MedicalProviders/cc/mmai/Pages/default.aspx>;
- Contractors are encouraged to offer a broader drug formulary than minimum requirements.

A.2.6 Any value-added services offered by the plans through their PBP.

A.2.7 Institution for Mental Diseases in lieu of Covered Services. The Contractor may provide psychiatric and substance use disorder inpatient services in an Institution for Mental Diseases (IMD) that are medically appropriate and cost effective in lieu of the Covered Services under the State Plan to Enrollees between the ages of twenty-one and sixty-four (21-64) who have inpatient stays in an IMD of no more than fifteen (15) days in a calendar month. The Contractor shall not require an Enrollee to use such in lieu of services. The Department represents that Capitation rates paid hereunder for IMD in lieu of services are actuarially sound and based on covered services under the State Plan. Eligibility and length of stay will be determined by IMD admissions status on the first day of every calendar month.

A.3 Cost-sharing for Covered Services

A.3.1 Except as described below, cost-sharing of any kind is not permitted in this Demonstration.

A.3.2 Cost sharing for Part D drugs.

A.3.2.1. Co-pays charged by Demonstration Plans for Part D drugs must not exceed the applicable amounts for brand and generic drugs established yearly by CMS under the Part D Low Income Subsidy.

A.3.2.2. The Contractor may establish lower cost-sharing for prescription drugs than the maximum allowed.

A.3.3 Cost sharing for Medicaid Services.

A.3.3.1. For Medicaid services beyond the pharmacy cost sharing described here, Demonstration Plans will not charge cost sharing to Enrollees above levels established under the State Plan.

A.3.3.2. Demonstration Plans are free to waive Medicaid cost sharing.

A.3.3.3. For Enrollees who are residents of NFs, Demonstration Plans may require the Enrollee to contribute to the cost of NF care that amount listed for the Enrollee on the Department's patient credit file, which will be transmitted monthly to the Demonstration Plan.

A.4 Excluded Services. The following services are not Covered Services

A.4.1 Services that are provided in a State Facility operated as a psychiatric hospital as a result of a forensic commitment;

A.4.2 Services that are provided through a Local Education Agency (LEA);

A.4.3 Services that are experimental or investigational in nature;

A.4.4 Services that are provided by a non-Affiliated Provider and not authorized by Contractor, unless this Contract specifically requires that such services be Covered Services;

A.4.5 Services that are provided without a required Referral or prior authorization as set forth in the Provider Handbook;

A.4.6 Medical and surgical services that are provided solely for cosmetic purposes;

A.4.7 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)(16) of the Social Security Act.

A.4.8 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, except such items or services that are Emergency Services or included as additional Covered Services in an addendum to Appendix A.

A.5 Limitations on Covered Services. The following services and benefits shall be limited as Covered Services:

A.5.1 Termination of pregnancy may be provided only as allowed by applicable State and federal law and regulation (42 C.F.R. Part 441, Subpart E). In any such case, the requirements of such laws must be fully complied with and HFS Form 2390 must be completed and filed in the Enrollee's medical record. Termination of pregnancy shall not be provided to Enrollees who are eligible under the State Children's Health Insurance Program (215 ILCS 106).

A.5.2 Sterilization services may be provided only as allowed by State and federal law (see 42 C.F.R. Part 441, Subpart F). In any such case, the requirements of such laws must be fully complied with and a HFS Form 2189 must be completed and filed in the Enrollee's medical record.

A.5.3 If a hysterectomy is provided, a HFS Form 1977 must be completed and filed in the Enrollee's medical record.

Addendum 1: HCBS Waiver Covered Services

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

Service	DoA	DHS-DRS			HFS	Definition	Standards	HFS Fee-For-Service Service Limits
	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury	Supportive Living Facility			
Supported Employment				x		Supported employment services consist of intensive, ongoing supports that enable 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 42 C.F.R. 440.70, with the exception that limitations on the amount, duration, and scope of such services imposed by the State's approved Medicaid State Plan shall not be applicable.	DRS: Individual: 210 ILCS 45/3-206 Agency: 210 ILCS 55	Services provided are in addition to any services provided through the State Plan. The amount, duration, and scope of services are based on the determination of need assessment conducted by the case manager and the service cost maximum determined by the DON.

Service	DoA	DHS-DRS			HFS	Definition	Standards	HFS Fee-For-Service Service Limits
	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury	Supportive Living Facility			
Nursing, Intermittent		x	x	x		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			HFS	Definition	Standards	HFS Fee-For-Service Service Limits
	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury	Supportive Living Facility			
Physical Therapy		x	x	x		Service provided by a licensed physical therapist that meets Illinois standards. Services are in addition to any Medicaid State Plan services for which the Enrollee may qualify. Physical Therapy through the HCBS Waiver focuses on long term habilitative needs rather than short-term acute restorative needs.	DRS: Physical Therapist 225 ILCS 90 Home Health Agency: 210 ILCS 55	DRS All HCBS Waiver clinical services require a prescription from a Physician. The duration and/or frequency of these services are dependent on continued authorization of the Physician, and relevance to the Enrollee's service plan. The amount, duration, and scope of services is based on the service plan and is included in the service cost maximum.
Speech Therapy		x	x	x		Service provided by a licensed speech therapist that meets Illinois standards. Services are in addition to any Medicaid State Plan services for which the Enrollee may qualify. Speech Therapy through the HCBS Waiver focuses on long term habilitation needs rather than short-term acute restorative needs.	DRS: Speech Therapist 225 ILCS 110 Home Health Agency: 210 ILCS 55	DRS All HCBS Waiver clinical services require a prescription from a Physician. The duration and/or frequency of these services are dependent on continued authorization of the Physician, and relevance to the Enrollee's service plan. The amount, duration, and scope of services is based on the service plan and is included in the service cost maximum.
Prevocational Services				x		Prevocational services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. This can include teaching concepts such as compliance, attendance, task completion, problem solving and safety. Prevocational Services are provided to persons expected to be able to join the general 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.

