ILLINOIS REGULATORY REQUIREMENTS MANUAL

Meridian Health Plan of Illinois ("Plan") contracts with various network providers, hospitals, ancillary providers, specialists and other practitioners ("You" or "Provider"). To the extent that you are a Provider contracted with Plan, this Regulatory Requirements Manual (the "Manual") incorporates various sections required by law, regulation or a regulatory body into your agreement with Plan. The applicable sections of this Manual will control in the event of a conflict with your agreement. Meridian will update this Manual as there are changes to state and federal laws, regulations, guidance or in the case of Medicare or Medicaid (or other related program) requirements, as Meridian's agreements with Payors are revised. Nothing in this Manual or the Agreement releases you from any independent obligation to comply with applicable statutory or regulatory authority.

Without limiting the generality of the foregoing, and notwithstanding anything in the agreement to the contrary, Provider has agreed to comply with the applicable requirements based on the selected networks Provider has agreed to participate in with Plan:

Illinois Statutory/Regulatory Requirements

1. Hold Harmless. Provider agrees that in no event, including, but not limited to nonpayment by Plan of amounts due the Provider under this contract, insolvency of the organization or any breach of this contract by Plan, shall the Provider or its assignees or subcontractors have a right to seek any type of payment from, bill, charge, collect a deposit from, or have any recourse against, the Enrollee, persons acting on the Enrollee's behalf (other than Plan), the employer or group contract holder for services provided pursuant to this contract except for the payment of applicable co-payments or deductibles for services covered by Plan or fees for services not covered by Plan. The requirements of this clause shall survive any termination of the Agreement for services rendered prior to such termination, regardless of the cause of such termination. Plan's Enrollees, the persons acting on the Enrollee's behalf (other than the Plan) and the employer or group contract holder shall be third party beneficiaries of this clause. This clause supersedes any oral or written agreement now existing or hereafter entered into between the provider and the Enrollee, persons acting on the Enrollee's behalf (other than Plan) and the employer or group contract holder. [215 ILCS 125/2-8(a)/ 50 Ill. Admin. Code Section 5421.50]

2. Quality Assurance Program Participation. Provider shall participate in Plan's quality assurance programs mandate by law. [215 ILCS 125/2-8(b)/ Ill. Admin. Code 50, Section 5421.50]

3. Termination without Cause. This Agreement may be terminated without cause by either party upon written notice given ninety (90) days in advance of such termination. [Ill. Admin. Code 50, Section 5421.50]

4. Termination for Cause. Either party may terminate this Agreement for a material breach of this Agreement upon written notice given sixty (60) days in advance of such termination. The failure of Provider to comply with Plan Policies may be deemed a material breach. In the event of notification of intent to terminate with cause by either party, the breaching party shall have twenty one (21) days to cure such breach. Unless the material breach is cured, the twenty one (21) day period to cure will not extend the termination date. [Ill. Admin. Code 50, Section 5421.50]

5. Insurance. Provider shall maintain at all times a self-funded trust program or policies of general liability and professional liability insurance or self-insurance with minimum limits of liability of one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in annual aggregate covering Provider, its agents and employees against any claims for damages out of any act or omission by Provider, its agents and employees during terms of this Agreement. Provider shall also maintain at all times automobile insurance, unemployment compensation insurance and workers' compensation insurance or self-insurance in accordance with the requirements of applicable federal and state laws and regulations. Upon request, Provider shall furnish Plan with original certificates of insurance evidencing the insurance coverages and riders required. Provider shall notify Plan fifteen (15) days in advance of any change or cancellation in insurance. [Ill. Admin. Code 50, Section 5421.50]

Medicare Regulatory Requirements

Where Provider provides services to Medicare Enrollees of Plan, the following provisions shall be incorporated into the Agreement and shall control where conflicting:

CMS requires that specific terms and conditions be incorporated into the Agreement between a Medicare Advantage Organization or First Tier Entity and a First Tier Entity or Downstream Entity to comply with the Medicare laws, regulations, and CMS instructions, including, but not limited to, the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 ("MMA"); and

Except as provided herein, all other provisions of the Agreement between Plan and Provider not inconsistent herein shall remain in full force and effect.

Definitions:

<u>Centers for Medicare and Medicaid Services ("CMS")</u>: the agency within the Department of Health and Human Services that administers the Medicare program.

<u>Completion of Audit</u>: completion of audit by the Department of Health and Human Services, the Government Accountability Office, or their designees of a Medicare Advantage Organization, Medicare Advantage Organization contractor or related entity.

<u>Downstream Entity</u>: any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between an MA organization (or applicant) and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

<u>Final Contract Period</u>: the final term of the contract between CMS and the Medicare Advantage Organization.

<u>First Tier Entity</u>: any party that enters into a written arrangement, acceptable to CMS, with an MA organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the MA program.

<u>Medicare Advantage ("MA")</u>: an alternative to the traditional Medicare program in which private plans run by health insurance companies provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.

<u>Medicare Advantage Organization ("MA organization")</u>: a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.

