Illinois Health and Hospital Association

June 14, 2017

Felicia Norwood
Director
Department of Healthcare and Family Services
201 South Grand Avenue East
Springfield, IL 62763

Dear Director Norwood:

We appreciate the ongoing dialogue between the Department of Healthcare and Family Services (HFS) and the Illinois Health and Hospital Association (IHA) regarding Illinois' Medicaid managed care program, and recognize HFS' recent efforts to implement practical solutions to address the concerns of our member hospitals and health systems. We look forward to further discussions regarding the proposed centralization of the provider credentialing process and the use of data collected through the recently launched HFS Provider Complaint Portal. We believe these efforts reflect a desire on the part of HFS to strengthen its oversight of the Medicaid Managed Care Organizations (MCOs) and to begin identifying specific MCO performance trends.

As HFS prepares to award new MCO contracts that will facilitate a statewide expansion of Medicaid managed care, IHA would like to take the opportunity to share suggestions for strengthening the MCO Model Contract, which will be utilized in contracting with the selected MCOs.

Attached is a summary document outlining a series of recommendations for possible incorporation into the MCO Model Contract. We believe that these changes will eliminate or substantially reduce the day-to-day challenges experienced by our members and allow for greater standardization across MCOs, creating efficiencies both for providers and HFS. While the Model Contract does not eliminate the need for providers to negotiate specific contract terms directly with the MCOs, it lays the foundation for MCO understanding of and compliance with HFS' overall expectations.

IHA's recommendations include the following operational and technical considerations, auditable performance standards, and financial penalties for noncompliance with contract requirements:

- Clearly defined care coordination requirements.

222 S. Riverside Plaza
Suite 1900
Chicago, IL 60606
312.906.6000

1151 East Warrenville Rd.
P.O. Box 3015
Naperville, IL 60566
630.276.5400

700 South 2nd St.
Springfield, IL 62704
217.541.1150

400 North Capitol St. N.W.
Suite #585
Washington, DC 20001
202.624.7899

www.team-iha.org

- Provider resources and supports, including online provider portals and trained provider services staff.
- Liaisons dedicated to timely resolution of provider issues, with a clear escalation process for unresolved concerns.
- Standardization of routinely accessed forms and common requirements (e.g., compliance training, data/roster collection, prior authorization forms, etc.).
- Defined timeframes for notifying providers of policy changes, responding to requests for contracts, and loading provider information.
- Adherence to HFS' payment methodologies and billing requirements for fee-for-service claims.
- Use of standard electronic transactions, as well as Electronic Funds Transfer (EFT) capabilities.

We support the enhanced sanctioning authority given to HFS in this version of the MCO Model Contract, and have recommended the inclusion of additional sanctions that address some of the performance areas listed above.

Additionally, IHA has begun work with a consulting firm and several IHA members to assess Medicaid MCO data regarding scope of claims denials and rejections, and we anticipate sharing some additional suggestions to HFS based upon those findings.

IHA appreciates HFS' continued efforts to strengthen its oversight of Medicaid MCO performance, and our members continue to be committed to the success of a managed care model that delivers timely, high quality health care. We look forward to continued dialogue and collaboration.

Sincerely,

A.J. Wilhelmi
President & CEO
Illinois Health and Hospital Association

CC: Patrick Gallagher, Sr. Vice President, Health Policy and Finance, IHA
Teresa Hursey, Acting Administrator, Division of Medical Programs, HFS
Robert Mendonsa, Deputy Administrator, Care Coordination, HFS

Illinois Health and Hospital Association

2018 Medicaid MCO Model Contract Recommendations

Section	Model Contract	Suggested Revisions
ARTICLE II	**TERMS AND CONDITIONS**	
2.3	**LIST OF INDIVIDUALS IN AN ADMINISTRATIVE CAPACITY**	**LIST OF INDIVIDUALS IN AN ADMINISTRATIVE CAPACITY**
2.3.1.8	2.3.1.8 **Provider Service Director.** The Provider Service Director shall be a full-time position that coordinates communications between Contractor and its Network Providers and other Subcontractors.	2.3.1.8 **Provider Service Director.** The Provider Service Director shall be a full-time position that coordinates communications between Contractor and its Network Providers and other Subcontractors. This position shall ensure that Contractor maintains sufficient and adequately trained Provider service staff to enable Providers to receive prompt resolution of their problems or inquiries.
2.3.1.9	2.3.1.9 **Management Information System Director.** The MIS Director shall be a full-time position that oversees and maintains Contractor's data management system such that is capable of valid data collection and processing, timely and accurate reporting, and correct claims payment. This individual shall be trained and experienced in information systems, data processing, and data reporting to the extent required to oversee all information system aspects identified in this Contract.	2.3.1.9 **Management Information System Director.** The MIS Director shall be a full-time position that oversees and maintains Contractor's data management system such that is capable of valid data collection and processing, timely and accurate reporting, and correct claims payment. This individual shall be trained and experienced in information systems, data processing, data reporting, and the Department's unique claims processing requirements to the extent required to oversee all information system aspects identified in this Contract.
2.3.2 2.3.2.9 - NEW	2.3.2 **Designated liaisons.** Contractor shall designate the following liaisons, who may also serve in a key position outlined in section 2.3.1. No individual shall serve as more than two (2) designated liaison roles. Designated liaisons will include:	2.3.2 **Designated liaisons.** Contractor shall designate the following liaisons, who may also serve in a key position outlined in section 2.3.1. No individual shall serve as more than two (2) designated liaison roles. Designated liaisons will include: 2.3.2.9 A liaison who will interact with designated staff at the Department's Hospital Billing Unit and Non-Institutional Provider Billing Unit to ensure adherence to and understanding of the Department's unique billing

