Department of Healthcare & Family Services
HealthChoice Illinois
Your Health. Your Choice.

ILLINOIS DEPARTMENT OF
HFS Healthcare and Family Services

Division of Medical Programs

2021-2024

Comprehensive Medical Programs

Quality Strategy

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Contents

Section 1. Quality Framework

Purpose

The Illinois Department of Healthcare and Family Services (HFS) developed a transformative person-centered, integrated, equitable *Comprehensive Medical Programs Quality Strategy* (Quality Strategy) designed to improve outcomes in the delivery of healthcare at a community level. The Quality Strategy provides a framework to accomplish HFS' mission.

Mission

HFS is committed to improving lives by addressing social and structural determinants of health, by empowering customers to maximize their health and well-being, and by maintaining the highest standards of program integrity on behalf of Illinoisans. HFS is committed to making equity the foundation of quality improvement.

Objectives

Our transformation puts a strong new focus on equity, prevention, and public health; pays for value and outcomes rather than volume and services; proactively uses analytics and data to drive decisions and address health disparities; and works to move individuals from institutions to the community in an effort to keep individuals in the least restrictive environment and to keep them more closely connected with families and communities.

Goals

Better Care

1. Improve population health.
2. Improve access to care.
3. Increase effective coordination of care.

Healthy People/Healthy Communities

4. Improve participation in preventive care and screenings.
5. Promote integration of behavioral and physical healthcare.
6. Create consumer-centric healthcare delivery system.
7. Identify and prioritize reducing health disparities.
8. Implement evidence-based interventions to reduce disparities.
9. Invest in the development and use of health equity performance measures.
10. Incentivize the reeducation of health disparities and achievement of health equity.

Affordable Care

11. Transition to value- and outcome-based payment.
12. Deploy technology initiatives and provide incentives to increase adoption of electronic health records (EHRs) and streamline and enhance performance reporting, eligibility and enrollment procedures, pharmacy management, and data integration.

Roadmap for Quality Framework

Illinois Department of Healthcare and Family Services Comprehensive Medical Programs Quality Strategy

Pillars of Improvement

- Maternal and Child Health
- Adult Behavioral Health
- Child Behavioral Health
- Equity
- Community-Based Services and Supports

Data Collection ▶ Analytics ▶ Measure and Monitor Performance

Actionable and Timely

- HEDIS
- Encounter Data
- Pay for Value

Partnership

- HFS Illinois Department of Healthcare and Family Services
- Health Plans, Customers, Providers
- IDPH
- IDoA
- DCFS Illinois Department of Children & Family Services
- IDHS
- HealthChoice Illinois

Diversity|Support|Collaboration

Continuous Quality Improvement

CURRENT STATE

KEY DRIVERS

- Pillar-Focused Initiatives
- Social Determinants of Health
- Technology Initiatives
- Trained, Diverse Workforce
- Strong Partnerships and Community Engagement
- Business Enterprise Program

FUTURE STATE
Improved Health Outcomes
Equity

- Framework
- Vision
- Mission
- Objectives
- Goals
- Targets

Initiatives

Maternal and Child Health
Moms & Babies Program
Bright Smiles from Birth Program

Child Behavioral Health
IM+CANS Provider Portal
Mobile Crisis Response (MCR) Programs
Specialized Family Support Program

Community-Based Services and Supports
Managed Care Transitions of Care Programs
Community Transitions Initiative

Vision for Improvement—Program Goals

Improve Maternal and Infant Health Outcomes

- **Reduce preterm birth rate and infant mortality**
- **Improve the rate and quality of postpartum visits**
- **Improve well-child visits rates for infants and children**
- **Increase immunization rates for infants and children**

Improve Behavioral Health Services and Supports for Adults

- **Improve integration of physical and behavioral health**
- **Improve transitions of care from inpatient to community-based services**
- **Improve care coordination and access to care for individuals with alcohol and/or substance use disorders**

Improve Behavioral Health Services and Supports for Children

- **Improve integration of physical and behavioral health**
- **Improve transitions of care from inpatient to community-based services**
- **Reduce avoidable psychiatric hospitalizations through improved access to community-based services**
- **Reduce avoidable emergency department visits by leveraging statewide mobile crisis response**

Increase Preventive Care Screenings—Use Data to Identify Target Areas in Priority Regions where Disparities in Optimal Outcomes are the Highest

- **Focus on health equity**

Serve More People in the Settings of Their Choice

- **Increase the percentage of older adults and people receiving institutional care (nursing facilities) to home- or community-based programs to maximize the health and independence of the individual**

The vision for improvement and program goals are inclusive of the populations served by Medicaid, including women and infant health, consumers with behavioral health needs, consumers with chronic conditions, and healthy children and adults with a central focus on health equity. The HFS Quality Strategy framework prioritizes equity across all program goals as the ultimate aim for improvement efforts by analyzing data to strategically pinpoint improvement needs.

As the framework demonstrates, HFS is committed to making equity the foundation of everything it does. HFS defines equity as providing every employee, individual, community, or population what is needed to succeed, so everyone can reach their full potential by examining differences in outcomes for

various populations and working to mitigate negative impacts. In the pursuit of equity, HFS will identify appropriate equity tools to assess the effectiveness of its programs. A key component of equity is incorporating enterprises that are culturally competent with the capability of mitigating challenges across the continuum of healthcare, including the social and structural determinants of health. The State of Illinois' Business Enterprise Program is an integral part of addressing equity, and the goals of the program will be incorporated in how quality is measured.

Section 2. Introduction

Scope

The Illinois Department of Healthcare and Family Services (HFS or the Department) developed its *Comprehensive Medical Programs Quality Strategy* (Quality Strategy) in accordance with the Code of Federal Regulations (CFR) at 42 CFR §438.340 et seq.

The Quality Strategy is designed to foster the delivery of the highest-quality, most cost-effective services possible by establishing a framework for ongoing assessment and the identification of potential opportunities for healthcare coordination and improvement. See Section 1 for further details.

The Quality Strategy's goals and objectives, scope, assessment of performance, improvement interventions, plan for periodic evaluation, and accomplishments are detailed in this Quality Strategy. See a list of acronyms used in this report in Appendix A.

Managed Care Expansion

Statewide

In 2018, HFS expanded its managed care program, HealthChoice Illinois, to cover all counties in Illinois. The rebooted program was designed to enhance care while managing costs to keep the program sustainable in coming years. Expansion included continued efforts to streamline administration, include tools to measure and promote success, and incorporate a coordinated care system that addresses the total health history and needs of each customer such as built-in enhancements for care coordination, quality measures, and whole-person care.

In 2020, HFS' obtained a 1915(b) Waiver to include populations of children with complex health and social service needs in HealthChoice Illinois (see Section 6 for more details).

Six Medicaid managed care health plans (health plans) serve Medicaid customers statewide, including Aetna Better Health (Aetna), Blue Cross Blue Shield of Illinois (BCBSIL) also known as Blue Cross Community Health Plan, CountyCare Health Plan (CountyCare), MeridianHealth (Meridian), Molina HealthCare of Illinois (Molina), and YouthCare.

Transforming Medical Assistance

In the summer of 2019, the Governor enacted a Medicaid overhaul (Senate Bill 1321) to increase the timeliness of applications, redeterminations, and payments to providers; decrease the number of Medicaid claims denials; and to expand transparency throughout the program. Aggressive action before and after has been undertaken through a broad range of strategies to bring down the unacceptable Medicaid backlog that built up over a number of years under previous administrations. The Department has been working closely with key stakeholders, including healthcare associations, hospitals, and other providers that rely heavily on Medicaid to improve efficiencies around billing,

payment, administration, and other systems so that the Department can serve our customers efficiently and effectively.

In addition to addressing backlogs, among the areas of managed care enhancements and reforms addressed by SB 1321 are reimbursement for stays beyond medical necessity, expedited payments, timely payment interest penalties, dispute resolution process, claims rejection/denial management, timely filing extension for eligibility errors, provider effective dates, provider directory updates, operational standardization, medical loss ratios, and value-based payment models. SB 1321 passed with bipartisan support and forms a central part of the Department's wide-ranging improvements and enhancements of Medicaid managed care.

Response to COVID-19 Challenges

In 2020, the coronavirus disease 2019 (COVID-19) swept across our nation leaving in its devastating wake millions of individuals, including Medicaid enrollees, without access to services or protection against the virus. The State immediately jumped into action. HFS pursued numerous flexibilities related to eligibility, coverage, benefits, provider participation, and billing to simplify processes and directly address customers' sudden and dramatically changing healthcare needs during the COVID-19 public health emergency (PHE). While HFS had the authority to implement some flexibilities immediately, including many telehealth flexibilities, the majority required approval from the federal Centers for Medicare & Medicaid Services (CMS) through waivers or state plan amendments (SPAs).

The changes and flexibilities implemented included, but were not limited to, the following: giving the State presumptive eligibility authority and expanding presumptive eligibility for children and pregnant women to up to two times per calendar year (CY); prior authorization requirement suspensions; post-screenings for Preadmission Screening and Resident Review (PASRR); physical signature requirement flexibilities that allow for modes of communication for telehealth that may not be compliant with Health Insurance Portability and Accountability Act of 1996 (HIPAA); provider payments for care in alternate settings; long-term care nurse aid training and certification flexibilities; cost increases for services provided to Home- and Community-Based Services (HCBS) Waiver customers; and reimbursements to encounter rate clinics for virtual check-ins and e-visits outside of their encounter rates. Additionally, HFS amended the health plan contract to cover COVID-19 diagnoses and treatment by non-network providers, added a risk corridor to address the impact of COVID-19 on the utilization of covered services, and allowed initial health plan enrollment through direct auto-assignment to make care coordination service available to customers sooner.

Due to the impact of the pandemic on the health plans' abilities to collect medical record data for hybrid measures, National Committee for Quality Assurance (NCQA) and HFS authorized health plans to rotate measure rates (i.e., report the health plans' Healthcare Effectiveness Data and Information Set [HEDIS®][2-1] 2019 rates in place of the HEDIS 2020 rates) for the hybrid measures.

Building on its investments to fight against the COVID-19 public health and medical emergency, HFS modified the 2020 pay-for-performance (P4P) framework to reinvest in strategies that mitigate the impact of the virus. HFS determined that its quality metrics would be affected in unprecedented ways

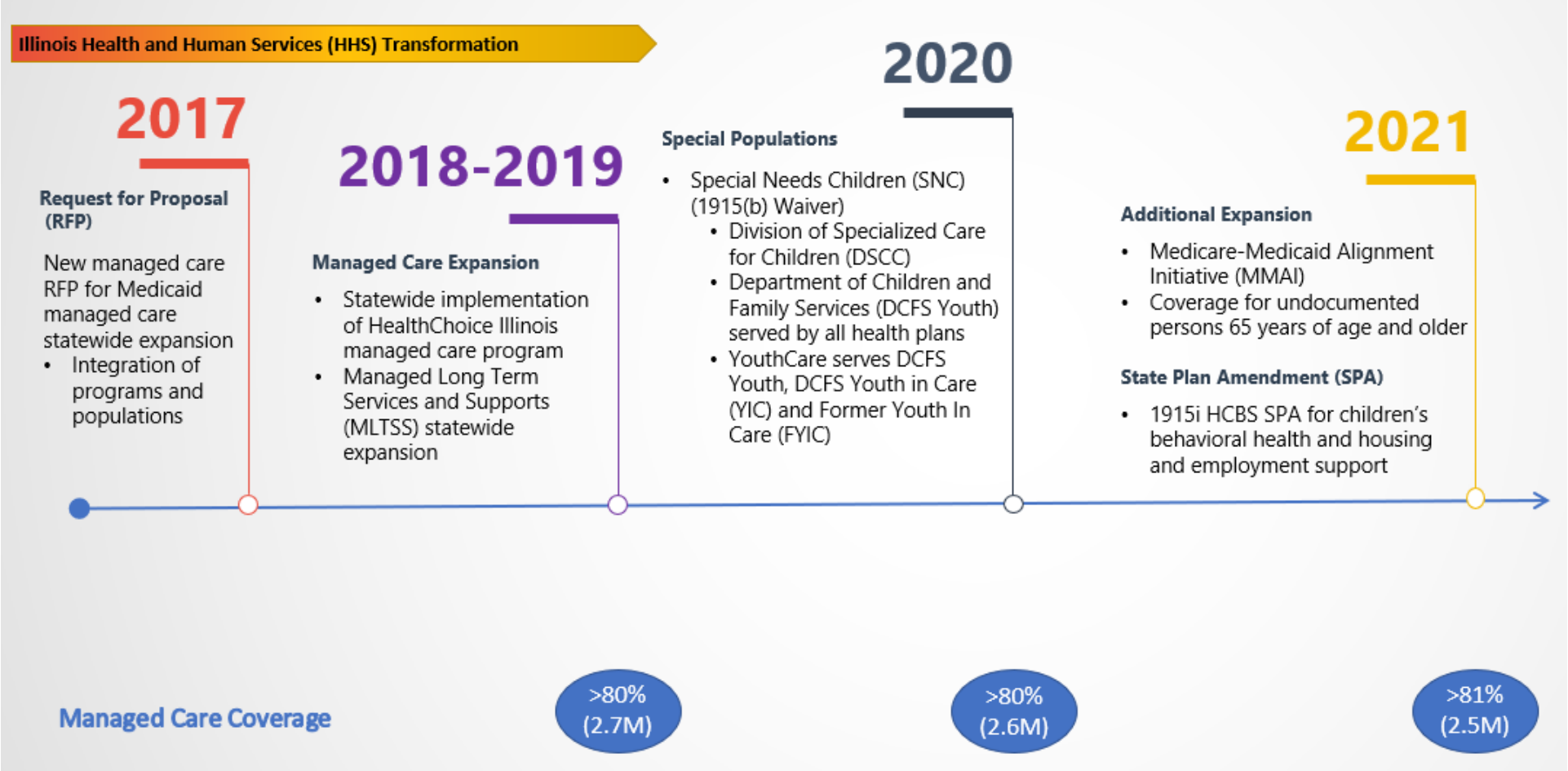
[2-1] HEDIS is a registered trademark of the National Committee for Quality Assurance.

because of changes in utilization associated with the pandemic. Rather than relying on performance metrics disrupted by the pandemic, HFS asked the health plans to submit proposals for how they would invest the funding into Illinois communities. Approximately $100 million of the P4P quality payments was reinvested, as additional capital, into community organizations and providers across Illinois. Investments were directed with a lens toward equity and the greatest impact for organizations and providers that were not already receiving other support. Nearly half of the total redirected quality payments were spent in disproportionately impacted areas.

Health plans invested in critical services and initiatives to help Medicaid customers and providers during the pandemic, such as increasing reimbursement rates for behavioral health providers; expanding telehealth capabilities and infrastructure; contracting with vendors and community-based organizations owned by minorities, women, and people with disabilities to increase community engagement in African American and Latin communities which were the hardest hit by the pandemic; providing technology assistance; extending housing benefits; and providing food and funding to school-based health centers.

Managed Care Timeline

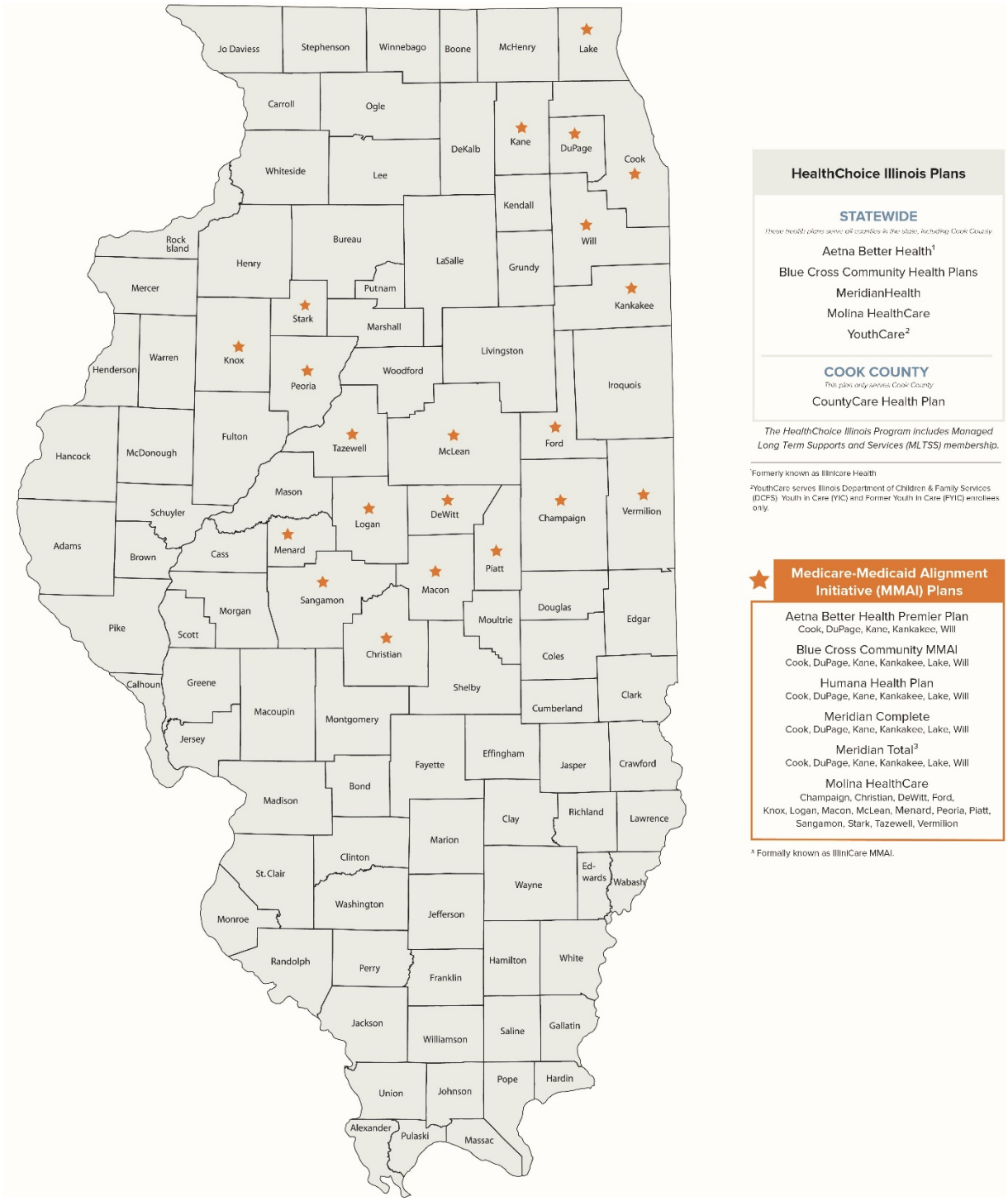
Figure 2-1—Managed Care Timeline



Managed Care Expansion Map

This map graphically displays the Medicaid Reform Care Coordination Expansion in Illinois as of September 2020.

Figure 2-2—HealthChoice Illinois Managed Care Program Map



Managed Care Programs

HFS medical programs pay for a wide range of health services, provided by thousands of medical providers throughout Illinois. The primary medical programs are:

- Medical Assistance, as authorized under the Illinois Public Aid Code (305 ILCS 5/5 et seq.) and Title XIX of the Social Security Act, Medicaid.
- Children's Health Insurance, as authorized under the Illinois Insurance Code (215 ILCS 106/1 et seq.) and Title XXI of the Social Security Act, the State Children's Health Insurance Program (SCHIP).

Most people who enroll are covered for comprehensive services, including but not limited to doctor visits and dental care, well-childcare, immunizations for children, mental health and substance abuse services, hospital care, emergency services, prescription drugs, and medical equipment and supplies. Some programs, however, cover a limited set of services.

With managed care statewide expansion, most Medicaid customers in Illinois are served through HealthChoice Illinois. HealthChoice Illinois health plans provide the full spectrum of Medicaid-covered services to the general Medicaid population through an integrated care delivery system. Populations/services covered include:

- Families and children eligible for Medicaid through Title XIX or Title XXI (Children's Health Insurance Program).
- Affordable Care Act expansion Medicaid-eligible adults.
- Medicaid-eligible adults with disabilities who are not eligible for Medicare.
- Medicaid-eligible older adults who are not eligible for Medicare.
- Dual-eligible adults who are receiving long term services and supports (LTSS) in an institutional care setting or through a HCBS Waiver, excluding those receiving partial benefits who are enrolled in the Illinois Medicare-Medicaid Alignment Initiative (MMAI), or are subject to other exclusions.
- Special needs children, defined as customers under the age of 21 who are eligible for Medicaid through Supplemental Security Income (SSI), DSCC, or a disability category of eligibility.
- Children in the care of the Department of Children and Family Services (DCFS Youth), including those formerly under this care who have been adopted or who entered a guardianship.
- Managed Long Term Services and Supports (MLTSS) and waiver services (including the Elderly Waiver, Supportive Living Program, and Division of Rehabilitation Services).

However, the MMAI program continues to operate under a separate three-way contract between HFS, CMS, and the health plans. Statewide expansion is scheduled for 2021.

Managed Care Enrollment

HealthChoice Illinois provides comprehensive healthcare coverage to more than 2.3 million Illinoisans. Enrollment figures as of June 2020 are displayed in Table 2-1. More detailed enrollment, including enrollment by health plan, by gender and age, and by ethnicity can be found in Appendix B.

Table 2-1—Illinois Medicaid Enrollment

Program Type	June 2020 Enrollment
HealthChoice Illinois	2,592,122
MLTSS	60,502
MMAI	51,592
Total Customers	**2,704,216**

Quality Management Structure

The **Bureau of Managed Care** administers and monitors HFS' managed care/care coordination programs. The **Bureau of Quality Management** is purposed to improve healthcare quality for HFS customers in Illinois. Together, these bureaus work to administer initiatives and programs to help customers improve their health status by ensuring the highest-quality, most cost-effective services possible to meet their needs, including disease management, hospital quality and utilization management, interfaces between primary care and behavioral health, as well as ongoing assessment and analysis of potential opportunities for healthcare coordination and improvement. The Quality Strategy establishes clear aims, goals, and objectives to drive improvements in care delivery and health outcomes as well as metrics by which progress will be measured.

The bureaus are responsible for developing an overarching agency quality improvement strategy, coordinating agency-wide quality initiatives and overseeing the development of outcome measurements, and implementing quality improvement projects (QIPs) for current providers and managed care/care coordination programs. They evaluate the quality and effectiveness of Medicaid-funded programs by systematically monitoring and evaluating the quality of care and services; overseeing the design, implementation, monitoring, and evaluation of the quality management activities statewide; and developing and implementing a quality management workplan that identifies specific activities, measures, indicators, and health equity that are the focus of the Quality Management program. The Quality Strategy supports the mission and vision of HFS.

The bureaus are also responsible for oversight, monitoring, and evaluation of quality assurance to ensure health plans are in compliance with State standards, federal regulations, and contract requirements. HFS monitors each health plan's compliance with its contract, and with the goals and objectives identified in the Quality Strategy, via its internal quality management program and on-site reviews of compliance with various quality assessment/improvement standards. HFS' external quality review organization (EQRO), Health Services Advisory Group, Inc., conducts compliance reviews at least once every three years. The purpose of the reviews is to determine a health plan's understanding and application of federal regulations and contractually required standards from a review of documents, observations, and interviews with key health plan staff, as well as file reviews conducted during an on-

site evaluation. The reviews include an assessment of each plan's quality improvement structure. This structure is necessary in facilitating quality improvement of performance measures and performance improvement projects (PIPs), which measure each health plan's performance in achieving quality goals and objectives identified in the Quality Strategy. The report enables the health plans to implement improvement interventions to correct any areas of deficiency. The report also helps HFS determine each health plan's compliance with the contract and identify contractual areas that need to be modified or strengthened to ensure that a health plan complies with the standards and can achieve the goals and objectives identified in the Quality Strategy.

HFS routinely conducts quality driven meetings to discuss progress/outcomes, facilitate staff education, promote equity initiatives, and promote quality-related information specific to health plan performance.

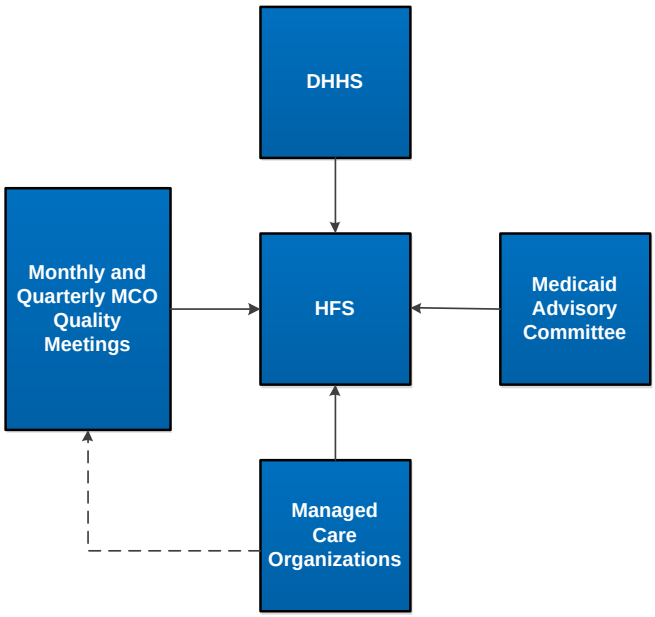
HFS holds monthly conference calls and quarterly meetings with health plans to provide a forum for discussion of quality of care and outcomes for Illinois Medicaid customers. During these meetings, HFS and health plan staff review and discuss performance measure results, PIP results, and whether the quality improvement outcomes align with the Quality Strategy goals and objectives. The meetings shall include representatives from the Managed Care Organization Quality Team, Bureau of Quality Management, Bureau of Managed Care, and other units who have a vested interest in the topic being discussed. The representatives will discuss quality objectives and policies and procedures, as well as provide resources and guest speakers to discuss outcomes and evidence-based interventions. Quarterly Monitoring Reports to are submitted to the Bureau of Quality Management for review and discussion during the Quarterly Quality Meeting. These quarterly reports shall include data relative to the quality measures identified, member and provider outreach, and any new initiatives related to the quality measures. In an effort to align health plan reporting, a template was created identifying general and specific reporting instructions to provide essential guidance to effectively compare performance. Further, the health plans are required to present information on quality improvement results, barrier analyses, and planned quality improvement activities to be implemented to overcome obstacles that impede performance.

HFS is committed to the delivery of equitable access of its programs and services removing disparate impact on its customers by ensuring each population gets what they need to thrive. HFS will work with service providers, vendors, and contractors to institute approaches that prioritize equity and remove conditions and barriers to achieve optimal outcomes for customers. HFS further commits to engaging with customers who will have input in decision-making and opportunities to assist in advancing racial equity. HFS is committed to making equity the foundation of everything it does.

HFS meets with the health plans independently for monthly operations meetings and quarterly business reviews (QBRs) to monitor plan performance. Each plan is asked to provide HFS with a presentation on its recent activities and developments. These meetings serve as an interactive environment for open communication between health plans and HFS. This time also provides the opportunity for the health plans to ask any operational questions or receive assistance from HFS. HFS is interested in seeing what works well for the health plans, what needs improvement, any planned future developments, and what HFS can do to help. On-site visits enhance HFS' ability to oversee the health plans and build relationships with plan leadership. As the quarterly operations meetings progress, HFS is anticipating an overall presentation of each health plan's latest data, achievements, and issues/concerns. In addition, the Medicaid Advisory Committee (MAC) advises HFS with respect to

policy and planning related to the health and medical services provided under HFS' medical programs pursuant to federal Medicaid requirements established at 42 CFR §431.12. The MAC consists of up to 15 members, at least five of whom must be consumers or advocates. The MAC meets six times a year and currently has five subcommittees: Quality Care, Public Education, Pharmacy, Health Equity, and Telemedicine. The subcommittees are supported by workgroups.

Figure 2-3—Illinois HFS Quality Strategy Organizational Structure



Contracting for Managed Care

Right Care, Right Time, Right Place

Effective managed care expansion has been central to the Department's planning as it offers a way to deliver enhanced health coordination and quality services with the promise of reduced and predictable costs. Robust data collection, transparency and accountability, and clear performance targets are necessary to achieve true cost-effectiveness while also improving quality. HFS is working closely with key stakeholders to improve efficiencies around billing, payment, administration, and other systems. HFS believes managed care enhances HFS' ability to offer the right care, at the right time, in the right place. The graphic below outlines the primary potential benefits of implementing statewide managed care.

Paying for Value

Evidence-based practices in service delivery to move from fee-for-service (FFS) to value-based payment. HFS is focusing on helping with treatment of high-volume, costly, high-risk, and preventable conditions. Risk and performance must be tied to reimbursement to continue to transform the Medicaid healthcare delivery system to one with a focus on improved health outcomes.

Care Coordination

Public Act 96-1501 required that at least 50 percent of all Medicaid recipients eligible for full benefits would be enrolled in care coordination, which means the deliberate organization of patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care.[2-2] As of January 2021, over 70 percent of managed care customers are enrolled in care coordination.

1915(b) Waiver Programs

To extend the benefits of managed care, HFS obtained 1915(b) or 1915(c) Waivers to include the following populations in HealthChoice Illinois:

1. Managed Long Term Services and Supports.
2. Home- and Community-Based Services.
3. Special Needs Children, including children from the DSCC Core Program and DCFS Youth.

Tech Integration

When the IMPACT initiative is fully implemented, HFS' state-of-the-art technology platform serving a single statewide managed care system will allow for efficient and effective reporting, analytics, and timely decision making which enhances program integrity and increases efficiency while reducing costs.

[2-2] Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies: Volume 7—Care Coordination. Publication No. 04(07)-0051-7, June 2007. Agency for Healthcare Research and Quality, Rockville, MD. Available at: http://www.ahrq.gov/clinic/tp/caregaptp.htm. Accessed on: October 17, 2012.

Goals and Objectives

To support health equity and HFS' mission and to drive progress in the five pillars of improvement, HFS restructured its P4P program in 2020.

P4P Baseline Measures

Collection of baseline rates for the P4P program begins in measurement year (MY) 2019 (reporting year [RY] 2020) for the following P4P measures.

Better Care

Pillar: Adult Behavioral Health

1. *Follow-Up After Hospitalization for Mental Illness (FUH)*
    - *7-Day*
    - *30-Day*
2. *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)*
    - *7-Day*
    - *30-Day*

Pillar: Child Behavioral Health

1. *Follow-Up After Hospitalization for Mental Illness (FUH)*—6–17 years of age stratification
    - *7-Day*
    - *30-Day*
2. *Follow-Up After Emergency Department Visit for Mental Illness (FUM)*—6–17 years of age stratification
    - *7-Day*
    - *30-Day*

Pillar: Maternal and Child Health

1. *Prenatal and Postpartum Care (PPC)*
    - *Timeliness of Prenatal Care*
    - *Postpartum Care*
2. *Childhood Immunization Status (CIS)—(Combo 3)*

Healthy People/Healthy Communities

Pillar: Equity

1. *Breast Cancer Screening (BCS)*
2. *Cervical Cancer Screening (CCS)*
3. *Controlling High Blood Pressure (CBP)*
4. *Adults' Access to Preventive/Ambulatory Health Services (AAP)*

Pillar: Community-Based Services and Supports

Measures for this pillar are included as reporting measures until baseline rates and health plan performance on the measures are established

Reporting Measures

HFS has also identified a portion of the P4P withhold to incentivize the reporting of the following measures that will be incorporated as P4P measures in subsequent years.

Better Care

Pillar: Adult Behavioral Health

1. *Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)*
    - *7-Day*
    - *30-Day*
2. *Pharmacotherapy for Opioid Use Disorder (POD)*

Pillar: Child Behavioral Health

1. *Mobile Crisis Response Services That Result in Hospitalization*
2. *Visits to the Emergency Department Visit for Behavioral Health Services That Result in Hospitalization*
3. *Overall Number and Length of Behavioral Health Hospitalizations*
4. *Number of Repeat Behavioral Health Hospitalizations*

Pillar: Maternal and Child Health

1. *Well-Child Visits in the First 30 Months of Life (W30)*
2. *Child and Adolescent Well-Care Visits (WCV)*
3. *Annual Dental Visit (ADV)*—Age Groups: 2–3 years, 4–6 years, 7–10 years, 11–14 years, 15–18 years, and 19–20 years
4. *Childhood Immunization Status (CIS)—(Combo 10)*

Healthy People/Healthy Communities

Pillar: Equity

1. HIV Viral Load Suppression
2. Gap in HIV Medical Visits
3. Prescription of HIV Antiretroviral Therapy

Pillar: Community-Based Services and Supports

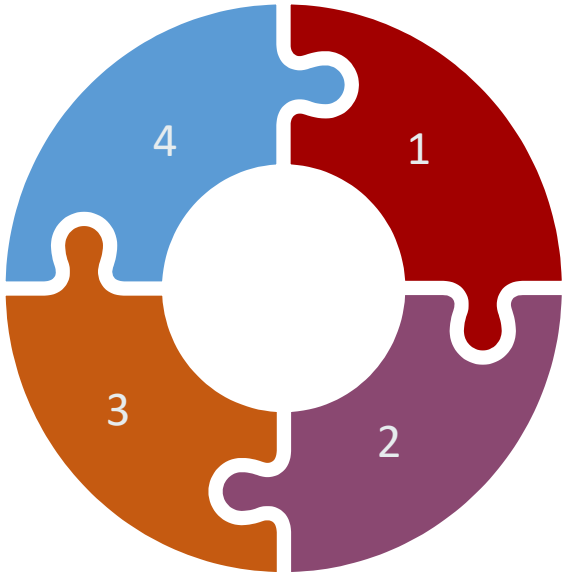
1. LTSS Comprehensive Care Plan and Update
2. Successful Transition after Long-Term Care Stay

Development and Review of the Quality Strategy

HFS meets the requirements for development, evaluation, revision, and availability of the Quality Strategy as described in §438.340(c) and (d).

Developing a Quality Strategy

HFS obtains input from customers and stakeholders as well as the MAC in drafting and revising the Quality Strategy.



Review

HFS reviews and updates the Quality Strategy as needed, but no less than every three years. Reviews include evaluation of the effectiveness of the Quality Strategy using data from multiple data sources. Results of reviews are made available on HFS' website.

Public Comment

The Quality Strategy is shared with stakeholders for public comment. HFS takes recommendations into consideration before submitting the strategy to CMS for review.

Updates

Updates are made as necessary based on health plan performance; stakeholder input and feedback; achievement of goals; changes resulting from legislative, State, federal, or other regulatory authority; and/or significant changes to the Medicaid program. HFS considers statewide expansion or the addition of new programs/delivery systems as significant changes that necessitate updates to the Quality Strategy. HFS submits the Quality Strategy to CMS as required and makes the strategy available on its website required by §438.10(c)(3).

Additional Information

For more information about HealthChoice Illinois, visit: https://enrollhfs.illinois.gov/news/healthchoice-illinois.

For additional information about Medicaid programs, eligibility, enrollment, and HFS, visit: https://www.illinois.gov/hfs/MedicalClients/Pages/default.aspx.

Section 3. Assessment

Assessing and Improving the Quality of HealthCare and Services

As required in CFR §438.340, this section describes HFS' strategies for assessing and improving the quality of healthcare and services furnished by its Medicaid managed care health plans. Table 3-1 summarizes HFS' assessment strategies for each federal regulation designated in CMS' Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule (Final Rule) as requirements of HFS' Quality Strategy.[3-1]

Table 3-1—HFS Strategies to Assess and Improve the Quality of HealthCare and Services

42 CFR	Summary of Requirement	HFS Strategy
§438.334	Adopt a Medicaid managed care quality rating system in accordance with CMS requirements.	HFS implemented the HealthChoice Illinois Plan Report Card. This **quality rating system (QRS)** helps customers pick the health plan that is best for them by showing each plan's performance in providing care and services to its customers for specific measures in key performance areas. HFS produces a statewide report card and a Cook County report card, both of which are available online. See Appendix C. In 2021, HFS will evaluate its QRS to determine if revisions are needed based on the revised Quality Strategy and alignment to the new P4P program. HFS will also revise its QRS to comply with the minimum set of mandatory performance measures in CMS' MAC QRS framework when it is published.
§438.340(b)(1)	State-defined quantitative network adequacy standard and availability of services standards. Validation of health plan network adequacy during the preceding 12 months to comply with requirements set forth in §438.68 and §438.206.	**Provider Network Capacity Reviews** conducted by the EQRO include the types of providers specified in §438.68 as well as LTSS providers. Quarterly monitoring is conducted for HealthChoice Illinois and LTSS. As specified in §438.68(b)(iv), HFS defines specialists in whatever way is deemed most appropriate for their programs. **Network Capacity Readiness Reviews** to monitor the capacity of each health plan's provider network in the expansion counties, including LTSS providers.

[3-1] Medicaid.gov. Medicaid and CHIP Managed Care Final Rule. Available at: https://www.medicaid.gov/medicaid/managed-care/guidance/final-rule/index.html. Accessed on: November 3, 2020.

Table 3-1—HFS Strategies to Assess and Improve the Quality of HealthCare and Services

42 CFR	Summary of Requirement	HFS Strategy
		Annual Time and Distance Annual Analysis implemented by HFS and conducted by the EQRO to evaluate the degree to which health plans are complying with the time and distance network standards as outlined in the model Medicaid contract. **Geographic Distribution Tables and Maps** must be generated by health plans to plot enrollee and network provider locations by ZIP Code and analyze the information, considering the prevalent modes of transportation available to enrollees, enrollees' ability to travel, and enrollees' ability to be in an office setting. The results must be reported to HFS as requested. **Access and Availability Surveys** implemented by HFS and conducted by the EQRO to evaluate appointment availability and after-hours access among the health plans' networks by utilizing secret shopper telephone surveys for primary care providers (PCPs), obstetricians/gynecologists (OB/GYNs), dental and specialty providers. Health plans are also required to monitor appointment availability as part of their access and availability plan. **Monitoring of Other Network Adequacy Indicators** is contractually required by health plans including: enrollee and provider complaints related to access; call center requests from enrollees, providers, advocates, and external organizations for help with access; and the percentage of completely open primary care provider panels versus the percentage open only to existing patients.
§438.340(b)(1)	Examples of evidence-based clinical practice guidelines the State requires in accordance with §438.236.	HFS requires health plans to incorporate **practice guidelines** that meet nationally recognized standards and that: • Are based on valid, reliable clinical evidence. • Consider the needs of enrollees. • Are adopted in consultation with network providers. • Are reviewed and updated periodically as appropriate. All clinical practice guidelines shall be based on established evidence-based best practice standards of care, promulgated by leading academic and national clinical organizations, and shall be adopted by the contractor's quality improvement plan (QAP) Committee with sources referenced and guidelines documented in the contractor's QAP.

Table 3-1—HFS Strategies to Assess and Improve the Quality of HealthCare and Services

42 CFR	Summary of Requirement	HFS Strategy
§438.340(b)(3)(i)	Description of the quality metrics and performance targets to measure the performance and improvement of each health plan.	HFS collects quarterly Managed Care Organization Performance Reporting (MPR) data from all health plans. QBR thresholds are set for a variety of metrics in the categories of New Enrollee Screening and Assessments, Enrollee Engagement: Risk Stratification, and Provider and Enrollee Service Call Center. A range of other metrics are collected quarterly, and HFS will continue to set QBR thresholds for these metrics, including enrollee plans of care, maternity dental services, enrollee grievances and appeals, claims, prior authorizations, and provider disputes.
§438.340(b)(3)(i)(i)	Mandatory PIPs.	HFS implemented the Institute for Healthcare Improvement's (IHI's) rapid-cycle performance improvement approach for PIPs in 2019, which places a greater emphasis on improving outcomes using quality improvement science. HFS requires HealthChoice Illinois health plans to **conduct PIPs** and MMAI health plans to conduct QIPs. All health plans are required to participate in two mandatory PIPs: The *Follow-up After Hospitalization for Mental Illness (FUH)* PIP (behavioral health [BH] PIP) and a *Transition of Care* PIP (TOC PIP). The TOC PIP focuses on patient engagement after inpatient discharge. The BH PIP aims to reduce the rate of avoidable behavioral health-related rehospitalization. The HEDIS *FUH* measure is the study indicator for this PIP since it is an industry standard for measurement of transitions in care between inpatient and behavioral health outpatient levels of care.
§438.340(b)(4)	Arrangements for annual, external independent reviews of the quality outcomes and timeliness of, and access to, the services covered by the health plans.	HFS contracted with its EQRO to perform the external quality review (EQR) activities newly required by the Final Rule. See the "External Quality Review" section.
§438.340(b)(5)	A description of the State's Transition of Care (TOC) policy.	HFS requires health plans to **manage TOC** and continuity of care for new enrollees and for enrollees moving from an institutional setting to a community living arrangement. Health plans are required to submit a TOC Plan to HFS initially and when there are updates to the plan. HFS requires health plans to implement a quality improvement plan to address the EQR recommendations to improve the effectiveness of care transitions. To comply with §438.62, HFS account managers oversee the implementation of health plans' quality improvement plan for improving TOCs and monitor progress through weekly and quarterly

Table 3-1—HFS Strategies to Assess and Improve the Quality of HealthCare and Services

42 CFR	Summary of Requirement	HFS Strategy
		meetings with the health plans. In addition, all health plans are required to participate in a TOC PIP. Under the new Community Transitions Initiative (CTI), HealthChoice Illinois plans may receive incentive payments for the successful transition of customers living in skilled nursing facilities and specialized mental health rehabilitation facilities.
§438.340(b)(6)	State's plan to identify, evaluate, and reduce health disparities based on age, race, ethnicity, sex, primary language, and disability status.	HFS developed the following new goals for its Quality Strategy to focus improvement efforts on the reduction of health disparities: 1. Identify and prioritize reducing health disparities. 2. Implement evidence-based interventions to reduce disparities. 3. Invest in the development and use of health equity performance measures. 4. Incentivize the reduction of health disparities and achievement of health equity. P4P measures have been selected to evaluate performance in the following categories: Male, Female, African-American, and Hispanic. HFS identifies the **race, sex, age, ethnicity, disability status, primary language spoken**, and **waiver type** for each Medicaid beneficiary and provides this information to the health plans at the time of enrollment. The Illinois Client Enrollment Broker (CEB) transmits an enrollment file containing race/ethnicity and primary language of each enrollee to the health plans monthly. Health plans are required to develop and implement a **cultural competency plan**, offer appropriate foreign language versions of all beneficiary materials, and develop member materials which can be easily understood at a sixth-grade reading level. The plan is submitted to HFS for approval. Health plans are required to offer trainings to health plan staff and network providers. Health plans are required to monitor network provider compliance with **Americans with Disabilities Act (ADA) requirements**. The health plans also make ADA access information available in the online and hard copy provider directory. Health plans are required to proactively attempt to hire staff who reflect the diversity of enrollee demographics. Plan staff are required to complete linguistic and cultural competence training upon hire and no less frequently than annually.

Table 3-1—HFS Strategies to Assess and Improve the Quality of HealthCare and Services

42 CFR	Summary of Requirement	HFS Strategy
		Health plans are required to have a process to verify subcontractors' and provider network's compliance with the health plans' Cultural Competency Plan. Health plans are required to collaborate with community-based organizations to address social determinants of health, assess beneficiary needs, formulate collaborative responses, and evaluate outcomes for community health improvement and eliminating health disparities.
§438.340(b)(7)	Appropriate use of intermediate sanctions for health plans.	HFS sets forth the right to impose civil money penalties, late fees, and performance penalties (collectively, "monetary sanctions"), and other sanctions, on health plans for failure to substantially comply with the terms of the contract with HFS. Sanctionable events are included in the Medicaid model contract.
§438.340(b)(9)	State's mechanisms to identify persons who need LTSS or persons with special healthcare needs and specify those mechanisms in the Quality Strategy.	HFS has had a mechanism in place since 2012 to identify persons who need LTSS services and children with special healthcare needs using a program code in the enrollment file. HFS requires health plans to have specific mechanisms in place to identify individuals who need LTSS services or have special healthcare needs. Health plans are required to have a full-time LTSS program manager who oversees the LTSS program and acts as a liaison among LTSS statewide agency liaisons. HFS requires health plans to conduct comprehensive assessments for individuals in need of LTSS as well as special healthcare needs by qualified service coordinators. To assess satisfaction of customers with special needs, HFS added supplemental questions to the health plan Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[3-2] surveys that include the HCBS population as well as adults with mental health conditions. Questions covering children with special healthcare needs were added to the HFS statewide CAHPS survey. HFS **defines special healthcare needs** children as children under the age of 21 who are eligible under the Medicaid Program pursuant to Article III of the Public Aid Code (305 ILCS 5/3-1 *et seq.*) or Medicaid-eligible and eligible to receive benefits pursuant to Title XVI of the Social Security Act. Children with special healthcare needs (CSHN) also include

[3-2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.

Table 3-1—HFS Strategies to Assess and Improve the Quality of HealthCare and Services

42 CFR	Summary of Requirement	HFS Strategy
		Medicaid-eligible children under the age of 21 who receive services under the Specialized Care for Children Act (110 ILCS 345/0.01 *et seq*.) via the Division of Specialized Care for Children (DSCC) or other such entity that the Department may designate for providing such services and CSHN as specified in Section 1932 (a)(2)(A) of the Social Security Act. HFS requires health plans to have a **special healthcare needs plan** to conduct timely identification and screening, comprehensive assessments, and appropriate case management services. Compliance is reviewed by HFS' EQRO. HFS monitors quality and appropriateness of services for customers with LTSS and special healthcare needs through compliance monitoring activities and regular review of health plan reporting. Health plans are required to have a consumer advisory board. Health plans are required to identify a liaison who will be a consumer advocate for high-needs children. The individual is responsible for internal advocacy for these enrollees' interests, including input in policy development, planning, decision-making, and oversight.
§438.340(b)(10)	Nonduplication of mandatory activities with Medicare or accreditation review.	HFS requires all health plans to obtain **NCQA accreditation**. All six health plans have obtained NCQA accreditation. HFS will consider conducting a nonduplication review of mandatory activities now that all HealthChoice Illinois plans have achieved NCQA accreditation.

National Performance Measures

Core Measure Sets

CMS publishes sets of core measures programs to aid in the assessment of the quality of care and health outcomes for adults participating in Medicaid and children enrolled in Medicaid and CHIP. The core sets are for voluntary use by state Medicaid and CHIP and include a range of quality measures encompassing both physical and mental health.

HFS includes a number of core set measures in its quality monitoring program and requires health plans to report results, as listed below. Measures with an asterisk are included in the revised P4P program.

Adult Core Set

- *Cervical Cancer Screening**
- *Chlamydia Screening in Women Ages 21 to 24*
- *Breast Cancer Screening**
- *Prenatal and Postpartum Care: Postpartum Care**
- *Controlling High Blood Pressure**
- *Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control*
- *HIV Viral Load Suppression**
- *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment*
- *Follow-Up After Hospitalization for Mental Illness: Age 18 and Older**
- *Use of Pharmacotherapy for Opioid Use Disorder**
- *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence**
- *Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H—Adult Version**

Child Core Set

- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
- *Childhood Immunization Status**
- *Well-Child Visits in the First 30 Months of Life**
- *Immunizations for Adolescents*
- *Child and Adolescent Well-Care Visits**
- *Prenatal and Postpartum Care: Timeliness of Prenatal Care**
- *Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17**
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics*
- *Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H – Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items**

State Monitoring

Monitoring System

As required in CFR §438.66, this section describes HFS' monitoring system which addresses all aspects of the managed care program, including the performance of each health plan in the areas designated in the CFR, as summarized in Table 3-2. The table also indicates areas that are included as key indicators in health plan scorecards. Scorecards are a key component of HFS' monitoring system, developed to depict health plan performance on key metrics and performance indicators. The scorecards are reviewed quarterly. See the scorecard example in Appendix C.

Table 3-2—HFS Monitoring System

42 CFR	Summary of Requirement	HFS Monitoring	EQRO Monitoring
§438.66(b)(1)	Administration and management.	HFS has established key required position requirements for the administration and management of key operational areas/positions for the health plans.	Key required positions are reviewed during readiness and administrative reviews.
§438.66(b)(2)	Appeal and grievance systems. 	Health plans are required to maintain a health information system that collects, analyzes, integrates, and reports appeal/grievance data. See the grievance system requirements in Appendix D. Quarterly grievance and appeal report including summary count and outcomes. Reports are monitored and trended. Health plans are required to identify outliers and action plans for improvement. HFS hosts a **provider resolution portal** for providers to submit complaints to HFS about issues they are experiencing with health plans in an electronic, secure format. Providers' complaints are reviewed	Grievance and appeal file reviews are conducted during the administrative compliance reviews to determine compliance with contract standards regarding the intake and timeliness of processing grievances and appeals. Health plan grievance and appeals systems are evaluated during readiness and administrative reviews. The provider complaint resolution process is reviewed during readiness and administrative reviews.

Table 3-2—HFS Monitoring System

42 CFR	Summary of Requirement	HFS Monitoring	EQRO Monitoring
		and resolved in compliance with the portal resolution timeframes to encourage communication between the two entities and to ensure fair resolution of disputes. HFS tracks and reports the volume of complaints received and resolved to each health plan as part of the QBR process and will be developing complaint trend reports to post on the portal home page beginning in 2021. Health plans are required to have a **provider complaint resolution process** which is linked to the HFS resolution portal for provider education efforts.	
§438.66(b)(3)	Claims management. Key Scorecard Indicator	Health plans are required to submit the following claims and encounter management reports: • Monthly encounter data report. • Monthly adjudicated claims inventory summary. • Monthly pharmacy claims monitoring report. • Quarterly report of percent of denied or rejected claims.	An enrollment and claims system review was conducted during 2017 as part of the HealthChoice Illinois program readiness reviews.
§438.66(b)(4)	Enrollee materials and customer services, including the activities of the beneficiary support system. Key Scorecard Indicator	All enrollee materials must be approved by HFS initially and as revised. Enrollee service call center reporting metrics are monitored through the scorecard and quarterly health plan reporting in the MPR and QBR processes. HFS offers a variety of avenues for an individual to receive education and enrollment assistance under its beneficiary support system, including an enrollment call center that provides education and	The readiness and administrative reviews include a review of enrollment materials and review of service level agreement (SLA) reporting for the member services for each health plan.

Table 3-2—HFS Monitoring System

42 CFR	Summary of Requirement	HFS Monitoring	EQRO Monitoring
		enrollment assistance, a secure online enrollment portal, program web pages, and the availability of education and enrollment materials in other formats or languages (auxiliary aids) when requested.	
§438.66(b)(5)	Finance, including medical loss ratio (MLR) reporting.	Quarterly unaudited financial reports and annual audited financial reports. HFS defers review of the MLR reporting to the Department of Insurance (DOI). Annual submission of benefit expense claims for each MLR reporting year, including an attestation to the accuracy of all data and of the MLR calculation. Health plans are also required to collect all underlying data associated with MLR reporting from any third-party vendors and to calculate and validate the accuracy of MLR reporting. Each health plan must submit an annual cost report that provides a reconciliation of its audited financial statement to the annual cost report. The reconciliation must be reviewed and certified by an independent auditor or by an executive officer of the health plan.	The EQRO does not monitor this requirement.
§438.66(b)(6)	Information systems, including encounter data reporting.	Health plans submit a monthly encounter data report, and HFS conducts two levels of review. The review includes a check for completeness and accuracy of the data, and health plans are required to correct and resubmit the data if errors are identified.	An enrollment and claims system review is conducted for the HealthChoice Illinois program readiness reviews.
§438.66(b)(7)	Marketing.	All marketing materials, plans, and procedures must be approved initially and as revised.	The EQRO does not monitor this requirement.

Table 3-2—HFS Monitoring System

42 CFR	Summary of Requirement	HFS Monitoring	EQRO Monitoring
§438.66(b)(8)	Medical management, including utilization management and case management.  	**Care Management** Care management and disease management program descriptions are submitted initially and as revised. Health plans are required to submit the following monthly and quarterly reports: • Monthly care coordination effectiveness summary report. • Annual care gap plan. • Quarterly outreach summary report. • Quarterly enrollee engagement metrics. • Transition of care plan, initially and as revised. • Care management metrics are also monitored through the scorecard. **Utilization Management** Health plans are required to submit the following monthly utilization management (UM) reports: • Monthly prior authorization report. • Monthly utilization management report, pharmacy utilization monitoring report, psychotropic review report, and drug utilization report. • Utilization metrics are also monitored through the scorecard.	The readiness and administrative reviews include utilization management and care management program requirements and case file reviews. The EQRO also conducts a care management/care coordination (CM/CC) staffing, qualifications, and training review to review the educational qualifications, related experience, annual training hours, full-time equivalency (FTE) allocation, and caseloads of CM/CC staff serving the Medicaid managed care population against state-selected requirements.

Table 3-2—HFS Monitoring System

42 CFR	Summary of Requirement	HFS Monitoring	EQRO Monitoring
§438.66(b)(9)	Program integrity.	Health plans are required to submit the following program integrity reports: • Quarterly fraud and abuse report. • Annual certification to confirm compliance of each contractor and its subcontractors. • Recipient verification procedure, initially, annually, and as revised. • Fraud, Waste, and Abuse (FWA) compliance plan.	Review of the FWA compliance plan, reporting, training, and mechanisms in place to detect FWA is conducted during readiness and administrative reviews.
§438.66(b)(10)	Provider network management, including provider directory standards. 	Monthly provider directory attestation reports. Quarterly review of health plan network capacity status. Provider metrics are also monitored through the scorecard.	Review of provider contracts for the following provider types: ancillary, facility, federally qualified health center (FQHC), hospital, physician hospital organization (PHO), and provider. The EQRO reviews a template contract against 15 elements to determine compliance with requirements. A review of the health plan provider complaint resolution process is conducted during the readiness review. Compliance with provider directory standards is reviewed during the readiness and administrative reviews.

Table 3-2—HFS Monitoring System

42 CFR	Summary of Requirement	HFS Monitoring	EQRO Monitoring
§438.66(b)(11)	Availability and accessibility of services, including network adequacy standards. 	Health plans are required to submit the following weekly and monthly provider network reports: • Weekly PCP, hospital, and affiliated specialist file (CEB Provider File). • Monthly provider network file (complete). • Provider site closures/terminations notification (as each occurs). • Network access metrics are also monitored through the scorecard.	Biannual provider network monitoring for HealthChoice Illinois and LTSS. Biannual network provider capacity reviews. Network capacity reviews as part of administrative and readiness reviews. Ad hoc network capacity analysis. Review of health plan provider access and appointment availability audit results to assess health plans' monitoring of provider compliance with appointment availability and after-hours access standards. Annual analysis of time/distance standards for specific network providers including PCPs, OB/GYNs, behavioral health, specialists, hospitals, pharmacy, and adult and pediatric dental.
§438.66(b)(12)	Quality improvement. 	Health plans are required to submit the following quarterly and annual reports: • A Quality Assessment and Performance Improvement (QAPI) program description annually and evaluate the effectiveness of the QAPI program as indicated in the annual Quality Assurance, Utilization Review, and Peer Review (QA/UR/PR) Report/Program Evaluation. • Adult and child CAHPS results are reported in the health plan's annual QAPI evaluation report.	Review of the QAPI program description and annual QAPI evaluation report. Administrative, readiness, and focused reviews. PIPs. The EQR report includes the results of the CAHPS surveys, quality measures, and all EQR mandatory and optional activities conducted during the preceding 12 months.

Table 3-2—HFS Monitoring System

42 CFR	Summary of Requirement	HFS Monitoring	EQRO Monitoring
		• Quarterly HEDIS measure rates report. • Submission of QA/UR/PR committee meeting minutes at the request of HFS.	
§438.66(b)(13)	Areas related to the delivery of LTSS not otherwise included in paragraphs (b)(1) through (12) of this section as applicable to the managed care program. 	Health plans are required to submit the following critical incident reports: • Health plans are required to submit policies and procedures for processing critical incidents, initially and as revised. • Monthly critical incident detail report and quarterly critical incidents summary report. Critical incident metrics are monitored through the scorecard. • The EQRO also submits the following reports as a result of monitoring of critical incidents and health, safety, and welfare (HSW). • EQR HSW reports identified during quarterly record reviews. • Quarterly summary of HSW reports.	Quarterly record review of plan compliance with the HCBS CMS performance measures. Review of HSW concerns during quarterly record reviews and review of health plan remediation actions. Quarterly critical incident monitoring through case file reviews and follow up on findings and remediation actions. Annual review of LTSS care management qualifications, training, and caseload requirements. Review of compliance with critical incident reporting during administrative reviews.
§438.66(b)(14)	All other provisions of the contract, as appropriate.	See the section on health plan reporting below.	See the "External Quality Review" section.

Health Plan Reporting

HFS has established a rigorous data collection and reporting schedule for routine monitoring and oversight to ensure compliance with contract requirements and evaluate performance.

HFS requires health plans to submit regular reports to assist HFS in monitoring performance. HFS staff analyze data in the health plan reports, examine trends over time, and compare the performance of health plans to each other, when applicable. HFS has implemented a reporting system that collects data from the health plans and permits reliable comparisons on various topics and specified outcome measures. HFS ensures a regular flow of information by inserting a list of required reports (or deliverables), along with frequency requirements, into the health plan contracts.

Health plans submit most of their regular reports and deliverables to HFS using Microsoft SharePoint technology. The HFS SharePoint site was designed as a report repository to facilitate document collaboration and incorporates document management best practices specific to report review. When reports are uploaded to the SharePoint site, they are automatically date and time stamped and reside in each health plan's respective library for assignment and review by HFS staff.

Reporting is required monthly, quarterly, and annually as demonstrated in the reporting tables found in Attachment XIII (Required Deliverables, Submissions, and Reporting) of the health plan contract as included in Appendix H.

The MMAI program has specific federal reporting requirements that can be reviewed at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Illinois.html.

Using Monitoring Data to Improve Performance

As required in CFR §438.66(c), HFS uses data collected from its monitoring activities to improve the performance of its managed care program, including:

- Enrollment and disenrollment trends in each health plan.
- Member grievance and appeal logs.
- Provider complaint and appeal logs.
- Findings from the EQR process.
- Results from any enrollee or provider satisfaction survey conducted by HFS or the health plan.
- Performance on required quality measures.
- Medical management committee reports and minutes.
- Annual quality improvement plan for each health plan.
- Audited financial and encounter data submitted by each health plan.
- Medical loss ratio summary reports required by CFR §438.8.
- Customer service performance data submitted by each health plan and performance data submitted by the beneficiary support system.
- Any other data related to the provision of LTSS not otherwise included in this section as applicable to the managed care program.

Monitoring Through Readiness Reviews

As required in CFR §438.66(d), HFS assesses the readiness of each contracted health plan as follows:

- Prior to the State implementing a managed care program, whether the program is voluntary or mandatory.
- When the specific health plan entity has not previously contracted with the State.
- When any health plan currently contracting with the State will provide or arrange for the provision of covered benefits to new eligibility groups.

HFS ensures that readiness reviews are:

- Initiated at least three months prior to the effective date of the events described above.
- Completed in sufficient time to ensure smooth implementation of an event described above.
- Submitted to CMS for CMS to make a determination that the contract or contract amendment is approved.

HFS also ensures that readiness reviews include both a desk review of documents and on-site reviews as required by federal regulations and assess the ability and capacity of the health plan to perform satisfactorily in all the applicable areas outlined in CFR §438.66(d)(4).