Service	DoA	DHS-DRS			HFS	Definition	Standards	HFS Fee-For-Service Service Limits
	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury	Supportive Living Facility			
Habilitation-Day				x		BI Day habilitation assists with the acquisition, retention, or improvement in self-help, socialization, and adaptive skills which takes place in a 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.
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.
Individual Provider,		x	x	x		Individual Providers, including Personal Assistants, provide assistance with eating,	89 Il. Adm. Code 686.10	The amount, duration, and scope of services is based on the

Service	DoA	DHS-DRS			HFS	Definition	Standards	HFS Fee-For-Service Service Limits
	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury	Supportive Living Facility			
including Personal Assistant (Contingent upon compliance with collective bargaining agreement and accompanying side letter between SEIU and the State.)						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.		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			HFS	Definition	Standards	HFS Fee-For-Service Service Limits
	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury	Supportive Living Facility			
Respite		x	x	x		<p>DRS Respite services provide relief for unpaid family or primary care givers, who are currently meeting all service needs of the Enrollee. 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.</p> <p>DSCC Respite care services allow for the needed level of care and supportive services to enable the Enrollee to remain in the community, or home-like environment, while periodically relieving the family of care-giving responsibilities. These services will be provided in the Enrollee's home or in a Children's Community-Based Health Care Center Model, licensed by the Illinois Department of Public Health.</p>	<p>Adult Day Care 89 Il. Adm.Code 686.100 Home Health Aide 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</p>	<p>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</p> <p>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.</p>

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

Service	DoA	DHS-DRS			HFS	Definition	Standards	HFS Fee-For-Service Service Limits
	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury	Supportive Living Facility			
Behavioral Services (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 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 NF. 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: <ul style="list-style-type: none"> • Nursing Services • Personal Care • Medication administration, oversight and assistance in self-administration • Laundry • Housekeeping • Maintenance • Social and recreational programming • Ancillary Services • 24 Hour Response/Security staff • Health Promotion and Exercise • Emergency call System • Daily Checks • Quality Assurance Plan • Management of Resident Funds, if applicable

APPENDIX B: ENROLLEE RIGHTS

The Contractor must have written policies regarding the Enrollee rights specified in this appendix, as well as written policies specifying how information about these rights will be disseminated to Enrollees. Enrollees must be notified of these rights and protections at least annually, and in a manner that takes in to consideration cultural considerations, Functional Status and language needs. Enrollee rights include, but are not limited to, those rights and protections provided by 42 C.F.R. § 438.100, 42 C.F.R. §422 Subpart C, and the Memorandum of Understanding (MOU) between CMS and the State. Specifically, Enrollees must be guaranteed:

- A. The right to be treated with dignity and respect.
- B. The right to be afforded privacy and confidentiality in all aspects of care and for all health care information, unless otherwise required by law.
- C. The right to be provided a copy of his or her medical records, upon request, and to request corrections or amendments to these records, as specified in 45 C.F.R. part 164.
- D. The right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's condition, Functional Status, and language needs.
- E. The right not to be discriminated against based on race, ethnicity, national origin, religion, sex, age, sexual orientation, medical or claims history, mental or physical disability, genetic information, or source of payment.
- F. The right to have all plan options, rules, and benefits fully explained, including through use of a qualified interpreter if needed.
- G. Access to an adequate network of primary and specialty Providers who are capable of meeting the Enrollee's needs with respect to physical access, and communication and scheduling needs, and are subject to ongoing assessment of clinical quality including required reporting.
- H. The right to receive a second opinion on a medical procedure and have the Contractor pay for the second opinion consultation visit.
- I. The right to choose a plan and Provider at any time, including a plan outside of the demonstration, and have that choice be effective the first calendar day of the following month.
- J. The right to have a voice in the governance and operation of the integrated system, Provider or health plan, as detailed in this three-way contract.
- K. The right to participate in all aspects of care and to exercise all rights of appeal. Enrollees have a responsibility to be fully involved in maintaining their health and making decisions about their health care, including the right to refuse treatment if desired, and must be appropriately informed and supported to this end. Specifically, Enrollees must:
 - a. Receive an in-person Comprehensive Assessment upon enrollment in a plan and to participate in the development and implementation of an Individualized Care Plan. The assessment must include considerations of social, functional, medical, behavioral, Wellness and prevention domains, an evaluation of the Enrollee's strengths and weaknesses, and a plan for managing and coordination Enrollee's care. Enrollees, or their designated representative, also have the right to request a reassessment by the interdisciplinary team, and be fully involved in any such reassessment.

- b. Receive complete and accurate information on his or her health and Functional Status by the interdisciplinary team.
- c. Be provided information on all program services and health care options, including available treatment options and alternatives, presented in a culturally appropriate manner, taking in to consideration Enrollee's condition and ability to understand. An Enrollee who is unable to participate fully in treatment decisions has the right to designate a representative. This includes the right to have translation services available to make information appropriately accessible. Information must be available:
 - i. Before enrollment.
 - ii. At enrollment.
 - iii. At the time a Potential Enrollee's or Enrollee's needs necessitate the disclosure and delivery of such information in order to allow the Potential Enrollee or Enrollee to make an informed choice.
- d. Be encouraged to involve caregivers or family members in treatment discussions and decisions.
- e. Have Advance Directives explained and to establish them, if the participant so desires, in accordance with 42 C.F.R. §§ 489.100 and 489.102.
- f. Receive reasonable advance notice, in writing, of any transfer to another treatment setting and the justification for the transfer.
- g. Be afforded the opportunity file an Appeal if services are denied that he or she thinks are medically indicated, and to be able to ultimately take that Appeal to an independent external system of review.
- L. The right to receive medical and non-medical care from a team that meets the beneficiary's needs, in a manner that is sensitive to the beneficiary's language and culture, and in an appropriate care setting, including the home and community.
- M. The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- N. Each Enrollee is free to exercise his or her rights and that the exercise of those rights does not adversely affect the way the Contractor and its Providers or the State Agency or CMS provide, or arrange for the provision of, medical services to the Enrollee.
- O. The right to receive timely information about plan changes. This includes the right to request and obtain the information listed in the Orientation materials at least once per year, and , the right to receive notice of any significant change in the information provided in the Orientation materials at least thirty (30) days prior to the intended effective date of the change. See 438.10(g),(h).
- P. The right to be protected from liability for payment of any fees that are the obligation of the Contractor.
- Q. The right not to be charged any cost sharing for Medicare Parts A and B services.