Section	Model Contract	Suggested Revisions
		requirements and to cooperate on other applicable billing issues. Contractor shall notify designated Department staff no later than three (3) business days prior to the assigned liaison no longer serving in that capacity. Contractor shall also notify designated Department staff within seven (7) business days of transition plans, including the designation of replacement liaison.
2.7	**CULTURAL COMPETENCE**	**CULTURAL COMPETENCE**
2.7.4	2.7.4 **Providers.** Contractor shall contract with a culturally-diverse network of Providers of both genders and prioritize recruitment of bilingual or multilingual Providers. Contractor's contracts with providers shall require that Provider comply with Contractor's Cultural Competence plan. During the credentialing and re-credentialing process, Contractor will confirm the languages used by the Providers, including American Sign Language, and ensure physical access to Providers' office locations.	2.7.4 **Providers.** Contractor shall contract with a culturally-diverse network of Providers of both genders and prioritize recruitment of bilingual or multilingual Providers. Contractor's contracts with providers shall require that Provider comply with Contractor's Cultural Competence plan. During the credentialing and re-credentialing process, Contractor will confirm the languages used by the Providers, including American Sign Language, and ensure physical access to Providers' office locations. The Department shall require Contractor to utilize a uniform data collection form for collection of such information.
2.7.6	2.7.6 **Provider Monitoring.** Contractor shall perform QA evaluations of Provider practices, which shall include monitoring of enrollee accessibility to ensure linguistic and physical accessibility. Contractor shall support Providers in achieving accessibility.	2.7.6 **Provider Monitoring.** Contractor shall perform QA evaluations of Provider practices, which shall include monitoring of enrollee accessibility to ensure linguistic and physical accessibility. Contractor shall support Providers in achieving accessibility. Contractor shall provide at least 90 days prior written notice of its intent to conduct evaluations under this section.
2.7.8 - NEW		2.7.8 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. Contractor also agrees, upon submission and review, to allow Provider practices to substitute Provider practice-

Section	Model Contract	Suggested Revisions
		developed cultural competency programs and evidence of completion or other reasonable requests that ensure providers will be in compliance, in lieu of Contractor's program. Contractor agrees to review such requests and provide a response no later than thirty (30) days after such request is made. The Department reserves the right to define "provider staff" relative to requirements for cultural competency training and Contractor shall be required to comply with the Department's definition.
ARTICLE IV	**ENROLLMENT, COVERAGE, AND TERMINATION OF COVERAGE**	
4.6	**ENROLLMENT OF NEWBORNS**	**ENROLLMENT OF NEWBORNS**
4.6 4.6.3 – NEW	4.6 Newborns and infants who are added to the Case of an adult Enrollee who is the Head of Case and enrolled with Contractor are enrolled as follows:	4.6 Newborns and infants who are added to the Case of an adult Enrollee who is the Head of Case and enrolled with Contractor are enrolled as follows: 4.6.3 Contractor shall permit inpatient hospital claims for newborns to be billed under the baby's name and mother's recipient identification number (RIN) or the mother's Contractor-assigned enrollee ID number. Contractor shall not require prior authorization for inpatient newborn claims.
4.8	**UPDATE OF ENROLLMENT INFORMATION**	**UPDATE OF ENROLLMENT INFORMATION**
4.8	4.8 Within five (5) Business Days after receipt of the 834 Audit File, Contractor shall update all electronic systems maintained by Contractor to reflect the information contained in the 834 Audit File received from the Department. Contractor shall use the 834 Audit File to verify Contractor's Enrollees for the subsequent calendar month. Contractor shall not wait for the 820 Payment File to update eligibility.	4.8 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. Contractor shall distribute enrollment information to applicable subcontractors (e.g., pharmacy, vision, behavioral health, DME) and clearinghouses within five (5)