HFS' Monitoring of Quality Assessment and Performance Improvement (QAPI) Programs

According to 42 CFR §438.330, HFS requires health plans to have an ongoing QAPI program that assesses the quality of care and adjusts processes and operations to improve the quality of care provided to customers. The QAPI programs consist of a committee that must meet regularly, with a frequency sufficient to demonstrate that the committee is following up on all findings and required actions. To ensure continuous quality improvement, HFS requires health plans to conduct regular examination (annually at a minimum) of the scope and content of the QAP to ensure that it covers all types of services, including behavioral health services, in all settings. Health plans are required to submit a written report on the QAP as a component of the QA/UR/PR Annual Report. The report includes an executive summary that provides a high-level discussion/analysis of each area of the annual report of findings, accomplishments, barriers, and continued need for quality improvement and provides detailed analysis of each of the following:

- QA/UR/PR plan with overview of goal areas
- Major initiatives to comply with the State Quality Strategy
- Quality improvement and workplan monitoring
- Contractor network access and availability and service improvements, including access and utilization of dental services
- Cultural competency
- FWA monitoring
- Population profile
- Improvements in CM/CC and clinical services/programs

- Effectiveness of care coordination model of care
- Effectiveness of quality program structure
- Summary of monitoring conducted including issues or barriers addressed or pending remediation
- Comprehensive quality improvement workplans
- Chronic health conditions
- Behavioral health (includes mental health and substance use disorder services)
- Dental care
- Discussion of the health education program
- Member satisfaction
- Enrollee safety
- FWA and privacy and security
- Delegation

The EQR technical report also addresses the effectiveness of a health plan's QAPI program.

External Quality Review

HFS contracts with an EQRO to perform external oversight, monitoring, and evaluation of the quality assurance component of managed care. In accordance with 42 CFR §438.356, the EQRO conducts the mandatory and optional EQR activities as set forth in 42 CFR §438.358. The EQRO performs services in accordance with 42 CFR and the Balanced Budget Act of 1997. To see the 2020–2021 EQR workplan, see Appendix F.

Mandatory EQR Activities

To evaluate the quality and timeliness of, and access to, the services covered under the health plan contract, HFS' EQRO conducts the mandatory EQR activities listed below.

42 CFR	Summary of EQRO Activity to Meet Federal Requirements
§438.358(b)(1)(i)	**Validates PIPs** in accordance with §438.330(b)(1) to determine if PIPs were designed to achieve improvement in clinical and nonclinical care, and if the PIPs would have a favorable effect on health outcomes and beneficiary satisfaction.
§438.358(b)(1)(ii)	**Validates performance measures**. Conducts NCQA HEDIS Compliance Audits™[3-2] and performance measure validation (PMV) audits in accordance with §438.330(b)(2). For a list of healthcare and quality of life measures included in the HealthChoice Illinois contract, see Appendix G.
§438.358(b)(1)(iii)	**Conducts a review**, at least every three years, **to determine health plan compliance** with federal standards (subpart D) and the QAPI requirements described in §438.330. HFS' EQRO conducts a variety of types of compliance reviews including: • Administrative Reviews and Remediation o To determine health plan compliance with various quality assessment/improvement standards in 18 areas of compliance (as listed in Appendix H). • Readiness Reviews and Remediation o To evaluate, prior to client enrollment, whether a health plan's internal organizational structure, health information systems, staffing, and oversight are sufficient to enroll customers. • HCBS Record Reviews and Remediation o In accordance with CMS requirements, quarterly on-site record reviews of a statistically valid sample, weighted by waiver type, are conducted by the EQRO. All record review findings and remediation of findings are tracked in the record review database. Annual reviews of HCBS staffing, experience, qualifications, FTEs, and caseload assignments are conducted on all health plans that provide services to HCBS Waiver customers. See a list of CMS HCBS Waiver performance measures in Appendix I. • Critical Incident/HSW Reviews and Remediation o To audit health plan processes for identifying and resolving Critical Incident/HSW concerns by conducting case file reviews.

[3-2] NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

42 CFR	Summary of EQRO Activity to Meet Federal Requirements
§438.358(b)(1)(iv)	**Validates managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) network adequacy** to comply with requirements set forth in §438.68. The EQRO conducts a biannual review of the provider network, annual time/distance analysis of selected providers to evaluate compliance with time/distance standards requirements, and appointment availability surveys to evaluation compliance with appointment standards and after-hours access for customers. HFS' EQRO also conducts an analysis of the health plans' provider networks as a key component of pre- and post-implementation readiness reviews to evaluate the progress of each health plan in contracting with a sufficient number of providers to establish network capacity in the expansion areas.
§438.364	**Produces an annual EQR technical report** and submits to the State in accordance with the CFR requirements. The EQRO works with HFS to follow up on EQR recommendations by building and monitoring EQR recommendations, quality improvement plans, and corresponding implementation plans with each health plan. See Appendix J.

Optional EQR Activities

To evaluate the quality and timeliness of, and access to, the services covered under the health plan contract, HFS' EQRO conducts the optional EQR activities listed below.

42 CFR	Summary of EQRO Activity to Meet Federal Requirements
§438.358(c)(1)	**Validates encounter data** reported by health plans. Encounter data can be used to assess and improve quality, as well as monitor program integrity and determine capitation payment rates; however, these data must be valid, complete, and accurate.
§438.358(c)(2)	**Validates and administers consumer surveys of quality of care**. Each year, the health plans are required to independently administer a consumer satisfaction survey for both adults and children as applicable to the programs they cover. The EQRO administers a CAHPS survey on behalf of HFS for the statewide Illinois Medicaid (Title XIX) and All Kids (Title XXI) programs. The EQRO summarizes the health plan and statewide data and includes the results of the CAHPS surveys in the annual EQR technical report.
§438.358(c)(3)	**Validates performance measures for the Children's Health Insurance Program Reauthorization Act (CHIPRA) Program** using the CMS protocol. The primary objectives are to evaluate the processes used to collect the performance measure data by HFS and determine the extent to which the specific performance measures calculated by HFS followed the specifications established for each performance measure.
§438.358(c)(5)	**Conducts studies on quality** that focus on an aspect of clinical or nonclinical services at a point in time. The goal of focused studies is to measure and improve an aspect of care or service affecting a significant number of health plan customers.
§438.358(c)(6)	**Assists** with the development and production of the **quality rating of health plans** report card consistent with §438.334.

42 CFR	Summary of EQRO Activity to Meet Federal Requirements
§438.358(d)	**Provides technical guidance (TA)** to HFS and the health plans. The EQRO has provided a variety of TA to HFS that has led to quality outcomes, including TA in the following areas: PIPs, grievance and appeals process, CM/CC programs, CAHPS sampling and development of CAHPS supplemental questions, P4P program measures, health plan compliance and readiness reviews, identification and selection of program-specific performance measures, developing and implementing new Medicaid programs, HCBS Waiver program requirements, and more.
§438.340(c)(2)(ii)	**Evaluation of Quality Strategy**. States are required to review the Quality Strategy including an evaluation of its effectiveness. This can be done by means of the annual EQR technical report by ensuring the report includes a section that addresses the effectiveness of the State's Quality Strategy and determines whether any updates to the strategy are necessary based on EQR results.

Section 4. State Standards

HFS' contracts with HealthChoice Illinois health plans include the standards for access, structure and operations, and quality measurement and performance improvement as specified in 42 CFR Part 438 Subpart D.

Access Standards

Standards for HealthChoice Illinois related to access can be found in Article 5 of the model contract, including Section 5.7 (Provider Network) and Section 5.8 (Access to Care Standards).
A detailed crosswalk between the CFR requirements for access standards and HFS' contract references can be found in Appendix H.

Structure and Operations Standards

Standards for HealthChoice Illinois related to structure and operations can be found in Article 5 of the model contract. A detailed crosswalk between the CFR requirements for structure and operations standards and HFS' contract references can be found in Appendix H.

Measurement and Improvement Standards

Standards for HealthChoice Illinois related to measurement and improvement can be found in Article 5 of the model contract. A detailed crosswalk between the CFR requirements for measurement and improvement standards and HFS' contract references can be found in Appendix H.

Section 5. Improvement and Interventions

Continuous Quality Improvement

HFS recognizes that having standards is a first step in promoting safe and effective healthcare. In order to ensure that standards are followed, HFS regularly monitors the health plans and managed care programs. HFS is also committed to ongoing assessment and identification of opportunities for improvement to ensure delivery of the highest-quality, most cost-effective services. Based on the results of the assessment and monitoring activities outlined in sections 3 and 4 of this report, Illinois has implemented comprehensive approaches for continuous quality improvement with the goal of improving healthcare outcomes to all customers enrolled in a Medicaid program. HFS' major, overarching strategies for improvement are described below.

Scorecards and Claims Analysis	Scorecards are developed to depict health plan performance on key metrics and performance indicators. See the example in Appendix C. Health plans use the scorecards to assist in developing action plans for improvement. In addition, MCO hospital claims processing and payment performance analysis is conducted twice a year.	HFS restructured management to add a new layer of Medicaid oversight. Each health plan is assigned an HFS account manager. Weekly meetings and monthly operations meetings are conducted to follow up on action plans. HFS also developed an Account Manager inbox so all requests and responses flow through one channel and are tracked across health plans.	**Account Managers**
Quarterly Business Reviews (QBRs)	QBRs are conducted with all health plans to review scorecards, discuss trends in performance, identify barriers, share best practices, and promote continuous improvement.	HFS account managers track the progress of health plan implementation of CAPs developed in response to administrative and readiness reviews, network monitoring, and HCBS record reviews.	**Corrective Action Plans (CAPs)**
EQR Recommendations	HFS has developed a phased process for the State and health plans to follow up on recommendations from the annual EQR process. See an example of EQR recommendations, quality improvement plan, and implementation plan in appendices J and K.	To provide feedback and analysis on the health plans' compliance with HSW and critical incident (CI) requirements, HFS' EQRO conducts quarterly reviews of HSW/CI records. The results of these reviews are used to highlight strengths and identify areas that require immediate and/or additional attention. Health plans are required to complete remediation of any findings.	**Health, Safety, and Welfare (HSW) and Critical Incidents**

Quality Improvement Interventions

As part of HealthChoice Illinois, HFS, and health plans will partner on awareness initiatives that encourage informed healthcare choices. Pooling resources, they will speak with a common voice to foster medical provider participation, coordinated care, prevention, early treatment of chronic conditions, and other strategies that help people lead healthier lives. HFS has directed the health plans' efforts on the focus populations and initiatives described in this section.

Pillar	Initiatives
Maternal and Child Health	The HFS Illinois Moms & Babies Program covers insurance for moms during the course of their pregnancy and for 60 days postpartum. It provides screening and coverage for postpartum depression as well as any medical complications that can arise. Additionally, moms can sign up for the "text4baby" program that provides them with advice on infant care and postpartum issues. The State of Illinois also has a Section 1115 Waiver pending which would extend coverage for postpartum care for women to one year. Research indicates that infants and children with mothers who are insured are more likely to receive adequate medical care. Based on low rates of breast and cervical cancer screening according to electric case reporting (eCR) reports, particularly in Black and Hispanic populations, HFS added P4P measures in the equity pillar for both topics. HFS, in cooperation with the Illinois Chapter of the American Academy of Pediatrics (ICAAP), developed a **statewide Bright Smiles from Birth Program** that uses web-based training to educate physicians, nurse practitioners, and FQHCs on how to perform oral health screenings, assessments, and fluoride and varnish applications in both the FFS and managed care delivery system. The program also gives guidance and makes referrals to dentists for necessary follow-up care and establishment of ongoing dental services. The initiative has proven successful in improving access to dental care, and studies confirm that fluoride varnish applications are effective in reducing early childhood caries in young children. See http://www.brightsmilesfrombirth.org for more information. **DCFS Youth** are now served by HealthChoice Illinois.

Pillar	Initiatives
Adult and Child Behavioral Health	Illinois' 1915(i) Home- and Community-Based Services (HCBS) State Plan Amendment will add new community behavioral health services to the Illinois Medicaid service array for a targeted population of individuals who meet specified needs-based eligibility criteria. HFS will work closely with health plans on the implementation of new services. In 2020, HFS launched the **IM+CANS Provider Portal** to collect and manage data from the Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS) instrument. The IM+CANS serves as HFS' standardized mental health assessment and treatment plan for community behavioral health providers. The IM+CANS Provider Portal will provide HFS with the clinical data necessary to better track outcomes for customers receiving community behavioral health services. As the State's Medicaid infrastructure began to evolve through the introduction of care coordination and managed care service delivery systems, the State's approach to crisis response has also evolved. Many of the children and youth who are experiencing a mental health crisis and whose care requires public funding are now being served by **Mobile Crisis Response (MCR) programs** administered and funded by the health plans. MCR features centralized intake via the **Crisis and Referral Entry System (CARES)** and access to face-to-face crisis intervention services. HFS actively works with health plans to ensure coordination and continuity across the crisis response systems. The **Specialized Family Support Program (SFSP)** launched in April 2017 pursuant to the Custody Relinquishment Prevention Act 20 ILCS 540. It is a collaborative effort between HFS, DCFS, Department of Human Services (DHS), Department of Juvenile Justice (DJJ), Department of Public Health (DPH), and the Illinois State Board of Education (ISBE). The SFSP is designed to identify the behavioral health needs of youth at risk of custody relinquishment and to link them to appropriate services. In July 2018, HFS began its implementation of a five-year **Section 1115 Demonstration Waiver** to establish a series of behavioral health pilot projects, with a strong focus on piloting substance use disorder treatment services not covered under the Illinois Medicaid State Plan. HFS plans to develop **measures** that will gauge the success of **behavioral health/medical integration** to help direct adjustments and needed resources. HFS is **enhancing the validation of the behavioral health provider network** through the addition of a time/distance analysis of the behavioral health network. State activities are currently being planned to focus on telemedicine.

Pillar	Initiatives
Equity	**Supplemental CAHPS questions** are added to the health plan adult surveys to obtain input on the satisfaction with HCBS services, including satisfaction with direct support staff and receipt of waiver services. HFS' **Quality Care Subcommittee** has assigned a workgroup to **assess** racial or ethnic **disparity in LTSS programs** and recommend strategies for equality and quality of services for LTSS customers throughout Illinois. Health plans are required to have a member advisory committee with a reasonable representation of LTSS customers. HealthChoice Illinois and CountyCare were selected as one of seven teams nationwide to work together to reduce health disparities as customers of the Advancing Health Equity (AHE) Learning Collaborative that launched on October 2, 2019. The AHE Learning Collaborative is a component of the Advancing Health Equity: Leading Care, Payment, and Systems Transformation program funded by the Robert Wood Johnson Foundation. The AHE Learning Collaborative is based at the University of Chicago and conducted in partnership with the Institute for Medicaid Innovation and the Center for Health Care Strategies. The AHE Learning Collaborative convenes the seven teams over the course of two years to design integrated payment and healthcare delivery reforms to reduce health disparities. The teams will also address social determinants of health as part of their efforts and generate best practice and policy recommendations for national dissemination.
Community-Based Services and Supports	**Supplemental CAHPS questions** are added to the health plan adult surveys to obtain input on the satisfaction with HCBS services, including satisfaction with direct support staff and receipt of waiver services. HFS' **Quality Care Subcommittee** has assigned a workgroup to **assess** racial or ethnic **disparity in LTSS programs** and recommend strategies for equality and quality of services for LTSS customers throughout Illinois. Health plans are required to have a member advisory committee with a reasonable representation of LTSS customers. On October 1, 2020, HFS, in partnership with DHS and the University of Illinois at Chicago's College of Nursing, operationalized the Community Transitions Initiative (CTI). Under this initiative, HealthChoice Illinois plans may receive incentive payments for the successful transition of customers living in skilled nursing facilities and specialized mental health rehabilitation facilities (SMHRFs) as well as for thorough evaluations of customers who are ultimately determined to have an impairment so significant that transition is not in their best interest.

Pillar	Initiatives
All Pillars	**Performance Management Initiative: Transition of Care Programs** (including CM/CC) • Increase HFS' performance management oversight of the MCOs. • MCOs identification of top hospitals with which they are working relative to transitions of care. • MCOs will submit weekly rosters to HFS account managers identifying behavioral health inpatient admissions. • HFS account managers will have weekly discussions with the MCOs to review the roster and to understand how the MCO is actively managing transition(s) of care. **Performance Management Initiative: Emergency Department Utilization** **Performance Management Initiative: Executive Scorecard Performance.** MedInsight metrics and MCO self-reported metrics. **Telemedicine task force** is charged with expanding the use of telemedicine within the Medicaid program. **P4P Program.** Health plans may earn payments based on performance with respect to select quality metrics that support the Quality Strategy goals. Collection of data and calculation of health plan performance against the P4P measures are in accordance with national HEDIS timelines, specifications, and benchmarks. Due to the impacts of the COVID-19 pandemic on health plans' abilities to collect medical record data for hybrid measures, the NCQA and HFS authorized MCOs to rotate rates (i.e., report the MCOs' HEDIS 2019 rates in place of the HEDIS 2020 rates) for hybrid measures. In addition, approximately $100 million of the P4P quality payments was reinvested, as additional capital, into community organizations and providers across Illinois. HFS is working to **engage customers in an advisory capacity** and participation in the MAC. **Health Plan Accreditation.** Pursuant to 305 ILCS 5/5-30 (a) and (h), HFS requires that any health plan serving at least 5,000 seniors, or people with disabilities, or 15,000 customers in other populations covered by the Medical Assistance Program that have been receiving full-risk capitation for at least one year are considered eligible for accreditation and will be accredited by the NCQA within two years after the date the health plan was eligible for accreditation. The health plans must achieve and/or maintain a status of "Excellent," "Commendable," or "Accredited."

Health Plan Sanctions

In accordance with Section 7.16 of the health plan contract, HFS may impose civil money penalties, late fees, performance penalties (collectively, "monetary sanctions"), and other sanctions on health plans for failure to substantially comply with the terms of the contract. Monetary sanctions may be imposed, as detailed in the contracts, with determination of the amount at the sole discretion of HFS, within the ranges set forth in the contracts. Self-reporting by a health plan is taken into consideration in determining the sanction amount. HFS may waive the imposition of sanctions for failures determined to be minor or insignificant. Upon determination of substantial noncompliance, HFS gives written notice to the health plan describing the noncompliance, the opportunity to cure the noncompliance where a cure is not otherwise disallowed under the contracts, and the sanction that HFS will impose. HFS may impose a performance penalty and/or suspend enrollment of potential customers. Areas subject to sanctions are included in the contract and include failure to submit required reports or performance results, misrepresentation of information, or failure to provide covered services.

Corrective/Remedial Actions

In accordance with Section 7.16.9 of the health plan contract, if HFS determines a health plan has not made significant progress in monitoring or carrying out its required QAP, implementing its QAP, or demonstrating improvement in deficient areas, HFS shall provide notice that the health plan is required to develop a CAP. The CAP must specify the types of problems requiring remedial/corrective action; the type of corrective action to be taken; the goals of the corrective action; the timetable and workplan for action; the identified changes in processes, structure, and internal and external education; the type of follow-up monitoring, evaluation, and improvement; and the identified improvements and enhancements of existing outreach and care management activities, if applicable. Health plans are required to monitor and evaluate corrective actions to assure that appropriate changes have been made and to follow up on identified issues to ensure that actions for improvement have been effective and provide documentation on this process.

Health Information Technology (HIT)

Technology initiatives are also an essential part of HFS' Medicaid transformation agenda. Systems changes support initial and ongoing operation and review of the Quality Strategy as well as ensure progress toward HFS' goals.

INTEGRATED ELIGIBILITY SYSTEM (IES)	• Eligibility system used to determine eligibility for medical programs: Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF); and cash assistance for Aged, Blind, or Disabled (ABD). • In collaboration with DHS and the Department of Innovation and Technology (DoIT). • Cost of development and installation largely defrayed by enhanced 90 percent match from federal government.
ILLINOIS MEDICAID PROGRAM ADVANCED CLOUD TECHNOLOGY (IMPACT)	The IMPACT initiative is a multi-agency effort that modernizes HFS' 30-year-old Medicaid Management Information System (MMIS) which was built to support a FFS Medicaid program. The MMIS supports claims processing for the HFS medical assistance programs.
IMPACT'S FOUR PHASES	• **Electronic Health Records Medicaid Incentive Payment Program (eMIPP)**: Provides incentive payments to EPs, EHs, and critical access hospitals to adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology. • **Web Provider Enrollment**: Beginning in July 2015, providers have been required to enroll and revalidate their enrollment through the new IMPACT Web portal. • **Pharmacy Benefits Management System (PBMS)**: Internet-based application capable of interacting with providers, manufacturers, and other stakeholders to conduct the business processes of managing the Pharmacy Services and Drug Rebate program. • **Full Implementation/CoreSystem**: This phase is the largest and most complex. It encompasses numerous subsystems including claims/encounters, prior approval, eligibility/enrollment, business administration, and financials. The Full Implementation/CoreSystem is projected to be completed in 2023. Once completed, the Department will have a modern, single, cloud-enabled MMIS for all Medicaid claims processing.

ELECTRONIC HEALTH RECORDS (EHR) PAYMENT INCENTIVE PROGRAM	Section 4210 of the Health Information Technology for Economic and Clinical Health (HITECH) Act established an EHR provider incentive payment program, which allows Medicaid to pay an incentive to eligible professionals who attested to adopt, implement, upgrade, or meaningfully use certified EHR technology. In September 2011, HFS launched Illinois' Medicaid EHR Incentive Payment Program, allowing attestations via a State Web application (now called the EHR Medicaid Incentive Payment Program [eMIPP]) from providers who had initiated the registration process on a CMS website. Since the program's inception through December 13, 2020, HFS has awarded over $656.2 million in incentive payments to 9,339 eligible Medicaid providers (EPs) and 174 eligible Medicaid hospitals (EHs) to encourage them to adopt, implement, or upgrade their local EHR system, with a later goal of engaging in the "meaningful use" of said technology. The State estimates that the 100 percent federally funded payments to eligible providers may exceed $700 million over the life of the program, which continues through 2021.
ADMISSION, DISCHARGE, TRANSFER (ADT) INITIATIVE	HFS will begin an Admission, Discharge, Transfer (ADT) initiative beginning spring 2021, with a planned completion by fall 2021. ADT is a statewide data exchange platform that will deliver vital information to Illinois Medicaid providers in a timely and secure manner. The platform will send real-time ADT notifications from the admitting or discharging facility, including emergency room visits, to a patient care coordinator or primary care provider. This real-time information will improve care coordination opportunities by highlighting high utilizers of hospitals and emergency departments. The platform will also provide higher quality care and produce more successful outcomes, decrease unnecessary hospital admissions and readmissions, decrease emergency room visits, as well as outline the timeliness and type of care coordination response to notifications by end users. The ADT platform fits well into the pillar-focused initiatives of the Quality Strategy.

Section 6. Delivery System Reforms

This section describes delivery system reforms made by HFS to incorporate additional services/populations into the State's comprehensive mandatory Medicaid managed care delivery system, HealthChoice Illinois.

Special Needs Children (SNC)

To achieve optimal benefits of care coordination, enhance quality, improve outcomes, integrate physical and behavioral health, and to best manage costs without compromising quality of care or access to care, HFS obtained a 1915(b) Waiver to include populations of children with complex health and social service needs in HealthChoice Illinois. HFS defined the SNC population as individuals under the age of 19 who meet any of the following criteria:

1. Are eligible for Supplemental Security Income (SSI) under Title XVI;
2. Receive Title V care coordination services through the Division of Specialized Care for Children (DSCC) (also known as the Core Program);
3. Qualify as disabled;
4. Are under the legal custody or guardianship of the Illinois Department of Children and Family Services (DCFS) (also known as current Youth in Care); or
5. Formerly were under the legal care of DCFS and are receiving assistance through Title IV-E (also known as former Youth in Care).

All of the HealthChoice Illinois health plans were contracted to provide services for the SNC populations. Additionally, a new specialized program (YouthCare) was implemented to provide services for DCFS current and former Youth in Care.

HFS is working to develop performance measures and performance improvement projects (PIPs) applicable to this population.

Managed Long Term Services and Supports (MLTSS)

MLTSS was also incorporated in HealthChoice Illinois. Illinois' MLTSS Waiver allowed for the mandatory Medicaid managed care enrollment of beneficiaries 21 years of age and older receiving institutional or community-based long term services and supports (LTSS) who are not enrolled in the State's Medicare-Medicaid Alignment Initiative (MMAI) but are eligible for both Medicare and Medicaid, unless they meet the eligibility exclusions. The State's goals are to redesign the healthcare delivery system for dual-eligible beneficiaries with a focus on:

- Improving health outcomes, care delivery, and utilization of community-based services.
- Rebalancing its Medicaid LTSS systems from a primary reliance on nursing facility services to expanded utilization of community-based services and supports.
- Implementing Illinois Public Act 96-15013.

The State designed a program that:

- Provides beneficiaries with opportunities for involvement in all healthcare decisions and a choice for better coordination of care, as members work with a team of providers to give them the best possible healthcare.
- Incentivizes health plans to provide robust care coordination and increased utilization of community-based services through a reimbursement structure that encourages use of community-based programs and focuses on performance measurement.

When HealthChoice Illinois was implemented, all health plans began receiving MLTSS enrollment in the greater Chicago area. MLTSS services were expanded statewide to all counties when CMS approved Illinois' MLTSS Waiver amendment, effective July 1, 2019.

HFS is working to develop performance measures and PIPs applicable to this population.

Section 7. Conclusions

Evaluation of the Effectiveness of the Quality Strategy

The Department works closely with the EQRO throughout the year to support, oversee, and monitor quality activities and evaluate the HealthChoice Illinois Medicaid Managed Care Program's achievement of goals and objectives. The EQRO provides ongoing technical support to the Department in the development of monitoring strategies. The EQRO also works with the Department to ensure that the health plans stay informed about new State and federal requirements and evolving technologies for quality measurement and reporting. Additionally, the Department and the EQRO conduct a formal, annual evaluation of the Quality Strategy to assess its overall effectiveness and determine whether demonstrated improvement in the quality of services provided to recipients, providers, and integrated stakeholders was accomplished.

In accordance with federal regulations at 42 CFR §438.340(c)(2), HFS reviews its Quality Strategy and that review includes an evaluation of the effectivities of the Quality Strategy using data from multiple sources. The evaluation includes an assessment of:

- The effectiveness of quality interventions and remediation strategies during the previous year (demonstrated by improvements in care and services) and trending of indicator data.
- The appropriateness of the program structure, processes, and objectives.
- The identification of program limitations.
- The evaluation of all internal activities, including quality improvement committees; task forces; recipient complaints, grievances, and appeals; and provider complaints and issues.
- Recommendations resulting from the previous year's EQR activities.
- Feedback obtained from Department leadership, health plans, the provider community, advocacy groups, Medicaid recipients, and other internal and external stakeholders.
- Recommendations for enhanced goals and objectives for the upcoming year.

The Department uses several tools to evaluate the effectiveness and achievement of goals, including:

- The annual EQRO technical report.
- Validated healthcare and quality of life performance measure results.
- Validated PIP results.
- Plan compliance review results.
- Ongoing review of contractually required health plan deliverables.
- Recipient complaint and grievance information.
- Stakeholder feedback emailed to the Department via the Department website.

Performance-Driven Revisions to Quality Strategy

Due to the HealthChoice Illinois Medicaid Managed Care Program's statewide expansion, changes to the program, health plan performance, and the impacts of the COVID-19 pandemic, HFS revamped its P4P program in state fiscal year (SFY) 2020. Performance metrics will center on five pillars measured through an equity lens: (1) adult behavioral health, (2) children's behavioral health, (3) maternal and child health, (4) improving opportunities for people to be treated in their communities, and (5) improving health equities around breast cancer, cervical cancer screenings, high blood pressure, and access to primary care. Each pillar has been carefully chosen to better serve the Department's three million Medicaid customers and to ensure the best possible allocation of the State's scarce resources.

Performance Snapshot

Quality, Timeliness, and Access Performance Measures

HFS establishes performance measure standards and monitors health plan performance on nationally recognized measure sets to evaluate health plan performance on HFS Quality Strategy goals within the Medicaid population. For a full list of HFS-required performance measures, see Appendix G. For the most recent performance results for each of the measures, see Appendix K; and for trended results by health plan for each of the performance measures, see Appendix L.

Comparison of health plan performance on these measures to minimum performance standards helps determine what percentage of new members are assigned to the plan (quality-based assignment) and the percentage of payments withheld (quality withhold). The overall health plan-specific star ratings for the 2020 (CY 2019) aggregate quality scores did not change when compared to the 2019 (CY 2018) results, with all health plans receiving three stars (i.e., the plans' average rating was at or between the 50th and 74th percentiles). The overall rates declined for two plans (Aetna and BCBSIL and improved for three (CountyCare, Meridian, and Molina). For the most recent quality rating results, see Appendix M.

Access to Care Measures Performance

In the Access to Care domain, the HEDIS 2020 statewide average for the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure indicator fell below the 50th percentile, and the HEDIS 2020 statewide average for the *Adult BMI Assessment* measure indicator fell below the 25th percentile, indicating an area for improvement. The HEDIS 2020 statewide average for the *Annual Dental Visit* measure indicator ranked at or above the 50th percentile.

Keeping Kids Healthy Measures Performance

In the Keeping Kids Healthy domain, the HEDIS 2020 statewide average ranked above the 50th percentile for only four of nine (44.4 percent) measure rates. Despite slight increases in the rates from HEDIS 2019, the *Childhood Immunization Status* measure rates continued to fall below the 50th percentile, indicating opportunities to increase immunizations for children. Additionally, the statewide average fell below the 50th percentile for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicators, demonstrating opportunities for health

plans to ensure young children receive weight assessment and counseling for nutrition and physical activity during well-child visits.

Women's Health Measures Performance

In the Women's Health domain, the HEDIS 2020 statewide average ranked above the 50th percentile for one of the three (33.3 percent) measure rates. Conversely, the statewide average for the *Breast Cancer Screening* and *Cervical Cancer Screening* measure indicators fell below the 50th percentile, demonstrating opportunities for health plans to ensure women receive appropriate screenings.

Living With Illness Measures Performance

In the Living With Illness domain, the HEDIS 2020 statewide average exceeded the 90th percentile for the *Statin Therapy for People With Diabetes—Received Statin Therapy* measure indicator, indicating strong performance. Conversely, the statewide average fell below the 50th percentile for four of the eight (50.0 percent) measure rates. Of note, the statewide average for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure indicator ranked below the 50th percentile in HEDIS 2019 and HEDIS 2020 and demonstrated a slight rate decline from HEDIS 2019. The health plans should ensure beneficiaries with diabetes receive appropriate eye exams to ensure the measure rate does not continue to decline.

Behavioral Health Measures Performance

Within the Behavioral Health domain, the statewide average for HEDIS 2020 ranked at or above the 50th percentile for three of five (60.0 percent) measure rates. Conversely, the statewide average and measure rates for all six health plans ranked below the 50th percentile for both *Follow-Up After Hospitalization for Mental Illness* measure indicators, demonstrating opportunities to ensure timely follow-up with beneficiaries after a discharge for mental illness from a hospital.

Overall Performance

Table 7-1 provides a high-level snapshot of statewide performance for HEDIS measures, compliance monitoring, PIPs, and CAHPS results for SFY 2020. The percentiles refer to national Medicaid percentiles.

Table 7-1—Performance Snapshot SFY 2020

	Indicators of Performance	Overall Domain Performance		
		Quality	**Timeliness**	**Access**
	HEDIS	**26 Quality Measure Rates[i]**	**4 Timeliness Measure Rates[ii]**	**6 Access Measure Rates[ii]**
Notable 	HEDIS	**≥90th Percentile and Above** • 1 of 26 measure rates (3.8%) o *Statin Therapy for Patients with Diabetes—Received Statin Therapy* **Between the 75th and 89th Percentiles** • 1 of 26 measure rates (3.8%) o *Immunizations for Adolescents—Combination 1* **Between the 50th and 75th Percentiles** • 10 of 26 measure rates (38.5%)	**Between the 50th and 75th Percentiles** • 2 of 4 measure rates (50%) o *Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment (IET)—Initiation of AOD Treatment—Total* and *Engagement of AOD Treatment—Total*	**Between the 50th and 75th Percentiles** • 3 of 6 measure rates (50%) o *Annual Dental Visits* o *IET—Initiation of AOD Treatment—Total* and *Engagement of AOD Treatment—Total*
	Compliance	An Evaluation of Administrative Processes & Compliance Review (Compliance Review) for a subset of standards for HealthChoice Illinois demonstrated that all health plans achieved an overall compliance score between 81–87%.		
	PIPs	As approved by CMS, HFS implemented a new rapid-cycle approach for PIPs. The duration of rapid-cycle PIPs is 18 months; therefore, the two new mandatory PIPs, *Follow-Up After Hospitalization for Mental Illness* and *Transitions of Care—Patient Engagement After Inpatient Discharge*, will continue into the next fiscal year.		
	CAHPS	**At or Between the 50th and 74th Percentiles** Adult Aggregate Results: • *How Well Doctors Communicate* • *Customer Service* • *Rating of All Health Care* • *Rating of Personal Doctor* Child Aggregate Results: • *How Well Doctors Communicate* • *Rating of All Health Care* • *Rating of Personal Doctor* • *Rating of Specialist Seen Most Often*	No timeliness measures achieved notable performance	No access measures achieved notable performance

Table 7-1—Performance Snapshot SFY 2020

	Indicators of Performance	Overall Domain Performance		
		Quality	Timeliness	Access
	HEDIS	26 Quality Measures Rates[i]	4 Timeliness Measures Rates[ii]	6 Access Measures Rates[iii]
Needs Work 	HEDIS	**≤ 25th Percentile** • 5 of 26 measure rates (19.2%) o *Adult Body Mass Index (BMI) Assessment* o *Childhood Immunization Status (CIS)—Combination 3* o *Controlling High Blood Pressure* o *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* **Between the 25th and 50th Percentiles** o 9 of 26 measure rates (34.6%)	**≤ 25th Percentile** • 2 of 4 measure rates (50%) o *FUH—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*	**≤ 25th Percentile** • 2 of 6 measure rates (33.3%) o *FUH—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* **Between the 25th and 50th Percentiles** o *Adults' Access to Preventive/Ambulatory Health Services—Total*
	Compliance	A Compliance Review for a subset of standards for HealthChoice Illinois identified the standards of Children's Behavioral Health (CBH) Services and Subcontractual Relationships and Delegation as needing the most improvement. File reviews identified that quality improvement efforts are needed in the following areas: case management, denials, CBH, appeals, grievances, delegation, provider complaints, and provider directories. See Section 3 of this report for more details.		
	PIPs	During SFY 2020, the primary PIP activities included Module 3 and Module 4 of the process—identifying and testing interventions. At this stage, PIPs are not yet formally evaluated on the Specific, Measurable, Attainable, Relevant, Time-bound (SMART) Aim measure outcomes. The PIPs will receive a final validation status after the completed Module 4s and Module 5s are submitted to HSAG in February 2021.		
	CAHPS	**At or Between 25th and 49th Percentiles** Adult Aggregate Results: • *Rating of Specialist Seen Most Often* • *Rating of Health Plan* **< 25th Percentile** Child Aggregate Results: • *Customer Service* • *Rating of Health Plan*	**At or Between 25th and 49th Percentiles** Adult Aggregate Results: • *Getting Care Quickly* Child Aggregate Results: • *Getting Care Quickly*	**At or Between 25th and 49th Percentiles** Adult Aggregate Results: • *Getting Needed Care* **< 25th Percentile** Child Aggregate Results: • *Getting Needed Care*

i. HEDIS results are based on the statewide weighted average (inclusive of all health plans). The Quality Measures reported for this table are those that could be compared to NCQA's Quality Compass®[7-1] national Medicaid percentiles for HEDIS 2019. Refer to Appendix A2 for a list of the measures and rates that are included in the quality, timeliness, and access domains. Due to changes in the technical specifications for *Prenatal and Postpartum Care* and *Metabolic Monitoring for Children and Adolescents on Antipsychotics (Blood Glucose Testing—Total* and *Cholesterol Testing—Total* rates*)*, NCQA recommends a break in trending between 2020 and prior years; therefore, comparisons to benchmarks are not performed for this measure. Four quality measure rates (two measures) are also included in the timeliness and access domains.

ii. Four timeliness measure rates were compared to national Medicaid percentiles for HEDIS 2019, but please note that both measures (four measure rates) are also included in the quality and access domains.

iii. Six access measure rates were compared to national Medicaid percentiles for HEDIS 2019, but please note that two measures (four measure rates) are also included in the quality and timeliness domains.

[7-1] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2019.* Washington, DC: NCQA, September 2019.

Home- and Community-Based Services (HCBS) Performance

HFS' EQRO conducts quarterly on-site reviews of HCBS Waiver beneficiary records to evaluate compliance with CMS waiver performance measures requirements. Table 7-2 provides a high-level snapshot of statewide performance for HealthChoice Illinois, MLTSS, and MMAI. More details about health plan performance on HCBS measures can be found in Appendix I.

Table 7-2—HCBS Performance SFY 2020

Health Plan	HealthChoice Illinois	MLTSS	MMAI
Aetna	NA*	NA	99%
BCBSIL	94%	94%	95%
CountyCare	89%	88%	NA
Humana	NA	NA	88%
IlliniCare Health (IlliniCare)‡	93%	91%	94%
Meridian	93%	91%	92%
Molina	89%	80%	92%
NextLevel Health Partners (NextLevel)†	89%	89%	NA

* Health plan did not serve the population.

‡ IlliniCare was purchased by CVS Aetna and is now referred to as Aetna Better Health, effective December 1, 2020.

† NextLevel ceased operations on July 1, 2020.

Three of the six HealthChoice Illinois plans averaged greater than 90 percent compliance in SFY 2020. There was a 5-percentage point difference (89 percent to 94 percent) among health plans. Three of the six plans averaged greater than 90 percent compliance for the MLTSS population in SFY 2020. There was a 14-percentage point difference (80 percent to 94 percent) among health plans for MLTSS records. Five of the six MMAI health plans averaged greater than 90 percent overall compliance in SFY 2020. There was an 11-percentage point difference (88 percent to 99 percent) among MMAI plans.

A year-to-year comparative analysis revealed many improvements in performance scores. These improvements were the results of efforts made by the health plans to address HSAG recommendations following the conclusion of SFY 2019 reviews, efforts to incorporate technical assistance received during on-site reviews, and efforts to integrate HFS guidance into internal processes.

Health Plan Annual Quality Assurance/Utilization Review/Peer Review (QA/UR/PR) Report

The health plans are required to submit a QA/UR/PR evaluation of the quality improvement program and quality improvement activities employed by the health plan for the previous year. The health plans' annual evaluations include trends and statistical information that describe and depict the performance for each quality activity and associated indicators developed by the health plan. Annual evaluations also include an analysis and evaluation of clinical and related service areas requiring

improvement for each of the quality measures that pertain to the population. The Department requires the health plans to follow an approved outline for the report and provide an evaluation of each of the HealthChoice Illinois Managed Care Program Healthcare and Quality of Life performance measures. The Department's EQRO reviews the annual quality evaluations submitted by each plan to verify that the health plan has followed the Department's outline and stratified and reported the data according to the parameters set by the Department. HFS requires the EQRO to include recommendations and observations about the reports including the use of appendices, ability to expand on the outline provided, and success of "telling the story" of its population. The following presents overall observations and similarities among health plans:

- Most health plans have an opportunity to more successfully utilize the data and information in their attached appendices by referencing the information in their narrative report. For instance, appendices related to population assessment would be appropriate to reference in the health plan's sections related to cultural competency and care management.
- Most health plans followed the HFS outline to establish heading and subheadings in their reports, some using the outline verbatim to report the year's activities. However, the health plans have an opportunity to use the outline more as a guide for information that must be included, rather than following the outline for report setup. For instance, behavioral health utilization and PIPs are both required on the outline in different areas but could be reported together to better draw conclusions about the success of PIP efforts on utilization or to identify additional opportunities for improvement related to behavioral health utilization. Health plans should determine if the annual report would benefit from restructuring to "tell the story," which would allow the health plans to include all outline elements but in a different order set.
- HSAG noted that the health plans' reports indicate different maturity and sophistication levels of providing narrative information, drawing conclusions, or assessing data to determine success of their QI programs. Some health plans may benefit from additional direction from HFS regarding expectations for analysis and reporting.

As part of future reporting, the health plans will be required to stratify performance measure rates by race, ethnicity, and gender. After stratifying the data, the health plans will be required to identify any healthcare disparities among the groups and develop a plan for targeted interventions to reduce and/or eliminate disparities for customers and increase performance measure rates overall.

Successes

Aligning with Quality Improvement Science

In 2014, the EQRO received permission from CMS to align its PIP process with the Model for Improvement developed by Associates in Process Improvement and popularized by the Institute for Healthcare Improvement (IHI). The redesigned methodology is intended to improve processes and outcomes of healthcare by way of continuous quality improvement. The redesigned framework redirects health plans to focus on small tests of change in order to determine which interventions have the greatest impact and can bring about real improvement.

Prior to implementation of the rapid-cycle PIP process, HSAG provided training to the health plans and HFS on the rapid-cycle PIP approach, components, submission process, and validation criteria. In addition to this training, HSAG conducts module-specific trainings throughout the PIP process. The module-specific trainings solely focus on the requirements of the targeted module. The health plans may also seek one-on-one individualized TA throughout the PIP process and between the initial submission and resubmission(s) of modules.

The health plans submit two state-mandated PIPs for validation, *Follow-Up After Hospitalization for Mental Illness*, with emphasis on 30-day follow-up, and *Transitions of Care—Patient Engagement After Inpatient Discharge*. Both topics are based on HEDIS measures; however, with the rapid-cycle approach, the plans use data analyses to determine a narrowed focus for each PIP. The topics addressed CMS requirements related to quality outcomes, specifically the quality and timeliness of and access to care and services. The health plans continued the topics from the prior fiscal year and concluded the PIPs by December 31, 2020.

Provider Network Monitoring

Validation of network adequacy is a mandatory EQR activity, and states must begin conducting this activity, described in the CMS rule §438.358(b)(1)(iv), no later than one year from the issuance of the associated EQR protocol. While this protocol is expected to be released in the future, HFS conducts biannual network reviews of the numbers and types of network providers, time and distance validation studies, access and availability surveys, and online provider directory audits that align with current federal regulations and will help prepare HFS to meet the network adequacy validation requirements once the provisions go into effect.

Biannual Network Monitoring

The EQRO produces biannual health plan-specific and comparative network reports to identify the number of provider types within each region and county. These reports also included contracted providers within state-specific contiguous counties. Any identified network gaps are communicated to HFS and the health plans. Health plans are required to respond to all identified deficiencies in writing.

Analysis and monitoring of the HealthChoice Illinois provider network verifies that the health plans are contracted with a sufficient number of required providers types within each service region.

Time/Distance Analysis

The purpose of the time and distance study was to evaluate the degree to which health plans comply with network standards outlined in the HFS—Medicaid Model Contract—2018-24-001, Sections 5.8.1.1.1–5.8.1.1.7.

The study conducted in SFY 2020 validated the time and distance requirements for 22 provider categories within each health plan's service region. The findings of the study identified that generally all health plans were compliant with the time and distance contract standards, ranging from 19 to 22 provider categories across all regions. Health plans not meeting contract standards were required to submit a corrective action plan for any provider category not meeting time and distance contract standards.

A pediatric provider study conducted in the SFY 2020 validated the time and distance between pediatric enrollees and 25 pediatric provider categories serving pediatric enrollees in the health plans' networks. The findings of the study identified that generally all health plans were compliant with the time and distance contract standards, ranging from 21 to 25 provider categories across all regions. Health plans not meeting contract standards were required to submit a corrective action plan for any provider category not meeting time and distance contract standards.

Access and Availability Survey

HFS requested HSAG conduct access and availability secret shopper surveys of provider offices to evaluate the average time to an appointment for Illinois Medicaid enrollees. HSAG conducted two secret shopper telephone surveys. The results of the first survey of PCPs and OB/GYNs were completed in 2020. The findings of the survey identified several barriers to obtaining appointment dates, including pre-registration or requiring personal information before scheduling, Medicaid eligibility verification, designation with the PCP through insurance prior to appointment scheduling, and medical record review. While some barriers pose unique limitations to a secret shopper survey where caller information cannot be provided to the office (i.e., pre-registration or requiring personal information to schedule), other limitations may pose barriers to all Medicaid enrollees trying to schedule appointments. Other findings identified that 30 percent of sampled cases for each health plan and a key nonresponse reason involved call attempts in which the provider was no longer at the location listed in the provider data. Health plans were required to follow up on the findings of the survey, and HFS will require the EQRO to conduct a provider directory review to validate the information provided to enrollees in the online provider directory.

Children's Behavioral Health Services

In 2019, the findings of a health plan record review of children with a behavioral health diagnosis receiving care management/care coordination services identified several opportunities for improving services including: oversight of mobile crisis response providers; oversight of the crisis line vendor; communication with inpatient psychiatric facilities regarding admission and discharge information; community stabilization and integrated care teams; and establishment of Family Leadership Council meetings. In 2020, HFS required the EQRO to conduct a follow-up review to evaluate the effectiveness of the remediation actions taken to improve care management care coordination services for this population. The overall findings of the follow-up review identified improved oversight of the crisis line vendor, including improved referrals to the mobile crisis providers; improved communication and compliance by the mobile crisis providers in completion of the Illinois Medicaid Crisis Assessment Tool (IM-CAT); improved communication with high-volume inpatient psychiatric facilities for admissions and discharges; defined roles of health plan staff and mobile crisis providers to improve community stabilization activities; and established quarterly Family Leadership Council meetings to provide enrollees and families with a mechanism for input and feedback regarding its service delivery system.

Critical Incident Reporting

The EQRO conducts quarterly reviews of critical incident (CI) records to evaluate health plan compliance with CI contract requirements. The results of these reviews are used to highlight strengths and identify areas that require immediate and/or additional attention. Ongoing performance is monitored through quarterly CI record reviews, health plan-specific feedback, and remediation of review findings. The CI review evaluates the health plans' compliance with all CI requirements required by contract, State and federal statutes and regulations, and 1915(b) and 1915(c) Waiver conditions. The health plan's quality improvement efforts taken to improve the CI reporting process has demonstrated improved compliance with the CI requirements through monitoring and oversight of the quality department to ensure compliance with CI requirements and monitoring of CIs; improved documentation of steps taken to resolve critical incidents; more thorough completion of the CI form by the staff reporting the CI and the quality department; and improved consistency and accuracy of the data universe submission for selection of the sampled cases for the monitoring reviews.

Statewide Expansion of Managed Care for Additional Populations

1915(b) Illinois Managed Long Term Services and Supports (MLTSS) Demonstration Waiver

Illinois' MLTSS Demonstration Waiver application was approved by CMS, effective July 1, 2016 (CMS Control # IL-01.M01). Illinois' MLTSS Waiver allowed for the mandatory Medicaid managed care enrollment of beneficiaries 21 years of age and older receiving institutional or community-based LTSS who are not enrolled in the State's MMAI but are eligible for both Medicare and Medicaid, unless they meet the eligibility exclusions.

MLTSS services were expanded statewide to all counties when CMS approved Illinois' MLTSS Waiver amendment, effective July 1, 2019. The goals of the State's MLTSS Waiver are to redesign the healthcare delivery system for dual-eligible beneficiaries, with a focus on:

- Improving health outcomes, care delivery, and utilization of community-based services.
- Rebalancing its Medicaid LTSS systems from a primary reliance on nursing facility services to expanded utilization of community-based services and supports.
- Implementing Illinois Public Act 96-1501.[7-1]

HFS contracted with its EQRO to complete the access and quality of care Independent Assessment (IA) of Illinois' MLTSS Waiver. HFS also contracted with Chicago-Milwaukee Milliman, Inc. (Milliman), an independent actuarial firm, to complete the assessment of the MLTSS Waiver's cost-effectiveness.

The IA evaluated the availability of services under the MLTSS Waiver and compared it to the level of waiver services that existed prior to the waiver, if comparison information was available, to:

- Ensure that the program did not substantially impair beneficiary access to services as compared to accessibility of services prior to or without the waiver.
- Ensure that the quality of services was not less than the quality of services prior to or without the waiver.

The IA evaluation findings identified that HFS demonstrated monitoring and oversight for all areas reviewed by HSAG in this IA. HFS' processes and health plan performance are well aligned with the commitments made in the MLTSS Waiver application. These processes also demonstrated enhancements in comparison to existing Medicaid FFS processes, thereby showing the waiver ensures that beneficiary access to services and quality of care are comparable or improved in comparison to pre-waiver enrollment. While program improvement recommendations are noted in the IA report, no areas of risk or concern were identified, as both access to care and quality of care have been determined to be as effective or more effective than access to and quality of care received prior to the MLTSS Waiver.

1915(b) Special Needs Children (SNC) Waiver

Illinois' SNC 1915(b) Waiver application was approved by CMS, effective April 1, 2019, through March 31, 2021 (CMS Control # IL-02. R00.00). Statewide implementation of the program began February 1, 2020. Illinois' SNC Waiver allowed for the mandatory Medicaid managed care enrollment of beneficiaries under the age of 19 who meet any of the following criteria:

1. Are eligible for Supplemental Security Income (SSI) under Title XVI;
2. Receive Title V care coordination services through the Division of Specialized Care for Children (DSCC) (also known as the CORE Program);
3. Qualify as disabled;
4. Are under the legal custody or guardianship of the Illinois Department of Children and Family Services (DCFS) (also known as Youth in Care); or
5. Formerly were under the legal care of DCFS and are receiving assistance through Title IV-E also known as former Youth in Care.

[7-1] Illinois MLTSS Section 1915(b) Waiver Proposal for MCO, PIHP, PAHP, PCCM Programs, and FFS Selective Contracting Programs: MMA Amendment Version April 1, 2016, April 1, 2018, Revised July 10, 2018, Second Revision September 18, 2018.

The goals of the State's Medicaid managed care program, including the SNC Waiver are to:

1. Achieve optimal benefits of care coordination.
2. Enhance quality of care and services.
3. Improve outcomes.
4. Integrate physical and behavioral health.
5. Manage costs without compromising quality of care or access to care.[7-2]

Pursuant to Title 42 CFR §431.55(b)(4), CMS monitors and evaluates the implementation of Medicaid managed care programs to ensure that requirements for granting federal waivers are being met. Pursuant to Section 2111(B) of the State Medicaid Manual, states must arrange for an IA of their waiver programs and submit the findings when renewing their waiver programs. CMS requires that a contractor or agency independent of the state Medicaid agency complete the assessment by evaluating access to services and care, quality of care, and cost-effectiveness of the program prior to renewal of the waiver.

HFS will utilize its EQRO to complete the access and quality of care IA of Illinois' SNC Waiver. HFS will also utilize Milliman to complete the assessment of the MLTSS Waiver's cost-effectiveness as required by CMS.

Medicare-Medicaid Alignment Initiative (MMAI)—Statewide Expansion

Finally, statewide expansion of the MMAI, serving customers eligible for both Medicare and Medicaid services, is scheduled for July 1, 2021.

[7-2] Illinois SNC Section 1915(b) Waiver Proposal for MCO, PIHP, PAHP, PCCM Programs: Final Version, December 6, 2018.

Advanced Cloud Technology (IMPACT)

The IMPACT initiative is a multi-agency effort that modernizes HFS' 30-year-old MMIS which was built to support the FFS Medicaid program. The fourth phase, Full Implementation/CoreSystem, is the largest and most complex. It encompasses numerous subsystems including claims/encounters, prior approval, eligibility/enrollment, business administration, and financials. It is projected to be completed in 2023. Once completed, the Department will have a modern, single, cloud-enabled MMIS for all Medicaid claims processing.

Medicaid Plan Report Card

Illinois Public Act 099-0725 set forth requirements for the Medicaid quality rating system. HFS continued to publish its consumer quality comparison tool, called the HealthChoice Illinois Plan Report Card, to reflect the performance of each of the four statewide health plans and six Cook County health plans. The report card compares Illinois' health plans across six performance areas which align with Illinois' goals and pillar-focused population streams. The six performance areas include: (1) doctors' communication, (2) access to care, (3) women's health, (4) living with illness, (5) behavioral health, and (6) keeping kids healthy. Each plan is assigned up to five stars to indicate how it performs relative to other plans on each of these six measures. The information used to create the Medicaid managed care report is collected from the health plans and their customers and is reviewed for accuracy by the EQRO. The most current information from the NCQA HEDIS and CAHPS is used.

HFS produces two report cards. The Cook County report card includes an analysis of the plans that are available to Medicaid beneficiaries in Cook County. The statewide report card included an analysis of the plans that are available statewide to Medicaid beneficiaries.

A copy of the most recently published statewide report card can be found in Appendix C and at: https://www.illinois.gov/hfs/healthchoice/reportcard/Pages/statewide_sc20.aspx

A copy of the most recently published Cook County report card can be found in Appendix C and at: https://www.illinois.gov/hfs/healthchoice/reportcard/Documents/ILHealthChoiceReportCardCookCounty.pdf

NCQA Accreditation

Illinois amended its Public Aid Code to require Medicaid health plans to be accredited by NCQA. NCQA accreditation is a comprehensive evaluation based on results of clinical performance (i.e., HEDIS measures) and consumer experience (i.e., CAHPS measures) and is a widely recognized symbol of quality. HFS believes requiring NCQA accreditation lays the framework for health plans serving Medicaid beneficiaries to improve care, enhance service, and reduce costs. As required by §438.10(c)(3), HFS makes the accreditation status of each health plan available on its website. As of September 2019, all health plans have achieved an accreditation level of "Accredited." NCQA awards an accreditation status of Accredited for service and clinical quality that meet the basic requirements of NCQA's rigorous standards for consumer protection and quality improvement.

Challenges/Opportunities

Challenges in Improving Quality of Care

Over the past few years, the Department has been faced with a number of challenges to improving quality of care. These challenges included an outdated PIP structure that focused more heavily upon documentation than achieving results, uncoordinated care, a lack of transparency, and communication between Illinois' providers and managed care entities that resulted in an uncoordinated approach to care coordination by Illinois' health plans.

These challenges are being addressed through several activities, including: the redesign of Illinois' Medicaid PIPs to incorporate data-driven approaches and rapid-cycle methods of quality improvement through alignment with the IHI model; efforts to eliminate fragmentation in the care delivery system; increasing transparency through the use of provider and managed care report cards and dashboards showing performance on key metrics; increasing the collaborative use of data; and a focusing on care coordination for managed care enrollees.

Implementing Integrated Health Homes (IHH)

In November 2020, HFS announced it was indefinitely pushing back the rollout of its IHH program due to the need to amend timelines and prioritize plans around the public health emergency prompted by COVID-19. The IHH initiative, aimed at integrating physical and behavioral health, was a key part of the State's overhaul of behavioral healthcare in Medicaid aimed at addressing social determinants of health, reducing barriers to healthcare access, and building collaborations among community groups. The state is working with the University of Illinois at Chicago on the strategic plan in an effort to change the status quo and reorient the system around people and communities.

COVID-19 Implications

HFS stays informed of recommendations from nationally recognized organizations such as the NCQA, CMS, and the National Quality Forum regarding the impact of COVID-19. HFS continues to monitor the impact of the pandemic on health plan business operations, including potential effects on performance measurement, quality, medical record data collection, access to provider offices, and a host of other related issues.

Ongoing Medicaid Quality Improvement Activities

Future Medicaid quality improvement activities will address improving services and health outcomes within the five population-focused pillars measured through an equity lens: (1) adult behavioral health, (2) children's behavioral health, (3) maternal and child health, (4) improving opportunities for people to be treated in their communities, and (5) improving health equities around breast cancer, cervical cancer screenings, high blood pressure, and access to primary care.

The Department has dedicated program staff members in quality and performance improvement to assist the health plans in optimizing the impact of improvement initiatives and in evaluating the

effectiveness of their programs. The Department's performance and improvement staff members actively work with Illinois' contracted health plans in order to understand their approaches to quality, identify additional areas for improvement, and spread best practices.

The Department will continue to actively support its contracted health plans in the pursuit of quality by fostering opportunities for learning and collaboration, providing coaching resources for quality improvement activities, and providing a clear vision for improving the care of Illinoisans.

Next Steps

The Department will continue looking for innovative ways of improving the health of Illinoisans through service delivery in a managed care environment. The Department is committed to promoting a system dedicated to quality over volume and will continue to foster approaches that improve the health and economic vitality of Illinoisans in an efficient and cost-effective manner. Person-centered care that empowers individuals in making their own healthcare decisions and honors personal choice will continue to be a priority. Increased methods for ensuring data sharing and transparency will help HFS achieve desired outcomes through promoting greater coordination of care, responsiveness, integrity, and accountability.

These steps and approaches are essential for achieving HFS' mission of empowering Illinoisans to make sound decisions about their wellbeing, delivering quality healthcare coverage at sustainable costs, and maintaining the highest standards of program integrity on behalf of the citizens of Illinois.

AAP ..... Adults' Access to Preventative/Ambulatory Health Services

ABD ..... Aged, Blind, or Disabled

ADA ..... Americans with Disabilities Act

ADV ..... Annual Dental Visit

AHE ..... Advancing Health Equity

AOD ..... Alcohol and Other Drug

BCS ..... Breast Cancer Screening

BH ..... Behavioral Health

BMI ..... Body Mass Index

CAHPS®[1] ..... Consumer Assessment of Healthcare Providers and Systems

CAP ..... Corrective Action Plan

CARES ..... Crisis Referral Entry System

CBP ..... Controlling High Blood Pressure

CBH ..... Children's Behavioral Health

CCS ..... Cervical Cancer Screening

CEB ..... Client Enrollment Broker

CFR ..... Code of Federal Regulations

CHIP ..... Children's Health Insurance Program

CI ..... Critical Incident

CIS ..... Childhood Immunization Status

CM/CC ..... Care Management/Care Coordination

CMS ..... Centers for Medicare & Medicaid Services

COVID-19 ..... Coronavirus Disease 2019

CSHCN ..... Children with Special Health Care Needs

CTI ..... Community Transitions Initiative

CY ..... Calendar Year

[1] CAHPS is a registered trademark of the Agency for Healthcare Research and Quality.

DCFS..... Department of Children and Family Services

DDJ .....Department of Juvenile Justice

DHS..... Department of Human Services

DOI ..... Department of Insurance

DoIT .....Department of Innovation and Technology

DPH.....Department of Public Health

DSCC ..... Division of Specialized Care for Children

eCR .....Electric Case Reporting

EH .....Eligible Hospital

EHR..... Electronic Health Record

eMIPP ..... Electronic Health Records Medicaid Incentive Payment Program

EP .....Eligible Provider

EQR..... External Quality Review

EQRO..... External Quality Review Organization

FFS .....Fee-For-Service

FQHC..... Federally Qualified Health Center

FTE ..... Full-Time Equivalent

FUA..... Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

FUH..... Follow-Up After Hospitalization for Mental Illness

FUI .....Follow-Up After High-Intensity Care for Substance Use Disorder

FUM.....Follow-Up After Emergency Visit for Mental Illness

FWA.....Fraud, Waste, and Abuse

FYIC .....Former Youth in Care

HbA1c ..... Hemoglobin A1c

HCBS ..... Home- and Community-Based Services

HEDIS®[2].....Healthcare Effectiveness Data and Information Set

[2] HEDIS is a registered trademark of the National Committee for Quality Assurance.