Member or Enrollee: a Medicare Advantage eligible individual who has enrolled in or elected coverage through a Medicare Advantage Organization.

Provider: (1) any individual who is engaged in the delivery of health care services in a State and is licensed or certified by the State to engage in that activity in the State; and (2) any entity that is engaged in the delivery of health care services in a State and is licensed or certified to deliver those services if such licensing or certification is required by State law or regulation.

Related entity: any entity that is related to the MA organization by common ownership or control and (1) performs some of the MA organization's management functions under contract or delegation; (2) furnishes services to Medicare enrollees under an oral or written agreement; or (3) leases real property or sells materials to the MA organization at a cost of more than $2,500 during a contract period.

Required Provisions:

Provider agrees to the following:

1. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation of the first tier, downstream, and entities related to CMS' contract with Plan, (hereinafter, "MA organization") through 10 years from the final date of the final contract period of the contract entered into between CMS and the MA organization or from the date of completion of any audit, whichever is later. [42 C.F.R. §§ 422.504(i)(2)(i) and (ii)]

2. Provider will comply with the confidentiality and enrollee record accuracy requirements, including: (1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by enrollees to the records and information that pertain to them. [42 C.F.R. §§ 422.504(a)(13) and 422.118]

3. Enrollees will not be held liable for payment of any fees that are the legal obligation of the MA organization. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

4. For all enrollees eligible for both Medicare and Medicaid, enrollees will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Providers will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. Provider may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Providers will: (1) accept the MA plan payment as payment in full, or (2) bill the appropriate State source. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

5. Any services or other activity performed in accordance with a contract or written agreement by Provider are consistent and comply with the MA organization's contractual obligations. [42 C.F.R. § 422.504(i)(3)(iii)]

6. Contracts or other written agreements between the MA organization and providers or between first tier and downstream entities must contain a prompt payment provision, the terms of which are developed and agreed to by the contracting parties. The MA organization is obligated to pay contracted providers under the terms of the contract between the Plan and Provider. [42 C.F.R. §§ 422.520(b)(1) and (2)] In accordance with 42 C.F.R. § 422.520(b), Provider shall provide to Plan all information necessary for Plan to establish proper payment. Plan shall pay Provider for Covered Services rendered to Covered Persons in accordance with Section 7 of the Agreement. Any Clean Claim, as defined in 42 C.F.R. § 422.500, shall be paid within thirty (30) days of receipt by Plan at such address as may be designated by Plan, and Plan shall pay interest on any Clean Claim not paid within thirty (30) days of such receipt by Plan at the rate of interest required by law, or as otherwise set forth in the Provider Manual. Plan's payment of such interest shall be Provider's sole remedy for Plan's failure to pay a Clean Claim within the applicable time period and shall be inclusive of any applicable penalties.

7. Provider and any related entity, contractor or subcontractor will comply with all applicable Medicare laws, regulations, and CMS instructions. [42 C.F.R. §§ 422.504(i)(4)(v)]

8. If any of the MA organization's activities or responsibilities under its contract with CMS are delegated to any first tier, downstream and related entity:

(i) The delegated activities and reporting responsibilities are specified in the Agreement, if any.

(ii) CMS and the MA organization reserve the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where CMS or the MA organization determine that such parties have not performed satisfactorily.

(iii) The MA organization will monitor the performance of the parties on an ongoing basis.

(iv) The credentials of medical professionals affiliated with the party or parties will be either reviewed by the MA organization or the credentialing process will be reviewed and approved by the MA organization and the MA organization must audit the credentialing process on an ongoing basis.

(v) If the MA organization delegates the selection of providers, contractors, or subcontractor, the MA organization retains the right to approve, suspend, or terminate any such arrangement. [42 C.F.R. §§ 422.504(i)(4) and (5)]

Illinois HealthChoice Medicaid Requirements

Where Provider provides services to Medicaid Enrollees of Plan, the following provisions shall be incorporated into the Agreement and shall control where conflicting:

1. Cultural Considerations. Provider shall provide culturally competent services to Enrollees, including those with limited English proficiency or reading skills, and diverse culture and ethnic backgrounds. Provider agrees to participate in and be bound by all policies and procedures set forth in Plan's Cultural Competence Plan. Provider shall assist Plan in confirming the languages used by Provider, including American Sign Language, and ensure physical access to Providers' office locations. Provider shall permit Plan to perform quality assurance evaluations of Provider practices, including monitoring Enrollee accessibility to ensure linguistic and physical accessibility. [Contract Section 2.7]

2. ADA Compliance. All Provider locations where Enrollees receive services shall comply with the requirements of the Americans with Disabilities Act (ADA). Provider shall provide reasonable assistance to Plan in collecting sufficient information to assess Provider's compliance with the ADA. [Contract Section 2.8; 5.8.2]

3. 340B Drug Billing. Providers must identify 340B-purchased drugs on pharmacy, medical, and hospital claims following the IDHFS billing guidelines applied in the FFS program. [Contract Section 5.3.1.6]