Section	Model Contract	Suggested Revisions
		Business Days after receipt of the 834 Audit File.
4.16	**IDENTIFICATION CARD**	**IDENTIFICATION CARD**
4.16.1 4.16.1.5 - NEW	4.16.1 Contractor shall send each new Enrollee an identification card bearing: 4.16.1.1 the name of Contractor; 4.16.1.2 the Effective Enrollment Date; 4.16.1.3 the twenty-four (24)–hour telephone number to confirm eligibility for benefits and authorization for services; and 4.16.1.4 the name and phone number of the Enrollee's PCP.	4.16.1 Contractor shall send each new Enrollee an identification card bearing: 4.16.1.1 the name of Contractor; 4.16.1.2 the Effective Enrollment Date; 4.16.1.3 the twenty-four (24)–hour telephone number to confirm eligibility for benefits and authorization for services; 4.16.1.4 the name and phone number of the Enrollee's PCP; and 4.16.1.5 the Enrollee's RIN or Contractor-assigned enrollee ID number.
ARTICLE V	**DUTIES OF CONTRACTOR**	
5.7	**PROVIDER NETWORK**	**PROVIDER NETWORK**
5.7.2	5.7.2 **Provider Contracts.** Contractor shall ensure all Network Provider Contracts are tailored to the requirements of this contract. Contractor shall be responsive to Network Providers with respect to contract negotiation	5.7.2 **Provider Contracts.** Contractor shall ensure all Network Provider Contracts are tailored to the requirements of this contract. Contractor shall be responsive to Network Providers with respect to contract negotiation. Contractor shall respond to initial inquiries from Network Providers within three (3) business days of the initial request. The above provisions shall also apply to Subcontracted Vendors of the Contractor. Contractor and Subcontractor shall make available at the time of initial contract discussion any and all applicable documents, including but not limited to contracts, attachments or other addendums, provider directories, or any policy and procedure manuals referenced in contracting documents. Such material shall be made available prior to execution of any agreements.
5.7.6	5.7.6 **Non-Network Providers.** It is understood that in some instances, Enrollees will require specialty care not available from a Network Provider and that Contractor will arrange	5.7.6 **Non-Network Providers.** It is understood that in some instances, Enrollees will require specialty care not available from a Network Provider and that Contractor will arrange

Section	Model Contract	Suggested Revisions
	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.	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. Contractor shall pay for authorized covered services rendered by a non-network provider at no less than the same rate the Department would pay for such services under the Illinois Medicaid fee-for-service program methodology, including all policy adjusters, including but not limited to Medicaid High Volume Adjustments, Medicaid Percentage Adjustments, Outpatient High Volume Adjustments, Psychiatric and Safety Net Hospital Add-ons and all outlier add-on adjustments to the extent such adjustments are incorporated in the development of the applicable MCO capitated rates, unless a different rate was agreed upon by Contractor and the non-network provider.
5.7.7	5.7.7 **Provider Reimbursement.** The Department may define an alternative payment methodology to which Contractor must adhere to when reimbursing Providers for provided services.	5.7.7 **Provider Reimbursement.** The Department may define an alternative payment methodology to which Contractor must adhere to when reimbursing Providers for provided services. For inpatient and outpatient hospital services, Contractor must (i) adhere to the payment methodology the Department applies to Medicaid fee-for-service claims; and (ii) implement any applicable updates to these payment methodologies within 30 days of implementation by the Department.
5.8	**ACCESS TO CARE STANDARDS**	**ACCESS TO CARE STANDARDS**
5.8.1.3 – NEW		5.8.1.3 The Department shall require that Contractor supply the following: • A comprehensive plan that outlines the Contractor's

Section	Model Contract	Suggested Revisions
		method for determination of an adequate network; • Publicly available documentation outlining adherence to network adequacy standards; and • Documentation or other verification that network providers reported as accepting new patients and specialists reported as accepting referrals are accurate.
5.9	**PROVIDER CREDENTIALING AND RECREDENTIALING**	**PROVIDER CREDENTIALING AND RECREDENTIALING**
5.9.7 – NEW		5.9.7 The Department shall require Contractor to utilize a common data collection form.
5.10	**PROVIDER EDUCATION**	**PROVIDER SERVICES AND EDUCATION**
5.10.1	5.10.1 **Provider Orientation.** Contractor shall conduct orientation sessions for Network Providers and their office staff.	5.10.1 **Provider Orientation.** Contractor shall conduct orientation sessions for Network Providers and their office staff. Contractor shall make best efforts to give no less than ninety (90) days of advance notice of provider orientation sessions. The Department shall require the development of a common schedule of orientation schedules by the Contractor. The Department shall require Contractor to demonstrate an adequate staff to network provider ratio to ensure timely servicing and issue resolution for network providers.
5.10.3	5.10.3 **Cultural Competency.** Contractor will provide Cultural Competence requirements at orientation, training sessions and updates as needed.	5.10.3 **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.

Section	Model Contract	Suggested Revisions
		Contractor also agrees, upon submission and review, to allow Provider practices to substitute Provider practice-developed cultural competency programs and evidence of completion or other reasonable requests that ensure providers will be in compliance, in lieu of Contractor's program. Contractor agrees to review such requests and provide response no later than thirty (30) days after such request is made. The Department reserves the right to define "provider staff" relative to requirements for cultural competency training and Contractor shall be required to comply with the Department's definition.
5.10.4	5.10.4 **Provider manual.** The Provider manual shall be a comprehensive online reference tool for Providers and staff regarding administrative, prior authorization, and Referral processes; claims and Encounter submission processes; and plan benefits. The Provider manual shall also address topics such as clinical practice guidelines, availability and access standards, Care Management programs, and Enrollee rights.	5.10.4 **Provider manual.** The Provider manual shall be a comprehensive online reference tool for Providers and staff regarding administrative, eligibility verification, prior authorization, and Referral processes; claims and Encounter submission processes; provider claim dispute and authorization dispute processes; member grievance/appeal process; and plan benefits. The Provider manual shall also address topics such as clinical practice guidelines, availability and access standards, Care Management and Utilization Review programs, and Enrollee rights. The provider manual shall be available to both in-network and out-of-network providers on the Contractor's Website. The Department reserves the right to define minimum content requirements and a standard format for the Provider manual. In-network providers must be notified, in writing, of any change to the Provider manual at least 15 business day days prior to the effective date of the revision.
5.10.5	5.10.5 **Provider Portal.** After six (6) months' notice, in writing, from the Department, the Contractor shall establish and maintain a secure Provider Web Portal which shall	5.10.5 **Provider Portal.** Prior to the Effective Date, the Contractor shall establish and maintain a secure Provider Web Portal which shall include population health, quality,