HFS ..... The Illinois Department of Healthcare and Family Services

HIPAA .....Health Insurance Portability and Accountability Act

HIT ..... Health Information Technology

HITECH Act ..... Health Information Technology for Economic and Clinical Health Act

HSW ..... Health, Safety, and Welfare

IA ..... Independent Assessment

IET ..... Initiation and Engagement Treatment

ICAAP.....Illinois Chapter of the American Academy of Pediatrics

IDHS ..... Illinois Department of Human Services

IDoA ..... Illinois Department of Aging

IDPH .....Illinois Department of Public Health

IES.....Integrated Eligibility System

IHH .....Integrated Health Homes

IHI ..... Institute for Healthcare Improvement

IM+CANS..... Illinois Medicaid Comprehensive Assessment of Needs and Strengths

IM-CAT .....Illinois Medicaid Crisis Assessment Tool

IMPACT .....Illinois Medicaid Program Advanced Cloud Technology

ISBE..... Illinois State Board of Education

LTSS .....Long-Term Services and Supports

MAC ..... Medical Advisory Committee

MCO .....Managed Care Organization

MCR.....Mobile Crisis Response

MLTSS..... Managed Long-Term Services and Supports

MMAI .....Medicare-Medicaid Alignment Initiative

MMIS..... Medicaid Management Information System

MY ..... Measurement Year

NCQA ..... National Committee for Quality Assurance

OB/GYN ..... Obstetrician/Gynecologist

P4P ..... Pay-For-Performance
PAHP ..... Prepaid Ambulatory Health Plan
PASRR ..... Preadmission Screening and Resident Review
PBMS ..... Pharmacy Benefits Management System
PCCM ..... Primary Care Case Management
PCP ..... Primary Care Physician
PHE ..... Public Health Emergency
PHO ..... Physician Hospital Organization
PIHP ..... Prepaid Inpatient Health Plan
PIP ..... Performance Improvement Project
PMV ..... Performance Measure Validation
POD ..... Pharmacotherapy for Opioid Use Disorder
PPC ..... Prenatal and Postpartum Care
PR ..... Peer Review
QA ..... Quality Assurance
QAP ..... Quality Assessment Plan
QAPI ..... Quality Assessment and Performance Improvement
QBR ..... Quarterly Business Review
QI ..... Quality Improvement
QIP ..... Quality Improvement Project
QRS ..... Quality Rating System
RY ..... Remeasurement Year
SCHIP ..... State Children's Health Insurance Program
SFSP ..... Specialized Family Support Program
SFY ..... State Fiscal Year
SMART ..... Specific, Measurable, Attainable, Relevant, and Time-Bound
SMHRF ..... Specialized Mental Health Rehabilitation Facility
SNAP ..... Supplemental Nutrition Assistance Program

SNC ..... Special Needs Children

SLA ..... Service Level Agreement

SPA ..... State Plan Amendment

SSI ..... Supplemental Security Income

TA ..... Technical Assistance

TANF ..... Temporary Assistance for Needy Families

TOC ..... Transition of Care

UM ..... Utilization Management

UR ..... Utilization Review

W30 ..... Well-Child Visits in the First 30 Months of Life

WCV ..... Child and Adolescent Well-Care Visits

YIC ..... Youth in Care

HealthChoice Illinois Enrollment

As of January 1, 2021, there were six health plans that participated: Aetna Better Health (Aetna), Blue Cross Community Health Plans (BCBSIL), CountyCare Health Plan (CountyCare), MeridianHealth (Meridian), Molina HealthCare (Molina), and YouthCare.

Enrollment figures for HealthChoice Illinois are displayed in the tables below. Table 1-2 presents overall enrollment, Table 1-3 and Table 1-4 display the gender and age bands of Medicaid/non-CHIP and CHIP enrollment, respectively, as of January 1, 2021. Table 1-5 presents non-match figures (non-match refers to State funding with no federal matching dollars), and Table 1-6 presents the race/ethnicity composition of beneficiaries.

Table 1-1—HealthChoice Illinois Enrollment

HEALTH PLANS	JAN 2021 ENROLLMENT
Aetna	397,619
BCBSIL	614,893
CountyCare (Cook County Only)	380,483
Meridian	878,238
Molina	301,289
YouthCare	19,600
Total HealthChoice Illinois Enrollment	**2,592,122**

Table 1-2— HealthChoice Illinois Non-CHIP Enrollment by Gender and Age

GENDER/AGE BAND	JAN 2021 ENROLLMENT
<1 year	60,925
1–2 years	126,041
3–14 years	717,122
Males 15-18	104,375
Females 15-18	102,136
Males 19-34	220,817
Females 19-34	343,357
Males 35+	322,354
Females 35+	424,004
Total non-CHIP	**2,421,131**

Table 1-3— HealthChoice Illinois CHIP Enrollment by Gender and Age

GENDER/AGE BAND	JAN 2021 ENROLLMENT
<1 year	422
1 - 2 years	5,558
3 - 14 years	76,628
Males 15-18	14,389
Females 15-18	13,676
Males 19-34	2,714
Females 19-34	12,732
Females 35+	4,334
Total CHIP	**130,453**

Table 1-4— HealthChoice Illinois Non-Match Enrollment by Gender and Age

GENDER/AGE BAND	JAN 2021 ENROLLMENT
<1 year	38
1 - 2 years	704
3 - 14 years	18,507
Males 15-18	4,674
Females 15-18	4,570
Males 19-34	2,685
Females 19-34	3,382
Males 35+	2,830
Females 35+	3,143
Total Non-Match	**40,533**

Table 1-5— HealthChoice Illinois Enrollment Race/Ethnicity Composition

	COOK COUNTY			DOWNSTATE			
Race	**Ethnicity-Unknown**	**Hispanic-Latino**	**Not-Hispanic-Latino**	**Ethnicity-Unknown**	**Hispanic-Latino**	**Not-Hispanic-Latino**	**TOTAL**
American Indian/Alaska Native	0	3	7	2,078	914	2,116	5,118
Asian	56	93	413	12,141	3,915	68,089	84,707
Black	484	57	7,367	49,712	7,748	559,321	624,689
Did Not Answer/ Unknown	861	623	404	737,897	66,004	26,575	832,364
Hawaiian Native/ Other Pacific Islander	1	2	6	257	342	714	1,322
Multi-Race				2	14	22	38
White	806	684	7,361	205,760	177,517	651,752	1,043,880
Total	**2,208**	**1,462**	**15,558**	**1,007,847**	**256,454**	**1,308,589**	**2,592,118**

Managed Long Term Care Services and Supports (MLTSS) Enrollment

Effective July 1, 2019, the Managed Long Term Services and Supports (MLTSS) program was expanded statewide when MLTSS and waiver services were incorporated into HealthChoice Illinois. HFS submitted to CMS a 1915(b) waiver application to implement the MLTSS waiver. Under the waiver, in specified geographies, dual eligible beneficiaries who receive institutional (except those receiving developmental disability institutional services) or community-based long-term services and supports (through five of the State's 1915(c) waiver programs) are required to enroll in managed care, unless they meet another exclusion. Current eligibility determination guidelines for institutional or hand community based (HCBS) services will not change under the waiver unless modified by the State. Under the waiver, beneficiaries receive the Medicaid institutional and community-based long-term services and supports (LTSS), transportation, and behavioral health services through a HealthChoice Illinois plan. Table 1-7 presents MLTSS enrollment.

Table 1-7—Managed Long-Term Care Services and Supports Enrollment

HEALTH PLANS	JAN 2021 ENROLLMENT
Aetna	13,304
BCBSIL	19,665
CountyCare (Cook County Only)	6,712
Meridian	15,301
Molina	5,520
Total	**60,502**

Medicare-Medicaid Alignment Initiative (MMAI) Enrollment

There are seven health plans that participate in select counties: Aetna Better Health Premier Plan (Aetna MMAI), Blue Cross Community (Blue Cross), Meridian Complete and Meridian Total (Meridian), and Molina Healthcare (Molina). Overall MMAI enrollment figures are displayed in Table 1-8.

Table 1-8—Medicare-Medicaid Alignment Initiative Enrollment

HEALTH PLANS	JAN 2021 ENROLLMENT
Aetna MMAI	8,586
Blue Cross	19,773
Meridian	14,634
Molina	8,599
Total	**51,592**

HealthChoice Illinois – Scorecard

HealthChoice Illinois: 2019 HealthChoice Illinois Plan Report Card

Comparing HealthChoice Illinois Plans

This report card is for individuals in the HealthChoice Illinois Managed Care Program. The report shows how the **Statewide** managed care plans compare to one another in key performance areas. The ratings for each plan are to help pick a plan that is best for you. The change for each performance area shows if the plan's rating got better, worse, or stayed the same from last year's report card.

Performance Rating		Performance Change
Highest Performance ★★★★★	Average Performance ★★★	Rating Got Better ↑
High Performance ★★★★	Low Performance ★★	Rating Stayed the Same –
	Lowest Performance ★	Rating Got Worse ↓

Plan	Doctors' Communication	Change	Access to Care	Change	Women's Health	Change	Living With Illness	Change	Behavioral Health	Change	Keeping Kids Healthy	Change
Aetna Better Health*	★★★	–	★★★	–	★	–	★★★	–	★★★★★	–	★	–
Blue Cross Community Health Plans	★★★★	–	★★★	–	★★★	–	★★★	–	★★★	–	★★★	–
MeridianHealth	★★★	–	★★★	–	★★★★★	–	★★★	–	★★★	–	★★★	–
Molina Healthcare	★★★	–	★★★	–	★★★	–	★★★	–	★	–	★★★★★	–

*Formerly known as IlliniCare

What is Rated in Each Performance Area?

Doctors' Communication
- Doctors explain things well to members
- How happy members are with their doctor

Access to Care
- Members get the care they need, when they need it

Women's Health
- Women get screenings and tests for female cancers and diseases
- Women receive care before and after their babies are born

Living With Illness
- Members living with conditions, like diabetes and asthma, get the care they need by getting tests, checkups, and the right medicines

Behavioral Health
- Members with behavioral health conditions get the follow-up care they need

Keeping Kids Healthy
- Children get regular checkups and important shots that help them stay healthy

HealthChoice Illinois – Scorecard

Choosing a HealthChoice Illinois Plan

Choosing the plan that best meets your health care needs is important. Here are some questions to ask before you pick a plan:

- **Have you read all of the materials that were included in this enrollment packet?**
- **Which plans have the extra services you want? (See Your Health Plan Choices that came with this packet.)**
- **How did the plans rate in each area on the front of this report card? Do the doctors in the plan I like communicate with their members?**
  - **Do the members in the plan I like get care when they need it?**
  - **Do women get the care they need?**
  - **Do members with behavioral health conditions get the care they need?**
  - **Do kids get the care they need to stay healthy?**
- **Which plans have the doctors, clinics, hospitals, specialists, long term care waiver service providers, and other providers you use? Call your providers to find out which HealthChoice Illinois plans they accept.**
- **Do you need providers that speak a certain language?**
- **How far do you want to travel to see your providers?**
- **Which plans have co-pays?**
- **Did the plan receive any sanctions from the state?**
  - **For more information, visit the website here.**

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About This Report Card

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Published 9/2020

You can get this information in other languages or formats, such as large print or audio.

HealthChoice Illinois – Scorecard

HealthChoice Illinois Plans' National Ratings

The star ratings below show how the **Statewide** managed care plans compare to national Medicaid ratings for each measure within key performance areas.

Key

Highest Performance ★★★★★	High Performance ★★★★
Average Performance ★★★	Low Performance ★★
Lowest Performance ★	

Plan	Aetna Better Health*	Blue Cross Community Health Plans	MeridianHealth	Molina Healthcare
Doctors' Communication				
Adult—How Well Doctors Communicate	★★★	★★★★	★★★	★★★
Child—How Well Doctors Communicate	★★	★★★	★★★	★★★★
Adult—Rating of Personal Doctor	★★★	★★★★	★★	★★★★
Child—Rating of Personal Doctor	★	★★★	★★★★	★★
Talking to Tobacco Users About How to Quit	★★★	★★	★	★
Talking About Medicines to Stop Tobacco Use	★★★★	★★★	★★★	★★
Talking About Plans to Stop Tobacco Use	★★★★	★★	★★	★★
Access to Care				
Adult—Getting Needed Care	★★	★	★★	★★
Child—Getting Needed Care	NA	★	★★	★★★
Adult—Getting Care Quickly	★	★★	★★	★★★
Child—Getting Care Quickly	NA	★	★★★	★★★
Outpatient or Preventive Care Visits	★★	★★★★	★★	★
Adult Body Mass Index (BMI)	★	★	★★	★★★
Annual Dental Visits	★★	★★★★	★★	★★

*Formerly known as IlliniCare
NA = not enough data

HealthChoice Illinois – Scorecard

Plan	Aetna Better Health*	Blue Cross Community Health Plans	MeridianHealth	Molina Healthcare
Women's Health				
Breast Cancer Screening	★★	★★	★★★	★
Cervical Cancer Screening	★	★★	★★★	★★
Chlamydia Screening in Women	★★	★★	★★	★★
Moms Got Care Before Babies Were Born	National rules on how to collect and report this data changed.			
Moms Got Care After Babies Were Born	National rules on how to collect and report this data changed.			
Living With Illness				
Diabetics Had HbA1c Testing	★★★	★★★★	★★	★★★
Diabetics Had an Eye Exam	★★	★★	★★★	★★
Diabetics Were Tested for Kidney Disease or Damage	★★★	★★★★	★★★	★★★
Adults Have Controlled High Blood Pressure	★	★	★	★★
Diabetics Received Statin Drugs	★★★★★	★★★★★	★★★★★	★★★★
Diabetics Received Statin Drugs and Stayed on Them	★★★	★★★	★★★	★★★
People With Asthma Used the Right Medicine	★★	★★	★★	★★

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HealthChoice Illinois – Scorecard

Plan	Aetna Better Health*	Blue Cross Community Health Plans	MeridianHealth	Molina Healthcare
Behavioral Health				
Follow-Up Care Within 7 Days After a Hospital Visit Due to Mental Illness	★	★	★★	★★
Follow-Up Care Within 30 Days After a Hospital Visit Due to Mental Illness	★	★	★★	★★
Start of Addiction Treatment	★★★	★★★	★★	★★★
Start and Continue Addiction Treatment	★★★	★★★	★★★	★★
Checkups for Kids/Teenagers on Mental Health Medications (Antipsychotics)	★★★	★★★★	★★	★★
Keeping Kids Healthy				
Doctor Visits for Kids Younger Than 15 Months	★★	★★	★★★★★	★★★
Doctor Visits for Kids Ages 3 to 6 Years	★★	★★★	★★★	★★
Kids Received Immunizations, Combo 2	★	★	★★	★★★★
Kids Received Immunizations, Combo 3	★	★	★	★★
Human Papillomavirus (HPV) Immunization for Teenagers	★★	★★★★	★★	★★★
BMI Percentile for Kids/Teenagers	★★	★	★★	★★
Counseling for Nutrition for Kids/Teenagers	★★	★	★★	★★
Counseling for Physical Activity for Kids/Teenagers	★★★	★	★★	★★

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HealthChoice Illinois – Scorecard

HealthChoice Illinois: 2019 HealthChoice Illinois Plan Report Card

Comparing HealthChoice Illinois Plans

This report card is for individuals in the HealthChoice Illinois Managed Care Program in **Cook County**. The report shows how the managed care plans compare to one another in key performance areas. The ratings for each plan are to help pick a plan that is best for you. The change for each performance area shows if the plan's rating got better, worse, or stayed the same from last year's report card.

Performance Rating		Performance Change
Highest Performance ★★★★★	Average Performance ★★★	Rating Got Better ↑
High Performance ★★★★	Low Performance ★★	Rating Stayed the Same –
	Lowest Performance ★	Rating Got Worse ↓

Plan	Doctors' Communication	Change	Access to Care	Change	Women's Health	Change	Living With Illness	Change	Behavioral Health	Change	Keeping Kids Healthy	Change
Aetna Better Health*	★★★	–	★★★	–	★	–	★★★	–	★★★★★	–	★	–
Blue Cross Community Health Plans	★★★★	–	★★★	–	★★	–	★★★	–	★★★★	–	★	–
CountyCare Health Plan	★★★	–	★★★	–	★★★★★	–	★★	–	★★★	–	★★★★★	–
MeridianHealth	★★★	–	★★★	–	★★★★	–	★★★	–	★★★	–	★★★	–
Molina Healthcare	★★★	–	★★★	–	★★	–	★★★	–	★	–	★★★★	–

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What is Rated in Each Performance Area?

Doctors' Communication
- Doctors explain things well to members
- How happy members are with their doctors

Access to Care
- Members get the care they need, when they need it

Women's Health
- Women get screenings and tests for female cancers and diseases
- Women receive care before and after their babies are born

Living With Illness
- Members living with conditions, like diabetes and asthma, get the care they need by getting tests, checkups, and the right medicines

Behavioral Health
- Members with behavioral health conditions get the follow-up care they need

Keeping Kids Healthy
- Children get regular checkups and important shots that help them stay healthy

HealthChoice Illinois – Scorecard

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Choosing the plan that best meets your health care needs is important. Here are some questions to ask before you pick a plan:

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- **Which plans have the extra services you want? (See Your Health Plan Choices that came with this packet.)**
- **How did the plans rate in each area on the front of this report card? Do the doctors in the plan I like communicate with their members?**
  - **Do the members in the plan I like get care when they need it?**
  - **Do women get the care they need?**
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About This Report Card

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HealthChoice Illinois – Scorecard

HealthChoice Illinois Plans' National Ratings

The star ratings below show how the managed care plans in **Cook County** compare to national Medicaid ratings for each measure within key performance areas.

Key

Highest Performance	High Performance	Average Performance	Low Performance	Lowest Performance
★★★★★	★★★★	★★★	★★	★

Plan	Aetna Better Health*	Blue Cross Community Health Plans	CountyCare Health Plan	MeridianHealth	Molina Healthcare
Doctors' Communication					
Adult—How Well Doctors Communicate	★★★	★★★★	★★	★★★	★★★
Child—How Well Doctors Communicate	★★	★★★	★	★★★	★★★★
Adult—Rating of Personal Doctor	★★★	★★★★	★★★★	★★	★★★★
Child—Rating of Personal Doctor	★	★★★	★★★	★★★★	★★
Talking to Tobacco Users About How to Quit	★★★	★★	★★★★	★	★
Talking About Medicines to Stop Tobacco Use	★★★★	★★★	★★★★	★★★	★★
Talking About Plans to Stop Tobacco Use	★★★★	★★	★★★★★	★★	★★
Access to Care					
Adult—Getting Needed Care	★★	★	★★	★★	★★
Child—Getting Needed Care	NA	★	★	★★	★★★
Adult—Getting Care Quickly	★	★★	★★	★★	★★★
Child—Getting Care Quickly	NA	★	★★	★★★	★★★
Outpatient or Preventive Care Visits	★★	★★★★	★★	★★	★
Adult Body Mass Index (BMI)	★	★	★★	★★	★★★
Annual Dental Visits	★★	★★★★	★★★★	★★	★★

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NA = not enough data

HealthChoice Illinois – Scorecard

Plan	Aetna Better Health*	Blue Cross Community Health Plans	CountyCare Health Plan	MeridianHealth	Molina Healthcare
Women's Health					
Breast Cancer Screening	★★	★★	★★★★	★★★	★
Cervical Cancer Screening	★	★★	★★★	★★★	★★
Chlamydia Screening in Women	★★	★★	★★★★	★★	★★
Moms Got Care Before Babies Were Born	National rules on how to collect and report this data changed.				
Moms Got Care After Babies Were Born	National rules on how to collect and report this data changed.				
Living With Illness					
Diabetics Had HbA1c Testing	★★★	★★★★	★★★	★★	★★★
Diabetics Had an Eye Exam	★★	★★	★★	★★★	★★
Diabetics Were Tested for Kidney Disease or Damage	★★★	★★★★	★★★★	★★★	★★★
Adults Have Controlled High Blood Pressure	★	★	★	★	★★
Diabetics Received Statin Drugs	★★★★★	★★★★★	★★★★	★★★★★	★★★★
Diabetics Received Statin Drugs and Stayed on Them	★★★	★★★	★★★	★★★	★★★
People With Asthma Used the Right Medicine	★★	★★	★	★★	★★
Behavioral Health					
Follow-Up Care Within 7 Days After a Hospital Visit Due to Mental Illness	★	★	★	★★	★★
Follow-Up Care Within 30 Days After a Hospital Visit Due to Mental Illness	★	★	★	★★	★★
Start of Addiction Treatment	★★★	★★★	★★★	★★	★★★
Start and Continue Addiction Treatment	★★★	★★★	★★	★★★	★★
Checkups for Kids/Teenagers on Mental Health Medications (Antipsychotics)	★★★	★★★★	★★★	★★	★★

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Plan	Aetna Better Health*	Blue Cross Community Health Plans	CountyCare Health Plan	MeridianHealth	Molina Healthcare
Keeping Kids Healthy					
Doctor Visits for Kids Younger Than 15 Months	★★	★★	★★	★★★★★	★★★
Doctor Visits for Kids Ages 3 to 6 Years	★★	★★★	★★★★	★★★	★★
Kids Received Immunizations, Combo 2	★	★	★★★	★★	★★★★
Kids Received Immunizations, Combo 3	★	★	★★★	★	★★
Human Papillomavirus (HPV) Immunization for Teenagers	★★	★★★★	★★★★	★★	★★★
BMI Percentile for Kids/Teenagers	★★	★	★★★	★★	★★
Counseling for Nutrition for Kids/Teenagers	★★	★	★★★★	★★	★★
Counseling for Physical Activity for Kids/Teenagers	★★★	★	★★★★	★★	★★

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Grievance System

Definitions

Grievance: An expression of dissatisfaction about any matter other than an action, as "action" is defined below.

Action:
1. the denial or limited authorization of a requested service, including the type of level of service;
2. the reduction, suspension, or termination of a previously authorized service;
3. the denial, in whole or in part, of payment for a service.
4. the failure to provide services in a timely manner, as defined by the State;
5. the failure of a Managed Care Organization (MCO) to act within the timeframes provided below;
6. for a resident of a rural area with only one MCO, the denial of a Medicaid enrollee's request to exercise his or her right, under the Balanced Budget Act (BBA) (438.52(b)(2)(ii), to obtain service outside the network.

Appeal: A request for review of an action as "action" is defined above.

	Grievance Process	Appeal Process	State of Illinois HealthChoice Model Contract	Managed Care Reform and Patient Rights Act 215 ILCS 134 Citation	BBA Citation, 42 CFR Part 438 Subpart F—Grievance Systems
General Requirements	**Grievance System.** Contractor shall have a formally structured Grievance system that is compliant with Sections 45 of the Managed Care Reform and Patient Rights Act, 215 ILCS 134, and 42 CFR Parts 431 Subpart E and 438 Subpart F to handle all Grievances and Appeals subject to the provisions of such sections of the Act and regulations.		Article 5.30		42 CFR 431 Subpart E 42 CFR 438 Subpart F
	MCO establishes and maintains a procedure for reviewing Grievances by an Enrollee or an Enrollee's Authorized Representative. A Grievance may be submitted orally or in writing, using any medium, at any time, and all Grievances shall be registered with MCO.	MCO establishes and maintains a procedure for reviewing Appeals by Enrollees or an Enrollee's Authorized Representative pursuant to 42 CFR §438 Subpart F. An Appeal may be submitted orally or in writing, and all Appeals shall be registered initially with MCO and may later be appealed to the State, as provided herein.	Article 5.30.1 Article 5.30.2		42 CFR 438 Subpart F

* The BBA states "A provider, acting on behalf of the enrollee and with the enrollee's written consent, may file an appeal."

** The Managed Care Reform Patient Rights Act has different timeframes for appeal resolution and notice and acknowledgement standards than the BBA. Extensions are not included in the Act.

Grievance System

	Grievance Process	Appeal Process	State of Illinois HealthChoice Model Contract	Managed Care Reform and Patient Rights Act 215 ILCS 134 Citation	BBA Citation, 42 CFR Part 438 Subpart F—Grievance Systems
Enrollee Welcome Packet	Contractor sends to each new Enrollee a welcome packet that contains the Enrollee Handbook and addresses important topics, such as how to get needed care, a benefits summary, and information about the Complaint, Grievance and Appeal processes.		Article 5.21.8.4		
Enrollee Handbook	The MCO's Enrollee Handbook contains information concerning the MCO's Grievance and Appeals process and the State's Appeal and fair hearing process, including how to register a Grievance or Appeal.		Article 5.21.5.12		
Review and Amendment	MCO reviews its Grievance and Appeal procedures at least annually for the purpose of amending such procedures when necessary. MCO amends its procedures only upon receiving the written Prior Approval of the Department. This information shall be furnished to the Department.		Article 5.30.5		
Registration Requirements	All Grievances are registered with MCO.	All Appeals are registered with MCO that may later be appealed to the State.	Article 5.26.1 Article 5.26.2		
General Procedures	Requirements for MCO procedures: 1. Submit to the Department in writing and approved in writing by the Department; 2. Provide for prompt resolution, and 3. Assure the participation of individuals with authority to require corrective action.	Requirements for MCO procedures: 1. Submit to the Department in writing and approved in writing by the Department; 2. Provide for resolution within contractually-specified time frames 3. Provide for only one level of Appeal by Enrollee; and 4. Assure the participation of individuals with authority to require corrective action.	Article 5.30.1.1 through 5.30.1.3 Article 5.30.2.1 through 5.30.2.4	Section 45 (a), (b) and (f); Section 50(a)(1)	*42 CFR 438.402* *42 CFR 438.406*

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Grievance System

	Grievance Process	Appeal Process	State of Illinois HealthChoice Model Contract	Managed Care Reform and Patient Rights Act 215 ILCS 134 Citation	BBA Citation, 42 CFR Part 438 Subpart F—Grievance Systems
Informal Resolution	MCO shall attempt to resolve all Grievances as soon as possible but no later than ninety (90) days from receipt of a Grievance. MCO may inform an Enrollee of the resolution orally or in writing.		Article 5.30.1.5		*42 CFR 438.408* *42 CFR 438.416*
Filing Authority	MCO provides a form and instructions on how an Enrollee may appoint any authorized representative that may include a guardian, caretaker relative, or Provider,* to represent the Enrollee throughout the Grievance process.	MCO provides a form and instructions on how an Enrollee may appoint any authorized representative that may include a guardian, caretaker relative, or Provider*, to represent the Enrollee throughout the Appeal process.	Article 5.30.1.6 Article -5.30.3.2	Section 45(d)	*42 CFR 438.402*
Enrollee Information Provision	MCO provides Grievance and fair hearing procedures and timeframes, provided that such information must be submitted to the Department for Prior Approval before distribution.		Article 5.21.1.9		
Telephone Access	MCO has a toll-free number available, at a minimum during the hours of 8:30 a.m. until 5:00 p.m. Central Time on Business Days. This number is used for Enrollees, at a minimum, to file Complaints or Grievances, to request disenrollment, to ask questions or to obtain other administrative information.		Article 5.21.6.2		

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Grievance System

	Grievance Process	Appeal Process	State of Illinois HealthChoice Model Contract	Managed Care Reform and Patient Rights Act 215 ILCS 134 Citation	BBA Citation, 42 CFR Part 438 Subpart F—Grievance Systems
Standard Appeal Procedure Filing		MCO permits an Enrollee to file an oral or written Appeal within sixty (60) calendar days following the date of the notice of Adverse Benefit Determination that generates such Appeal.	Article 5.30.3.1		*42 CFR 438.404* *42 CFR 438.406*
Expedited Appeal Notification Provision		In the case of an Enrollee-requested expedited Appeal pursuant to 42 CFR 438.410, MCO notifies the Enrollee within twenty-four (24) hours after the submission of the Appeal, of all information from the Enrollee that MCO requires to evaluate the Appeal.	Article 5.30.3.3		*42 CFR 438.408*
Expedited Appeal Decision Notification		MCO renders a decision on an expedited Enrollee Appeal within twenty-four (24) hours after receipt of the required information.	Article 5.30.3.3	Section 45(b)	*42 CFR 438.408*
Standard Appeal Decision Notification		MCO renders its decision on an Enrollee Appeal that is not filed as an expedited Appeal within fifteen (15) business days after submission of the Appeal.	Article 5.30.3.4	Section 45(c)	*42 CFR 438.408*

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Grievance System

	Grievance Process	Appeal Process	State of Illinois HealthChoice Model Contract	Managed Care Reform and Patient Rights Act 215 ILCS 134 Citation	BBA Citation, 42 CFR Part 438 Subpart F—Grievance Systems
Appeal Extension Provision		MCO grants an Appeal process extension for up to fourteen (14) calendar days upon an Enrollee's request, or if MCO demonstrates to the satisfaction of the appropriate state agency's Hearing Office that there is a need for additional information and the delay is in the Enrollee's interest.**	Article 5.30.3.4		*42 CFR 438.408*
Appeal to State		MCO provides for final decisions of Appeals not resolved wholly in favor of the Enrollee to be appealed by the Enrollee to the State under its Fair Hearings system within one hundred twenty (120) calendar days after the date of MCO's Decision Notice.	Article 5.30.3.5		*42 CFR 438.408*
Independent Review Procedure		MCO has procedures for allowing an Enrollee to request an external independent review, both standard and expedited timeframes, of Appeals that are denied by MCO within thirty (30) calendar days after the date of MCO's Decision Notice. Such MCO independent review procedures shall not extend to denial of Waiver services that are not subject to review by an external independent entity.	Article 5.30.3.6		*42 CFR 438.408*

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Grievance System

	Grievance Process	Appeal Process	State of Illinois HealthChoice Model Contract	Managed Care Reform and Patient Rights Act 215 ILCS 134 Citation	BBA Citation, 42 CFR Part 438 Subpart F—Grievance Systems
MCO Participation in Appellate State Hearing		If an Appeal is filed with the State Fair Hearing system, MCO participates in the pre-hearing process, including scheduling coordination and submission of documentary evidence at least three (3) business days prior to the hearing, and participates in the hearing, including providing a witness to offer testimony supporting the MCO's decision.	Article 5.30.3.7		
Reversed Decision Enrollee Compensation		MCO pays for Enrollee-disputed services received during the pending Appeal process, in accordance with State policy and regulations in the case of a reversed decision to deny authorization of services by the MCO or State Fair Hearing Officer.	Article 5.30.3.9		*42 CFR 438.424*
Enrollee Benefit Continuance		MCO continues Enrollee's benefits during the Appeal process.	Article 5.30.3.10		*42 CFR 438.420*
Quarterly Reporting		MCO submits quarterly report to the Department summarizing all Appeals filed by Enrollees and the responses to and disposition of those matters (including decisions made following an external independent review).	Article 5.30.3.11	Section 55	42 CFR 438.416

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Grievance System

	Grievance Process	Appeal Process	State of Illinois HealthChoice Model Contract	Managed Care Reform and Patient Rights Act 215 ILCS 134 Citation	BBA Citation, 42 CFR Part 438 Subpart F—Grievance Systems
Information to Providers	An MCO's affiliated Providers are furnished with information about MCO's Grievance and Appeal procedures at the time the Provider enters into an agreement with MCO and within fifteen (15) days following any substantive change to such procedures.		Article 5.32.7		
Provider Complaints	The MCO has an established complaint and resolution system for Providers that includes a Provider dispute process.		Article 5.29.7		

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ATTACHMENT XIII: REQUIRED DELIVERABLES, SUBMISSIONS, AND REPORTING

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

Failure to submit required deliverables, submissions and reports outlined in this section will be grounds for the imposition of sanctions as described in 7.16.

Name of report/submission	Frequency	HFS Prior Approval	Report description and requirements
Administrative			
Encounter Data	At least monthly	No	**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. Contractor shall submit Encounter Data such that it is accepted by the Department within one-hundred twenty (120) days after Contractor's payment or final rejection of the claim or, for services paid through a Capitation arrangement, within one-hundred twenty (120) days after the date of service. Any claims processed by Contractor for services provided subsequent to submission of an Encounter Data file shall be reported on the next Encounter Data file. **Testing.** Upon receipt of each submitted Encounter Data file, the Department shall perform two distinct levels of review: The first level of review and edits performed by the Department shall check the data file format. These edits shall include, but are not limited to the following: check the data file for completeness of records; correct

Name of report/submission	Frequency	HFS Prior Approval	Report description and requirements
			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. 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. **Production.** Once Contractor's testing of data specified above is completed, Contractor will be certified for production. Once certified for production, Contractor shall continue to submit Encounter Date in accordance with these requirements. The Department will continue to review the Encounter Data for correct format and quality. Contractor shall submit as many files as necessary, in a time frame agreed upon by the Department and Contractor, to ensure all Encounter Data are current. Records that fail the edits described above will be returned to Contractor for correction. Corrected Encounter Data must be returned to the Department for reprocessing. **Electronic data certification.** In a format determined by the Department, Contractor shall certify by the 5th day of each month that all electronic data submitted during the previous calendar month are accurate, complete and true.
Disclosure statement	Initially, annually, on request, and as changes occur	No	Contractor shall submit disclosure statements as specified in 42 CFR, Part 455.

Name of report/submission	Frequency	HFS Prior Approval	Report description and requirements
Report of transactions with Parties of Interest	Annually	No	Contractor shall report all "transactions" with a "party of interest" (as such terms are defined in Section 1903(m)(4)(A) of the Social Security Act and SMM 2087.6(A-B)), as required by Section 1903(m)(4)(A) of the Social Security Act.
Adjudicated claims inventory summary	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.
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).

Name of report/submission	Frequency	HFS Prior Approval	Report description and requirements
Fraud and Abuse			
Fraud and Abuse Referral	Immediately upon notification or knowledge of suspected Fraud and Abuse	N/A	Contractor shall report all suspected Fraud and Abuse to the Department as required in Article V and Article IX of this Contract. Contractor shall provide a preliminary investigation report as each occurrence is identified.
Fraud and Abuse Report	Quarterly	No	Contractor shall provide a summary report of referrals made and program integrity activities conducted in the previous quarter.
Recipient Verification Procedure	Initially, annually and as revised	Yes	Contractor shall submit Contractor's plan for verifying with Enrollees whether services billed by Providers were received, as required by 42 CFR 455.20, for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in information conveyed. This does not need to be provided to the Department separately by population.
Recipient Verification Results	Annually and within ten (10) Business Days after the Department's request	No	Contractor shall submit a summary of the results of the Recipient Verification Procedure.
Fraud and Abuse Compliance Plan	Initially and annually	Yes	Per 42 CFR 438.608, Contractor shall submit its compliance plan designed to guard against Fraud and Abuse to the Department for Prior Approval. This does not need to be provided to the Department separately by population.

Name of report/submission	Frequency	HFS Prior Approval	Report description and requirements
Marketing			
Marketing Gifts and Incentives	Initially and within ten (10) Business Days after the Department's request	Yes	Contractor shall submit all plans to distribute gifts and incentives, as well as description of gifts and incentives, for Prior Approval.
Marketing Materials	Initially and as revised	Yes	Contractor shall submit all Marketing Materials for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed.
Marketing Plans and Procedures	Initially and as revised	Yes	Contractor shall submit descriptions of proposed Marketing concepts, strategies, and procedures for Prior Approval.
Community Outreach Events	Monthly, by the last day of the reporting month	No	Contractor shall submit to the Department a list of all previously approved community outreach events that occurred during the submission month. The report must include the Event name, date, time, address/location, county, audience type, estimated number of attendees and date of Department approval.

Name of report/submission	Frequency	HFS Prior Approval	Report description and requirements
Provider Network			
Primary care Provider, Hospital, and Affiliated Specialist File (CEB Provider File)	No less often than weekly	Yes	Contractor shall submit to the Department or its designee, in a format and medium designated by the Department, an electronic file of Contractor's PCPs, Hospitals and Affiliated Specialists. The primary care Providers must include, but not limited to, the following information: • Provider name, Provider number, office address, and telephone number; • Type of specialty (e.g., family practitioner, internist, oncologist, etc.), subspecialty if applicable, and treatment age ranges; • Identification of Group Practice, if applicable; • Geographic service area, if limited; • Areas of board-certification, if applicable; • Language(s) spoken by Provider and office staff; • Office hours and days of operation; • Special services offered to the deaf or hearing impaired (i.e., sign language, TDD/TTY, etc.); • Wheelchair accessibility status (e.g., parking, ramps, elevators, automatic doors, personal transfer assistance, etc.); • PCP indicator; • 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 Site Closures/Terminations	As each occurs	No	Contractor shall submit Provider Site Closures/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.

Name of report/submission	Frequency	HFS Prior Approval	Report description and requirements
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.

Name of report/submission	Frequency	HFS Prior Approval	Report description and requirements
Summary of Grievances, Appeals and Resolutions and External Independent Reviews and Resolutions – Summary Report	Quarterly	No	Contractor shall submit a summary of the Grievances and Appeals filed by Enrollees, organized by categories of quality of care, access to care, medical necessity reviews, transportation, Long Term Services and Supports (LTSS), 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. Contractor shall also report Grievances and Appeals separately for the categories of: Nursing Facility Services; Persons who are Elderly; Assisted Living, Supportive Living Program; Persons with Physical Disabilities; Persons with HIV/AIDS; and Persons with Brain Injury. The report shall only include Grievances and Appeals related specifically to LTC and Waiver services and providers.
Quality Assurance, Utilization Review and Peer Review (QA/UR/PR) Annual Report / Program Evaluation	Annually, no later than ninety (90) days after close of reporting period	No	Contractor shall submit a QA/UR/PR Annual Report/Program Evaluation reviewing the effectiveness of Contractor's QAP. The summary shall contain Contractor's processes for Quality Assurance, utilization review and peer review. This report shall include a comprehensive description of Contractor's network and an annual work-plan outlining Contractor's intended activities relating to QA, utilization review, peer review and health education. Contractor may submit one report that includes all care coordination programs in which it participates; however, Contractor must clearly identify program-specific activities.

Name of report/submission	Frequency	HFS Prior Approval	Report description and requirements
QA/UR/PR Committee Meeting Minutes	As needed, and within ten (10) Business Days after the Department's request	No	Contractor shall submit the minutes of its QA/UR/PR Committee meetings.
QA/UR/PR and Health Education Plans	Initially and as revised	Yes	Contractor shall submit the Quality Assurance, Utilization Review, Peer Review and Health Education Plans for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed. Contractor shall identify all areas, activities and performance data that differ among care coordination programs.
Conditions Report	As needed, and within ten (10) Business Days after the Department's request	No	Contractor shall submit the aggregate count of the primary health conditions of its Enrollees and their associated risk levels. These reports may be generated utilizing Contractor's unique internal algorithms and systems to determine primary conditions and risk level of Enrollees.
Care Management and Disease Management Program Descriptions	Initially and as revised	Yes	Contractor shall submit the descriptions of its Care Management and Disease Management programs for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed. Contractor shall identify all areas in its CM/DM program that differ among care coordination programs.

Name of report/submission	Frequency	HFS Prior Approval	Report description and requirements
Care Coordination effectiveness Summary Report	Monthly	No	Contractor shall track Enrollees based on enrollment date and show the data points of initial screenings completed, comprehensive assessments completed, Enrollee care plans completed, opt outs (Enrollees who declined Care Management), and attempting to locate. Contractor shall report separately for the categories of: Families and Children; Persons with Developmental Disabilities; Persons with Disabilities; Persons with Brain Injury; Persons with HIV/AIDS; Persons who are Elderly; Assisted Living, Supportive Living Program; LTC; Behavioral Health (by primary diagnoses, including Substance Abuse); ACA Adult; and High-Needs Children. Contractor shall also report on all Enrollees who are assigned to Contractor's Care Management and Disease Management interventions, including a count of those who are risk-stratified, in process of stratification, attempting to locate, opt out of care management, high ED utilizers, and the percentage of Enrollees at each level. Contractor shall provide summary data for each of the categories listed above.
Care Gap Plan	Annually	No	Contractor shall submit its plan for ensuring provision of services missed by Enrollees, including, but not limited to, annual preventive exams, immunizations, women's healthcare, PAP and missed services for Chronic Health Conditions and Behavioral Health follow-up. Contractor may submit one plan that includes all care coordination programs in which it participates; however, Contractor must clearly identify program-specific activities.
Outreach Summary Report	Quarterly	No	Contractor shall submit a summary report that shows Enrollee outreach for each level of stratification 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.

Name of report/submission	Frequency	HFS Prior Approval	Report description and requirements
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.
Physician Quality Measurement Report	As needed, and within ten (10) Business Days after the Department's request	No	Contractor shall submit a report for each Provider or Provider group that shows actual performance relative to measures of performance.
Enrollee Profiles/ Statistics for Care Integration	As needed, and within ten (10) Business Days after the Department's request	No	Contractor shall submit a report that provides comprehensive information on Contractor's care integration systems for Enrollees' care. This report shall include, but not be limited to, an annual summary of physical and behavioral health conditions, service utilization such as primary care Provider and specialist visits, Emergency Services, inpatient hospitalizations and pharmacy utilization.
Processes and Procedures to Receive Reports of Critical Incidents	Initially and as revised	Yes	Contractor shall submit Critical Incident Processes and Procedures for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed. Contractor may submit one set of processes and procedures that includes all care coordination programs in which it participates; however, Contractor shall identify all areas that differ among care coordination programs.

Name of report/submission	Frequency	HFS Prior Approval	Report description and requirements
Critical Incidents – Detail Report	Monthly	No	Contractor shall submit a detailed report on Critical Incidents providing Enrollee name, Enrollee Medicaid number, incident summary, date received, source, incident date, date referred, referral entity, date resolved, and resolution summary, grouped in the following categories: Abuse; Neglect; Exploitation; and Other. Contractor shall report Critical Incidents for each of the following: Nursing Facility Services; HCBS Waiver for Persons who are Elderly; HCBS Waiver for Assisted Living, Supportive Living Program; HCBS Waiver for Persons with Physical Disabilities; HCBS Waiver for Persons with HIV/AIDS; and HCBS Waiver for Persons with Brain Injury.
Critical Incidents – Summary Report	Quarterly	No	Contractor shall submit a summary report on Critical Incidents that includes the total Critical Incidents and the total Critical Incidents referred. Contractor shall submit a summary count of Critical Incidents in the following categories: Abuse, Neglect, Exploitation, and Other. Contractor shall report Critical Incidents separately for each of the following: Nursing Facility Services; HCBS Waiver for Persons who are Elderly; HCBS Waiver for Assisted Living, Supportive Living Program; HCBS Waiver for Persons with Physical Disabilities; HCBS Waiver for Persons with HIV/AIDS; and, HCBS Waiver for Persons with Brain Injury. This report shall only include Critical Incidents specifically related to Enrollees receiving Long-Term Services and Supports (LTSS).
Transition of Care Plan	Initially and as revised	Yes	Contractor shall submit its Transition of Care Plan to the Department for review and Prior Approval. The Transition of Care Plan shall include policies and procedures and a staffing model designed to achieve a seamless, efficient transition with minimal impact to an Enrollee's care. Contractor may submit one plan that includes all care coordination programs in which it participates; however, Contractor shall identify all areas that differ among care coordination programs.

Name of report/submission	Frequency	HFS Prior Approval	Report description and requirements
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.

Name of report/submission	Frequency	HFS Prior Approval	Report description and requirements
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			
Pharmacy Monitoring Report	Monthly	No	Contractor shall submit pharmacy data utilization reports based on total utilization, claims summaries, cost summaries and cost per claim.
Psychotropic Review Report	Monthly	No	Contractor shall submit a summary report of Enrollees' Psychotropic medication utilization and the prescribing patterns of Providers. The report must include information on the following criteria: use of 5 or more psychotropics for 60 or more days, use of 2 or more ADHD medications for 60 or more days, use of 3 or more antidepressants for 60 or more days, use of 5 or more drugs for bipolar disorder (mood stabilizers, atypical antipsychotics, antidepressants) for 60 or more days, use of 2 or more SSRIs for 60 or more days, use of 2 or more antipsychotics for 60 or more days, use of 2 or more atypical antipsychotics for 60 or more days, and use of 2 or more benzodiazepine or benzodiazepine hypnotics for 60 or more days.

Name of report/submission	Frequency	HFS Prior Approval	Report description and requirements
Drug Utilization Review Report	Quarterly	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.

Name of report/submission	Frequency	HFS Prior Approval	Report description and requirements
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.

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External Quality Review (EQR) Activities
January 1, 2021 – December 31, 2022
D.5.26 –2021-2022 Work Plan

EQR Activities	2021												2022											
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
E.1.2.1 Quality Strategy																								
1.1.2 & 1.1.13.2 – Quality Assurance Strategy Improvement Plan & Quality Strategy Report – HFS will evaluate the timing for future revisions/updates to the Quality Strategy																								
Develop Draft Quality Strategy Report	D.3.2.1.2 – QAS Report																							
D.3.2.1.7- Submit Final Quality Strategy Report (Annual)	D.3.2.1.7 – Quality Strategy Report																							
E.1.2.2 Administrative and Compliance Processes																								
D.2.3 Evaluation of Administrative Process and Compliance (MCO and MMAI) – 1.1.3 & 1.2.2.1.3																								
Schedule and conduct planning meeting with the Department – discuss scope of reviews and timeline																								
Develop and obtain approval for Administrative Compliance Audit including; review tools, MCO communication, agenda, and associated review materials																								
Develop on-site Administrative Compliance review schedule, obtain Department approval and communicate schedule to MCOs																								

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EQR Activities	2021												2022											
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Forward Administrative Compliance review materials																								
Conduct desk review																								
Conduct on-site Administrative Compliance review																								
Submit Draft Administrative Compliance Audit Report																								
D.3.2.1.3 – Submit Final Administrative Compliance Audit Report																								
D.2.28 – Annual review and audit of MCO/MMAI Billing Policies and Procedures – (Discuss need for this review with HFS) – ***Not Scheduled for 2021 – HFS will evaluate the need for conducting the activity in 2022***																								
D.2.27 Review and Validation of MCO/MMAI Encounter Data – 1.1.17.5.3 – ***Activity not planned for 2021; HFS will evaluate the need for conducting the activity in 2022***																								
D.2.28 MCO/MMAI Administrative Claim Denials – ***Activity not scheduled for 2021; HFS will evaluate the need for conducting the activity in 2022***																								
D.2.5 Readiness Reviews for MCOs and MMAI plans – 1.1.5 – ***MMAI Statewide Expansion – Aetna/IlliniCare***																								
Schedule and conduct planning meeting with the Department – discuss scope of review and timeline	Conduct Readiness Review within 30 days of Department Request																							
Develop and obtain approval for Readiness Reviews including; review tools, MCO communication, agenda, and	Submit all criteria and tools to Department for review and approval 30 days following contract execution																							

D.3.2.1.3 – Administrative Compliance Audit Report

D.3.2.1.3 – Administrative Compliance Audit Report

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EQR Activities	2021												2022											
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
associated review materials (due to Department no later than 30 days following contract execution)																								
Develop on-site Readiness review schedule, obtain Department approval and communicate schedule to MCOs	D.3.2.8 – MMAI Statewide Expansion Readiness Review																							
Forward Readiness review materials to MCOs																								
Conduct desk Readiness review																								
Conduct on-site (Webinar due to COVID-19) Readiness review																								
Submit Draft Readiness Report																								
Corrective action - remediation phase																								
D.3.2.3 – Submit Initial Readiness Review Report (7 calendar days after completion of the readiness review)	D.3.2.3 – Initial Readiness Review Report – within 7 business days after completion of a readiness review.																							
Remediation Phase																								
D.3.2.4 Submit Final Readiness Review Report (30 calendar	D.3.2.4 – Final Readiness Review Report – within 30 calendar days after completion of a readiness review.																							

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EQR Activities	2021												2022											
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
days after completion of the readiness review)																								
D.3.2.7 – Submit Post-Implementation Readiness Review CAP Items Report (30 calendar days after completion of readiness review)			D.3.2.8 – MMAI Statewide Expansion Readiness Review Report																					
D.2.6 Post-Implementation Readiness Reviews for MCOs and MMAI Plans – 1.1.6																								
Schedule and conduct planning meeting with the Department – discuss Post-Implementation Readiness Review CAP Items Report with the Department and timeline	DCFS – Post Implementation Review – Schedule for 2nd Quarter 2021 SNC – Post Implementation review - Schedule to coincide with Administrative Review in 2021/2022 MMAI – Post Implementation review – schedule to coincide with MMAI Administrative Review in 2022																							
Schedule and conduct planning meeting with the Department – discuss Post-Implementation Readiness Review CAP Items Report with the Department and timeline																								
Develop and obtain approval for Post-Implementation Reviews																								

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EQR Activities	2021												2022											
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
including; review tools, MCO communication, agenda, and associated review materials																								
Develop on-site Post-Implementation review schedule, obtain Department approval and communicate schedule to MCOs																								
Forward Post-Implementation review materials to MCOs																								
Conduct desk Post-Implementation review	D.3.8 – Pre and Post-Implementation Review Report – within 30 calendar days after completion of the post-implementation readiness review.																							
Conduct on-site Post-Implementation review									D.3.2.8 – MCO Post-Implementation Review Report															
D.3.2.8 - Submit Pre-and Post-Implementation Review Report																								
D.3.2.8 - Submit final Pre-and Post-Implementation Review Report	Pre and Post-Implementation Review Report – including remediation of CAP items.																							
D.2.7 Quality Assurance Plan Assessment Report – 1.1.1.3 & 1.1.7.4 – QA/UR/PR Report Evaluation																								

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EQR Activities	2021												2022											
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Schedule and conduct planning meeting with the Department – discuss scope of review and timeline																								
Develop and obtain approval for Quality Assurance Plan Assessment tool																								
Receive QA/UR/PR Reports from MCOs																								
Conduct Desk Review																								
D.3.2.5 Submit MMAI Quality Assurance Plan Assessment Report – (due 30 calendar days after completing assessment)	D.3.2.5 – Quality Assurance Plan Assessment Report											D.3.2.5 – Quality Assurance Plan Assessment Report											
D.2.11 Quality Assurance Program Compliance Reviews (QAPCR) – 1.1.11 – ***Activity not scheduled for 2021; HFS will evaluate the need for conducting the activity in 2022***																								
D.2.12 Corrective Action Plan Development and Oversight – 1.1.12																								
As needed and approved by the Department	Develop and prepare corrective action plans for MCOs not meeting expected performance levels – at the direction of the Department																							
D.3.2.9 Submit Corrective Action Plan Report – 30 days after CAP completion				2020 HCI & MMAI Administrative Compliance Review CAPS Reports																				
E.1.2.3 Adequate Capacity and Services																								

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	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
D.2.8 Review of Provider Network Capacity (MCO and MMAI) – 1.1.8 – Bi-Annual Review – Quarterly Data Submission																								
Provider File Layout (PFL) update from MCOs																								
Report findings of quarterly network analysis to the Department and MCOs.																								
Submit Quarterly Network Capacity Report to the Department					E.1.2.3 – Bi-Annual Plan-Specific Provider Network Report					E.1.2.3 – Bi-Annual Plan-Specific Provider Network Report							E.1.2.3 – Bi-Annual Plan-Specific Provider Network Report				E.1.2.3 – Bi-Annual Plan-Specific Provider Network Report			
D.2.8 Review of Staffing, Qualifications and Training (MCO and MMAI) – 1.1.8 – Bi-Annual Review –																								
Forward Staffing Workbook to MCOs																								
Conduct staffing analysis																								
Report findings of staffing, qualifications and training analysis to the Department and MCOs.																								
Prepare and submit Staffing, Qualifications, and Training Report to the Department.			Annual staffing, Qualifications and Training Report						Annual staffing, Qualifications and Training Report						Annual staffing, Qualifications and Training Report					Annual staffing, Qualifications and Training Report				
D.2.9 Access and Availability Survey(s) – 1.1.9 – Bi-Annual Review																								
Schedule and conduct planning meeting with the Department –																								

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	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
discuss scope of review and timeline																								
Develop and obtain approval for Access and Availability review																								
Conduct survey																								
3.2.1.4 – Submit Access and Availability Aggregate Report to the Department																								
D.2.10 Time and Distance Study and Analysis – 1.1.10.4 – Annual Review																								
Schedule and conduct planning meeting with the Department – discuss scope of review and timeline																								
Develop and obtain approval for Time and Distance Study and Analysis																								
Conduct study and analysis																								
D.3.2.1.5 – Submit Time and Distance Analysis Compliance Report to the Department																								
D.2.25 MLTSS Provider Network Monitoring and Waiver Evaluation Report – 1.1.25																								
Schedule and conduct planning meeting with the Department –																								

D.3.2.1.4–Access and Availability Aggregate Report

D.3.2.1.4–Access and Availability Aggregate Report

D.3.2.1.5–Time and Distance Analysis Compliance Report

D.3.2.1.5–Time and Distance Analysis Compliance Report

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	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
discuss scope of review and timeline – ***(**Timeline will be revised to accommodate CMS reporting requirements)***																								
Develop and obtain approval for Provider File Layout (PFL)																								
Quarterly submission and network analysis																								
Report findings of quarterly network analysis to the Department and MCOs.																								
D.3.2.2.4 – Submit Quarterly MLTSS Provider Network Capacity Report to the Department (Quarterly)		D.3.2.2.4–MLTSS Provider Network Capacity Report							D.3.2.2.4–MLTSS Provider Network Capacity Report					D.3.2.2.4–MLTSS Provider Network Capacity Report							D.3.2.2.4–MLTSS Provider Network Capacity Report			
D.2.25 MLTSS 1915(b) Waiver Independent Evaluation Report – 1.1.24.2 – *Completed MLTSS Independent Assessment Report in 2019*																								
E.1.2.4 Performance Improvement Projects (PIPS) & Quality Improvement Projects (PIPS)																								
D.2.15 Written Strategy for HCI Collaborative PIPs and MMAI Plan Collaborative QIPs – 1.1.15.2 & 1.1.16																								
Schedule and conduct planning meeting with the Department – discuss scope of review and timeline		1.1.15.2 & 1.1.16.1 – Written Strategy for HCI Collaborative PIPs and MMAI Plan Collaborative QIPs												1.1.15.2 & 1.1.16.1 – Written Strategy for HCI Collaborative PIPs and MMAI Plan Collaborative QIPs											

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	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Develop and submit to the Department for review a written strategy for PIPs and QIPs ***(no later than 30 business days following contract execution)***																								
D.2.16 Oversight and Validation of HCI Collaborative PIPs and MMAI Plan Collaborative QIPs – 1.1.15 & 1.1.16																								
Complete data and analysis and findings for each PIP – Module (M) dates identified in work plan	Module 4 & 5 – Validation												Reporting PIP Results.											
Prepare Draft PIP/QIP Aggregate Report																								
D.3.2.1.8 – Submit Final PIP/QIP Aggregate Report		D.3.2.1.8–PIP/QIP Aggregate Report												D.3.2.1.8–PIP/QIP Aggregate Report										
2.15 & 2.16 – MCO/MMAI Monthly and Quarterly Meetings – 1.1.15.5																								
Plan and conduct MCO/MMAI PIP/QIP monthly teleconference meetings	**Plan and Conduct monthly conference calls and meetings as directed by the Department**																							
Plan and conduct MCO/MMAI PIP/QIP monthly teleconference meetings	**Plan and Conduct quarterly conference calls and meetings as directed by the Department**																							
E.1.2.5 Performance Measures: Audit Review and Validation																								
D.2.4 Health, Safety and Welfare/Critical Incident Monitoring Reviews – 1.1.4 – Quarterly Review																								

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	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Schedule and conduct planning meeting with the Department – discuss scope of review and timeline			Q1			Q2			Q3			Q4			Q1			Q2			Q3			Q4
Develop and obtain approval for Health, Safety and Welfare reviews.	Q4			Q1			Q2			Q3			Q4			Q1			Q2			Q3		
Conduct Health, Safety and Welfare monitoring reviews	Q4	Q4		Q1	Q1			Q2	Q2	Q3	Q3		Q4	Q4		Q1	Q1			Q2	Q2		Q3	Q3
D.3.2.2.1 – Submit Health, Safety and Welfare Monitoring Report (quarterly) reports to the Department and MCOs	D.3.2.2.1–Health Safety and Welfare Monitoring Reports – Quarterly			D.3.2.2.1–Health Safety and Welfare Monitoring Reports – Ouarterlv			D.3.2.2.1–Health Safety and Welfare Monitoring Reports – Quarterly			D.3.2.2.1–Health Safety and Welfare Monitoring Reports – Quarterly				D.3.2.2.1–Health Safety and Welfare Monitoring Reports – Quarterly		D.3.2.2.1–Health Safety and Welfare Monitoring Reports – Quarterly			D.3.2.2.1–Health Safety and Welfare Monitoring Reports – Quarterly			D.3.2.2.1–Health Safety and Welfare Monitoring Reports – Quarterly		
D.2.17 Audit and Validation of Performance Measures for MCO's and MMAI's – 1.1.17																								

EQR Activities	2021												2022											
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Schedule and conduct planning meeting with the Department –																								

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EQR Activities	2021												2022											
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
discuss scope of review and timeline																								
Schedule PMV Reviews -																								
On-site Audit																								
Complete validation activities and draft and submit reports																								
D.3.2.1.9 - Submit Validation of Performance Measures HEDIS Audit Report.																								
D.3.2.1.10 – Submit Validation of P4P Measures Audit Report								D.3.2.1.10–Submit Validation of P4P Measures Audit Report												D.3.2.1.10–Submit Validation of P4P Measures Audit Report					
D.3.2.1.11 – Submit Audit and Validation of Self-Reported Performance Measures Report								D.3.2.1.11– Audit and Validation of Self-Reported Performance Measures Report												D.3.2.1.11–Audit and Validation of Self-Reported Performance Measures Report					
D.3.2.1.12 – Submit Audit and Validation of CHIPRA Performance Measures Report								D.3.2.1.12–Audit and Validation of CHIPRA Performance Measures Report												D.3.2.1.12– Audit and Validation of CHIPRA Performance Measures Report					
D. 2.18 Consumer Focused Quality of Life Study – 1.1.18 & 1.1.18.3 –																								
Schedule and conduct planning meeting with the Department – discuss scope of review and																								

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	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
timeline																								
Develop and obtain approval for Consumer-Focused Quality Study																								
Forward review materials to MCOs																								
Collect and perform administrative data review																								
Collect and perform review of medical records																								
D.3.2.1.13 – Submit Focused Quality Study Report and Quality of Life Studies Report																				D.3.2.1.13–Consumer Focused Quality Study Report				
D.3.2.1.14 - Submit Quality of Life Studies Report (SBD)																								
D.2.23 HCBS Waiver Program – Performance Measure Compliance/Remediation Reviews – 1.1.22																								
Schedule and conduct planning meeting with the Department – discuss scope of review and timeline		Q3		Q4				Q1		Q2			Q3			Q4				Q1				

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	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Schedule and conduct on-site record reviews and submit plan-specific reports to the Department and MCOs		Q3	Q3		Q4	Q4			Q1	Q2	Q2		Q3	Q3	Q3	Q4	Q4	Q4						
D.3.2.2.7 – Submit HCBS Waiver Program Performance Measures Review Status Report (Quarterly)			D.3.2.11–HCBS Waiver Program Performance Measures Enrollee Specific Findings Report - Quarterly						D.3.2.2.7–HCBS Waiver Program Performance Measures Review Status Report – Quarterly		Q2				D.3.2.11–HCBS Waiver Program Performance Measures Enrollee Specific Findings Report - Quarterly				D.3.2.11–HCBS Waiver Program Performance Measures Enrollee Specific Findings Report - Quarterly					
D.3.2.11 – Submit HCBS Waiver Program Performance Measures Enrollee Specific Findings Report (30 days after completion of HCBS Program Performance Measures Review) – Annual Report							D.3.2.1.19–HCBS Waiver Program Performance Measures Analysis Report – Annual												D.3.2.1.19–HCBS Waiver Program Performance Measures Analysis Report – Annual					
D.3.2.1.19 – Prepare data file and submit to the Department for CMS reporting											D.3.2.1.19–Annual Data File										D.3.2.1.19–Annual Data File			
E.1.2.6 MCO System Review and Monitoring – 1.1.14 – ***HFS may request System Reviews for Meridian and IlliniCare/Aetna in 2021 – HFS will evaluate need for Systems Reviews in 2022***																								
Schedule and conduct planning meeting with the Department – discuss scope of review and timeline																								
Develop and obtain approval for System Review																								