4. Right of Conscience. In the event that Provider exercises the right of conscience, Provider, upon request by an Enrollee, shall refer or transfer the Enrollee to, or provide written information to the Enrollee about, other Plan network providers who Provider reasonably believes may offer the Covered Service the Provider refuses to permit, perform, or participate in because of a conscience-based objection. In such an event, Provider shall provide copies of medical records to the Enrollee or to the Provider if requested by the Enrollee. [Contract Section 5.6]

5. Network Provider Enrollment and Termination. Provider must enroll in the IDHFS Medical Program, if such enrollment is required by IDHFS rules or policy, in order to submit claims for reimbursement or otherwise participate in the IDHFS Medical Program. Provider acknowledges that if Plan becomes aware that Provider serving one-hundred (100) or more active Enrollees will be terminated, Plan must inform IDHFS of this termination in writing (e-mail or letter) within three (3) Business Days. [Contract Section 5.7.3]

6. Benefit Expense Claim Data. Provider shall submit accurate claim data for all Covered Services provided to Enrollees to Plan or IDHFS as directed by Plan. Claim information shall include all elements mandated by IDHFS or, if greater, as described in Plan Policies. [Contract Section 5.7.8]

7. Hours of Operation. Provider shall offer hours of operation to Enrollees that are no less than the hours of operation offered to individuals who are not Plan Enrollees. [Contract Section 5.8.3]

8. After Hours. Providers who are Primary Care Practitioners or Specialty Care Practitioners 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 Section 5.8.4]

9. Medicaid Program Enrollment. To participate in Plan's network, Provider must be enrolled in IDHFS' provider enrollment program, currently called the Illinois Medicaid Program Advanced Cloud Technology (IMPACT). [Contract Section 5.9]

10. Provider Directory. Provider agrees to provide reasonable assistance to Plan in populating data necessary for Plan's provider directory, including responding to inquiries regarding network participation, hours of operation and helping to correct inaccurate information. [Contract Section 5.10.6]

11. Health Education. Provider shall 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. [Contract Section 5.10.7]

12. Health, Safety, and Welfare Reporting. To the extent permitted or required by applicable law and professional standards, Provider shall make best efforts to comply with the standards described in Plan's IDHFS contract associated with identifying, preventing and reporting Abuse, Neglect, exploitation, and Critical Incidents. Plan has training on Abuse, Neglect, exploitation and Critical Incidents available for Provider. [Contract Sections 5.10.8; 5.23.1.4]

13. Self-Directed Care. Provider is encouraged to support Enrollees in directing their own care and developing an Integrated Plan of Care as defined in the IDHFS Contract. [Contract Section 5.13.5]

14. Lab Result Reporting. If Provider provides laboratory services, Provider shall be capable of reporting lab values to Plan directly using a secure, electronic mechanism for Plan's quality improvement activities. [Contract Section 5.22.2]

15. Medical Records. If Provider is a PCP, PCP must maintain a permanent Enrollee medical record. The medical record shall be available to the PCP, the women's health care provider, and other providers. Copies of the medical record shall be sent to any new PCP to which the Enrollee transfers and transferring PCP shall document efforts to obtain the Enrollee's consent when required by law in the Enrollee's medical record. PCP shall release original medical records only in accordance with federal or State law, including court orders or subpoenas, or a valid records-release form executed by an Enrollee or to persons authorized by the Enrollee or at law. PCPs must maintain and share such records for IDHFS upon request and in accordance with professional standards. Medical records must include PCP identification. Medical-records reporting requirements shall be adequate to provide for acceptable Continuity of Care to Enrollees. All entries in the medical record must be legible, accurate, complete, and dated, and include the following, where applicable: Enrollee identification; personal health, social history and family history, with updates as needed; risk assessment; obstetrical history and profile; hospital admissions and discharges; relevant history of current illness or injury and physical findings; diagnostic and therapeutic orders; clinical observations, including results of treatment; reports of procedures, tests, and results; diagnostic impressions; Enrollee disposition and pertinent instructions to the Enrollee for follow-up care; immunization record; allergy history; periodic exam record; weight and height information and, as appropriate, growth charts; referral information; health education and anticipatory guidance provided; and Family Planning and counseling. [Contract Section 5.26.3]

16. Provider Preventable Condition Reporting. Provider shall, as a condition of receiving payment from Plan, complete the reporting requirements in 42 CFR §447.26(d). [Contract Section 5.29.9]

17. Bound to IDHFS Contract. Provider shall be bound by the terms and conditions of Plan's contract with IDHFS that are appropriate to the service or activity delegated under this Agreement. Such requirements include, but are not limited to, the record keeping and audit provisions of the contract between Plan and IDHFS, such that IDHFS or authorized persons shall have the same rights to audit and inspect Provider as they have to audit and inspect Plan. [Contract Section 5.32.2.1]