Section	Model Contract	Suggested Revisions
	include population health, quality, utilization and claims information for PCP Enrollee populations. Department retains the right to define minimum content requirements for the Provider portal.	utilization, eligibility verification, prior authorization and claims information. The provider portal shall be available to Network and non-Network providers. Department retains the right to define minimum content requirements for the Provider portal.
5.10.6 5.10.6.5	5.10.6 **Provider Directory**. Contractor shall meet all Provider directory requirements under 305 ILCS 5/5-30.3 and 42 CFR §438.10, including: 5.10.6.5 Provider Directory information in paper form must be updated at least monthly and in electronic Provider Directories must be updated no later than thirty (30) days after Contractor receives updated Provider Information.	5.10.6 **Provider Directory**. Contractor shall meet all Provider directory requirements under 305 ILCS 5/5-30.3 and 42 CFR §438.10, including: 5.10.6.5 Provider Directory information in paper form must be updated at least monthly and in electronic Provider Directories must be updated no later than thirty (30) days after Contractor receives updated Provider Information. The Department shall require or conduct random audits to ensure compliance with this provision. Failure to meet the thirty (30) day standard may result in financial or other administrative sanctions at the discretion of the Department.
5.10.10 - NEW		5.10.10 **Provider Communication.** Contractor must maintain a regular means of communicating and providing information on changes in policies and procedures to Providers. The Department shall require that Contractor provide no less than ninety (90) days written notice to providers of proposed policy changes prior to implementation by Contractor. Contractor must notify providers of any changes to prior authorization policies no less than ninety (90) days prior to the date of implementation. Contractor shall ensure that Contractor staff, employees, agents, subcontractors and others acting on its behalf have received all required training and education in order to

Section	Model Contract	Suggested Revisions
		effectively service network providers. Department may establish a process for network providers to evaluate the performance of contractor staff.
5.10.11 – NEW		5.10.11 **Provider Services.** Contractor shall maintain sufficient and adequately trained Provider service staff to enable Network and non-Network Providers to receive prompt resolution of their problems or inquiries. Contractor shall not limit the number of inquiries providers may make per call per day to the provider services telephone line.
5.12	**CARE MANAGEMENT**	**CARE MANAGEMENT**
5.12.2.4	5.12.2.4 Contractor shall implement procedures to coordinate services provided between settings of care, including discharge planning for hospital and institutional stays.	5.12.2.4 Contractor shall implement procedures to coordinate services provided between settings of care, including timely discharge planning for hospital and institutional stays. Contractor shall also provide case management assistance to hospitals in securing timely transfer of patients from out-of-network hospitals to contracted facilities.
5.19	**CONTINUITY OF CARE**	**CONTINUITY OF CARE**
5.19.1.1	5.19.1.1 Contractor must offer an initial ninety (90)–day transition period for Enrollees new to the Health Plan, in which Enrollees may maintain a current course of treatment with a Provider who is currently not a part of Contractor's Provider Network. Contractor must offer a ninety (90)–day transition period for Enrollees switching from another Health Plan to Contractor. The ninety (90)–day transition period is applicable to all Providers, including behavioral-health Providers and Providers of LTSS. Non-Network Providers and specialists providing an ongoing course of treatment will be offered single case agreements to continue to care for that Enrollee beyond the transition period if the Enrollee remains outside the network or until a qualified Network Provider is available.	5.19.1.1 Contractor must offer an initial ninety (90)–day transition period for Enrollees new to the Health Plan, in which Enrollees may maintain a current course of treatment with a Provider who is currently not a part of Contractor's Provider Network. Contractor must offer a ninety (90)–day transition period for Enrollees switching from another Health Plan to Contractor. The ninety (90)–day transition period is applicable to all Providers, including behavioral-health Providers and Providers of LTSS. Contractor shall pay for covered services rendered by a non-Network Provider during the ninety (90)-day transition period at the same rate the Department would pay for such services under the Illinois Medicaid fee-for-service program methodology, including all policy adjusters, including but not limited to Medicaid High Volume Adjustments, Medicaid Percentage Adjustments,