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	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Forward System Review materials to MCOs																								
Conduct Desk Review																								
Conduct on-site Information System Review																								
D.3.2.10 – Submit MCO Systems Review and Monitoring Report			D.3.2.10–MCO Systems Review and Monitoring Report																					
E1.2.7 CAHPS Survey																								
D.2.19 Consumer Assessment of Health Providers and Systems Survey (CAHPS) – 1.1.19																								
Prepare administrative forms and project timeline																								
D.3.2.1.15 – Submit CAHPS Survey Timeline (by November 15th)																								
Select survey sample																								
Survey administration																								
Data analysis and findings to the Department																								
D.3.2.1.16 – Submit CAHPS Aggregate Report to the Department								D.3.2.1.16–CAHPS Aggregate Report and Cross tabulations report												D.3.2.1.16–CAHPS Aggregate Report and Cross Tabulations report				

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	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
E.1.2.8 Consumer Report Care for Health Plans																								
D.2.20 Health Plan Consumer Report Card – 1.1.20																								
Schedule and conduct planning meeting with the Department – discuss scope of review and timeline																								
Develop and obtain approval for Health Plan Consumer Report Card																								
Conduct analysis of MCO data and produce performance ratings and report card – Statewide and Cook County																								
Present Consumer Report Card methodology and findings to the MCOs and Quality Sub-Committee																								
D.3.2.2.2 – Submit Consumer Report Card Analysis Report – Statewide and Cook County							D.3.2.2.2–Consumer Report Card Analysis Report												D.3.2.2.2–Consumer Report Card Analysis Report					
E.1.2.9 Technical Assistance																								

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EQR Activities	2021												2022											
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
D.2.21 Ad Hoc Technical Assistance and General Assistance – 1.1.22																								
Schedule and conduct planning meeting with the Department – discuss scope of technical assistance and timeline																								
D.3.2.1.18 - Develop an annual Department-approved Ad Hoc Technical Assistance Plan			D.3.2.1.18–Annual Technical Assistance Plan												D.3.2.1.18–Annual Technical Assistance Plan									
Conduct technical assistance according to the plan and timeline	Conduct technical assistance as outlined in the Technical Assistance Plan and timeline																							
D.3.2.2.3 – Submit Ad Hoc Technical Assistance Report (Quarterly)																								
E.1.2.10 Special Projects																								
As needed and approved by the Department	As needed and requested by the Department																							
E.1.2.11 Individual Reports																								
D.3.1.8 Annual Work Plan – 1.2.2.1.18																								
D.3.2.1.17 – Submit Annual Work Plan **(no later than the 30th June each year)**					D.3.2.1.17–Annual Work Plan												D.3.2.1.17–Annual Work Plan							

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D.3.2.1.1 External Quality Review (EQR) Technical Report – 1.2.21.1																								
Schedule and conduct planning meeting with the Department – discuss EQR Report and timeline																								
Prepare and submit draft EQR report																								
Department and MCO review																								
D.3.2.1.1 – Submit final EQR Report																								
Forward to CMS and post to State Website **(due to CMS by Aril 30th each year)**		D.3.2.1.1–Annual EQR Technical Report												D.3.2.1.1–Annual EQR Technical Report											
D.3.2.12 General Ad Hoc Reports – 1.2.2.12																								
D.3.2.12 – Submit General Ad Hoc Reports	Submit Ad Hoc reports at the request of the Department																							
MLTSS Quarterly Monitoring Report – ***Pending CMS Feedback on the need for continuing the MLTSS Monitoring Report***																								
Special Needs IA Evaluation – ***Pending direction from CMS/HFS on re-submission of the SNC IA Evaluation Report***																								

Table 1 to Attachment XI: Healthcare and Quality of Life Performance Measures
Revised 2/22/2021

Acronym	Performance Measure	Further Description	Reporting Methodology	Source
P4P **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	HEDIS
AMB	Ambulatory Care	This measure summarizes utilization of ambulatory care in the following categories: • Outpatient Visits • ED Visits. (Reported per 1,000 member months, on 9 age ranges and total)	Admin	HEDIS
P4P **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. • *Timeliness of Prenatal Care*. 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. • *Postpartum Care*. Percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.	Hybrid / Admin	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. • Initiation of AOD Treatment. Percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. • Engagement of AOD Treatment. Percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.	Admin	HEDIS

Acronym	Performance Measure	Further Description	Reporting Methodology	Source
P4P Reporting **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	HEDIS
P4P Reporting **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	HEDIS
P4P Reporting **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
P4P **BCS**	Breast Cancer Screening	Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.	Admin	HEDIS
P4P **CCS**	Cervical Cancer Screening	Percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria: • Women age 21-64 who had a cervical cytology performed every 3 years. • Women age 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.	Hybrid / Admin	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
P4P **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: • Members 18-59 years of age whose BP was <140/90mm Hg.	Hybrid	HEDIS

Acronym	Performance Measure	Further Description	Reporting Methodology	Source
		• 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.		
CIS	Childhood Immunization Status – Combo 3	Percentage of children 2 years of age who had four DTaP; three IPV; one MMR; three HiB; three HepB; one VZV; four PCV;	Hybrid / Admin	HEDIS
CIS	Childhood Immunization Status – Combo 10	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	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: • 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 13th birthday. This measure calculates a rate for each vaccine and two combination rates.	Hybrid / Admin	HEDIS
CDC	Comprehensive Diabetes Care	Percentage of members18–75 years of age with diabetes (type 1 and type 2) who had each of the following: • Hemoglobin A1c (HbA1c) testing.* • HbA1c poor control (>9.0%).* • HbA1c control (<8.0%).* • Eye exam (retinal) performed • BP control (<140/90 mm Hg). **Organizations must use the same data collection method (Administrative or Hybrid) to report these indicators.*	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	Admin	HEDIS

Acronym	Performance Measure	Further Description	Reporting Methodology	Source
		cardiovascular disease (ASCVD) who met the following criteria. Two rates are reported: 1) *Received Statin Therapy*. Members who were dispensed at least one statin medication of any intensity during measurement year. 2) *Statin Adherence 80%*. Members who remained on a statin medication of any intensity for at least 80% of the treatment period		
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	Percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing. (Report three age stratifications and total)	Admin	HEDIS
FUH	Follow-Up After Hospitalization for Mental Illness - 7 and 30- day 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	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
FUI	Follow-Up High Intensity Care for Substance Use Disorder - 7 and 30-day follow-up	The percentage of acute inpatient hospitalizations, residential treatment or detoxification visits for a diagnosis of substance use disorder among members 13 years of age and older that result in a follow-up visit or service for substance use disorder. Two rates are reported: 1. The percentage of visits or discharges for which the member received follow-up for substance use disorder within the 30 days after the visit or discharge.	Admin	HEDIS

Acronym	Performance Measure	Further Description	Reporting Methodology	Source
		2. The percentage of visits or discharges for which the member received follow-up for substance use disorder within the 7 days after the visit or discharge.		
P4P Reporting **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 members age 16 and older with a diagnosis of OUD.	Admin	HEDIS
P4P **FUA**	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 and 30-day follow-up	The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD. Two rates are reported: 1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). 2. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).	Admin	HEDIS
P4P **FUM**	Follow-Up After Emergency Department Visit for Mental Illness - Child age stratification 6-17 years of age - 7 and 30-day follow-up	The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. Two rates are reported: 1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). 2. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).	Admin	HEDIS

Acronym	Performance Measure	Further Description	Reporting Methodology	Source
P4P Reporting **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	CMS Adult Core Set
P4P Reporting **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	NQF #2079 and State Defined
P4P Reporting **HIV**	Prescription of HIV Antiretroviral Therapy	Percentage of patients, regardless of age, with a diagnosis of HIV prescribed antiretroviral therapy1 for the treatment of HIV infection during the measurement year	Admin	NQF #2083 and State Defined
P4P Reporting **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	HEDIS
P4P Reporting **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	Admin	NQF #9999

Acronym	Performance Measure	Further Description	Reporting Methodology	Source
		(community residence for 60 or more days). This measure is reported as an observed rate and a risk-adjusted rate.		
P4P Reporting **CBH**	Mobile Crisis Response Services that Result in Hospitalization	Specification under development	Admin	Non-HEDIS – State Defined
P4P Reporting **CBH**	Visits to the ER for BH services that Result in Hospitalization	Specification under development	Admin	Non-HEDIS – State Defined
P4P Reporting **CBH**	Overall Number and Length of BH Hospitalizations	Specification under development	Admin	Non-HEDIS – State Defined
P4P Reporting **CBH**	Number of Repeat BH Hospitalizations	Specification under development	Admin	Non-HEDIS – State Defined

Appendix H. Access Standards

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
1. Amount, Duration, and Scope of Coverage 42 CFR 438.206 42 CFR 438.210 89 Ill. Adm. Code, Part 140	Contractor shall comply with the terms of 42 CFR §438.206 (b) and (c) and provide, or arrange to have provided, to all Enrollees the services described in 89 Ill. Adm. Code, Part 140, 59 Ill. Adm. Code, Part 132, the State Plan and related waivers, as amended from time to time and not specifically excluded therein in accordance with the terms of this Contract. Covered Services shall be provided in the amount, duration, and scope as set forth in 89 Ill. Adm. Code, Part 140, in 59 Ill. Adm. Code, Part 132, in the State Plan and related waivers, and in this Contract, and shall be sufficient to achieve the purposes for which such Covered Services are furnished. This duty shall commence at the time of initial coverage for each Enrollee. Contractor shall, at all times, cover the appropriate level of service for all Emergency Services and non-Emergency Services in an appropriate setting. Contractor shall notify the Department in writing as soon as practicable, but no later than five (5) days following a change in Contractor's Provider Network that renders Contractor unable to provide one (1) or more Covered Services within the access-to-care standards set forth in section 5.8. Contractor shall not refer Enrollees to publicly supported healthcare entities to receive Covered Services for which Contractor receives payment from the Department, unless such entities are Network Providers with Contractor or are operated by Contractor. Such publicly supported healthcare entities include, but are not limited to, the Chicago Department of Public Health and its clinics, and the Certified Local Health Departments. Contractor shall provide a mechanism for an Enrollee to obtain a second opinion from a qualified Provider, whether Network or non-Network, at no cost to the Enrollee. Contractor will assist in coordinating and obtaining any second opinion from a non-Network Provider. *Contract 2018-24-001, Section 5.1*
2. General Provisions: Service Package I *42 CFR 438.206(a)*	Contractor shall provide, or arrange for the provision of, all Covered Services for Service Package I, to Enrollees at all times during the term of this Contract, whenever Medically Necessary. Service Package I includes all federally approved Medicaid services, including EPSDT screenings and services, except those included in Service Package II (see Attachment I). Additional services that are explicitly excluded from Service Package I are listed in section 5.4. *Contract 2018-24-001, Sections 5.2.1.1 and 5.4 through 5.4.10*
3. General Provisions: Service Package II *42 CFR 438.206(a)*	Contractor shall provide, or arrange for the provision of, all Covered Services for Service Package II, to Enrollees at all times during the term of this Contract. Service Package II includes all Covered Services identified in Attachment I. Personal Assistant services in Service Package II shall be considered Covered Services only if such services can be included in a manner consistent with any existing collective bargaining agreement, or pertinent side letter, between DCMS and SEIU Healthcare Illinois. Contractor must abide by the rules and policies provided in each HCBS Waiver. *Contract 2018-24-001, Section 5.2.1.2*
4. General Provisions: Service Package III	Service Package III includes Developmental Disability waiver services and ICF/DD services. The Department reserves the right to require Contractor to provide Service Package III services. Department will provide contractor one hundred eighty (180) days' notice, in writing, before requiring the provision of these services. *Contract 2018-24-001, Section 5.2.1.3*

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE

5. MLTSS Services	MLTSS Services includes the Behavioral Health and non-emergency transportation services from Service Package I and the Nursing Facility and waiver services from Service Package II that are not covered by Medicare (see Attachment I). Medicare remains the primary payer of Medicare-covered services for MLTSS Enrollees. Crossover claims and other federally approved Medicaid services not covered by Medicare are not covered MLTSS Services and will be billed to Fee-for-Service. Personal Assistant services shall be considered MLTSS Services only if such services can be included in a manner consistent with any existing collective bargaining agreement, or pertinent side letter, between DCMS and SEIU Healthcare Illinois. Contractor must abide by the rules and policies provided in each HCBS Waiver.
	The following Medicaid services are included in the waiver:
	• Long-term Services and Supports provided under Illinois State Plan excluding ICF/MR services and including:
	  o Nursing Facility Services
	  o All services designed to assist individuals to live independently in the community, such as home health aides, adult day, and environmental adaptations, that are provided under the following IL Home and Community Based Waivers:
	  ▪ Persons who are Elderly;
	  ▪ Persons with Disabilities;
	  ▪ Persons with HIV/AIDS;
	  ▪ Persons with Brain Injury; and
	  ▪ Supportive Living Facilities Waiver.
	• Mental health services provided under the Medicaid Clinic Option or Medicaid Rehabilitation Option;
	• Subacute alcoholism and substance abuse services pursuant to 89 Ill. Admin. Code Sections 120, 148.340 through 148.390, and 77 Ill. Admin. Code Part 2090; and
	• Transportation to secure Covered Services.
	
	Contract 2018-24-001, Section 5.2.2 and Attachment I

6. Institution for Mental Diseases in lieu of Covered Services	Contractor may provide psychiatric and substance use disorder inpatient services in an Institution for Mental Diseases (IMD) that are medically appropriate and cost effective in-lieu of the Covered Services under the State Plan to Enrollees between the ages of twenty-one and sixty-four (21–64) who have inpatient stays in an IMD of no more than fifteen (15) days in a calendar month. Contractor shall not require an Enrollee to use such in lieu of services. The Department represents that Capitation rates paid hereunder for IMD in lieu of services are actuarially sound and based on covered services under the State Plan. Eligibility and length of stay will be determined by IMD admissions status on the first day of every calendar month. *Contract 2018-24-001, Section 5.2.3*

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
7. Parity in Mental Health and Substance Use Disorder Benefits	• Contractor may not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder Covered Services. • Contractor will not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to Enrollees (whether or not the benefits are furnished by the same MCO). • When an Enrollee is provided mental health or substance use disorder benefits in any classification of benefits (inpatient, outpatient, emergency care, or prescription drugs), Contractor shall provide mental health or substance use disorder benefits to the Enrollee in every classification in which medical/surgical benefits are provided. • Contractor may not apply any cumulative financial requirements for mental health or substance use disorder benefits in a classification (inpatient, outpatient, emergency care, prescription drugs) that accumulates separately from any established for medical/surgical benefits in the same classification. • Contractor may not impose any non-quantitative treatment limitation (NQTL) for mental health or substance use disorder benefits in any classification unless, under the policies and procedures of Contractor as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification. • Contractor shall establish and demonstrate compliance with 42 CFR part 438, subpart K regarding parity in mental health and substance use disorder benefits. Contractor shall provide the necessary documentation, reporting, and analyses, in the format and frequency required by the Department. *Contract 2018-24-001, Sections 5.8.10 to 5.8.10.6*

8. Access Standards – Appointments
 	
42 CFR 438.206 (c)(1)(i)
	Contractor shall require that time-specific appointments:
	• for routine preventive care are available within five (5) weeks from the date of request for such care, and within two (2) weeks from the date of request for infants under age six (6) months.
	• Enrollees with more serious problems not deemed Emergency Medical Conditions shall be triaged and, if necessary or appropriate, immediately referred for urgent Medically Necessary care or provided with an appointment within one (1) Business Day after the request.
	• Enrollees with problems or Complaints that are not deemed serious shall be seen within three (3) weeks from the date of request for such care.
	• Initial prenatal visits without expressed problems shall be made available
	  o within two (2) weeks after a request for an Enrollee in her first trimester,
	  o within one (1) week for an Enrollee in her second trimester, and
	  o within three (3) days for an Enrollee in her third trimester.
	• Network Providers shall offer hours of operation that are no less than the hours of operation offered to Persons who are not Enrollees.
	
	Contract 2018-24-001, Section 5.8.3

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
9. Travel Time and Distance Standards- PCP *42 CFR 438.206 (b)(v)*	Travel time and distance standards to which Contractor will adhere are provided below, by Provider type. An Enrollee may elect to travel beyond the distance standards when the Enrollee exercises choice in selecting a Provider. The free exercise of such choice by the Enrollee will not negatively impact the results of any reporting by Contractor on access to care. • Primary care Provider access: Contractor shall ensure an Enrollee has access to at least two (2) primary care Providers within a thirty (30)–mile radius of or thirty (30)–minute drive from the Enrollee's residence. If an Enrollee lives in a Rural Area, the Enrollee shall have access to at least one (1) primary care Provider within a sixty (60)–mile radius of or sixty (60)–minute drive from the Enrollee's residence. *Contract 2018-24-001, Sections 5.8.1.1 to 5.8.1.1.1*
10. Travel Time and Distance Standards- Behavioral Health	Travel time and distance standards to which Contractor will adhere are provided below, by Provider type. An Enrollee may elect to travel beyond the distance standards when the Enrollee exercises choice in selecting a PCP or specialty care Provider. The free exercise of such choice by the Enrollee will not negatively impact the results of any reporting by Contractor on access to care. • Behavioral Health service Provider access: Contractor shall ensure an Enrollee has access to at least two (2) Behavioral Health service Providers within a thirty (30)–mile radius of or thirty (30)–minute drive from the Enrollee's residence. If an Enrollee lives in a Rural Area, the Enrollee shall have access to at least one (1) Behavioral Health service Provider within a sixty (60)–mile radius of or sixty (60)–minute drive from the Enrollee's residence. *Contract 2018-24-001, Section 5.8.1.1.2*
11. Travel Time and Distance Standards- OB/GYN	Travel time and distance standards to which Contractor will adhere are provided below, by Provider type. An Enrollee may elect to travel beyond the distance standards when the Enrollee exercises choice in selecting a PCP or specialty care Provider. The free exercise of such choice by the Enrollee will not negatively impact the results of any reporting by Contractor on access to care. • OB/GYN access: Contractor shall ensure an Enrollee has access to at least two (2) OB/GYN Providers within a thirty (30)–mile radius of or thirty (30)–minute drive from the Enrollee's residence. If an Enrollee lives in a Rural Area, the Enrollee shall have access to at least one (1) OB/GYN Provider within a sixty (60)–mile radius of or sixty (60)–minute drive from the Enrollee's residence. *Contract 2018-24-001, Section 5.8.1.1.3*
12. Travel Time and Distance Standards- Dental Access for Children	Travel time and distance standards to which Contractor will adhere are provided below, by Provider type. An Enrollee may elect to travel beyond the distance standards when the Enrollee exercises choice in selecting a PCP or specialty care Provider. The free exercise of such choice by the Enrollee will not negatively impact the results of any reporting by Contractor on access to care. • Dental access for Children: Contractor shall ensure an Enrollee has access to at least one (1) dentist, who serves Children, within a thirty (30)–mile radius of or thirty (30)–minute drive from the Enrollee's residence. If an Enrollee lives in a Rural Area, the Enrollee shall have access to at least one (1) dentist, who serves Children, within a sixty (60)–mile radius of or sixty (60)–minute drive from the Enrollee's residence. *Contract 2018-24-001, Section 5.8.1.1.4*

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
13. Travel Time and Distance Standards- Hospital Access	Travel time and distance standards to which Contractor will adhere are provided below, by Provider type. An Enrollee may elect to travel beyond the distance standards when the Enrollee exercises choice in selecting a PCP or specialty care Provider. The free exercise of such choice by the Enrollee will not negatively impact the results of any reporting by Contractor on access to care. • Hospital access: Contractor shall ensure an Enrollee has access to at least one (1) hospital within a thirty (30)–mile radius of or thirty (30)–minute drive from the Enrollee's residence. If an Enrollee lives in a Rural Area, the Enrollee shall have access to at least one (1) hospital within a sixty (60)–mile radius of or sixty (60)–minute drive from the Enrollee's residence. *Contract 2018-24-001, Section 5.8.1.1.5*
14. Travel Time and Distance Standards- Other Specialists	Travel time and distance standards to which Contractor will adhere are provided below, by Provider type. An Enrollee may elect to travel beyond the distance standards when the Enrollee exercises choice in selecting a PCP or specialty care Provider. The free exercise of such choice by the Enrollee will not negatively impact the results of any reporting by Contractor on access to care. • Other specialist Provider access: Contractor shall ensure an Enrollee has access to at least one (1) specialty services Provider within a sixty (60)–mile radius of or sixty (60)–minute drive from the Enrollee's residence. If an Enrollee lives in a Rural Area, the Enrollee shall have access to at least one (1) specialty services Provider within a ninety (90)–mile radius of or ninety (90)–minute drive from the Enrollee's residence. *Contract 2018-24-001, Section 5.8.1.1.6*
15. Travel Time and Distance Standards- Pharmacy	Travel time and distance standards to which Contractor will adhere are provided below, by Provider type. An Enrollee may elect to travel beyond the distance standards when the Enrollee exercises choice in selecting a PCP or specialty care Provider. The free exercise of such choice by the Enrollee will not negatively impact the results of any reporting by Contractor on access to care. • Pharmacy access: Contractor shall ensure an Enrollee has access to at least one (1) pharmacy within a fifteen (15)–mile radius of or fifteen (15)–minute drive from the Enrollee's residence. If an Enrollee lives in a Rural Area, the Enrollee shall have access to at least one (1) pharmacy within a sixty (60)–mile radius of or sixty (60)–minute drive from the Enrollee's residence. *Contract 2018-24-001, Section 5.8.1.1.7*
16. LTSS Provider types in which Enrollee travels to Provider	Contractor shall ensure an Enrollee has access to at least two (2) LTSS Providers within a thirty (30)-minute drive from the Enrollee's residence. If an Enrollee lives in a Rural Area, the Enrollee shall have access to at least two (2) LTSS Providers within a sixty (60)-mile radius of or sixty (60)-minute drive from the Enrollee's residence. *Contract 2018-24-801 KA2 Amendment, Section 5.8.1.1.8*
17. Monitoring of Timely Access	N/A

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
18. Accessibility of Provider Locations *42 CFR 438.206 (b)(v)*	Contractor must ensure Providers provide physical access, reasonable accommodations, and accessible equipment for Enrollees with physical or mental disabilities. Contractor shall collect sufficient information from Providers to assess compliance with the Americans with Disabilities Act. As necessary to serve Enrollees, Provider locations where Enrollees receive services shall be ADA compliant. In addition, Contractor shall include within its Provider Network, Provider locations that are able to accommodate the needs of individual Enrollees. *Contract 2018-24-001, Section 5.8.2*
19. Provider Monitoring	Contractor shall perform QA evaluations of Provider practices, which shall include monitoring of Enrollee accessibility to ensure linguistic and physical accessibility. Contractor shall support Providers in achieving accessibility. *Contract 2018-24-001, Section 2.7.6*
20. Americans with Disabilities Act	N/A
21. Network Management	N/A
22. After Hours *42 CFR 438.206 (c)(1)(iii)*	Primary care and specialty Providers shall provide coverage for their respective practices twenty-four (24) hours a day, seven (7) days a week, and they shall have a published after-hours telephone number; voicemail alone after hours is not acceptable. *Contract 2018-24-001, Section 5.8.4*
23. Choice of Primary Care Provider *42 CFR 438.6(m)*	Contractor shall afford to each Enrollee a choice of PCP, which may be, where appropriate, a WHCP. Contractor shall provide direct access to a WHCP for routine and preventative women's health care Covered Services when a female Enrollee's PCP is not a WHCP. Contractor shall offer pregnant Enrollees and Enrollees with Chronic Health Conditions, disabilities, or special healthcare needs the option of choosing a specialist to be their PCP. Such Enrollees or their Providers may request a specialist as a PCP at any time. Contractor shall contact the Enrollee promptly after the request to schedule an assessment. Contractor's medical director will approve or deny requests after determining whether the Enrollee meets criteria and whether the specialist is willing to fulfill the role and all the obligations of a PCP. *Contract 2018-24-001, Sections 5.8.5 to 5.8.6*
24. Provider Education	Prior to any enrollment of Enrollees under this Contract and thereafter, Contractor shall conduct Network Provider education regarding Contractor policies and procedures, including as provided in section 5.35.1.9. • Provider orientation. Contractor shall conduct orientation sessions for Network Providers and their office staff.

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
24. Provider Education (Cont.)	• Integrated health homes. Contractor shall educate Network Providers about the IHH model, the importance of using it to integrate all aspects of each Enrollee's care, and how to become an IHH, including educating Network Providers about resources, support, and incentives, both financial and nonfinancial, available for becoming an IHH and receiving applicable recognition. • Cultural Competency. Contractor will provide Cultural Competence requirements at orientation, training sessions, and updates as needed. Contractor, upon request of Provider, shall agree to allow Provider to certify compliance with this provision if completed through another Contractor in the Medicaid program. • Provider manual. The Provider manual shall be a comprehensive online reference tool for Providers and staff regarding administrative, prior authorization, and Referral processes; claims and Encounter submission processes; and plan benefits. The Provider manual shall also address topics such as clinical practice guidelines, availability and access standards, Care Management programs, and Enrollee rights. • Provider portal. Prior to the Effective Date, Contractor shall establish and maintain a secure Provider web portal, which shall include population health, quality, utilization, eligibility verification, prior authorization, and claims information for PCP Enrollee populations. The Department retains the right to define minimum content requirements for the Provider portal. • Provider directory. Contractor shall meet all Provider directory requirements under 305 ILCS 5/5-30.3 and 42 CFR §438.10, • Provider-based health education for Enrollees. Contractor shall encourage PCPs to provide health education to Enrollees. Contractor shall ensure that Providers have the preventive-care, disease-specific, and plan-services information necessary to support Enrollee education in an effort to promote compliance with treatment directives and to encourage self-directed care. • Health, safety, and welfare education. As part of its Provider education, Contractor shall include information related to identifying, preventing, and reporting Abuse, Neglect, exploitation, and Critical Incidents, including the information in Attachment XVII, Attachment XVIII, and Attachment XIX. • DHS HCBS Waiver Provider education. Contractor shall distribute Provider packets, which the State or its designee will provide, to Enrollees and educate each Enrollee regarding the Enrollee's responsibility to ensure Personal Assistants and all other Individual Providers who provide Covered Services under the Persons with disabilities HCBS Waiver, Persons with HIV/AIDS HCBS Waiver, or Persons with brain injury HCBS Waiver receive the Provider packets. Contractor shall further educate Enrollees that such Providers may not begin providing Covered Services until the fully and correctly completed packets have been returned to and accepted by the local DHS-DRS office. *Contract 2018-24-001, Sections 5.10 to 5.10.9*
25. Provider Communication	Contractor must maintain a regular means of communicating and providing information on changes in policies and procedures to Providers. Contractor shall provide no less than thirty (30) days' notice to Providers of policy changes prior to implementation by Contractor. Contractor must notify Providers of any changes to prior authorization policies no less than thirty (30) days before the date of implementation. In circumstances where the Department provides Contractor with less than thirty (30) days' notice from the effective date of a policy change, Contractor must notify Providers within three (3) Business Days of receipt of the Department's notification. *Contract 2018-24-001, Section 5.10.10*

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
26. Additional Covered Services	Contractor shall obtain Prior Approval from the Department before offering 5.2.4any additional service or benefit to Enrollees not required under this Contract. Contractor shall provide thirty (30) days' prior written notice to Enrollees and Prospective Enrollees before discontinuing an additional service or benefit. The notice must receive Prior Approval from the Department. *Contract 2018-24-001, Section 5.2.4*
27. Limitations on Covered Services 42 CFR §441	The following services and benefits shall be limited as Covered Services: • Contractor may provide termination of pregnancy only as allowed by 5.5.1applicable State and federal law. In any such case, Contractor shall fully comply with the requirements of such laws, complete HFS Form 2390, and file the completed form in the Enrollee's medical record. Contractor shall not provide termination of pregnancy to Enrollees who are eligible under SCHIP (215 ILCS 106). • Contractor may provide sterilization services only as allowed by State and 5.5.2 federal law (see 42 CFR §441, Subpart F). In any such case, Contractor shall fully comply with the requirements of such laws, complete HFS Form 2189, and file the completed form in the Enrollee's medical record. • If Contractor provides a hysterectomy, Contractor shall complete HFS Form 5.5.31977 and file the completed form in the Enrollee's medical record. *Contract 2018-24-001, Sections 5.5 to 5.5.3*
28. Right of Conscience	The Parties acknowledge that, pursuant to 745 ILCS 70/1 et seq., Contractor 5.6.1may choose to exercise a right of conscience by refusing to pay or arrange for the payment of certain Covered Services if such refusal is documented in its ethical guidelines, mission statement, constitution, bylaws, articles of incorporation, regulations, or other governing documents. If Contractor chooses to exercise this right, Contractor must promptly notify the Department in writing of its intent to exercise its right of conscience and submit proof that such refusal is incorporated in Contractor's governing documents in accordance with 745 ILCS 70/11.2. Such notification shall contain the otherwise Covered Services that Contractor refuses to pay, or to arrange for the payment of, pursuant to the exercise of the right of conscience. The Parties agree that upon such notice the Department shall adjust the Capitation payment to Contractor. If Contractor chooses to exercise this right, Contractor must notify Potential 5.6.2 Enrollees, Prospective Enrollees, and Enrollees that it has chosen not to render certain Covered Services, as follows: • to Potential Enrollees, prior to enrollment; • to Prospective Enrollees, during enrollment; and • to Enrollees, within ninety (90) days after adopting a policy with respect to any particular service that previously was a Covered Service, but in all events, Enrollees shall be informed no fewer than thirty (30) days before implementation of such a policy. Such notice shall include information on how Potential Enrollees, Prospective 5.6.3Enrollees, and Enrollees can obtain information from the Department regarding those Covered Services subject to this section 5.6.

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
28. Right of Conscience (Cont.)	If any Network Provider exercises the right of conscience, Contractor must 5.6.4require such Network Provider, upon request by an Enrollee, to refer or transfer the Enrollee to, or provide written information to the Enrollee about, other Providers who Contractor reasonably believes may offer the Covered Service the Network Provider refuses to permit, perform, or participate in because of a conscience-based objection. Contractor also shall require Network Providers in such an event, and if requested by the Enrollee, to provide copies of medical records to the Enrollee or to the Provider. *Contract 2018-24-001, Sections 5.6 to 5.6.4*
29. Homebound Enrollees	If an Enrollee is homebound or has significant mobility limitations, Contractor shall provide access to primary care through home visits by Providers to support the Enrollee's ability to live as independently as possible in the community. *Contract 2018-24-001, Section 5.8.7*

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
1. Primary Care Provider to Enrollee Ratio *42 CFR 438.206* *42 CFR 438.207(a)*	Contractor's maximum primary care Provider panel size shall be as set forth below. If Contractor does not satisfy the primary care Provider requirements set forth below, Contractor may demonstrate compliance with these requirements by demonstrating that Contractor's full-time-equivalent primary care Provider ratios exceed ninety percent (90%) of the requirements set forth below, and that Covered Services are being provided in the Contracting Area in a manner that is timely and otherwise satisfactory. Contractor shall comply with Section 1932(b)(7) of the Social Security Act. *Contract 2018-24-001, Section 5.8.8*
2. PCP Panel Size - FHP/ACA	For the Families and Children Population and ACA Adult Enrollees, Contractor's maximum primary care Provider panel size shall be one-thousand eight hundred (1,800) Enrollees. An additional maximum of nine hundred (900) of such Enrollees is allowed for each resident Physician, nurse practitioner, Physician assistant, and APN who is one hundred percent (100%) full-time equivalent employee or contractor. *Contract 2018-24-001, Section 5.8.8.1*
3. PCP Panel Size - SPD	For Seniors and Persons with Disabilities Enrollees, Contractor's maximum provider care Provider panel size shall be six hundred (600) Enrollees. An additional maximum of three hundred (300) of such Enrollees is allowed for each resident Physician, nurse practitioner, Physician assistant, and APN who is one-hundred percent (100%) full-time equivalent employee or contractor. *Contract 2018-24-001, Section 5.8.8.2*
4. Capacity *42 CFR 438.206*	Contractor offers an appropriate range of preventive services, primary care, Behavioral Healthcare, and specialty services that is adequate for the anticipated number of Enrollees in the Contracting Area, and that Contractor maintains a Provider Network that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Enrollees. *Contract 2018-24-001, Section 4.15.2*
5. Culturally Diverse Network	Contractor shall contract with a culturally-diverse network of Providers of both genders and prioritize recruitment of bilingual or multi-lingual Providers. Contractor's contracts with Providers shall require that Providers comply with Contractor's Cultural Competence plan. Contractor shall confirm the languages used by Providers, including American Sign Language, and ensure physical access to Providers' office locations. *Contract 2018-24-001, Section 2.7.4*
6. Provider Panel Documentation	Contractor shall establish, maintain, and monitor a Provider Network, including hospitals, primary care Providers, WHCPs, specialist Physicians, clinical laboratories, dentists, OB/GYNs, oral surgeons, pharmacies, behavioral-health Providers, substance-abuse Providers, CMHCs, and all other provider types. This network shall be sufficient to provide adequate access to all Covered Services under the Contract, taking into consideration: • the anticipated number of Enrollees;

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
6. Provider Panel Documentation (Cont.) *42 CFR 206* *42 CFR 206(c)(1)* *42 CFR 438.207(b)(1) and (2)* *42 CFR 422.112* *42 CFR 423.120*	• the expected utilization of services, in light of the characteristics and healthcare needs of Contractor's Enrollees; • the number and types of Providers required to furnish the Covered Services; • the number of Network Providers who are not accepting new patients; and • the geographic location of Providers and Enrollees, taking into account distance, travel time, the means of transportation, and whether the location provides physical access for Enrollees with disabilities. *Contract 2018-24-001, Sections 5.7.1 to 5.7.1.1.5*
7. Miscellaneous provider network/contracting requirements	N/A
8. Family Planning Services *42 CFR §438.206*	Contractor shall demonstrate that its network includes sufficient Family-Planning Providers to ensure timely access to Covered Services as provided in 42 CFR §438.206. *Contract 2018-24-001, Section 5.8.9*
9. Provider Directories	Contractor shall meet all Provider directory requirements under 305 ILCS 5/5-30.3 and 42 CFR §438.10, including: • Ensure its Provider directory available to Enrollees and Providers via Contractor's web portal and in paper form upon request. • Request, at least annually, Provider office hours for each Provider type and publish such hours in the Provider directory. • Confirm with Providers who have not submitted claims within the six (6) months prior to the start of this Contract that the Provider intends to remain in the network and correct any incorrect Provider directory information. • Conspicuously display an e-mail address and a toll-free number to which any individual may report an inaccuracy in the Provider directory. • Provider directory information in paper form must be updated at least monthly and in electronic Provider directories must be updated no later than thirty (30) days after Contractor receives updated Provider information. • Investigate and correct any inaccurate information communicated from any person or from Department within thirty (30) days after receiving the report. *Contract 2018-24-001, Sections 5.10.6 to 5.10.6.6*

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
10. Pharmacy Directory Specifications	N/A
11. Directory Maintenance and Distribution	N/A
12. Integrated Health Home	Contractor must adhere to and implement all aspects of the IHH program designed and approved by the Department. Where requirements of the Department's IHH program overlap with the requirements of this Contract, the IHH requirements will be prioritized. *Contract 2018-24-001, Section 5.7.9*
13. Network Adequacy Standards	Contractor's Provider Network must include all necessary Provider types, including primary care Providers, Behavioral Health Providers, OB/GYNs, dental care Providers, hospitals, other specialists, and pharmacies, with sufficient capacity to provide timely Covered Services to Enrollees in accordance with the standards outlined herein. For each Provider type, Contractor must provide access to at least ninety percent (90%) of Enrollees within each county of the Contracting Area within the prescribed time and distance standard required by this section 5.8.1, with the exception of pharmacy services, which must provide one-hundred percent (100%) coverage to Enrollees as required in section 5.8.1.1.7. Exceptions to the time and distance standards may be considered and approved at the discretion of the Department. Exception requests must be submitted to the Department in writing. *Contract 2018-24-001, Section 5.8.1*
14. Network Adequacy Analysis	Contractor shall analyze the geographic distribution of the Provider Network and provide the results of this analysis to the Department on a quarterly basis. Contractor shall also monitor other network adequacy indicators, such as Enrollee and Provider Complaints related to access; call center requests from Enrollees, Providers, advocates, and external organizations for help with access; and the percentage of completely open primary care Provider panels versus the percentage open only to existing patients. Contractor shall generate geographic distribution tables and maps to plot Enrollee and Network Provider locations by zip code and analyze the information, considering the prevalent modes of transportation available to Enrollees, Enrollees' ability to travel, and Enrollees' ability to be in an office setting. When material gaps in the Contracting Area are identified, Contractor shall within five (5) Business Days develop and implement a recruitment strategy to fill the gaps and immediately thereafter submit its strategy and proposed timeline to the Department. *Contract 2018-24-001, Section 5.7.4*
15. Safety Net Providers	Contractor will prioritize recruiting safety-net Providers, such as FQHCs, and RHCs as Network Providers. Contractor shall not refuse to contract with a FQHC or RHC that is willing to accept Contractor's rates and contractual requirements and meets Contractor's quality standards. *Contract 2018-24-001, Section 5.7.5*

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
16. Non-Network Providers	It is understood that in some instances, Enrollees will require specialty care not available from a Network Provider and that Contractor will arrange that such services be provided by a non-Network Provider. In such event, Contractor will promptly negotiate an agreement (single case agreement) with a non-Network Provider to treat the Enrollee until a qualified Network Provider is available. Contractor shall make best efforts to ensure that any non-Network Provider billing for services rendered in Illinois is enrolled in the HFS Medical Program prior to paying a claim. *Contract 2018-24-001, Section 5.7.6*
17. Specialty Care 17. Specialty Care (Cont.)	Contractor shall establish a comprehensive network to ensure the availability and accessibility of specialists and subspecialists to meet the needs of Enrollees. Care Coordinators shall have authority to authorize services and will not require approval by Contractor's medical director for the majority of services in accordance with recognized Medically Necessary criteria. For Enrollees with special healthcare needs who require an ongoing course of treatment or regular care monitoring, Contractor must provide mechanism for Enrollee to directly access specialists, as appropriate for the condition and needs. *Contract 2018-24-001, Section 5.7.10*
18. Hospitalist	Contractor shall provide Hospitalist services, either through direct employment or through a direct employment as a Network Provider or through a sub-contractual relationship. *Contract 2018-24-001, Section 5.7.11*
19. SNFist Program	N/A
20. Medical Homes	N/A
21. Governmental Providers	Contractor shall contract with the University of Illinois, Cook County, by and through its Cook County Health and Hospitals System, and Southern Illinois University (collectively, governmental Provider entities) in order to provide certain Covered Services to Enrollees if such governmental Provider entity is located within Contractor's Contracting Area set forth in Attachment II. Contractor shall reimburse the University of Illinois for inpatient hospital, outpatient hospital, Physician services, and encounter rate clinics at no less than their rates as determined by the Medicaid approved reimbursement methodologies, as provided to Contractor by the Department. Contractor shall reimburse Southern Illinois University for Physician services at no less than its rate as determined by the Medicaid-approved reimbursement methodologies, as provided to Contractor by the Department. For the period January 1, 2018 through December 31, 2019, Contractor shall reimburse Cook County for inpatient hospital, outpatient hospital, Physician services, and encounter rate clinics at no less than their rates a determined by the Medicaid approved reimbursement methodologies, as provided to Contractor by the Department. Contractor shall not limit equal access to such Providers. *Contract 2018-24-001, Section 5.7.13*
22. DSCC Care Coordination	The Department encourages and reserves the right to require Contractor to contract with the University of Illinois, Division of Specialized Care for Children (DSCC), to provide Care Coordination services to designated Special Needs Children populations. The Department may designate other entities that

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
22. DSCC Care Coordination (Cont.)	demonstrate the requisite capability and experience to appropriately provide care coordination services for Special Needs Children populations with which Contractor may contract for providing such Care Coordination services. *Contract 2018-24-001, Section 5.7.14*
23. Community Mental Health Center	Contractor shall enter into a contract with any willing and qualified community mental health center (Medicaid Provider Type 36) in the Contracting Area so long as the Provider agrees to Contractor's rate and adheres to Contractor's QA requirements. Contractor may establish quality standards in addition to those State and federal requirements and, after the first (1st) year of contracting, contract with only those community mental health centers that meet such standards, provided that each the contracting Provider is informed of any such additional standards no later than ninety (90) days after the start of its contract and that the Department has given Prior Approval. Any such standards that are not established within ninety (90) days after the start of the contract with the community mental health center must be in effect for one (1) year before Contractor may terminate a contract of a Provider based on a failure to meet such standards. *Contract 2018-24-001, Sections 5.20.2.2 to 5.20.2.2.1*
24. Local Health Departments	Contractor shall offer contracts to all the local health departments recognized by the Department of Public Health that are in Contractor's Contracting Area. Contractor shall not require prior authorization or a Referral as a condition of payment for local health department services provided by those local health departments with which Contractor has contracts. For local health departments outside of the Contracting Area, Contractor shall accept claims from non-Network Providers of local health department services. Contractor shall make payment to non-Network Providers of such services according to the Department's applicable Medicaid FFS reimbursement schedule. Contractor may require local health departments to follow Contractor's protocols for communication regarding services rendered in order to further care coordination. *Contract 2018-24-001, Sections 5.20.2.3 to 5.20.2.3.2*
25. Nursing Facilities (NF) and Supported Living Facilities (SLF)	For NFs and SLFs, Contractor must maintain the adequacy of its Provider Network sufficient to provide Enrollees with reasonable choice within each county of the Contracting Area, provided that each Network Provider meets all applicable State and federal requirements for participation in the HFS Medical Program. Contractor may require as a condition for participation in its network that a NF agree to provide access to Contractor's or Subcontractor's Care Management team to permit qualified members of the team to write medication and lab orders, to access Enrollees in order to conduct physical examinations, and to serve as PCP for an Enrollee. *Contract 2018-24-001, Section 5.7.1.3*

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
26. Providers: HCBS Waiver Services	For Providers of each of the Covered Services identified in this section 5.7.1.4 under a HCBS Waiver, Contractor must enter into contracts with a sufficient number of such Providers within each county in the Contracting Area to assure that the Network Providers served at least eighty percent (80%) of the number of Participants in each county who were receiving such services on the day immediately preceding the day such services became Covered Services. For counties served by more than one (1) Provider of such Covered Services, Contractor shall enter into contracts with at least two (2) such Providers, so long as such Providers accept Contractor's rates, even if one (1) Provider served more than eighty percent (80%) of the Participants, unless the Department grants Contractor an exception, in writing. These Covered Services include: • Adult day care • Homecare/in-home services • Day Habilitation • Supported employment • Home-delivered meals • Home health aides • Nursing services • Occupational Therapy • Speech Therapy • Physical Therapy *Contract 2018-24-001, Sections 5.7.1.4 to 5.7.1.4.10*
27. Covered Services: HCBS Waiver Services	For the following Covered Services that are services under a HCBS Waiver, the requirements are as follows: • Environmental accessibility adaptations—home. Contractor shall make its best efforts, and document those efforts, to ensure that the work required to meet the need for the Covered Service is satisfactorily completed by a qualified Provider within ninety (90) days after Contractor becomes aware of the need. • Personal Assistants. Contractor shall refer Enrollees, as necessary and appropriate, to the Centers for Independent Living or other available resources for assistance in locating potential Personal Assistants. • Personal Emergency Response System. Contractor shall enter into contracts that meet the requirements of 89 Ill. Admin. Code 240.235 with at least one (1) Provider serving each county within a Contracting Area. • Automated Medication Dispenser. Contractor shall enter into contracts that meet the requirements of 89 Ill. Admin. Code 240.741. *Contract 2018-24-001, Sections 5.7.1.5 to 5.7.1.5.4*

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
28. Covered Services: HCBS Waiver Services	In arranging for Covered Services for Enrollees under the IDoA Persons Who are Elderly HCBS Waiver for such Enrollees who do not express a choice of a Provider of such Covered Services, Contractor shall fairly distribute such Enrollees, taking into account all relevant factors, among those Network Providers who are willing and able to accept such Enrollees and who meet applicable quality standards. *Contract 2018-24-001, Section 5.7.1.7*
29. Nursing Facility and Waiver Services QA Requirements	Contractor shall enter into a contract with any willing and qualified Provider in the Contracting Area that renders Nursing Facility or HCBS waiver services, as set forth in Attachment I, so long as the Provider agrees to QA requirements. To be considered a qualified Provider, the Provider must be in good standing with the Department's FFS Medical Program. Contractor may establish quality standards in addition to those State and federal requirements and contract only with Providers that meet such standards. Such standards must be approved by the Department, in writing, and Contractors may only terminate a contract of a Provider based on failure to meet such standards if two (2) criteria are met: a) such standards have been in effect for at minimum one (1) year, and b) Providers are informed at the time such standards come into effect. *Contract 2018-24-001, Section 5.7.1.2*
30. Network Provider Enrollment and Termination	Contractor shall ensure that all Network Providers, including out-of-state Network Providers, are enrolled in the HFS Medical Program, if such enrollment is required by the Department's rules or policy in order to submit claims for reimbursement or otherwise participate in the HFS Medical Program. Once a Contractor is aware that a Network Provider serving one-hundred (100) or more active Enrollees will be terminated, Contractor must inform the Department of this termination in writing (e-mail or letter) within three (3) Business Days. This written notification must include: the Provider name; the reason for termination; the expected termination date; the current number of Enrollees served by (that is, who received primary care from, or was seen on a regular basis by) the terminated Provider; and the plan of action for transferring Enrollees to another Provider. *Contract 2018-24-001, Sections 5.7.3 to 5.7.3.1.5*
31. Provider Termination – Notice to Enrollee and Provider	Contractor shall make a good-faith effort to give written notice of termination of a Provider as soon as practicable, but in no event later than fifteen (15) days after issuance of the termination notice by Contractor to a Provider, or receipt of a termination notice from a Provider. Each Enrollee who was served by the Provider shall receive notice that Provider was terminated. In this notification, Contractor will provide direction to the Enrollee regarding how the Enrollee may select a new Provider. Contractor shall give at least sixty (60) days written notice in advance of its nonrenewal or termination effective date of a Provider to the Provider and to each Enrollee served by the Provider. The notice shall include a name and address to which the Provider or an Enrollee may direct comments and concerns

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
31. Provider Termination – Notice to Enrollee and Provider (Cont.)	regarding the nonrenewal or termination. In the notification to the Enrollee, Contractor will provide direction regarding how the Enrollee may select a new Provider. Contractor may provide immediate written notice when a Provider's license has been disciplined by a State licensing board. *Contract 2018-24-001 and Amendment KA2, Sections 5.7.3.2 to 5.7.3.3*
32. Information from Provider	Contractor shall confirm with Provider within three (3) Business Days of receipt of all required information from Provider entering or exiting Contractor's Provider Network. *Contract 2018-24-001 Amendment KA2, Section 5.7.3.4*
33. Pharmacy Formulary – Preferred Drug *42 CFR 423.100* *438.10 (i)(3)* *438.210 (d)(3)* 438.3(s)(1)	Contractor shall provide coverage of covered outpatient drugs as defined in Section 1927(k)(2) of the Social Security Act. Non-preferred drugs meet the definition of a covered outpatient drug and cannot be excluded from coverage. In the event a covered outpatient drug is not covered through Contractor's pharmacy benefit, it must be covered through Contractor's medical benefit. In the event Contractor does not include a covered outpatient drug on its pharmacy formulary, Contractor must have a process for Enrollees to access that drug through a prior authorization process, in accordance with 42 CFR §438.3(s)(1). • Contractor shall cover as a preferred and non-preferred products as listed on the Department's weekly Preferred Drug List (PDL) NDC file. • Contractor shall provide the PDL file to their Pharmacy Benefit Manager (PBM) within two (2) Business Days of receipt. • The PDL file will be a full file containing all NDCs included on the Department's PDL and include age limitations, days' supply allowances, and drug class. Contractor shall load the file within seven (7) Business Days of receipt of the file. • The Department will provide Contractor with negative formulary changes at least forty-five (45) days prior to the effective date of the change. Contractor shall make all system and programming changes necessary to implement the change on the effective date. • When Contractor loads new NDCs for products that are listed on the Department's PDL, Contractor shall code the product's preferred or non-preferred status the same as other drugs that are the same drug, dosage form, strength, and route of administration. When the drug is multi-source, and the brand/innovator product and generic/non-innovator products are coded differently, then the new NDCs for a non-innovator/generic drug shall be coded the same as the non-innovator/generic NDCs, and the new NDCs for brand/innovator products shall be coded the same as the innovator/brand NDCs. • Contractor shall report any discrepancies it identifies on the PDL file to the Department, in a format and manner prescribed by the Department, within three (3) Business Days of identification of the discrepancy. • Contractor shall not disadvantage any preferred product to another preferred or non-preferred product in the same drug class on the Department's PDL. • Where the Department lists a brand name product as preferred, and its generic equivalent as non-preferred, Contractor must also list and treat the brand name product as preferred and the generic drug as non-preferred.

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
33. Pharmacy Formulary – Preferred Drug (Cont.)	• Contractor shall submit an attestation of its adherence to the Department's PDL for the first quarter of calendar year 2020, and quarterly thereafter, on a schedule and in a format provided by the Department. • The Contractor, including the Contractor's Pharmacy Benefit Manager (PBM) or their Subcontractors, is prohibited from negotiating any rebates with drug manufacturers for drugs or other products listed on the Department's PDL. In the event Contractor, its PBM or other subcontractors have an existing rebate agreement with a manufacturer, all products listed on the Department's PDL must be exempt from such rebate agreements. *Contract 2018-24-001, Amendment KA5, Sections 5.3.2.2 to 5.3.2.9*
34. Removal from Formulary Notification	N/A

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
1. Capacity to Perform Care Management	Contractor shall have the capacity to perform the full range of Care Management prior to implementation, and the State will monitor Contractor's performance throughout the term of the Contract. *Contract 2018-24-001, Section 5.12.2.3*
2. Care Management	Contractor shall offer Care Management to the following populations: Enrollees stratified as Level 3 (high-risk) and Level 2 (moderate-risk) as described at section 5.13.1.4.1, pregnant Enrollees, Dual-Eligible Adult Enrollees, Enrollees residing in a Nursing Facility, and Enrollees who receive Covered Services under an HCBS Waiver. In addition, any Enrollee may request Care Management. *Contract 2018-24-001, Amendment KA2, Section 5.12.1*
3. Provision of Care Management *CFR 438.208 (a)(2)*	Contractor shall provide Care Management to all Enrollees that accept or request it, through a Care Coordinator who participates in an Interdisciplinary Care Team (ICT). Care Management includes assessment of the Enrollee's clinical risks and needs, medication management, and health education on complex clinical conditions, as appropriate to the individual needs and preferences of the Enrollee. *Contract 2018-24-001, Section 5.12.2*
4 DON - Provide Entity Name to the Department	If Contractor enters into any contract with any entity that also administers the DON or prescreening required under HCBS Waivers, Contractor shall immediately provide the name of that Provider to the Department. *Contract 2018-24-001, Section 5.12.2.1*
5. Coordinate Services *CFR 438.208 (2)(iv)*	Contractor shall coordinate services with the services Enrollee receives from community and social support providers. *Contract 2018-24-001, Section 5.12.2.2*
6. Services for Enrollees in a Nursing Facility	For Enrollees residing in a Nursing Facility, Contractor shall ensure that Care Management services required by this Contract are provided. Nursing Facility Care Coordinators may provide Care Management services that supplement Contractor's Care Management services. *Contract 2018-24-001, Section 5.12.2.5*
7. Coordinate services between setting of Care *CFR 438.208 (2)(i)*	Contractor shall implement procedures to coordinate services provided between settings of care, including timely discharge planning for hospital and institutional stays. Contractor shall also provide Care management assistance to hospitals in securing timely transfer of patients from non-Network hospitals to contracted facilities. *Contract 2018-24-001, Section 5.12.2.4*

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
8. Care Coordination *CFR 438.208 (ii) (b)(1)*	Each Enrollee identified as requiring Care Management, and any other Enrollee who agrees or wishes to receive Care Management, will be assigned a Care Coordinator. Contractor must provide Enrollee information on how to contact the Enrollee's designated person or entity primarily responsible for coordinating services. *Contract 2018-24-001, Section 5.12.3*
9. Care Coordinators Qualifications	Care Coordinators who serve High-Needs Children, Special Needs Children, Enrollees within the IDoA Persons Who are Elderly HCBS Waiver, DHS-DRS Persons with a Brain Injury HCBS Waiver, DHS-DRS Persons with HIV/AIDS HCBS Waiver, or DHS-DRS Persons with Disabilities HCBS Waiver must meet the applicable qualifications set forth in Attachment XVI. Care Coordinators for all other Enrollees must have the appropriate qualifications to address the needs of Enrollees. *Contract 2018-24-001, Amendment KA5, Section 5.12.3.1 and Attachment XVI*
10. Training Requirements	Care Coordinators who serve High-Needs Children, Special Needs, Children, Enrollees within the IDoA Persons Who are Elderly HCBS Waiver, DHS-DRS Persons with a Brain Injury HCBS Waiver, DHS-DRS Persons with HIV/AIDS HCBS Waiver, DHS-DRS Persons with Disabilities HCBS Waiver, or HFS Supportive Living Program HCBS Waiver must meet the applicable training requirements set forth in Attachment XVI. Care Coordinators for all other Enrollees must have the appropriate training to address the needs of Enrollees. *Contract 2018-24-001, Amendment KA5, Section 5.12.3.2 and Attachment XVI*
11. Caseload Requirements	Care Coordinators responsible for the Care Management of Enrollees with varying risk levels shall have their overall caseload weighted and a blended overall caseload limit set. The maximum weighted caseload for a Care Coordinator is 600 with Level 1 (low risk) weighted as one (1), Level 2 (moderate risk) weighted as four (4), and Level 3 (high risk) weighted as eight (8). The Department may review existing caseloads at any time and may require a change in methodology or an Enrollee's assignment to a caseload. *Contract 2018-24-001, Section 5.17.1*
12. Caseload Standards	Caseloads of Care Coordinators shall not exceed the standards outlined as follows: Maximum caseloads for Care Coordinators for the stratified categories identified in section 5.13.1.4.1 are defined in the table below and shall be adhered to by Contractor unless specified in section 5.17.2.2. Risk Category and caseload maximum (cases per care coordinator): Level 1: 600:1

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
12. Caseload Standards (Cont.)	Level 2: 150:1 Level 3: 75:1 Contractor will adhere to the following caseload maximum requirements for specific populations: • For Enrollees in the Persons with Brain Injury Waiver or the Persons with HIV/AIDS Waiver, the caseloads shall not exceed 30:1. *Contract 2018-24-001, Sections 5.17.2 to 5.17.2.2*
13. Contact Standards	Care Coordinators who provide Care Management shall maintain contact with Enrollees as frequently as appropriate. Care Coordinators who provide Care Management to Level 3 (high-risk) Enrollees shall have contact with such Enrollees at least once every ninety (90) days. The Care Coordinator or a member of the Enrollee's ICT shall have a face-to-face contact at least once every six (6) months with each Level 3 (high-risk) Enrollee who is not receiving HCBS Waiver services. Care Coordinators providing Care Management to Enrollees receiving HCBS Waiver services shall maintain contact as follows: • Persons who are elderly: The Care Coordinator shall have a face-to-face contact with the Enrollee not less often than once every ninety (90) days. • Persons with brain injury: The Care Coordinator shall have contact with the Enrollee not less often than one (1) time per month. • Persons with HIV/AIDS: The Care Coordinator shall contact the Enrollee not less than one (1) time per month, and not less than one (1) face-to-face contact every two (2) months. • Persons with disabilities: The Care Coordinator shall have a face-to-face contact with the Enrollee no less often than once every ninety (90) days in the Enrollee's home. • Persons living in a Supportive Living Program: The Care Coordinator shall contact the Enrollee no less often than one (1) time per year. *Contract 2018-24-001, Sections 5.17.3 to 5.17.3.5*
14. Unable to contact HCBS Enrollee	If Contractor is unable to contact an Enrollee in a HCBS Waiver within ninety (90) days after enrollment, Contractor must, after documenting all forms of no fewer than five (5) attempts to contact the Enrollee, contact the appropriate operating agency, provide documentation of the various attempts to contact the Enrollee, and request that the Enrollee no longer be in a HCBS Waiver. *Contract 2018-24-001, Section 5.7.1.6*
15. Money Follows the Person (MFP)	Contractor shall assume the lead role in supporting individuals transitioning from institutional settings to the community. Contractor will work in collaboration with the existing community agencies that provide MFP transition coordination services.