APPENDIX C: RELATIONSHIP WITH FIRST TIER, DOWNSTREAM, AND RELATED ENTITIES

- A. The Contractor shall ensure that any contracts or agreements with First Tier, Downstream and Related Entities performing functions on the Contractor's behalf related to the operation of the Medicare-Medicaid plan are in compliance with 42 C.F.R. §§ 422.504, 423.505, and 438.3(k).
- B. The Contractor shall specifically ensure:
 - 1. HHS, the Comptroller General, the Department, the Department's Office of Inspector General, the Medicaid Fraud Control Unit of the Illinois State Police, the Illinois Auditor General, and their designees, and other State and federal agencies with monitoring authority related to Medicare and Medicaid, have the right to audit, evaluate, and inspect any books, contracts, computer or other electronic systems, including medical records and documentation of the First Tier, Downstream and Related Entities; and
 - 2. HHS's, the Comptroller General's, the Department's, the Department's Office of Inspector's General, the Medicaid Fraud Control Unit's of the Illinois State Police, the Illinois Auditor's General, and or their designees', and other State and federal agencies with monitoring authority related to Medicare and Medicaid, right to inspect, evaluate, and audit any pertinent information for any particular contract period for ten years from the final date of the contract period or from the date of completion of any audit, whichever is later.
- C. The Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities contain the following:
 - 1. Enrollee protections that include prohibiting Providers from holding an Enrollee liable for payment of any fees that are the obligation of the Contractor;
 - 2. Language that any services or other activity performed by a First Tier, Downstream and Related Entities is in accordance with the Contractor's contractual obligations to CMS and the Department, including the requirements at 42 CFR 438.414 in relation to the grievance system;
 - 3. Language that specifies the delegated activities and reporting requirements;
 - 4. Language that provides for revocation of the delegation activities and reporting requirements or specifies other remedies in instances where CMS, the Department or the Contractor determine that such parties have not performed satisfactorily;
 - 5. Language that specifies the performance of the parties is monitored by the Contractor on an ongoing basis and the Contractor may impose corrective action as necessary;
 - 6. Language that specifies the First Tier, Downstream and Related Entities agree to safeguard Enrollee Privacy and confidentiality of Enrollee health records; and
 - 7. Language that specifies the First Tier, Downstream and Related Entities must comply with all Federal and State laws, regulations and CMS instructions.
- D. The Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities that are for credentialing of medical Providers contains the following language:

1. The credentials of medical professionals affiliated with the party or parties will be reviewed by the Contractor; or
 2. The credentialing process will be reviewed and approved by the Contractor and the Contractor must audit the credentialing process on an ongoing basis.
- E. The Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities that delegate the selection of Providers include language that the Contractor retains the right to approve, suspend, or terminate any such arrangement.
- F. The Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities shall state that the Contractor has the right to terminate the contract with cause upon sixty (60) days' notice, and without cause upon 120 days' notice, and shall require the provider assist with transitioning Enrollees to new Providers, including sharing the Enrollee's medical record and other relevant Enrollee information as directed by the Contractor or Enrollee. In a for cause termination, Contractor must have an internal grievance procedure that allows the Provider to contest the grounds for the termination prior to the effective date of the termination.
- G. The Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities shall state that the Contractor shall provide a written statement to a Provider of the reason or reasons for termination with cause.
- H. The Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities for medical Providers include additional provisions. Such contracts or arrangements must contain the following:
1. Language that the Contractor is obligated to pay contracted medical Providers under the terms of the contract between the Contractor and the medical Provider. The contract must contain a prompt payment provision, the terms of which are developed and agreed to by both the Contractor and the relevant medical Provider;
 2. Language that services are provided in a culturally competent manner to all Enrollees, including those with limited English proficiency or reading skills, and diverse culturally and ethnic backgrounds;
 3. Language that medical Providers abide by all Federal and State laws and regulations regarding confidentiality and disclosure of medical records, or other health and enrollment information;
 4. Language that medical Providers ensure that medical information is released in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas;
 5. Language that medical Providers maintain Enrollee records and information in an accurate and timely manner;
 6. Language that medical Providers ensure timely access by Enrollees to the records and information that pertain to them;
 7. Language that Enrollees will not be held liable for Medicare Part A and B cost sharing. Specifically, Medicare Parts A and B services must be provided at zero cost-sharing to Enrollees;
 8. Language that clearly state the medical Providers EMTALA obligations and must not create any conflicts with hospital actions required to comply with EMTALA;

9. Language prohibiting Providers, including, but not limited to PCPs, from closing or otherwise limiting their acceptance of Enrollees as patients unless the same limitations apply to all commercially insured enrollees;
10. Language that prohibits the Contractor from refusing to contract or pay an otherwise eligible health care Provider for the provision of Covered Services solely because such Provider has in good faith:
 - (a) Communicated with or advocated on behalf of one or more of his or her prospective, current or former patients regarding the provisions, terms or requirements of the Contractor's health benefit plans as they relate to the needs of such Provider's patients; or
 - (b) Communicated with one or more of his or her prospective, current or former patients with respect to the method by which such Provider is compensated by the Contractor for services provided to the patient;
11. Language that states the Provider is not required to indemnify the Contractor for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against the Contractor based on the Contractor's management decisions, utilization review provisions or other policies, guidelines or actions;
12. Language that states the Contractor shall require Providers to comply with the Contractor's requirements for utilization review, quality management and improvement, credentialing and the delivery of preventive health services.
13. Language that states the Contractor shall notify Providers in writing of modifications in payments, modifications in Covered Services or modifications in the Contractor's procedures, documents or requirements, including those associated with utilization review, quality management and improvement, credentialing and preventive health services, that have a substantial impact on the rights or responsibilities of the Providers, and the effective date of the modifications. The notice shall be provided 30 days before the effective date of such modification unless such other date for notice is mutually agreed upon between the Contractor and the Provider or unless such change is mandated by CMS or the Department without 30 days prior notice;
14. Language that states all First Tier, Downstream and Related Entities must comply with all applicable requirements governing physician incentive plans, including but not limited to such requirements appearing at 42 C.F.R. Parts 417, 422, 434, 438, and 1003. Specifically, Contractor shall ensure that contracts or arrangements with First Tier, Downstream and Related Entities for medical providers do not include incentive plans that include a specific payment made directly or indirectly to a provider as an inducement to deny, reduce, delay, or limit specific, Medical Necessary Services furnished to an individual Enrollee.

Contractor shall ensure its First Tier, Downstream and Related Entities comply with all Enrollee payment restrictions, including balance billing restrictions, and develop and implement a plan to identify and revoke or provide other specified remedies for any member of the Contractor's First Tier, Downstream and Related Entities that does not comply with such provisions.

