STATE OF ILLINOIS

CONTRACT

Between the

**DEPARTMENT OF HEALTHCARE
AND FAMILY SERVICES**

and

ILLINICARE HEALTH PLAN, INC.

for

**Furnishing Health Services in an
Integrated Care Program by a
Managed Care Organization**

2010-24-005-K

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THIS CONTRACT FOR FURNISHING HEALTH SERVICES ("Contract"), made pursuant to Section 5-11 of the Illinois Public Aid Code (305 ILCS 5/5-11), is by and between the **Illinois Department of Healthcare and Family Services** ("the Department"), and **IlliniCare Health Plan, Inc.** ("Contractor"), which certifies that it is a Managed Care Organization and whose principal office is located at **999 Oakmont Plaza Drive, Westmont, IL 60559**.

RECITALS

WHEREAS, Contractor is a health maintenance organization operating pursuant to a Certificate of Authority issued by the Illinois Department of Financial and Professional Regulation and wishes to provide Covered Services to Potential Enrollees (as defined herein); and

WHEREAS, the Department, pursuant to the laws of the State of Illinois, provides for medical assistance under the HFS Medical Program to Participants wherein Potential Enrollees may enroll with Contractor to receive Covered Services; and

WHEREAS, Contractor warrants that it is able to provide or arrange to provide the Covered Services set forth in this Contract to Enrollees under the terms and conditions set forth herein;

NOW, THEREFORE, in consideration of the mutual covenants and promises contained herein, the Parties agree as follows:

ARTICLE I

DEFINITIONS AND ACRONYMS

The following terms and acronyms as used in this Contract and the attachments, exhibits, addenda and amendments hereto shall be construed and interpreted as follows, unless the context otherwise expressly requires a different construction or interpretation:

Definitions

1.1 **820 Payment File** means the electronic HIPAA transaction that Contractor retrieves from the Department that identifies each Enrollee for whom payment was made by the Department to Contractor.

1.2 **834 Audit File** means the electronic HIPAA transaction that Contractor retrieves monthly from the Department that reflects its Enrollees for the following calendar month.

1.3 **834 Daily File** means the electronic HIPAA transaction that Contractor retrieves from the Department each day that reflects changes in enrollment subsequent to the previous 834 Audit File.

1.4 **837D File** means the electronic HIPAA transaction that Contractor transfers to the Department that identifies health care claims for dental claims or Encounters.

1.5 **837I File** means the electronic HIPAA transaction that Contractor transfers to the Department that identifies health care claims for institutional claims and Encounters.

1.6 **837P File** means the electronic HIPAA transaction that Contractor transfers to the Department that identifies health care claims for professional claims and Encounters.

1.7 **Abuse** means (i) a manner of operation that results in excessive or unreasonable costs to the Federal or State health care programs, generally used in conjunction with Fraud; or (ii) the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish (42 C.F.R. Section 488.301), generally used in conjunction with Neglect.

1.8 **Action** means (i) the denial or limitation of authorization of a requested service; (ii) the reduction, suspension, or termination of a previously authorized service; (iii) the denial of payment for a service; (iv) the failure to provide services in a timely manner; (v) the failure to respond to an Appeal in a timely manner, or (vi) solely with respect to an MCO that is the only contractor serving a rural area, the denial of an Enrollee's request to obtain services outside of the Contracting Area.

1.9 **Activities of Daily Living (ADL)** means activities such as eating, bathing, grooming, dressing, transferring and continence.

1.10 **Administrative Allowance** means that portion of the Capitation allocated by the Department for the administrative cost of the Contract.

1.11 **Administrative Rules** means the sections of the Illinois Administrative Code that govern the HFS Medical Program.

1.12 **Adults with Disabilities** means individuals who are nineteen (19) years of age or older, who meet the definition of blind or disabled under Section 1614(a) of the Social Security Act (42 U.S.C.1382), and who are eligible for Medicaid.

1.13 **Advance Directive** means an individual's written directive or instruction, such as a power of attorney for health care or a living will, for the provision of that individual's health care if the individual is unable to make his or her health care wishes known.

1.14 **Advanced Practice Nurse (APN)** means a Provider of medical and preventive services, including Certified Nurse Midwives, Certified Family Nurse Practitioners and Certified Pediatric Nurse Practitioners, who is licensed as an APN, holds a valid license in Illinois, is legally authorized under statute or rule to provide services, and is enrolled with the Department and contracted with Contractor.

1.15 **Affiliate** means any individual, firm, corporation (including, without limitation, service corporation and professional corporation), partnership (including, without limitation, general partnership, limited partnership and limited liability partnership), limited liability company, joint venture, business trust, association or other contractor that now or in the future directly or indirectly controls, is controlled by, or is under common control with Contractor.

1.16 **Affiliated** means associated with Contractor for the purpose of providing health care services under the Contract for the Integrated Care Program pursuant to a written contract or agreement, including, but not limited to, a contracted Provider and network Provider. Affiliated Providers, however, shall not include a Provider who has an agreement or contract with an MCO for the provision of limited services (e.g., a single case agreement).

