STATE OF ILLINOIS
EXCEPTIONS TO CONTRACT TERMS AND CONDITIONS

The Roger Baldwin Foundation of ACLU, Inc. ("ACLU of Illinois") submits the following suggested exceptions for incorporation into the final version of the Model Contract issued pursuant to the State of Illinois Request for Proposal ("RFP") (Reference Number: 2018-24-001). These suggestions relate to concerns detailed in our March 9, 2017 letter to the Department of Healthcare and Family Services ("the Department"), about ensuring that enrollees have adequate access to medically necessary covered services as required by state and federal law. For additional background on these concerns, please refer to the March 9, 2017 letter (enclosed).

	CHANGES TO STANDARD TERMS AND CONDITIONS
Section or Subsection No.	State the exception, specifying the section or subsection number and the desired language, using terms such as "add," "replace," "delete," etc.
1.1.79 (page 17)	The full spectrum of reproductive-health services includes abortion care, yet there is considerable confusion about the extent of abortion coverage under Illinois Medicaid. Other states (such as New York) clearly state in Medicaid handbooks and contracts that abortion is part of the range of covered family planning and reproductive health services. Therefore, we suggest adding the underlined text (and deleting the strikethrough text) in the definition of Family Planning as follows: "**Family Planning** means a full spectrum of family-planning options (all FDA-approved birth control methods) and reproductive-health services, appropriately provided within the Provider's scope of practice and competence. Family-Planning and reproductive-health services are defined as those services offered, arranged, or furnished for the purpose of preventing an unintended pregnancy, <u>terminating pregnancy,</u> or ~~to improve~~ <u>improving</u> maternal health and birth outcomes."
5.5.1 (page 68)	This subsection offers a description of abortion coverage under Illinois Medicaid that is incomplete and potentially misleading, as the Model Contract does not explain when abortion is covered and directs Contractors to Illinois regulations (89 Ill. Adm. Code 140.413) regarding abortion coverage which have been enjoined by court order (*Doe v. Wright*). This subsection's guidance is also inaccurate with respect to SCHIP enrollees, as the *Doe v. Wright* order applies generally to state medical assistance programs and is not limited to Medicaid; furthermore, it conflicts with the Illinois CHIP State Plan, which permits individuals eligible under SCHIP to enroll under Medicaid to obtain coverage for abortion services. We therefore suggest replacing the text of Subsection 5.5.1 with the following underlined text: <u>"Abortion (termination of pregnancy) is a covered service when the abortion is, in the medical judgment of the attending health care provider, necessary to preserve the woman's health or her life, or when the pregnancy is the result of rape or incest. A medical judgment that an abortion is necessary to preserve a woman's health may consider all factors — such as physical, emotional, psychological, and familial health and the woman's age — which are relevant to the patient's health</u>

	and wellbeing. In any such case, Contractor shall complete HFS Form 2390, and file the completed form in the Enrollee's medical record. Enrollees who are eligible for assistance under SCHIP (215 ILCS 106) may enroll under Medicaid in order to obtain coverage for abortion services."
5.6.3 (page 69)	We suggest adding the following underlined text (and deleting the strikethrough text) in this subsection to ensure that Enrollees receive timely access to medically necessary Covered Services, in accordance with the Health Care Right of Conscience Act, 745 ILCS 70/1 *et seq.*: "Such notice shall include information on how ~~an Enrollee~~ Potential Enrollees, Prospective Enrollees and Enrollees can obtain information from the Department explaining how to access ~~regarding~~ those Covered Services subject to this section 5.6."
5.6.4 (page 69)	We suggest adding the following underlined text (and deleting the strikethrough text) in this subsection (and additional subsections set forth below) to ensure that Enrollees receive timely access to medically necessary Covered Services, in accordance with the Health Care Right of Conscience Act: "As set forth in section 5.32, all Provider agreements entered into by Contractor must include a list of any Covered Services that the Network Provider refuses to permit, perform, or participate in because of a conscience-based objection, and document the Network Provider's written access to care and information protocols that are designed to ensure that conscience-based objections do not cause impairment of Enrollees' health and that explain how conscience-based objections will be addressed in a timely manner to facilitate Enrollees' access to Covered Services. Contractor must require Network Providers to inform Enrollees of their condition, prognosis, legal treatment options, and risks and benefits of the treatment options in a timely manner, consistent with current standards of medical practice or care. If any Network Provider is unable, because of a conscience-based objection, to permit, perform, or participate in a Covered Service that is a diagnostic or treatment option requested by the Enrollee, ~~exercises the right of conscience,~~ Contractor must require such Network Provider to notify the Enrollee that the Covered Service will not be provided and, upon request by an Enrollee, refer or transfer the Enrollee to, or provide written information to the Enrollee about, other Providers who Contractor reasonably believes may offer the Covered Service the Network Provider refuses to permit, perform, or participate in because of a conscience-based objection. Contractor also shall require Network Providers in such an event, and if requested by the Enrollee, to provide copies of medical records to the Enrollee or to the Provider designated by the Enrollee in accordance with Illinois law, without undue delay. Contractor must notify Potential Enrollees, Prospective Enrollees, and Enrollees regarding which Network Providers have conscience-based objections, and the Covered Services each such Network Provider refuses to permit, perform, or participate in because of a conscience-based objection, as follows:

	5.6.4.1 to Potential Enrollees, prior to enrollment; 5.6.4.2 to Prospective Enrollees, during enrollment; and 5.6.4.3 to Enrollees, within ninety (90) days after entering into a Provider agreement with a Network Provider that refuses to permit, perform, or participate in Covered Services because of a conscience-based objection. Such notice shall include information about other Network Providers who may offer such Covered Services as well as information on how an Enrollee can obtain information from the Department explaining how to access those Covered Services subject to this section 5.6. Contractor shall also publish such notice and information in the Provider directory as set forth in subsection 5.10.6." **5.10.6 (pages 82-83)** We suggest adding the following underlined text (and deleting the strikethrough text) to this subsection: "**Provider directory**. Contractor shall meet all Provider directory requirements under 305 ILCS 5/5-30.3 ~~and,~~ 42 CFR §438.10, and section 5.6, including: 5.10.6.1 Ensure its Provider directory is available to Enrollees and Providers via Contractor's web portal and in paper form upon request. 5.10.6.2 Request, at least annually, Provider office hours for each Provider type and publish such hours in the Provider directory. 5.10.6.3 Confirm with Providers who have not submitted claims within the six (6) months prior to the start of this Contract that the Provider intends to remain in the network and correct any incorrect Provider directory information. 5.10.6.4 Conspicuously display an e-mail address and a toll-free number to which any individual may report an inaccuracy in the Provider directory. 5.10.6.5 Provider directory information in paper form must be updated at least monthly and electronic Provider directories must be updated no later than thirty (30) days after Contractor receives updated Provider information. 5.10.6.6 Investigate and correct any inaccurate information communicated to any individual Enrollee or from Department notification within three (3) days after notification by the Department. 5.10.6.6 Publish and update any information regarding which Network Providers have conscience-based objections to Covered Services, the Covered Services each such Network Provider refuses to permit, perform, or participate in because of a conscience-based objection, information about other Network Providers who may

	offer such Covered Services, and information about how an Enrollee can obtain information from the Department explaining how to access such Covered Services.
5.21.5.6 (page 107)	We suggest adding the following underlined text to this subsection: "the amount, duration, and scope of benefits available, in sufficient detail to ensure that the Enrollee understands the benefits to which the Enrollee is entitled, as well as any benefits that may be excluded pursuant to section 5.6, and information about how an Enrollee can obtain information from the Department explaining how to access benefits excluded pursuant to section 5.6;"
Attachment XXI, 2.1.3 (page 318)	We suggest adding the underlined text (and deleting the strikethrough text) to the first two sentences of this subsection regarding minimum covered services for Family Planning, as follows: "Contractor shall ensure provision of the full spectrum of Family Planning options and reproductive health services within the practitioner's scope of practice and demonstrated competence. Contractor shall follow federal and State laws regarding minor consents and confidentiality. Family Planning and reproductive health services are defined as those services offered, arranged, or furnished for the purpose of preventing an unintended pregnancy, terminating pregnancy, or ~~to improve~~ improving maternal health and birth outcomes."
	ADDITIONAL PROVISIONS
New Section or Subsection No.	State the new section or subsection number, the title of the new section or subsection, and the language of the desired term or condition.
5.21.1.16 (pages 103-104)	We suggest creating the following new subsection 5.2.1.16 as part of Subsection 5.2.1, specifying that the following must be provided as part of the required "basic information" for Enrollees: "any Covered Services which the Contractor, and/or any Network Provider, refuses to provide pursuant to section 5.6, and information about how an Enrollee can obtain information from Contractor and/or the Department explaining how to access such Covered Services."
5.32.16 (pages 126-129)	We suggest creating the following new subsection 5.32.16 as part of Section 5.32, specifying that Provider agreements are subject to the following condition: "As set forth in section 5.6, all Provider agreements entered into by Contractor must include a list of any Covered Services that the Network Provider refuses to permit, perform, or participate in because of a conscience-based objection, and document the Network Provider's written access to care and information protocols that are designed to ensure that conscience-based objections

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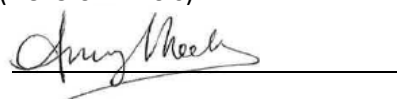
	do not cause impairment of Enrollees' health and that explain how conscience-based objections will be addressed in a timely manner to facilitate Enrollees' access to Covered Services.""
Attachment XXI, 2.1.3.18 (pages 319-328)	We suggest creating the following new subsection 2.1.3.18 as part of subsection 2.1.3, specifying that as part of the full spectrum of Family Planning options and reproductive health services, Contractor shall ensure the provision of the following: "Contractor shall have procedures in place to enable Enrollees to access abortion (termination of pregnancy) pursuant to subsection 5.5.1."

By: Amy Meek (ACLU of Illinois)

Signed: 

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