

STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

and

[Managed Care Organization]

AMENDMENT NO. 10 TO THE
CONTRACT FOR FURNISHING HEALTH SERVICES
BY A MANAGED CARE ORGANIZATION
2018-24-XXX-KA10

WHEREAS, the Parties to the Contract for Furnishing Health Services by a Managed Care Organization (“Contract”), the **Illinois Department of Healthcare and Family Services**, 201 South Grand Avenue East, Springfield, Illinois 62763-0001 (“Department”), acting by and through its Director, and **[Managed Care Organization]** (“Contractor”), desire to amend the Contract; and

WHEREAS, pursuant to Section 9.1.18, the Contract may be modified or amended by the mutual consent of the Parties; and

WHEREAS, the Contract has been previously amended;

NOW THEREFORE, the Parties agree to amend the Contract further as follows:

1. Section 1.1 is amended by deleting and replacing in their entirety subsections 1.1.14, 1.1.34, 1.1.51, 1.1.53, 1.1.104, 1.1.130, and is further amended by adding new subsections 1.1.40.1.1 and 1.1.104a:
 - 1.1.14 **Adverse Benefit Determination** means: the denial or limitation of authorization of a requested service; the reduction, suspension, or termination of a previously authorized service; the denial of payment for a service, not including a denial solely because the claim does not meet the definition of a “clean claim” at 42 CFR §447.45(b); the failure to provide services in a timely manner; the failure to respond to an Appeal or Grievance in a timely manner; solely with respect to an MCO that is the only Contractor serving a Rural Area, the denial of an Enrollee’s request to obtain services beyond the travel time and distance standards established for an Enrollee who lives in a Rural Area as set forth in section 5.8.1.1; or, the denial of an Enrollee’s request to dispute a financial liability, including cost sharing.
 - 1.1.34 [This Section Intentionally Left Blank]
 - 1.1.40.1.1 quarterly business review and ad hoc reports shall be presumed to be proprietary and confidential;
 - 1.1.51 **Crisis and Referral Entry Service (CARES)** means the single point of entry to the State’s Mobile Crisis Response system that provides telephone response and referral services for Enrollees requiring mental health crisis services.

1.1.53 **Crisis Safety Plan** means an individualized plan prepared for Enrollees at high risk of experiencing a Behavioral Health Crisis.

1.1.104 **Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM-CANS)** means a comprehensive, multi-purpose tool that provides a standardized, modular framework for assessing the global needs and strengths of individuals who require mental health treatment in Illinois.

1.1.104a **Illinois Medicaid Crisis Assessment Tool (IM-CAT)** means a screening tool used in the delivery of Mobile Crisis Response services. The IM-CAT is composed of a subset of items from the IM+CANS and is used as part of the crisis assessment to recommend whether an individual can be stabilized in the community or a higher level of care may be needed.

1.1.130 **Mobile Crisis Response** means urgent twenty-four (24) hour response Crisis intervention and stabilization services for Enrollees and their families who are experiencing a Crisis related to psychiatric or behavioral problems.

2. Subsection 2.3.1 is amended by renumbering subsection 2.3.1.18 that references “Other key personnel...” as subsection 2.3.1.21, and is further amended by adding new subsections 2.3.1.19 and 2.3.1.20:

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

2.3.1.20 Children’s Behavioral Health (CBH) Program Manager. The Children’s Behavioral Health Program Manager shall be a full-time position filled by Contractor, no later than the second quarter of calendar year 2022, that oversees and ensures alignment of Contractor’s Behavioral Health service delivery system for Children with Department requirements, Attachment XXII of this Contract, the N.B. implementation plan dated December 2, 2019, and any subsequent revisions. The Children’s Behavioral Health Program Manager shall: (1) serve as the single point of contact for HFS related to Children’s Behavioral Health; (2) maintain annual certification in the IM+CANS; (3) attend training on the Behavioral Health services available to N.B. class members and achieve certification in the

Wraparound process; (4) ensure that Contractor's reports and other information specific to N.B. class members are submitted timely and accurately to the Department or its designee; and, (5) co-chair Contractor's Family Leadership Council and participate in the Children's Behavioral Health Family Leadership Workgroup as required by the N.B. implementation plan.

2.3.1.21 Other key personnel identified by Contractor.

3. Section 4.11 is deleted in its entirety and replaced with the following:

4.11 Re-enrollment after resumption of eligibility

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

4. Subsection 5.3.1.4 is amended by adding new subsection 5.3.1.4.1:

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

5. Subsection 5.7.12 is deleted in its entirety and replaced with the following:

5.7.12 [This Section Intentionally Left Blank]

6. Subsection 5.8.3 is amended by adding new subsection 5.8.3.1:

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

7. Subsection 5.11.3 is deleted in its entirety and replaced with the following, and is further amended by adding new subsection 5.11.3.1:

5.11.3 Admissions, Discharge, and Transfer (ADT) system. Upon the Effective Date, the Department reserves the right to select an ADT system to be used by all MCOs within the State. Contractor must implement and integrate the Department's ADT system once determined by the Department. The Department will provide one hundred eighty (180) days' notice to Contractor, in writing, prior to the requirement of this section 5.11.3 being in effect.

5.11.3.1 Pursuant to the Department's written notice provided as required in section 5.11.3, Contractor shall work with the Department's selected ADT system vendor to implement the ADT system. Throughout implementation of the ADT system, Contractor shall submit all ad hoc reports as

requested by the Department until such time ADT-related reports are established as ongoing reporting requirements.

8. Subsection 5.15.1 is deleted in its entirety and replaced with the following:

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

9. Subsection 5.18.6 is deleted in its entirety and replaced with the following, and is further amended by adding new subsections 5.18.6.1 and 5.18.6.2:

5.18.6 Community Transitions Initiative (CTI)

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

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

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

10. Subsections 5.20.2.2 and 5.20.2.2.1 are deleted in their entirety and replaced with the following:

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

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

or BHC must be in effect for one (1) year before Contractor may terminate a contract of a CMHC or BHC based on a failure to meet such standards.

11. Section 5.29 is amended by adding new subsection 5.29.14:

5.29.14 Effective July 1, 2019, Contractor shall pay critical access pharmacies a rate no less than the Department's Medicaid rate for the professional dispensing fee associated with filling a prescription for an Enrollee.

12. Subsection 5.30.3.1 is deleted in its entirety and replaced with the following:

5.30.3.1 An Enrollee may file an oral or written Appeal within sixty (60) days following the date of the Adverse Benefit Determination that generates such Appeal. The notice must include Contractor's Adverse Benefit Determination; reasons for the determination; right of Enrollee to request and be provided, free of cost, access to and copies of all relevant information; right of Enrollee to request an Appeal and procedures to request an Appeal, including an expedited Appeal; and the Enrollee's right to request and have benefits continue during the Appeal process. Contractor must comply with the timing of notice requirements required at 42 CFR §438.404(c).

13. Subsections 5.40.8, 5.40.8.1 and 5.40.8.2 are deleted in their entirety and replaced with the following, and subsection 5.40.8 is further amended by adding new subsections 5.40.8.3, 5.40.8.4, 5.40.8.5 and 5.40.8.6:

5.40.8 Family Leadership Council (FLC). Contractor shall establish the FLC within ninety (90) days after the Special Needs Children population is brought into managed care under the scope of this Contract, as defined by the Department, to create opportunities to engage families directly regarding issues in Children's Behavioral Health. The role of the FLC shall be outlined in Contractor's plan for Family Driven Care, as required by Attachment XXII of this Contract. Contractor shall establish a meaningful feedback loop through its FLC to inform its service delivery system and the delivery of Behavioral Health services that are person- and family-centric. The FLC shall meet, at a minimum, on a quarterly basis. The FLC shall not be used to review the needs of individual Enrollees.

5.40.8.1 Each FLC meeting shall minimally include opportunities and dedicated agenda items for FLC members to provide input and feedback to Contractor on its policies, procedures, operations, and special initiatives related to Children's Behavioral Health. Contractor shall specifically seek input on its Mobile Crisis Response service system, its implementation of the various components of the N.B. consent decree, and access and availability of Behavioral Health services. Contractor shall provide the FLC with available aggregated data to inform its recommendations including number of Enrollees served, service utilization, access, wait times, lengths of stay, and other relevant system reports.