18. Admissions Privileges. All of Provider's physicians shall have and maintain admitting privileges and, as appropriate, delivery privileges at a hospital that is a Plan network provider; or, in lieu of these admitting and delivery privileges, the physician shall have a written referral agreement with a physician who is an Plan network provider and who has such privileges at a hospital that is an affiliated provider. The agreement must provide for the transfer of medical records and coordination of care between physicians. [Contract Section 5.32.2.2]

19. HCBS Waivers. Each Provider that provides Covered Services under a DHS HCBS Waiver, under the Medicaid clinic option, or under the Medicaid Rehabilitation Option, or sub-acute 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 is required under State rules, or a contract between the provider and DHS, into any subsystem maintained by DHS, including, but not limited to, the DHS' Automated Reporting and Tracking System (DARTS). [Contract Section 5.32.2.3]

20. Plan's Responsibility. Plan shall remain responsible for the performance of any of its responsibilities delegated to Provider. [Contract Section 5.32.3]

21. No Termination of Legal Responsibilities. This Agreement cannot terminate the legal responsibilities of Plan to the IDHFS to assure that all activities under its contract with IDHFS will be carried out. [Contract Section 5.32.4]

22. Enrollment in IDHFS Medical Program. All of Provider's providers must be enrolled as a provider in the IDHFS Medical Program. Neither Provider nor any practitioner shall be an Ineligible Person or a person who has voluntarily withdrawn from the IDHFS Medical Program as the result of a settlement agreement. [Contract Section 5.32.5]

23. Lobbying

23.1 Certification. Provider certifies to the best of Provider's knowledge and belief, that no federally appropriated funds have been paid or will be paid by or on behalf of Provider, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal loan or grant, or the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan or cooperative agreement. [Contract Section 5.32.6; Article IX]

23.2 Funds. If any funds other than federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this federal contract, grant, loan or cooperative agreement, Provider shall complete and submit Standard Form LLL, "Disclosure Forms to Report Lobbying," in accordance with its instructions. Such Form is to be obtained at Provider's request from the IDHFS' Bureau of Fiscal Operations.

24. Grievance and Appeals Procedures. Provider acknowledges that it has received information or that information was made available regarding Plan's grievance and appeal procedures. Plan will provide or make available information about its grievance and appeal procedures within fifteen (15) days following any substantive change to such procedures. [Contract Section 5.32.7]

25. Termination/Sanctions for Performance. Plan may promptly terminate this Agreement or any provider subcontract or impose sanctions if the performance of Provider or any of its affiliated providers is inadequate. [Contract Section 5.32.8; 5.32.10.2]]

26. Compensation. Provider-compensation models shall reimburse for Covered Services provided and may reimburse for performance. Provider is not permitted to obtain payment for Covered Services provided hereunder from any source other than Plan except when specifically required by Plan's agreement with IDHFS or applicable law as provided in 42 CFR §438.60. [Contract Section 5.32.9]

27. Binding Nature. The parties acknowledge and agree that this Agreement is binding on each. [Contract Section 5.32.10.1]

28. Termination. Plan shall promptly terminate this Agreement if Provider is terminated, barred, suspended, or voluntarily withdrawn as a result of a settlement agreement, under either Section 1128 or Section 1129A 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 IDHFS Medical Program. [Contract Section 5.32.10.3]

29. Laboratory Services. Provider shall adhere to the provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA) Public Law 100-578 requirements for supplying laboratory services and comply with the CLIA regulations found at 42 CFR §493. [Contract Section 5.32.10.4]

30. Monitoring. Plan will monitor the performance of Provider and its providers on an ongoing basis. Provider shall be subject to formal review on at least a triennial basis, and, to the extent deficiencies or areas for improvement are identified during an informal or formal review, Provider shall to take appropriate corrective action. [Contract Section 5.32.10.5]

31. IDHFS Final Authority. The parties acknowledge that IDHFS shall have the right to require Plan and Provider to amend this Agreement as reasonably necessary to conform to Plan's duties and obligations under Plan's agreement(s) with the State of Illinois. [Contract Section 5.32.11]

32. Fees to Enrollees Prohibited. Provider shall not seek nor obtain funding through fees or charges to any Enrollee receiving Covered Services pursuant to this Agreement, except as permitted or required by the IDHFS in 89 Ill. Adm. Code 125 and IDHFS' Fee-For-Service copayment policy then in effect, and subject to Plan's election to charge copayments to Enrollees under Plan's contract with the State of Illinois. Provider acknowledges that imposing charges in excess of those permitted under this Agreement is a violation of §1128B(d) of the Social Security Act may subject Provider to criminal penalties. Provider shall have language in all of its provider agreements or subcontracts reflecting this requirement. [Contract Section 5.32.12]

33. Reporting Fraud, Waste and Abuse. If Provider identifies suspected Fraud, Waste, Abuse, or financial misconduct, Provider shall immediately make a report to Plan. Plan shall make Fraud, Waste, Abuse or financial misconduct training available to Provider. [Contract Sections 5.35.1.6; 5.35.1.9]