15. Language that states that Providers shall not bill patients for charges for Covered Services other than pharmacy co-payments, if applicable;
16. Language that states that no payment shall be made by the Contractor to a Provider for a Provider Preventable Condition; and

17. As a condition of payment, the Provider shall comply with the reporting requirements as set forth in 42 C.F.R. § 447.26(d) and as may be specified by the Contractor. The Provider shall comply with such reporting requirements to the extent the Provider directly furnishes services.
 18. Language that states the Contractor shall monitor and ensure that all Utilization Management activities provided by a First Tier, Downstream, or Related Entity comply with all provisions of this three-way Contract.
 19. Language that prohibits Providers from billing Enrollees for missed appointments or refusing to provide services to Enrollees who have missed appointments. Such Provider contracts shall require Providers to work with Enrollees and the Contractor to assist Enrollees in keeping their appointments.
 20. Language that prohibits Providers from refusing to provide services to an Enrollee because the Enrollee has an outstanding debt with the Provider from a time prior to the Enrollee becoming a Member.
- I. The Contractor shall ensure that contracts or arrangements with First Tier, Downstream and Related Entities for medical Providers do not include incentive plans that include a specific payment to a Provider as an inducement to deny, reduce, delay, or limit specific, Medical Necessary Services and:
 - a. The Provider shall not profit from provision of Covered Services that are not Medically Necessary or medically appropriate.
 - b. The Contractor shall not profit from denial or withholding of Covered Services that are Medically Necessary or medically appropriate.
 - c. Nothing in this paragraph I shall be construed to prohibit contracts that contain incentive plans that involve general payments such as Capitation payments or shared risk agreements that are made with respect to Physicians or Physician groups or that are made with respect to groups of Enrollees if such agreements, which impose risk on such Physicians or Physician groups for the costs of medical care, services and equipment provided or authorized by another Physician or health care Provider, comply with paragraph J, below.
 - J. The Contractor shall ensure that contracts or arrangements with First Tier, Downstream and Related Entities for medical Providers includes language that prohibits the Contractor from imposing a financial risk on medical Providers for the costs of medical care, services or equipment provided or authorized by another Physician or health care Provider unless such contract includes specific provisions with respect to the following:
 1. Stop-loss protection;
 2. Minimum patient population size for the Physician or Physician group; and
 3. Identification of the health care services for which the Physician or Physician group is at risk.
 - K. The Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities for laboratory testing sites providing services include an additional provision that such laboratory testing sites must have either a Clinical Laboratory Improvement Amendment (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.

- L. Nothing in this section shall be construed to restrict or limit the rights of the Contractor to include as Providers religious non-medical Providers or to utilize medically based eligibility standards or criteria in deciding Provider status for religious non-medical Providers.

APPENDIX D: 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 for Covered Services. 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 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 necessity criteria used and the process used to review and approve the provision of Covered 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 Sections 2.9.5.3 and 2.13 of this Contract;
 - iii. Review decisions shall be supervised by qualified medical 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 health care 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 Physician, 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 with Sections 2.9.5.3 and 2.13 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 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 medical review, including behavioral health services, 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) medical 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 problem or diagnostic category. Contractor's medical 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 the peer review procedures 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.
 7. The Department may conduct its own peer reviews at its discretion.

**APPENDIX E: ADDENDUM TO CAPITATED FINANCIAL
ALIGNMENT CONTRACT PURSUANT TO SECTIONS 1860D-1
THROUGH 1860D-43 OF THE SOCIAL SECURITY ACT FOR THE
OPERATION OF A VOLUNTARY MEDICARE PRESCRIPTION DRUG
PLAN**

The Centers for Medicare & Medicaid Services (hereinafter referred to as “CMS”) , the State of Illinois, acting by and through the Department of Healthcare and Family Services (Department), and a Medicare-Medicaid Managed Care Organization (hereinafter referred to as Contractor) agree to incorporate as part of the contract [Contract Number] governing Contractor’s operation of a Medicare-Medicaid plan described in § 1851(a)(2)(A) of the Social Security Act (hereinafter referred to as “the Act”) this Appendix F under which Contractor shall operate a Voluntary Medicare Prescription Drug Plan pursuant to §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act.

Article I
Voluntary Medicare Prescription Drug Plan

- A. Contractor agrees to operate one or more Medicare Voluntary Prescription Drug Plans as described in its application and related materials submitted to CMS for Medicare approval, including but not limited to all the attestations contained therein and all supplemental guidance, and in compliance with the provisions of this Appendix F, which incorporates in its entirety the *2013 Capitated Financial Alignment Application*, released on March 29, 2012 (hereinafter collectively referred to as “the addendum”). Contractor also agrees to operate in accordance with the regulations at 42 C.F.R. Part 423 (with the exception of Subparts Q, R, and S), §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act, and the applicable solicitation identified above, as well as all other applicable Federal statutes, regulations, and policies. This addendum is deemed to incorporate any changes that are required by statute to be implemented during the term of this Contract and any regulations or policies implementing or interpreting such statutory or regulatory provisions.
- B. CMS agrees to perform its obligations to Contractor consistent with the regulations at 42 C.F.R. Part 423 (with the exception of Subparts Q, R, and S), §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act, and the applicable solicitation, as well as all other applicable Federal statutes, regulations, and policies.
- C. CMS agrees that it will not implement, other than at the beginning of a calendar year, regulations under 42 C.F.R. Part 423 that impose new, significant regulatory requirements on Contractor. This provision does not apply to new requirements mandated by statute.
- D. This addendum is in no way intended to supersede or modify 42 C.F.R. Parts 417, 422, 423, 431 or 438. Failure to reference a regulatory requirement in this addendum does not affect the applicability of such requirements to Contractor, Illinois, and CMS.

Article II
Functions to be Performed by Contractor

A. ENROLLMENT

1. Contractor agrees to enroll in its Medicare-Medicaid plan only Medicare-Medicaid eligible beneficiaries as they are defined in 42 C.F.R. § 423.30(a) and who have elected to enroll in Contractor’s Capitated Financial Alignment benefit.

B. PRESCRIPTION DRUG BENEFIT

1. Contractor agrees to provide the required prescription drug coverage as defined under 42 C.F.R. § 423.100 and, to the extent applicable, supplemental benefits as defined in 42 C.F.R. § 423.100 and in accordance with Subpart C of 42 C.F.R. Part 423. Contractor also agrees to provide Part D benefits as

described in Contractor's Part D plan benefit package(s) approved each year by CMS (and in the Attestation of Benefit Plan and Price, attached hereto).

2. Contractor agrees to maintain administrative and management capabilities sufficient for the organization to organize, implement, and control the financial, marketing, benefit administration, and quality assurance activities related to the delivery of Part D services as required by 42 C.F.R. § 423.505(b)(25).