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

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

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

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

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

14. Article V is amended by adding a new section 5.42 and subsections:

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

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

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

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

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

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

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

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

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

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

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

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

15. Section 7.10 and its subsections are deleted in their entirety and replaced with the following:

7.10 MEDICAL LOSS RATIO GUARANTEE

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

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

7.10.3 MLR calculations.

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

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

7.10.4 For each MLR calculation, Contractor shall:

7.10.4.1 include each of Contractor's expenses under only one (1) type of expense, unless a portion of the expense fits under the definition of, or criteria for, one (1) type of expense and the remainder fits into a different type of expense, in which case the expense must be prorated between types of expenses; and

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

7.10.5 For each MLR calculation, Contractor shall:

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

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

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

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

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

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

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

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

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

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

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

7.10.9.1 total incurred claims;

7.10.9.2 expenditures on quality-improving activities;

7.10.9.3 expenditures related to activities compliant with program integrity requirements;

7.10.9.4 non-claims costs;

7.10.9.5 premium revenue, which, for purposes of the MLR calculation, will consist of the Capitation payments, as adjusted pursuant to section 7.4, due from the Department for services provided during the Coverage Year, including withheld amounts earned and paid pursuant to section 7.9.1;

7.10.9.6 taxes;

7.10.9.7 licensing fees;

7.10.9.8 regulatory fees;

7.10.9.9 methodology(ies) for allocation of expenditures;

- 7.10.9.10 any credibility adjustment applied;
- 7.10.9.11 the calculated MLR;
- 7.10.9.12 any remittance owed to the State, if applicable;
- 7.10.9.13 a comparison of the information reported with the audited financial report;
- 7.10.9.14 a description of the aggregation method used to calculate total incurred claims; and
- 7.10.9.15 the number of Enrollee months.

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

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

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

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

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

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

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

16. Subsection 7.16.6.1 is amended by adding subsection 7.16.6.1.1:

7.16.6.1.1 impose a monetary penalty of up to US \$100,000 for each unmet standard, beginning with the calendar year 2022 third quarter EUM data;

17. Section 7.23 and its subsections are deleted in their entirety and replaced with the following:

7.23 Community Transitions Initiative Incentive Arrangement

The Department shall make incentive payments to Contractor, in accordance with 42 CFR 438.6, for the Community Transitions Initiative discussed in section 5.18.6 consistent with the following:

7.23.1 Incentive Payments for Successful Community Transitions. Effective March 1, 2022: (1) the Department will pay Contractor an incentive payment for each successful transition, approved by the Department or its designee, of an Enrollee from an institutional setting to the community in the amount of \$5,000 for Colbert and Williams class members, and (2) the Department will not pay Contractor an incentive payment for community transitions for non-class members that initiate on or after March 1, 2022.

7.23.1.1 To be considered a successful community transition, the Enrollee must continuously reside in the community setting for a minimum of six (6) months after the date of transition.

7.23.1.2 The Department will pay Contractor an additional incentive payment of \$500 upon an Enrollee's community transition anniversary date when the Enrollee has continued to reside continuously in the community. Contractor may earn this incentive payment, for each transitioned Enrollee, up to a maximum of three such annual payments. Enrollees who have not resided continuously in the community are not eligible for any subsequent incentive payments.

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

7.23.3 Performance Targets. The Department will establish separate annual minimum performance targets for successful community transitions of Colbert class members and Williams class members, as well as annual minimum performance targets for Department-approved evaluations for class members documenting impairments pursuant to section 7.23.2. For each calendar year, transition performance targets will be specified in a counter-signed letter between the Department and Contractor.

7.23.3.1 In the event Contractor achieves the annual minimum performance target for successful community transitions of Colbert and Williams class members, the Department will pay Contractor an additional \$500 incentive payment for each Colbert and Williams class member's successful community transition that occurred within the calendar year.

7.23.3.2 In the event Contractor fails to meet the annual minimum performance target for successful community transitions of Colbert and Williams class members, the Department will implement a performance penalty as described in section 7.16.18 in the amount of \$5,000 for each community transition that fails to meet Contractor's established minimum performance target.

18. Article VII is amended by adding a new section 7.27 and subsections:

7.27 VALUE-BASED PAYMENTS (VBP)

Value-Based Payments (VBP) include a broad set of Provider payment strategies intended to improve health care quality, outcomes, and efficiency by linking financial incentives to performance. Measurement of performance is based on a set of defined outcome metrics of quality, cost, and patient-centered care. Contractor shall develop and maintain a VBP strategy that follows the Alternate Payment Model (APM) framework in the 2017 White Paper developed by the Health Care Payment Learning and Action Network (HCP-LAN) with a special emphasis on APM models in categories three (3) and four (4).

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

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

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

7.27.1.3 Assessment of Provider readiness for VBP within Contractor's Provider Network, specifically analyzing Provider readiness to participate in APM categories 3 and 4;

7.27.1.4 Methods and frequency for collection and assessment of quality performance data from Providers;

7.27.1.5 Communication and collaboration approach with Providers on reviewing performance and defining strategies for improvement;

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

7.27.1.7 Relationship to Contractor's commercial and/or Medicare Advantage VBP strategy, as applicable, and discussion of how these VBP strategies align with VBP efforts under the HealthChoice Illinois program; and

7.27.1.8 Alignment with the program goals under the Department's Comprehensive Medical Programs Quality Strategy.

7.27.2 Contractor shall annually update and submit a VBP Plan by January 1 of each calendar year to achieve both Contractor and Department goals to advance VBP. The Department reserves the right to request revisions to Contractor's VBP Plan to align with Department priority areas. These revisions may include alignment across patient populations and payer types to align with multi-payer initiatives

in which Medicaid is a participant (i.e., multi-payer alignment of incentives across Medicare, Medicaid, and/or commercially insured populations in Illinois).

7.27.3 VBP Status Report. Contractor shall submit an annual VBP Status Report which includes additional details on the status and outcomes of its Medicaid VBP initiatives by April 1 of each calendar year. At a minimum, Contractor shall include the following information for each VBP initiative:

7.27.3.1 VBP category (and applicable subcategory, using the HCP-LAN model);

7.27.3.2 short description (including brief discussion of associated performance measures);

7.27.3.3 goal(s) and measurable results;

7.27.3.4 description of targeted Providers and number of Providers eligible and participating;

7.27.3.5 description of targeted Enrollees, number of eligible Enrollees whose services are covered by the VBP initiative, and number of participating Enrollees;

7.27.3.6 total Medicaid payments to Providers for services covered under VBP initiative;

7.27.3.7 total potential payment adjustment (either percentage or dollars) and type of adjustment (bonus, penalty, risk sharing) related to VBP initiative; and,

7.27.3.8 potential overlap with other VBP programs or initiatives.

7.27.4 VBP Status Report Submission. As part of its annual VBP Status Report submission, Contractor shall complete the Medicaid APM data collection tool developed by HCP-LAN by April 1 of each calendar year utilizing data from the prior calendar year (e.g., April 2023 submission will cover CY 2022). Contractor submissions must include numerators and denominators, as defined by the Department, that account for all relevant spending for medical services. The Department will use measurement methodologies developed by HCP-LAN to evaluate the adoption, evolution, and growth of VBP arrangements in Contractor's Provider Network.

The VBP Status Report, including the HCP-LAN Data Collection Submission, shall be submitted to the Department in a manner and format determined by the Department. The VBP Status Report shall be due by April 1 of each calendar year beginning in CY 2023 and the submission shall cover the prior calendar year. The HCP-LAN APM data collection tool survey shall be submitted directly to HCP-LAN by Contractor by April 1 of each calendar year.

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

additions or revisions to specific VBP penetration targets shall be effective the calendar year immediately following notice from the Department.

19. Section 8.2 and its subsections are deleted in their entirety and replaced with the following:

8.2 RENEWAL

8.2.1 If the Contract is renewed, the renewal shall be subject to the same terms and conditions as the Contract unless otherwise stated. The Contract may not renew automatically, nor may the Contract renew solely at Contractor's option. The Department reserves the right to renew for a total of four (4) years in any of the following manners or combination thereof:

8.2.1.1 one renewal covering the entire renewal allowance;

8.2.1.2 individual one-year renewals up to and including the entire renewal allowance; and/or

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

8.2.2 TERM OF CONTRACT RENEWAL

Effective January 1, 2022, this Contract is renewed, in accordance with and subject to the requirements of section 8.2, for a single renewal term of four (4) years.

20. Subsection 9.1.31 is deleted and replaced with the following:

9.1.31 Media relations and public information. Subject to any disclosure obligations of Contractor under applicable law, rule, or regulation, including any open meeting and freedom of information obligations Contractor has as a governmental body, all information to be disseminated to the media or general public, such as news releases, responses to media inquiries, proactive media outreach, publications, presentations, technical papers, or other information pertaining to this Contract or the Illinois Medicaid Program shall be in coordination with and requires Prior Approval by the Department. The Parties shall work in good faith to resolve any differences they may have regarding a public disclosure to the media or general public. Contractor shall submit items to the Department for Prior Approval: (1) as soon as practicable when responding to a media inquiry, and (2) no later than two (2) Business Days in advance of public dissemination when communicating proactively.