34. Enrollee-Provider Communications. In accordance with the Managed Care Reform and Patient Rights Act, Provider is not prohibited nor shall Provider prohibit or otherwise restrict a provider from advising an Enrollee about the health status of the Enrollee or medical care or treatment for the Enrollee's condition or disease regardless of whether benefits for such care or treatment are provided under this Agreement or Plan's contract with the State of Illinois, if the provider is acting within the lawful scope of practice, and neither Plan nor Provider shall retaliate against a provider for so advising Enrollee. [Contract Section 5.36]

35. Recoveries from Providers. If IDHFS requires Plan to recover established overpayments made to Provider by IDHFS for performance or non-performance of activities not governed by Plan's Agreement with IDHFS, Provider shall immediately remit such overpayment to Plan. [Contract Section 7.21]

37. Orderly Transfer. Provider agrees, in the event of termination of this Agreement, to cooperate with Plan in the orderly transfer of Enrollees being treated or evaluated. [Contract Section 8.3]

38. Submission of Encounter Data to IDHFS. Provider shall ensure that encounter data for all Covered Services provided to Enrollees is submitted to IDHFS or Plan, as the case may be, in accordance with Plan's agreement with the State of Illinois. [Contract Section 7.4]

39. Participation in Quality Assurance Program. Provider shall reasonably cooperate with Plan's Quality Assurance Program (QAP), including but not limited to permitting Plan or its designees to access medical records of Enrollees. [Contract Section Attachment XI, (6)(b)]

Medicaid Mobile Crisis Response Provider Requirements

To the extent that Provider maintains or provides a Mobile Crisis Response Program or is otherwise responsible for providing Mobile Crisis Response services, the following requirements apply:

Definitions:

As used in this "Medicaid Mobile Crisis Response Provider Requirements" Section to the Regulatory Requirements Manual, the following capitalized terms shall have the following meanings:

Behavioral Health Crisis means an individual's significant mental reaction to an event which cannot be addressed by customary community and mental health services. Also be referred to as "Crisis."

Crisis and Referral Entry Service (CARES) means the single point of entry to the State of Illinois' Mobile Crisis Response system that provides telephone response and referral services for children requiring mental health crisis services.

Crisis Intervention means services provided by an emergency mental health services program to an individual in Crisis or in a situation that is likely to develop into a Crisis if supports such as assessment and planning, Crisis linkage and follow-up services, and Crisis stabilization services, are not provided.

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

Illinois Medicaid Child and Adolescent Needs and Strengths (IM-CANS) is the Illinois Medicaid version of a multi-purpose tool developed for children's services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services.

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

Stabilization or Stabilized means a determination with respect to an Emergency Medical Condition made by an attending emergency room Physician or other treating provider that, within reasonable medical probability, no material deterioration of the condition is likely to result upon discharge or transfer to another facility.

Required Provisions:

Provider agrees to the following:

1. Provider staff responsible for providing Behavioral Health Crisis services must hold the following credentials:
  a) Mental Health Professional (MHP) with direct access to a Qualified Mental Health professional (QMHP);
  b) Qualified Mental Health Professional; or
  c) Licensed Practitioner of the Healing Arts.

2. Provider shall utilize 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. Once an Enrollee has been stabilized, Provider shall utilize the prevailing Illinois decision support tool, the Illinois Medicaid Child and Adolescent Needs and Strengths (IM-CANS) or any State-defined successor.

3. Provider shall provide immediate Crisis and Stabilization services when an Enrollee in Crisis can be stabilized in the community and 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.

4. Providers shall make Mobile Crisis Response Services, including a face-to-face crisis screening, available to all Enrollees experiencing a behavioral health crisis within ninety (90) minutes of notification.

5. Provider shall provide an Enrollee's family with contact information that may be used at any time, twenty-four (24) hours a day, to contact Plan's Mobile Crisis Response system in moments of Crisis.

6. Provider shall do each of the following as it relates to Crisis Safety Plan Development:
  a) Create a Crisis Safety Plan for all Enrollees that present in Behavioral Health Crisis, in collaboration with the Enrollee and the Enrollee's family;
  b) Provide Enrollees and families of Enrollees with physical copies of the Crisis Safety Plans consistent with the following timelines:
    i. Prior to the completion of the Crisis screening using the screening tool described in Plan Policies for any Enrollee stabilized in the community; and
    ii. Prior to the Enrollee's discharge from an inpatient psychiatric hospital setting for any Enrollee that is admitted to such a facility.
  c) Educate and orient the Enrollee's family to the components of the Crisis Safety Plan, to ensure that the plan is reviewed with the family regularly, and to detail how the plan is updated as necessary; and
  d) Share the Crisis Safety Plan with all necessary medical professionals, including Plan care coordinators, consistent with the authorizations established by consent or release.

7. Provider shall facilitate the Enrollee's admission to an appropriate inpatient institutional treatment setting when the Enrollee in Crisis cannot be stabilized in the community.

8. Provider shall inform the Enrollee's parents, guardian, caregivers, or residential staff about all of the available Plan Participating Providers and any pertinent policies needed to allow the involved parties to select an appropriate inpatient institutional treatment setting.