C. DISSEMINATION OF PLAN INFORMATION

1. Contractor agrees to provide the information required in 42 C.F.R. § 423.48.
2. Contractor acknowledges that CMS releases to the public summary reconciled Part D Payment data after the reconciliation of Part D Payments for the contract year as provided in 42 C.F.R. § 423.505(o).
3. Contractor certifies that all materials it submits to CMS under the File and Use Certification authority described in the Medicare Marketing Guidelines are accurate, truthful, not misleading, and consistent with CMS marketing guidelines.

D. QUALITY ASSURANCE/UTILIZATION MANAGEMENT

1. Contractor agrees to operate quality assurance, drug Utilization Management, and medication therapy management programs, and to support electronic prescribing in accordance with Subpart E of 42 C.F.R. Part 423.
2. Contractor agrees to address complaints received by CMS against the Contractor as required in 42 C.F.R. § 423.505(b)(22) by:
 - (a) Addressing and resolving complaints in the CMS complaint tracking system; and
 - (b) Displaying a link to the electronic complaint form on the Medicare.gov Internet Web site on the Part D plan's main Web page.

E. APPEALS AND GRIEVANCES

Contractor agrees to comply with all requirements in Subpart M of 42 C.F.R. Part 423 governing coverage determinations, Grievances and Appeals, and formulary exceptions and the relevant provisions of Subpart U governing reopenings. Contractor acknowledges that these requirements are separate and distinct from the Appeals and Grievances requirements applicable to Contractor through the operation of its Medicare Parts A and B and Medicaid benefits.

F. PAYMENT TO CONTRACTOR

Contractor and CMS and the Department agree that payment paid for Part D services under the addendum will be governed by the rules in Subpart G of 42 C.F.R. Part 423.

G. PLAN BENEFIT SUBMISSION AND REVIEW

If Contractor intends to participate in the Part D program for the next program year, Contractor agrees to submit the next year's Part D plan benefit package including all required information on benefits and cost-sharing, by the applicable due date, as provided in Subpart F of 42 C.F.R. Part 423 so that CMS, the Department and Contractor may conduct negotiations regarding the terms and conditions of the proposed benefit plan renewal. Contractor acknowledges that failure to submit a timely plan benefit package under this section may affect the Contractor's ability to offer a plan, pursuant to the provisions of 42 C.F.R. § 422.4(c).

H. COORDINATION WITH OTHER PRESCRIPTION DRUG COVERAGE

1. Contractor agrees to comply with the coordination requirements with State Pharmacy Assistance Programs (SPAPs) and plans that provide other prescription drug coverage as described in Subpart J of 42 C.F.R. Part 423.
2. Contractor agrees to comply with Medicare Secondary Payer procedures as stated in 42 C.F.R. § 423.462.

I. SERVICE AREA AND PHARMACY ACCESS

1. Contractor agrees to provide Part D benefits in the Service Area for which it has been approved by CMS and the Department(as defined in Appendix H) to offer Medicare Parts A and B benefits and Medicaid benefits utilizing a pharmacy network and formulary approved by CMS and the Department that meet the requirements of 42 C.F.R. § 423.120.
2. Contractor agrees to provide Part D benefits through out-of-network pharmacies according to 42 C.F.R. § 423.124.
3. Contractor agrees to provide benefits by means of point-of-service systems to adjudicate prescription drug claims in a timely and efficient manner in compliance with CMS standards, except when necessary to provide access in underserved areas, I/T/U pharmacies (as defined in 42 C.F.R. § 423.100), and long-term care pharmacies (as defined in 42 C.F.R. § 423.100) according to 42 C.F.R. § 423.505(b)(17).
4. Contractor agrees to contract with any pharmacy that meets Contractor's reasonable and relevant standard terms and conditions according to 42 C.F.R. § 423.505(b)(18).

J. EFFECTIVE COMPLIANCE PROGRAM/PROGRAM INTEGRITY

Contractor agrees that it will develop and implement an effective compliance program that applies to its Part D-related operations, consistent with 42 C.F.R. §423.504(b)(4)(vi).

K. LOW-INCOME SUBSIDY

Contractor agrees that it will participate in the administration of subsidies for low-income subsidy eligible individuals according to Subpart P of 42 C.F.R. Part 423.

L. BENEFICIARY FINANCIAL PROTECTIONS

Contractor agrees to afford its Enrollees protection from liability for payment of fees that are the obligation of Contractor in accordance with 42 C.F.R. § 423.505(g).

M. RELATIONSHIP WITH FIRST TIER, DOWNSTREAM, AND RELATED ENTITIES

1. Contractor agrees that it maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this addendum.
2. Contractor shall ensure that any contracts or agreements with First Tier, Downstream and Related Entities performing functions on Contractor's behalf related to the operation of the Part D benefit are in compliance with 42 C.F.R. § 423.505(i).

N. CERTIFICATION OF DATA THAT DETERMINE PAYMENT

Contractor must provide certifications in accordance with 42 C.F.R. § 423.505(k).

O. SUBMISSION OF PRESCRIPTION DRUG EVENT DATA

1. Contractor shall submit prescription drug event data in accordance with 42 C.F.R. § 423.329(b) (3).

P. CONTRACTOR REIMBURSEMENT TO PHARMACIES

1. If Contractor uses a standard for reimbursement of pharmacies based on the cost of a drug, Contractor will update such standard not less frequently than once every 7 days, beginning with an initial update on January 1 of each year, to accurately reflect the market price of the drug.
2. Contractor will issue, mail, or otherwise transmit payment with respect to all claims submitted by pharmacies (other than pharmacies that dispense drugs by mail order only, or are located in, or contract with, a Long-Term Care Facility) within 14 days of receipt of an electronically submitted claim or within 30 days of receipt of a claim submitted otherwise.
3. Contractor must ensure that a pharmacy located in, or having a contract with, a Long-Term Care Facility will have not less than 30 days (but not more than 90 days) to submit claims to Contractor for

reimbursement.

Article III Record Retention and Reporting Requirements

A. RECORD MAINTENANCE AND ACCESS

Contractor agrees to maintain records and provide access in accordance with 42 C.F.R. §§ 423.505 (b)(10) and 423.505(i)(2).

B. GENERAL REPORTING REQUIREMENTS

Contractor agrees to submit information to CMS according to 42 C.F.R. §§ 423.505(f) and 423.514, and the “Final Medicare Part D Reporting Requirements,” a document issued by CMS and subject to modification each program year.