Section	Model Contract	Suggested Revisions
		Outpatient High Volume Adjustments, Psychiatric and Safety Net Hospital Add-ons and all outlier add-on adjustments to the extent such adjustments are incorporated in the development of the applicable MCO capitated rates, unless a different rate was agreed upon by Contractor and the non-network provider. Non-Network Providers and specialists providing an ongoing course of treatment will be offered single case agreements to continue to care for that Enrollee beyond the transition period if the Enrollee remains outside the network or until a qualified Network Provider is available.
5.27	**HEALTH INFORMATION SYSTEMS**	**HEALTH INFORMATION SYSTEMS**
5.27.2 5.27.2.4 – NEW 5.27.2.5 - NEW	5.27.2 Contractor shall, at a minimum, comply with the following:	5.27.2 Contractor shall, at a minimum, comply with the following: 5.27.2.4 meet the ASC X12 5010 electronic transaction standards, including eligibility (270/271), claim status (276/277), referrals/authorizations (278), claims (837), and remittances (835). 5.27.5 use standard ASC X12 claim codes.
5.29	**PAYMENTS TO PROVIDERS**	**PAYMENTS TO PROVIDERS**
5.29	5.29 Contractor shall make payments to Providers (including the fiscal agent making payments to Personal Assistants under the HCBS Waivers; see Attachment XX) for Covered Services on a timely basis consistent with the claims payment procedure described at 42 U.S.C. § 1396a(a)(37)(A) and 215 ILCS 5/368a. Complaints or disputes concerning payments for the provision of services as described in this section 5.29 shall be subject to Contractor's Provider Grievance-resolution system. Contractor must pay ninety percent (90%) of all clean claims from Providers for Covered Services within thirty (30) days following receipt. Contractor	5.29 Contractor shall make payments to Providers (including the fiscal agent making payments to Personal Assistants under the HCBS Waivers; see Attachment XX) for Covered Services on a timely basis consistent with the claims payment procedure described at 42 U.S.C. § 1396a(a)(37)(A) and 215 ILCS 5/368a. Complaints or disputes concerning payments for the provision of services as described in this section 5.29 shall be subject to Contractor's Provider complaint resolution system pursuant to section 5.29.6 Contractor must pay ninety percent (90%) of all clean claims from Providers for Covered Services within thirty (30) days

Section	Model Contract	Suggested Revisions
	must pay ninety-nine percent (99%) of all clean claims from Providers for Covered Services within ninety (90) days following receipt. For purposes of this section 5.29, a "clean claim" means a claim from a Provider for Covered Services that can be processed without obtaining additional information from the Provider of the service or from a Third Party, except that it shall not mean a claim submitted by or on behalf of a Provider who is under investigation for Fraud or Abuse, or a claim that is under review for determining whether it was Medically Necessary. For purposes of an Enrollee's admission to a NF, a "clean claim" means that the admission is reflected on the patient credit file that Contractor receives from the Department. Contractor will not be considered to be in breach of this section 5.29, and the Department will not impose a monetary sanction pursuant to section 7.16.17 for Contractor's failure to meet the requirements of this section 5.29 if such purported breach or failure occurs at a time when the Department has not paid any of the required Capitation to Contractor for four (4) consecutive months.	following receipt. Contractor must pay ninety-nine percent (99%) of all clean claims from Providers for Covered Services within ninety (90) days following receipt. For purposes of this section 5.29, a "clean claim" means a claim from a Provider for Covered Services that can be processed without obtaining additional information from the Provider of the service or from a Third Party, except that it shall not mean a claim submitted by or on behalf of a Provider who is under investigation for Fraud or Abuse, or a claim that is under review for determining whether it was Medically Necessary. For purposes of an Enrollee's admission to a NF, a "clean claim" means that the admission is reflected on the patient credit file that Contractor receives from the Department. Contractor will not be considered to be in breach of this section 5.29, and the Department will not impose a monetary sanction pursuant to section 7.16.17 for Contractor's failure to meet the requirements of this section 5.29 if such purported breach or failure occurs at a time when the Department has not paid any of the required Capitation to Contractor for four (4) consecutive months. Contractor shall notify Providers at least 30 days in advance of failing to meet the requirements of this section 5.29 if the required Capitation to Contractor has not been paid for four (4) consecutive months.
5.29.1	5.29.1 Contractor shall pay for all appropriate Emergency Services rendered by a non-Network Provider within thirty (30) days after receipt of a clean claim. If Contractor determines it does not have sufficient information to make payment, Contractor shall request all necessary information from the non- Network Provider within thirty (30) days of receiving the claim, and shall pay the non-Network Provider within thirty (30) days after receiving such information. Determination of appropriate levels of service for payment	5.29.1 Contractor shall pay for all appropriate Emergency Services rendered by a non-Network Provider within thirty (30) days after receipt of a clean claim. If Contractor determines it does not have sufficient information to make payment, Contractor shall request all necessary information from the non- Network Provider within thirty (30) days of receiving the claim, and shall pay the non-Network Provider within thirty (30) days after receiving such information. Payment shall be made at the same rate the Department