1.17 **Anniversary Date** means the annual anniversary date of an Enrollee's initial enrollment in the MCO. For example, if an Enrollee's enrollment in an MCO became effective on October 1, 2011, the Anniversary Date with that MCO would be each October 1 thereafter.

1.18 **Appeal** means a request for review of a decision made by Contractor with respect to an Action.

1.19 **Authorized Person(s)** means the Department's Office of Inspector General, the Medicaid Fraud Control Unit of the Illinois State Police, DHHS, the Illinois Auditor General and other State and federal agencies with monitoring authority related to Medicaid.

1.20 **Business Day** means Monday through Friday, 8:00 a.m. to 5:00 p.m. Central Time and including State holidays except for New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day and Christmas Day.

1.21 **Capitation** means the reimbursement arrangement in which a fixed rate of payment per Enrollee per month is made, regardless of whether the Enrollee receives Covered Services in that month, to Contractor for the performance of all of Contractor's duties and responsibilities pursuant to the Contract.

1.22 **Care Coordinator** means an employee of Contractor who, together with an Enrollee and Providers, establishes an Enrollee Care Plan for the Enrollee and, through interaction with network Providers, ensures the Enrollee receives necessary services.

1.23 **Care Management** means services that assist Enrollees in gaining access to needed services, including medical, social, educational and other services, regardless of the funding source for the services.

1.24 **Centers for Medicare & Medicaid Services (Federal CMS)** means the agency within DHHS that is responsible for the administration of the Medicare program and, in partnership with the states, administers Medicaid, the State Children's Health Insurance Program (SCHIP), and the Health Insurance Portability and Accountability Act (HIPAA).

1.25 **Certified Local Health Department** means an agency of local government authorized under 77 Ill. Adm. Code Part 600 to develop and administer programs and services that are aimed at maintaining a healthy community.

1.26 **Change of Control** means any transaction or combination of transactions resulting in: (i) the change in ownership of a contractor; (ii) the sale or transfer of fifty percent (50%) or more of the beneficial ownership of a contractor; or (iii) the divestiture, in whole or in part, of the business unit or division of a Party that is obligated to provide the products and services set forth in this Contract.

1.27 **Chronic Health Condition** means a health condition with an anticipated duration of at least twelve (12) months.

1.28 **Cognitive Disabilities** means a disability that may cover a wide range of needs and abilities that vary for each specific individual. Conditions range from individuals having a serious mental impairment caused by Alzheimer's disease, bipolar disorder or medications to non-organic disorders such as dyslexia, attention deficit disorder, poor literacy or problems understanding information. At a basic level, these disabilities affect the mental process of knowledge, including aspects such as awareness, perception, reasoning, and judgment.

1.29 **Complaint** means a phone call, letter or personal contact from a Participant, Enrollee, family member, Enrollee representative or any other interested individual expressing a concern related to the health, safety or well-being of an Enrollee.

1.30 **Computer Aided Real-time Translation (CART)** means the instant translation of spoken word into text performed by a CART reporter using a stenotype machine, notebook computer and real-time software.

1.31 **Confidential Information** means any material, data, or information disclosed by either Party to the other that, pursuant to agreement of the Parties or the State's grant of a proper request for confidentiality, is not generally known by or disclosed to the public or to Third Parties including, without limitation: (i) all materials, know-how, processes, trade secrets, manuals, confidential reports, services rendered by the State, financial, technical and operational information, and other matters relating to the operation of a Party's business; (ii) all information and materials relating to Third Party contractors of the State that have provided any part of the State's information or communications

infrastructure to the State; (iii) software; and (iv) any other information that the Parties agree should be kept confidential.

1.32 **Consumer Assessment of Healthcare Providers and Systems (CAHPS)** means the survey developed by the program funded by the U.S. Agency for Healthcare Research and Quality which works closely with a consortium of public and private organizations. The CAHPS program develops and supports the use of a comprehensive and evolving family of standardized surveys that ask consumers and patients to report on and evaluate their experience with ambulatory and facility level care.

1.33 **Contract** means this document, inclusive of all attachments, exhibits, schedules, addenda, and any subsequent amendments hereto.

1.34 **Contracting Area** means the area in which the Integrated Care Program is operational, consisting of those geographic areas as set forth in Attachment IV.

1.35 **Coverage Year** means the period of time described by this term as set forth in Section 7.11.5.

1.36 **Covered Services** means those benefits and services agreed to by the Parties as described in Section 5.1 of this Contract.

1.37 **Determination of Need (DON)** means the tool used by the Department or the Department's authorized representative to determine eligibility (level of care) for Nursing Facility and Home and Community-Based Services (HCBS) Waivers for individuals with disabilities, HIV/AIDS, brain injury, supportive living and the elderly. This assessment includes scoring for a mini-mental state examination_(MMSE), functional impairment and unmet need for care in fifteen (15) areas including Activities of Daily Living and Instrumental Activities of Daily Living. The final score is calculated by adding the results of the MMSE, the level of impairment and the unmet need for care scores. In order to be eligible for Nursing Facility or HCBS Waiver services, an individual must receive at least fifteen (15) points on functional impairment section and a minimum total score of twenty-nine (29) points.