C. CMS AND ILLINOIS LICENSE FOR USE OF CONTRACTOR FORMULARY

Contractor agrees to submit to CMS and the Department the Contractor's formulary information, including any changes to its formularies, and hereby grants to CMS and the Department, and any person or entity who might receive the formulary from CMS and the Department, a non-exclusive license to use all or any portion of the formulary for any purpose related to the administration of the Part D program, including without limitation publicly distributing, displaying, publishing or reconfiguration of the information in any medium, including www.medicare.gov, and by any electronic, print or other means of distribution.

Article IV HIPAA Provisions

- A. Contractor agrees to comply with the confidentiality and Enrollee record accuracy requirements specified in 42 C.F.R. § 423.136.
- B. Contractor agrees to enter into a business associate agreement with the entity with which CMS has contracted to track Medicare beneficiaries' true out-of-pocket costs.

Article V Addendum Term and Renewal

A. TERM OF ADDENDUM

This addendum is effective from the date of CMS' authorized representative's signature through December 31, 2019. This addendum shall be renewable for successive one-year periods thereafter according to 42 C.F.R. § 423.506.

B. QUALIFICATION TO RENEW ADDENDUM

1. In accordance with 42 C.F.R. §423.507, Contractor will be determined qualified to renew this addendum annually only if –
 - (a) Contractor has not provided CMS or the Department with a notice of intention not to renew in accordance with Article VII of this addendum, and
 - (b) CMS or the Department has not provided Contractor with a notice of intention not to renew.
2. Although Contractor may be determined qualified to renew its addendum under this Article, if Contractor, CMS, and the Department cannot reach agreement on the Part D plan benefit package under Subpart F of 42 C.F.R. Part 423, no renewal takes place, and the failure to reach agreement is not subject to the appeals provisions in Subpart N of 42 C.F.R. Parts 422 or 423. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment contract.)

Article VI Nonrenewal of Addendum

A. NONRENEWAL BY CONTRACTOR

Contractor may non-renew this addendum in accordance with 42 C.F.R. § 423.507(a).

B. NONRENEWAL BY CMS

CMS may non-renew this addendum under the rules of 42 C.F.R. § 423.507(b). (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment contract.)

Article VII Modification or Termination of Addendum by Mutual Consent

This addendum may be modified or terminated at any time by written mutual consent of the Parties in accordance with 42 C.F.R. § 423.508. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment contract.)

Article VIII Termination of Addendum by CMS

CMS may terminate this addendum in accordance with 42 C.F.R. § 423.509. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment contract.)

Article IX
Termination of Addendum by Contractor

- A. Contractor may terminate this addendum only in accordance with 42 C.F.R. § 423.510.
- B. If the addendum is terminated under section A of this Article, Contractor must ensure the timely transfer of any data or files. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment contract.)

Article X
Relationship between Addendum and Capitated Financial Alignment Contract

- A. Contractor acknowledges that, if it is a Capitated Financial Alignment contractor, the termination or nonrenewal of this addendum by any Party may require CMS to terminate or non-renew the Contractor's Capitated Financial Alignment contract in the event that such non-renewal or termination prevents Contractor from meeting the requirements of 42 C.F.R. § 422.4(c), in which case the Contractor must provide the notices specified in this contract, as well as the notices specified under Subpart K of 42 C.F.R. Part 422.
- B. The termination of this addendum by any Party shall not, by itself, relieve the Parties from their obligations under the Capitated Financial Alignment contract to which this document is an addendum.
- C. In the event that Contractor's Capitated Financial Alignment contract is terminated or nonrenewed by any Party, the provisions of this addendum shall also terminate. In such an event, Contractor, the Department and CMS shall provide notice to Enrollees and the public as described in this contract as well as 42 C.F.R. Part 422, Subpart K or 42 C.F.R. Part 417, Subpart K, as applicable.

Article XI
Intermediate Sanctions

Consistent with Subpart O of 42 C.F.R. Part 423, Contractor shall be subject to sanctions and civil money penalties.

Article XII
Severability

Severability of the addendum shall be in accordance with 42 C.F.R. § 423.504(e).

Article XIII
Miscellaneous

- A. DEFINITIONS

Terms not otherwise defined in this addendum shall have the meaning given such terms at 42 C.F.R. Part 423 or, as applicable, 42 C.F.R. Parts 417, 422, 431 or Part 438.

B. ALTERATION TO ORIGINAL ADDENDUM TERMS

Contractor agrees that it has not altered in any way the terms of the Contractor addendum presented for signature by CMS. Contractor agrees that any alterations to the original text Contractor may make to this addendum shall not be binding on the Parties.

C. ADDITIONAL CONTRACT TERMS

Contractor agrees to include in this addendum other terms and conditions in accordance with 42 C.F.R. § 423.505(j).

D. CMS AND ILLINOIS APPROVAL TO BEGIN MARKETING AND ENROLLMENT ACTIVITIES

Contractor agrees that it must complete CMS operational requirements related to its Part D benefit prior to receiving CMS and the Department's approval to begin Contractor marketing activities relating to its Part D benefit. Such activities include, but are not limited to, establishing and successfully testing connectivity with CMS and the Department systems to process enrollment (or contracting with an entity qualified to perform such functions on Contractor's behalf) and successfully demonstrating the capability to submit accurate and timely price comparison data. To establish and successfully test connectivity, Contractor must, 1) establish and test physical connectivity to the CMS data center, 2) acquire user identifications and passwords, 3) receive, store, and maintain data necessary to send and receive transactions to and from CMS, and 4) check and receive transaction status information.

E. Pursuant to §13112 of the American Recovery and Reinvestment Act of 2009 (ARRA), Contractor agrees that as it implements, acquires, or upgrades its health information technology systems, it shall utilize, where available, health information technology systems and products that meet standards and implementation specifications adopted under § 3004 of the Public Health Service Act, as amended by §13101 of the ARRA.

F. Contractor agrees to maintain a fiscally sound operation by at least maintaining a positive net worth (total assets exceed total liabilities) as required in 42 C.F.R. § 423.505(b)(23), and by meeting and maintaining all financial requirements established by State laws and regulations.

APPENDIX F: DATA USE ATTESTATION

The Contractor shall restrict its use and disclosure of Medicare and Medicaid data obtained from CMS and the Department (herein, Illinois) information systems (listed in Attachment A) to those purposes directly related to the administration of the Demonstration for which it has contracted with the CMS and Illinois to administer. The Contractor shall only maintain data obtained from CMS and Illinois information systems that are needed to administer the Demonstration that it has contracted with CMS and Illinois to administer. The Contractor (or its First Tier, Downstream or other Related Entities) may not re-use or provide other entities access to the CMS or Illinois information systems, or data obtained from the CMS or Illinois information systems, to support any line of business other than the Demonstration for which the Contractor contracted with CMS and Illinois.