Section	Model Contract	Suggested Revisions
	shall be based upon the symptoms and condition of the Enrollee at the time the Enrollee is initially examined by the non-Network Provider and not upon the final determination of the Enrollee's actual medical condition, unless the actual medical condition is more severe. Within the time limitation stated above, Contractor may review the need for, and the intensity of, the services provided by non-Network Providers.	would pay for such services according to the level of services provided. Determination of appropriate levels of service for payment shall be based upon the symptoms and condition of the Enrollee at the time the Enrollee is initially examined by the non-Network Provider and not upon the final determination of the Enrollee's actual medical condition, unless the actual medical condition is more severe. Within the time limitation stated above, Contractor may review the need for, and the intensity of, the services provided by non-Network Providers.
5.29.4 5.29.4.1 – NEW 5.29.4.2 – NEW 5.29.4.3 – NEW	5.29.4 Contractor shall accept claims from non-Network Providers for at least six (6) months after the date the services are provided. Contractor shall not be required to pay for claims initially submitted by such non-Network Providers more than six (6) months after the date of service.	5.29.4 Contractor shall accept claims from Network and non-Network Providers for at least six (6) months after the date the services are provided. For hospital inpatient claims, this six (6) month period begins on the date of discharge. Contractor shall not be required to pay for claims initially submitted by such Network and non-Network Providers more than six (6) months after the date of service. Contractor shall comply with the following exceptions: 5.29.4.1 For Providers whose enrollment is in process by the Department, the 180 day period shall not begin until the "As-Of Date" on the Department's Provider Information Sheet. This date identifies when the provider enrollment was completed. 5.29.4.2 Claims for services rendered during a period for which a recipient's enrollment information was incorrect in the Department or Contractor's electronic enrollment verification system. Claims must be filed in accordance with the timely filing provisions outlined in 89 Ill. Adm. Code 104.74. 5.29.4.3 For errors attributable to the Contractor or any of

Section	Model Contract	Suggested Revisions
		its claims processing intermediaries which result in an inability to receive, process, or adjudicate a claim, the six (6) month period shall not begin until the error has been fixed and the provider has been notified of the resolution.
5.29.6	5.29.6 Contractor shall establish a complaint and resolution system for Providers that includes a Provider dispute process. Contractor shall provide a substantive response intended to resolve a complaint received through the Department's Provider complaint portal on the Department's website within two (2) Business Days if the complaint is categorized as urgent and within fifteen (15) Business Days if it is not categorized as urgent.	5.29.6 Contractor shall establish a complaint resolution system for Network and non-Network Providers, including (i) a claim dispute process that allows Providers to contest a payment decision after a claim has been adjudicated; and (ii) 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 of receipt of the dispute request. An authorized representative form shall not be required to submit a claim dispute or a service authorization dispute. Contractor shall provide a substantive response intended to resolve a complaint received through the Department's Provider complaint portal on the Department's website within two (2) Business Days if the complaint is categorized as urgent and within fifteen (15) Business Days if it is not categorized as urgent.
5.29.8 – NEW		5.29.8 Contractor shall pay for authorized covered services rendered by a non-network provider at no less than the same rate the Department would pay for such services under the Illinois Medicaid fee-for-service program methodology, including all policy adjusters, including but not limited to Medicaid High Volume Adjustments, Medicaid Percentage Adjustments, Outpatient High Volume Adjustments, Psychiatric and Safety Net Hospital Add-ons and all outlier add-on adjustments to the extent such adjustments are incorporated in the development of the applicable MCO capitated rates, unless a different rate was agreed upon by Contractor and the non-network provider. Covered services

Section	Model Contract	Suggested Revisions
		are considered authorized if the Contractor does not respond to a request for authorization pursuant to section 5.19.7.
5.29.9 – NEW		5.29.9 Contractor must ensure providers bill the Contractor using the same format and coding instructions required for the Medicaid fee-for-service program according to the policies and procedures outlined in the Department's provider handbooks, provider notices, and other applicable billing instructions. Contractor must not require providers to complete additional fields on the electronic forms not specified in Medicaid FFS Policy. Contractor must implement new or revised billing requirements within 30 days of the applicable manual update, provider notice, or other Department instruction. Contractor must maintain and post to its website a list of known system issues preventing claims from being adjudicated correctly and the expected resolution date. Contractor shall give Providers advance notice of large claim projects requiring adjustments, recoupments, or reprocessing.
5.29.10 - NEW		5.29.10 Contractor shall offer Network providers the ability to enroll in Electronic Funds Transfer (EFT).
5.30	**GRIEVANCE AND APPEAL SYSTEM**	**ENROLLEE GRIEVANCE AND APPEAL SYSTEM**
5.30.1.6	5.30.1.6 An Enrollee may appoint any individual, including a guardian, caretaker relative, or Provider, to represent the Enrollee throughout the Grievance process as an authorized representative. Contractor shall provide a form and instructions on how an Enrollee may appoint an authorized representative.	5.30.1.6 An Enrollee may appoint any individual, including a guardian, caretaker relative, or Provider, to represent the Enrollee throughout the Grievance process as an authorized representative. Contractor shall provide a form and instructions on how an Enrollee may appoint an authorized representative. The Department shall require Contractor to use a standard authorized representative form.
5.30.3.2	5.30.3.2 An Enrollee may appoint any authorized representative, including a guardian, caretaker relative, or Provider, to represent the Enrollee throughout the Appeal process. Contractor shall provide a form and instructions on	5.30.3.2 An Enrollee may appoint any authorized representative, including a guardian, caretaker relative, or Provider, to represent the Enrollee throughout the Appeal process. Contractor shall provide a form and instructions on