1.38 **Developmental Disability(ies) (DD)** means a disability that (i) is attributable to a diagnosis of mental retardation or related condition such as cerebral palsy or epilepsy, (ii) manifests before the age of twenty-two (22) and is likely to continue indefinitely, (iii) results in impairment of general intellectual functioning or adaptive behavior, and (iv) results in substantial functional limitations in three (3) or more areas of major life activities, such as self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living.

1.39 **DHHS** means the United States Department of Health and Human Services.

1.40 **DHS** means the Illinois Department of Human Services, and any successor agency.

1.41 **DHS-DASA** means the Division of Alcohol and Substance Abuse within DHS that operates treatment services for alcoholism & addiction through an extensive treatment provider network throughout the State. http://www.dhs.state.il.us/page.aspx?item=29725**DHS-DDD** means the Division of Developmental Disabilities within DHS that operates programs for individuals with Developmental Disabilities.

1.42 **DHS-DMH** means the Division of Mental Health within DHS that is the State mental health authority.

1.43 **DHS-DRS** means the Division of Rehabilitation Services within DHS that operates the home services programs for individuals with physical disabilities, brain injury and HIV/AIDS.

1.44 **DHS-OIG** means the Department of Human Services Office of Inspector General that is the entity responsible for investigating allegations of Abuse and Neglect of people who receive Mental Health or Developmental Disabilities services in Illinois and for seeking ways to prevent such Abuse and Neglect. Annual reporting is conducted in response to the Department of Human Services Act (20 ILCS 1305/1-17) and the Adults with Disabilities Domestic Abuse Intervention Act (20 ILCS 2435). http://www.dhs.state.il.us/page.aspx?item=29972

1.45 **Diagnostic Related Grouping (DRG)** means the methodology by which a hospital is reimbursed based on the diagnoses and procedures performed during the hospital stay. The diagnoses associated with the hospital stay are placed into groups requiring a similar intensity of services. The DRG reimbursement, similar to the system used by the federal Medicare program, is based on the average cost of providing services for the specific diagnosis group, regardless of how long a specific Participant may have actually been in the hospital.

1.46 **Disaster** means an outage or failure of the Department's or Contractor's data, electrical, telephone, technical support, or back-up system, whether such outage or failure is caused by an act of nature, equipment malfunction, human error, or other source.

1.47 **Disease Management Program (DM)** means a program that employs a set of interventions designed to improve the health of individuals, especially those with Chronic Health Conditions. Disease Management Program services include: (i) a population identification process; (ii) use and promotion of evidence-based guidelines; (iii) use of collaborative practice models to include Physician and support service Providers; (iv) Enrollee self-management education (includes primary prevention, behavioral modification, and compliance surveillance); (v) Care Management; (vi) process and outcome measurement, evaluation and management; and (vii) routine reporting/feedback loop (includes communication with the Enrollee, Physician, ancillary Providers and practice profiling). A Disease Management Program may be a part of a Care Management program.

1.48 **DoA** means the Illinois Department on Aging, and any successor agency.

1.49 **DPH** means the Illinois Department of Public Health, and any successor agency, that is the State survey agency responsible for promoting the health of the people of Illinois through the prevention and control of disease and injury, and conducting the activities related to licensure and certification of NF's and ICF/DD facilities.

1.50 **Effective Date** means the date of the last signature by a Party in Execution of this Contract.

1.51 **Emergency Medical Condition** means a medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to, severe pain) such that a prudent layperson, who possesses an average knowledge of health

and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

1.52 **Emergency Services** means those inpatient and outpatient health care services that are Covered Services, including transportation, needed to evaluate or Stabilize an Emergency Medical Condition, and which are furnished by a Provider qualified to furnish Emergency Services.

1.53 **Encounter** means an individual service or procedure provided to an Enrollee that would result in a claim if the service or procedure were to be reimbursed as Fee-For-Service under the HFS Medical Program.

1.54 **Encounter Data** means the compilation of data elements, as specified by the Department in written notice to Contractor, identifying an Encounter that includes information similar to that required in a claim for Fee-For-Service payment under the HFS Medical Program.

1.55 **Enrollee** means a Participant who is enrolled in an MCO. "Enrollee" shall include the guardian where the Enrollee is an adult for whom a guardian has been named; provided, however, that Contractor is not obligated to cover services for any individual who is not enrolled as an Enrollee with Contractor.

1.56 **Enrollee Care Plan** means an Enrollee-centered, goal-oriented, culturally relevant, and logical, written plan of care that assures that the Enrollee receives medical and medically-related necessary services in a supportive, effective, efficient, timely and cost-effective manner that emphasizes prevention and continuity of care.