9. Providers who are Inpatient psychiatric providers shall 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.

10. Provider shall adhere to Plan Policies regarding discharge and transitional planning, including the following:
  a) Planning shall begin upon admission;
  b) Community-based providers responsible for providing service upon the Enrollee's discharge shall participate in all inpatient staffing by phone, videoconference, or in person;
  c) The Enrollee's Care Coordinator shall notify the Enrollee's family and caregiver of key dates and events related to the admission, staffing, discharge, and transition of the Enrollee, and he or she shall make every effort to involve the Enrollee and the Enrollee's family and caregiver in decisions related to these processes;
  d) The Enrollee's Care Coordinator shall speak directly with the Enrollee at least once each week;

e) The Enrollee's Care Coordinator or Network Provider shall educate and train the Enrollee's family on how to use the Crisis Safety Plan while the Enrollee is receiving inpatient institutional treatment; and
f) The Enrollee's Care Coordinator shall participate in and oversee staffing, discharge, and transition processes.

11. Provider shall ensure that Psychiatric providers shall be available for consultation and medication management services, as medically necessary, within the following timeframes:
a) Fourteen (14) calendar days after an Enrollee's discharge from an inpatient psychiatric hospital setting; or,
b) Within three (3) calendar days after the date of the Crisis event for an Enrollee for whom community-based services were put in place in lieu of psychiatric hospitalization.

12. Provider acknowledges that CARES has the authority to authorize and dispatch Mobile Crisis Response services, which may be reimbursed by Plan in accordance with all applicable Plan Policies and the following standards:
a) In the event that CARES is unable to dispatch Plan's Mobile Crisis Response service, CARES shall engage the fee-for-service SASS Program to ensure Crisis response to the Enrollee.
b) In the event that an Enrollee is screened, due to necessity, by an out of network provider of SASS services, Plan shall pay for the screening at the Medicaid rate.

13. Provider shall notify Plan 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.

Medicaid/Medicare - MMAI Requirements

Where Provider provides services to MMAI Enrollees of Plan, the following provisions shall be incorporated into the Agreement and shall control where conflicting:

CMS requires that specific terms and conditions be incorporated into the Agreement between a Medicare Advantage Organization or First Tier Entity and a First Tier Entity or Downstream Entity to comply with the Medicare laws, regulations, and CMS instructions, including, but not limited to, the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 ("MMA"); and

Except as provided herein, all other provisions of the Agreement between Plan and Provider not inconsistent herein shall remain in full force and effect.

Definitions:

Centers for Medicare and Medicaid Services ("CMS"): the agency within the Department of Health and Human Services that administers the Medicare program.

Completion of Audit: completion of audit by the Department of Health and Human Services, the Government Accountability Office, or their designees of a Medicare Advantage Organization, Medicare Advantage Organization contractor or related entity.

Downstream Entity: any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between an MA organization (or applicant) and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Final Contract Period: the final term of the contract between CMS and the Medicare Advantage Organization.

First Tier Entity: any party that enters into a written arrangement, acceptable to CMS, with an MA organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the MA program.

Medicare Advantage ("MA"): an alternative to the traditional Medicare program in which private plans run by health insurance companies provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.

Medicare Advantage Organization ("MA organization"): a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.

Member or Enrollee: a Medicare Advantage eligible individual who has enrolled in or elected coverage through a Medicare Advantage Organization.

Provider: (1) any individual who is engaged in the delivery of health care services in a State and is licensed or certified by the State to engage in that activity in the State; and (2) any entity that is engaged in the delivery of health care services in a State and is licensed or certified to deliver those services if such licensing or certification is required by State law or regulation.

Related entity: any entity that is related to the MA organization by common ownership or control and (1) performs some of the MA organization's management functions under contract or delegation; (2) furnishes services to Medicare enrollees under an oral or written agreement; or (3) leases real property or sells materials to the MA organization at a cost of more than $2,500 during a contract period.

Required Provisions:

Provider agrees to the following:

1. The delegated activities and reporting requirements, if any, are contained in the Agreement. Provider shall ensure compliance in any delegated activities with 42 C.F.R. §§ 422.504, 423.505, and 438.6(l), as applicable. [MMAI Contract Appendix C, Section A]

2. HHS, the Comptroller General, IDHFS, IDHFS's office of Inspector General, the Medicaid Fraud Control Unit of the Illinois State Police, the Illinois Auditor General, and their designees, and other State and federal agencies with monitoring authority related to Medicare and Medicaid, have the right to audit, evaluate, and inspect any books, contracts, computer or other electronic systems, including medical records and documentation of the First Tier, Downstream and Related Entities. HHS's, the Comptroller General's, the IDFHS's, IDHFS's Office of Inspector's General, the Medicaid Fraud Control Units of the Illinois State Police, the Illinois Auditor's General, and or their designees', and other State and federal agencies with monitoring authority related to Medicare and Medicaid, right to inspect, evaluate, and audit any pertinent information for

any particular contract period for ten years from the final date of the contract period or from the date of completion of any audit, whichever is later. [MMAI Contract Appendix C, Section B, 1-2]