Section	Model Contract	Suggested Revisions
	how an Enrollee may appoint a representative.	how an Enrollee may appoint a representative. The Department shall require Contractor to use a standard authorized representative form.
5.41 - NEW		**MANDATED TRAININGS**
5.41 –NEW		The Department shall establish a common set of mandated trainings per CMS requirements (e.g., cultural competency; fraud, waste and abuse, etc.). Contractor shall not require additional provider training requirements beyond what the Department requires for fee-for-service programs.
ARTICLE VI	**DUTIES OF THE DEPARTMENT**	
6.5 – NEW		**AUDITS OF MCO PERFORMANCE**
6.5 - NEW		6.5 The Department shall conduct periodic, but no less than semi-annual, standard audits of Contractor performance. Audits will involve examining a sample of claims submitted to Contractor to determine, at a minimum, the following: • Timeliness of payment • Accuracy of payments • Rate of claim denials • Timeliness of responses to grievances and appeals • Timeliness of responses to claim disputes • Timeliness of prior authorization requests • Rate and overall number of claims settlements entered into with providers after January 1, 2018. • Dollar value of all claims settlements entered into with providers after January 1, 2018.
6.6 – NEW		**OPERATIONAL UNIFORMITY**
6.6.1 – NEW		6.6.1 The Department shall require Contractors to agree to uniformity in operational practices including but not limited to the following areas: • Standard credentialing and loading of provider information; • Prior authorizations;

Section	Model Contract	Suggested Revisions
		• Provider manuals; • Consistent timeframes for provider notification of policy changes
6.6.2 – NEW		6.6.2 The Department shall require increased uniformity in Contractors' prior authorization processes that may include, but are not limited to: • Common prior authorization form; • Industry standard medical review criteria; • Medical record requests; • Timely access to real-time peer-to-peer reviews; • Consistent method for submission of prior authorization requests; • Acknowledgement of receipt of request to avoid duplicate requests; and • Communication to providers regarding Contractor decisions.
6.7 –NEW		**NETWORK ADEQUACY**
6.7 – NEW		6.7 The Department shall provide ongoing oversight of Contractors' reported network adequacy. Failure to demonstrate compliance with reported network adequacy may result in financial penalties applied against Contractor.
ARTICLE VII	**PAYMENT AND FUNDING**	
7.1	**CAPITATION PAYMENT**	**CAPITATION PAYMENT**
7.1.3 – NEW		7.1.3 The Department shall withhold 2 percent of capitation payments, which will be paid to Contractor only after successfully meeting the Department's established thresholds for the following: • Timeliness of payments • Accuracy of payments • Rate of claim denials • Timeliness of responses to grievance and appeals process

Section	Model Contract	Suggested Revisions
		• Timeliness of responses to claim disputes • Timeliness of prior authorization requests
7.1.4 – NEW		7.1.4 The Department shall establish individual MCO reserve funds in order to reimburse providers regardless of state budget backlogs.
7.16	**SANCTIONS**	**SANCTIONS**
7.16.18 – NEW 7.16.18.1 – NEW 7.16.18.2- NEW 7.16.18.3 – NEW 7.16.18.4 – NEW		7.16.18 **Failure to Meet Other Standards.** If the Department determines that Contractor is out of compliance with the performance thresholds listed in 7.1.3, resulting from audits conducted under provisions cited in 6.5, the Department shall impose performance penalties or sanctions, including but not limited to the following: 7.16.18.1 Financial penalties; 7.16.18.2 Enrollment suspension on Contractor 7.16.18.3 Both 7.16.18.4 Other penalties as determined by the Department
7.22 – NEW		**OTHER RECOVERIES FROM PROVIDERS**
7.22 – NEW 7.22.1 – NEW 7.22.2 – NEW 7.22.3 – NEW		7.22 If the Contractor is required to recover overpayments made to a Provider in error, the Department shall ensure that Contractor has a uniform process for recoveries, including but not limited to the following: 7.22.1 Contractor must provide prior written notification of error to Provider, to be no less than sixty (60) business days; 7.22.2 Contractor must supply documentation substantiating reason for overpayment request, including, but not limited to, member name, date of service, and amount of overpayment; 7.22.3 Contractor must allow Provider a timeframe for reviewing and responding to the Contractor's request for