21. *Attachment I: Service Package II Covered Services and MLTSS Covered Services* is amended by deleting from the service Environmental Accessibility Adaptations Home the following:
DSCC Vehicle modifications (wheelchair lifts and tie downs) are also provided under environmental modifications.
22. *Attachment I: Service Package II Covered Services and MLTSS Covered Services* is amended by revising the *MLTSS Covered Services* table as follows:

060	Home Care [* Hospice room and board(revenue code D0658) is covered]	EXCLUDED *
106	Methadone Medication Assistance	COVERED SERVICE
117	Medical Assisted Transport	COVERED SERVICE

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

- Participants in a hospital receiving inpatient psychiatric services as a result of a forensic commitment;

24. *Attachment XI: Quality Assurance* is amended by deleting and replacing subsection 1.1.5.1 as follows:

1.1.5.1 Regular meetings. The QAP Committee shall meet on a regular basis with specified frequency to oversee QAP activities. This frequency shall be sufficient to demonstrate that the structure/committee is following-up on all findings and required actions, but in no case shall such meetings be held less frequently than quarterly. A copy of the meeting summaries/minutes shall be submitted to the Department upon request.

25. *Table 1 to Attachment XI: Healthcare and Quality of Life Performance Measures* is deleted and replaced with the attached revised *Table 1*.

26. *Attachment XIII: Required Deliverables, Submissions and Reporting* is deleted in its entirety and replaced with the attached updated *Attachment XIII*.

27. *Attachment XVI: Qualifications and Training Requirements of Certain Care Coordinators and Other Care Professionals* is amended by deleting subsections 1.3.2, 1.3.2.1, and 1.3.2.2.

28. *Attachment XXII: Children’s Behavioral Health Service Requirements* is deleted in its entirety and replaced with the attached updated *Attachment XXII*.

IN WITNESS WHEREOF, the Parties have hereunto caused this Amendment No. 10 to the Contract to be executed by their duly authorized representatives, effective as of the date of last signature.

[MANAGEDCARE ORGANIZATION]

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

By: _____

By: _____

Printed Name: _____

Printed Name: _____

Title: _____

Title: Director _____

Date: _____

Date: _____

FEIN: _____

TABLE 1 TO ATTACHMENT XI: HEALTHCARE AND QUALITY OF LIFE PERFORMANCE MEASURES

Acronym	Performance measure	Further description	Reporting methodology	Source
AAP	Adults' Access to Preventive/Ambulatory Health Services	Percentage of member's 20 years and older who had an ambulatory or preventive care visit during the measure year. (Report 3 age ranges and total)	Admin [P4P measure]	HEDIS
AMB	Ambulatory Care	This measure summarizes utilization of ambulatory care in the following categories: <ul style="list-style-type: none"> • Outpatient Visits • ED Visits. (Reported per 1,000 member months, on 9 age ranges and total)	Admin	HEDIS
PPC	Prenatal and Postpartum Care	Percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care. <ul style="list-style-type: none"> • <i>Timeliness of Prenatal Care.</i> Percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date or within 42 days of enrollment in the organization. • <i>Postpartum Care.</i> Percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery. 	Hybrid / Admin [P4P measure]	HEDIS
IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Percentage of adolescents and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following. <ul style="list-style-type: none"> • <i>Initiation of AOD Treatment.</i> 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. • <i>Engagement of AOD Treatment.</i> 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. 	Admin	HEDIS
W30	Well-Child Visits in the First 30 Months of Life	The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported: 1. Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits. 2. Well-Child Visits for Age 15 Months–30 Months. Children who turned 30 months old during the measurement year: Two or more well-child visits.	Admin [P4R measure]	HEDIS

Acronym	Performance measure	Further description	Reporting methodology	Source
WCV	Child and Adolescent Well-Care Visits	The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	Admin [P4R measure]	HEDIS
ADV	Annual Dental Visit	Percentage of members 2-20 years of age who had at least one dental visit during the measurement year. (Report 6 age ranges and total)	Admin	HEDIS
BCS	Breast Cancer Screening	Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.	Admin [P4P measure]	HEDIS
CCS	Cervical Cancer Screening	Percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria: <ul style="list-style-type: none"> • Women age 21-64 who had a cervical cytology performed every 3 years. • Women age 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years. 	Hybrid / Admin [P4P measure]	HEDIS
CHL	Chlamydia Screening in Women	Percentage of women age 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measure year.	Admin	HEDIS
CBP	Controlling High Blood Pressure	Percentage of members 18-85 years of age who had a diagnosis of hypertension and who's BP was adequately controlled during the measurement year based on the following criteria: <ul style="list-style-type: none"> • Members 18-59 years of age whose BP was <140/90mm Hg. • Members 60-85 years of age with a diagnosis of diabetes whose BP was <140/90mm Hg. • Members 60-85 years of age without a diagnosis of diabetes whose BP was <150/90mm Hg. 	Hybrid [P4P measure]	HEDIS
CIS	Childhood Immunization Status	Percentage of children 2 years of age who had four DTaP; three IPV; one MMR; three HiB; three HepB; one VZV; four PCV; one HepA; two or three RV; and two Flu vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.	Hybrid / Admin [P4P measure – Combo 3 P4R measure – Combo 10]	HEDIS
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year: <ul style="list-style-type: none"> • BMI percentile documentation. • Counseling for nutrition. • Counseling for physical activity. 	Hybrid / Admin	HEDIS
IMA	Immunizations for Adolescents	Percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine and all required doses of the Human Papillomavirus (HPV) vaccine by their 13 th birthday. This measure	Hybrid / Admin	HEDIS

Acronym	Performance measure	Further description	Reporting methodology	Source
		calculates a rate for each vaccine and two combination rates.		
CDC	Comprehensive Diabetes Care	Percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following: <ul style="list-style-type: none"> • Hemoglobin A1c (HbA1c) testing. • HbA1c poor control (>9.0%). • HbA1c control (<8.0%). • Eye exam (retinal) performed. • BP control (<140/90 mm Hg). 	Hybrid / Admin	HEDIS
SPD	Statin Therapy for Patients with Diabetes	Percentage of members 40-75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria. Two rates are reported: 1) <i>Received Statin Therapy</i> . Members who were dispensed at least one statin medication of any intensity during measurement year. 2) <i>Statin Adherence 80%</i> . Members who remained on a statin medication of any intensity for at least 80% of the treatment period.	Admin	HEDIS
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	Percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing. (Report three age stratifications and total)	Admin	HEDIS
FUH	Follow-Up After Hospitalization for Mental Illness – 30 days and 7 days follow-up	Percentage of discharges for member’s 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported: 1) Percentage of discharges for which the member received follow-up within 30 days of discharge. 2) Percentage of discharges for which the member received follow-up within 7 days of discharge.	Admin [P4P measure]	HEDIS
MPT	Mental Health Utilization	The number and percentage of members receiving the following mental health services during the measurement year: any service, inpatient, intensive outpatient or partial hospitalization, outpatient or ED	Admin	HEDIS
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	Percentage of ED visits for which enrollees 13 years and older with a principal diagnosis of alcohol or other drug abuse or dependence received follow-up within 30 days of the ED visit (31 total days) and within 7 days of the ED visit (8 total days). (Effective for measure year 2020, reporting year 2021)	Admin [P4P measure]	HEDIS
FUI	Follow-Up After High-Intensity Care for Substance Use Disorder	Percentage of visits or discharges for which enrollees 13 years and older received follow-up for substance use disorder within the 30 days after the visit	Admin [P4R measure]	HEDIS