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
15. Money Follows the Person (MFP) (Cont.)	*Contract 2018-24-001, Section 5.1.8.5*
16. Interdisciplinary Care Team	Contractor will support an interdisciplinary care team (ICT) for all Enrollees stratified as high-risk (Level 3), Dual-Eligible Adult Enrollees, and Enrollees who receive Covered Services under an HCBS Waiver. The ICT will ensure the integration of the Enrollee's medical and Behavioral Health services, and, if appropriate, Service Package II services. Duties of the ICT are separate from utilization management duties. *Contract 2018-24-001, Section 5.14.1*
17. ICT Care Team Staff	Each ICT will be person-centered, built on each Enrollee's specific preferences and needs, and deliver services with transparency, individualization, respect, linguistic and Cultural Competence, and dignity. Each ICT shall consist of clinical and nonclinical staff whose skills and professional experience will complement and support one another in the oversight of each Enrollee's needs. *Contract 2018-24-001, Section 5.14.2*
18. ICT Functions	ICT functions shall include: • Providing Care Management for Enrollees; assisting in the development, implementation, and monitoring of IPoCs, including HCBS service plans where applicable; and, assisting in assuring integration of services and coordination of care across the spectrum of the healthcare system; • Ensuring a primary Care Coordinator is responsible for coordination of all benefits and services the Enrollee may need (Care Coordinators will have prescribed caseload limits as set forth in section 5.17.2); • Assigning a Care Coordinator who has the experience most appropriate to support the Enrollee; • Using motivational interviewing techniques; • Explaining alternative care options to the Enrollee; • Maintaining frequent contact with the Enrollee through various methods including face-to-face visits, e-mail, and telephone, as appropriate to the Enrollee's needs and risk level or upon the Enrollee's request. *Contract 2018-24-001, Sections 5.14.3 to 5.14.3.6*
19. Identifying Need for Care Management	Contractor's goals, benchmarks, and strategies for managing the care of Enrollees in its traditional Disease Management Programs shall be incorporated in, and included as part of, Contractor's Care Management program. Contractor shall use population- and individual-based tools and real-time Enrollee data to identify an Enrollee's risk level. *Contract 2018-24-001, Section 5.13.1*

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
20. Health Risk Screening *CFR 438.208 (3)*	Contractor will develop and maintain a health risk screening tool, which includes Behavioral Health risk, and will provide that tool to the Department. Contractor shall administer the tool to all new Enrollees within sixty (60) days after enrollment to collect information about the Enrollee's physical, psychological, and social health. Contractor will use the results to guide the administration of more in-depth health assessments. Contractor may administer a health risk assessment in place of the health risk screening, provided that it is administered within sixty (60) days after enrollment. Contractor shall notify the appropriate PCPs of the enrollment of any new Enrollee who has not completed a health risk screening within the time period set forth above and whom Contractor has been unable to contact. Contractor shall conduct outreach to their Enrollees and to schedule visits. *Contract 2018-24-001, Section 5.13.1.1*
21. Stratification	Based upon an analysis of the information gathered through the process in this section, Contractor shall stratify all Enrollees to determine the appropriate level of intervention by its Care Management program. Contractor shall systematically assign an initial risk level within the first fifteen (15) days after enrollment. Initial risk levels shall be evaluated and updated to reflect the results of a health-risk screening, health-risk assessment, and other relevant tools and data. Ongoing risk stratification shall occur as described at section 5.16. Enrollees shall be assigned to one (1) of three (3) levels: • Level 1: Low. Includes low- or no-risk Enrollees to whom Contractor provides, at a minimum, prevention and wellness messaging and condition-specific education materials. • Level 2: Moderate. Includes moderate-risk Enrollees for whom Contractor provides problem-solving interventions. • Level 3: High. Enrollees for whom Contractor provides intensive Care Management for reasons such as addressing acute and chronic health needs, behavioral health needs or addressing lack of social support. Contractor shall stratify Enrollee groups using the minimum requirements provided below: • Population: Families and Children: Level 2 and 3 (combined moderate and high risk): N/A and Level 3: 2% • Population: ACA Adults: Level 2 and 3 (combined moderate and high risk): N/A and Level 3: 2% • Population: Special Needs Children: Level 2 and 3 (combined moderate and high risk): 40% and Level 3: 20% • Population: Seniors/Persons with Disability: Level 2 and 3 (combined moderate and high risk): 20% and Level 3: 5% • Population: Dual-Eligible Adults: Level 2 and 3 (combined moderate and high risk): 90% and Level 3: 20% *Contract 2018-24-001, Amendment KA5, Sections 5.13.1.4 to 5.13.1.4.1*

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
22. Outreach	Contractor shall use its best efforts to locate all Enrollees who are identified through risk stratification as being high risk or moderate risk. For the purpose of this section, the Department will define best efforts on an annual basis. Where appropriate, Contractor shall use community-based organizations to locate and engage such Enrollees. *Contract 2018-24-001, Section 5.13.3*
23. Enrollee Engagement and Education	Contractor shall use a multifaceted approach to locate, engage, and educate Enrollees and shall capitalize on every Enrollee contact to obtain and update Enrollee information. Contractor shall solicit input from Enrollees and other stakeholders to help develop strategies to increase motivation for enhanced independent and healthy living. *Contract 2018-24-001, Section 5.13.4*
24. Self-Directed Care	Contractor will encourage Providers to support Enrollees in directing their own care and developing an IPoC. *Contract 2018-24-001, Section 5.13.5*
25. Health Risk Assessment	Contractor shall use its best efforts to complete a health risk assessment within thirty (30) days for any Enrollee whose health-risk screening indicates a need for further assessment. For the purpose of this section 5.13.2, the Department will define best efforts on an annual basis. However, Contractor shall complete a health-risk assessment for the following populations: • All Enrollees stratified as Level 3 (high-risk) or Level 2 (moderate risk). The assessment will be conducted, in-person or over the phone, within ninety (90) days after enrollment. • Enrollees receiving HCBS Waiver Services or residing in NFs as of their Effective Enrollment Date with Contractor: The health risk assessment must be in person and completed within ninety (90) days after enrollment. • Enrollees transitioning to NFs: The health risk assessment must be in-person and completed within ninety (90) days of Contractor's receipt of the 834 Daily File that indicates an Enrollee has transitioned to a Nursing Facility. • Enrollees deemed newly eligible for HCBS Waiver Services: The health risk assessment must be in-persona and completed within fifteen (15) days after Contractor is notified that the Enrollee is determined eligible for HCBS waiver services. *Contract 2018-24-001, Amendment KA2 and Amendment KA5, Sections 5.13.2. to 5.1.3.2.4*
26. Individual Plan of Care Reassessment	Contractor will analyze predictive-modeling reports and other surveillance data of all Enrollees monthly to identify risk-level changes. As risk levels change, assessments and reassessments will be completed as necessary and IPoCs created or updated. For Enrollees whose risk level is updated to Level 3 (high-risk) or Level 2 (moderate-risk), Contractor shall make best effort to complete a health-risk assessment and IPoC within ninety (90) days of the risk level update. Contractor shall review IPoCs of Level 3 (high-risk) Enrollees at least every thirty (30) days, and of Level

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26. Individual Plan of Care Reassessment (Cont.)	2 (moderate risk) Enrollees at least every ninety (90) days, and conduct reassessments as necessary based upon such reviews. At a minimum, Contractor shall conduct a health-risk reassessment annually for each Enrollee who has an IPoC. In addition, Contractor shall conduct a face-to-face health-risk reassessment for Enrollees receiving HCBS Waiver services or residing in NFs each time there is a significant change in the Enrollee's condition or an Enrollee requests reassessment. Contractor will provide updated IPoCs to Providers that are involved in providing Covered Services to Enrollee within no more than five (5) Business Days. *Contract 2018-24-001, Amendment KA2, Section 5.16*
27. Individualized Plan of Care/Service Plans	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 in a HCBS Waiver 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. 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. *Contract 2018-24-001, Amendment KA2, Section 5.15.1*
28. Individualized Plan of Care	The IPoC must: • Incorporate of the all Enrollee's care needs, including: medical, behavioral-health, Service Package II care, social, and functional needs; • Include identifiable short- and long-term treatment and service goals to address the Enrollee's needs and preferences and to facilitate monitoring of the Enrollee's progress and evolving service needs; and • Include, in the development, implementation, and ongoing assessment of the IPoC, an opportunity for Enrollee participation and an opportunity for input from the PCP, other Providers, a legal or Personal representative, and the family or caregiver if appropriate. *Contract 2018-24-001, Sections 5.15.1.1 to 5.15.1.3*
29. IPoC Requirements	• Contractor shall identify and evaluate risks associated with the Enrollee's care. Factors considered include the potential for deterioration of the Enrollee's health status; the Enrollee's ability to comprehend risk; caregiver qualifications; appropriateness of the residence for the Enrollee; and behavioral or other compliance risks. Contractor shall incorporate the results of the risk assessment into the IPoC. IPoCs that include Negotiated Risks shall be submitted to Contractor's medical director for review. Negotiated Risks shall not allow or create a risk for other Residents in a group setting. • The Enrollee or the Enrollee's authorized representative must review and sign the IPoC and all subsequent revisions. Acceptable forms of signature include electronic forms such as e-signatures and voice recordings. In the event the Enrollee refuses to sign the IPoC, Contractor shall:

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29. IPoC Requirements (Cont.)	○ Document in detail the specific reason why the Enrollee refuses to sign the IPoC; and, ○ Document actions taken by the Care Coordinator to address Enrollee's concerns. *Contract 2018-24-001, Section 5.15.2*
30. IPoC- Requirements, (cont.)	• For Enrollees transferring MCOs for whom an IPoC has been developed, Contractor will use the Enrollee's existing service plan, and that service plan will remain in effect for at least a ninety- (90) day transition period unless changed with the input and consent of the Enrollee and only after completion of a face-to-face comprehensive needs assessment. *Contract 2018-24-001, Section 5.15.3*
31. IPoC- Requirements, (cont.)	• The Enrollee or the Enrollee's authorized representative must review and sign the IPoC and all subsequent revisions. Acceptable forms of signature include electronic forms such as e-signatures and voice recordings. In the event the Enrollee refuses to sign the IPoC, Contractor shall: ○ Document in detail the specific reason why the Enrollee refuses to sign the IPoC; and, ○ Document actions taken by the Care Coordinator to address Enrollee's concerns. *Contract 2018-24-001, Sections 5.15.4 - 5.15.4.2*
32. IPoC- Transferring from another MCO	• For new Enrollees transferring from another MCO, the Department will notify Contractor of the Enrollee's previous MCO, and Contractor will immediately request the Enrollee's IPoC from that MCO. • For past Enrollees who have left Contractor's Health Plan, Contractor shall provide an Enrollee's IPoC within ten (10) Business Days after receiving a request for it from the MCO in which the individual is enrolled. *Contract 2018-24-001, Sections 4.1.2 to 4.1.3*
33. IPoC Additional Elements	The IPoC will include, as appropriate, the following elements: • The Enrollee's Personal or cultural preferences, such as types or amounts of services; • The Enrollee's preference of Providers and any preferred characteristics, such as gender or language; • The Enrollee's living arrangements; • Covered Services and non-Covered Services to address each identified need, provided that Contractor shall not be required to pay for non-Covered Services; • Actions and interventions necessary to achieve the Enrollee's objectives; • Follow-up and evaluation;

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33. IPoC Additional Elements (Cont.)	• Collaborative approaches to be used; • Desired outcome and goals, both clinical and nonclinical; • Barriers or obstacles; • Responsible parties; • Standing Referrals; • Community resources; • Informal supports; • Timeframes for completing actions; • Status of the Enrollee's goals; • Home visits as necessary and appropriate for Enrollees who are homebound (as defined in 42 U.S.C. 1395n(a)(2)), who have physical or Cognitive Disabilities, or who may be at increased risk for Abuse, Neglect, or exploitation; • Back-up plan arrangements for critical services; • Crisis Safety Plans for an Enrollee with Behavioral Health conditions; and • Wellness Program plans. *Contract 2018-24-001, Sections 5.15.1.4 to 5.15.1.4.19*
34. Enrollee support to ensure compliance	To the extent possible, Contractor shall involve the Enrollee in IPoC development. Enrollee education will occur through telephone contact, face-to-face contact, education groups, and educational mailings. Education shall include information about monitoring daily disease-specific indicators. If appropriate, the Care Coordinator will link the Enrollee with available community-based disease-specific educational programs and support groups. *Contract 2018-24-001, Section 5.21.8.8*
35. IPoC Communication	Contractor shall ensure that the Enrollee's IPoC is communicated to all of the Enrollee's ICT members and Providers, as appropriate. *Contract 2018-24-001, Section 5.15.5*
36. HCBS Waiver Service Plan *CFR 438.208 (c)(3)* *42 CFR 441.301(c)*	Include a HCBS Waiver service plan for Enrollees receiving HCBS Waiver services. Contractor shall ensure the person-centered service plan is developed in accordance with 42 CFR 441.301(c) and as follows: • Contractor shall ensure that the person-centered planning process is initiated and the service plan is developed within fifteen (15) days after Contractor is notified that the Enrollee is determined eligible for HCBS Waiver services. The planning process shall be led, when possible, by

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36. HCBS Waiver Service Plan (Cont.)	the Enrollee and include individuals chosen by the Enrollee. An Enrollee's HCBS Provider(s), or those who have an interest in or are employed by the HCBS Provider(s), shall not participate in the planning process, unless the provision at 42 CFR 441.301(c)(1)(vi) is met. Contractor is responsible for procedures to assist Enrollees in the planning process, including how to resolve conflicts and disagreements that includes conflict-of-interest guidelines. The Enrollee's Care Coordinator will assist the Enrollee in leading the HCBS Waiver person-centered service planning and will coordinate with the Interdisciplinary Care Team (ICT). • Informed Client Choice. Contractor's person-centered planning process shall provide sufficient information and guidance to ensure the Enrollee is enabled to make informed choices regarding services, supports and Providers. The planning process must reflect cultural considerations of the Enrollee and is conducted using accessible information presented in readily understood language. Alternative home and community-based settings considered during the planning process must be documented in the service plan. • Service Plan Contents. Each person-centered service plan must be written in a manner that is understandable to the Enrollee and include: (1) documentation that the setting in which the Enrollee resides is chosen by the Enrollee, is integrated into and supports access to the community, and meets, when applicable, the HCBS Settings rule requirements at 42 CFR 441.301(c)(4)-(5); (2) the Enrollee's strengths and preferences; (3) the clinical and support needs identified through the Determination of Need; (4) person-centered goals and desired outcomes; (5) paid and unpaid services and supports that will assist Enrollee to achieve identified goals, the Providers of those services and supports, including those self-directed by the Enrollee; (6) identified risk factors and strategies, including back-up plans, to minimize potential undesirable outcomes associated with those risks; and (7) the individual or entity responsible for monitoring the service plan. • Contractor shall ensure that the final person-centered service plan is finalized with the informed written consent of the Enrollee and is signed by and distributed to individuals and Providers responsible for the service plan's implementation, as applicable. • Contractor shall ensure that an Enrollee's person-centered service plan is reviewed and revised upon reassessment of functional need at least every twelve (12) months, when an Enrollee's circumstances or needs change significantly, or at the Enrollee's request. • For an Enrollee who is receiving HCBS Waiver services through Contractor and who ceases to be eligible for Contractor services, Contractor shall notify the Enrollee's existing HCBS Waiver Provider(s) in writing of Contractor' service authorization termination date no later than seven (7) days from such date. *Contract 2018-24-001, Amendment KA2, Sections 5.15.1.5 to 5.15.1.5.4*
37. Behavioral Service Plan: Williams Consent Decree	Contractor shall implement any behavioral health service plan developed by DHS Contractors for an Enrollee who is a class member under the Williams consent decree unless the Enrollee and the Enrollee's Williams Provider consent to a modification of such plan. Contractor is responsible for payment of services under such plan only to the extent the services are Covered Services. The State, or its designee, will provide Contractor with a timely copy of any such plan. To the extent that Covered Services in such plan would not have been paid by Contractor due to Contractor's utilization controls, Contractor is not obligated to pay until Contractor has received a copy of the plan.

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37. Behavioral Service Plan: Williams Consent Decree (Cont.)	*Contract 2018-24-001, Section 5.2.5*
38. Colbert Service Plans	N/A
39. Transition of Care Process *CFR 438.62*	Contractor will manage Transition of Care and Continuity of Care for new Enrollees and for Enrollees moving from an institutional setting to a community setting. Contractor's process for facilitating Continuity of Care will include: • Identification of Enrollees deemed critical for Continuity of Care; • Communication with entities involved in Enrollees' transition; • Stabilization and provision of uninterrupted access to Covered Services; • Assessment of Enrollees' ongoing care needs; • Monitoring of continuity and quality of care, and services provided; and • Medication reconciliation. *Contract 2018-24-001, Sections 5.18.1 to 5.18.1.6*
40. Transition of Care Plan *CFR 438.62*	Contractor shall initially, and as revised, submit to the Department, for the Department's review and Prior Approval, the transition-of-care policies, procedures, and staffing model designed to achieve a seamless, efficient transition with minimal impact to an Enrollee's care. *Contract 2018-24-001, Section 5.18.2*
41. Transition of Care Team *CFR 438.62*	Contractor shall have an interdisciplinary Transition-of-Care team to design and implement the Transition-of-Care plan, as part of the IPoC, and provide oversight and management of all Transition-of-Care processes. The team will consist of skilled personnel with extensive knowledge and experience transitioning Enrollees with special healthcare needs. *Contract 2018-24-001, Section 5.18.3*
42. Transition of Care for new Enrollees *CFR 438.62*	Contractor will identify new Enrollees who require transition services by using a variety of sources, including: • Prior claim history as provided by the Department; • IPoC provided by the previous Contractor; • Health risk screenings completed by new Enrollees; • Providers requesting information and service authorizations for Enrollees (existing prior authorizations for new Enrollees shall be honored by Contractor); • Communications from Enrollees; and

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42. Transition of Care for new Enrollees (Cont.)	• Communication with existing agencies or service Providers that are supporting Enrollees at the time of transition. *Contract 2018-24-001, Sections 5.18.4 to 5.18.4.6*
43. Community Transitions Initiative *CFR 438.62*	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 one-hundred twenty (120) days. Contractor shall prioritize community transitions for class members of the *Williams v. Quinn* and *Colbert v. Quinn* consent decrees. The initiative shall be in effect for each calendar year through 2021. *Contract 2018-24-001, Amendment KA5, Section 5.18.6*
44. Preexisting Conditions	Upon the Effective Enrollment Date, Contractor shall assume full responsibility for any Covered Services necessary to treat medical conditions that may have existed prior to an Enrollee's enrollment with Contractor. Contractor shall support the continuation of any existing treatment plan provided that the Enrollee's treatment plan is current, a Covered Service, and Medically Necessary. Contractor shall evaluate the appropriateness of integrated Care Management and education for each Enrollee who it determines to have a preexisting condition. *Contract 2018-24-001, Section 5.19.9*
45. Continuity of Care *45 CFR parts 160 and 164 subparts A and E*	Contractor must develop policies and procedures to ensure Continuity of Care for all Enrollees upon initial enrollment, as follows: • Effective upon the implementation date of the HealthChoice Illinois – Children with Special Needs 1915(b) Waiver, the provisions of Section 5.19.1.1 apply for Special Needs Children Enrollees, with the exception that the transition period must be no less than one-hundred eighty (180) days. • Contractor must offer an initial ninety (90)–day transition period for Enrollees new to the Health Plan, in which Enrollees may maintain a current course of treatment with a Provider who is currently not a part of Contractor's Provider Network. Contractor must offer a ninety (90)–day transition period for Enrollees switching from another Health Plan to Contractor. The ninety (90)–day transition period is applicable to all Providers, including Behavioral Health Providers and Providers of LTSS. Contractor shall pay for Covered Services rendered by a non-Network Provider during the ninety (90)–day transition period at the same rate the Department would pay for such services under the Illinois Medicaid FFS methodology. Non-Network Providers and specialists providing an ongoing course of treatment will be offered agreements to continue to care for an individual Enrollee on a case-by-case basis beyond the transition period if the Provider remains outside the Network or until a qualified Network Provider is available. • Contractor may choose to transition Enrollees to a Network Provider during the transition period only if:

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45. Continuity of Care (Cont.)	o the Enrollee is assigned to an IHH that is capable of serving the Enrollee's needs appropriately; o a health screening and a comprehensive assessment, if necessary, are complete; o Contractor consulted with the new IHH and determined that the IHH is accessible and competent and that it can appropriately meet the Enrollee's needs; o a transition-of-care plan is in place (to be updated and agreed to with the new PCP, as necessary); and o the Enrollee agrees to the transition prior to the expiration of the transition period. *Contract 2018-24-001, Amendment KA5, Sections 5.19.1 to 5.19.1.2.5*
46. Transition Enrollees to a Network Specialist or LTSS Provider	N/A
47. Transition of Authorized Services	N/A
48. Transition Process – Part D Drugs	N/A
49. Managed Care and Patient's Rights Act	Contractor shall provide for the transition of services in accordance with 215 ILCS 134/25, Managed Care Reform and Patient's Rights Act. *Contract 2018-24-001, Section 5.19.2*
50. Continuity of Inpatient Care Upon Enrollment	If an Enrollee is receiving medical care or treatment as an inpatient in an acute-care hospital on the Effective Enrollment Date, Contractor shall assume responsibility for the management of such care and shall be liable for all claims for Covered Services from that date. For hospital stays that would otherwise be reimbursed under the HFS Medical Program on a per-diem basis, Contractor's liability shall begin on the Effective Enrollment Date. Notwithstanding the foregoing, for hospital stays that would otherwise be reimbursed under the HFS Medical Program on a DRG basis, Contractor will have no liability for the hospital stay. *Contract 2018-24-001, Section 5.19.3*
51. Continuity of Inpatient Care Upon Termination of Coverage	If an Enrollee is receiving medical care or treatment as an inpatient in an acute-care hospital at the time coverage under this Contract is terminated, Contractor shall arrange for the Continuity of Care or treatment for the current episode of illness until such medical care or treatment has been fully transferred to a treating Provider who has agreed to assume responsibility for such medical care or treatment for the remainder of that hospital episode and subsequent follow-up care. Contractor must maintain documentation of such transfer of responsibility of medical care or treatment. For hospital stays that would otherwise be reimbursed under the Department's medical program on a per-diem basis, Contractor shall be liable for

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51. Continuity of Inpatient Care Upon Termination of Coverage (Cont.)	payment for any medical care or treatment provided to an Enrollee until the effective disenrollment date. For hospital stays that would otherwise be reimbursed under the Department's medical program on a DRG basis, Contractor shall be liable for payment for any inpatient medical care or treatment provided to an Enrollee where the discharge date is after the effective disenrollment date. *Contract 2018-24-001, Section 5.19.4*
52. Continuity of Care for Nursing Facility Residents	When a resident in a NF first transitions to the Contractor from the fee-for-service system or from another plan, the Contractor shall honor the existing IPoC and any necessary changes to that IPoC until it has completed a comprehensive assessment and new IPoC, to the extent such services are covered benefits under the Contract, which shall be consistent with the requirements of the Resident Assessment Instrument (RAI) Manual. When an Enrollee is moving from a community setting to a NF, and the Contractor is properly notified of the proposed admission by a network NF, and the Contractor fails to participate in developing an IPoC within the time frames required by NF regulations and this Contract, the Contractor must honor an IPoC developed by the NF until the Contractor has completed a comprehensive assessment and a new IPoC to the extent such services are covered benefits under the contract, consistent with the requirements of the RAI Manual. *Contract 2018-24-001, Sections 5.19.5 to 5.19.5.2*
53. Continuity of Care – Services Not Covered	N/A
54. Coordination of Care	Contractor shall provide coordination-of-care assistance to Prospective Enrollees to access a PCP or WHCP or to continue a course of treatment before Contractor's coverage becomes effective, if requested to do so by Prospective Enrollees, or if Contractor has knowledge of the need for such assistance. The Care Coordinator assigned to the Prospective Enrollee shall attempt to contact the Prospective Enrollee no later than two (2) Business Days after the Care Coordinator is notified of the request for coordination of care. *Contract 2018-24-001, Section 5.19.6*
55. Advance Directives	Contractor shall comply with all rules concerning the maintenance of written policies and procedures with respect to Advance Directives set forth in 42 CFR §422.128. Contractor shall provide adult Enrollees with oral and written information on Advance Directives policies and include a description of applicable State law. Such information shall reflect changes in State law as soon as possible, but no later than ninety (90) days after the effective date of the change. *Contract 2018-24-001, Section 5.33*

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1. Utilization Management Incentives *42 CFR 438.210 (e)* *42 C.F.R. §§ 438.3(i)* *422.208*	Contractor shall not compensate individuals or entities that conduct utilization-review activities on its behalf in a manner that is structured to provide incentives for the individuals or entities to deny, limit, or discontinue Covered Services that are Medically Necessary for any Enrollee. *Contract 2018-24-001, Section 5.22.9*
2. Medical Necessity	N/A
3. Medical Necessity Guidelines	N/A
4. Medical Necessity – Behavioral Health	N/A
5. Individuals Authorizing Services	N/A
6. Authorization of Services *42 CFR 438.210 (b)*	Contractor shall have in place and follow written policies and procedures when processing requests for initial and continuing authorizations of Covered Services. Such policies and procedures shall provide for consistent application of review criteria for authorization decisions by a healthcare professional or professionals with expertise in addressing the Enrollee's medical, Behavioral Health, or LTSS needs. Contractor shall consult with the Provider requesting such authorization when appropriate and provided that LTSS authorizations are based on the Enrollee's current needs assessment and Person-centered service plan. *Contract 2018-24-001, Section 5.19.7*
7. Enrollee Restriction Program 89 Ill. Admin. Code 120.80	Contractor must have an Enrollee restriction program in place, in which, at a 4.19.1minimum, Contractor must restrict an Enrollee for a reasonable period to a designated PCP or Provider of pharmacy services when: • the Department indicates the Enrollee was included in the Department's Recipient Restriction Program pursuant to 89 Ill. Admin. Code 120.80 prior to enrollment with Contractor; or • Contractor determines that the Enrollee is over-utilizing Covered Services. Contractor's criteria for such determination, and the conditions of the restriction, must meet the standards of 42 CFR §431.54(e). Contractor's policies on Enrollee restriction must receive Prior Approval and shall include the right of the Enrollee to file a Grievance or Appeal. *Contract 2018-24-001, Sections 4.19 to 4.19.2*

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8. Services Not Subject to Prior Authorization	N/A
9. Services Requiring Prior Authorization *42 CFR 438.210 (d)(1)* *42 CFR 438.404* *305 ILCS 5/5F-32*	Contractor shall authorize or deny Covered Services that require prior authorization, including pharmacy services, as expeditiously as the Enrollee's health condition requires. Ordinarily, requests for authorizations shall be reviewed and decided on within four (4) days after receiving the request for authorization from a Provider, with a possible extension of up to four (4) additional days, if the Enrollee requests the extension or Contractor informs the Provider that there is a need for additional written justification demonstrating that the Covered Service is Medically Necessary and the Enrollee will not be harmed by the extension. *Contract 2018-24-001, Section 5.19.8*
10. Expedited Authorizations *42 CFR 438-210(d)(2)* *42 CFR 438.404* *305 ILCS 5/5F-32*	If the Provider indicates, or Contractor determines, that following the ordinary review and decision time frame could seriously jeopardize the Enrollee's life or health, Contractor shall authorize or deny the Covered Service no later than forty-eight (48) hours after receipt of the request for authorization. *Contract 2018-24-001, Section 5.19.8*
11. Authorization of Pharmacy Services *42 CFR 438.210 (d)(3)*	Contractor shall authorize or deny a prior authorization request for pharmacy services no later than twenty-four (24) hours after receipt of the request for authorization. *Contract 2018-24-001, Section 5.19.8*
12. Authorize Services–Chronic Conditions and LTSS	Contractor shall authorize services supporting individuals with ongoing or chronic conditions, or who require LTSS, in a manner that reflects the Enrollee's ongoing need for such services. *Contract 2018-24-001, Section 5.19.8.1*
13. Authorizations for Enrollees Residing in a NF	For authorizations for Enrollees residing in a NF, if a response to the authorization is not provided within twenty-four (24) hours of the request and the NF is required by regulation to provide a service because a Physician ordered it, the Contractor must pay for the service if it is a Covered Service, provided that the request is consistent with the policies and procedures of the Contractor. *Contract 2018-24-001, Amendment KA2, Section 5.19.8.3*
14. Direct Access Services/ Emergency Services	Contractor shall cover Emergency Services for all Enrollees whether the Emergency Services are provided by a Network or a non-Network Provider. • Contractor shall not impose any requirements for Prior Approval of Emergency Services, including emergency medical screening, or restrict coverage of Emergency Services on the basis of lists of diagnoses or symptoms.

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42 CFR 438.11	• Contractor shall cover Emergency Services provided to Enrollees who are temporarily away from their residences and outside the Contracting Area to the extent that the Enrollees would be entitled to the Emergency Services if they were still within the Contracting Area. • Contractor shall cover Emergency Services regardless of whether the emergency department Provider or hospital notified the Enrollee's PCP or Contractor of the Enrollee's services in the emergency department. • Unless a representative of Contractor instructed the Enrollee to seek Emergency Services, Contractor shall have no obligation to cover medical services provided on an emergency basis that are not Covered Services under this Contract. • Elective care, or care required as a result of circumstances that could reasonably have been foreseen prior to the Enrollee's departure from the Contracting Area, is not covered. Unexpected hospitalization due to complications of pregnancy shall be covered. Routine delivery at term outside the Contracting Area, however, shall not be covered if the Enrollee is outside the Contracting Area against medical advice, unless the Enrollee is outside of the Contracting Area due to circumstances beyond her control. Contractor must educate the Enrollee regarding the medical and financial implications of leaving the Contracting Area and the importance of staying near the treating Provider throughout the last month of pregnancy. • Contractor shall provide ongoing education to Enrollees regarding the appropriate use of Emergency Services. Contractor shall use a range of management techniques, policies, and Enrollee or Provider initiatives to avoid unnecessary utilization of Emergency Services and to promote Care Management through an Enrollee's PCP. • Contractor shall not condition coverage for Emergency Services on the treating Provider notifying Contractor of the Enrollee's screening and treatment within ten (10) days after presentation for Emergency Services. • The determination of the attending emergency Physician, or the Provider treating the Enrollee, of whether an Enrollee is sufficiently Stabilized for discharge or transfer to another facility shall be binding on Contractor. • Contractor shall not hold an Enrollee liable for payment of subsequent screening and treatment needed to diagnose the specific condition or to stabilize the Enrollee. *Contract 2018-24-001, Amendment KA2, Sections 5.20.1 to 5.20.1.1.9*
15. Post-Stabilization Services *42 CFR 438.114 (b)(1)-(2), (e)*	Contractor shall cover Post-Stabilization Services provided by a Network or non-Network Provider in any of the following situations: • Contractor authorized such services; • Such services were administered to maintain the Enrollee's Stabilized condition within one (1) hour after a request to Contractor for authorization of further Post-Stabilization Services; or • Contractor does not respond to a request to authorize further Post-Stabilization Services within one (1) hour, Contractor could not be contacted, or Contractor and the treating Provider cannot reach an agreement concerning the Enrollee's care and a Network Provider is unavailable for a consultation, in which case the treating Provider must be permitted to continue the care of the Enrollee until a Network Provider is reached and either concurs with the treating Provider's plan of care or assumes responsibility for the Enrollee's care.

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	Contract 2018-24-001, Sections 5.20.1.2 to 5.20.1.2.3
16. Family Planning *42 CFR 438.210 (a)(4)(ii)(C)* *745 ILCS 70/1 et seq.* *42 CFR Part 441, Subpart E - F*	Subject to sections 5.5 and 5.6, Contractor shall cover Family-Planning services for all Enrollees, whether the Family-Planning services are provided by a Network or a non-Network Provider. *Contract 2018-24-001, Section 5.20.1.3*
17. School-Based Health Centers	• Contractor shall offer contracts to all the school health centers recognized by the Department of Public Health that are in Contractor's Contracting Area. Contractor shall not require prior authorization or a Referral as a condition of payment for school-based health center services provided by those school-based health centers with which Contractor has contracts. • For Illinois school-based health centers outside of the Contracting Area, Contractor shall accept claims from non-Network Providers of school-based health center services. Contractor shall make payment to non-Network Providers of such services according to the Department's applicable Medicaid FFS reimbursement schedule. Contractor may require school-based health centers to follow Contractor's protocols for communication regarding services rendered in order to further care coordination. *Contract 2018-24-001, Sections 5.20.2.1 to 5.20.2.1.2*
18. School Dental	Contractor shall cover dental services that are Covered Services provided in a school for Enrollees who are under the age of twenty-one (21). Contractor shall accept claims from non-Network Providers of such services outside of its Contracting Area. Contractor shall make payment to non-Network Providers of such services according to the Department's applicable Medicaid FFS reimbursement schedule. Contractor may require the program to follow Contractor's protocols for communication regarding services rendered in order to further care coordination. *Contract 2018-24-001, Section 5.20.1.4*
19. State Operated Hospitals	Contractor shall provide inpatient psychiatric care at an SOH for an Enrollee admitted under civil status, at Medicaid established rates, whether that SOH is a Network or non-Network Provider. Payment shall be made for all days utilized as determined by the DMH and is not subject to the UR determinations or admission authorization standards of Contractor. *Contract 2018-24-001, Section 5.20.1.5*
20. Telephone Access	• Contractor shall establish a toll-free telephone number, available twenty-four (24) hours a day, seven (7) days a week, for Enrollees to confirm eligibility for benefits and for Providers to seek prior approval for treatment where required by Contractor, and shall assure twenty-four (24)–hour access, via telephone(s), to medical professionals, either to Contractor directly or to PCPs, for consultation to obtain medical care.

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20. Telephone Access (Cont.)	• Contractor shall establish a toll-free number that will be available at a minimum from 8:30 a.m. until 5:00 p.m. Central Time on Business Days. This number will be used at a minimum for Enrollees to file Complaints or Grievances, to request disenrollment, to ask questions, or to obtain other administrative information. *Contract 2018-24-001, Sections 5.21.6 to 5.21.6.2*
21. Telephone Access – Pharmacy Services	N/A
22. Authorization Denial Notice *42 CFR 438.404 & 438.210*	If Contractor declines to authorize Covered Services that are requested by a Provider or authorizes one or more services in an amount, scope, or duration that is less than that requested, Contractor shall notify the Provider orally or in writing and shall furnish the Enrollee with written notice of such decision. Such notice shall meet the requirements set forth in 42 CFR §438.404. *Contract 2018-24-001, Section 5.19.7*
23. Adverse Benefit Determination Notice Requirements	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). *Contract 2018-24-001, Section 5.30.3.1*
24. Integrated Notice Requirements	N/A
25. Authorization Denial Drug Notification	For all covered outpatient drug authorization decisions, Contractor shall provide notice as described in Section 1927(d)(5)(A) of the SSA. *Contract 2018-24-001, Section 5.19.8.2*
26. Pharmacy Formulary – Drug Rebate Program	Pharmacy Formulary and Preferred Drug List (PDL) Effective January 1, 2020 Contractor shall cover only drugs made by manufacturer who participate in the federal Medicaid drug rebate program. This requirement applies to both prescription and over-the-counter drugs. This requirement does not apply to non-drug items such as blood-glucose monitoring supplies, as those products are not drugs and are not eligible for the federal Medicaid drug rebate program. *Contract 2018-24-001, Amendment KA5, Section 5.3.2.1*

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27. Drug Rebate Program	N/A
28. Electronic and Print Formularies	Contractor's electronic and print formularies shall comply with the standardized format developed by the Department. Contractor shall adopt the Department's PDL categorization of drug classes and shall use the class names listed on the PDL. Contractor's published formulary shall contain, at minimum, the following: • Brand and generic medications covered; • If medication if preferred or non-preferred and each term's definition; • Each medication's tier and the definition of each tier; • Utilization controls, including step therapy, prior approval, dosage limits, gender or age restrictions, quantity limits, and other policies; • Cost sharing; • Glossary of key terms and explanation of utilization controls and cost sharing; • A key for all utilization controls visible on every page in which specific medication coverage is displayed; • Directions to obtain more information if a medication is not covered or listed in the formulary; • An email and toll-free number to which an individual can report inaccuracies in the formulary; and • A disclosure that identifies the date of publication, a statement that the formulary is up to date as of publication and contact information for questions and requests to receive updated information. *Contract 2018-24-001, Amendment KA5, Sections 5.3.2.12 to 5.3.2.12.10*
29. Pharmacy Formulary Requirements	Contractor shall publish formulary on its program website and make the formulary easily understandable and publicly accessible without a password, username or personality identifiable information. • Contractor shall provide printed formularies upon request. • Upon reports of formulary inaccuracies, Contractor must investigate and make correction to the data displayed. Data correction shall be completed within three (3) business days of notification of error. • Contractor shall attest to the Department on a quarterly basis that it is making updates to the pharmacy formulary within three (3) business days after investigation of reported inaccuracies. • Contractor shall ensure that it requires pharmacy, medical, and hospital Providers to identify 340B-purchased drugs on pharmacy, medical, and hospital claims following the Department billing guidelines applied in the FFS program. Contractor shall ensure that its Encounter claims to the Department also identify these drugs. • For outpatient drugs not identified in section 5.3.2.17, Contractor shall collect information on the total number of units of each dosage form and strength and package size by National Drug Code of each covered outpatient drug dispensed to Enrollees. This requirement is considered met through the detail included on the pharmacy claims submitted to Contractor for pharmacy reimbursement.

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29. Pharmacy Formulary Requirements (Cont.)	• Contractor shall report to the Department through pharmacy Encounter claims information on the total number of units of each dosage form and strength and package size by National Drug Code of each covered outpatient drug identified in section 5.3.2.18 dispensed to Enrollees. • Contractor shall establish and maintain a process for resolving disputes over generic drug maximum allowable costs (MAC), subject to approval by the Department. The MAC dispute-resolution process shall enable pharmacies to report pricing disputes to Contractor up to sixty (60) days from the claim date, and Contractor is required to resolve the pricing dispute within twenty-one (21) days after the report of the pricing dispute by adjusting the reimbursement rate to represent the acquisition cost of the drug, or by informing the pharmacy of alternative generic equivalent products that can be purchased at or below Contractor's existing MAC price. *Contract 2018-24-001, Amendment KA5, Sections 5.3.2.13. to 5.3.2.20*
30. Pharmacy Utilization Controls	Unless otherwise prohibited in this contract, Contractor may establish clinically appropriate utilization controls, such as quantity and dose. Limits. Contractor shall utilize the Department's step therapy and prior authorization requirements for family-planning drugs and devices pursuant to the Department's PDL and Attachment XXI. *Contract 2018-24-001, Amendment KA5, Section 5.3.2.7*
31. Drug Utilization Review Program *42 CFR 423.153*	Contractor shall develop and implement a system of policies and procedures, coverage criteria, and processes for Contractor's Drug Utilization Review (DUR) program. The DUR program shall include a prospective review process for all drugs prior to dispensing and all non-formulary drug requests, and a retrospective DUR process to detect patterns in prescribing, dispensing, or administration of medication and to prevent inappropriate use or abuse. Contractor is required to complete the Federal CMS MCO DUR annual report and return it to the Department for submission to CMS. *Contract 2018-24-001, Amendment KA5, Section 5.3.2.21*
32. Utilization and Peer Review Committee	Contractor shall have a utilization review and peer review committee(s) whose purpose will be to review data gathered and the appropriateness and quality of care. The committee(s) shall review and make recommendations for changes when problem areas are identified and report suspected Fraud and Abuse in the HFS Medical Program to the Department's Office of Inspector General. The committees shall keep minutes of all meetings, the results of each review and any appropriate action taken. A copy of the minutes shall be submitted to the Department as needed, and within ten (10) Business Days after the Department's request. At a minimum, these programs must meet all applicable federal and State requirements for utilization review. Contractor and the Department may further define these programs. *Contract 2018-24-001, Attachment XII, Section 1.1.1*
33. Utilization Management Program	Contractor shall have a Utilization Management Program that includes a utilization-review plan, a utilization-review committee, and appropriate mechanisms covering preauthorization and review requirements.

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	Contract 2018-24-001, Amendment KA2, Section 5.22.4
34. Utilization Review Plan 89 Ill. Adm. Code, Part 140 59 Ill. Adm. Code, Part 132	Contractor shall implement a Utilization Review Plan, including medical, behavioral health and dental peer review as required. Contractor shall provide the Department with documentation of its utilization review process. The process shall include: • Written program description —Contractor shall have a written Utilization Management Program description which includes, at a minimum, procedures to evaluate medical and behavioral health necessity criteria used and the process used to review and approve the provision of medical and behavioral health services. • Scope — The program shall have mechanisms to detect under-utilization as well as over-utilization. • Preauthorization and concurrent review requirements — For organizations with preauthorization and concurrent review programs: o Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; o Utilize practice guidelines that have been adopted, pursuant to Attachment XI. o Review decisions shall be supervised by qualified medical, behavioral health or dental professionals and any decision to deny a Service Authorization Request or to authorize a service in an amount, duration or scope that is less than requested must be made by a qualified professional who has appropriate clinical expertise in treating the Enrollee's condition or disease; o Efforts shall be made to obtain all necessary information, including pertinent clinical information, and consultation with the treating Provider, as appropriate; o The reasons for decisions shall be clearly documented and available to the Enrollee and the requesting Provider, provided, however, that any decision to deny a service request or to authorize a service in an amount, duration or scope that is less than requested shall be furnished in writing to the Enrollee; o There shall be written well-publicized and readily available Appeal mechanisms for both Providers and Enrollees; o Decisions and appeals shall be made in a timely manner as required by the circumstances and shall be made in accordance with the timeframes specified in this Contract for standard and expedited authorizations; o There shall be mechanisms to evaluate the effects of the program using data on Enrollee satisfaction, Provider satisfaction or other appropriate measures; and o If Contractor delegates responsibility for utilization management, it shall have mechanisms to ensure that these standards are met by the subcontractor. *Contract 2018-24-001, Attachment XII, 1.1.2 to 1.1.2.3.9*
35. Review of Utilization Management Program	Contractor further agrees to review the utilization review procedures, at regular intervals, but no less frequently than annually, for the purpose of amending same, as necessary in order to improve said procedures. All amendments must receive Prior Approval. Contractor further agrees to supply the

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
35. Review of Utilization Management Program (Cont.)	Department and its designee with the utilization information and data, and reports prescribed in its approved utilization review system or the status of such system. This information shall be furnished in accordance to Attachment XIII of this Contract or upon request by the Department. *Contract 2018-24-001, Attachment XII, 1.1.3*
36. Peer Review	Contractor shall establish and maintain a peer review program, subject to Prior Approval, to review the quality of care being offered by Contractor, employees and subcontractors. This program shall provide, at a minimum, the following: • A peer review committee comprised of Physicians, behavioral health professionals and dentists, formed to organize and proceed with the required reviews for both the health professionals of Contractor's staff and any Affiliated Providers which include: o A regular schedule for review; o A system to evaluate the process and methods by which care is given; and o A medical record review process. • Contractor shall maintain records of the actions taken by the peer review committee with respect to Providers and those records shall be available to the Department upon request. • A system of internal review, including medical, behavioral health, dental, waiver and long term care services, medical evaluation studies, peer review, a system for evaluating the processes and outcomes of care, health education, systems for correcting deficiencies, and utilization review. *Contract 2018-24-001, Section 5.22.5 and Attachment XII, Section 1.1.4 to 1.1.4.3*
37. Review of Peer Review Activities	Contractor further agrees to review the peer review procedures, at regular intervals, but no less frequently than annually, for the purpose of amending same in order to improve said procedures. All amendments must be approved by the Department. Contractor shall supply the Department and its designee with the information and reports related to its peer review program upon request. *Contract 2018-24-001, Attachment XII, 1.1.5*

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1. Credentialing and Re-credentialing *42 CFR 438.214 (a)(b)(2)* *410 ILCS 517 Health Care Professional Credentials Data Collection Act*	In accordance with 42 CFR 438.214, provider enrollment in the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system constitutes Illinois' Medicaid managed care uniform credentialing and re-credentialing process. To participate in Contractor's provider network, Contractor must verify that provider is enrolled in IMPACT. Upon receipt of a Provider's completed and accurate Universal Roster Template, Contractor shall load the Provider information into its system within thirty (30) days. Contractor is prohibited from requiring providers to undergo additional recredentialing processes that are not a part of this Contract. *Contract 2018-24-001 and Amendment KA2, Sections 5.9.1, 5.9.1.1 and 5.9.4*
2. Process for Selecting and Retaining Providers	On a continuing basis, Contractor shall monitor Enrollee Complaints and Appeals, quality-of-care and quality-of-service events, and medical record review. Contractor shall document its process for selecting and retaining Providers. *Contract 2018-24-001, Section 5.9.2*
3. QA Activities	QA information shall be used in recontracting and annual performance evaluations. QA activities shall be coordinated with other performance monitoring activities, including utilization management, risk management, and resolution and monitoring of Enrollee complaints and grievances. *Contract 2018-24-001, Attachment XI, 1.1.11.1 and 1.1.11.2*
4. Verifications of Qualifications of Providers of Covered Services under HCBS Waivers	Contractor shall ensure that only those Providers that are approved and authorized by the Department are providing Covered Services under HCBS Waivers, and that those Providers are providing to Enrollees only Covered Services for which they are approved and authorized. The Department will provide Contractor with a weekly Department extract file containing the list of such approved and authorized Providers. Contractor is not required to credential Providers of Covered Services under HCBS Waivers. *Contract 2018-24-001, Section 5.9.3*
5. Nondiscrimination *42 CFR 438.12*	Contractor may not discriminate against any Provider who is acting within the scope of his/her licensure solely on the basis of that licensure or certification. Contractor will provide each Provider or group of Providers whom it declines to include in its network written notice of the reason for its decision. Nothing in sections 9.1.22.3, 9.1.22.4 or 9.1.22.5.may be construed to require Contractor to contract with Providers beyond the number necessary to meet the needs of its Enrollees; preclude Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or preclude Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to Enrollees.

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5. Nondiscrimination (Cont.)	*Contract 2018-24-001, Sections 9.1.22.3 to 9.1.22.4 and 9.1.22.6*
6. Nondiscrimination – High Risk Populations *42 CFR 438.214(c)*	Contractor shall not discriminate against Providers that serve high-risk populations or that specialize in conditions that require costly treatment. *Contract 2018-24-001, Section 9.1.22.5*
7. Culturally-Diverse Network *42 CFR 438.206 (c)(2)*	Contractor shall contract with a culturally-diverse network of Providers of both genders and prioritize recruitment of bilingual or multi-lingual Providers. Contractor's contracts with Providers shall require that Providers comply with Contractor's Cultural Competence plan. Contractor shall confirm the languages used by Providers, including American Sign Language, and ensure physical access to Providers' office locations. *Contract 2018-24-001, Section 2.7.4*

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1. Compliance with the Children's Mental Health Act *Contract 2018-24-001, Attachment XXII, 1.2.1*	Contractor shall ensure that all Enrollees potentially requiring psychiatric inpatient hospitalization, acute care, or subacute care in a Psychiatric Residential Treatment Facility (PRTF), are screened, prior to admission, for the viability of stabilization in the community, as required by the Children's Mental Health Act of 2003 (405 ILCS 49/l et seq.).
2. Family Driven Care Plan *Contract 2018-24-001, Attachment XXII, 1.3.2.1.1 to 1.3.2.1.1.4*	Contractor shall establish a Family Driven Care Plan, focused on establishing opportunities for Enrollees and families to provide Contractor with input and feedback regarding its service delivery system. Contractor shall submit its initial Family and Driven Care Plan, to the Department for review and approval ninety (90) days prior to the Effective Enrollment Date of the first Enrollee. Contractor shall thereafter annually update its Family Driven Care Plan and submit it to the Department for review and approval by no later than the anniversary of the Effective Date. The Family Driven Care Plan shall, at a minimum: • Address how Contractor will establish and maintain a service delivery system that is person and family centric; • Address how Contractor will promote and ensure family and Enrollee input across all of the Contracting Area; • State the annual goals, objectives, and activities Contractor will complete related to family and youth driven care; and Establish the role of the Family Leadership Council (FLC) in the Family Driven Care Plan. Contractor shall ensure that the FLC reviews and provides official comment on the Family Driven Care Plan prior to Contractor submitting the Family Driven Care Plan for review and approval by the Department.
3. Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM-CANS) *Contract 2018-24-001, Attachment XXII, 1.3.3 to 1.3.3.3*	Contractor shall ensure the utilization of the IM-CANS, as defined or selected by the Department, as the standardized mental health assessment and treatment plan for all Enrollees requiring mental health services. Contractor shall ensure the completion of the IM-CANS on all Enrollees who require mental health services within the timelines established by the Department. Contractor shall provide the Department with data related to the IM-CANS on an ongoing basis, in a manner established by the Department.
4. Mobile Crisis Response Services: Crisis Line	Contractor shall establish a dedicated Behavioral Health Crisis line for Enrollees, family members of Enrollees, or other concerned parties seeking to refer the Enrollee to Behavioral Health Crisis services. • Contractor shall ensure that Contractor's Crisis line shall not require callers to navigate a telephonic menu in order to make a referral for crisis services.

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Contract 2018-24-001, Attachment XXII, 1.4.2 to 1.4.2.1	
5. Mobile Crisis Response Services: Knowledgeable Staff *Contract 2018-24-001, Attachment XXII, 1.4.2.2 to 1.4.2.2.3*	Contractor shall ensure that the Crisis line is answered by staff who are: • Capable of addressing a Behavioral Health Crisis upon direct answer; • Knowledgeable and authorized to engage Contractor's Mobile Crisis Response System; and • Knowledgeable about Contractor's Disease Management Model for Children's Mental Health.
6. Face to Face Screening *Contract 2018-24-001, Attachment XXII, 1.4.3*	Contractor shall ensure the availability of Mobile Crisis Response Services, including a face-to-face crisis screening within ninety (90) minutes of notification, to all Enrollees experiencing a Behavioral Health Crisis.
7. Services Available *Contract 2018-24-001, Attachment XXII, 1.4.4*	Contractor shall ensure that Mobile Crisis Response Services are available every day of the year and twenty-four (24) hours per day.
8. Inform Enrollees and Families *Contract 2018-24-001, Attachment XXII, 1.4.5*	Contractor shall inform the Enrollees and families of all Enrollees how to seek Mobile Crisis Response Services with Contractor's Network Providers.
9. Provider Agreement: Provider Credentials	Contractor shall require, as a provision of its Provider agreement with Network Providers of Mobile Crisis Response Services, that staff responsible for providing the services hold the following credentials: • Mental Health Professional (MHP) with direct access to a Qualified Mental Health professional (QMHP); • Qualified Mental Health Professional; or

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Contract 2018-24-001, Attachment XXII, 1.4.6 to 1.4.6.3	• Licensed Practitioner of the Healing Arts.
10. Childhood Severity of Psychiatric Illness (CSPI) *Contract 2018-24-001, Attachment XXII, 1.4.7 and 1.4.7.1*	Contractor shall require the utilization of the prevailing Illinois decision support tool, the Illinois Medicaid Childhood Severity of Psychiatric Illness (IM-CSPI) or any State-defined successor, for all face- to-face mobile Crisis screening. • Contractor shall report clinical IM-CSPI data, in a manner defined by the Department, for all Enrollees receiving Mobile Crisis Response Services.
11. Mobile Crisis Service Model *Contract 2018-24-001, Attachment XXII, 1.4.8*	Contractor shall make available the details of its Mobile Crisis Service Model to the Department as required in Attachment XI, "Quality Assurance." As a component of the QA/UR/PR Annual Report, the Contractor shall provide a report relating to the previous State Fiscal Year on its Mobile Crisis Response Service Model to the Department, in a format developed by the Department that includes a detailed report of utilization, outcomes, and hospitalization rates.
12. Community Stabilization *Contract 2018-24-001, Attachment XXII, 1.5.1*	Contractor shall require Network Providers responsible for providing Mobile Crisis Response Services to provide immediate Crisis and stabilization services when an Enrollee in Crisis can be stabilized in the community.
13. Crisis Safety Plan *Contract 2018-24-001, Attachment XXII, 1.5.1.1*	Contractor shall require its Network Providers responsible for providing Mobile Crisis Response Services to establish a Crisis Safety Plan unique to the Enrollee and circumstances that includes concrete interventions and techniques that will assist in ameliorating the circumstances leading to the Crisis situation.
14. Policies for Crisis and Stabilization	Contractor's Mobile Crisis Response Services shall include policies defining the delivery of Crisis and stabilization services, which shall not require Contractor's prior authorization, for an established period of time post-Crisis that shall not be less than thirty (30) days.

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Contract 2018-24-001, Attachment XXII, 1.5.1.2	
15. Non-CARES Mobile Crisis Response Contact Information *Contract 2018-24-001, Attachment XXII, 1.5.1.3*	Contractor shall require, in lieu of utilizing the publicly funded Crisis and Referral Entry Service (CARES) line service (Attachment XXII, section 10 below), Network Providers responsible for providing Mobile Crisis Response Services to provide the Enrollee's family with contact information that may be used at any time, twenty-four (24) hours a day, to contact Contractor's Mobile Crisis Response system in moments of Crisis.
16. Network of Affiliated Providers *Contract 2018-24-001, Attachment XXII, 1.5.1.4*	Contractor shall include within its network of Network Providers the necessary levels of care, with sufficient intensity, required to meet the needs of Enrollees in order to provide true alternatives to institutions (e.g., PRTFs and hospitals) when clinically appropriate.
17. Crisis Safety Plan *Contract 2018-24-001, Attachment XXII, 1.5.2 to 1.5.2.1*	Contractor shall require its Network Providers responsible for providing Mobile Crisis Response Services to create a Crisis Safety Plan for all Enrollees that present in Behavioral Health Crisis, in collaboration with the Enrollee and the Enrollee's family.
18. Physical Copies of Crisis Safety Plans *Contract 2018-24-001, Attachment XXII, 1.5.2.2 to 1.5.2.2.2*	Contractor shall require its Network Providers responsible for providing Mobile Crisis Response Services to provide Enrollees and families of Enrollees with physical copies of the Crisis Safety Plans consistent with the following timelines: • Prior to the completion of the Crisis screening as provided in Attachment XXII, section 9(b) for any Enrollee stabilized in the community; and • Prior to the Enrollee's discharge from an inpatient psychiatric hospital setting for any Enrollee that is admitted to such a facility.

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19. Crisis Safety Plan Education and Review *Contract 2018-24-001, Attachment XXII, 1.5.2.3*	Contractor shall require its Network Providers responsible for providing Mobile Crisis Response Services to educate and orient the Enrollee's family to the components of the Crisis Safety Plan, to ensure that the plan is reviewed with the family regularly, and to detail how the plan is updated as necessary.
20. Sharing Crisis Safety Plan *Contract 2018-24-001, Attachment XXII, 1.5.2.4*	Contractor shall require its Network Providers responsible for providing Mobile Crisis Response Services to share the Crisis Safety Plan with all necessary medical professionals, including Care Coordinators, consistent with the authorizations established by consent or release.
21. Crisis Event – ICT Meeting *Contract 2018-24-001, Attachment XXII, 1.5.2.5*	If an Enrollee experiences a Crisis event, Contractor shall convene a ICT meeting for the Enrollee within fourteen (14) days after the event if the Enrollee is community stabilized and within fourteen (14) days after discharge if the Enrollee is hospitalized.
22. Post-Discharge Appointment *Contract 2018-24-001, Attachment XXII, 1.5.2.6*	Contractor shall ensure that the Enrollee has a scheduled appointment with a Behavioral Health Provider and the Enrollee's primary care Provider or psychiatric resource within thirty (30) days after the Enrollee's discharge from hospitalization.
23. Youth at Risk *Contract 2018-24-001, Attachment XXII, 1.5.2.7*	When Contractor receives notification from DCFS that an Enrollee in Contractor's plan has been designated a Youth at Risk, Contractor will involve DCFS on the Enrollee's ICT.

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24. Inpatient Institutional Treatment *Contract 2018-24-001, Attachment XXII, 1.5.3*	Contractor shall require its Network Providers responsible for providing Mobile Crisis Response Services to facilitate the Enrollee's admission to an appropriate inpatient institutional treatment setting when the Enrollee in Crisis cannot be stabilized in the community.
25. Available Service Providers *Contract 2018-24-001, Attachment XXII, 1.5.3.1*	Contractor shall require its Network Providers responsible for providing Mobile Crisis Response Services to inform the Enrollee's parents, guardian, caregivers, or residential staff about all of the available Network Providers and any pertinent policies needed to allow the involved parties to select an appropriate inpatient institutional treatment setting.
26. Transportation for Inpatient Admission *Contract 2018-24-001, Attachment XXII, 1.5.3.2*	Contractor shall arrange for the necessary transportation when an Enrollee requires transportation assistance to be admitted to an appropriate inpatient institutional treatment setting.
27. Physical Examination 24 Hours After Admission *Contract 2018-24-001, Attachment XXII, 1.5.3.3*	Contractor shall require its inpatient psychiatric Network Providers to administer a physical examination to the Enrollee within twenty-four (24) hours after admission when an Enrollee requires admission to an appropriate inpatient institutional treatment setting.
28. Discharge and Transitional Planning	Contractor shall provide and have documented procedures for its Network Providers regarding, discharge, and transitional planning consistent with the following: • Planning shall begin upon admission; • Community-based Providers responsible for providing service upon the Enrollee's discharge shall participate in all inpatient staffing by phone, videoconference, or in person;

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Contract 2018-24-001, Attachment XXII, 1.5.3.4 to 1.5.3.4.6	• The Enrollee's Care Coordinator shall notify the Enrollee's family and caregiver of key dates and events related to the admission, staffing, discharge, and transition of the Enrollee, and he or she shall make every effort to involve the Enrollee and the Enrollee's family and caregiver in decisions related to these processes; • The Enrollee's Care Coordinator shall speak directly with the Enrollee at least once each week; • The Enrollee's Care Coordinator or Network Provider shall educate and train the Enrollee's family on how to use the Crisis Safety Plan while the Enrollee is receiving inpatient institutional treatment; and • The Enrollee's Care Coordinator shall participate in and oversee staffing, discharge, and transition processes.
29. Promote Continuity of Care *Contract 2018-24-001, Attachment XXII, 1.5.3.5*	Contractor shall coordinate communication of admission, pharmaceutical, and discharge data, consistent with the consents and releases secured, to the necessary primary care and Network Providers to promote Continuity of Care.
30. Follow-Up Appointments *Contract 2018-24-001, Attachment XXII, 1.5.3.6*	Contractor shall coordinate all necessary follow-up appointments and referrals for the Enrollee upon transition back into the community. Appointments shall be established prior to discharge to ensure continuity across care providers.
31. Psychiatric Resource and Pharmacological Services *Contract 2018-24-001, Attachment XXII, 1.5.4.1 to 1.5.4.1.2*	For all Enrollees referred for Mobile Crisis Response Services, Contractor shall facilitate priority access to a psychiatric resource to provide consultation and medication management services, as medically necessary, within the following timeframes: • Fourteen (14) calendar days after an Enrollee's discharge from an inpatient psychiatric hospital setting; or, • Within three (3) calendar days after the date of the Crisis event for an Enrollee for whom community-based services were put in place in lieu of psychiatric hospitalization.
32. Communication with PCP	Contractor shall have procedures for communicating to the Enrollee's PCP the psychiatric resource and medication efforts performed as part of Mobile Crisis Response Service, consistent with all consents and releases.

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Contract 2018-24-001, Attachment XXII, 1.5.4.2	
33. Tele-psychiatry Services *Contract 2018-24-001, Attachment XXII, 1.5.4.3*	Contractor shall attempt to supplement the psychiatric resources available through its network with tele-psychiatry services. Tele-psychiatry services may include identifying available psychiatric resources and enhancing access outside the Coverage Area by connecting such resources to the Coverage Area or utilizing resources within the Coverage Area more efficiently by making such resources available to more rural Enrollees via electronic means. All telehealth services must be delivered consistent with the rules on tele-health established by HFS.
34. Interface with Illinois Crisis and Referral Entry Service (CARES) *Contract 2018-24-001, Attachment XXII, 1.6 to 1.6.3*	• Contractor acknowledges the existence of the State-funded Crisis and Referral Entry Service (CARES) cooperatively administered by the DHS Division of Mental Health, and the Department. • Contractor acknowledges that the Department shall issue the CARES per call rate annually. • Contractor shall provide CARES with the details of its Mobile Crisis Response System, including the telephone numbers needed to access its Crisis response team.
35. CARES Reimbursement *Contract 2018-24-001, Attachment XXII, 1.6.4 to 1.6.4.2*	If an Enrollee seeks Crisis intervention service outside of the Contractor's Mobile Crisis Response Service System and a Crisis call is routed to CARES for a Crisis referral, Contractor shall reimburse CARES at the annual CARES Per Call Rate. • Contractor shall accept invoices from CARES on a monthly basis. • Contractor shall remit payment to CARES within forty-five (45) days after receiving an invoice for Crisis referral services.
36. Provisions in Provider Agreements *Contract 2018-24-001, Attachment XXII, 1.6.5 to 1.6.5.2*	Contractor shall have provisions in the Provider agreements of its Network Providers responsible for providing Mobile Crisis Response Services for CARES to authorize and dispatch Mobile Crisis Response Services, which shall be reimbursed by Contractor. • In the event that CARES is unable to dispatch the Contractor's Mobile Crisis Response Service, CARES shall engage the fee-for-service SASS Program to ensure Crisis response to the Enrollee. • In the event that an Enrollee is screened, due to necessity, by a Non- Network Provider of SASS services, Contractor shall pay for the screening at the Medicaid rate.

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
37. Changes of Contact Numbers *Contract 2018-24-001, Attachment XXII, 1.6.6*	Contractor shall notify CARES of any changes to its contact numbers before any known changes or updates are made. When changes are necessary due to urgent or emergent circumstances, Contractor shall notify CARES as soon as possible.
38. Discharge Planning and Transitional Services *Contract 2018-24-001, Attachment XXII, 1.7 to 1.7.2 and 1.7.10*	Contractor shall provide Enrollees with access to discharge planning and transitional services when being discharged from higher levels of care to lower levels or community-based services. Contractor shall work with the involved parties to facilitate appropriate follow-up services, including the scheduling of follow-up treatment appointments. Contractor shall require the Care Coordinator to retain accountability and responsibility for the Enrollee as the transition between levels of care occurs. Upon discharge, Contractor shall monitor and manage the Enrollee's care as necessary.
39. Discharge Planning and Transitional Services – Intervention Required *Contract 2018-24-001, Attachment XXII, 1.7.3*	Contractor shall encourage the Enrollee and the Enrollee's family to contact the Enrollee's Care Coordinator whenever a biological, psychological, or social intervention is required or requested. Contractor shall ensure that the entry and exit from any level of care is managed effectively, efficiently, and, when possible and appropriate, within Contractor's Provider Network.
40. Discharge Planning and Transitional Services – Non-Network Providers *Contract 2018-24-001, Attachment XXII, 1.7.4*	Contractor shall establish and implement procedures for Enrollees to obtain access to Non-Network Providers and to facilitate the timely provision of necessary and appropriate records to those Non-Network Providers.