1.57 **Enrollment Period** means the twelve (12) month period beginning with the effective date of enrollment of the Enrollee in an MCO.

1.58 **Execution** means the point at which all of the Parties have signed the Contract between Contractor and the Department.

1.59 **External Quality Review Organization (EQRO)** means an organization contracted with the Department that meets the competence and independence requirements set forth in 42 C.F.R. Section 438.354, and performs external quality review (EQR) and EQR-related activities as set forth in 42 C.F.R. Section 438.358.

1.60 **Family Training** means training for unpaid family members, including instruction about treatment regimens, Cardiopulmonary Resuscitation (CPR), and use of equipment or other services identified in the Enrollee Care Plan.

1.61 **Federally Qualified Health Center (FQHC)** means a health center that meets the requirements of 89 IL Admin Code 140.461(d).

1.62 **Fee-For-Service** means the method of charging that bills for each Encounter or service rendered.

1.63 **Fraud** means knowing and willful deception, or a reckless disregard of the facts, with the intent to receive an unauthorized benefit.

1.64 **Grievance** means an expression of dissatisfaction by an Enrollee, including Complaints and requests for disenrollment, about any matter other than a matter that is properly the subject of an Appeal.

1.65 **Group Practice** means a group of PCPs who share a practice or are affiliated and provide direct medical or other services to Enrollees of any PCP within that practice.

1.66 **Habilitation** means an effort directed toward the alleviation of a disability or toward increasing an individual's level of physical, mental, social or economic functioning. Habilitation may include, but is not limited to, diagnosis, evaluation, medical services, residential care, day care, special living arrangements, training, education, sheltered employment, protective services, counseling and other services.

1.67 **Health Insurance Portability and Accountability Act (HIPAA)** means the federal law that includes provisions that allow individuals to qualify immediately for comparable health insurance coverage when they change their employment relationships, and that authorizes DHHS to: (i) mandate standards for electronic exchange of health care data; (ii) specify what medical and administrative code sets should be used within those standards; (iii) require the use of national identification systems for health care patients, Providers, payers (or plans), and employers (or sponsors); and (iv) specify the types of measures required to protect the security and privacy of personally identifiable health care information.

1.68 **Health Maintenance Organization (HM0)** means a health maintenance organization as defined in the Health Maintenance Organization Act (215 ILCS 125/1-1 et seq.).

1.69 **Health Plan Employer Data and Information Set (HEDIS®)** means the Healthcare Effectiveness Data and Information Set established by the National Committee for Quality Assurance (NCQA).

1.70 **HFS** means the Illinois Department of Healthcare and Family Services and any successor agency. In this Contract, HFS may also be referred to as "Agency" or "the Department".

1.71 **HFS Medical Program** means the (i) Illinois Medical Assistance Program administered under Article V of the Illinois Public Aid Code (305 ILCS 5/5-1 et seq.) or its successor program, and Title XIX (42 USC 1396 et seq.) and XXI (42 USC 1397aa et seq.) of the Social Security Act, and Section 12-4.35 of the Illinois Public Aid Code (305 ILCS 5/12-435); and (ii) the State Children's Health Insurance Program administered under 215 ILCS 106 and Title XXI of the Social Security Act (42 USC 1397aa et seq.)

1.72 **Home and Community-Based Services (HCBS) Waivers** means waivers under Section 1915(c) of the Social Security Act that allow Illinois to cover home and community services and provide programs that are designed to meet the unique needs of individuals with disabilities who qualify for the level of care provided in an institution but who, with special services, may remain in their homes and communities.

1.73 **Homemaker Service** means general non-medical support by supervised and trained homemakers to assist Participants with their ADL and IADL.

1.74 **Hospitalist** means a Physician who is part of a coordinated group working together, whose entire professional focus is the general medical care of hospitalized Enrollees in an acute care facility and whose activities include Enrollee care, communication with families, significant others, PCPs, and hospital leadership related to hospital medicine.

1.75 **ILCS** means Illinois Compiled Statutes, an unofficial version of which can be viewed at http://www.ilga.gov/legislation/ilcs/ilcs.asp.

1.76 **Illinois Client Enrollment Broker (ICEB)** means the entity contracted by the Department to conduct enrollment activities for Potential Enrollees, including providing impartial education on health care delivery choices, providing enrollment materials, assisting with the selection of an MCO and PCP, and processing requests to change MCOs.

1.77 **Institutionalization** means residency in a nursing facility, ICF/DD or State operated facility, but does not include admission in an acute care or Rehabilitation hospital setting.

1.78 **Instrumental Activities of Daily Living (IADL)** means managing money, meal preparation, telephoning, laundry, housework, being outside the home, routine health, special health and being alone.

1.79 **Integrated Care Program** means the program under which the Department will contract with MCOs to provide the full spectrum of Medicaid Covered Services to Enrollees through an integrated care delivery system in the Contracting Area.

1.80 **Intermediate Care Facility (ICF)** means a facility for Residents who have long-term illnesses or disabilities and who may have reached a relatively stable plateau, that provides basic nursing care and other restorative services under periodic medical direction, including services that may require skill in administration.