Acronym	Performance measure	Further description	Reporting methodology	Source
		or discharge and within the 7 days after the visit or discharge. (Effective for measure year 2020, reporting year 2021)		
FUM	Follow-Up After Emergency Department Visit for Mental Illness	Percentage of ED visits for which enrollees 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm received follow-up within 30 days of the ED visit (31 total days) and within 7 days of the ED visit (8 total days). (Effective for measure year 2020, reporting year 2021)	Admin [P4P measure]	HEDIS
POD	Pharmacotherapy for Opioid Use Disorder	The percentage of new opioid use disorder (OUD) pharmacotherapy events with OUD pharmacotherapy for 180 or more days among enrollees age 16 and older with a diagnosis of OUD. (Effective for measure year 2020, reporting year 2021)	Admin [P4R measure]	HEDIS
HIV	HIV Viral Load Suppression	Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/ml at last viral load test during the measurement year.	Admin [P4R measure]	NQF #2082
HIV	Gap in HIV Medical Visits	Percentage of patients, regardless of age, with a diagnosis of HIV who did not have a medical visit in the last 6 months of the measurement year.	Admin [P4R measure]	NQF #2079
HIV	Prescription of HIV Antiretroviral Therapy	Percentage of patients, regardless of age, with a diagnosis of HIV prescribed antiretroviral therapy ¹ for the treatment of HIV infection during the measurement year.	Admin [P4R measure]	NQF #2083
LTSS-CPU	LTSS Comprehensive Care Plan Update	The percentage of long-term services and supports (LTSS) organization members 18 years of age and older who have documentation of a comprehensive LTSS care plan in a specified timeframe that includes core elements. The following rates are reported: 1. Care Plan with Core Elements Documented. Members who had a comprehensive LTSS care plan with nine core elements documented within 120 days of enrollment (for new members) or during the measurement year (for established members). 2. Care Plan with Supplemental Elements Documented. Members who had a comprehensive LTSS care plan with nine core elements and at least four supplemental elements documented within 120 days of enrollment (for new members) or during the measurement year (for established members).	LTSS Case Management Record Review [P4R measure]	HEDIS
LTSS	Successful Transition after Long-Term Care Stay	The proportion of long-term institutional facility stays among MLTSS plan members age 18 and older, which result in successful transitions to the community (community residence for 60	Admin [P4R measure]	NQF #9999

Acronym	Performance measure	Further description	Reporting methodology	Source
		or more days). This measure is reported as an observed rate and a risk-adjusted rate.		
CBH	Mobile Crisis Response Services that Result in Hospitalization		Admin [P4R measure]	Non-HEDIS – State Defined
CBH	Visits to the ER for BH services that Result in Hospitalization		Admin [P4R measure]	Non-HEDIS – State Defined
CBH	Overall Number and Length of BH Hospitalizations		Admin [P4R measure]	Non-HEDIS – State Defined
CBH	Number of Repeat BH Hospitalizations		Admin [P4R measure]	Non-HEDIS – State Defined

ATTACHMENT XIII: REQUIRED DELIVERABLES, SUBMISSIONS, AND REPORTING

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

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

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

Name of report/submission	Frequency	HFS Prior Approval	Report description and requirements
			<p>Production. Once Contractor’s testing of data specified above is completed, Contractor will be certified for production. Once certified for production, Contractor shall continue to submit Encounter Data in accordance with these requirements. The Department will continue to review the Encounter Data for correct format and quality. Contractor shall submit as many files as necessary, in a time frame agreed upon by the Department and Contractor, to ensure all Encounter Data are current.</p> <p>Records that fail the edits described above will be returned to Contractor for correction. Corrected Encounter Data must be returned to the Department for reprocessing.</p> <p>Electronic data certification. In a format determined by the Department, Contractor shall certify by the 5th day of each month that all electronic data submitted during the previous calendar month are accurate, complete and true.</p>
Disclosure statement	Initially, annually, on request, and as changes occur	No	Contractor shall submit disclosure statements as specified in 42 CFR, Part 455.
Report of transactions with Parties of Interest	Annually	No	Contractor shall report all “transactions” with a “party of interest” (as such terms are defined in Section 1903(m)(4)(A) of the Social Security Act and SMM 2087.6(A-B)), as required by Section 1903(m)(4)(A) of the Social Security Act.
Adjudicated claims inventory summary	Monthly, no later than fifteen (15) days after the close of the reporting month	No	Contractor shall report the number of claims Contractor adjudicated by claim type, in-network and out-of-network break out, and the number the claims took to process.
Compliance certification	Annually, no later than July 1	No	Contractor shall submit a Certification confirming that Contractor and its subcontractors are in compliance with Section 9.2 and each subsection thereof.
Enrollee Materials			
Certificate of Coverage, Description of Coverage, and any changes or amendments	Initially and as revised	Yes	Contractor shall submit the Certificate of Coverage and Description of Coverage for Prior Approval that comply with the Managed Care Reform and Patient Rights Act (215 ILCS 134) and the Illinois Administrative Code, Title 50, Chapter 1, Subchapter kkk, Part 5421.
Enrollee Handbook	Initially and as revised	Yes	Contractor shall submit an Enrollee Handbook for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed.

Name of report/submission	Frequency	HFS Prior Approval	Report description and requirements
Identification Card	Initially and as revised	Yes	Contractor shall submit the Enrollee identification card for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed.
Provider Directory	Initially and as changes occur	Yes	Contractor shall submit separate Provider Directories that are on Contractor's website for Prior Approval. Provider updates shall not be required to be submitted for Prior Approval.
Provider Directory Attestation	Monthly	No	Contractor shall submit an attestation that they have met the provider directory requirements in 305 ILCS 5/5-30.3(b)(1) and 305 ILCS 5/5 30.1(f)(2).
Fraud and Abuse			
Fraud and Abuse Referral	Immediately upon notification or knowledge of suspected Fraud and Abuse	N/A	Contractor shall report all suspected Fraud and Abuse to the Department as required in Article V and Article IX of this Contract. Contractor shall provide a preliminary investigation report as each occurrence is identified.
Fraud and Abuse Report	Quarterly	No	Contractor shall provide a summary report of referrals made and program integrity activities conducted in the previous quarter.
Recipient Verification Procedure	Initially, annually and as revised	Yes	Contractor shall submit Contractor's plan for verifying with Enrollees whether services billed by Providers were received, as required by 42 CFR 455.20, for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in information conveyed. This does not need to be provided to the Department separately by population.
Recipient Verification Results	Annually and within ten (10) Business Days after the Department's request	No	Contractor shall submit a summary of the results of the Recipient Verification Procedure.
Fraud and Abuse Compliance Plan	Initially and annually	Yes	Per 42 CFR 438.608, Contractor shall submit its compliance plan designed to guard against Fraud and Abuse to the Department for Prior Approval. This does not need to be provided to the Department separately by population.
Marketing			
Marketing Gifts and Incentives	Initially and within ten (10) Business Days after the Department's request	Yes	Contractor shall submit all plans to distribute gifts and incentives, as well as description of gifts and incentives, for Prior Approval.

Name of report/submission	Frequency	HFS Prior Approval	Report description and requirements
Marketing Materials	Initially and as revised	Yes	Contractor shall submit all Marketing Materials for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed.
Marketing and Outreach Plan	Annually	Yes	Contractor shall submit descriptions of proposed Marketing concepts, strategies, and procedures for Prior Approval.
Community Outreach Events	Monthly, by the last day of the reporting month	No	Contractor shall submit to the Department a list of all previously approved community outreach events that occurred during the submission month. The report must include the Event name, date, time, address/location, county, audience type, estimated number of attendees and date of Department approval.

Provider Network			
Primary care Provider, Hospital, and Affiliated Specialist File (CEB Provider File)	No less often than weekly	Yes	<p>Contractor shall submit to the Department or its designee, in a format and medium designated by the Department, an electronic file of Contractor's PCPs, Hospitals and Affiliated Specialists. The primary care Providers must include, but not limited to, the following information:</p> <ul style="list-style-type: none"> • Provider name, Provider number, office address, and telephone number; • Type of specialty (e.g., family practitioner, internist, oncologist, etc.), subspecialty if applicable, and treatment age ranges; • Identification of Group Practice, if applicable; • Geographic service area, if limited; • Areas of board-certification, if applicable; • Language(s) spoken by Provider and office staff; • Office hours and days of operation; • Special services offered to the deaf or hearing impaired (i.e., sign language, TDD/TTY, etc.); • Wheelchair accessibility status (e.g., parking, ramps, elevators, automatic doors, personal transfer assistance, etc.); • PCP indicator; • Primary care Provider gender and panel status (open or closed); and • Primary care Provider hospital affiliations, including information about where the primary care Provider has admitting privileges or admitting arrangements and delivery privileges (as appropriate).
Provider Terminations	As each occurs	No	Contractor shall submit Provider Termination reports, in a format and medium designated by the Department.