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
41. Discharge Planning and Transitional Services – Oversight of Discharge and Follow-up Care *Contract 2018-24-001, Attachment XXII, 1.7.5*	Contractor shall provide oversight regarding admissions and discharge dates for the Enrollees. This oversight shall include facilitating the link between the institutional-based care Providers and Contractor's Care Coordinators. Contractor shall initiate follow-up care within seven (7) days after discharge from higher levels of care (e.g., hospital, PRTF, residential, and Crisis respite), and provide oversight that appropriate levels of services are being provided.
42. Discharge Planning and Transitional Services – Medication Management Review *Contract 2018-24-001, Attachment XXII, 1.7.6*	Contractor shall develop, implement, and follow a procedure to confirm that a medication management review has been completed prior to discharge from higher levels of care (e.g., hospital, PRTF, residential, and Crisis respite); to confirm that PCPs are made aware of any medications that have been prescribed for Enrollees during treatment at an institutional setting; and to confirm with the Enrollees that they have the ability to get prescribed medications.
43. Discharge Planning and Transitional Services – Enrollee Follow Up *Contract 2018-24-001, Attachment XXII, 1.7.7*	Contractor shall communicate directly with the Enrollee or Enrollee's family within forty-eight (48) hours after transition and shall see the Enrollee in person in the Enrollee's home, or another location as mutually agreed by the Enrollee or the Enrollee's family and Contractor, within seven (7) days after the discharge from higher levels of care (e.g., hospital, PRTF, residential, and Crisis respite).

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
44. Discharge Planning and Transitional Services – Post-Discharge Appointments *Contract 2018-24-001, Attachment XXII, 1.7.8*	Contractor shall assist the Enrollee in attending all post-discharge appointments for follow-up care. Contractor shall provide appropriate care management based on concurrent assessment for an appropriate period of time following discharge involving other parties (e.g. Mobile Crisis Response provider, DCFS caseworker) in the care management as necessary.
45. Discharge Planning and Transitional Services – Notification of Discharge *Contract 2018-24-001, Attachment XXII, 1.7.9*	Contractor shall include a provision in its contracts or other agreements with its hospitals and Network Providers to notify Contractor or the Mobile Crisis Response Team, as appropriate, at least twenty-four (24) hours in advance of any discharge from inpatient hospital stays, including psychiatric hospital stays.
46. Family Leadership Council *Contract 2018-24-001, Attachment XXII, 1.3.2.2 to 1.3.2.2.2*	Contractors shall establish an FLC to create opportunities to engage families directly regarding issues in Children's Behavioral Health within ninety (90) days after the Effective Enrollment Date of the first Enrollee. Contractor shall establish, through its FLC, a mechanism for providing Contractor with a direct Enrollee feedback loop. The FLC shall not be used to review the needs of each individual Enrollee.
47. Co-Chairmen of Family Leadership Council *Contract 2018-24-001, Attachment XXII, 1.3.2.2.3*	The FLC shall be co-chaired by a young adult, or the parent or guardian of a young adult, with lived experience within at least one of the public child-serving systems (e.g., mental health, child welfare, and education) and a member of Contractor's leadership team with the authority to speak to program design and issues.

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
48. Family and Young Adult Members *Contract 2018-24-001, Attachment XXII 1.3.2.2.4 to 1.3.2.2.6*	Contractor shall ensure that the FLC membership is comprised of, at a minimum of 51%, Enrollees or parents/guardians of Enrollees from across the Contracting Area who have lived experience with the public child-serving systems. Contractor shall seek to include representatives from across the Contracting Area in the FLC's membership, ensuring the FLC is reflective of the Contractor's enrolled membership. Contractor shall ensure Children's Behavioral Health is a component of the broader managed care Community Stakeholder Council, under section 50.40.8 of the Contract.

EVALUATION ELEMENTS	CONTRACT LANGUAGE REQUIREMENT
1. DCFS Liaisons *Contract 2018-24-401 Addendum 2.3.2.10*	Upon the contract addendum, effective date, 11 full-time liaisons will be stationed at and hosted by DCFS regional offices throughout the State, as designated by the Department in consultation with DCFS, to provide administrative coordination with DCFS staff and stakeholders. Liaisons will be available on-site during regular work hours to communicate with and to provide education and training to DCFS staff and stakeholders regarding managed care, and to engage in immediate problem resolution with contractor's administrative staff. Issues or barriers reported to a liaison must be addressed and the resolution communicated to the appropriate DCFS staff or stakeholder within two business days. Beginning no sooner than six months after the contract addendum effective date contractor may, as needed, adjust the number of full-time liaisons, subject to consultation with DCFS and the Department's prior approval.
2. Enrollment – Welcome Packet *Contract 2018-24-401, Addendum 4.9.1*	Within five business days after receipt of confirmation from the Department that an enrollment for a DCFS Youth was accepted, contractor shall send an enrollee welcome packet to the individual(s) designated by DCFS. The packet shall include all basic information as set forth in section 5.21.1.
3. Provider Network-Capacity *Contract 2018-24-401, Addendum 4.15.1.1*	Contractor must ensure adequate physical, professional and provider network capacity to accept and serve all DCFS Youth enrollees.
4. Provider Network *Contract 2018-24-401,* Addendum 5.7.1.8	Contractor shall enter into a contract with any qualified HealthWorks Provider, HealthWorks lead agency, pediatric hospital, hospital with pediatric wings, pediatric specialist, child psychologist, and other behavioral health provider who provided covered services to DCFS Youth in care prior to execution of this contract, as verified by the Department, and as long as the provider agrees to contractor's rates and adheres to contractor's QA requirements.
5. Provider Network Contract 2018-24-401, Addendum 5.7.1.8	If any existing provider serving DCFS Youth in care does not join the contractor's provider network, the contractor must show that reasonable efforts were made to engage the provider. To be considered a qualified provider, the provider must be in good standing with the Department's FFS Medical Program. Contractor may establish quality standards for providers, subject to the Department's prior approval. Contractor may terminate contracts with providers who do not meet those quality standards if the provider is informed at the time the standards come into effect and the standards have been in effect for at minimum one year.
6. Provider Network - Integrated Health Homes	Contractor shall ensure that Integrated Health Homes (IHH) serving DCFS Youth have previous experience coordinating services for Special Needs Children. Where requirements of the Department's IHH program overlap with the requirements of this contract addendum, the IHH requirements will be prioritized.

EVALUATION ELEMENTS	CONTRACT LANGUAGE REQUIREMENT
Contract 2018-24-401, Addendum 5.7.1.9.1	
7. Utilization Management-Pharmacy Requirements *Contract 2018-24-401, Addendum 5.3.2.20*	Contractor shall comply with the requirements of DCFS Rule and Procedure 325, including all requirements for consents and the development of a system that maintains the requirement of prior authorization from DCFS prior to the administration of any psychotropic medication and stops prescriptions for psychotropic medications from being filled at a pharmacy if no prior authorization has been received from DCFS.
8. Interim Medical Case Management Contracting-HealthWorks lead agencies. *Contract 2018-24-401, Addendum 5.7.15*	Contractor is responsible for the provision of Interim Medical Case Management. Contractor shall contract with all current qualified HealthWorks lead agencies to provide Interim Medical Case Management services to all DCFS Youth in care through the first 45 days of DCFS custody of the youth. The Interim Medical Case Management services shall include, at a minimum, • gathering of child and family health information, • initiation of requests for prior health records, • receipt of 24-hour Initial Health Screenings, • selection of primary care physician, • completion of the Comprehensive Health Evaluation within 21 days of DCFS temporary custody and • provision of the Health Passport to the DCFS Youth in care's caregivers.
9. Interim Medical Case Management Contracting-HealthWorks lead agencies. *Contract 2018-24-401, Addendum 5.7.15*	To be considered a qualified provider, the provider must be in good standing with the Department's FFS Medical Program. Contractor may establish quality standards for providers, subject to the Department's prior approval. Contractor may terminate contracts with providers who do not meet those quality standards if, the provider is informed at the time the standards come into effect and the standards have been in effect for at minimum one year. The contractor shall notify the Department no less than 60 days prior to the termination date of a contract with any HealthWorks lead agency.
10. Coordination Tools: Portals	Contractor shall have fully operational portals, which provide the DCFS Guardianship Administrator or authorized agents, DCFS caseworkers, enrollees, and providers access to relevant information from the care management system.

EVALUATION ELEMENTS	CONTRACT LANGUAGE REQUIREMENT
Contract 2018-24-401, Addendum 5.11.2.1	
11. Coordination Tool: Health Passport *Contract 2018-24-401, Addendum 5.11.2.2*	Contractor shall provide updates to a DCFS Youth in Care's Health Passport on a regular basis.
12. Care Management – Qualifications and Training – High-Needs Children *Contract 2018-24-401, Addendum 5.12.3.3 and Attachment XVI 1.1.5.5*	For the DCFS Youth Managed Care Specialty Plan, care coordinators shall meet the qualifications and training requirements as set forth in Attachment XVI. • Care coordinator qualifications for High-Needs Children apply to all enrollees in the DCFS Youth Managed Care Specialty Plan.
13. Care Management – Qualifications and Training – *Contract 2018-24-401, Attachment 5.12.3.3 and Attachment XVI 1.3.2*	Care Coordinators for the DCFS Youth Managed Care Specialty Plan: • Shall be familiar with DCFS required assessments for DCFS Youth in care and the DCFS team-based decision-making process. • Shall attend DCFS-sponsored training events on various aspects of the child welfare system prior to provision of care management of a DCFS Youth enrollee, and as needed thereafter.
14. Care Management – Qualifications and Training – *Contract 2018-24-401, Addendum 5.12.3.3 and*	Training topics are determined by the Department and include the following: Illinois child welfare system – history, law and process; child trauma; Illinois Medicaid Child and Adolescent Needs and Strengths (IM-CANS); confidentiality; significant events; psychotropic consent process; DCFS programs and sister agency programs. At the Department's discretion, required training topics can be added or modified with advance-notice of at minimum 60 days to contractor.

EVALUATION ELEMENTS	CONTRACT LANGUAGE REQUIREMENT
Attachment XVI 1.3.2	
15. Care Management Program for DCFS Youth *Contract 2018-24-401, Addendum 5.13.1.5*	Contractor's goals, benchmarks, and strategies for managing the care of DCFS Youth shall be incorporated in, and included as part of, contractor's care management program for DCFS Youth.
16. Risk Levels- DCFS Youth *Contract 2018-24-401, Addendum 5.13.1.5*	In order for the contractor to determine the appropriate risk level of care management for DCFS Youth in care, contractor shall use DCFS-specific assessments, evaluations and other relevant information provided by DCFS, real-time data, along with population- and individual-based tools specifically designed for DCFS Youth. Contractor shall, in collaboration with DCFS, determine measurable criteria to be utilized to establish each of the risk levels of care management.
17. Risk Levels of Care Management *Contract 2018-24-401, Addendum 5.13.1.5.1*	Contractor shall determine the appropriate risk level of care management in-lieu-of section 5.13.1.4 based upon an analysis of the information gathered through the process in this section. DCFS Youth enrollees shall be assigned to one of four risk levels of care management: low risk, moderate risk, high risk or complex risk. Section 5.13.1.4: *Based upon an analysis of the information gathered through the process in this section, contractor shall stratify all enrollees to determine the appropriate level of intervention by its care management program. Enrollees shall be assigned to one of three levels.*
18. Health Risk Screening - Enrolled on Contract Effective Date *Contract 2018-24-401, Addendum 5.13.1.5.1.1*	For DCFS Youth enrolled on the contract addendum effective date, contractor shall conduct a health risk screening within 60 days of enrollment. Contractor shall provide health risk screenings on a prioritized basis, as determined by the Department.

EVALUATION ELEMENTS	CONTRACT LANGUAGE REQUIREMENT
19. Health Risk Assessment-Enrolled on Contract Effective Date *Contract 2018-24-401, Addendum 5.13.1.5.1.1*	Any DCFS Youth enrollee who is determined to require a health risk assessment, based on the health risk screening, shall receive the health risk assessment within 90 days of enrollment. Contractor may administer a health risk assessment in place of a health risk screening provided it is administered within 60 days of enrollment.
20. Individualized Plan of Care (IPoC)-Enrolled on Contract Effective Date *Contract 2018-24-401, Addendum 5.13.1.5.1.1*	The contractor shall utilize information included in all health risk screenings, health risk assessments and other existing health evaluations to complete an IPoC, if required, within 90 days of enrollment.
21. Health Risk Screening and Health Risk Assessment-Enrolled after Contract Effective Date *Contract 2018-24-401, Addendum 5.13.1.5.1.2*	For DCFS Youth enrolled after the contract addendum effective date, contractor shall provide a health risk screening and, if needed, a health risk assessment within 60 days of enrollment.
22. IPoC - Enrolled after Contract Effective Date *Contract 2018-24-401,*	The contractor shall utilize information included in all health risk screenings, health risk assessments and other existing health evaluations to complete an IPoC, if required, within 60 days of enrollment.

EVALUATION ELEMENTS	CONTRACT LANGUAGE REQUIREMENT
Addendum 5.13.1.5.1.2	
23. Risk Level Determination *Contract 2018-24-401 Addendum 5.13.1.5.1.3*	If DCFS is not in agreement with the risk level Determination made by the contractor for a DCFS Youth in care, the contractor will work collaboratively with the Department and DCFS to resolve the disagreement and ensure that the best interest and needs of DCFS Youth in care are met.
24. DCFS Youth In Care Interdisciplinary Care Team *Contract 2018-24-401, Addendum 5.14.4.1*	Contractor shall support an ICT for all DCFS Youth enrollees categorized as moderate risk, high risk or complex risk. • For DCFS Youth in care enrollees, contractor shall ensure that the ICT for a DCFS Youth in care enrollee is coordinated with all DCFS team-based decision-making processes (e.g., Child and Family Team meetings) and that the care coordinator for the DCFS Youth in care enrollee participates, as needed, in the DCFS team-based decision-making process. The contractor shall ensure that the IPoC is updated as necessary with information or decisions made during a DCFS team-based decision-making process.
25 a. DCFS Youth in Care IPoC and Service Plans *Contract 2018-24-401, Addendum 5.15.1.6 to 5.15.6.7*	Individualized Plans of Care and Service Plans include for DCFS Youth in care enrollees categorized as moderate risk, high risk or complex risk,
25 b. DCFS Youth in Care IPoC and Service Plans Contract 2018-24-401, Addendum 5.15.1.6 to 5.15.6.7	A DCFS service plan, that is coordinated and consistent with the IPoC as follows: • The IPoC shall include all goals and services that are necessary to support the permanency goal established in the DCFS service plan.
25 c. DCFS Youth in Care IPoC and Service Plans	The DCFS service plan is developed by the DCFS caseworker and other members of the Child and Family Team in accordance with DCFS Procedure 300

EVALUATION ELEMENTS	CONTRACT LANGUAGE REQUIREMENT
Contract 2018-24-401, Addendum 5.15.1.6 to 5.15.6.7	
25 d. DCFS Youth in Care IPoC and Service Plans *Contract 2018-24-401, Addendum 5.15.1.6 to 5.15.6.7*	The DCFS Service Plan will be incorporated into the IPoC to ensure coordination of services, including services that are ordered by Juvenile Court. The Contractor will ensure that any changes or updates to the DCFS Service Plan are included in the IPoC, as necessary
25 e. DCFS Youth in Care IPoC and Service Plans *Contract 2018-24-401, Addendum 5.15.1.6 to 5.15.6.7*	Contractor shall notify the DCFS caseworker within two business days when the IPoC is updated. The updated IPoC shall be available for the DCFS caseworker through the enrollee portal.
26. Former Youth in Care IPoC and Service Plans *Contract 2018-24-401, Addendum 5.15.1.6 to 5.15.6.7*	Former Youth in care enrollees categorized as moderate risk, high risk or complex risk, reflect the requirements of 5.15.1.1 through 5.15.1.4. *Section 5.15.1.1 to 5.15.1.4* *The IPoC must:* • *incorporate all of the enrollee's care needs, including: medical, behavioral health, Service Package II care, social, and functional needs;* • *include identifiable short- and long-term treatment and service goals to address the enrollee's needs and preferences and to facilitate monitoring of the Enrollee's progress and evolving service needs;* • *include, in the development, implementation, and ongoing assessment of the IPoC, an opportunity for enrollee participation and an opportunity for input from the PCP, other providers, a legal or personal representative, and the family or caregiver if appropriate;* • *include, as appropriate, the following elements:* o *the enrollee's personal or cultural preferences, such as types or amounts of services;* o *the enrollee's preference of providers and any preferred characteristics, such as gender or language;* o *the enrollee's living arrangements;*

EVALUATION ELEMENTS	CONTRACT LANGUAGE REQUIREMENT
26. Former Youth in Care IPoC and Service Plans (Cont.)	o *Covered services and non-covered ervices to address each identified need, provided that contractor shall not be required to pay for non-covered services;* o *actions and interventions necessary to achieve the enrollee's objectives;* o *follow-up and evaluation;* o *collaborative approaches to be used;* o *desired outcome and goals, both clinical and nonclinical;* o *barriers or obstacles;* o *responsible parties;* o *standing referrals;* o *community resources;* o *informal supports;* o *timeframes for completing actions;* o *status of the enrollee's goals;* o *home visits as necessary and appropriate for enrollees who are homebound (as defined in 42 U.S.C. 1395n(a)(2)), who have physical or cognitive disabilities, or who may be at increased risk for abuse, neglect, or exploitation;* o *back-up plan arrangements for critical services;* o *crisis safety plans for an enrollee with behavioral health conditions; and* o *wellness program plans.*
27 a. DCFS Youth Enrollees – IPoC Review *Contract 2018-24-401, Addendum 5.16.1*	For DCFS Youth enrollees, contractor shall review IPoCs of complex risk and high risk DCFS Youth enrollees at least every 30 days, and of moderate risk DCFS Youth enrollees at least every 90 days and conduct reassessments as necessary based upon such reviews.
27 b. DCFS Youth Enrollees – Annual Risk Assessment *Contract 2018-24-401 Addendum 5.16.1*	At a minimum, contractor shall conduct a health risk reassessment annually for each DCFS Youth enrollee who has an IPoC.

<table>
<tr><th>EVALUATION ELEMENTS</th><th>CONTRACT LANGUAGE REQUIREMENT</th></tr>
<tr><td>27 c. DCFS Youth Enrollees – IPoC

Contract 2018-24-401, Addendum 5.16.1</td><td>Contractor will provide updated IPoCs to providers that are involved in providing covered services to the enrollee, and to the DCFS caseworker for DCFS Youth in care enrollees, within five business days.</td></tr>
<tr><td>28 Caseload Requirements

Contract 2018-24-401, Addendum 5.17.4</td><td>DCFS Youth caseload standards. For DCFS Youth enrollees, caseloads of care coordinators shall not exceed the standards outlined for each risk level of care management.
Maximum caseloads for care coordinators for the risk level of care management identified in section 5.13.1.5.1 are defined in the table below and shall be adhered to by contractor:
<table>
<tr><th>Risk Level of Care Management</th><th>Caseload maximum (cases per Care Coordinator)</th></tr>
<tr><td>Low Risk</td><td>600:1</td></tr>
<tr><td>Moderate Risk</td><td>125:1</td></tr>
<tr><td>High Risk</td><td>70:1</td></tr>
<tr><td>Complex Risk</td><td>30:1</td></tr>
</table></td></tr>
<tr><td>29 a. Contact Standards

Contract 2018-24-401, Addendum 5.17.4 to 5.17.5.4</td><td>DCFS Youth contact standards. Care coordinators who provide care management for DCFS Youth enrollees shall maintain contact as frequently as required to meet the DCFS Youth enrollee’s needs while adhering to the following minimum contact standards per risk level:
• Complex Risk. The care coordinator shall contact the DCFS Youth enrollee, and DCFS caseworker as appropriate, and not less than one time every 14 days, and not less than one face-to-face contact every month.</td></tr>
<tr><td>29 b. Contact Standards

Contract 2018-24-401, Addendum 5.17.4 to 5.17.5.4</td><td>High Risk. The care coordinator shall contact the DCFS Youth enrollee, and DCFS caseworker as appropriate, and not less than one time every 30 days, and not less than one face-to-face contact every 60 days.</td></tr>
<tr><td>29 c. Contact Standards

Contract 2018-24-401, Addendum 5.17.4 to</td><td>Moderate Risk. The care coordinator shall contact the DCFS Youth enrollee, and DCFS caseworker as appropriate, and not less than one time every 90 days.</td></tr>
</table>

EVALUATION ELEMENTS	CONTRACT LANGUAGE REQUIREMENT
5.17.5.4	
29 d. Contact Standards *Contract 2018-24-401, Addendum 5.17.4 to 5.17.5.4*	Low Risk. The care coordinator shall contact the DCFS Youth enrollee, and DCFS caseworker as appropriate, and not less than one time every 180 days.
30. Consents *Contract 2018-24-401, Addendum 5.1.1*	The contractor shall ensure that appropriate consents for medical and behavioral health services for DCFS Youth in care are obtained from the DCFS Guardianship Administrator or authorized agents in accordance with all DCFS rules and procedures.
31. Approved Contacts *Contract 2018-24-401, Addendum 5.17.4*	The contractor shall ensure that contact is made only with individuals approved by the DCFS Guardianship Administrator. The contractor shall be notified by the DCFS Guardianship Administrator at the time a DCFS Youth in care is enrolled regarding who is approved for contact.
32. Health, Safety, and Welfare Monitoring *Contract 2018-24-401, Addendum 5.23.4*	Contractor shall comply with DCFS rules and procedures for reporting critical incidents and significant events related to DCFS Youth in care.
33 a. Advisory and Stakeholder Committee *Contract 2018-24-401, Addendum 5.40.5.1*	For the DCFS Youth Managed Care Specialty Plan, contractor shall have a DCFS Youth enrollee advisory and stakeholder subcommittee that meets, at minimum, on a quarterly basis.
33 b. Advisory and Stakeholder Committee *Contract 2018-24-401,*	Members of the committee will be geographically, culturally, and racially diverse to best reflect the profile of DCFS Youth enrollees and must include a reasonably representative group of DCFS Youth enrollees and stakeholders.

EVALUATION ELEMENTS	CONTRACT LANGUAGE REQUIREMENT
Addendum 5.40.5.1	
33 c. Advisory and Stakeholder Committee *Contract 2018-24-401, Addendum 5.40.5.1*	The committee shall establish an ongoing mechanism for the community to provide contractor with direct feedback on contractor's implementation and operations of the DCFS Youth Managed Care Specialty Program.
33 d. Advisory and Stakeholder Committee *Contract 2018-24-401, Addendum 5.40.5.1*	Contractor shall keep minutes for all meetings.

Appendix H. Measurement and Improvement

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
1. Practice Guidelines- Based on Need	At a minimum, clinical practice guidelines and best practice standards of care shall be adopted by Contractor for the following conditions and services at a minimum, and not necessarily limited to: • Asthma; • Congestive Heart Failure (CHF); • Coronary Artery Disease (CAD); • Chronic Obstructive Pulmonary Disease (COPD); • Diabetes; • Adult Preventive Care; • EPSDT for children birth through age 20; • Smoking Cessation; • Behavioral Health (mental health and substance use) screening, assessment, and treatment, including medication management and PCP follow-up; • Psychotropic medication management; • Clinical Pharmacy Medication Review; • Coordination of community support and services for Enrollees in HCBS Waivers; • Dental services; • Pharmacy services; • Community reintegration and support; • Long-term Care (LTC) residential coordination of services; • Prenatal, obstetrical, postpartum and reproductive health care; and • Other conditions and services as deemed by the Contractor and/or the Department. *Contract 2018-24-001, Attachment XI 1.1.9 to 1.1.9.18*
2. Nationally Recognized Standards *42 CFR 438.236 (b)(2)*	These regulations require that Contractor have an ongoing fully implemented Quality Assurance Program for health services that: Incorporates widely accepted practice guidelines that meet nationally-recognized standards and are distributed to Network Providers, as appropriate, and to Enrollees and Potential Enrollees, upon request, and: • Are based on valid and reliable clinical evidence; • Consider the needs of Enrollees; • Are adopted in consultation with Network Providers; and

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
2. Nationally Recognized Standards (Cont.)	• Are reviewed and updated periodically as appropriate. *Contract 2018-24-001, Attachment XI, 1.1.1 to 1.1.1.1.4*
3. Scope of Required Minimum Standards of Care *42 CFR 438.206*	Contractor shall provide or arrange to provide to all Enrollees a list of Covered Services and locations serving the Contracting Area that assure timely availability and accessibility. *Contract 2018-24-001, Attachment XXI, 1*
4. Adoption of Guidelines and Provision to Providers and Enrollees	Contractor shall adopt practice guidelines that meet the minimum standards of care set forth in Attachment XXI and shall comply with such guidelines. Contractor shall provide guidelines to all affected Providers and, upon request, to Enrollees and Potential Enrollees. *Contract 2018-24-001, Section 5.22.3*
5. System to Notify Enrollees *42 CFR 438.208(b)(1)*	Contractor will implement written and verbal methods to notify and inform Enrollees of the need for and benefits of evidence-based initial and periodic health screenings and physical examinations. Contractor will provide or arrange to provide in a timely manner all such examinations to its Enrollees. *Contract 2018-24-001, Attachment XXI, 2*
6. Clinical Practice Guidelines and Professional Community Standards *42 CFR 438.206(b), (c) and (d)*	All Covered Services provided by or arranged to be provided by Contractor shall be in accordance with current Department policies and prevailing professional community standards. All clinical practice guidelines shall be based on established, evidence-based, best-practice standards of care, either required by federal and State statutes (including IL Public Act 099-0433 relating to breast cancer diagnosis and care), Center for Medicare and Medicaid Services (CMS) rules, guidance and conditions of federal match, or promulgated by the United States Preventive Services Task Force (USPSTF), the *Handbook for Providers of Healthy Kids Services* issued by the Department, the CDC recommended immunizations, leading academic and national clinical and specialty based organizations, and shall be adopted by Contractor's Quality Assessment and Performance (QAP) Committee with sources referenced and guidelines documented in Contractor's QAP plan. When there is conflict between clinical practice guidelines, standards or recommendations issued by above entities, Contractor will look to the Department for direction or clarification, and absent that, will have the option to adopt any one of those with appropriate documentation in Contractor's QAP plan. Contractor shall provide ongoing education to Network Providers on required clinical guideline application and provide ongoing monitoring to assure that its Network Providers are utilizing them. *Contract 2018-24-001, Attachment XXI, 3*

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7. EPSDT Services to Enrollees under Twenty-One Years *42 CFR 438.236(a)(b)(1-4)* *Social Security Act 1902(a)(43) and 1905(a)(4)(B)*	All Enrollees under twenty-one (21) years of age shall receive screening services inclusive of a comprehensive health history, developmental history (including assessment of both physical and mental health development); a comprehensive physical exam (with clothes off when clinically appropriate);laboratory tests (including blood lead-level assessment) and health education; vision screening and necessary follow-up services; dental screening and necessary follow-up services; hearing screening and necessary follow-up services; other necessary health care, diagnostic services, treatment and other measures to ameliorate defects, physical and mental illnesses and conditions identified; and appropriate childhood immunizations at intervals as specified by the Early Periodic Screening Diagnosis and Treatment (EPSDT) Program as set forth in §§1902(a)(43)and 1905(a)(4)(B) of the Social Security Act and 89 Ill. Adm. Code 140.485. Contractor shall provide EPSDT services in conformance with the *Handbook for Providers of Healthy Kids Services*, which can be found on Illinois.gov/hfs under the *Medical Provider Handbooks* section, including future revisions. *Contract 2018-24-001, Attachment XXI, 3.1.1*
8. EPSDT - Employ Strategies *42 CFR 438.238(b)(1)*	Contractor shall employ strategies to ensure that Child Enrollees receive comprehensive child health services, initially and per the Department's recommended periodicity schedule or more frequently, as needed, and shall perform Provider training to ensure that best-practice guidelines are followed in relation to well child services and to meet acute and Chronic Health Condition care needs. Immunizations will be administered according to the latest annual update of the CDC's *Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger*. *Contract 2018-24-001, Attachment XXI, 3.1.1.1*
9. EPSDT – Visit Due	Contractor shall inform eligible families of scheduled health (when an EPSTD visit is coming due and needs to be scheduled, or when a visit scheduled long in advance is forthcoming), vision, hearing, and dental screening periods. The child's parent, designated legal guardian, or adult caretaker, if applicable, shall receive notification of the next scheduled health, vision, hearing, and dental screening periods not less than ten (10) working days before the date on which the screening period begins as determined by the child's birthday, the periodicity schedule, and the date of the child's eligibility for services. *Contract 2018-24-001, Attachment XXI, 3.1.1.2*
10. EPSDT - Appropriate Source of Care *42 CFR 438.208(c)(4)*	Any condition discovered during the screening examination or screening test requiring further diagnostic study, referral, or treatment must be provided if within the scope of Covered Services. Contractor shall refer the Enrollee to an appropriate source of care for any required services that are not Covered Services. If, as a result of EPSDT services, Contractor determines an Enrollee is in need of services that are not Covered Services but are services otherwise provided for under the HFS Medical Program, Contractor will ensure that the Enrollee is referred to an appropriate source of care. Contractor shall have no obligation to pay for services that are not Covered Services**,** however, appropriate referral for necessary care remains Contractor's responsibility. *Contract 2018-24-001, Attachment XXI, 3.1.1.3*

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11. ESPDT – Inform Enrollees of Program	• Contractor shall, at least annually, inform Enrollees about the EPSDT program, including but not limited to the following: the importance of preventive healthcare; the services that are available; how to request assistance in identifying a willing and qualified Network provider; how to request assistance in obtaining transportation to and from healthcare appointments; and the services are available at no cost to an eligible recipient, except as may be limited by a spenddown requirement. • Contractor shall inform eligible families by mail or e-communication (e.g., e-mail) within sixty (60) calendar days after the Effective Enrollment Date and thereafter at least annually using a combination of written and oral methods of communication. • Contractor shall inform pregnant women about the availability of EPSDT services for children under age 21 (including children eligible as newborns. • Contractor shall assist pregnant women and new mothers, or their legal guardians, to enroll their newborns in Medicaid and to identify a PCP for the newborn. It is suggested that plans use HFS Form 4691 as an educational tool, but plans may use other means, including direct assistance, to help in enrollment. *Contract 2018-24-001, Attachment XXI, 3.1.1.4 to 3.1.1.6*
12. Health History and Physical Examination for Enrollees age 21 years or older	Contractor shall ensure that a complete health history and physical examination is provided to each Enrollee initially within the first twelve (12) months of his or her Effective Enrollment Date. Thereafter, for Enrollees from the age of twenty-one to the age of sixty-four (21 -64), Contractor shall ensure that a complete health history and physical examination is conducted every one to three (1–3) years, as indicated by Enrollee's assessed needs and clinical care guidelines. For Enrollees age sixty-five (65) or older, Contractor shall ensure that a complete health history and physical examination is conducted annually. For purposes of this section, a "complete health history and physical examination" shall include, at a minimum, the following health services regardless of age and gender of each Enrollee: • Initial and interval history, including past medical and surgical history of each Enrollee, history of allergies, an updated list of medications used (prescribed and over the counter), and a family medical history; • Height and weight measurement for body mass index (BMI); • Blood pressure, temperature, and pulse rate measurements; • Nutrition and physical activity assessment and counseling; • Assessment of social and economic determinants of health; housing, transportation availability, and employment • Screening for alcohol, tobacco, substance abuse, intimate partner violence, and depression screening and counseling; • Counseling for advanced directives (living will and healthcare power of attorney) and collection of those documents, if available; • Verification of contact information for medical follow up when necessary such as postal address, e-mail, and phone number (landline, mobile, and alternate number for a family member if unable to reach patient directly); and

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12. Health History and Physical Examination for Enrollees age 21 years or older (Cont.)	• Health promotion and anticipatory guidance, as clinically appropriate. Any known condition or condition discovered during the complete health history and physical examination requiring further Medically Necessary diagnostic study, specialty consultation, or treatment and follow up must be provided if within the scope of Covered Services. However, appropriate referral for further Medically Necessary care remains Contractor's responsibility, even when those services are not Covered Services. *Contract 2018-24-001, Attachment XXI, 3.1.2 to 3.1.2.9*
13. Preventive Services *42 CFR 438 208 (b)*	For preventive services, the Department minimally requires coverage of the *United States Preventive Services Task Force (USPSTF) A and B Recommendations, which are updated periodically.* Additional preventive services may be recommended based on a higher-than-average risk patient, clinical judgment of the practitioner, or alternative guidelines issued by leading academic and national clinical and specialty-based organizations, and included in Contractor's QAP plan. *Contract 2018-24-001, Attachment XXI, 3.1.2*
14. Preventive Services -Immunizations *42 CFR 438 208 (b)* *IL statute, PA 99-0433*	Immunizations will be administered according to the latest annual update of the CDC's *Recommended Immunization Schedule for Adults Aged 19 Years or Older*. In addition to following the USPSTF recommendations A and B, which include those for breast cancer and BRCA screening, Contractor will assure compliance with IL statute, PA 99-0433. *Contract 2018-24-001, Attachment XXI, 3.1.2*
15. Family Planning and Reproductive Health Care *42 CFR 438.208(b)* *IL statute, PA 99-0433*	Contractor shall ensure provision of the full spectrum of Family Planning options and reproductive health services within the practitioner's scope of practice and demonstrated competence. The Contractor shall follow federal and State laws regarding minor consents and confidentiality. Family Planning and reproductive health services are defined as those services offered, arranged, or furnished for the purpose of preventing an unintended pregnancy or to improve maternal health and birth outcomes. The Contractor must ensure that nationally recognized standards of care and guidelines for sexual and reproductive health, are followed, and drugs and devices are prescribed or placed in accordance with guidance from the USPSTF, Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA) in its approved product information label (also called PI or package insert) or the American College of Obstetricians and Gynecologists (ACOG) compliance with the requirements of the Affordable Care Act, and other applicable federal and State statutes is also required. *Contract 2018-24-001, Attachment XXI, 3.1.3*

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16. Family Planning and Reproductive Health: Barriers or Restrictions to Access to Care *42 CFR 438.208(b)*	Contractor policies shall not present barriers or restrictions to access to care, such as prior authorizations or step-failure therapy requirements. Contractor shall cover and offer all Food and Drug Administration (FDA)–approved birth control methods with education and counseling on the safest and most effective methods, if clinically appropriate for a particular patient. *Contract 2018-24-001, Attachment XXI, 3.1.3*
17. Family Planning and Reproductive Health Services: Reproductive Life Plan *42 CFR 438.208(b)*	Contractor shall provide education and counseling for the following Family Planning and reproductive health services and offer clinically safe and appropriate services, drugs, and devices: • A reproductive life plan, which may include a preconception care risk assessment (see HFS Form 27, Preconception Screening Checklist) and preconception and interconception care discussions. *Contract 2018-24-001, Attachment XXI, 3.1.3. to 3.1.3.1*
18. Family Planning and Reproductive Health Services: Contraceptive Methods *42 FR 438.208(b)*	Contractor shall provide education and counseling for the following Family Planning and reproductive health services and offer clinically safe and appropriate services, drugs, and devices: • All safe, effective, and clinically appropriate contraceptive methods, with emphasis on the most effective methods first, encouraging use of long-acting reversible contraceptives (LARCS), such as (IUDs) and Implants when clinically appropriate, and consistent with FDA approved product information label; • Contraceptive methods must also include over-the-counter and prescription emergency contraception, if indicated; and • Permanent methods of birth control, including tubal ligation, transcervical sterilization, and vasectomy, if clinically appropriate and desired by the patient. *Contract 2018-24-001, Attachment XXI, 3.1.3.2 to 3.1.3.4*
19. Family Planning and Reproductive Health Services: Basic Infertility Counseling *42 CFR 438.208(b)*	Contractor shall provide education and counseling for the following Family Planning and reproductive health services and offer clinically safe and appropriate services, drugs, and devices: • Basic infertility counseling, consisting of medical/sexual history review and fertility awareness education, if indicated. (Infertility medications and procedures are not Covered Services.) *Contract 2018-24-001, Attachment XXI, 3.1.3.5*

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20. Family Planning and Reproductive Health Services: Reproductive Health Exam *42 CFR 438.208(b)*	Contractor shall provide education and counseling for the following Family Planning and reproductive health services and offer clinically safe and appropriate services, drugs, and devices: • Reproductive health exam, if medically necessary to determine safety and provision of contraception. *Contract 2018-24-001, Attachment XXI, 3.1.3.6*
21. Family Planning and Reproductive Health Services: STI Screenings *42 CFR 438.208(b)*	Contractor shall provide education and counseling for the following Family Planning and reproductive health services and offer clinically safe and appropriate services, drugs, and devices: • Sexually transmitted infection (STI) screenings in accordance with USPSTF A and B recommendations. *Contract 2018-24-001, Attachment XXI, 3.1.3.7*
22. Family Planning and Reproductive Health Services: HIV Testing *42 CFR 438.208(b)*	Contractor shall provide education and counseling for the following Family Planning and reproductive health services and offer clinically safe and appropriate services, drugs, and devices: • Universal HIV testing, counseling, and screening in accordance with USPSTF A and B recommendations. *Contract 2018-24-001, Attachment XXI, 3.1.3.8*
23. Family Planning and Reproductive Health Services: Lab and Screening Tests *42 CFR 438.208(b)*	Contractor shall provide education and counseling for the following Family Planning and reproductive health services and offer clinically safe and appropriate services, drugs, and devices: • Lab and screening tests that are clinically necessary for safe and prudent delivery of Family Planning and reproductive health services. *Contract 2018-24-001, Attachment XXI, 3.1.3.9*
24. Family Planning and Reproductive Health Services: Cancer Screenings	Contractor shall provide education and counseling for the following Family Planning and reproductive health services and offer clinically safe and appropriate services, drugs, and devices: • Cervical, breast and other cancer screening, in accordance with USPSTFs A and B recommendations. *Contract 2018-24-001, Attachment XXI, 3.1.3.10*

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42 CFR 438.208(b)	
25. Family Planning and Reproductive Health Services: Vaccines *42 CFR 438.208(b)*	Contractor shall provide education and counseling for the following Family Planning and reproductive health services and offer clinically safe and appropriate services, drugs, and devices: • Vaccines for preventable reproductive health related conditions in accordance with current CDC recommended immunization schedule, update annually. *Contract 2018-24-001, Attachment XXI, 3.1.3.11*
26. Family Planning and Reproductive Health Services: Genetic Counseling *42 CFR 438.208(b)*	Contractor shall provide education and counseling for the following Family Planning and reproductive health services and offer clinically safe and appropriate services, drugs, and devices: • Genetic counseling and testing, if clinically indicated. *Contract 2018-24-001, Attachment XXI, 3.1.3.12*
27. Maternity Care: Prenatal Evaluation *42 CFR 438.206(b)(v)(2)*	Contractor shall demonstrate capability for provision of evidence-based, timely care for pregnant Enrollees. At a minimum, Contractor shall provide the following services: • A comprehensive prenatal evaluation, examination, testing, and care in accordance with the latest standards recommended by ACOGUSPSTF and other leading academic and national clinical or specialty based organizations, which shall include: ongoing risk assessment and development of an Individual Plan of Care (IPoC) most likely to result in a successful outcome of pregnancy and a healthy baby, and takes into consideration the medical, psychosocial, cultural/linguistic, and educational needs of the Enrollee and her family. *Contract 2018-24-001, Attachment XXI, 3.1.3.13 to 3.1.3.13.1*
28. Maternity Care: Systems and Protocols *42 CFR 438.206(b)(v)(2)*	At a minimum, Contractor shall provide the following services: • Contractor shall have systems and protocols in place to handle regular appointments; early prenatal care appointments; after-hours care with emergency appointment slots; a seamless process for timely transmittal of prenatal records to the delivering facility; and a Provider Network for social services support, and specialty care referrals including those for complex maternal and fetal health, genetic, emotional and Behavioral Health consultation, if indicated. Contractor must refer all pregnant Enrollees to the Women, Infants, and Children's (WIC) Supplemental Nutrition Program and have linkage to case management services for identified high-risk Enrollees. Contractor must demonstrate ability to provide equally high-quality obstetrical care to special populations such as adolescents, homeless women, and women with developmental or intellectual disabilities. *Contract 2018-24-001, Attachment XXI, 3.1.3.13.2*

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29. Prenatal Care: Risk Counseling *42 CFR 438.206(b)(v)(2)*	Specific areas to be addressed by Contractor in collaboration with network practitioners and Enrollees regarding the provision of prenatal care include but are not limited to the following items: • Risk detection by appropriate inquiry, testing and consultation if necessary, counseling and treatment if indicated for: various chronic medical conditions including hypertension and diabetes mellitus; STI/HIV; intimate partner violence; teratogen exposure; alcohol, tobacco, and substance abuse including prescription opioids and marijuana; and, to prevent when possible, potential of preeclampsia and eclampsia, a stillbirth, prematurity, low birth weight, fetal alcohol syndrome, and neonatal abstinence syndrome among other issues. Contractor must put in place and be able to demonstrate that various evidence based strategies and interventions (including 17 P and referral to substance abuse, alcohol and tobacco abstinence programs, when indicated) to reduce adverse maternal and birth outcomes are operational. *Contract 2018-24-001, Attachment XXI, 3.1.3.13.3 to 3.1.3.13.3.1*
30. Prenatal Care: Screening *42 CFR 438.206(b)(v)(2)*	Specific areas to be addressed by Contractor in collaboration with network practitioners and Enrollees regarding the provision of prenatal care include but are not limited to the following items: • Screening for, diagnosing, and treating depression before, during, and after pregnancy with a standard screening tool (refer to the *Handbook for Providers of Healthy Kids Services* for a list of approved screening tools). *Contract 2018-24-001, Attachment XXI, 3.1.3.13.3.2*
31. Prenatal Care: Health Maintenance *42 CFR 438.206(b)(v)(2)*	Specific areas to be addressed by Contractor in collaboration with network practitioners and Enrollees regarding the provision of prenatal care include but are not limited to the following item: • Health maintenance promotion, with attention to nutrition, exercise, dental care, CDC recommended immunizations, management of current Chronic Health Conditions, over-the-counter and prescription medication, breastfeeding counseling appropriate weight gain in pregnancy, obesity counseling, signs and symptoms of common pregnancy ailments, and management of the same, provision of appropriate maternal education and support, including training classes to help with childbirth, breastfeeding, and various other helpful maternity education tools, platforms and materials. *Contract 2018-24-001, Attachment XXI, 3.1.3.13.3.3*
32. Prenatal Care: Laboratory Screening and Physical Exam	Specific areas to be addressed by Contractor in collaboration with network practitioners and Enrollees regarding the provision of prenatal care include but are not limited to the following item: • Routine laboratory screening per ACOG and USPSTF recommendations, physical exam, and dating by ultrasound for accurate gestational age. Every prenatal exam at minimum should include weight and blood pressure check, fetal growth assessment, and fetal heart rate check. Genetic screening and counseling if indicated, should be offered depending on risk factors (Enrollee's age, previous birth history, medical/family history, and ethnic background).

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42 CFR 438.206(b)(v)(2)	*Contract 2018-24-001, Attachment XXI, 3.1.3.13.3.4*
33. Prenatal Care: Protocols for Visits *42 CFR 438.206(b)(v)(2)*	Specific areas to be addressed by Contractor in collaboration with network practitioners and Enrollees regarding the provision of prenatal care include but are not limited to the following item: • Visits close to the third (3rd) trimester should include labor preparation, education regarding preeclampsia, warning signs of miscarriage, fetal movements/kick count, preterm labor and labor, options for intrapartum care, including options for anesthesia, breastfeeding encouragement, postpartum Family Planning including for selection of most appropriate and safe contraceptive method with informed consent obtained prior to labor and delivery when indicated, circumcision, newborn care, car seat, sudden infant death syndrome (SIDS), the importance of waiting at least thirty-nine (39) weeks to deliver unless medical necessity or safety of mother and fetus dictates otherwise, referral to parenting classes and WIC, and transition of maternal healthcare after the postpartum visit. Contractor shall have all protocols in place to facilitate the appropriate continuity of care after the current pregnancy. *Contract 2018-24-001, Attachment XXI, 3.1.3.13.3.5*
34. Identify High-Risk Pregnancies *42 CFR 438.206(b)(v)(2)*	Contractor shall assure, and provide a plan to the Department, for provision of early identification of high-risk pregnancies and, if clinically indicated, ability to arrange for evaluation by a maternal fetal medicine specialist or transfer to Level III perinatal facilities in accordance with ACOG guidelines and the Illinois Perinatal Act requirements. Risk-appropriate care shall be ongoing during the perinatal period. *Contract 2018-24-001, Attachment XXI, 3.1.3.13.4*
35. Postpartum Care: Immediate and Subsequent Postpartum Visits *42 CFR 438.206(b)(v)(2)*	Contractor shall require that all contracted hospitals and birthing centers have policies in place that safely reduce C-sections and early elective delivery (EED). Contractor shall enable Enrollees to receive timely and evidence-based postpartum care. At a minimum, Contractor shall provide and document the following services: • Postpartum visits, in accordance with the Department's approved schedule, to assess and provide education on areas such as perineum care, breastfeeding/feeding practices, nutrition, exercise, immunization, sexual activity, effective Family Planning, pregnancy intervals, physical activity, SIDS, and the importance of ongoing well-woman care, and referral to parenting classes, maternity education tools, platforms and materials, and WIC. *Contract 2018-24-001, Attachment XXI, 3.1.3.13.5 to 3.1.3.13.5.1*
36. Postpartum Care: Depression Screening	Contractor shall provide evidence-based postpartum care for Enrollees. At a minimum, Contractor shall provide and document the following services: • Postpartum depression screening during the one (1)–year period after delivery to identify high-risk mothers who have an acute or long-term history of depression, using an HFS-approved screening tool (refer to the *Handbook for Providers of Healthy Kids Services* for a list of approved screening tools). After

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42 CFR 438.206(b)(v)(2)	delivery and discharge, the Enrollee shall have a mechanism to readily communicate with her health team and not be limited to a single six (6)–week postpartum visit. *Contract 2018-24-001, Attachment XXI, 3.1.3.13.5.2*
37. Postpartum Care: Seamless Referrals *42 CFR 438.206(b)(v)(2)*	Contractor shall provide evidence-based postpartum care for Enrollees. At a minimum, Contractor shall provide and document the following services: • Contractor must continue to engage the Enrollee in health promotion and Chronic Health Condition maintenance by supporting the postpartum mother with seamless referrals, if medically necessary, to avoid interruption of care. *Contract 2018-24-001, Attachment XXI, 3.1.3.13.5.3*
38. Postpartum Care: Well Woman Care *42 CFR 438.206(b)(v)(2)*	Contractor shall provide evidence-based postpartum care for Enrollees. At a minimum, Contractor shall provide and document the following services: • Contractor shall assure that Enrollees are transitioned to a medical home for ongoing well-woman care, as needed. After the postpartum period, Contractor shall identify and closely follow Enrollees who delivered and who are at risk of or diagnosed with diabetes, hypertension, heart disease, depression, alcohol, tobacco, or other substance use, obesity, or renal disease. *Contract 2018-24-001, Attachment XXI, 3.1.3.13.5.4*
39. Postpartum Care: Interconception Care Management *42 CFR 438.206(b)(v)(2)*	Contractor shall provide evidence-based postpartum care for Enrollees. At a minimum, Contractor shall provide and document the following services: • Contractor shall provide or arrange for interconception care management services for identified high-risk women for twenty-four (24) months following delivery. *Contract 2018-24-001, Attachment XXI, 3.1.3.13.5.5*
40. Well Woman Exam *42 CFR 438.206(b)(v)(2)*	• Contractor shall ensure provision of evidence-based annual well-woman care to female Enrollees, which will include preconception care, interconception care, and reproductive life planning. At a minimum, Contractor shall provide and document an annual exam that includes ACOG and USPSTF recommended screening, counseling, evaluation, education, and age appropriate CDC recommended immunizations. • Appropriate referrals should be made to support services including WIC, interconception core management, and classes that enhance pregnancy, labor and delivery and parenting experiences and outcomes. • A routine pelvic exam should be performed when clinically and age appropriate. • Cervical and breast screening per USPSTF A and B recommendations.

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	Contract 2018-24-001, Attachment XXI, 3.1.3.14 to 3.1.3.14.4
41. Complex and Serious Medical Conditions: Provide Quality Care *42 CFR 438.208(c)(v)(2)*	Contractor shall provide or arrange to provide quality care for Enrollees with complex and serious medical conditions. At a minimum, Contractor shall provide and document the following: • Timely identification of Enrollees with complex and serious medical conditions. • Assessment of such conditions and identification of appropriate medical procedures necessary for optimal monitoring, treatment, and early identification and management of complications. • A chronic care action plan that is clinically-based and developed in conjunction with the Enrollee. A copy of this chronic care action plan shall be provided to the Enrollee, members of the healthcare team including specialty consultants and assigned care coordinator. *Contract 2018-24-001, Attachment XXI, 3.1.3.15 to 3.1.3.15.3*
42. Complex and Serious Medical Conditions: Identification of Special Healthcare Needs *42 CFR 438.208(c)(v)(2)*	Contractor shall have procedures in place to identify Enrollees with special health care needs to identify any ongoing special conditions that require a course of treatment or regular care monitoring including indicated examinations and tests. Appropriate health care professionals shall make these assessments. Such procedures must be delineated in Contractor's QAP and include ongoing monitoring. *Contract 2018-24-001, Attachment XXI, 3.1.3.16 and Attachment XI, Sections 3.a.iv(b) and (c)*
43. Enrollees with Special Healthcare Needs: Direct Access *42 CFR 438.208(c)(v)(4)*	Contractor shall have procedures and specialty networks in place to enable Enrollees with special healthcare needs, as defined by HFS and specified in its quality strategy and assure direct access to a specialist as appropriate for each Enrollee's condition and identified needs. *Contract 2018-24-001, Attachment XXI, 3.1.3.17*
44. Coordination with Other Service Providers	Contractor shall encourage Network Providers and Subcontractors to cooperate and communicate with other service providers who serve Enrollees. Such other service providers may include WIC programs, Head Start programs, Early Intervention programs, day care programs, and school systems among others. Such cooperation may include performing annual physical examinations for school and the sharing of information (with the consent of the Enrollee, parent or legal

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44. Coordination with Other Service Providers (Cont.)	guardian if the enrollee is underage). Annual health examinations for school include an age-appropriate developmental screening, and an age-appropriate social and emotional screening, as required by Public Act 99-927. *Contract 2018-24-001, Attachment XXI, 3.1.4*
45. Coordination with Other Service Providers: Family Case Management Program	Contractor shall coordinate with the Family Case Management (FCM) and Better Birth Outcomes (BBO) programs, which shall include, but is not limited to: • Coordinating services and sharing information with existing FCM/BBO providers for its Enrollees; • Developing internal policies, procedures, and protocols for the organization and its provider network for use with FCM/BBO Providers serving Enrollees; and • Conducting periodic meetings with FCM/BBO Providers performing problem resolution and handling of Grievances and issues, including policy review and technical assistance. *Contract 2018-24-001, Attachment XXI, 3.1.4 to 3.1.4.3*

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1. Quality Assurance, Utilization Review and Peer Review *42 CFR 456*	All services provided, or arranged to be provided, by Contractor shall be in accordance with prevailing community standards. Contractor must have in effect a program consistent with the utilization control requirements of 42 CFR §456. This program will include, when so required by the regulations, written plans of care and certifications of need of care. *Contract 2018-24-001, Section 5.22.1*
2. QA- Affiliated Labs	Contractor shall ensure Network Providers' labs are capable of reporting lab values to Contractor directly. Contractor shall use the electronic lab values to calculate HEDIS® Performance Measures. *Contract 2018-24-001, Section 5.22.2*
3. QA Program Structure *42 C.F.R. § 438, 42 C.F.R. § 422, 42 C.F.R. § 417.106, 42 C.F.R. § 438.200 and 42 C.F.R. § 417.418(c)*	N/A
4. Quality Assurance Program *42 CFR 438.330* *Section 1915(c) of the Social Security Act*	Contractor agrees to comply with the QA standards attached hereto as Attachment XI. Contractor agrees to conduct a program of ongoing review that evaluates the effectiveness of its QA and performance improvement strategies designed in accordance with the terms of this Section 5.22. The Contractor shall have an ongoing fully implemented Quality Assurance Program for health services that: • Monitors the health care services Contractor provides, including assessing the appropriateness and quality of care; • Stresses health outcomes and monitors Enrollee risks status and improvement in health outcomes; • Describes its use of Care Coordination Claims Data (CCCD) files for risk stratification, risk management, Care Coordination and case management of enrollees or other uses; • Provides for systematic activities to monitor and evaluate the dental services and Behavioral Health services rendered.

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	Contract 2018-24-001, Sections 5.22.6 and 5.22.8 and Attachment XI, Sections 1.1.1.2, 1.1.1.3, 1.1.1.5, and 1.1.1.19
5. Quality Assurance Program – CM/DM/Health Education	The Contractor shall have an ongoing fully implemented Quality Assurance Program for health services that: • Provides a comprehensive program of Care Coordination, Care Management, and Disease Management, with needed outreach to assure appropriate care utilization and community referrals; • Describes its health education procedures and materials for Enrollees; processes for training, monitoring, and holding providers accountable for health education; and oversight of Provider requirements to coordinate care and provide health education topics (e.g. childhood immunizations, well child visits, prenatal care, obesity, heart smart activities, mental health and substance abuse resources) and outreach documents (e.g., about chronic conditions) using evidence based guidelines and best practice strategies. *Contract 2018-24-001, Attachment XI, 1.1.1.4 and 1.1.1.17*
6. Quality Assurance Program – Providers	The Contractor shall have an ongoing fully implemented Quality Assurance Program for health services that: • Provides review by Physicians and other health professionals of the process followed in the provision of health services; • Establishes and monitors access standards; • Uses systematic data collection of performance and Enrollee results, provides interpretation of these data to its Network Providers (including, without limitation, Enrollee-specific and aggregate data provided by the Department, such as HEDIS® and State defined measures in this Attachment XI), and institutes needed changes; and • Details any compensation structure, incentives, pay-for-performance (P4P) programs, value purchasing strategies, and other mechanisms utilized to promote the goals of Integrated Health Homes (IHHs) and accountable, coordinated care. *Contract 2018-24-001, Attachment XI, 1.1.1.6, 1.1.1.8, 1.1.1.9, and 1.1.1.16*
7. Quality Assurance Program – Fraud & ANE *42 CFR 438.330(b)(5)(ii)*	These regulations require that Contractor have an ongoing fully implemented Quality Assurance Program for health services that: • Includes fraud control provisions; and • Describes its processes for addressing Abuse and Neglect and unusual incidents in the community setting. *Contract 2018-24-001, Attachment XI, 1.1.1.7 & 1.1.1.15*
8. Quality Assurance Program – Remedial and Corrective Action	These regulations require that Contractor have an ongoing fully implemented Quality Assurance Program for health services that: • Includes written procedures for taking appropriate remedial action and developing corrective action and quality improvement whenever, as determined under the Quality Assurance Program, inappropriate or substandard services have been furnished or Covered Services that should have been furnished have not been provided.

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	Contract 2018-24-001, Attachment XI, 1.1.1.10
9. Quality Assurance Program – Utilization Processes	These regulations require that Contractor have an ongoing fully implemented Quality Assurance Program for health services that: • Describes its implementation process for reducing unnecessary emergency room utilization and inpatient services, including (thirty) 30-day readmissions; • Describes its process for obtaining clinical results, findings, including emergency room and inpatient care, pharmacy information, lab results, feedback from other care providers, etc., to provide such data and information to the PCP or specialist, or others, as determined appropriate, on a real-time basis; and • Describes its process to assure follow up services from inpatient care for Behavioral Health, with a Behavioral Health provider; follow up for inpatient medical care including delivery care, to assure women have access to contraception and postpartum care or follow up after an emergency room visit. *Contract 2018-24-001, Attachment XI. 1.1.1.11 to 1.1.1.13*
10. Quality Assurance Program – Nursing Home & HCBS *42 CFR 438.208(c)(2)* *42 CFR 438.240* *42 CFR 438.330* *Section 1915(c) of the Social Security Act*	These regulations require that Contractor have an ongoing fully implemented Quality Assurance Program for health services that: • Details its process for determining and facilitating Enrollees needing nursing home, supportive living program (SLP) or ICF/DD level of care, or to live in the community with HCBS supports. *Contract 2018-24-001, Attachment XI, 1.1.1.14*
11. Quality Assurance Program – Provision of Health Services	The Contractor shall have an ongoing fully implemented Quality Assurance Program for health services that: • Describes its process for developing, implementing, and evaluating care plans for children transitioning to adulthood *Contract 2018-24-001, Attachment XI, 1.1.1.18*
12. Quality Assurance Program – Medical Homes	N/A
13. Quality Assurance Program – CQI Principles	N/A

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14. Quality Assurance Plan *42 CFR 438.330*	Contractor shall provide to the Department a written description of its Quality Assurance Plan (QAP) for the provision of clinical services (e.g., medical, medically-related services, Behavioral Health services) and Care Coordination services (e.g., Care Management, intensive care management, perinatal care management and Disease Management). This written description must meet federal and State requirements. *Contract 2018-24-001, Attachment XI, 1.1.2*
15. QAP- Goals and Objectives	The written description shall contain a detailed set of Quality Assurance objectives that are developed annually and include a work plan and timetable for implementation and accomplishment. *Contract 2018-24-001, Attachment XI, 1.1.2.1*
16. Annual Workplan Components	N/A
17. QAP- Scope	The scope of the QAP shall be comprehensive, addressing both the quality of clinical care and non-clinical aspects of service, such as and including: availability, accessibility, coordination, and continuity of care. *Contract 2018-24-001, Attachment XI, 1.1.2.2*
18. QAP Scope Components	N/A
19. QAP- Methodology	The QAP methodology shall provide for review of the entire range of care provided, by assuring that all demographic groups, care settings, (e.g., inpatient, ambulatory, and home care), and types of services (e.g., preventive, primary, specialty care, Behavioral Health, dental, pharmacy, and ancillary services) are included in the scope of the review. Documentation of the monitoring and evaluation plan shall be provided to the Department upon request. *Contract 2018-24-001, Attachment XI, 1.1.2.3*
20. QAP- Activities	The written description shall specify quality of care studies and other activities to be undertaken over a prescribed period of time, and methodologies and organizational arrangements to be used to accomplish them. Individuals responsible for the studies and other activities shall be clearly identified in the written workplan and shall be appropriately skilled or trained to undertake such tasks. The written description shall provide for continuous performance of the activities, including tracking of issues over time. *Contract 2018-24-001, Attachment XI, 1.1.2.4*
21. QAP- Provider Review	The written description shall document how Physicians and other health professionals will be involved in reviewing quality of care and the provision of health services and how feedback to health professionals and Contractor staff regarding performance and Enrollee results will be provided.