1.81 **Intermediate Care Facility for the Developmentally Disabled (ICF/DD)** means a facility for Residents who have physical, intellectual, social and emotional needs, that provides services primarily for ambulatory adults with Developmental Disabilities and addresses itself to the needs of individuals with mental disabilities or those with related conditions. Also known as Intermediate Care Facility for the Mentally Retarded (ICF/MR).

1.82 **Key Oral Contact** means contact between Contractor and the Enrollee, Potential Enrollee or Prospective Enrollee, including, but not limited to: (i) a contact with a Care Coordinator and other Contractor staff involved with direct Enrollee care; (ii) a contact to explain benefits, initial choice or change of PCP and WHCP; (iii) a telephone call to the toll-free phone line(s); and, (iv) an Enrollee's face-to-face encounters with a Provider rendering care.

1.83 **Long-Term Care (LTC) Facility or Nursing Facility (NF)** means: (i) a facility that provides Skilled Nursing or intermediate long-term care services, whether public or private and whether organized for profit or not-for-profit, that is subject to licensure by the DPH under the Nursing Home Care Act, including a county nursing home directed and maintained under Section 5-1005 of the Counties Code; and (ii) a part of a hospital in which Skilled Nursing or intermediate long-term care services within the meaning of Title XVIII or XIX of the Social Security Act are provided.

1.84 **Managed Care Organization (MCO)** means an entity that meets the definition of managed care organization as defined at 42 C.F.R. 438.2 and that has a contract with the Department for the Integrated Care Program. It includes Contractor and may also include another such entity with a contract with the Department to provide Covered Services in the Contracting Area.

1.85 **Mandated Reporting** means immediate reporting required from a mandated reporter of suspected maltreatment when the mandated reporter has reasonable cause to believe that an individual known to the mandated reporter in a professional or official capacity may be Abused or Neglected. .

1.86 **Marketing** means any written or oral communication from Contractor or its representative that can reasonably be interpreted as intended to influence a Participant to enroll, not to enroll, or to disenroll from a health care delivery system.

1.87 **Marketing Materials** means materials produced in any medium, by or on behalf of Contractor or its representative that can reasonably be interpreted as intended to market to Potential Enrollees. Marketing Materials includes Written Materials and oral presentations.

1.88 **Marketing Misconduct** means any activity by an employee or representative of Contractor that is in violation of any provisions related to Marketing.

1.89 **Medicaid Program** means the program under Title XIX of the Social Security Act that provides medical benefits to people with low income.

1.90 **Medically Necessary** means a service, supply or medicine that is appropriate and meets the standards of good medical practice in the medical community, as determined by the Provider in accordance with Contractor's guidelines, policies or procedures, for the diagnosis or treatment of a covered illness or injury, for the prevention of future disease, to assist in the Enrollee's ability to attain, maintain, or regain functional capacity, or to achieve age-appropriate growth.

1.91 **Mental Illness (MI)** means a diagnosis of schizophrenia, delusional disorder, schizoaffective disorder, psychotic disorder not otherwise specified, bipolar disorder, or recurrent major depression resulting in substantial functional limitations.

1.92 **National Committee for Quality Assurance (NCQA)** means a private 501(c)(3) not-for-profit organization that is dedicated to improving health care quality and that has a process for providing accreditation, certification and recognition, e.g., health plan accreditation.

1.93 **National Council for Prescription Drug Program (NCPDP)** means the electronic HIPAA transaction that Contractor transfers to the Department that identifies health care claims for pharmacy claims and Encounters.

1.94 **Neglect** means a failure (i) to notify the appropriate health care professional, (ii) to provide or arrange necessary services to avoid physical or psychological harm to a Resident, or (iii) to terminate the residency of a Participant whose needs can no longer be met, causing an avoidable decline in function. Neglect may be either passive (non-malicious) or willful.

1.95 **Negotiated Risk** means the process by which an Enrollee, or his or her representative, may negotiate and document with Providers what risks each is willing to assume in the provision of Medically Necessary Covered Services and the Enrollee's living environment, and by which the Enrollee is informed of the risks of these decisions and of the potential consequences of assuming these risks.

1.96 **Nursing Facility (NF)** - See Long-Term Care Facility.

1.97 **Occupational Therapy** means a medically prescribed service identified in the Enrollee Care Plan that is designed to increase independent functioning through adaptation of the tasks and environment, and that is provided by a licensed occupational therapist who meets Illinois licensure standards. http://www.idfpr.com/dpr/WHO/ot.asp.

1.98 **Office of Inspector General (OIG)** means the Office of Inspector General for the Department as set forth in 305 ILCS 5/12-13.1.

1.99 **Older Adult** means an individual who is sixty-five (65) years of age or older and who is eligible for Medicaid.

1.100 **Open Enrollment Period** means the specific period of time each year in which an Enrollee shall have the opportunity to change from one MCO to another MCO.