Provider Grievance-Resolution System and Procedures	Initially and as revised	Yes	Contractor shall submit details of its Provider Grievance-resolution system and related procedures for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed.
Summary of Provider Complaints and Resolutions – Summary Report	Quarterly	No	Contractor shall submit a summary of the Complaints filed by Providers. Reporting shall include total Provider Grievances per/1,000 Enrollees. The report shall include a summary count of any such Provider Complaints received during the reporting period.
Provider network file (complete)	Monthly	No	Contractor shall submit to the Department or its designee, in a format and medium designated by the Department, an electronic file of Contractor’s full provider network.
Pharmacy Formulary Attestation	Annually	No	Contractor shall submit an attestation that they have met pharmacy formulary requirements in 305 ILCS 5/5-30(b)(1).
Quality Assurance/medical			
Grievance and Appeals Procedures	Initially and as revised	Yes	Contractor shall submit Grievance and Appeals Procedures for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed.
Summary of Grievances, Appeals and Resolutions and External Independent Reviews and Resolutions – Summary Report	Quarterly	No	<p>Contractor shall submit a summary of the Grievances and Appeals filed by Enrollees, organized by categories of quality of care, access to care, medical necessity reviews, transportation, Long Term Services and Supports (LTSS), mental health and substance use disorder parity, and “Other” issues. Reporting shall include total Grievances and Appeals per/1,000 Enrollees. The report shall include a summary count of any such Grievances or Appeals received during the reporting period including those that go through fair hearings and external independent reviews. Contractor shall report on Covered Services and include Appeals and Grievances outcomes and the levels at which the Grievances or Appeals were resolved, and whether the Appeals were upheld or overturned. Contractor shall provide this report for each population for which it provides Covered Services.</p> <p>Contractor shall also report Grievances and Appeals separately for the categories of: Nursing Facility Services; Persons who are Elderly; Assisted Living Supportive Living Program; Persons with Physical Disabilities; Persons with HIV/AIDS; and Persons with Brain Injury. The report shall only include Grievances and Appeals related specifically to LTC and Waiver services and providers.</p>

Quality Assurance, Utilization Review and Peer Review (QA/UR/PR) Annual Report / Program Evaluation	Annually, no later than ninety (90) days after close of reporting period	No	Contractor shall submit a QA/UR/PR Annual Report/Program Evaluation reviewing the effectiveness of Contractor's QAP. The summary shall contain Contractor's processes for Quality Assurance, utilization review and peer review. This report shall include a comprehensive description of Contractor's network and an annual work-plan outlining Contractor's intended activities relating to QA, utilization review, peer review and health education. Contractor may submit one report that includes all care coordination programs in which it participates; however, Contractor must clearly identify program-specific activities.
QA/UR/PR Committee Meeting Minutes	As needed, and within ten (10) Business Days after the Department's request	No	Contractor shall submit the minutes of its QA/UR/PR Committee meetings.
Care Management and Disease Management Program Descriptions	Initially and as revised	Yes	Contractor shall submit the descriptions of its Care Management and Disease Management programs for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed. Contractor shall identify all areas in its CM/DM program that differ among care coordination programs.
Care Coordination effectiveness Summary Report	Monthly	No	<p>Contractor shall track Enrollees based on enrollment date and show the data points of initial screenings completed, comprehensive assessments completed, Enrollee care plans completed, opt outs (Enrollees who declined Care Management), and attempting to locate. Contractor shall report separately for the categories of: Families and Children; Persons with Developmental Disabilities; Persons with Disabilities; Persons with Brain Injury; Persons with HIV/AIDS; Persons who are Elderly; Assisted Living, Supportive Living Program; LTC; Behavioral Health (by primary diagnoses, including Substance Abuse); ACA Adult; and High-Needs Children.</p> <p>Contractor shall also report on all Enrollees who are assigned to Contractor's Care Management and Disease Management interventions, including a count of those who are risk-stratified, in process of stratification, attempting to locate, opt out of care management, high ED utilizers, and the percentage of Enrollees at each level. Contractor shall provide summary data for each of the categories listed above.</p>
Care Gap Plan	Annually	No	Contractor shall submit its plan for ensuring provision of services missed by Enrollees, including, but not limited to, annual preventive exams, immunizations, women's healthcare, PAP and missed services for Chronic Health Conditions and Behavioral Health follow-up. Contractor may submit one plan that includes all care coordination programs in which it participates; however, Contractor must clearly identify program-specific activities.

Outreach Summary Report	Quarterly	No	Contractor shall submit a summary report that shows Enrollee outreach for each level of stratification and for top ED utilizers. Enrollees' risk levels will be determined by which level they are in the end of the quarter. Contractor shall report separately for the categories of: Persons with Disabilities; Persons with Brain Injury; Persons with HIV/AIDS; Persons who are Elderly; LTC; and Assisted Living, Supportive Living Program.
Prior Authorization Report	Monthly	No	Contractor shall submit turnaround times for routine, expedited and pharmacy prior authorizations for its Enrollees, by operating region, provider size, and provider type
HEDIS® and State-Defined Plan Goals	Quarterly	No	Contractor shall submit a HEDIS® measures report that is based on the Performance Measures required by this Contract, and that includes HEDIS® measures, modified HEDIS® measures, and State defined measures. This report shall include the numerator, denominator and rate for each measure and will display information in a manner that includes trending data, based on previous quality indicators.
Processes and Procedures to Receive Reports of Critical Incidents	Initially and as revised	Yes	Contractor shall submit Critical Incident Processes and Procedures for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed. Contractor may submit one set of processes and procedures that includes all care coordination programs in which it participates; however, Contractor shall identify all areas that differ among care coordination programs.
Critical Incidents - Detail Report	Monthly	No	Contractor shall submit a detailed report on Critical Incidents providing Enrollee name, Enrollee Medicaid number, incident summary, date received, source, incident date, date referred, referral entity, date resolved, and resolution summary, grouped in the following categories: Abuse; Neglect; Exploitation; and Other. Contractor shall report Critical Incidents for each of the following: Nursing Facility Services; HCBS Waiver for Persons who are Elderly; HCBS Waiver for Assisted Living, Supportive Living Program; HCBS Waiver for Persons with Physical Disabilities; HCBS Waiver for Persons with HIV/AIDS; HCBS Waiver for Persons with Brain Injury; ACA Expansion Adults; Non-Disabled Children; Non-Disabled Adults; Special Needs Children; and IMD Residents.

Critical Incidents – Summary Report	Quarterly	No	Contractor shall submit a summary report on Critical Incidents that includes the total Critical Incidents and the total Critical Incidents referred. Contractor shall submit a summary count of Critical Incidents in the following categories: Abuse, Neglect, Exploitation, and Other. Contractor shall report Critical Incidents separately for each of the following: Nursing Facility Services; HCBS Waiver for Persons who are Elderly; HCBS Waiver for Assisted Living, Supportive Living Program; HCBS Waiver for Persons with Physical Disabilities; HCBS Waiver for Persons with HIV/AIDS; HCBS Waiver for Persons with Brain Injury; ACA Expansion Adults; Non-Disabled Children; Non-Disabled Adults; Special Needs Children; and IMD Residents.
Transition of Care Plan	Initially and as revised	Yes	Contractor shall submit its Transition of Care Plan to the Department for review and Prior Approval. The Transition of Care Plan shall include policies and procedures and a staffing model designed to achieve a seamless, efficient transition with minimal impact to an Enrollee’s care. Contractor may submit one plan that includes all care coordination programs in which it participates; however, Contractor shall identify all areas that differ among care coordination programs.
Cultural Competence Plan	At least two (2) weeks prior to the Department’s Readiness Review	No	Contractor shall submit its Cultural Competence Plan that addresses the challenges of meeting the healthcare needs of Enrollees. Contractor’s Cultural Competence Plan shall contain, at a minimum, the provisions listed in Section 2.7.2 of the Contract. Contractor may submit one plan that includes all care coordination programs in which it participates; however, Contractor shall identify all areas that differ among care coordination programs.
Executive Summary	Quarterly	No	Contractor shall submit an Executive Summary that summarizes the data within the reports submitted to the Department for that quarter (including monthly and quarterly reports). The Executive Summary shall contain, at a minimum, an analysis of the reports submitted during the quarter, an explanation of the data submitted, and highlights from the reports.
Children with Special Health Care Needs (CSHN) Plan	Initially and as revised	No	Contractor shall submit the Children with Special Health Care Needs Plan to conduct timely identification and screening, comprehensive assessments, and appropriate case management services for any CSHN.
Provider-preventable Conditions Report	Quarterly	No	Contractor shall report provider-preventable conditions that are identified in the State Plan to the Department.