The Contractor further attests that it shall limit the use of information it obtains from its Enrollees to those purposes directly related to the administration of such Demonstration. The Contractor acknowledges two exceptions to this limitation. First, the Contractor may provide its Enrollees information about non-health related services after obtaining consent from the Enrollees. Second, the Contractor may provide information about health-related services without obtaining prior Enrollee consent, as long as the Contractor affords the Enrollee an opportunity to elect not to receive such information.

CMS may terminate the Contractor's access to the CMS data systems, and Illinois may terminate the Contractor's access to the Illinois data systems, immediately upon determining that the Contractor has used its access to a data system, data obtained from such systems, or data supplied by its Medicare-Medicaid Enrollees beyond the scope for which CMS and Illinois have authorized under this Appendix G (herein, data use agreement). A termination of this data use agreement may result in CMS or Illinois terminating the Contractor's Contract(s) on the basis that it is no longer qualified to administer a Demonstration Plan. This data use agreement shall remain in effect as long as the Contractor has a Demonstration Plan. This data use agreement excludes any public use files or other publicly available reports or files that CMS or Illinois make available to the general public on their respective websites.

Attachment A

The following list contains a representative (but not comprehensive) list of CMS information systems to which the Data Use Attestation applies. CMS will update the list periodically as necessary to reflect changes in CMS' information systems.

Automated Plan Payment System (APPS)
Common Medicare Environment (CME)
Common Working File (CWF)
Coordination of Benefits Contractor (COBC)
Drug Data Processing System (DDPS)
Electronic Correspondence Referral System (ECRS)
Enrollment Database (EDB)
Financial Accounting and Control System (FACS)
Front End Risk Adjustment System (FERAS)
Health Plan Management System (HPMS), including Complaints Tracking and all other modules
HI Master Record (HIMR)
Individuals Authorized Access to CMS Computer Services (IACS)
Integrated User Interface (IUI)
Medicare Advantage Prescription Drug System (MARx)
Medicare Appeals System (MAS)
Medicare Beneficiary Database (MBD)
Payment Reconciliation System (PRS)
Premium Withholding System (PWS)
Prescription Drug Event Front End System (PDFS)
Retiree Drug System (RDS)
Risk Adjustments Processing Systems (RAPS)

The following list contains a representative (but not comprehensive) list of the Department's information systems to which the Data Use Attestation applies. The Department will update the list periodically as necessary to reflect changes in the Department's information systems.

Illinois Medical Program Data Analytics Reporting Knowledgebase (MPARK)
Illinois Care Coordination Claims Data (CCCD)

APPENDIX G: MODEL FILE & USE CERTIFICATION FORM

Pursuant to the contract between the Centers for Medicare & Medicaid Services (CMS), the State of Illinois, acting by and through the Department of Healthcare and Family Services (herein, Department), and [PLAN NAME], hereafter referred to as the Contractor, governing the operations of the following health plan: [PLAN NAME], [Contract Number], the Contractor hereby certifies that all qualified materials for the Demonstration is accurate, truthful and not misleading. Organizations using File & Use Certification agree to retract and revise any materials (without cost to the government) that are determined by CMS or the Department to be misleading or inaccurate or that do not follow established Medicare Marketing Guidelines, Regulations, and sub-regulatory guidance. In addition, organizations may be held accountable for any beneficiary financial loss as a result of mistakes in marketing materials or for misleading information that results in uninformed decision by a beneficiary to elect the plan. Compliance criteria include, without limitation, the requirements in 42 C.F.R. § 422.2260 – § 422.2276 and 42 C.F.R. § 422.111 for Demonstration Plans and the Medicare Marketing Guidelines.

I agree that CMS or the Department may inspect any and all information, including those held at the premises of the Contractor, to ensure compliance with these requirements. I further agree to notify CMS and Illinois immediately if I become aware of any circumstances that indicate noncompliance with the requirements described above.

I possess the requisite authority to make this certification on behalf of the Contractor

APPENDIX H: MEDICARE MARK LICENSE AGREEMENT

THIS AGREEMENT is made and entered into January 1, 2018

by and between

THE CENTERS FOR MEDICARE & MEDICAID SERVICES (hereinafter “Licensor”),
with offices located at 7500 Security Blvd., Baltimore, MD 21244

and

[PLAN NAME] (hereinafter “Licensee”),
with offices located at
[PLAN ADDRESS]

CMS Contract ID:

WITNESSETH

WHEREAS, Licensors are the owner of the Medicare Prescription Drug Benefit program, a program authorized under Title XVIII, Part D of the Social Security Act (Part D), Mark (the "Mark").

WHEREAS, Licensee desires to use the Mark on Part D marketing materials (including the identification card) beginning January 1, 2018.

WHEREAS, both parties, in consideration of the premises and promises contained herein and other good and valuable consideration which the parties agree is sufficient, and each intending to be legally bound thereby, the parties agree as follows:

1. Subject to the terms and conditions of this Agreement, Licensors hereby grants to Licensee a non-exclusive right to use the Mark in their Part D marketing materials.
2. Licensee acknowledges Licensors' exclusive right, title, and interest in and to the Mark and will not, at any time, do or cause to be done any act or thing contesting or in any way impairing or tending to impair any part of such right, title, and interest. Licensee acknowledges that the sole right granted under this Agreement with respect to the Mark is for the purposes described herein, and for no other purpose whatsoever.
3. Licensors retain the right to use the Mark in the manner or style it has done so prior to this Agreement and in any other lawful manner.
4. This Agreement and any rights hereunder are not assignable by Licensee and any attempt at assignment by Licensee shall be null and void.
5. Licensors, or its authorized representative, has the right, at all reasonable times, to inspect any material on which the Mark is to be used, in order that Licensors may satisfy itself that the material on which the Mark appears meets with the standards, specifications, and instructions submitted or approved by Licensors. Licensee shall use the Mark without modification and in accordance with the Mark usage policies described within the Medicare Marketing Guidelines. Licensee shall not take any action inconsistent with the Licensors' ownership of the Mark, and any goodwill accruing from use of such Mark shall automatically vest in Licensors.
6. This agreement shall be effective on the date of signature by the Licensee's authorized representative through December 31, 2019, concurrent with the execution of the Part D addendum to the three way contract. This Agreement may be terminated by any Party upon written notice at any

time. Licensee agrees, upon written notice from Licensor, to discontinue any use of the Mark immediately. Starting January 1, 2018, this agreement shall be renewable for successive one-year periods running concurrently with the term of the Licensee's Part D contract. This agreement shall terminate, without written notice, upon the effective date of termination or non-renewal of the Licensee's Part D contract (or Part D addendum to a Capitated Financial Alignment Demonstration contract).