1.101 **Participant** means any individual determined to be eligible for the Medicaid Program.

1.102 **Party/Parties** means the State, through HFS, and Contractor.

1.103 **Performance Improvement Project** means an ongoing program for improvement that focuses on clinical and nonclinical areas, and that involves (i) measurement of performance using objective quality indicators, (ii) implementation of system interventions to achieve improvement in quality, (iii) evaluation of the effectiveness of the interventions, and (iv)planning and initiation of activities for increasing or sustaining improvement.

1.104 **Performance Measure** means a quantifiable measure to assess how well an organization carries out a specific function or process.

1.105 **Person** means any individual, corporation, proprietorship, firm, partnership, trust, association, governmental authority, contractor, or other legal entity whatsoever, whether acting in an individual, fiduciary, or other capacity.

1.106 **Person With an Ownership or Controlling Interest** means a Person that: (i) has a direct or indirect, singly or in combination, ownership interest equal to five percent (5%) or more in Contractor; (ii) owns an interest of five percent (5%) or more in any mortgage, deed of trust, note or other obligations secured by Contractor if that interest equals at least five percent (5%) of the value of the property or assets of Contractor; (iii) is an officer or director of Contractor if Contractor is organized as a corporation, (iv) is a member of Contractor if Contractor is organized as a limited liability company; or, (v) is a partner in Contractor if Contractor is organized as a partnership.

1.107 **Personal Assistant** means an individual who provides Personal Care to a Participant when it has been determined by the care manager that the Participant has the ability to supervise the Personal Assistant.

1.108 **Personal Care** means assistance with meals, dressing, movement, bathing or other personal needs or maintenance or general supervision and oversight of the physical and mental well-being of a Participant.

1.109 **Personal Emergency Response System (PERS)** means an electronic device that enables a Participant who is at high risk of Institutionalization to secure help in an emergency.

1.110 **Physical Therapy** means a medically-prescribed service that is provided by a licensed physical therapist and identified in the Enrollee Care Plan that utilizes a variety of methods to enhance an Enrollee's physical strength, agility and physical capacity for ADL.

1.111 **Physician** means an individual licensed to practice medicine in all its branches in Illinois under the Medical Practice Act of 1987 or any such similar statute of the state in which the individual practices medicine.

1.112 **Post-Stabilization Services** means Medically Necessary Non-Emergency Services furnished to an Enrollee after the Enrollee is Stabilized following an Emergency Medical Condition, in order to maintain such Stabilization.

1.113 **Potential Enrollee** means a Participant who is subject to mandatory enrollment, or is eligible to voluntarily enroll, in the Integrated Care Program, but is not yet an Enrollee of an MCO. Participants who are Potential Enrollees covered by this Contract are set forth in Attachment IV. Potential Enrollee includes Participants within the Contracting Area who, pursuant to federal law, have the option to enroll with an MCO.

1.114 **Primary Care Provider (PCP)** means a Provider, including a WHCP, who within the Provider's scope of practice and in accordance with State certification requirements or State licensure requirements, is responsible for providing all preventive and primary care services to his or her assigned Enrollees in the MCO.

1.115 **Prior Approval** means review and written approval by the Department of any Contractor materials or actions, as set forth in the Contract, including but not limited to, subcontracts, intended courses of conduct, or procedures or protocols, that Contractor must obtain before such materials are used or such actions are executed, implemented or followed.

1.116 **Prospective Enrollee** means a Potential Enrollee who has begun the process of enrollment with Contractor but whose coverage with Contractor has not yet begun.

1.117 **Protected Health Information (PHI)** means, except as otherwise provided in HIPAA, which shall govern the definition of PHI, information created or received from or on behalf of a Covered Contractor as defined in 45 C.F.R. Section 160.103, that relates to (i) the provision of health care to an individual; (ii) the past, present or future physical or mental health or condition of an individual; or (iii) the past, present or future payment for the provision of health care to an individual. PHI includes demographic information that identifies the individual or that there is a

reasonable basis to believe can be used to identify the individual. PHI is the information transmitted or held in any form or medium.

1.118 **Provider** means a Person enrolled with the Department to provide Covered Services to a Participant. Contractor is not a Provider.

1.119 **Quality Assessment and Performance Improvement (QAPI)** means the program required by 42 C.F.R. Section 438.240, in which MCOs are required to have an ongoing quality assessment and performance improvement program for the services furnished to Enrollees, that: (i) assesses the quality of care and identifies potential areas for improvement, ideally based on solid data and focused on high volume/high risk procedures or other services that promise to substantially improve quality of care, using current practice guidelines and professional practice standards when comparing to the care provided; and (ii) corrects or improves processes of care and clinic operations in a way that is expected to improve overall quality.

1.120 **Quality Assurance (QA)** means a formal set of activities to review, monitor and improve the quality of services by a Provider or MCO, including quality assessment, ongoing quality improvement and corrective actions to remedy any deficiencies identified in the quality of direct Enrollee, administrative and support services.