Utilization Review			
Utilization Management Report	Monthly	No	Contractor shall submit an analysis of Inpatient and Emergency Services utilization. Inpatient services shall be based on inpatient days and be categorized as follows: Utilization for total Inpatient, Medical/Surgical, Rehabilitation, Mental Health including Substance Use, Emergency Services, and Outpatient visits. Data will be based on utilization per 1,000 Enrollees and Total utilization. Reporting for Inpatient, Emergency Services, and Outpatient visits utilization shall be divided into separate worksheets for LTC, HCBS Waiver for Persons with Developmental Disabilities, HCBS Waiver for Persons with Disabilities, HCBS Wavier for Persons with Brain Injury, HCBS Waiver for Persons with HIV/AIDS, HCBS Waiver for Persons who are Elderly, HCBS Waiver for Assisted Living, Supportive Living Program, and total population as defined by Department standards.
Pharmacy			
Psychotropic Review Report	Monthly	No	Contractor shall submit a summary report of Enrollees' Psychotropic medication utilization and the prescribing patterns of Providers. The report must include information on the following criteria: use of 5 or more psychotropics for 60 or more days, use of 2 or more ADHD medications for 60 or more days, use of 3 or more antidepressants for 60 or more days, use of 5 or more drugs for bipolar disorder (mood stabilizers, atypical antipsychotics, antidepressants) for 60 or more days, use of 2 or more SSRIs for 60 or more days, use of 2 or more antipsychotics for 60 or more days, use of 2 or more atypical antipsychotics for 60 or more days, and use of 2 or more benzodiazepine or benzodiazepine hypnotics for 60 or more days.
Drug Utilization Review Report	Annual	No	Contractor shall report its prospective and retrospective Drug Utilization Review activities to the Department.
Subcontracts and Provider agreements			
Executed Subcontracts	Initially and as revised	N/A	Contractor shall submit copies of each executed subcontract relating to an arrangement for the provision of Covered Services, but not those subcontracts for the direct provision of Covered Services. For example, a subcontract with a behavioral health or dental administrator shall be submitted to the Department, but an agreement with a therapist or dentist providing direct care to an Enrollee need not be submitted unless otherwise required or requested by the Department.
Executed Provider Agreements	Within ten (10) Business Days after the Department's request	N/A	Contractor shall submit copies of executed Provider agreements to the Department upon request.

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

Attachment XXII: Children’s Behavioral Health Service Requirements

1.1 CHILDREN’S BEHAVIORAL HEALTH (CBH) SERVICE DELIVERY DESIGN.

1.1.1 For the purposes of this Attachment XXII:

1.1.1.1 **Care Coordination and Support Organization (CCSO)** means a provider with responsibility for delivering Mobile Crisis Response and Care Coordination to eligible Enrollees within a designated service area.

1.1.1.2 **Pathways to Success** means a program that provides an evidence-informed model of intensive Care Coordination and additional home and community-based services for Enrollees under the age of twenty-one (21) who meet eligibility criteria demonstrating complex Behavioral Health needs requiring intensive services.

1.1.2 Contractor shall design its Behavioral Health service delivery system for Children consistent with the values and principles of Systems of Care, Wraparound, and the N.B. consent decree program design. This includes a commitment to working collaboratively with the Department to ensure that Behavioral Health services are delivered in a manner that is family-driven, youth-guided, strengths-based, individualized, community-based, trauma-informed, data-driven, and culturally and linguistically competent.

1.1.3 Contractor shall adhere to and implement all aspects of the N.B. consent decree relevant to the Medicaid Managed Care Program as set forth in the N.B. consent decree dated January 16, 2018, and the N.B. implementation plan dated December 2, 2019, and any subsequent revisions, updates or related court orders, all of which shall be incorporated herein and made part of this contract and are available here: <https://www2.illinois.gov/hfs/info/legal/Pages/NBConsentDecree.aspx>.

1.1.4 Contractor shall incorporate the specific requirements of the N.B. consent decree and implementation plan into Contractor’s overall Children’s Behavioral Health service delivery design. Where requirements of the N.B. consent decree or implementation plan overlap with or conflict with other requirements of this Contract, the N.B. consent decree or implementation plan shall prevail.

1.1.5 **Plan for Implementing N.B. Requirements.** Contractor shall establish a plan for implementing the requirements of this Contract related to the N.B. consent decree. The plan shall include specific activities and timeframes and shall minimally address the following: Enrollee communication and education, Provider Network development and oversight, necessary system updates (e.g. claiming), Care Coordination, Utilization Management, coordination with CCSOs, and Continuity of Care. Contractor shall submit its initial plan to the Department for review and Prior Approval ninety (90) days after the effective date of this Amendment. Contractor shall thereafter annually update its plan for implementing N.B. requirements and submit it to the Department for review and Prior Approval by July 1 of each year.

1.1.6 **Plan for Family Driven Care.** Contractor shall establish a plan for Family Driven Care, focused on establishing opportunities for Enrollees and families to provide Contractor with input and feedback regarding its service delivery system. Contractor shall submit its initial plan for Family Driven Care to the Department for review and Prior Approval ninety (90) days prior to the Effective Enrollment Date of the first Enrollee. Contractor shall thereafter annually update its plan for Family Driven Care and submit it to the Department for review and Prior Approval by no later than July 1st of each calendar year. The plan for Family Driven Care shall, at a minimum:

1.1.6.1 Address how Contractor will establish and maintain a service delivery system that is person and family centric and that incorporates the values and principles of Systems of Care and

Wraparound;

- 1.1.6.2 Address how Contractor will promote and ensure family and Enrollee input across all of the Contracting Area;
- 1.1.6.3 State the annual goals, objectives, and activities Contractor will complete related to family and youth driven care; and
- 1.1.6.4 Establish the role of the Family Leadership Council (FLC) in the plan for Family Driven Care. Contractor shall ensure that the FLC reviews and provides official comment on the plan for Family Driven Care prior to Contractor submitting the plan for Family Driven Care for review and approval by the Department at initiation and annually thereafter.
- 1.1.6.5 Contractor is encouraged to seek technical assistance on best practices for enhancing Family Driven Care from an organization that is led by and that employs individuals with lived experience in navigating one or more child-serving systems as a caregiver or as a customer (also known as a family-run organization) or similar resource with appropriate expertise, such as the National Federation of Families or the Family Run Executive Director Leadership Association (FREDLA).

1.2 REQUIREMENTS FOR N.B. CLASS MEMBERS.

- 1.2.1 Contractor acknowledges and agrees to provide eligible Enrollees access to the Pathways to Success (Pathways) program as a core component of the Department's implementation of the N.B. consent decree. Contractor acknowledges that all Enrollees the Department determines eligible for Pathways are N.B. class members and shall provide access to services consistent with all eligibility determinations made by the Department.
- 1.2.2 Contractor agrees to meet all applicable requirements in this agreement regarding N.B. class members for any Enrollee identified by the Department as an N.B. class member, regardless of the extent to which the Enrollee participates in the Pathways program.
- 1.2.3 Contractor shall provide communication, education, and assistance to N.B. class members regarding the Pathways to Success program, their rights, service options, and applicable processes as needed to comply with the N.B. consent decree and N.B. implementation plan.
- 1.2.4 Contractor shall provide coverage of the following home and community-based services to Enrollees in the Pathways to Success program, referred to hereafter as Pathways Services: Care Coordination and Support (CCS), Respite, Intensive Home-Based (IHB), Family Peer Support, and Therapeutic Mentoring.
- 1.2.5 Contractor shall participate in a Joint Pathways Oversight Committee convened by the Department. The Joint Pathways Oversight Committee shall be responsible for monitoring and providing oversight of all components of Pathways administration and operation, including but not limited to: Provider Network development; conducting Provider audits and quality reviews; establishing standardized reporting templates and processes for Pathways Providers and N.B. class members; reviewing process and outcome reports, establishing corrective action plans, incentive strategies, or other quality improvement efforts with Providers of Pathways Services; and, providing technical assistance and support to Providers in the implementation of Pathways.
- 1.2.6 Contractor shall provide to the Department all requested reports, report methodologies, and data related to the requirements of Attachment XXII and the N.B. consent decree in a format and manner defined by the Department, and shall work collaboratively with the Department in the development of any new required reports. The Department will provide Contractor with no less than thirty (30) days

written notice prior to implementing any new report requirements.

1.2.7 Provider Network Requirements.

1.2.7.1 Contractor shall collaborate with the Department in the selection and implementation of Care Coordination and Support Organizations (CCSOs), including participating in credentialing, readiness review, and other related processes designed to ensure the capacity and capability of CCSOs to provide CCS to Enrollees in Pathways.

1.2.7.2 In collaboration with the Department or its designee, Contractor shall provide ongoing training, support, and technical assistance to CCSOs, CMHCs, BHCs, hospitals, PCPs, and other Behavioral Health Providers on the CBH Service Delivery System and the N.B. implementation plan.

1.2.7.3 Contractor shall recruit Providers of Pathways Services into Contractor's Provider Network and shall monitor its Provider Network to ensure adequate access to Medically Necessary services for Enrollees in Pathways consistent with sections 5.8.1 and 5.8.3 of this Contract. Contractor shall negotiate in good faith and enter into a Network Agreement with any willing Providers enrolled with the Department to deliver Pathways services.