3. Provider shall not hold Enrollees liable for payment of any fees that are the obligation of Plan. [Appendix C, Section C (1)]

4. Any services or other activity performed by Provider or any First Tier, Downstream and Related Entities shall be performed in accordance with the Plan's contractual obligations to CMS and IDHFS. [MMAI Contract Appendix C, Section C (2)]

5. The delegated activities and reporting requirements, if any are specified in the Agreement. [MMAI Contract Appendix C, Section C (3)]

6. Plan shall revoke the delegation activities and reporting requirements or specify other remedies in instances where CMS, the IDHFS or the Plan determine that Provider has not performed delegated activities or reporting requirements satisfactorily. [MMAI Contract Appendix C, Section C (4)]

7. The performance of the parties is monitored by Plan on an ongoing basis and Plan may impose corrective action as necessary. [MMAI Contract Appendix C, Section C (5)]

8. Provider and all First Tier, Downstream and Related Entities agree to safeguard Enrollee privacy and confidentiality of Enrollee health records. [MMAI Contract Appendix C, Section C (6)]

9. Provider and all First Tier, Downstream and Related Entities must comply with all Federal and State laws, regulations and CMS instructions. [MMAI Contract Appendix C, Section C (7)]

10. To the extent that Provider or a First Tier, Downstream and Related Entities provides credentialing of medical Providers, such agreement shall contain the following language:

A. The credentials of medical professionals affiliated with the Provider will be reviewed by Plan; or

B. The credentialing process will be reviewed and approved by Plan and Plan shall audit the credentialing process on an ongoing basis.

[MMAI Contract Appendix C, Section D (1-2)]

11. Plan retains the right to approve, suspend, or terminate any arrangement relating to the delegation of selection of providers. [MMAI Contract Appendix C, Section E]

12. Plan has the right to terminate the MMAI line of business in the Agreement for cause upon sixty (60) days' notice, and without cause upon 120 days' notice, and the Provider shall be required to assist with transitioning Enrollees to new Providers, including sharing the Enrollee's medical record and other relevant Enrollee information as directed by the Contractor or Enrollee. In the event of a for-cause termination, Plan must have an internal grievance procedure that allows the Provider to contest the grounds for the termination prior to the effective date of the termination. [MMAI Contract Appendix C, Section F]

13. Plan shall provide a written statement to Provider of the reason or reasons for termination for cause. [MMAI Contract Appendix C, Section G]

14. Plan is obligated to pay Provider under the terms of the Agreement. [MMAI Contract Appendix C, Section H (1)]

15. Services shall be provided in a culturally competent manner to all Enrollees, including those with limited English proficiency or reading skills, and diverse culturally and ethnic backgrounds. [MMAI Contract Appendix C, Section H (2)]

16. Provider shall abide by all Federal and State laws and regulations regarding confidentiality and disclosure of medical records, or other health and enrollment information. [MMAI Contract Appendix C, Section H(3)]

17. Provider shall ensure that medical information is released in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas. [MMAI Contract Appendix C, Section H (4)]

18. Provider shall maintain Enrollee records and information in an accurate and timely manner. [MMAI Contract Appendix C, Section H (5)]

19. Provider shall ensure timely access by Enrollees to the records and information that pertain to them. [MMAI Contract Appendix C, Section H (6)]

20. Enrollees will not be held liable for Medicare Part A and B cost sharing. Medicare Parts A and B services must be provided at zero cost-sharing to Enrollees. [MMAI Contract Appendix C, Section H (7)]

21. Provider shall ensure that a medical provider's EMTALA obligations are fulfilled as described by law and/or in the Agreement and must not create any conflicts with any hospital actions required to comply with EMTALA. [MMAI Contract Appendix C, Section H (8)]

22. Provider shall not limit acceptance of Enrollees as patients unless the same limitations apply to all commercially insured enrollees. [MMAI Contract Appendix C, Section H (9)]

23. Plan shall not refuse to contract or pay Provider for the provision of Covered Services solely because Provider has in good faith:

(a) Communicated with or advocated on behalf of one or more of his or her prospective, current or former patients regarding the provisions, terms or requirements of the Plan's health benefit plans as they relate to the needs of such Provider's patients; or

(b) Communicated with one or more of his or her prospective, current or former patients with respect to the method by which such Provider is compensated by the Plan for services provided to the patient.