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	Contract 2018-24-001, Attachment XI, 1.1.2.5
22. QAP- Focus on Health Outcomes	The QAP methodology shall address health outcomes; a complete description of the methodology shall be fully documented and provided to Department. *Contract 2018-24-001, Attachment XI, 1.1.2.6*
23. QAP- Systematic Process of Quality Assessment and Improvement *42 CFR 438.330*	The QAP shall objectively and systematically monitor and evaluate the quality, appropriateness of, and timely access to, care and service to Enrollees, and pursue opportunities for improvement on an ongoing basis. Documentation of the monitoring activities and evaluation plan shall be provided to the Department. *Contract 2018-24-001, Attachment XI, 1.1.2.7*
24. QAP- Enrollee and Advocate Input	The QAP shall detail its operational and management plan for including Enrollee and advocate input into its QAP processes. *Contract 2018-24-001, Attachment XI, 1.1.2.8*
25. QAP -Written Guidelines	Contractor shall provide the Department with the QAP written guidelines which delineate the QA process, specifying clinical areas to be monitored: • The monitoring and evaluation of clinical care shall reflect the population served by Contractor in terms of age groups, disease categories, and special risk status, and shall include quality improvement initiatives, as determined appropriate by Contractor or as required by the Department. • The QAP shall, at a minimum, monitor and evaluate care and services in certain priority clinical areas of interest specified by the Department, based on the needs of Enrollees. • At its discretion or as required by the Department, Contractor's QAP must monitor and evaluate other important aspects of care and service, including coordination with community resources. *Contract 2018-24-001, Attachment XI, 1.1.3 to 1.1.3.1*
26. QAP- Areas to Be Monitored-All Populations	At a minimum, the following areas shall be monitored: • Emergency room utilization. • Inpatient hospitalization. • Thirty (30)-day readmission rate. • Assistance to Enrollees accessing services outside the Covered Services, such as housing, social service agencies and senior centers. • Health education provided. • Coordination of primary and specialty care.

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26. QAP- Areas to Be Monitored-All Populations (Cont.)	• Coordination of care, Care Management, Disease Management, and other activities. • Individualized Plan of Care (IPoC). • Utilization of dental benefits. • Utilization of family planning services. • Preventive health care for enrollees (e.g., annual health history and physical exam; mammography; Papanicolaou test, immunizations). • PCP or Behavioral Health follow-up after emergency room or inpatient hospitalization. • Utilization of Behavioral Health services. *Contract 2018-24-001, Attachment XI, 1.1.3.1.1 to 1.1.3.1.13*
27. QAP- Areas to Be Monitored-for Pregnant Women	For pregnant women: • Timeliness and frequency of prenatal visits; postpartum care rate. • Provision of American Congress of Obstetricians and Gynecologists (ACOG) recommended prenatal screening tests. • Birth outcomes. • Birth intervals. • Early Elective Delivery (EED) policies of contracted hospitals of delivery. • Development of reproductive life plans. • Utilization of 17P. • Referral to the Perinatal Centers, as appropriate. • Length of hospitalization for the mother. • Length of newborn hospital stay for the infant. • Utilization of post-partum family planning services, including LARC • Assistance to Enrollees in finding an appropriate PCP/Pediatrician for the infant. *Contract 2018-24-001, Attachment XI, 1.1.3.1.14 to 1.1.3.1.26*
28. QAP- Areas to Be Monitored- for Children	For children from birth through age twenty (20): • Number of preventive and well-child visits appropriate for age. • Immunization status. • Lead screenings conducted (measured using HEDIS Lead Screening in Children (LSC) measure, or other department approved measure), and blood-level status. • Objective developmental screenings and evaluations conducted (measured as per guidelines in the Handbook for Providers of Healthy Kids Services).

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28. QAP- Areas to Be Monitored- for Children (Cont.)	• Number of hospitalizations. • Length of hospitalizations. • Medical management for a limited number of medically complicate conditions as agreed to by Contractor and Department. *Contract 2018-24-001, Attachment XI, 1.1.3.1.27 to 1.1.3.1.33*
29. QAP- Areas to Be Monitored- Chronic Health Conditions	For Chronic Health Conditions (such conditions specifically including, without limitation, diabetes, asthma, congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease, Behavioral Health, including those with one or more co-morbidities). • Appropriate treatment, follow-up care, and coordination of care, for all Enrollees. • Identification of Enrollees with special health care needs and processes in place to assure adequate, ongoing risk assessments, care plan developed with the Enrollee's participation in consultation with any specialists caring for the Enrollee, to the extent possible, the appropriateness and quality of care, and if approval is required, such approval occurs in a timely manner. • Care coordination, Care Management, Disease Management, and Chronic Health Conditions action plan, as appropriate. *Contract 2018-24-001, Attachment XI, 1.1.3.1.34 to 1.1.3.1.36*
30. QAP- Areas to Be Monitored- for Behavioral Health	For Behavioral Health: • Behavioral Health network adequate to serve the Behavioral Health needs of Enrollees, including mental health and substance abuse services sufficient to provide care within the community in which the Enrollee resides. • Assistance sufficient to access Behavioral Health services, including but not limited to transportation and escort services. • Enrollee access to timely Behavioral Health services. • An IPoC or Service Plan and provision of appropriate level of care. • Coordination of care between Providers of medical and Behavioral Health services to assure follow-up and continuity of care. • Involvement of the PCP in aftercare. • Enrollee satisfaction with access to and quality of Behavioral Health services • Mental health outpatient and inpatient utilization and follow up. • Chemical dependency outpatient and inpatient utilization and follow up. *Contract 2018-24-001, Attachment XI, 1.1.3.1.37 to 1.1.3.1.45*

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31. QAP- Areas to Be Monitored- for Enrollees in Nursing Facilities & Enrollees Receiving HCBS Waiver Services	For Enrollees in Nursing Facilities and Enrollees receiving HCBS Wavier services: • Maintenance in, or movement to, community living. • Number of hospitalizations and length of hospital stay. • Falls resulting in hospitalization. • Behavior resulting in injury to self or others. • Enrollee non-compliance of services. • Medical errors resulting in hospitalizations. • Occurrences of pressure ulcers, unintended weight loss, and infections. *Contract 2018-24-001, Attachment XI, 1.1.3.1.46 to1.1.3.1.52*
32. QAP- Use of Quality Indicators	Quality indicators are measurable variables relating to a specified clinical area, which are reviewed over a period of time to monitor the process of outcomes of care delivered in that clinical area: • Contractor shall identify and use quality indicators that are objective, measurable, and based on current knowledge and clinical experience. • Contractor shall document that methods and frequency of data collected are appropriate and sufficient to detect the need for a program change. • For the priority clinical areas specified by the Department, Contractor shall monitor and evaluate quality of care through studies, which address, but are not limited to, the quality indicators also specified by the Department including those specified in this attachment. *Contract 2018-24-001, Attachment XI, 1.1.3.2 to 1.1.3.2.3*
33. QAP- Analysis of Clinical Care and Related Services.	Analysis of clinical care and related services, including Behavioral Health, Long Term Care and HCBS Waiver services. Appropriate clinicians shall monitor and evaluate quality through review of individual cases where there are questions about care, and through studies analyzing patterns of clinical care and related service. • Multi-disciplinary teams shall be used, where indicated, to analyze and address systems issues. • Clinical and related service areas requiring improvement shall be identified and documented, and a corrective action plan shall be developed and monitored. *Contract 2018-24-001, Attachment XI, 1.1.3.3 to 1.1.3.3.2*
34. QAP- Implementation of Remedial or Corrective Actions	The QAP shall include written procedures for taking appropriate remedial action whenever, as determined under the QAP, inappropriate or substandard services are furnished, including in the area of Behavioral Health, or services that should have been furnished were not. Quality Assurance actions that result in remedial or corrective actions shall be forwarded by Contractor to the Department on a timely basis. Written remedial or corrective action procedures shall include: • Specification of the types of problems requiring remedial or corrective action; • Specification of the person(s) or entity responsible for making the final determinations regarding quality problems; • Specific actions to be taken;

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34. QAP- Implementation of Remedial or Corrective Actions (Cont.)	• A provision for feedback to appropriate health professionals, providers and staff; • The schedule and accountability for implementing corrective actions; • The approach to modifying the corrective action if improvements do not occur; and • Procedures for notifying a PCP group that a particular Physician is no longer eligible to provide services to Enrollees. *Contract 2018-24-001, Attachment XI, 1.1.3.5 to 1.1.3.5.7*
35. QAP- Assessment of Effectiveness of Corrective Actions	Contractor shall monitor and evaluate corrective actions taken to assure that appropriate changes have been made. Contractor shall assure follow-up on identified issues to ensure that actions for improvement have been effective and provide documentation of the same. *Contract 2018-24-001, Attachment XI, 1.1.3.6*
36. QAP- Evaluation of Continuity and Effectiveness of QAP	At least annually, Contractor shall conduct a regular examination of the scope and content of the QAP to ensure that it covers all types of services, including Behavioral Health services, in all settings, through an Executive Summary and Overview of the Quality Improvement Program, including Quality Assurance (QA), Utilization Review (UR) and Peer Review (PR). *Contract 2018-24-001, Attachment XI, 1.1.3.7*
37. QAP – Annual Report *42 CFR 438.330(e)(1)*	At the end of each year (as specified in Attachment XIII), a written report on the QAP shall be prepared by Contractor and submitted to the Department as a component part of the QA/UR/PR Annual Report. The report shall include an Executive Summary that provides a high-level discussion/analysis of each area of the Annual Report of findings, accomplishments, barriers and continued need for quality improvement. The report shall, at a minimum, provide detailed analysis of each of the following: • QA/UR/PR Plan with overview of goal areas; • Major Initiatives to comply with the State Quality Strategy, • Quality Improvement and work plan monitoring; • Contractor Network Access and Availability and Service Improvements, including access and utilization of dental services; • Cultural Competency; • Fraud, Waste and Abuse Monitoring; • Population Profile; • Improvements in Care Coordination/Care Management and Clinical Services/Programs; • Effectiveness of Care Coordination Model of Care;

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37. QAP – Annual Report (Cont.)	• Effectiveness of Quality Program Structure; • Summary of monitoring conducted pertaining to Attachment XI including issues or barriers addressed or pending remediation; • Comprehensive Quality Improvement Work Plans; • Chronic Conditions; • Behavioral Health (includes mental health and substance abuse services); • Dental care; • Discussion of Health Education Program; • Member Satisfaction; • Enrollee Safety; • Fraud, waste and abuse and privacy and security; and • Delegation. *Contract 2018-24-001, Attachment XI, 1.1.3.7 to 1.1.3.7.20*
38. Leadership Meetings and committee structure	Contractor must have in place a schedule of leadership meetings and committee structure to provide appropriate oversight to the program as required by this Contract. At minimum, this will include a quarterly quality and performance meeting with the Department. *Contract 2018-24-001, Section 5.40.1*
39. Establish Quality Management Committee	Contractor shall establish the Quality Management Committee (QMC) within one-hundred eighty (180) days after the Effective Date of this Contract. The QMC shall establish an ongoing mechanism for reviewing and ensuring continuous quality improvement. *Contract 2018-24-001, Section 5.40.9*
40. Quality Assurance Plan Committee	Contractor shall have a QAP Committee. Contractor shall have a governing body to which the QA Committee shall be held accountable (“Governing Body”). The Governing Body of Contractor shall be the Board of Directors or, where the Board’s participation with quality improvement issues is not direct, a designated committee of the senior management of Contractor. This Board of Directors or Governing Body shall be ultimately responsible for the execution of the QAP. However, changes to the medical Quality Assurance Program shall be made by the chair of the QA Committee. Quality Assurance plan committee. Contractor shall have a QA plan committee that meets quarterly. Duties of the QAP committee are outlined in Attachment XI.

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	Contract 2018-24-001, Attachment XI, 1.1.4 and Section 5.40.2
41. QAP Committee – Responsibilities of the Governing Body	Responsibilities of the Governing Body include: • Oversight of QAP — Contractor shall document that the Governing Board has approved the overall Quality Assurance Program and an annual QAP. • Oversight Entity — The Governing Board shall document that it has formally designated an accountable entity or entities within the organization to provide oversight of QA, or has formally decided to provide such oversight as a committee of the whole. • QAP Progress Reports — The Governing Body shall routinely receive written reports from the QAP Committee describing actions taken, progress in meeting QA objectives, and improvements made. • Annual QAP Review — The Governing Body shall formally review on a periodic basis (but no less frequently than annually) a written report on the QAP which includes: studies undertaken, results, subsequent actions, and aggregate data on utilization and quantity of services rendered, to assess the QAP's continuity, effectiveness and current acceptability. Behavioral Health shall be included in the Annual QAP Review. • Program Modification — Upon receipt of regular written reports from the QAP Committee delineating actions taken and improvements made, the Governing Body shall take action when appropriate and direct that the operational QAP be modified on an ongoing basis to accommodate review findings and issues of concern within Contractor. This activity shall be documented in the minutes of the meetings of the Governing Board in sufficient detail to demonstrate that it has directed and followed up on necessary actions pertaining to Quality Assurance. *Contract 2018-24-001, Attachment XI 1.1.4 to 1.1.4.5*
42. QAP Committee Structure	The QAP shall delineate an identifiable structure responsible for performing QA functions within Contractor. Contractor shall describe its committees' structure in its QAP and shall be submitted to the Department for approval. This committee or committees and other structure(s) shall have: • Regular Meetings — The QAP Committee shall meet on a regular basis with specified frequency to oversee QAP activities. This frequency shall be sufficient to demonstrate that the structure/committee is following-up on all findings and required actions, but in no case shall such meetings be held less frequently than quarterly. A copy of the meeting summaries/minutes shall be submitted to the Department no later than thirty (30) days after the close of the quarterly reporting period. • Established Parameters for Operating — The role, structure and function of the QAP Committee shall be specified. • Documentation — There shall be records kept documenting the QAP Committee's activities, findings, recommendations and actions. • Accountability — The QAP Committee shall be accountable to the Governing Body and report to it on a scheduled basis on activities, findings, recommendations and actions. • Membership — There shall be meaningful participation in the QAP Committee by the Medical Director, practicing physicians, senior leadership and other appropriate personnel. *Contract 2018-24-001, Attachment XI, 1.1.5 to1.1.5.5*

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43. Quality Management Committee- Chair	The QMC shall be chaired by Contractor's Quality Management Coordinator and a member of the Family Leadership Council (FLC). Contractor may initially designate Contractor's Medical Director as a QMC co-chair, for a period to last no longer than one hundred eighty (180) days, while the FLC is being developed. Contractor's executive team shall nominate prospective QMC members for approval by the FLC to establish the membership of the QMC. Contractor will seek to include on the QMC Enrollees or parents/guardians of Enrollees sufficient to reasonably represent Contractor's Contracting Area. To enforce the local Locus of Control related to Systems of Care, the QMC shall: review consumer satisfaction, performance, and outcome data at least twice (2 times) per year to determine whether new processes or further review are necessary; and prepare the official Quality Management Committee Report, as detailed in Attachment XI. *Contract 2018-24-001, Sections 5.40.9.1 to 5.40.9.5.2*
44. Enrollee Advisory and Community Stakeholder Committee	Contractor shall have an Enrollee advisory and community stakeholder committee that meets, at minimum, on a quarterly basis. Members of the committee will be geographically, culturally, and racially diverse to best reflect the profile of Contractor's Enrollee base. The committee shall establish an ongoing mechanism for the community to provide Contractor with direct feedback on Contractor's implementation and operations of the Medicaid Managed Care Program. Contractor will keep minutes for all meetings. Enrollee Advisory and Community Stakeholder Committee – There shall be an Enrollee Advisory and Community Stakeholder Committee that will provide feedback to the QAP Committee on the Plan's performance from Enrollee and community perspectives. The committee shall recommend program enhancements based on Enrollee and community needs; review Provider and Enrollee satisfaction survey results; evaluate performance levels and telephone response timelines; evaluate access and provider feedback on issues requested by the QAP Committee; identify key program issues; such as disparities, that may impact community groups; and offer guidance on reviewing Enrollee materials and effective approaches for reaching enrollees. The Committee will be comprised of randomly selected Enrollees, family members and other caregivers, local representation from key community stakeholders such as churches, advocacy groups, and other community-based organizations. Contractor will educate Enrollees and community stakeholders about the committee through materials such as handbooks, newsletters, websites and communication events. *Contract 2018-24-001, Section 5.40.5 & Attachment XI, 1.1.5.6*

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45. Regulatory Compliance Committee	Contractor shall have a Regulatory Compliance committee that meets, at minimum, on a quarterly basis. *Contract 2018-24-001, Section 5.40.7*
46. QAP – Medical Director Responsibility	Contractor's Medical Director shall have substantial involvement in QA activities and shall be responsible for the required reports. *Contract 2018-24-001, Attachment XI, 1.1.6*
47. QAP – Provider Participation	Provider Participation in the QAP: • Network Providers shall be kept informed about the written QAP. • Contractor shall include in all agreements with Network Providers and Subcontractors a requirement securing cooperation with the QAP. • Contracts shall specify that Network Providers and Subcontractors shall allow access to the medical records of its Enrollees to Contractor and the Department. *Contract 2018-24-001, Attachment XI 1.1.6.2 to 1.1.6.2.3*
48. QAP- Affiliated Providers Qualifications	The QAP shall contain provisions to assure that Network Providers, are qualified to perform their services and are credentialed by Contractor. Contractor's written policies shall include procedures for selection and retention of Physicians and other Providers. *Contract 2018-24-001, Attachment XI, 1.1.8*
49. QAP- Clinical Practice Guidelines	All services coordinated by Contractor shall be in accordance with Departmental policies and prevailing professional community standards. Contractor shall provide EPSDT services in conformance with the Handbook for Providers of Healthy Kids Services, including future revisions. All clinical practice guidelines shall be based on established evidence-based best practice standards of care, promulgated by leading academic and national clinical organizations, and shall be adopted by Contractor's QAP Committee with sources referenced and guidelines documented in Contractor's QAP. Contractor's QAP shall be updated no less than annually and when new significant findings or major advancements in evidence-based best practices and standards of care are established. Contractor shall provide ongoing education to Network Providers on required clinical guideline application and provide ongoing monitoring to assure that its Network Providers are utilizing them. *Contract 2018-24-001, Attachment XI, 1.1.9*
50. QAP- System for Continuity of Care Management	Contractor shall put a basic system in place which promotes continuity of Care Management. Contractor shall provide documentation on: • Monitoring the quality of care across all services and all treatment modalities. • Studies, reports, protocols, standards, worksheets, minutes, or such other documentation as may be appropriate, concerning its QA activities and corrective

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50. QAP- System for Continuity of Care Management (Cont.)	actions and make such documentation available to the Department upon request. *Contract 2018-24-001, Attachment XI, 1.1.10 to 1.1.10.2*
51. QAP- Findings, Conclusions, Recommendations, Actions Taken, Results of Actions Taken	• The findings, conclusions, recommendations, actions taken, and results of the actions taken as a result of QA activity, shall be documented and reported to appropriate individuals within the organization and through the established QA channels. Contractor shall document coordination of QA activities and other management activities. There shall be a linkage between QA and the other management functions of Contractor such as: o Network changes o Benefits redesign o Medical management systems (e.g., pre-certification) o Practice feedback to Physicians o Other services, such as dental, vision, pharmacy etc. o Member services o Care Management and Disease Management o Enrollee education *Contract 2018-24-001, Attachment XI, 1.1.11 to 1.1.11.3.8*
52. QAP – Compliance	In the aggregate, without reference to individual Physicians/Providers or Enrollee identifying information, all Quality Assurance findings, conclusions, recommendations, actions taken, results or other documentation relative to QA shall be reported to Department on a quarterly basis or as requested by the Department. The Department shall be notified of any Provider or Subcontractor who ceases to be a Network Provider or Subcontractor for a quality of care issue. *Contract 2018-24-001, Attachment XI, 1.1.11.4*
53. QAP- Cooperate with EQRO	Contractor shall, at the direction of the Department, cooperate with the external, independent quality review process conducted by the EQRO. Contractor shall address the findings of the external review through its Quality Assurance Program by developing and implementing performance improvement goals, objectives and activities, which shall be documented in the next quarterly report submitted by Contractor following the EQRO's findings. *Contract 2018-24-001, Attachment XI, 1.1.12*
54. QAP- Collect Data *42 CFR 438.330(b)(2)*	Contractor's Quality Assurance Program shall systematically and routinely collect data to be reviewed for quality oversight, monitoring of performance, and Enrollee care outcomes. The Quality Assurance Program shall include provision for the interpretation and dissemination of such data to Contractor's Network Providers. The Quality Assurance Program shall be designed to perform quantitative and qualitative analytical activities to assess opportunities to improve

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Section 1915(c) of the Social Security Act	efficiency, effectiveness, appropriate health care utilization, and Enrollee health status per 42 C.F.R. 438.242 (2). Contractor shall ensure that data received from Providers and included in reports are accurate and complete by (1) verifying the accuracy and timeliness of reported data; (2) screening the data for completeness, logic, and consistency; and (3) collecting service information in standardized formats to the extent feasible and appropriate. Contractor shall have in effect a program consistent with the utilization control requirements of 42 CFR Part 456. This program will include, when required by the regulations, written plans of care and certifications of need of care. *Contract 2018-24-001, Attachment XI, 1.1.13*
55. QAP- Perform and Report Quality and Utilization Measures *42 CFR 438.330(b)(3) & (4)*	Contractor shall perform and report the Healthcare and Quality of Life Performance Measures identified in Attachment XI, Table 1, Healthcare and Quality of Life Measures, using HEDIS® and HEDIS®-like Quality Measure Specifications methodology, as provided by the Department. Contractor shall not modify the reporting specifications methodology prescribed by the Department without first obtaining the Department's written approval. Contractor must obtain an independent validation of its HEDIS® and HEDIS®-like findings by a recognized entity, e.g., NCQA-certified auditor, as approved by the Department. The Department's External Quality Review Organization will perform an independent validation of at least a sample of Contractor's findings. *Contract 2018-24-001, Attachment XI, 1.1.14*
56. QAP – HCBS Reporting *Section 1915(c) of the Social Security Act*	Contractor shall perform and report the performance measures in Table 2 – HCBS Wavier Performance Measures using measure specifications methodology, as provided by the Department. Contractor shall not modify the reporting specifications methodology prescribed by the Department without first obtaining the Department's written approval. *Contract 2018-24-001, Attachment XI, 1.1.15*
57. QAP- CMS Performance Measures & Projects	Contractor shall monitor other Performance Measures as required by the federal Centers for Medicare and Medicaid Services (CMS) in accordance with notification by the Department. *Contract 2018-24-001, Attachment XI, 1.1.16*
58. Participate in PIP/QIP	Contractor shall participate in the annual collaborative PIPS/QIPs, as mutually agreed upon and directed by the Department. *Contract 2018-24-001, Section Attachment XII, 1.1.4.5*

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42 C.F.R. §§ 438.330(d) and 422.152 (d)	
59. QAP- Conduct PIPs/QIPs *42 CFR 438.330(e)(ii)*	Performance measurements and interventions shall be submitted to the Department annually as part of the QA/UR/PR Annual Report and at other times throughout the year upon request by the Department. If Contractor implements a PIP/QIP that spans more than one (1) year, Contractor shall report annually the status of such project and the results thus far. The PIPs/QIPs topics and methodology shall be submitted to the Department for Prior Approval. *Contract 2018-24-001, Attachment XI, 1.1.3.4*
60. Measurement and Improvement Projects	N/A
61. Enrollee Satisfaction Survey – CAHPS	Contractor shall conduct an annual CAHPS survey as approved by the Department. The survey sampling and administration must follow specifications contained in the most current HEDIS® volume. Contractor must contract with an NCQA-certified HEDIS® survey vendor to administer the survey and submit results as provided in the HEDIS® survey specifications. Contractor shall submit its findings and explain what actions it will take on its findings as part of the comprehensive annual QA/UR/PR report. *Contract 2018-24-001, Section 5.31.1*
62. POSM	Contractor shall administer IDoA's Participant Outcomes and Status Measures (POSM) Quality of Life Survey to each IDoA Persons who are elderly HCBS Waiver Enrollee at each annual reassessment to determine each Enrollee's perception of the quality of life. *Contract 2018-24-001, Amendment KA2, Section 5.31.2*
63. Assess Risks	N/A
64. Cultural Competence	Contractor shall implement a Cultural Competence plan, and Covered Services shall be provided in a culturally competent manner by ensuring the Cultural Competence of all Contractor staff, from clerical to executive management, and Providers. Contractor shall implement the NCQA Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards). *Contract 2018-24-001, Section 2.7.1*
65. Cultural Competence Plan	Contractor's Cultural Competence plan shall address the challenges of meeting the healthcare needs of Enrollees. Contractor's Cultural Competence plan shall, at a minimum, address the following: • Involvement of executive management, IPoCs, and Providers in the development and ongoing operation of the Cultural Competence plan;

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
65. Cultural Competence Plan (Cont.)	• The individual executive employee responsible for executing and monitoring the Cultural Competence plan; • The creation and ongoing operation of a committee or group within Contractor to assist Contractor to meet the cultural needs of its Enrollees. The committee shall: o be reflective of the geographical and cultural groups served by Contractor, and o at minimum have fifty-one percent (51%) of its committee members be Enrollees or community-based participants; • The assurance of Cultural Competence at each level of care; • Indicators within the Cultural Competence plan that Contractor will use as benchmarks toward achieving Cultural Competence; • Contractor's written policies and procedures for Cultural Competence; • Contractor's strategy and method for recruiting staff with backgrounds representative of Enrollees served; • The availability of interpretive services; • Contractor's ongoing strategy and method to ameliorate transportation barriers and its operation; • Contractor's ongoing strategy and method to meet the unique needs of Enrollees who have Developmental Disabilities and Cognitive Disabilities and its operation; • Contractor's ongoing strategy and method to provide services for home-bound Enrollees and its operation; • Contractor's ongoing strategy and method to engage local organizations to develop or provide cultural-competency training and collaborate on initiatives to increase and measure the effectiveness of culturally competent service delivery and its operation; and • A description of how Cultural Competence is and will continue to be linked to health outcomes. *Contract 2018-24-001, Sections 2.7.2 to 2.7.2.13*
66. Staff- Diversity	Contractor shall proactively attempt, within the conditions imposed by any court order or consent decree, to hire staff who reflect the diversity of Enrollee demographics. Contractor shall require all staff, including employees and contract personnel, to complete linguistic and Cultural Competence training upon hire and no less frequently than annually thereafter. *Contract 2018-24-001, Section 2.7.3*
67. Accreditation Requirements	Pursuant to 305 ILCS 5/5-30 (a) and (h), if Contractor is serving at least 5,000 SPDs or 15,000 individuals in other populations covered by the HFS Medical Program and has received full-risk Capitation for at least one (1) year, then Contractor is considered eligible for accreditation and shall achieve accreditation by the NCQA within two (2) years after the date Contractor became eligible for accreditation. Subject to the foregoing:

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67. Accreditation Requirements (Cont.)	• Contractor must achieve and maintain a status of "excellent," "commendable," or "accredited." If Contractor receives a "provisional" accreditation status, Contractor shall complete a "re-survey" within twelve (12) months after the accreditation determination. • During the period in which Contractor is in a "provisional" accreditation status, the Department may limit enrollment. If the subsequent "re-survey" results in a "provisional" or "denied" status, such status shall constitute a breach of this Contract, and Contractor's failure to achieve full accreditation may result in the termination of this Contract. • Upon completion of each annual accreditation survey, Contractor must immediately authorize the NCQA to submit directly to the Department a copy of the final accreditation survey. Thereafter and on an annual basis between accreditation surveys, Contractor must submit a copy of the accreditation summary report issued as a result of the annual HEDIS® update to the Department no later than ten (10) days after receipt from NCQA. Upon the Department's request, Contractor must provide any and all documents related to achieving accreditation. The Department will thereafter annually review Contractor's accreditation status as of September 15 of each year. *Contract 2018-24-001, Sections 5.39 to 5.39.3*
68. QAPI- Adequate Resources	The QAP shall have sufficient material resources, and staff with the necessary education, experience, and/or training, to effectively carry out its specified activities. *Contract 2018-24-001, Attachment XI, 1.1.6.1*

Appendix H. Structure and Operations

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
1. Enrollee Handbook *42 CFR 438.10 (g)(1)* *42 CFR 438.100 (a) (1-2)* *42 CFR 422.111* *42 CFR 423.128* *215 ILCS 180 Health Carrier External Review Act*	Department will provide Contractor with an Enrollee handbook template. Contractor shall complete and submit the template to the Department for Prior Approval before the first enrollment, when revised, and upon the Department's request. Contractor shall mail an Enrollee handbook to new Enrollees no later than five (5) Business Days following receipt of the Enrollee's initial enrollment record on the 834 Audit File. Contractor must include terms defined by the Department as provided in 42 CFR §438.10(c)(4)(i) and follow the requirements of 42 CFR §438.10(g). At a minimum, the Enrollee handbook must contain: • Contractor's contact information, including the toll-free telephone number for member services, medical management and any other unit providing services directly to Enrollees. *Contract 2018-24-001, Sections 5.21.5 to 5.21.5.1*
2. Enrollee Handbook: Rights and Responsibilities *42 CFR 438.10 (g) (2)* *42 CFR 438.100*	At a minimum, the Enrollee handbook must contain: The Enrollee's rights and responsibilities and the Enrollee's freedom to exercise those rights without negative consequences. The Enrollee's rights include the right to: • Be treated with respect and with due consideration for the Enrollee's dignity and privacy; • Receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's condition and ability to understand; • Participate in decisions regarding the Enrollee's healthcare, including the right to refuse treatment; • Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation; • Request and receive a copy of the Enrollee's medical records, and to request that the records be amended or corrected; and • Exercise the Enrollee's rights, with the assurance that the exercise of those rights will not adversely affect the way the Enrollee is treated. *Contract 2018-24-001, Sections 5.21.5.2 to 5.21.5.2.6*
3. Enrollee Handbook: Rights and Responsibilities – Additional Rights	N/A
4. Enrollee Rights – Participation in Care	N/A

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
5. Enrollee Handbook: Accessing Services *42 CFR 438.10(g)(3)(i-iv)*	At a minimum, the Enrollee handbook must contain: • The PCP network and the PCP's role in directing and managing the Enrollee's care. • An explanation of open enrollment and the open Enrollment Period. • How to select and change a PCP, change "for cause," whether Contractor may impose a restriction on the number of times the Enrollee can change PCPs during the Enrollment Period, and the circumstances under which an Enrollee may select a specialist as a PCP. • The amount, duration, and scope of benefits available, in sufficient detail to ensure that the Enrollee understands the benefits to which the Enrollee is entitled as well as any benefits that may be excluded pursuant to section 5.6. • How and the extent to which the Enrollee may obtain direct-access services, including family-planning services. • The policies and procedures for obtaining services, including clinical advice, self-referred services, services requiring prior authorization, and services requiring a Referral. • How to access after-hours, nonemergency care. *Contract 2018-24-001, Sections 5.21.5.3 to 5.21.5.9*
6. Enrollee Handbook: Emergency Services	At a minimum, the Enrollee Handbook must contain: • The procedures for obtaining Emergency Services. The information shall specify that Emergency Services do not require a Referral, directions regarding the 911 telephone system, and refer the Enrollee to the Provider directory or the call center for a list of facilities providing Emergency Services and Post-Stabilization Services. The information shall clearly communicate that the Enrollee has a right to use any hospital or other setting for Emergency Services. • How to identify what constitutes an Emergency Medical Condition, Emergency Services, or the need for Post-Stabilization Services, as defined by 42 CFR §438.114(a). *Contract 2018-24-001, Sections 5.21.5.10 to 5.21.5.11*
7. Enrollee Handbook: Other Information	At a minimum, the Enrollee Handbook must contain: • Contractor's Grievance and Appeals process and the State's Appeal and fair-hearing process, including how to register a Grievance or Appeal. • How to access and receive written and oral information in languages other than English and in alternate language formats, including TDD/TTY. • The formulary and how to obtain prescription drugs. • The Disease Management Program and the services offered, and how to access these services. • Care coordination and services provided by a Care Coordinator. • How to exercise an advance directive.

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7. Enrollee Handbook: Other Information (Cont.)	• how to access auxiliary aids and services. • how to report suspected fraud or abuse; and • Any basic information, as set forth in section 5.21.1, that is not otherwise specifically set forth in this section 5.21.5. *Contract 2018-24-001, Sections 5.21.5.12 to 5.21.5.20*
8. Telephone Access	• Contractor may use one (1) toll-free number for these purposes or may establish separate numbers. • On-hold messaging for the Enrollee services telephone line will include health education briefs, general reminders, and Contractor benefits and services information. The messaging will be changed periodically to meet identified Enrollee trends or topical issues. • Contractor's administrative QA and improvement policies and procedures shall contain standards and a monitoring plan for all telephone access and call-center performance on an ongoing basis, and Contractor shall take immediate corrective action when standards are not met. Contractor shall analyze data collected from its phone system as requested by the Department and as necessary to perform QA and improvement tasks, monitor compliance with performance standards, and ensure adequate staffing of the call centers. Upon request from the Department, Contractor shall document compliance in these areas. • Contractor shall record all incoming calls for quality control, program integrity, and training purposes. Staff at Contractor's call center shall advise callers that calls may be monitored and recorded for QA purposes. Administrative lines do not need to be recorded. Contractor shall archive the recordings for no fewer than twelve (12) months or as otherwise required by law. *Contract 2018-24-001, Sections 5.21.6.3 to 5.21.6.6*
9. Enrollee Service Representatives (ESRs)	N/A
10. Nurse Advice Line	N/A
11. Engaging Enrollees	Contractor shall use a multifaceted approach to locate and engage Enrollees and shall capitalize on every Enrollee contact to obtain and update Enrollee contact information and engage Enrollees in their own care. Input will be solicited from Contractor's Enrollee advisory and community stakeholder committee to help develop strategies to increase motivation of Enrollees to participate in their own care. *Contract 2018-24-001, Section 5.21.7*

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
12. Member Relationship Management System	Contractor shall have a system dedicated to the management of information about Enrollees, specifically designed to collect Enrollee-related data and to process workflow needs in healthcare administration. The system shall have, at a minimum, three (3) core integrated components: • Enrollee demographics tracking and information; • Means to automate, manage, track, and report on Contractor's workflows for outbound and outreach Enrollee campaigns as well as targeted outbound interventions (such as engaging high-risk Enrollees in care or Disease Management Programs); and • Technology for use in inbound Enrollee contact and query management. *Contract 2018-24-001, Sections 5.21.7.1 to 5.21.7.1.3*
13. Telephonic Outreach	Contractor will implement a telephonic outreach program to educate and assist Enrollees in accessing services and managing their care. Calls will be made by Contractor staff to new Enrollees and to targeted populations such as Enrollees who are identified or enrolled in disease or Care Management, who have frequent emergency-room utilization, or who are due or past due for services. *Contract 2018-24-001, Section 5.21.7.2*
14. Written Contacts	Contractor shall produce mailings to all Enrollees enrolled in care management that will include reminders about the benefits of participating in the care-management program and of receiving the screenings and preventive care required for their condition. The mailing shall include Contractor's toll-free phone number and invite Enrollees to contact ICT or the nurse advice line with any questions. Contractor mailings shall include reminders about needed preventive services or screenings, reminders about the risks associated with progression of the Enrollee's disease, and information about any available incentives for receiving a needed service. *Contract 2018-24-001, Section 5.21.7.4*
15. Enrollee Health Education	Contractor will offer an expansive set of health-education programs that use comprehensive outreach and communication methods to effectively educate Enrollees, their families, and other caregivers about health and self-care and how to access plan benefits and supports. • Collaborative education development and oversight. Contractor's medical management department and Medical Director shall be responsible for development, maintenance, and oversight of Enrollee health-education programs. • Health education outreach. Contractor will identify regional community health education opportunities, improve outreach and communication with Enrollees and community-based organizations, and actively promote healthy lifestyles through activities such as disease prevention and health promotion. • Flu-prevention program. Contractor shall make a flu-prevention program available for all Enrollees and will provide targeted outreach to high-risk Enrollees. The program will educate Enrollees about preventing the transmission of the influenza virus. • Enrollee newsletters. Contractor will distribute quarterly Enrollee newsletters that include health education and Contractor events, and a calendar listing of health fairs, screening days, and other Contractor-sponsored or organized health activities.

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
15. Enrollee Health Education (Cont.)	• Education through Care Coordinators. Contractor's Care Coordinators will attempt to contact all Enrollees who frequently use or recently visited an emergency room to determine whether the Enrollees are experiencing barriers to primary and preventive care; to help resolve those barriers, if any; and to educate Enrollees on the appropriate use of emergency-room services and the Enrollees' health home. • Enrollee support to ensure compliance. To the extent possible, Contractor shall involve the Enrollee in IPoC development. Enrollee education will occur through telephone contact, face-to-face contact, education groups, and educational mailings. Education shall include information about monitoring daily disease-specific indicators. If appropriate, the Care Coordinator will link the Enrollee with available community-based disease-specific educational programs and support groups. *Contract 2018-24-001, Sections 5.21.8 to 5.21.8.3 and 5.21.8.6 to 5.21.8.8*
16. Transient Enrollees	Contractor shall utilize various strategies and methodologies as appropriate to connect with transient Enrollees, including the following. • Web portal. Contractor shall provide educational materials on the Enrollee Web portal. • Enrollee contact. Contractor shall verify Enrollee address and phone numbers during each contact. • Other methods. Contractor shall use other methods available to locate and educate transient Enrollees, such as community organizations, Physicians, family, the Internet, and reverse phone number look-up systems to locate active phone numbers and Enrollee demographics on paid claims. Contractor representatives may be dispatched to an Enrollee's home when a valid phone number is not found. *Contract 2018-24-001, Sections 5.21.9 to 5.21.9.3*
17. Obligation to Provide Basic Information	Contractor shall provide basic information to the following Participants, and shall notify such Participants that translated materials in Spanish and other prevalent languages are available and how to obtain them, once a year: • to each Enrollee or Prospective Enrollee no later than five (5) Business Days following receipt of the Enrollee's initial enrollment record on the 834 Audit File, and to each Enrollee within thirty (30) days before a significant change to the basic information; and • to any Potential Enrollee who requests it. *Contract 2018-24-001 and Amendment KA2, Sections 5.21.2 to 5.21.2.2*
18. Basic Information: Other Information *42 CFR 438.236*	Contractor shall provide the following additional information when requested by any Enrollee, Prospective Enrollee, or Potential Enrollee:

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
18. Basic Information: Other Information (Cont.)	• MCO licensure or county MCCN certification (whichever is applicable to Contractor), and the healthcare facility licensure; • Practice guidelines maintained by Contractor in accordance with 42 CFR §438.236; • Information about Network Providers of healthcare services, including education, board certification, and recertification, if appropriate; and • Any Physician incentive plans in place as set forth at 42 CFR §438.3(i). *Contract 2018-24-001 and Amendment KA2, Sections 5.21.3 to 5.21.3.4*
19. Basic Information – Summary of Benefits	N/A
20. Basic Information – Ongoing Basis	N/A
21. Basic Information – Part D & Formulary	N/A
22. Basic Information Requirements – MMAI	N/A
23. Communications with Prospective Enrollees, Potential Enrollees, and Enrollees *42 CFR 438.10 (c) (1-3)*	The requirements outlined in this section apply to all Key Oral Contacts and Written Materials. • Contractor shall proactively attempt, within the conditions imposed by any court order or consent decree, to promote the hiring of staff from in and around the Contracting Area to ensure Cultural Competence. • All Contractor staff will receive training on all Contractor policies and procedures during new-hire orientation and ongoing job-specific training to ensure effective communication with a diverse Enrollee population, including translation assistance, assistance to the hearing impaired, and assistance to those with limited English proficiency. • Contractor shall meet quarterly with its Enrollee advisory and community stakeholder committee to assess the results of Enrollee calls. • Enrollee feedback will be sought at the close of each contact to inquire if the Enrollee's needs or issues have been resolved. • Contractor shall conduct targeted Enrollee focus groups to obtain additional input on Contractor materials and program information and shall also seek input from local organizations that serve Enrollees. *Contract 2018-24-001, Section 5.21.4*

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
24. Obligation to Provide Basic Information: Interpretive Services *42 CFR 438.10 (d) (2)*	• Contractor shall make oral interpretation services available free of charge in all languages to all Potential Enrollees, Prospective Enrollees, or Enrollees who need assistance understanding Key Oral Contacts or Written Materials. • Contractor must include in all Key Oral Contacts and Written Materials notification that such oral interpretation services are available and how to obtain such services. • Contractor shall conduct Key Oral Contacts with a Potential Enrollee, Prospective Enrollee, or Enrollee in a language the Potential Enrollee, Prospective Enrollee, or Enrollee understands. If a Participant requests interpretive services by a family member or acquaintance, Contractor shall not allow such services by anyone who is under the age of eighteen (18). • Contractor shall accept such Participant's verification of the age of the individual providing interpretive services unless Contractor has a valid reason for requesting further verification. *Contract 2018-24-001, Section 5.21.4.1*
25. Obligation to Provide Basic Information: Reading Level *42 CFR 438.10 (d) (6)-(6i)*	All of Contractor's written communications with Potential Enrollees, Prospective Enrollees, and Enrollees must be produced at a sixth-grade reading level and easily understood by individuals with sixth-grade reading skills. Contractor will use the Flesch Reading Ease and Flesch-Kincaid Grade level tests, or other reading level test as approved by the Department, to ensure appropriate reading level. Written materials will be presented in a layout and manner that enhance Enrollees' understanding in a culturally competent manner. *Contract 2018-24-001, Section 5.21.4.2*
26. Obligation to Provide Basic Information: Alternative Methods of Communication *42 CFR 438.10 (d) (3)*	• Contractor shall make Key Oral Contacts and Written Materials available in such alternative formats as large print, Braille, sign language provided by interpreters in accordance with the Interpreters for the Deaf Act (225 ILCS 442), CART reporters, audio CDs, TDD/TTY, video relay interpretation, or video relay services, and in a manner that takes into consideration the special needs of those who are visually impaired, hearing impaired, or with limited reading proficiency. • Contractor shall inform Potential Enrollees, Prospective Enrollees, and Enrollees, as appropriate, that information is available in alternative formats and how to access those formats. • Contractor must provide TDD/TTY service upon request for communicating with Potential Enrollees, Prospective Enrollees, and Enrollees who are deaf or hearing impaired. • Contractor shall arrange interpreter services through Contractor's Enrollee services department when necessary (such as for Provider visits or consultations). • These services will be made available at no cost to the Enrollee.

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
	Contract 2018-24-001, Section 5.21.4.3
27. Obligation to Provide Basic Information: Translated Materials *2 CFR 438.10 (d) (4)*	Translated Written Materials and scripts for translated Key Oral Contacts require Prior Approval and must be accompanied by Contractor's certification that its certified translator certifies that the translation is accurate and complete, and that the translation is easily understood by individuals with a sixth (6th)–grade reading level and is culturally appropriate. Contractor's first submittal of the translated materials to the Department for Prior Approval must be accompanied by a copy of the Department's approval of the English version and the required translation certification. Contractor shall make all Written Materials distributed to English-speaking Potential Enrollees, Prospective Enrollees and Enrollees, as appropriate, available in Spanish and other prevalent languages, as determined by the Department in accordance with Section 1557 of the Affordable Care Act. Where there is a prevalent single-language minority within the low-income households in the relevant DHS local office area (which for purposes of this Contract shall exist when five percent (5%) or more of such households speak a language other than English, as determined by the Department according to published Census Bureau data), Contractor's Written Materials provided to Potential Enrollees, Prospective Enrollees, or Enrollees must be available in that language as well as in English. *Contract 2018-24-001, Section 5.21.4.4*
28. Obligation to Provide Basic Information: Font size and taglines	Contractor's Written Materials must be produced using a font size no smaller than 12 point. Written Materials must include taglines, in the prevalent non-English languages and in a large print font size that is no smaller than 18 point, explaining the availability of written translation or oral interpretation to understand the information provided, the toll-free and TTY/TDY telephone number of Contractor's member customer service unit, and information on how to request auxiliary aids and services, including the provision of the materials in alternative formats. *Contract 2018-24-001, Amendment KA2, Section 5.21.4.5*

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
1. Permitted Uses and Disclosures *45 CFR part 303.21* *42 CFR 438.224* *42 CFR 422.118*	Contractor may use or disclose PHI only to perform Services for, or on behalf of, the Department, and only provided that such use or disclosure would not violate the Privacy Rule. Contractor may disclose PHI for the proper management and administration of Contractor, provided that the disclosures are required by law or Contractor obtains reasonable assurances from the person or entity to whom the PHI is disclosed that the PHI will remain confidential and will be used or further disclosed only as required by law or for the purpose for which it was disclosed to the person or entity. Contractor shall require the person or entity to which the PHI was disclosed to notify Contractor of any breach of the confidentiality of the PHI of which the person is or becomes aware. Contractor shall make uses and disclosures and requests for PHI consistent with the "minimum necessary" standard set forth in 45 CFR Section 164.502(b). Contractor may not use or disclose PHI in a manner that, if done by the Department, would violate Subpart E of 45 CFR Part 164. Contractor may use PHI to report violations of law to appropriate federal and state authorities, consistent with 45 CFR Section 164.502(j)(1). *Contract 2018-24-001, Attachment VI, Sections 1.3 to 1.3.5*
2. Limitations on Contractor's Uses and Disclosures	Contractor shall: • Not use or disclose PHI other than as permitted or required by the Contract, this Attachment, or as permitted or required by law; • Use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to PHI, to prevent use or disclosure of PHI other than as provided for by the Contract or this Attachment; • Report to the Department any use or disclosure of PHI of which Contractor becomes aware that is not provided for by the Contract or this Attachment, including breaches of unsecured PHI and security incidents. A report of a breach to the Department does not alter Contractor's responsibility to notify the affected Individuals; • In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors that create, receive, maintain, or transmit PHI on behalf of Contractor agree to the same restrictions, conditions, and requirements that apply to Contractor with respect to such information; • Ensure that any agents, including a subcontractor, to whom Contractor provides PHI received from the Department or created or received by Contractor on behalf of the Department in connection with its performance of the Services, agree to restrictions and conditions at least as stringent as those that apply to Contractor under this Attachment with respect to such information. *Contract 2018-24-001, Attachment VI, Sections 1.2 to 1.2.5*

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
3 Limitations on Contractor's Uses and Disclosures	To the extent Contractor maintains PHI in a Designated Record Set, make such PHI available to the Department for amendment, and incorporate any amendments to such PHI that the Department directs. Provide to the Department or to an Individual, in a time and manner specified by the Department, information collected in accordance with the terms of the Contract to permit the Department to respond to a request by the Individual for an accounting of disclosures of PHI in accordance with 45 CFR Section 164.528. In the event that Contractor in connection with the Services uses or maintains an Electronic Health Record of PHI of or about an Individual, Contractor will make an accounting of disclosures of such PHI in accordance with Section 13405(c) of the HITECH Act. *Contract 2018-24-001, Attachment VI, Section 1.2.6 to 1.2.7*
4. Limitations on Contractor's Uses and Disclosures	To the extent the Contractor is to carry out one or more of the Department's obligation(s) under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to Covered Entity in the performance of such obligation(s). For purposes of allowing determination of the Department's compliance with the Privacy Rule, make available to the Department and to the Secretary of the United States Department of Health and Human Services, Contractor's internal practices, books, and records, including policies and procedures and PHI, that relate to the use and disclosure of PHI received from the Department or created or received by Contractor on behalf of the Department. *Contract 2018-24-001, Attachment VI, Section 1.2.8 to 1.2.9*
5. Limitations on Contractor's Uses and Disclosures	Mitigate, to the extent practicable, any harmful effect of a use or disclosure of PHI by Contractor in violation of the requirements of the Contract or this Attachment. To the extent possible, limit the use, disclosure or request of PHI to the minimum necessary to perform or fulfill a specific function required, contemplated or permitted under the Contract. Refrain from exchanging PHI with any entity which the Contractor knows has a pattern of activity or practice that constitutes a material breach or violation of HIPAA. Encrypt PHI in transit and at rest. Adopt internal procedures for reporting breaches and for mitigating potential damages associated with a Breach of Unsecured PHI and with uses and disclosures in violation of this Attachment VI. *Contract 2018-24-001, Attachment VI, Sections 1.2.10 to 1.2.14*

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
6. HIPAA Privacy Compliance Requirements: Breach Requirements *45 CFR part 164, subpart C*	If Contractor discovers a Breach of Unsecured PHI as defined in 45 CFR 164.402, within 10 calendar days after the Contractor first becomes aware of the incident Contractor shall notify the Department, except where a law enforcement official determines that a notification would impede a criminal investigation or cause damage to national security. Contractor shall notify the Department within the above time frame even if Contractor has not conclusively determined that the incident constitutes a Breach of Unsecured PHI. Contractor shall be deemed to have become aware of the Breach of Unsecured PHI as of the first day on which such Breach of Unsecured PHI is known or reasonably should have been known to any person, other than the person or entity committing the Breach of Unsecured PHI, that is an employee, officer or other agent of Contractor. Contractor shall notify the Department by completing and submitting the Notification of Unauthorized Access, Use, or Disclosure (Exhibit A). The Department and the Contractor will cooperate in investigating whether a breach has occurred and deciding how to provide breach notifications to individuals, the federal Health and Human Services' Office for Civil Rights, and potentially the media. *Contract 2018-24-001, Attachment VI, Sections 1.7 to 1.7.1.4*
7. HIPAA Privacy Compliance Requirements: Breach Notification *45 CFR, Part 164, Subpart D*	Contractor shall provide notification to the Individuals whose PHI was breached, unless the Department agrees to assume the notification and any associated costs. Contractor shall coordinate with the Department to draft a notice to inform Individuals about the breach. *Contract 2018-24-001, Attachment VI, Section 1.7.2*
8. HIPAA Privacy Compliance Requirements: Cost/Fines	Unless the Department agrees to assume the costs of providing Breach notifications to affected Individuals who are required by law to receive such notifications, Contractor shall pay directly or reimburse the Department for all reasonable and direct out-of-pocket costs, including, but not limited to, credit monitoring services for not less than 12 months provided to Individuals, and any litigation costs, fines, penalties or judgments resulting from the Breach. *Contract 2018-24-001, Attachment VI, Section 1.7.3*

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
9. HIPAA Privacy Compliance Requirements: Indemnification for Breach *45 CFR, Part 164, subparts D and E*	Contractor shall indemnify the Department for costs associated with any incident involving the acquisition, access, use or disclosure of Unsecured PHI in a manner not permitted under this Contract, Attachment or 45 CFR Section 164 Subparts D and E. *Contract 2018-24-001, Attachment VI, Section 1.7.4*
10. Confidential Information	It is understood that each Party to this Contract, including its agents and Subcontractors, may have or gain access to Confidential Information or data owned or maintained by the other Party in the course of carrying out its responsibilities under this Contract. Contractor shall presume that all information received from the State or to which it gains access pursuant to this Contract is confidential. Contractor's information (excluding information regarding rates paid by Contractor to its Providers and Subcontractors), unless clearly marked as confidential and exempt from disclosure under the Illinois Freedom of Information Act, shall be considered public. No confidential data collected, maintained, or used in the course of performance of the Contract shall be disseminated except as authorized by law and with the written consent of the disclosing Party, either during the term of the Contract or thereafter, or as otherwise set forth in this Contract. The receiving Party must return any and all data collected, maintained, created, or used in the course of the performance of the duties of this Contract, in whatever form they are maintained, promptly at the end of the term of this Contract, or earlier at the request of the disclosing Party, or notify the disclosing Party in writing of the data's destruction. The foregoing obligations shall not apply to confidential data or information that: • Are lawfully in the receiving Party's possession prior to its acquisition from the disclosing Party; • Are received in good faith from a Third Party not subject to any confidentiality obligation to the disclosing Party; • Are now, or become, publicly known through no breach of confidentiality obligation by the receiving Party; or • Are independently developed by the receiving Party without the use or benefit of the disclosing Party's Confidential Information. *Contract 2018-24-001 Sections 9.1.6 to 9.1.6.4*
11. Confidentiality Of Program Recipient Identification	Contractor shall ensure that all information, records, data, and data elements pertaining to applicants for and recipients of public assistance, or to Providers, facilities, and associations, shall be protected from unauthorized disclosure by Contractor and Contractor's employees, by Contractor's corporate Affiliates and their employees, and by Contractor's Subcontractors and their employees, pursuant to 305 ILCS 5/11-9, 11-10, and 11-12; 42 USC 654(26); 42 CFR §431, Subpart F; and 45 CFR §160 and 45 CFR §164, Subparts A and E. To the extent that Contractor, in the course of performing the Contract, serves as a business associate of the Department, as "business associate" is defined in the Draft: Subject to finalization and Federal CMS approval. 2018-24-001 (Rev. 2) Page 128 HIPAA Privacy Rule (45 CFR §160.103), Contractor shall assist the Department in responding to the client as provided in the HIPAA Privacy Rule, and shall maintain for a period of six (6) years any records relevant to an individual's eligibility for services under the DHFS Medical Program.

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
	Contract 2018-24-001, Section 9.1.21
12. Data Security	For all information systems that transmit, store, or access Protected Health Information: Contractor shall: • Establish an information security program in accordance with the FISMA (Federal Information Security Management Act), and follow the National Institute for Standards and Technology (NIST) Guidelines of the NIST Risk Management Framework (RMF), as amended. Contractor shall implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications, or other requirements of this subpart, taking into account those factors specified in 45 CFR §164.306(b)(2)(i), (ii), (iii), and (iv) [the Security Standards: General Rules, Flexibility of Approach]. This standard is not to be construed to permit or excuse an action that violates any other standard, implementation specification, or other requirements of this subpart. A covered entity may change its policies and procedures at any time, provided that the changes are documented and are implemented in accordance with this subpart. • Assess, review, and evaluate the information systems based upon security categorization and classification in accordance with Federal Information Processing Standards (FIPS) Publication 199 Standards for Security Categorization of Federal Information and Information Systems and FIPS Publication 200, Minimum Security Requirements for Federal Information and Information Systems. Additional guidance on defining the information type can be obtained from NIST SP 800-60 Revision 1 Volume I and II. • Select the baseline controls described in FIPS 200 and NIST SP 800-53 to develop a System Security Plan (SSP). Contractor must develop a SSP, in accordance with Section A.2 of this Attachment XIV, using the guidance from NIST RMF (NIST SP 800-18) to establish an information security program in accordance with the FISMA and demonstrate compliance. • Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the system and the information processed that it creates, receives, maintains, or transmits based on NIST SP 800-66 Revision 1, An Introductory Resource Guide for Implementing the Health Insurance Portability and Accountability Act (HIPAA) Security Rule. • Perform continuous monitoring of the system in compliance with NIST SP 800-137. • Implement four specifications with the Access Controls, Unique User Identification (Required), Unique User Identification (Required), Automatic Logoff (Addressable), and Encryption and Decryption (Addressable) which provides users with rights and/or privileges to access and perform functions using information systems, applications, programs, or files. Access controls shall enable authorized users to access the minimum necessary information needed to perform job functions. Rights and/or privileges shall be granted to authorized users based on a set of access rules that the covered entity is required to implement as part of 45 CFR §164.308(a)(4), the Information Access Management standard under the Administrative Safeguards section of the Rule. • Implement audit controls that allow Contractor to adhere to policy and procedures developed to comply with the required implementation specification at 45 CFR §164.308(a)(1)(ii)(D) for Information System Activity Review.