1.2.7.4 Contractor shall negotiate in good faith and enter into a Network Agreement with all Providers enrolled for participation as a CCSO in the Medical Assistance Program and must ensure that all Enrollees in the Pathways program have access to the CCSO in their home designated service area or other geographic area determined by the Department.

1.2.7.5 Contractor shall require that its Network Providers of CCSOs:

1.2.7.5.1 Deliver CCS services consistent with all service requirements established by the Department, including but not limited to those outlined in the applicable Department Handbook; and,

1.2.7.5.2 Provide Contractor with a minimum of ninety (90) days advance written notice in the event the Provider is no longer willing or capable of continuing to serve as a CCSO within parts or all the Provider's designated service area (DSA).

1.2.8 Care Coordination Requirements.

1.2.8.1 Contractor shall stratify all Enrollees designated as N.B. class members as high-risk (level 3). Enrollees shall remain stratified as high-risk for a period of no less than one hundred-eighty (180) days after the Enrollee is no longer designated as an N.B. class member by the Department.

1.2.8.2 Contractor shall assist CCSOs in locating, engaging, and educating Enrollees identified as N.B. class members or as eligible for participation in Pathways using a multifaceted approach that may include, but is not limited to: direct Enrollee outreach; use of Enrollee claims and care management data; PCP engagement; CFT member engagement; and usage of Care Coordinators, Community Health Workers, Family Peer Support workers, or other community liaisons.

1.2.8.3 Contractor shall assign a Care Coordinator to serve as a liaison to each child and family team (CFT) established for Enrollees in Pathways, helping provide education and navigation of the Contractor's processes and requirements, including helping identify providers in Contractor's network and other resources to ensure service provision consistent with the IPoCs for Enrollees in Pathways and reduce barriers to accessing care. The assigned Care Coordinator shall attend CFT meetings as needed, based upon family preference, and as requested by the CFT.

1.2.9 Utilization Management Requirements.

- 1.2.9.1 Contractor shall accept the IM+CANS established by the CCSO and the Enrollee's CFT, as applicable, as the IPoC for Enrollees who are N.B. class members.
- 1.2.9.2 Contractor shall establish Utilization Management and Prior Authorization policies and procedures, subject to Prior Approval, for N.B. class members that ensures the following:
 - 1.2.9.2.1 Utilization Management staff shall base any service utilization reviews conducted on community-based Behavioral Health services for N.B. class members on the Enrollee's completed IM+CANS.
 - 1.2.9.2.2 Any service authorization activity for an N.B. Class Member takes into consideration the service recommendations of the Enrollee's CFT, as applicable, and as documented on the Enrollee's IM+CANS or other related CFT documentation.
 - 1.2.9.2.3 Medical necessity and service utilization standards for community-based Behavioral Health services and Pathways services are consistent with Department established standards.
- 1.2.9.3 Contractor shall not prior authorize Pathways Services in a manner more restrictive than the Department's fee-for-service system or apply any prior authorization or utilization management policies or procedures to Pathways or community-based Behavioral Health services for N.B. class members beyond those established and specifically approved by the Department.
- 1.2.9.4 Contractor shall ensure that Utilization Management staff responsible for performing service utilization reviews for N.B. class members are adequately trained in the N.B consent decree and implementation plan requirements, IM+CANS, the Wraparound process including the role of the child and family team, and as appropriate other relevant tools and clinical assessments (e.g. functional behavioral assessments, behavioral health screening tools).

1.3 MOBILE CRISIS RESPONSE SYSTEM.

- 1.3.1 Contractor shall establish a Mobile Crisis Response (MCR) system capable of responding immediately to Enrollees experiencing a Behavioral Health Crisis and providing short-term crisis intervention and stabilization services to Enrollees post-crisis, consistent with the requirements of this section 1.3.
- 1.3.2 Contractor shall require that all Children potentially requiring psychiatric inpatient hospitalization, acute care, or subacute care in a Psychiatric Residential Treatment Facility (PRTF), are screened prior to admission for the viability of stabilization in the community, as required by the Children's Mental Health Act of 2003 (405 ILCS 49/1 *et seq.*).
- 1.3.3 Contractor acknowledges the existence of the Screening, Assessment, and Support Services (SASS) Program, cooperatively administered by DCFS, the DHS Division of Mental Health, and the Department.
- 1.3.4 Contractor shall provide Enrollees and their families with information on how and when to engage Contractor's Mobile Crisis Response (MCR) system, including how to access Contractor's Behavioral Health Crisis line and MCR providers. This information shall be included in Contractor's Member Handbook and easily accessible on Contractor's website.
- 1.3.5 **Behavioral Health Crisis Line.**
 - 1.3.5.1 Contractor shall establish a dedicated Behavioral Health Crisis line for Enrollees, family members

of Enrollees, or other concerned parties seeking to refer any Enrollee to Behavioral Health Crisis services.

1.3.5.2 Contractor shall ensure that Contractor's Crisis line does not require callers to navigate a telephonic menu to make a referral for Crisis services.

1.3.5.3 Contractor's Crisis line shall adjudicate crisis referrals for Enrollees in a timely and efficient manner to determine if the Enrollee meets clinical acuity for MCR services.

1.3.5.3.1 If the Enrollee is determined to meet clinical acuity, the Crisis line shall immediately dispatch Contractor's designated MCR provider to the location of the Enrollee in crisis.

1.3.5.3.2 Contractor shall establish protocols for the Crisis line to provide callers with information on how to access outpatient behavioral health services through the Contractor's behavioral health service delivery system when the Enrollee does not meet clinical acuity for MCR services.

1.3.5.3.3 Contractor's Behavioral Health Crisis Line protocols shall be subject to Department review and Prior Approval.

1.3.5.4 **Interface with the CARES.** Contractor acknowledges the existence of the Crisis and Referral Entry Service (CARES) Behavioral Health Crisis line cooperatively administered by DCFS, the DHS Division of Mental Health, and the Department.

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

1.3.5.4.2 CARES shall adjudicate all Crisis referrals received for Contractor's Enrollees. Contractor shall reimburse CARES at the Department issued per call rate in the instance Contractor does not have an executed contract with CARES.

1.3.5.4.3 Contractor shall provide CARES with the details of its MCR System, including the telephone numbers needed to access its designated MCR providers.

1.3.5.4.4 Contractor shall accept invoices from CARES monthly and shall remit payment to CARES within forty-five (45) days after receiving an invoice.

1.3.5.4.5 If CARES is unable to dispatch Contractor's designated MCR provider, CARES shall dispatch the fee-for-service designated MCR provider to ensure timely Crisis response to the Enrollee.

1.3.5.4.6 Contractor shall notify CARES of any changes to its contact numbers before any known changes or updates are made. When changes are necessary due to urgent or emergent circumstances, Contractor shall notify CARES as soon as possible.

1.3.6 **Mobile Crisis Response Services.**

1.3.6.1 Contractor shall ensure that MCR services are available twenty-four (24) hours per day, every day of the year, to Enrollees experiencing a Behavioral Health Crisis, regardless of where in the State, or any of the counties contiguous to the State, the Enrollee presents. This includes establishing a sufficient network of designated MCR providers responsible for receiving and appropriately serving all MCR referrals from the Contractor's Behavioral Health Crisis line and CARES on a no-decline basis.

1.3.6.2 Contractor shall ensure the availability of MCR services, by requiring all responding MCR Providers to complete an in-person crisis screening of all Enrollees experiencing a Behavioral Health Crisis consistent with the following timelines:

1.3.6.2.1 Within ninety (90) minutes of notification of an emergency referral. An emergency referral involves an Enrollee who presents in Behavioral Health Crisis and who requires an immediate screening and assessment to determine if they can be safely stabilized in the community.

1.3.6.2.2 Within twenty-four (24) hours of notification of a non-emergency referral. A non-emergency referral is when the Enrollee is not at immediate risk of harm, but still requires an MCR screening (i.e., court-ordered screening, Enrollees admitted to a psychiatric hospital prior to an MCR screening).

1.3.6.3 Contractor shall require that its Network Providers of MCR services:

1.3.6.3.1 Deliver MCR services consistent with all service requirements established by the Department including, but not limited to, those outlined in the Department's Handbook for Providers of Community-Based Behavioral Services, such as the usage of the IM-CAT as the standardized MCR screening tool;

1.3.6.3.2 Provide immediate and sufficient Crisis and Stabilization services to stabilize an Enrollee in the community when at all possible and appropriate for the Enrollee; and,

1.3.6.3.3 Provide Enrollees and their family with contact information that may be used at any time, twenty-four (24) hours a day, to contact the Provider in moments of Behavioral Health Crisis in lieu of utilizing the CARES line.