Section	Model Contract	Suggested Revisions
7.22.4 – NEW 7.22.5 – NEW		overpayment, to be no less than thirty (30) business days and no more than sixty (60) business days. 7.22.4 Contractor, upon mutual agreement with Provider, or in the event Provider does not respond to overpayment requests, Contractor may be authorized to recover monies from Provider. 7.22.5 Contractor may not, except in cases of fraud, recover monies from Providers after a six (6) month time frame.
ARTICLE VIII	**TERM, RENEWAL, AND TERMINATION**	
8.3	**CONTINUING DUTIES IN THE EVENT OF TERMINATION**	**CONTINUING DUTIES IN THE EVENT OF TERMINATION**
8.3	8.3 Upon termination of this Contract, the Parties are obligated to perform those duties that survive under this Contract. Such duties include payment to Network or non-Network Providers; completion of Enrollee satisfaction surveys; cooperation with medical records review; all reports for periods of operation, including Encounter Data; retention of records; and preservation of confidentiality and security of PHI. Termination of this Contract does not eliminate Contractor's responsibility to the Department for overpayments which the Department determines in a subsequent audit may have been made to Contractor, nor does it eliminate any responsibility the Department may have for underpayments to Contractor. Contractor warrants that if this Contract is terminated, Contractor shall promptly supply all information in its possession or that may be reasonably obtained that is necessary for the orderly transition of Enrollees and completion of all Contract responsibilities.	8.3 Upon termination of this Contract, the Parties are obligated to perform those duties that survive under this Contract. Such duties include payment to Network or non-Network Providers, including resolution of aged unpaid claims; completion of Enrollee satisfaction surveys; cooperation with medical records review; all reports for periods of operation, including Encounter Data; retention of records; and preservation of confidentiality and security of PHI. Termination of this Contract does not eliminate Contractor's responsibility to the Department for overpayments which the Department determines in a subsequent audit may have been made to Contractor, nor does it eliminate any responsibility the Department may have for underpayments to Contractor. Contractor warrants that if this Contract is terminated, Contractor shall promptly supply all information in its possession or that may be reasonably obtained that is necessary for the orderly transition of Enrollees and completion of all Contract responsibilities. Contractor must, for a period of time specified by the Department, provide all reasonable transition assistance requested by the Department. The

Section	Model Contract	Suggested Revisions
		Department reserves the right to place sanctions on Contractor for non-compliance with this provision.
ATT XII	**UTILIZATION REVIEW/PEER REVIEW**	
2. c.iv.	Efforts shall be made to obtain all necessary information, including pertinent clinical information, and consultation with the treating Provider, as appropriate;	Reasonable efforts shall be made to obtain all necessary information, including pertinent clinical information, and to provide clear guidelines for peer-to-peer consultations with the treating Provider, as appropriate; Contractor shall specify to providers the specific documentation requirements needed for the utilization review/peer review process.
2.c.x. – NEW		Inpatient initial and concurrent review decisions shall be made within 24 hours of submission of the request/notification.
2.c.y – NEW		The Department shall require Contractor to use a standard prior authorization form.
2.c.z – NEW		Once services are pre-certified by the Contractor, no retroactive denials can be made unless the Contractor can show that incorrect or erroneous information was given to Contractor by the provider at the time of the precertification.
2.c.z.(1) – NEW		The Department shall require Contractor to use a standard list of pre-certification requirements for commonly authorized services.
2.c.z.(2) – NEW		The Department shall require Contractor to periodically review authorization rates/percentages for commonly requested procedures, and accordingly, may require the Contractor to remove from listings of services that require prior authorization.
2.c.z.(3) – NEW		Contractor shall be required to provide real time peer-to-peer review with providers.
ATT XIII	**REQUIRED DELIVERABLES, SUBMISSIONS AND REPORTING**	
	ADMINISTRATIVE	**ADMINISTRATIVE**
	Adjudicated Claims Inventory Summary – Contractor shall	Adjudicated Claims Inventory Summary – Contractor shall

Section	Model Contract	Suggested Revisions
	report the number of claims Contractor adjudicated by claim type, in-network and out-of-network break out, and the number of days the claims took to process.	report the number of claims Contractor adjudicated by claim type, in-network and out-of-network break out, and the number of days the claims took to process. In the event that a system issue prevents claims from being adjudicated correctly, the number of days the claims took to process should begin on the date the applicable claims first denied or rejected in error. Contractor shall also provide a report of aging of unpaid claims. Claim Denial Inventory Summary – Contractor shall report the number of claims Contractor denied, sorted by claim type, in-network and out-of-network breakout and the number of days the denials took to process. Contractor shall also report the number of claim denials overturned through an appeals process as well as the length of time to overturn denials.
		Rejected Claims Inventory Summary – Contractor shall report the number of claims Contractor rejected by claim type, in-network and out-pf-network breakout, and the number of days it took to correct rejections
		Provider Directory Updates – Contractor shall report the overall timeframe of directory updates from time of initial receipt to final date in which information is uploaded. Contractor shall report the overall accuracy of directory updates.
		Contractor shall report the percentage and overall number of claims settlements entered into with providers, along with the dollar value of those settlements, for all dates of service on or after January 1, 2018. Settlements in excess of 2 percent of total claims payments to a provider category shall result in suspension of auto assignment and require an audit of Contractor's claims payment timeliness and accuracy.

Section	Model Contract	Suggested Revisions
	QUALITY ASSURANCE/MEDICAL	**QUALITY ASSURANCE/ MEDICAL**
	Prior Authorization Report – Contractor shall submit turnaround times for routine, expedited and pharmacy prior authorizations for its Enrollees.	Prior Authorization Report – Contractor shall submit turnaround times for routine, expedited and pharmacy prior authorizations for its Enrollees. Contractor shall also report percentage of routine, expedited and pharmacy prior authorizations that are approved. Contractor shall also report percentage of routine, expedited and pharmacy prior authorizations that are denied, along with the timeframe to review and overturn or continue to deny.
	Provider Manual	Contractor shall submit a Provider manual 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 agree that notices of non-format changes will be conveyed to network providers with no less than ninety (90) days' notice and to the individual identified in the "Notice" provision of the provider agreement.
	Provider Loading	Contractor shall report the number of providers loaded, including sorting by 30, 60 and 90 day timeframes.