7. Licensee shall indemnify, defend and hold harmless Licensor from and against all liability, demands, claims, suits, losses, damages, infringement of proprietary rights, causes of action, fines, or judgments (including costs, attorneys' and witnesses' fees, and expenses incident thereto), arising out of Licensee's use of the Mark.
8. Licensor will not be liable to Licensee for indirect, special, punitive, or consequential damages (or any loss of revenue, profits, or data) arising in connection with this Agreement even if Licensor has been advised of the possibility of such damages.
9. This Agreement is the entire agreement between the parties with respect to the subject matter hereto.
10. Federal law shall govern this Agreement.

APPENDIX I: SERVICE AREA TEMPLATE

The Service Area outlined below is contingent upon the Contactor meeting all Readiness Review requirements in each county. CMS and the Department reserve the right to amend Appendix I to revise the Service Area based on final Readiness Review results or subsequent determinations made by CMS and Department.

For Passive Enrollment, beginning no earlier than May 1, 2014, the Contractor shall receive no more than [5,000 for Greater Chicago/3,000 for Central Illinois] Eligible Enrollees per month.

Greater Chicago Service Area:

- Cook
- Lake
- Kane
- Dupage
- Will
- Kankakee

Central Illinois Service Area:

Knox	Macon
Peoria	Christian
Tazewell	Piatt
McLean	Champaign
Logan	Vermilion
DeWitt	Ford
Sangamon	Menard
	Stark

APPENDIX J: Taxpayer Identification Number Certification

I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. person (including a U.S. resident alien).

- *If you are an individual, enter your name and SSN as it appears on your Social Security Card.*
- *If you are a sole proprietor, enter the owner's name on the name line followed by the name of the business and the owner's SSN or EIN.*
- *If you are a single-member LLC that is disregarded as an entity separate from its owner, enter the owner's name on the name line and the d/b/a on the business name line and enter the owner's SSN or EIN.*
- *If the LLC is a corporation or partnership, enter the entity's business name and EIN and for corporations, attach IRS acceptance letter (CP261 or CP277).*
- *For all other entities, enter the name of the entity as used to apply for the entity's EIN and the EIN.*

Name: [Click here to enter text.](#)

Business Name: [Click here to enter text.](#)

Taxpayer Identification Number:

Social Security Number: [Click here to enter text.](#)

Or

Employer Identification Number: [Click here to enter text.](#)

Legal Status (check one):

- | | |
|--|--|
| <input type="checkbox"/> Individual | <input type="checkbox"/> Governmental |
| <input type="checkbox"/> Sole Proprietor | <input type="checkbox"/> Nonresident alien |
| <input type="checkbox"/> Partnership | <input type="checkbox"/> Estate or trust |
| <input type="checkbox"/> Legal Services Corporation | <input type="checkbox"/> Pharmacy (Non-Corp.) |
| <input type="checkbox"/> Tax-exempt
Home/Cemetery (Corp.) | <input type="checkbox"/> Pharmacy/Funeral |
| <input type="checkbox"/> Corporation providing or billing | <input type="checkbox"/> Limited Liability Company |

medical and/or health care services
classification)

☐ Corporation NOT providing or billing

medical and/or health care services

(select applicable tax

☐ D = disregarded entity

☐ C = corporation

☐ P = partnership

Signature of Authorized Representative: _____

Date: [Click here to enter a date](#)

APPENDIX K: 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. Doctorate of Philosophy (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

A. 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.

**APPENDIX L: Illinois Department of Human Services, Division of
Rehabilitation Services Critical Incident Definitions**

Death, HSP customer	All deaths will be reported via incident reporting, and will be reported to the DHS Office of Inspector General. Follow-up will be provided on deaths of an unusual nature per OIG direction. Criteria for investigating such incidents and reporting via the Incident reporting system may include a recent allegation or abuse/neglect/exploitation, customer was receiving home health services at time of passing, etc.
Death, Other parties	Events that result in significant event for customer. For example, customer's caregiver dies in the process of giving customer bath, thereby leaving customer 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 customer.
Physical abuse of customer	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 customer	Includes but is not limited to name calling, intimidation, yelling and swearing. May also include ridicule, coercion, and threats.
Sexual abuse of customer	Unwanted touching, fondling, sexual threats, sexually inappropriate remarks or other sexual activity with an adult with disabilities.
Exploitation of Customer	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 customer	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 customer	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 customer 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 a customer's care.
Significant Medical Event of Customer	This includes a recent event or new diagnosis that has the potential to impact on the customer's health or safety. Also included are unplanned hospitalizations or errors in medication administration by provider.

Customer arrested, charged with or convicted of a crime	In instance where the arrest, charge, or conviction has a risk or potential risk upon the customer'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 customer's health and safety should be reported.
Fraudulent activities or theft on the part of the Customer 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 customer property by a provider, as well as theft of provider property by a customer 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.
Customer is missing	Customer is missing or whereabouts are unknown for provision of services.
Problematic possession or use of a weapon by a customer.	Customers 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.
Customer displays physically aggressive behavior	Customer uses physical violence that results in harm or injury to the provider.
Property damage by customer of \$50 or more	Customer causes property damage to in the amount of \$50 or more to provider property.
Suicide attempt by customer	Customer attempts to take own life.
Suicide ideation/ threat by customer	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 customer	Use of alcohol or other substances that appears compulsive and uncontrolled and is detrimental to customer's health, personal relationships, safety of self and others. Social and legal status.
Seclusion of a customer	Seclusion is defined as placing a person in a locked or barricaded area that prevents contact with others.
Unauthorized Restraint of a customer	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 a customer'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 a customer 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.
Fire / Natural Disaster	Any event or force of nature that has catastrophic consequences, such as flooding, tornados, or fires.
please specify:	

APPENDIX M: Illinois Department on Aging Elder Abuse and Neglect Program

Elder abuse refers to the following types of mistreatment to any Illinois resident 60 years of age or older who lives in the community and must be committed by another person on the elder:

- **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, as 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.

APPENDIX N: 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.