1.3.6.4 If an Enrollee is screened, due to necessity, by a Non-Network Provider of MCR services, Contractor shall pay for the MCR service at the Medicaid rate.

1.3.7 Inpatient Institutional Treatment.

1.3.7.1 Contractor shall require its Network Providers of MCR services to facilitate the Enrollee's admission to an appropriate inpatient treatment setting, including arranging for the necessary transportation, when the Enrollee in Crisis cannot be stabilized in the community

1.3.7.2 Contractor shall require its Network Providers of MCR services to inform the Enrollee and their parents, guardians, or caregivers, as applicable, about all available inpatient Network Providers and any pertinent policies needed to allow the involved parties to select an appropriate inpatient institutional treatment setting.

1.3.7.3 Contractor shall establish policies that outline a process for Network Providers of MCR services and hospitals to escalate access to care issues to Contractor in instances when an Enrollee is experiencing a Behavioral Health Crisis. The policies shall minimally include a requirement and process for Network Providers of MCR services and hospitals to notify Contractor in the instance:

1.3.7.3.1 An Enrollee requiring psychiatric inpatient hospitalization remains in an Emergency Department for a period of 24 hours or greater due to the inability to locate a hospital willing or able to admit the Enrollee; and

1.3.7.3.2 An Enrollee receiving psychiatric inpatient services is identified as at significant risk

of remaining at the inpatient facility after the Enrollee has been medically cleared for discharge.

1.3.7.4 Contractor or, when applicable, its Network Provider of CCS services working with the Enrollee, shall convene an emergency ICT for any Enrollee identified through the process outlined in Section 1.3.7.3 of this Attachment XXII that minimally includes the MCR Provider, the Enrollee's guardian, if appropriate, any community providers offering community-based services to the Enrollee, and representatives from any State Agencies offering services to the Enrollee within 48 hours of notification of the Enrollee's status.

1.3.7.4.1 Contractor will continue to convene the ICT for the Enrollee until appropriate treatment services are identified and the Enrollee is transitioned to those services.

1.3.7.5 Contractor shall require its inpatient psychiatric Network Providers to administer a physical examination to the Enrollee within twenty-four (24) hours after admission when an Enrollee requires admission to an appropriate inpatient institutional treatment setting.

1.3.7.6 Contractor shall provide and have documented procedure requirements for Network Providers regarding discharge and transition planning, consistent with the following:

1.3.7.6.1 Discharge and Transition planning shall begin upon admission;

1.3.7.6.2 The Network Provider of MCR services shall:

1.3.7.6.2.1 Participate in and take lead in coordinating staffing, discharge, and transition processes with assistance from the Enrollee's Care Coordinator, including coordinating all necessary follow-up appointments and referrals for the Enrollee upon transition back into the community. Appointments shall be established prior to discharge to ensure continuity across care providers;

1.3.7.6.2.2 Notify the Enrollee's family and caregiver of key dates and events related to the admission, staffing, discharge, and transition of the Enrollee, and shall make every effort to involve the Enrollee and the Enrollee's family and caregiver in decisions related to these processes; and,

1.3.7.6.2.3 Speak directly with the Enrollee at least once each week while the Enrollee is receiving inpatient services.

1.3.7.6.3 The Enrollee's Care Coordinator and community-based Providers responsible for providing services upon the Enrollee's discharge shall participate in all inpatient staffings by phone, videoconference, or in person.

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

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

1.3.8 Crisis Safety Plans. Contractor shall require its Network Providers of MCR services to:

- 1.3.8.1 Create, or review and update, a Crisis Safety Plan for all Enrollees that present in Behavioral Health Crisis, in collaboration with the Enrollee and their family, consistent with the following timelines:
 - 1.3.8.1.1 Prior to the completion of crisis intervention and stabilization services necessary to stabilize an Enrollee in the community following an MCR screening;
 - 1.3.8.1.2 Prior to the Enrollee's discharge from an inpatient psychiatric hospital setting for any Enrollee admitted to such a facility. When applicable, the MCR provider shall coordinate the completion of the Crisis Safety Plan with the Enrollee's CCSO.
- 1.3.8.2 Provide Enrollees and their families with physical copies of the Crisis Safety Plan consistent with the timelines in section 1.3.8.1 of this Attachment XXII.
- 1.3.8.3 Educate and orient the Enrollee and their family to the components of the Crisis Safety Plan, ensure that the plan is reviewed with the family regularly, and explain to the Enrollee and their family how the plan is updated as necessary.
- 1.3.8.4 Share the Crisis Safety Plan with all necessary medical professionals, including Care Coordinators and the Enrollee's CCSO, consistent with the authorizations established by consent or release.

1.3.9 Follow-Up After a Crisis Event.

- 1.3.9.1 Contractor shall establish policies promoting access to and delivery of crisis stabilization and follow-up services that shall minimally include:
 - 1.3.9.1.1 Policies and protocols that refer and immediately link Enrollees who have been community stabilized following a Crisis event with an urgent appointment with a mental health provider within one (1) Business Day after the Crisis event, if deemed Medically Necessary.
 - 1.3.9.1.2 Policies defining an established period post-Crisis, no less than thirty (30) days, during which Contractor shall not require prior authorization of outpatient mental health services.
 - 1.3.9.1.3 Policies requiring Network Providers to educate Enrollees who may be eligible for the State-funded Family Support Program (FSP) pursuant to 89 Ill. Adm. Code 139 about FSP to help these Enrollees access community-based services.
- 1.3.9.2 For Enrollees not receiving CCS services, Contractor shall convene an ICT meeting for Enrollees within fourteen (14) days after a Crisis event if the Enrollee is community stabilized and within fourteen (14) days after discharge if the Enrollee is hospitalized.
 - 1.3.9.2.1 When Contractor receives notification from DCFS that an Enrollee in Contractor's plan has been designated a Youth at Risk, Contractor will involve DCFS on the Enrollee's ICT.
- 1.3.9.3 Contractor shall ensure that the Enrollee has a scheduled appointment with a Behavioral Health Provider for follow-up within seven (7) days after the Enrollee's discharge from hospitalization.
- 1.3.9.4 Psychiatric Resource and Pharmacological Services.
 - 1.3.9.4.1 For all Enrollees referred for MCR services, Contractor shall establish procedures and

facilitate priority access to a psychiatric resource to provide consultation and medication management services, as Medically Necessary, within the following timeframes:

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

1.3.9.4.1.2 Within three (3) days after the Crisis event for an Enrollee who is community stabilized.

1.3.9.4.2 Contractor shall have procedures for communicating to the Enrollee's PCP the pharmacological services performed as part of MCR service, consistent with all consents and releases.

1.3.9.4.3 Contractor shall attempt to supplement the psychiatric resources available through its network with telepsychiatry services. Telepsychiatry services may include identifying available psychiatric resources and enhancing access outside the Coverage Area by connecting such resources to the Coverage Area or utilizing resources within the Coverage Area more efficiently by making such resources available to more rural Enrollees via electronic means. All telehealth services must be delivered consistent with any rules or requirements on telehealth established by HFS including but not limited to 89 Ill. Adm. Code 140.403.

1.3.10 Contractor shall make available the details of its MCR service model to the Department as required in Attachment XI, "Quality Assurance." As a component of the QA/UR/PR Annual Report. Contractor shall provide a report relating to the previous State Fiscal Year on its MCR service model to the Department, in a format developed by the Department that includes but is not limited to a detailed report of utilization, outcomes, and hospitalization rates.

1.4 DISCHARGE PLANNING AND TRANSITIONAL SUPPORTS.

For Enrollees not receiving CCS services, Contractor shall:

1.4.1 provide Enrollees with access to discharge planning and transitional services when being discharged from a psychiatric institutional level of care (e.g., hospital, PRTF, residential, Crisis respite), to lower levels or community-based services. Contractor shall work with the involved parties to facilitate appropriate follow-up services, including the scheduling of follow-up treatment appointments.

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

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

1.4.4 develop, implement, and follow a procedure to confirm that a medication management review has been completed prior to discharge from institutional levels of care; to confirm that PCPs are made aware of any medications that have been prescribed for Enrollees during treatment at an institutional setting; and to confirm with the Enrollees that they have the ability to get prescribed medications.

1.4.5 communicate directly with the Enrollee or Enrollee's family within forty-eight (48) hours after transition.

1.4.6 assist the Enrollee in attending all post-discharge appointments for follow-up care. Contractor shall provide appropriate Care Management based on concurrent assessment for an appropriate period of time following discharge, involving other parties (e.g. CCSO, MCR provider, DCFS caseworker) in the Care Management as necessary.