1.121 **Quality Assurance Plan (QAP)** means a written document developed by Contractor in consultation with its QAP Committee and Medical Director that details the annual program goals and measurable objectives, utilization review activities, access and other performance measures that are to be monitored with ongoing Physician profiling and focus on quality improvement.

1.122 **Quality Assurance Plan (QAP) Committee** means a committee established by Contractor, with the approval of the Department, that consists of a cross representation of all types of Providers, including PCPs, specialists, dentists and long term care representatives from Contractor's network and throughout the entire Contracting Area and that, at the request of the Department, shall include the Department staff in an advisory capacity.

1.123 **Quality Assurance Program** means Contractor's overarching mission, vision and values, which, through its goals, objectives and processes committed in writing in the QAP, are demonstrated through continuous improvement and monitoring of medical care, Enrollee safety, behavioral health services, and the delivery of services to Enrollees, including ongoing assessment of program standards to determine the quality and appropriateness of care, Care Management and coordination. It is implemented through the integration, coordination of services, and resource allocation throughout the organization, its partners, Providers, other entities delegated to provide services to Enrollees, and the extended community involved with Enrollees.

1.124 **Quality Improvement Organization (QIO)** means an organization designated by Federal CMS as set forth in Section 1152 of the Social Security Act and 42 C.F.R. Section 476, that provides Quality Assurance, quality studies and inpatient utilization review for the Department in the Fee-For-Service program and Quality Assurance and quality studies for the Department in the HCBS setting.

1.125 **Quality Improvement System for Managed Care (QISMC)** means a quality assessment and improvement strategy to strengthen an MCO's efforts to protect and improve the health and satisfaction of Enrollees.

1.126 **Readiness Review** means the process by which the Department, or its designee, assesses Contractor's ability to fulfill Contractor's duties and obligations under the Contract, including, but not limited to, reviewing Contractor's model Provider agreements, the Affiliated Provider network, the Quality Assurance Program, staffing for operations, and information systems.

1.127 **Referral** means an authorization provided by a PCP to enable an Enrollee to seek medical care from another Provider.

1.128 **Rehabilitation** means the process of restoration of skills to an individual who has had an illness or injury so as to regain maximum self-sufficiency and function in a normal or as near normal manner as possible in therapeutic, social, physical, behavioral and vocational areas.

1.129 **Resident** means an Enrollee who is living in a facility and whose facility services are eligible for Medicaid payment.

1.130 **Respite** means services that provide the needed level of care and supportive services to enable the Enrollee to remain in the community, or home-like environment, while periodically relieving a non-paid family member or other caretaker of care-giving responsibilities.

1.131 **Rural Health Clinic (RHC)** means a Provider that has been designated by the Public Health Service, DHHS, or the Governor of the State of Illinois, and approved by the Public Health Service, in accordance with the Rural Health Clinics Act (Public Law 95-210) as a RHC.

1.132 **Serious Mental Illness** refers to emotional or behavioral functioning so impaired as to interfere with the individual's capacity to remain in the community without supportive treatment.

1.133 **Service Authorization Request** means a request by an Enrollee or by a Provider on behalf of an Enrollee for the provision of a Covered Service.

1.134 **Site** means any contracted Provider through which Contractor arranges the provision of primary care to Enrollees.

1.135 **Skilled Nursing** means nursing services provided within the scope of the Illinois Nurse Practice Act by registered nurses, licensed practical nurses, or vocational nurses licensed to practice in the State.

1.136 **Skilled Nursing Facility (SNF)** means a group care facility that provides Skilled Nursing care, continuous Skilled Nursing observations, restorative nursing and other services under professional direction with frequent medical supervision, during the post acute phase of illness or during reoccurrences of symptoms in long-term illness.

1.137 **SNFist** means a Physician or APN licensed under the Illinois Nurse Practice Act who is part of an organized system of care, meaning a coordinated group working

together, whose entire professional focus is the general medical care of individuals residing in a Nursing Facility and whose activities include Enrollee care oversight, communication with families, significant others, PCPs, and Nursing Facility administration.

1.138 **Speech Therapy** means a medically-prescribed speech or language-based service that is provided by a licensed speech therapist and identified in the Enrollee Care Plan, and that is used to evaluate or improve an Enrollee's ability to communicate.

1.139 **Spend-down** means the policy that allows an individual to qualify for the Medicaid Program by incurring medical expenses at least equal to the amount by which his or her income or assets exceed eligibility limits. It operates similarly to deductibles in private insurance in that the Spend-down amount represents medical expenses the individual is responsible to pay.

1.140 **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.

1.141 **State** means the State of Illinois, as represented through any State agency, department, board, or commission.

1.142 **State Fiscal Year (SFY)** means the State's fiscal year, which begins on the first day of July of each calendar year and ends on the last day of June of the following calendar year. For example, SFY 2013 begins July 1, 2012 and ends on June 30, 2013.

1.143 **State Plan** means the Illinois State Plan filed with Federal CMS, in compliance with Title XIX of the Social Security Act.