[MMAI Contract Appendix C, Section H (10)]

24. Provider is not required to indemnify Plan for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against Plan based on Plan's management decisions, utilization review provisions or other policies, guidelines or actions. [MMAI Contract Appendix C, Section H (11)]

25. Provider shall comply with all Plan's requirements and Plan Policies for utilization review, quality management and improvement, credentialing and the delivery of preventive health services. [MMAI Contract Appendix C, Section H (12)]

26. Plan shall notify Provider in writing of modifications in payments, modifications in Covered Services or modifications in Plan's procedures, documents or requirements, including those associated with utilization review, quality management and improvement, credentialing and preventive health services, that have a substantial impact on the rights or responsibilities of Provider, and the effective date of the modifications. The notice shall be provided 30 days before the effective date of such modification unless such other date for notice is mutually agreed upon between the Plan and Provider or unless such change is mandated by CMS or IDHFS without 30 days prior notice. [MMAI Contract Appendix C, Section H (13)]

27. All First Tier, Downstream and Related Entities must comply with all applicable requirements governing physician incentive plans, including but not limited to such requirements appearing at 42 C.F.R. Parts 417, 422, 434, 438, and 1003. Contracts or arrangements with First Tier, Downstream and Related Entities shall not include incentive plans that include a specific payment made directly or indirectly to a provider as an inducement to deny, reduce, delay, or limit specific, Medical Necessary Services furnished to an individual Enrollee. First Tier, Downstream and Related Entities shall comply with all Enrollee payment restrictions, including balance billing restrictions, and develop and implement a plan to identify and revoke or provide other specified remedies for any member of Plan's First Tier, Downstream and Related Entities that does not comply with such provisions. [MMAI Contract Appendix C, Section H (14)]

28. Provider shall not bill Enrollees for charges for Covered Services other than pharmacy co-payments, if applicable. [MMAI Contract Appendix C, Section H (15)]

29. No payment shall be made by Plan to Provider for a Provider-Preventable Condition as defined in 42 C.F.R. § 447.26(b). [MMAI Contract Appendix C, Section H (16)]

30. As a condition of payment, Provider shall comply with the reporting requirements as set forth in 42 C.F.R. § 447.26(d) and as may be specified by Plan. Provider shall comply with such reporting requirements to the extent Provider directly furnishes services. [MMAI Contract Appendix C, Section H (17)]

31. Plan shall monitor and ensure that all Utilization Management activities provided by a First Tier, Downstream, or Related Entity, including Provider comply with all provisions of Plan's three-way contract with CMS and IDHFS. [MMAI Contract Appendix C, Section H (18)]

32. Provider shall not bill Enrollees for missed appointments or refuse to provide services to Enrollees who have missed appointments. Provider shall work with Enrollees and Plan to assist Enrollees in keeping their appointments. [MMAI Contract Appendix C, Section H (19)]

33. Provider shall not refuse to provide services to an Enrollee because the Enrollee has an outstanding debt with Provider from a time prior to the Enrollee becoming a Member. [MMAI Contract Appendix C, Section H (20)]

34. Contracts or arrangements with First Tier, Downstream and Related Entities shall not include incentive plans that include a specific payment to a Provider as an inducement to deny, reduce, delay, or limit specific, Medically Necessary Covered Services and:

A. Provider shall not profit from provision of Covered Services that are not Medically Necessary or medically appropriate;

B. Plan shall not profit from denial or withholding of Covered Services that are Medically Necessary or medically appropriate; and

C. Nothing in this Section 34 shall be construed to prohibit contracts that contain incentive plans that involve general payments such as capitation payments or shared risk agreements that are made with respect to PP/PPGs or that are made with respect to groups of Enrollees if such agreements, which impose risk on such PP/PPGs for the costs of medical care, services and equipment provided or authorized by another Physician or health care Provider, comply with Section 35, below.

[MMAI Contract Appendix C, Section I]

35. Plan shall not impose a financial risk on Provider for the costs of medical care, services or equipment provided or authorized by another Physician or health care Provider such contract includes specific provisions with respect to the following:

A. Stop-loss protection;

B. Minimum patient population size for the Physician or Physician group; and

C. Identification of the health care services for which the Physician or Physician group is at risk.

[MMAI Contract Appendix C, Section J]

36. All contracts or arrangements with First Tier, Downstream and Related Entities for laboratory testing sites providing services include an additional provision that such laboratory testing sites must have either a Clinical Laboratory Improvement Amendment (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number. [MMAI Contract Appendix C, Section K]

37. Nothing in this section shall be construed to restrict or limit the rights of Plan to include as Providers religious non-medical Providers or to utilize medically based eligibility standards or criteria in deciding Provider's status for religious nonmedical Providers. [MMAI Contract Appendix C, Section L]

38. Provider shall meet all terms and requirements of Plan's MMAI Contract that are applicable to Provider. [MMAI Contract Section 2.7.2.2.1]

39. Provider and any subcontractors shall cooperate with and utilize Plan's Quality Assurance Plan. [MMAI Contract Section 2.13.4.2.2]

40. Provider, any Affiliated Providers and Subcontractors shall allow Plan to access the medical records of Plan Enrollees. [MMAI Contract Section 2.13.4.2.3]

41. Provider must be enrolled as a provider in the IDHFS Medical Program. Provider shall not be an Ineligible Person or a person who has voluntarily withdrawn from the IDHFS Medical Program as the result of a settlement agreement. [MMAI Contract Section 2.8.1.2]