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
12. Data Security (Cont.)	• Implement policies and procedures to protect electronic protected health information from improper alteration or destruction. Integrity is defined in the Security Rule, at 45 CFR §164.304, as "the property that data or information have not been altered or destroyed in an unauthorized manner." Protecting the integrity of EPHI is a primary goal of the Security Rule. *Contract 2018-24-001, Attachment XIV, Sections 1.1.1 to 1.1.1.8*
13. System Security Plan *45 CFR 95.62, 45 CFR 164, and 42 CFR 431.300-307*	The SSP developed by Contractor shall including the following: • The requirements traceability matrix (RTM) cross-referenced to the specific system design function that meets each requirement related to system security; • A description of how the system is to be compliant with all the Federal and State laws regarding the security and privacy of personally identifiable information and Protected Health Information, including but not limited to 45 CFR 95.62; 45 CFR Parts 164, Subparts C and E; 1902(a)(7) of the Social Security Act; and 42 CFR 431.300-307; • A description of the process Contractor will use to report security breach incidents, regardless of severity or loss of actual data, to HFS within 4 hours; • A description of measures to secure data and software; • A description of how data are encrypted in transit and in storage; • A description of physical and equipment security measures; • A description of personnel security; • A description of software used for security; • A description of the user roles and the access capabilities of each role; • A description of how users are assigned certain roles; • An identification of the staff responsible for controlling the system security; • A description of contingency security procedures during a disaster recovery event; • A description of how Contractor works with HFS to conduct an annual security review; • Password security; and • Audit trails for all data access. *Contract 2018-24-001, Attachment XIV, Sections 1.1.2 to 1.1.2.1.15*
14. Department Right to review SSP	The Department shall have to right to review the SSP. If the Department finds deficiencies in the SSP, the Department, at its sole discretion, may deny Contractor access to Department systems or data until Contractor corrects the deficiencies in the SSP, as determined by the Department. *Contract 2018-24-001, Attachment XIV, Section 1.1.2.2*

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
15. Cost Identity Theft	Contractor will be responsible for all costs associated with identity theft resulting from a security breach. *Contract, Attachment XIV, Section 1.1.3*
16. Statutory Requirements	N/A
17. Personal Data – Employee Education	N/A
18. Personal Data – Return of Data	N/A
19. Personal Data – Destroy PHI	N/A
20. Data Security	N/A
21. Research Data	N/A

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
1. Enrollment - General	Contractor will not discriminate against Potential Enrollees based on health status or need for healthcare services. Contractor shall not participate in facilitating enrollment, including during the Open Enrollment Period. Contractor may educate a Potential Enrollee regarding the specific elements of Contractor, provided that Contractor engages in no Marketing activities prohibited under section 4.17. Contractor shall refer all requests for enrollment to the ICES, which shall not be considered "facilitating enrollment." Nothing in this Contract shall be deemed to be a guarantee of any Potential Enrollee's enrollment with Contractor. *Contract 2018-24-001, Section 4.1.1*
2. Enrollment – Children Added to the Case of Adult Enrollee	Enrollment of Newborns, infants, and Children who are added to the Case of the mother whose RIN is on the IES transaction and who is enrolled with Contractor, are enrolled automatically as follows: • If the newborn is added to the case before the newborn is forty-six (46) days old, Contractor shall provide coverage of the newborn Enrollee retroactively to the date of birth. • If an infant is added to the case after the age of forty-five (45) days and up to, but not including, one (1) year old, Contractor shall provide coverage of the infant Enrollee prospectively as provided in section 4.7. Contractor shall provide coverage of the infant Enrollee prospectively as provided in section 4.7, based on the Effective Enrollment Date determined by the Department and provided to Contractor on the 834 Audit File. • Children under the age of nineteen (19), excluding newborns and infants, who are added to the case of a sibling, mother, or head of household and whose RIN is on the IES transaction and who is enrolled with the Contractor, are enrolled automatically. Contractor shall provide coverage of the child Enrollee prospectively as provided in section 4.7. • For newborn claims where newborn has not yet been determined Medicaid eligible and assigned a RIN, Contractor shall follow the claims processing rules for newborns not yet assigned a RIN established by the Department for fee-for-service claims. *Contract 2018-24-001, Sections 4.6 to 4.6.4*
3. Children's Behavioral Health	Contractor shall ensure that the provision of Care Coordination and services for Children's Behavioral Health is compliant with Attachment XXII. Nothing in this section 5.7.12 and Attachment XXII is intended to limit the Children's Behavioral Health and Care Coordination services that are Covered Services. Contractor must provide Children's Behavioral Health Services to all enrolled Children who meet eligibility criteria. To the extent possible, family members and Natural Supports of children with behavioral health conditions should be included in all planning and treatment for the child. *Contract 2018-24-001, Section 5.7.12*
4. Update of Enrollment Information	Within five (5) Business Days after receipt of the 834 Audit File, Contractor shall update all electronic systems maintained by Contractor to reflect the information contained in the 834 Audit File received from the Department. Contractor shall use the 834 Audit File to verify Contractor's Enrollees for the subsequent calendar month. Contractor shall not wait for the 820 Payment File to update eligibility. *Contract 2018-24-001, Section 4.8*

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
5. Enrollee Welcome Packet *42 CFR 438.54 (c) (3) (i) through (vi)*	Within five (5) Business Days after receipt of the 834 Audit File from the Department confirming that an enrollment was accepted, Contractor shall send an Enrollee welcome packet to the Enrollee. The packet shall include all basic information as set forth in section 5.21.1. New Enrollee welcome packet. Contractor shall send to each new Enrollee a welcome packet that contains the Enrollee handbook and addresses important topics, such as how to get needed care; a benefits summary; and information about the Complaint, Grievance, and Appeal processes. This may be combined with the Enrollee welcome packet required in section 4.9. *Contract 2018-24-001, Sections 4.9, 5.21.8.4, and 5.21.1*
6. Change of MCO	During the initial ninety (90) days after the Effective Enrollment Date, whether the Enrollee actively selected the MCO or was enrolled by automatic assignment, the Enrollee shall have the opportunity to select a different MCO. Except as provided in section 4.10.3, the Enrollee shall not be allowed to change MCOs again until the Open Enrollment Period. If the Enrollee contacts Contractor to request a change of MCO during this ninety (90) day period, Contractor shall attempt to identify and resolve the Enrollee's concerns and if not resolved to the Enrollee's satisfaction, Contractor shall refer the Enrollee to the ICES. The MCO to which the Enrollee changes to is responsible for Care Coordination and Transition of Care planning. Unless otherwise specified in section 5.19, the MCO in which the Enrollee was first enrolled is responsible for payment for Covered Services through the effective disenrollment date and for cooperating with the Care Coordination and Transition of Care planning. *Contract 2018-24-001, Section 4.10.1*
7. Disenrollment Requested by the Enrollee *42 CFR 438.56 (c) through (c)(2)(iv)(c)*	When an Enrollee is subject to voluntary managed care enrollment under the Medicaid Managed Care Program, an Enrollee may disenroll from Contractor at any time and for any reason by notifying ICES. When an Enrollee is subject to mandatory managed care enrollment under the Medicaid Managed Care Program, an Enrollee may request to disenroll from Contractor for any of the following reasons at any time by notifying Contractor, orally or in writing, of the Enrollee's request to disenroll. Subject to the requirements in section 4.14.4, such a request shall be granted by the Department when the reason matches any of the following as determined by the Department: • The Enrollee moves out of the Contracting Area; • Contractor, due to its exercise of right of conscience pursuant to section 5.6, does not provide the Covered Service that the Enrollee seeks; • The Enrollee needs related Covered Services to be performed at the same time, not all the related services are available through Contractor, and the Enrollee's Provider determines that receiving the services separately would subject the Enrollee to unnecessary risk; • When a change in Enrollee's LTSS Provider (residential, institutional, or employment support) from a Network Provider to a non-Network Provider results in a disruption to residence or employment; or • Other reasons, including: poor quality of care; a sanction imposed by the Department pursuant to 42 CFR 438.702(a)(4); lack of access to Covered Services; lack of access to Providers experienced in dealing with the Enrollee's healthcare needs, or; if the Enrollee is automatically re-enrolled pursuant to section 4.11

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
7. Disenrollment Requested by the Enrollee (Cont.)	and such loss of coverage causes the Enrollee to miss the open Enrollment Period; or an Enrollee's Primary Care Provider's contract with Contractor is terminated resulting in disruption to the Enrollee. *Contract 2018-24-001 and Amendment KA5, Sections 4.10.3.1 to 4.10.3.2.5*
8. Change of PCP/WHCP	Contractor shall process an Enrollee's oral or written request to change PCP or WHCP within thirty (30) days after the receipt of the request. *Contract 2018-24-001, Section 4.13*
9. Termination of Coverage *42 CFR 438.608 (3)(i)&(ii)*	The Department shall terminate an Enrollee's coverage when the Enrollee becomes ineligible for HFS Medical Program or otherwise is not within the population described as being Enrollees under this Contract, or upon the occurrence of any of the following conditions: • Upon the Enrollee's death. Termination of coverage shall take effect at 11:59 p.m. on the last day of the month in which the Enrollee dies. Termination may be retroactive to this date. • When an Enrollee elects to change MCOs during the change period (section 4.10.1) or Open Enrollment Period (section 4.10.2). Termination of coverage with the previous MCO shall take effect at 11:59 p.m. on the day immediately preceding the Enrollee's Effective Enrollment Date with the new MCO. • When an Enrollee no longer resides in the Contracting Area. If an Enrollee is to be disenrolled at the request of Contractor under the provisions of section 4.14.1.3 Contractor must first provide documentation satisfactory to the Department that the Enrollee no longer resides in the Contracting Area. Termination of coverage shall take effect at 11:59 p.m. on the last day of the month prior to the month in which the Department determines that the Enrollee no longer resides in the Contracting Area. Termination may be retroactive if the Department is able to determine the month in which the Enrollee moved from the Contracting Area. • When the Department determines that an Enrollee has other significant insurance coverage or is placed in Spend-Down status. The Department shall notify Contractor of such disenrollment on the 834 Daily File. This notification shall include the effective disenrollment date. • When the Department is made aware that an Enrollee is incarcerated in a county jail, Illinois Department of Corrections facility, or federal penal institution. Termination of coverage shall take effect at 11:59 p.m. on the last day of the month prior to the month in which the Enrollee was incarcerated. • When an Enrollee enters DCFS custody. Termination of coverage shall take effect at 11:59 p.m. on the day prior to the day on which the court grants DCFS custody of the Enrollee. *Contract 2018-24-001, Sections 4.14.1 to 4.14.1.6*
10. MCO Request for Enrollee Disenrollment	Contractor shall not seek to terminate enrollment because of an adverse change in an Enrollee's health status, or because of the Enrollee's utilization of Covered Services, diminished mental capacity, or uncooperative or disruptive behavior resulting from such Enrollee's special needs (except to the extent such Enrollee's continued enrollment with Contractor seriously impairs Contractor's ability to furnish Covered Services to the Enrollee or other Enrollees).

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
10. MCO Request for Enrollee Disenrollment (Cont.)	Contractor shall not take an Adverse Benefit Determination in connection with an Enrollee who attempts to exercise, or is exercising, his or her Appeal or Grievance rights. Any attempts to seek to terminate enrollment in violation of this section 4.14.5 will be considered a breach of this Contract. *Contract 2018-24-001, Sections 4.14.5 to 4.14.6*
11. Disenrollment Due to Disruptive Conduct	N/A
12. Disruptive Conduct – Evidentiary Standards	N/A
13. Limitations on Disenrollments	N/A
14. Disenrollment Due to Fraud or Abuse	N/A
15. Disenrollment Due to Necessary Consent or Release	N/A
16. Disenrollment – Transfer of Information	N/A
17. Identification Card	Contractor shall send each new Enrollee an identification card bearing: • The name of Contractor; • The Effective Enrollment Date; • The name of Enrollee; • The Enrollee's RIN; • Contractor-assigned enrollee ID number, if applicable; • the twenty-four (24)–hour telephone number to confirm eligibility for benefits and authorization for services; and • The name and phone number of the Enrollee's PCP (do not include for dual-eligible Enrollees). Contractor shall send the identification cards to the Enrollee no later than five (5) Business Days after receipt of the 834 Audit File.

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
17. Identification Card (Cont.)	For Dual-Eligible Enrollees whose enrollments are received by Contractor after receipt of the monthly 834 Audit File, Contractor shall send the identification card no later than five (5) Business Days after receipt of the 834 Daily File. Contractor shall send a draft of the identification card described herein to the Department for Prior Approval no fewer than five (5) Business Days prior to the Readiness Review and when the card content is revised. Contractor shall not be required to submit format changes to the card for Prior Approval, provided there is no change in the information conveyed. *Contract 2018-24-001 and Amendment KA5, Sections 4.16.1 to 4.16.3*
18. Welcome Calls	Contractor will conduct welcome calls to each new Enrollee within thirty (30) days after the Effective Enrollment Date. When an Enrollee has been successfully contacted, Contractor will provide health education, respond to questions about Covered Services and how to access them, and conduct a health-risk screening to identify an Enrollee's potential need for services and care management. *Contract 2018-24-001, Section 5.21.8.5*

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
1. Grievance System *42 CFR 431, Subpart E* *42 CFR 438, Subpart F* *42 CFR 438.228* *42 CFR 438.400*	Contractor shall have a formally structured Grievance system that is compliant with Sections 45 of the Managed Care Reform and Patient Rights Act, 215 ILCS 134, and 42 CFR §431 Subpart E and §438 Subpart F to handle all Grievances and Appeals subject to the provisions of such Sections of the act and regulations. *Contract 2018-24-001, Section 5.30*
2. Grievances *42 CFR 438.402 (c)(3)(i)*	Contractor shall establish and maintain a procedure for reviewing Grievances by an Enrollee or an Enrollee's Authorized Representative. A Grievance may be submitted orally or in writing, using any medium, at any time, and all Grievances shall be registered with Contractor. Contractor's procedures must: • be submitted to the Department in writing and approved in writing by the Department; • provide for prompt resolution; and • assure the participation of individuals with authority, no previous involvement of review, and appropriate clinical expertise to require corrective action. *Contract 2018-24-001, Sections 5.30.1 to 5.30.1.3*
3 Grievance Process *42 CFR 438.408 & 438.416*	At a minimum, the following elements must be included in the Grievance process: • Contractor will acknowledge the receipt of a Grievance within forty-eight (48) hours. • Contractor shall attempt to resolve all Grievances as soon as possible but no later than ninety (90) days from receipt of a Grievance. Contractor may inform an Enrollee of the resolution orally or in writing. *Contract 2018-24-001, Sections 5.30.1.4-5.30.1.5*
4. Grievance Process-Appointment of Authorized Representative *42 CFR 438.408 & 438.416*	At a minimum, the following elements must be included in the Grievance process: • An Enrollee may appoint any individual, including a guardian, caretaker relative, or Provider, to represent the Enrollee throughout the Grievance process as an authorized representative. Contractor shall provide a form and instructions on how an Enrollee may appoint an authorized representative. *Contract 2018-24-001, Section 5.30.1.6*
5. Grievance Process-Quarterly Report to the Department	At a minimum, the following elements must be included in the Grievance process: • Contractor shall submit to the Department, in the format required by the Department, a quarterly report summarizing all Grievances and the responses to and disposition of those matters.

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
42 CFR 438.408 & 438.416	*Contract 2018-24-001, Section 5.30.1.7*
6. Grievance and Appeals Committee *42 CFR 438.406*	Contractor shall have a Grievance and Appeals committee that meets, at minimum, on a quarterly basis. *Contract 2018-24-001, Section 5.40.6*
7. Expedited Grievance Response	N/A
8. Grievance Decision-Makers	N/A
9. Appeals Process *42 CFR 438.406 (b)(6)(i–ii)*	Contractor shall establish and maintain a procedure for reviewing Appeals by Enrollees or an Enrollee's Authorized Representative pursuant to 42 CFR §438 Subpart F. An Appeal may be submitted orally or in writing, and all Appeals shall be registered initially with Contractor and may later be appealed to the State, as provided herein. Contractor's procedures must: • Be submitted to the Department in writing and approved in writing by the Department; • Provide for resolution within the times specified herein; • Provide for only one level of Appeal by Enrollee; and • Assure the participation of individuals with authority, no previous involvement of review, and appropriate clinical expertise to require corrective action. *Contract 2018-24-001, Sections 5.30.2 to 5.30.2.4*
10. Appeals Process – Integrated/Unified Non-Part D Appeals *42 CFR 438.406 (b)(6)(i–ii)*	N/A
11. Appeals Process – Medicare A&B Service Appeals	N/A

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
12. Appeals Process – Medicaid Appeals	N/A
13. Appeals Process – Overlapping Services and Items	N/A
14. Appeals Process - Part D Appeals	N/A
15. Appeals Process – Hospital Discharges	N/A
16. Appeals Process – Other Medicare QIO Appeals 42 C.F.R. §§ 422.624 and 422.626	N/A
17. Appeals Decision Makers	N/A
18. Appeals Committee *42 CFR 438.406*	Contractor must have a committee in place for reviewing Appeals made by Enrollees. *Contract 2018-24-001, Section 5.30.3*
19. Oral or Written Appeal *42 CFR 438.404* *42 CFR 438.406 (b) (3)*	At a minimum, the following elements must be included in the Appeal process: • An Enrollee may file an oral or written Appeal within sixty (60) days following the date of the notice of action that generates such Appeal. If the Enrollee does not request an expedited Appeal pursuant to 42 CFR §438.410, Contractor must require the Enrollee to follow an oral Appeal with a written, signed Appeal. *Contract 2018-24-001, Section 5.30.3.1*
20. Authorized Representative for Appeals	An Enrollee may appoint any authorized representative, including a guardian, caretaker relative, or Provider, to represent the Enrollee throughout the Appeal process. Contractor shall provide a form and instructions on how an Enrollee may appoint a representative. *Contract 2018-24-001, Section 5.30.3.2*

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
42 CFR 438.402 (c)(1)(ii)	
21. Expedited Appeals *42 CFR 438.408 (b)(3)*	If an Enrollee requests an expedited Appeal pursuant to 42 CFR §438.410, Contractor shall notify the Enrollee within twenty-four (24) hours after the submission of the Appeal, of all information from the Enrollee that Contractor requires to evaluate the Appeal. Contractor shall render a decision on an expedited Appeal within twenty-four (24) hours after receipt of the required information. Contractor shall not discriminate or take punitive action against a Provider who either requests an expedited resolution of Appeal or supports an Enrollee's Appeal pursuant to 42 CFR §438.410(b). *Contract 2018-24-001, Section 5.30.3.3*
22. Notice of Denial of Expedited Appeal	N/A
23. Standard Appeal *42 CFR 438.408 (b)(2)* *42 CFR 438.408 (c)(1) (i-ii)*	If an Enrollee does not request an expedited Appeal, Contractor shall make its decision on the Appeal within fifteen (15) Business Days after submission of the Appeal. Contractor may extend this time frame for up to fourteen (14) days if the Enrollee requests an extension, or if Contractor demonstrates to the satisfaction of the appropriate State agency's Hearing Office that there is a need for additional information and the delay is in the Enrollee's interest. • If Contractor extends time frame not at request of Enrollee, Contractor must: make reasonable efforts to give Enrollee prompt oral notice of delay, give Enrollee written notice within two (2) days, and resolve the Appeal expeditiously, but no later than expiration date of extension. *Contract 2018-24-001, Sections 5.30.3.4 to 5.30.3.4.1*
24. Nursing Facility Non-Emergency Appeal 42 C.F.R. § 422.570	N/A
25. Notice of Appeal Decision	N/A
26. Continuation of Benefits *42 CFR 438.420*	If an Enrollee files for continuation of benefits on or before the latter of ten (10) days of Contractor sending notice of action, or the intended effective date of the proposed Adverse Benefit Determination, Contractor must continue the Enrollee's benefits during the Appeal process. A Provider, serving as Enrollee's authorized representative for the Appeal process, cannot file for continuation of benefits. Pursuant to 42 CFR §438.420, if the final resolution of the Appeal is adverse to the Enrollee, Contractor may recover the cost of the services that were furnished to the Enrollee. *Contract 2018-24-001, Section 5.30.3.10*

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
27. External Independent Review *42 CFR 438.408 (f)(1)(ii)*	Except for a denial of Waiver services, which may not be reviewed by an external independent entity, Contractor shall have procedures allowing an Enrollee to request an external independent review, at no cost to the Enrollee, on both standard and expedited time frames, of Appeals that are denied by Contractor within thirty (30) days after the date of Contractor's decision notice. *Contract 2018-24-001, Section 5.30.3.6*
28. Medicare A&B and Overlap Services – IRE	N/A
29. IRE Reversal of Decision – Medicare A&B	N/A
30. IRE Decision – Overlap Services	N/A
31. State Fair Hearing Pre-Hearing Process	If an Appeal is filed with the State fair hearing system, Contractor will participate in the prehearing process, including scheduling coordination and submission of documentary evidence at least three (3) Business Days prior to the hearing, and shall participate in the hearing, including providing a witness to offer testimony supporting the decision of Contractor. *Contract 2018-24-001, Section 5.30.3.7*
32. Reversal of Decision– MCO or State Fair Hearing *42 CFR 438.424*	If Contractor or the State fair hearing officer reverses a decision to deny, limit, or delay services, and those services were not furnished while the Appeal was pending, Contractor must authorize or provide the disputed services as expeditiously as the Enrollee's health condition requires, but no later than 72 hours from the date Contractor receives notice reversing the decision. If Contractor or the State fair hearing officer reverses a decision to deny authorization of services and the Enrollee received the disputed services while the Appeal was pending, Contractor must pay for those services, in accordance with State policy and regulations. *Contract 2018-24-001, Sections 5.30.3.8 to 5.30.3.9*

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
33. Final Appeal Decision Not in the Enrollee's Favor-State Fair Hearing 42 CFR 438.408	Final decisions of Appeals, including expedited Appeals, not resolved wholly in favor of the Enrollee may be appealed by the Enrollee to the State under its fair hearings system within one-hundred twenty (120) days after the date of Contractor's decision notice. If Contractor fails to meet notice and timing requirements, the Enrollee is deemed to have exhausted the Appeals process and may initiate a State fair hearing. *Contract 2018-24-001, Section 5.30.3.5*
34. Review of ALJ Decision	N/A
35. Quarterly Report: Appeals *42 CFR 438.416*	Contractor shall submit to the Department, in the format required by the Department, a quarterly report summarizing all Appeals filed by Enrollees and the responses to and disposition of those matters (including decisions made following an external independent review). *Contract 2018-24-001, Section 5.30.3.11*
36. Maintain Records	Contractor must maintain records of Grievances and Appeals. At a minimum, the record must contain general description of reason for Grievance or Appeal, date received, date reviewed, and resolution, including date, at each level, and name of Person for whom the Grievance or Appeal was filed. *Contract 2018-24-001, Section 5.30.4*
37. Annual Review of Grievance and Appeals Procedures	Contractor shall review its Grievance and Appeal procedures at least annually to amend such procedures when necessary. Contractor shall amend its procedures only upon receiving the written Prior Approval of the Department. This information shall be provided to the Department. *Contract 2018-24-001, Section 5.30.5*

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
1. Coordination Tools: Enrollee Profile	Contractor shall use technology and processes that effectively integrate data from a variety of sources to profile, measure, and monitor Enrollee profiles. Profiles will include demographics, eligibility data, claims payment information, care opportunities, care gap alerts, and Enrollee preferences. *Contract 2018-24-001, Section 5.11.1*
2. Coordination Tools: Care Management System	Contractor's Care Coordinators will use the Care Management system to review assessments, interventions, and management of Chronic Health Conditions to gather information to support IPoCs and identification of Enrollees' needs. Contractor shall have fully operational portals which provide Enrollees and Providers access to relevant information from the care management system. *Contract 2018-24-001, Section 5.11.2*
3 Admissions, Discharge and Transfer System	The Department reserves the right to select an ADT system to be used by all MCOs within the State. Contractor must implement and integrate the Department's ADT system once determined by the Department. The Department will provide one-hundred eighty (180) days' notice to Contractor, in writing, prior to the requirement of this section 5.11.3 being in effect. *Contract 2018-24-001, Section 5.11.3*
4. Predictive Modeling and Surveillance Data	Contractor shall utilize claims and CCCD to risk stratify the population and to identify high-risk conditions requiring immediate Care Management Contractor shall identify Enrollees through referrals, transition information, service authorizations, alerts, Grievance system, memos, results of the DON, or other assessment tools adopted by the State, and from families, caregivers, Providers, community organizations and Contractor personnel. *Contract 2018-24-001, Sections 5.13.1.2 to 5.13.1.3*
5. Enrollee Portal	Contractor shall establish and maintain a secure Enrollee Web portal and mobile application that shall include, at a minimum, the following functions or capabilities. • Information about Contractor;

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
5. Enrollee Portal (Cont.)	• "Contact us" information; • Local health events and news; • Provider search; • Access to the Enrollee's IPoC; • Access to the Enrollee's care gaps; and • Access to health-education materials. *Contract 2018-24-001, Sections 5.21.7.3 to 5.21.7.3.7*
6. Health Information System	Contractor shall maintain a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of this Contract. The system must provide information on areas including utilization, claims, grievances and appeals, and disenrollments for reasons other than loss of Medicaid eligibility. *Contract 2018-24-001, Section 5.27.1*
7. Health Information System Compliance	Contractor shall, at a minimum, comply with the following: • Section 6504(a) of the Affordable Care Act, which requires that claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems operated by the Department to meet the requirements of Section 1903(r)(1)(F) of the Social Security Act; • collect data on Enrollee and Provider characteristics as specified by the Department, and on all Covered Services furnished to Enrollees through an Encounter Data system or other methods as may be specified by the Department; • ensure that data received from Providers are accurate and complete as required in section 5.28. *Contract 2018-24-001, Sections 5.27.2 to 5.27.2.3*
8. Encounter Data 42 CFR §438.818	Contractor shall: • Collect and maintain sufficient Enrollee Encounter Data to identify the Provider who delivers any item(s) or service(s) to Enrollees; • Submit Enrollee Encounter Data to the Department at the frequency and level of detail specified by CMS and the Department, based on program administration, oversight, and program integrity needs as determined by CMS and the Department; • Submit all Enrollee Encounter Data that the Department is required to report to CMS under 42 CFR §438.818; • Submit Encounter Data to the Department in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format as appropriate, and as required by CMS under 42 CFR §438.818;

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
8. Encounter Data (Cont.)	• Meet the ASC X12 5010 electronic transaction standards, including eligibility (270/271), claim status (276/277), referrals/authorizations (278), claims (837), and remittances (835); • Use standard ASC X12 claim codes; and • Submit with Enrollee Encounter Data a certification signed by either Contractor's Chief Executive Officer, Chief Financial Officer, or an individual who reports directly to and has delegated authority to sign for the Chief Executive Officer or Chief Financial Officer that attests based on best information, knowledge and belief, the data is accurate, complete and truthful. *Contract 2018-24-001 and Amendment KA2, Sections 5.27.3 to 5.27.3.7*
9. Regular Information Reporting Requirement	Contractor shall submit to the Department, or its designee, regular reports and additional information as set forth in this section 5.28 and Attachment XIII. All data collected by Contractor shall be available to the Department and, upon request, to Federal CMS. Such reports and information shall be submitted in a format and medium designated by the Department or having received Prior Approval. A schedule of all reports and information submissions and the frequency required for each under this Contract are provided in Attachment XIII. *Contract 2018-24-001, Sections 5.28.1.1 and 5.28.1.2*
10. Connectivity Specifications: Internet Connection 45 CFR §164.312(a)(2)(iv)	The connection to the DoIT Data Center must be through a secure connection via the Internet. A secure connection over the Internet will require a Site-to-Site Virtual Private Network (VPN) or the use of TLS Session depending upon the communication requirements. Many compliance mandates reference NIST standards, including PCI, HIPAA, FIPS, Common Criteria, and so on. NIST SP 800-52 rev 1 provides updated guidance on secure TLS configurations and recommends migration to TLS 1.2. Implement technical security measures to guard against unauthorized access to electronic protected health information that is being transmitted over an electronic communications network. This standard has two (2) implementation specifications: integrity controls (addressable) and encryption (addressable). The encryption implementation specification is addressable, similar to the addressable implementation specification at 45 CFR §164.312(a)(2)(iv), which addresses encryption and decryption. *Contract 2018-24-001, Attachment XIV, 1.2.1*
11. Connectivity Specifications: Internet Site to Site VPN Requirements	Contractor will be responsible for the cost of the connection between Contractor and its Internet Service Provider (ISP), troubleshooting and any redundancy requirements associated with Contractor's connection to the Internet or for Disaster recovery. Contractor shall procure, install, and support any VPN equipment required at Contractor's location to support secure Site-to-Site VPN communications via the Internet with DoIT. HFS will coordinate with Contractor to ensure that any authorization/certificate paperwork required for the establishment of the VPN connection is completed. Please note that DoIT can only accept pubic assigned IP ranges from Contractor (No RFC-1918 addresses). *Contract 2018-24-001, Attachment XIV, 1.2.2*

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
12. Connectivity Specifications: Internet TLS Requirements for File Transfer Protocol	If Contractor's only communication requirement is to send or receive data files, the connection may be made using secure FTP (FTPS) via the Internet. Contractor will be responsible for the cost of the connection between Contractor and its Internet Service Provider (ISP), troubleshooting and any redundancy requirements associated with Contractor's connection to the Internet or for Disaster recovery. Contractor is responsible for any costs associated with obtaining a secure FTP client that supports TLS. Contractor will be responsible for initiating the secure FTP sessions to the DoIT Data Center and performing any necessary firewall changes to reach the provided IP address and ftp control and data ports. *Contract 2018-24-001, Attachment XIV, 1.2.3*
13. Connectivity Specifications: Exchanging Configuration Information	HFS will work with Contractor to determine the configuration and define any connection parameters between Contractor and the DoIT Data Center. This will include any security requirements DoIT requires for the specific connection type Contractor is using. Contractor shall work with both HFS and DoIT in exchanging configuration information required to make the connection secure and functional for all parties. *Contract 2018-24-001, Attachment XIV, 1.2.4*
14. Connectivity Specifications: Transmission Control Protocol/Internet Protocol	Contractor shall cooperate in the coordination of the interface with DoIT and HFS. TCP/IP (Transmission Control Protocol/Internet Protocol) must be used for all connections from Contractor to the DoIT Data Center. *Contract 2018-24-001, Attachment XIV, 1.2.5*
15. Connectivity Specifications: Firewall Devices	Contractor shall be responsible for the installation, configuration, and troubleshooting of any firewall devices required on Contractor's side of the data communication link. *Contract 2018-24-001, Attachment XIV, 1.2.6*
16. Information System	N/A
17. Information System General Requirements	N/A
18. Information System Design Requirements	N/A

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
19. System Exchange of Encounter Data	N/A
20. Accepting and Processing Assessment Data	N/A
21. System Availability and Performance Requirements	N/A
22. Encounter Reporting	N/A
23. Failure to Submit Encounter Data to the Department	N/A

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
1. Monitoring of Delegated Entities *42 CFR 438.20* *42 CFR 438.230 (a)(1) and (b)(3-4)*	Contractor shall require that its Subcontractors comply with Contractor's Cultural Competence plan and complete Contractor's initial and annual Cultural Competence training. Contractor's delegated oversight committee, established pursuant to section 5.40.4, shall ensure compliance by Subcontractors with contractual and statutory requirements, including the Illinois Human Rights Act, the US Civil Rights Act, and Section 504 of the federal Rehabilitation Act. *Contract 2018-24-001, Section 2.7.5*
2. Subcontractor Oversight Committee	Contractor shall have a subcontractor oversight committee that meets, at minimum, on a quarterly basis. This committee shall, at a minimum, conduct the following with regard to each Subcontractor: a predelegation audit, a quarterly delegation oversight review of subcontractor performance by the subcontractor oversight committee, monthly joint operation meetings, an annual audit of Contractor's delegated subcontractors, regular monitoring of Enrollee Complaints, documentation of issues, and development of a Corrective Action Plan, as warranted, to improve performance. *Contract 2018-24-001, Section 5.40.4*
3 Subcontractor: QA Activities	Contractor shall remain accountable for all QAP functions, even if certain functions are delegated to other entities. If Contractor delegates any QA activities to subcontractors: • There shall be a written description of the following: the delegated activities; the subcontractor's accountability for these activities; and the frequency of reporting to Contractor. • Contractor shall have written procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the actual quality of care being provided. • Contractor shall be held accountable for subcontractor's performance and must assure that all activities conform to this Contract's requirements. • There shall be evidence of continuous and ongoing evaluation and oversight of delegated activities, including approval of quality improvement plans and regular specified reports, as well as a formal review of such activities. Oversight of delegated activities must include no less than an annual audit, analyses of required reports and encounter data, a review of Enrollee complaints, grievances, Provider complaints, appeals, and quality of care concerns raised through encounter data, monitoring activities, or other venues. Outcomes of the annual audit shall be submitted to the Department as part of the QA/UR/PR Annual Report. • Contractor shall be responsible for, directly or through monitoring of delegated activities, credentialing and re-credentialing, and shall review such credentialing files performed by the delegated entity no less than annually, as part of the annual audit. • If Contractor or subcontractor identifies areas requiring improvement, Contractor and subcontractor, as appropriate, shall take corrective action and implement a quality improvement initiative. If one or more deficiencies are identified, the subcontractor must develop and implement a corrective action plan, with protections put in place by Contractor to prevent such deficiencies from recurring. Evidence of ongoing monitoring of the delegated activities sufficient to assure corrective action shall be provided to the Department through quarterly or annual reporting, or through a timeframe established by the Department with the Contractor.

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
	Contract 2018-24-001, Attachment XI, 1.1.7. to 1.1.7.6.
4. Provider Agreements and Subcontracts	Contractor may provide or arrange to provide any Covered Services with Network Providers, or fulfill any other obligations under this Contract, by means of subcontractual relationships. All Provider agreements and subcontracts entered into by Contractor must be in writing, must specify the delegated activities, duties or obligations, including any related reporting responsibilities, and are subject to the following conditions: • The Network Providers and Subcontractors shall be bound by the terms and conditions of this Contract that are appropriate to the service or activity delegated under the agreement or subcontract. Such requirements include the record keeping and audit provisions of this Contract, such that the Department or Authorized Persons shall have the same rights to audit and inspect Network Providers and Subcontractors as they have to audit and inspect Contractor. • All Physicians who are Network Providers shall have and maintain admitting privileges and, as appropriate, delivery privileges at a hospital that is a Network Provider; or, in lieu of these admitting and delivery privileges, the Physician shall have a written Referral agreement with a Physician who is a Network Provider and who has such privileges at a hospital that is a Network Provider. The provider contract shall include hospital affiliation. The agreement must provide for the transfer of medical records and coordination of care between Physicians. • Contractor shall require each Network Provider that provides Covered Services under a DHS HCBS Waiver, under the Medicaid clinic option, or under the Medicaid Rehabilitation option, or that provides subacute alcoholism and substance-abuse treatment services pursuant to 89 Ill. Admin. Code 148.340-148.390 and 77 Ill. Admin. Code Part 2090, to enter any data regarding Enrollees that are required under State rules, or a contract between the Provider and DHS, into any subsystem maintained by DHS, including DHS's automated reporting and tracking system (DARTS). • Contractor shall, no later than January 1, 2020, require that Subcontractors delegated to perform claims processing and payment activities offer Network Providers the option to utilize an electronic billing system. *Contract 2018-24-001, Amendment KA2, Sections 5.32.1 to 5.32.2.4*
5. Provider Agreements and Subcontracts	• Contractor shall remain responsible for the performance of any of its responsibilities delegated to Network Providers, subcontractors and other entities to which duties are delegated. • No Provider agreement or subcontract can terminate the legal responsibilities of Contractor to the Department to assure that all the activities under this Contract will be carried out. • All Network Providers providing Covered Services for Contractor under this Contract must be enrolled as Providers in the HFS Medical Program. Contractor shall not contract or subcontract with an excluded Person or a Person who has voluntarily withdrawn from the HFS Medical Program as the result of a settlement agreement. • All Provider agreements and subcontracts must comply with the lobbying certification contained in article IX of this Contract.

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
5. Provider Agreements and Subcontracts (Cont.)	• All Network Providers shall be furnished with information about Contractor's Grievance and Appeal procedures at the time the Provider enters into an agreement with Contractor and within fifteen (15) days following any substantive change to such procedures. • Contractor must retain the right to terminate any Provider agreement or subcontract or impose other sanctions if the performance of the Network Provider or Subcontractor is inadequate. *Contract 2018-24-001, Sections 5.32.3 to 5.32.8*
6. Provider Agreements and Subcontracts	With respect to all Provider agreements and subcontracts made by Contractor, Contractor further warrants: • that such Provider agreements and subcontracts are binding; • that it will promptly terminate all contracts with Network Providers and Subcontractors or impose other sanctions if the performance of the Network Provider or Subcontractor is inadequate, as determined by either the Department or Contractor; • that it will promptly terminate contracts with Providers that are terminated, barred, or suspended, or have voluntarily withdrawn, as a result of a settlement agreement under either Section 1128 or Section 1128A of the Social Security Act, from participating in any program under federal law including any program under Titles XVIII, XIX, XX, or XXI of the Social Security Act or are otherwise excluded from participation in the HFS Medical Program; • that all laboratory testing sites providing services under this Contract must possess a valid Clinical Laboratory Improvement Amendments (CLIA) certificate and comply with the CLIA regulations found at 42 CFR §493; and • that it will monitor the performance of all Network Providers and Subcontractors on an ongoing basis, subject each Network Provider and Subcontractor to formal review on a triennial basis, and, to the extent deficiencies or areas for improvement are identified during an informal or formal review, require that the Network Provider or Subcontractor take appropriate corrective action. *Contract 2018-24-001, Sections 5.32.10 to 5.32.10.5*
7. Provider Agreements and Subcontracts	• Upon request by the Department, Contractor will make available Provider agreements and subcontracts as provided in Attachment XIII. The Department reserves the right to require Contractor to amend any Provider agreement or subcontract as reasonably necessary to conform to Contractor's duties and obligations under this Contract. • Contractor may designate in writing certain information disclosed under this section 5.32 as confidential and proprietary. If Contractor makes such a designation, the Department shall consider said information exempt from copying and inspection under Section 7(1)(b) or (g) of the State Freedom of Information Act (5 ILCS 140/1 et seq.). If the Department receives a request for said information under the State Freedom of Information Act, however, it may require Contractor to submit justification for asserting the exemption. The Department may honor a properly executed criminal or civil subpoena for such documents without such being deemed a breach of this Contract or any subsequent amendment hereto. *Contract 2018-24-001, Sections 5.32.11 to 5.32.12*

EVALUATION ELEMENTS	HEALTHCHOICE CONTRACT LANGUAGE
8. Provider Agreements and Subcontracts	Prior to entering into a Provider agreement or subcontract, Contractor shall submit a disclosure statement to the Department specifying any Provider agreement or subcontract and Providers or Subcontractors in which any of the following have a financial interest of five percent (5%) or more: • any Person also having a five percent (5%) or more financial interest in Contractor or its Affiliates as defined by 42 CFR §455.101; • any director, officer, trustee, partner, or employee of Contractor or its Affiliates; or • any member of the immediate family of any Person designated above. *Contract 2018-24-001, Sections 5.32.13 to 5.32.13.3*
9. Provider Agreements and Subcontracts	Any contract or subcontract between Contractor and a FQHC or a RHC shall be executed in accordance with Sections 1902(a) (13) (C) and 1903(m)(2)(A)(ix) of the Social Security Act, as amended by the Balanced Budget Act of 1997, and shall provide payment that is not less than the level and amount of payment that Contractor would make for the Covered Services if the services were furnished by a Provider that was not a FQHC or a RHC. *Contract 2018-24-001, Section 5.32.14*
10. Provider Complaint and Resolution System	Contractor shall establish a complaint and resolution system for Network and non-Network Providers, including: • a claim dispute process that allows Providers to contest a payment decision after a claim has been adjudicated; and • a service authorization dispute process that allows Providers to contest an authorization denial or a reduction, suspension, or termination of a previously authorized service. Contractor shall provide a substantive response intended to resolve the dispute within thirty (30) business days after receipt of the dispute request. *Contract 2018-24-001, Sections 5.29.7 to 5.29.7.2*
11. Provider Complaint and Resolution System- Response	Contractor shall provide a substantive response intended to resolve a complaint received through the Department's Provider complaint portal on the Department's website within two (2) Business Days if the complaint is categorized as urgent and within fifteen (15) Business Days if it is not categorized as urgent. *Contract 2018-24-001, Section 5.29.8*

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection/Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
Subassurance C **The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.**								
29C	*# and % of case managers who meet waiver provider training requirements.* N: # of MCO case managers reviewed who meet waiver provider training requirements. D: Total # of MCO case managers reviewed.	EQRO/MCO	Quarterly and Annually	100%	MA/MCO	Quarterly and Annually	MCO Reports	Completion of case manager training; Moratorium of new waiver cases to non-certified MCO case managers. Remediation within 60 days.
Appendix D - Service Plan Development								
Subassurance A **Service plans address all participants' assessed needs (including health and safety factors) and personal goals, either by the provision of waiver services or through other means**								
31D	*# and % of MCO participants' service plans that address all*	EQRO /MCO	Quarterly and Ongoing	Representative Sample	MA/MCO	Quarterly and Annually	MCO Reports; EQRO Reviews	If plans do not address required items, the MA will require the plans be corrected and will

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection/Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
	personal goals identified by the assessment. N: # of MCO service plans reviewed that address all personal goals identified by the assessment. D: Total # of MCO service plans reviewed.							provide training of case managers. Remediation must be completed within 60 days.
32D	*# and % of MCO participants' service plans that address all participant needs identified by the assessment.* N: # of MCO service plans reviewed that address all participant needs identified by the assessment.	EQRO /MCO	Quarterly and Ongoing	Representative Sample	MA/MCO	Quarterly and Annually	MCO Reports; EQRO Reviews	If plans do not address required items, the MA will require the plans be corrected and will provide training of case managers. Remediation must be completed within 60 days.

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection/Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
	D: Total # of MCO service plans reviewed.							
33D	*# and % of MCO participants' service plans that address risks identified in the assessment.* N: # of MCO service plans reviewed that address risks identified in the assessment. D: Total # of MCO service plans reviewed.	EQRO /MCO	Quarterly and Ongoing	Representative Sample	MA/MCO	Quarterly and Annually	MCO Reports; EQRO Reviews	If plans do not address required items, the MA will require the plans be corrected and will provide training of case managers. Remediation must be completed within 60 days.
34D	*# and % of MCO satisfaction survey respondents in the sample who reported they receive services*	MCO	Annually	CAHPS Guidelines (BI, HIV, PD)	MA/MCO	Annually	CAHPS Survey (BI, HIV, PD)	If identifying information is available for individual surveys the MCO case managers will follow up on non-favorable

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection/Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
	they need when they need them. N: # of MCO satisfaction survey respondents who reported they receive services when needed. D: # of MCO satisfaction survey respondents in the sample.		Annually	100% (Elderly)			POSM Survey question E.1.a. (Elderly)	surveys. Resolution or remediation will be based on the nature of the concern. Anonymous survey responses will be used to identify need for system improvement.
	<u>Subassurance B</u> **The State monitors service plan development in accordance with its policies and procedures**							
	# and % of service plans that were implemented pre-authorization by MCO with remediation within 60 days N: # of service plans that were implemented pre-authorization by MCO with remediation within 60 days.	MCO	Quarterly and Ongoing	100%	MA/MCO	Quarterly and Annually	MCO Reports	The MCO provides training to case managers and authorizes service plans if appropriate. If remediation not completed within 60 days, the MCO reviews procedures and submits a plan of correction to MA. The MA follows-up to completion.

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection/Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
	D: Total # of service plans reviewed by MCO that were implemented pre-authorization.							
35D	*# and % of MCO participants' service plans that were signed and dated by the waiver participant (or representative) and the case manager.* N: # of MCO service plans that were signed by the waiver participant and the case manager. D: Total # of MCO service plans reviewed.	EQRO /MCO	Quarterly and Ongoing	Representative Sample	MA/MCO	Quarterly and Annually	MCO Reports; EQRO Reviews	If plans are not signed by appropriate parties, the MA will require the plans be corrected. The MCO may also provide training in both cases. Remediation must be completed within 60 days.
36D	*# and % of MCO participants who received contact by their case manager*	EQRO /MCO	Quarterly and Ongoing	Representative Sample	MA/MCO	Quarterly and Annually	MCO Reports; EQRO Reviews	If participants do not receive the required contact by case manager, the MA will

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection/Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
	every 12 months for Persons with Disabilities and Elderly; monthly for BI; and monthly contact with at 1 face to face bimonthly for HIV; in an effort to monitor service provision and to address potential gaps in service delivery. N: # of MCO participants reviewed who received contact by their case manager every 12 months for Persons with Disabilities and Elderly; monthly for BI; and *monthly contact with at 1 face to face bimonthly*, for HIV. D: Total # of MCO participants reviewed.							require the participant be contacted and provide training of case managers. Remediation must be completed within 60 days.

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection/Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
49G	*# and % of MCO participants who have personal assistant or other independently employed services whose service plan included back up plans.* N: # of MCO participants reviewed who have personal assistant or other independently employed services whose service plan included back up plans. D: Total MCO participants reviewed who have personal assistant or other independently employed services.	MCO	Quarterly and Ongoing	Representative Sample	MCO	Quarterly and Annually	MCO Reports	The MCO would develop and implement PA back up plans and revisions to customers' service plans. Timeline for remediation would be within 30 days.
<u>Subassurance C</u> Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs								

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection/Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
37D	*# and % of MCO waiver participants who have their Service Plan updated every 12 months for all waivers.* N: # of MCO waiver participants reviewed who have their Service Plan updated every 12 months for all waivers. D: Total # of MCO waiver participants with service plans due during the period reviewed.	EQRO /MCO	Quarterly and Ongoing	Representative Sample	MA/MCO	Quarterly and Annually	MCO Reports; EQRO Reviews	If service plans are untimely, the MA will require completion of overdue service plans and justification from the case manager. If service plans are not updated when there is documentation that a participant's needs changed, the MCO will require an update. In both cases the MCO may also provide training of case managers. Remediation within 60 days.
4A	# and % of overdue Service Plan renewals that were remediated within 30 days by the MCO (ELD, HIV/AIDS, PD- 12 months; BI- 6 months)	EQRO/MCO	Quarterly and Ongoing	100%	MA/MCO	Quarterly and Annually	MCO	The OA/MCO conducts timely completion of the overdue Support Plans and renewals. The OA/MCO may also provide training for case managers. If remediation not completed within 30 days, the OA/MCO reviews procedures and submits a plan of

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection/Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
								correction to MA. The MA follows-up to completion.
38D	*# and % of MCO waiver participants that received updates to service plans when participants needs changed.* N: # of MCO waiver participants reviewed that received updates to service plans when participants' needs changed. D: Total # of MCO waiver participants identified whose needs changed.	EQRO /MCO	Quarterly and Ongoing	Subset of Representative Sample	MCO	Quarterly and Annually	MCO Reports; EQRO Reviews	If plans do not address required items, the MCO will require that the plans be corrected and provide training of case managers. Remediation must be completed within 60 days.
<u>Subassurance D</u> **Services are delivered in accordance with the service plan, including type, scope, amount, duration, and frequency specified in the service plan**								

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection/Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
39D	*# and % of MCO participants who received services in the type, scope, amount, duration, and frequency as specified in the service plan.* N: # of MCO participants reviewed who received services as specified in the care plan/service plan. D: Total # of MCO participants reviewed.	EQRO /MCO	Quarterly and Ongoing	Representative Sample	MA/MCO	Quarterly and Annually	MCO Reports; EQRO Reviews	If a participant does not receive services as specified in the service plan, the MCO will determine if a correction or adjustment of service plan, services authorized, or services vouchered is needed. If not, services will be implemented as authorized. The MCO may also provide training to case managers. If the issue appears to be fraudulent, it will be reported by the MA to fraud control. Remediation must be completed within 60 days.
40D	*# and % of MCO satisfaction survey*	EQRO/MCO	Quarterly and Ongoing	Representative Sample (Elderly)	MA/MCO	Quarterly and Annually	POSM	If identifying information is

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection/Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
	respondents in the sample who reported the receipt of all services listed in the plan of care. N: # of MCO satisfaction survey respondents who reported the receipt of all services listed in the plan of care. D: # of MCO satisfaction survey respondents in the sample.		Annually	CAHPS Guidelines			CAHPS Survey	available for individual surveys the MCO case managers will follow up on non-favorable surveys. Resolution or remediation will be based on the nature of the concern. Anonymous survey responses will be used to identify need for system improvement.
<u>Subassurance E</u> Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers								
41D	*# and % of MCO participants records with the most recent plan of care indicating the participant had choice between waiver services and institutional care; and between/among*	EQRO /MCO	Quarterly and Ongoing	Representative Sample	MA/MCO	Quarterly and Annually	MCO Reports; EQRO Reviews	The MCO will assure that choice was provided as shown by the correction of documentation to indicate customer choice. The MCO may also provide training to case managers. Remediation must be

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection/Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
	services and providers. N:# of MCO participant records reviewed with a signed POC that indicates participant had choice between waiver services and between services and providers. D:Total # of MCO participant records reviewed.							completed within 60 days.
Appendix G - Participant Safeguards								
<u>Subassurance A</u> The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation								
42G	*# and % of participants who received*	EQRO /MCO	Quarterly and Ongoing	Representative Sample	MA/MCO	Quarterly and Annually	MCO Reports;	The MCO will assure that customers know how to report abuse,

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection/Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
	information from the MCO about how and to whom to report abuse, neglect, exploitation at the time of assessment-reassessment. N: # of participant records reviewed where the participant received information from the MCO about how and to whom to report abuse, neglect exploitation at the time of assessment-reassessment. D: Total # of MCO participant records reviewed.						EQRO Reviews	neglect or exploitation. This will be demonstrated by correction of case work documentation reflecting customers awareness, including evidence of steps taken to educate the customer. Remediation must be completed within 30 days.
25	# and % of medication errors for participants documented and reported to the Department	MCO	Quarterly and Ongoing	100%	MA/MCO	Annually and Ongoing	MCO Reports	If it was discovered a Medication Error Report requiring submission to the MA had not been sent, the SLF would need to complete a report (if not previously done)

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection/Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
	N: # of medication error reports documented and reported to the Department. D: Total # of incidents of medication errors requiring documenting and reporting to the Department.							and send it. MA staff would review the report form for completeness and accuracy to verify remediation.
43G	*# and % of participants' APS substantiated incidents that were reported to the MCO and resolved within recommended APS timelines.* N: # of APS substantiated incidents reported to the MCO that were resolved within recommended OIG timelines.	MCO	Quarterly and Ongoing	100%	MCO	Quarterly and Annually	MCO Reports	The MCO will follow up all outstanding DHS-OIG referrals and Unusual Incident Reports. Changes in customers' service plans will be made when needed. Remediation must be completed within 30 days.

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection/Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
	D: Total # of APS substantiated incidents reported to the OA and MCO.							
44G	*# and % of participants' substantiated cases of abuse, neglect or exploitation received from DHS-OIG where the MCO implemented APS recommendations within waiver-specified or regulatory timeframes* N: # of substantiated cases of abuse, neglect or exploitation received from APS where the MCO implemented the APS recommendations.	MCO	Quarterly and Ongoing	100%	MCO	Quarterly and Annually	MCO Reports	The MCO will implement the DHS-OIG recommendations for substantiated cases of abuse, neglect or exploitation. Changes in customers' service plans will be made when needed. Remediation must be completed within 30 days.

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection/Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
	D: Total # of substantiated cases of abuse, neglect or exploitation received by the MCO from APS.							
45G	*# and % of participants' deaths as a result of substantiated case of abuse, neglect or exploitation where appropriate follow-up actions were implemented by the MCO.* N: # of deaths as a result of a substantiated case of A/N/E where appropriate follow-up actions were implemented by the MCO. D: Total # of MCO deaths as a result of a substantiated case of A/N/E.	MCO	Quarterly and Ongoing	100%	MA/MCO	Quarterly and Annually	MCO Reports	The cause of death/circumstances would be reviewed by the MCO and need for training or other remediation; including sanction or termination of provider, would be determined based on circumstances and identified trends and patterns.

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection/Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
48G	*# and % of participants for whom identified critical incidents other than A/N/E were reviewed and corrective measures were appropriately taken by MCO.* N:# of participants for whom identified critical incidents other than A/N/E were reviewed and corrective measures were appropriately D:Total # of MCO participants for whom identified critical incidents were reviewed.	MCO	Quarterly and Ongoing	100%	MA/MCO	Quarterly and Annually	MCO Reports	The MCO will follow up on identified critical incidents, other than A/N/E, to ensure information was reviewed and corrective measures were appropriately taken. Resolution or remediation will be based on the nature of the concern. Survey responses will be used to identify need for system improvement.
<u>Subassurance C</u> **The State policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusions) are followed.**								
	# and % of waiver participants who are free from seclusion or restraints.	MCO	Quarterly	100%	MA/MCO	Quarterly, Annually and Ongoing	MCO Reports	If a participant was found to be in/have been in restraints or seclusion, the SLF would need to immediately

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection/Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
	N: # of waiver participants who are free from seclusion or restraints. D: Total # of waiver participants reviewed.							discontinue the practice. MA staff would verify the participant was not in restraints or seclusion in order to document remediation. In addition to the issuance of findings of non-compliance summarized below, the MA may also issue an Immediate Jeopardy, as outlined earlier in this section, if the participant was identified to be in immediate danger.
46G	*# and % of restraint applications, seclusion, or other restrictive interventions where appropriate intervention by the MCO occurred in accordance with waiver and within waiver prescribed timeframes.* N: # of restraint applications, seclusion, or other	MCO	Quarterly and Ongoing	100%	MA/MCO	Quarterly and Annually	MCO Reports	Restraint applications, seclusion, or other restrictive interventions will be reviewed by the MCO. The need for training or other remediation; including sanction or termination of provider, would be determined based on circumstances and identified trends and patterns.

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection/Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
	restrictive interventions where appropriate intervention by the MCO occurred. D: Total # of MCO restraint applications, seclusion, or other restrictive intervention.							
	<u>Subassurance D</u> **The State establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.**							
47G	*# and % of participant satisfaction survey respondents who reported to the MCO of being treated well by direct support staff.* N: # of participant satisfaction survey respondents who reported to the MCO of being	EQRO/MCO	Annually	CAHPS Guidelines (BI, HIV, PD)	MA/MCO	Quarterly and Annually	CAHPS Survey (BI, HIV, PD)	If identifying information is available for individual surveys the MCO case managers will follow up on non-favorable surveys. Resolution or remediation will be based on the nature of the concern. Anonymous survey responses will be used to identify need for system improvement.
			Quarterly	100% (Elderly)			POSM Survey question E.1.a. (Elderly)	

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection/Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
	treated well by direct support staff. D: Total # of MCO participant satisfaction survey respondents.							
33	*# and % of HSP Individual Provider evaluations returned reporting satisfaction as stated in the approved waiver* N: # of HSP Individual Provider evaluations completed that report satisfaction as stated in the approved waiver. D: Total # of Individual Provider evaluations completed.	MCO	Annually	CAHPS Guidelines (PD)	MA/MCO	Annually	CAHPS Survey	If identifying information is available for individual surveys the MCO case managers will follow up on non-favorable surveys. Resolution or remediation will be based on the nature of the concern. Anonymous survey responses will be used to identify need for system improvement.
34	*# and % of participants who received information from MCO regarding universal precautions.*	MCO	Annually	CAHPS Guidelines (PD)	MA/MCO	Annually	CAHPS Survey	If identifying information is available for individual surveys the MCO case managers will follow up on non-favorable surveys. Resolution or

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection/Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
	N: # of participant records reviewed where there is a signed document that shows the participant received information from the OA and MCO about universal precautions. D: Total # of OA and MCO participant records reviewed.							remediation will be based on the nature of the concern. Anonymous survey responses will be used to identify need for system improvement.

Table A1-1 displays a snapshot of health plan performance for measures selected by the HFS in domains of care that it prioritizes for improvement. Performance for HEDIS 2020 measures is compared to the NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS 2019, when available, which is an indicator of health plan performance on a national level. For most measures, two years of data (HEDIS 2019 and HEDIS 2020) are trended. Due to changes in the technical specifications for one measure in HEDIS 2020 (i.e., *Prenatal and Postpartum Care*), NCQA does not recommend trending between 2020 and prior years or comparisons to benchmarks; therefore, this measure is not displayed below. Additionally, *Ambulatory Care* and *Mental Health Utilization are* utilization measures and are provided for information only. A key and notes for Table A1-1 are listed in the table below.

Table A1-1—Summary of Performance Measures Results

Measure	# Plans Reporting 2020	Plan Performance 2020				Statewide Avg. 2020/Trended 2019-2020	Improved Performance 2019-2020	Quality (Q) Timeliness (T) Access (A)
		<25th	25th–49th	50th–74th	≥75th			
Access to Care								
Adults' Access to Preventive/Ambulatory Health Services								
Total	6	2	3	0	1	25th–49th ↑	5 of 6 plans	A
Adult BMI Assessment								
Adult BMI Assessment	6	3	2	1	0	<25th ↑	2 of 6 plans	Q
Ambulatory Care (per 1,000 Member Months)								
ED Visit—Total	6	1	3	2	0	25th–49th ↓	1 of 6 plans	Not Applicable (NA)
Outpatient Visit—Total	6	4	1	1	0	25th–49th ↑	6 of 6 plans	NA
Annual Dental Visits								
Annual Dental Visits	6	1	3	0	2	50th–74th ↓	1 of 5 plans[1]	A

Measure	# Plans Reporting 2020	Plan Performance 2020				Statewide Avg. 2020/Trended 2019-2020	Improved Performance 2019-2020	Quality (Q) Timeliness (T) Access (A)
		<25th	25th–49th	50th–74th	≥75th			
Keeping Kids Healthy								
Childhood Immunization Status								
Combination 2	6	3	1	1	1	25th–49th ↑	2 of 6 plans	Q
Combination 3	6	4	1	1	0	<25th ↑	2 of 6 plans	Q
Immunization for Adolescents								
Combination 1 (Meningococcal, Tdap)	6	1	0	3	2	>75th ↑	5 of 6 plans	Q
Combination 2 (Meningococcal, Tdap, HPV)	6	1	2	2	1	50th–74th ↑	5 of 6 plans	Q
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents								
BMI Percentile Documentation—Total	6	1	4	1	0	25th–49th ↓	0 of 6 plans	Q
Counseling for Nutrition—Total	6	1	4	0	1	25th–49th ↓	0 of 6 plans	Q
Counseling for Physical Activity—Total	6	1	3	1	1	25th–49th ↓	0 of 6 plans	Q
Well-Child Visits in the First 15 Months of Life								
Six or More Well-Child Visits	6	1	3	1	1	50th–74th ↑	4 of 6 plans	Q
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life								
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	6	1	2	2	1	50th–74th ↓	0 of 6 plans	Q
Women's Health								
Breast Cancer Screening								
Breast Cancer Screening	6	2	2	1	1	25th–49th ↑	6 of 6 plans	Q
Cervical Cancer Screening								
Cervical Cancer Screening	6	2	2	2	0	25th–49th ↑	2 of 6 plans	Q
Chlamydia Screening in Women								
Total	6	0	4	0	2	50th–74th ↓	3 of 6 plans	Q
Living With Illness								
Comprehensive Diabetes Care								

Measure	# Plans Reporting 2020	Plan Performance 2020				Statewide Avg. 2020/Trended 2019-2020	Improved Performance 2019-2020	Quality (Q) Timeliness (T) Access (A)
		<25th	25th–49th	50th–74th	≥75th			
HbA1c Testing	6	1	1	3	1	50th–74th ↑	3 of 6 plans	Q
Eye Exam (Retinal) Performed	6	1	4	1	0	25th–49th ↓	2 of 6 plans	Q
Medical Attention for Nephropathy	6	1	0	3	2	50th–74th ↑	3 of 6 plans	Q
Controlling High Blood Pressure								
Controlling High Blood Pressure	6	4	2	0	0	<25th ↓	1 of 6 plans	Q
Medication Management for People With Asthma								
Medication Compliance 50%—Total[1]	6	2	4	0	0	25th–49th ↑	5 of 6 plans	Q
Medication Compliance 75%—Total	6	2	4	0	0	25th–49th ↑	5 of 6 plans	Q
Statin Therapy for People With Diabetes								
Received Statin Therapy	6	1	0	0	5	≥75th ↑	5 of 6 plans	Q
Statin Adherence 80%	6	1	0	5	0	50th–74th ↑	6 of 6 plans	Q
Behavioral Health								
Follow-Up After Hospitalization for Mental Illness								
7-Day Follow-Up—Total	6	4	2	0	0	<25th ↑	3 of 6 plans	Q, T, A
30-Day Follow-Up—Total	6	4	2	0	0	<25th ↑	2 of 6 plans	Q, T, A
Initiation and Engagement of AOD Abuse or Dependence Treatment								
Initiation of AOD Treatment—Total	6	0	1	5	0	50th–74th ↓	3 of 6 plans	Q, T, A
Engagement of AOD Treatment—Total	6	0	3	3	0	50th–74th ↑	2 of 6 plans	Q, T, A
Mental Health Utilization								
Any Service—Total	6	1	5	0	0	25th–49th/NA	NA	NA
Inpatient—Total	6	0	0	1	5	≥75th /NA	NA	NA
Intensive Outpatient or Partial Hospitalization—Total	6	0	0	6	0	50th–74th/NA	NA	NA
Outpatient—Total	6	1	5	0	0	25th–49th/NA	NA	NA
ED—Total	6	3	1	2	0	25th–49th/NA	NA	NA

Measure	# Plans Reporting 2020	Plan Performance 2020				Statewide Avg. 2020/Trended 2019-2020	Improved Performance 2019-2020	Quality (Q) Timeliness (T) Access (A)
		<25th	25th–49th	50th–74th	≥75th			
Telehealth—Total	6	0	3	3	0	50th–74th/NA	NA	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics								
Blood Glucose and Cholesterol Testing—Total	6	0	2	3	1	50th–74th ↑	4 of 6 plans	Q

↑ *indicates performance improved from HEDIS 2019 to HEDIS 2020.*
↓ *indicates performance declined from HEDIS 2019 to HEDIS 2020.*

[1] *Quality Compass benchmarks were not available; therefore, the Audit Means and Percentiles were used for comparative purposes.*

IL 2020 MCO Report Card—Overall Rating Results

In order to potentially utilize the Consumer Report Card results in the auto-assignment algorithm, Health Services Advisory Group, Inc. (HSAG), calculated an Overall Rating using the 2020 (Calendar Year [CY] 2019) Report Card results for five Health Choice Illinois managed care organizations (MCOs). The Overall Rating analyzes all Healthcare Effectiveness Data and Information Set (HEDIS®)[1] and adult and child Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[2] measures and their associated weights to determine one overall rating for each MCO. Please refer to the *IL_2020 (CY 2019) Combined Report Card Methodology_F1* for more information on the measures and measure weights included in the Overall Rating. Due to changes in the *HEDIS 2020 Technical Specifications for Health Plans, Volume 2*, the National Committee for Quality Assurance (NCQA) recommended a break in trending for *Prenatal and Postpartum Care*; therefore, this measure was not compared to the 2019 Quality Compass® national Medicaid benchmarks and was not included in the 2020 Overall Ratings.[3] The Overall Rating uses stars to display results for each plan compared to the 2019 Quality Compass national Medicaid benchmarks, as shown in Table 1. Table 2, on the following page, displays the overall star ratings for each MCO.

Table 1—2020 (CY 2019) Report Card—Performance Ratings

Rating	Plan Performance Compared to 2019 Quality Compass National Medicaid Benchmarks	
★★★★★	**Highest Performance**	The plan's average rating for measures within the Report Card was at or above the 90th percentile.
★★★★	**High Performance**	The plan's average rating for measures within the Report Card was at or between the 75th and 89th percentiles.
★★★	**Neutral Performance**	The plan's average rating for measures within the Report Card was at or between the 50th and 74th percentiles.
★★	**Low Performance**	The plan's average rating for measures within the Report Card was at or between the 25th and 49th percentiles.
★	**Lowest Performance**	The plan's average rating for measures within the Report Card was at or below the 25th percentile.

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[3] Quality Compass® is a registered trademark of NCQA.

Table 2—2020 (CY 2019) Overall Ratings by MCO

MCO	Overall Rating
Aetna Better Health*	★★★ 2.56
Blue Cross Community Health Plans	★★★ 2.80
CountyCare Health Plan	★★★ 3.16
MeridianHealth	★★★ 2.94
Molina Healthcare	★★★ 2.98

*Formerly known as IlliniCare Health.

The top performing MCO was CountyCare Health Plan followed by Molina Healthcare, MeridianHealth, Blue Cross Community Health Plans, and Aetna Better Health.