1.144 **Subcontractor** means an entity, other than a Provider, with which Contractor has entered into a written agreement for the purpose of delegating responsibilities applicable to Contractor under this Contract. When not used as a defined term, "subcontractor" means any subcontractor of Contractor, including Providers and Subcontractors.

1.145 **Supportive Living Facility (SLF)** means a residential apartment-style (assisted living) setting in Illinois that is (i) certified by the Department to provide or coordinate flexible Personal Care services, twenty-four (24) hour supervision and assistance (scheduled and unscheduled), activities, and health related services with a service program and physical environment designed to minimize the need for Residents to move within or from the setting to accommodate changing needs and preferences; (ii) has an organizational mission, service programs and physical environment designed to maximize Residents' dignity, autonomy, privacy and independence; and (iii) encourages family and community involvement.

1.146 **Third Party** means any Person other than the Department, Contractor, or any of Contractor's Affiliates.

1.147 **Utilization Management Program** means a comprehensive approach and planned activities for evaluating the appropriateness, need and efficiency of services, procedures and facilities according to established criteria or guidelines under the provisions of the Integrated Care Program. Utilization Management typically includes new activities or decisions based upon the analysis of care, and describes proactive procedures, including discharge planning, concurrent planning, pre-certification and clinical case appeals. It also covers proactive processes, such as concurrent clinical reviews and peer reviews, as well as Appeals introduced by the Provider, payer or Enrollee.

1.148 **Wellness Programs** means comprehensive services designed to promote and maintain the good health of an Enrollee.

1.149 **Women's Health Care Provider (WHCP)** means a Physician specializing by certification or training in obstetrics, gynecology or family practice.

1.150 **Written Materials** means materials regarding choice of MCO, selecting a PCP or WHCP, Enrollee Handbooks, Basic Information as set forth in Section 5.18.1, and any information or notices distributed by Contractor or required to be distributed to Potential Enrollees, Prospective Enrollees or Enrollees by the Department or regulations promulgated from time to time under 42 C.F.R. Section 438.

Acronyms

1.151	AES:	Advanced Encryption Standard
1.152	APN:	Advanced Practice Nurse
1.153	BEP:	Business Enterprise Program Act for Minorities, Females and Persons with Disabilities
1.154	CAHPS:	Consumer Assessment of Healthcare Providers and Systems
1.155	CART:	Computer Aided Real-time Translation
1.156	C.F.R.:	Code of Federal Regulations
1.157	CMHC:	Community Mental Health Center
1.158	DD:	Developmental Disability
1.159	DHHS:	The United States Department of Health and Human Services
1.160	DHS:	The Illinois Department of Human Services
1.161	DHS-DASA:	The Division of Alcohol and Substance Abuse within DHS
1.162	DHS-DDD:	The Division of Developmental Disabilities within DHS
1.163	DHS-DMH:	The Division of Mental Health within DHS
1.164	DHS-DRS:	The Division of Rehabilitation Services within DHS
1.165	DHS-OIG:	The Department of Human Services Office of Inspector General
1.166	DoA:	The Illinois Department on Aging
1.167	DOC:	The Illinois Department of Corrections

1.168	DON:	Determination of Need
1.169	DPH:	The Illinois Department of Public Health
1.170	DRG:	Diagnostic Related Grouping
1.171	DSCC:	Division of Specialized Care for Children
1.172	EQRO:	External Quality Review Organization
1.173	Federal CMS:	Centers for Medicare & Medicaid Services
1.174	FQHC:	Federally Qualified Health Center
1.175	HCBS Waivers:	Home and Community-Based Services Waivers
1.176	HCP:	Home Care Program
1.177	HEDIS®:	Health Plan Employer Data and Information Set
1.178	HFS:	The Illinois Department of Healthcare and Family Services
1.179	HIPAA:	Health Insurance Portability and Accountability Act
1.180	HMO:	Health Maintenance Organization
1.181	HSP:	Home Services Program
1.182	IBNP:	Incurred But Not Paid
1.183	ICEB:	Illinois Client Enrollment Broker
1.184	ICF:	Intermediate Care Facility
1.185	ICF/DD:	Intermediate Care Facility for the Developmentally Disabled
1.186	ICF/MR:	Intermediate Care Facility for the Mentally Retarded
1.187	ILCS:	Illinois Compiled Statutes
1.188	IPSEC:	Internet Protocol Security
1.189	LTC:	Long-Term Care
1.190	MCO:	Managed Care Organization
1.191	MFTD:	Medically Fragile/Technology Dependent
1.192	MI:	Mental Illness
1.193	MIS:	Management Information System
1.194	NCQA:	National Committee for Quality Assurance
1.195	NF:	Nursing Facility
1.196	OIG:	Office of Inspector General
1.197	PCCM:	Primary Care Case Management
1.198	PCP:	Primary Care Provider
1.199	PERS:	Personal Emergency Response System
1.200	PHI:	Protected Health Information
1.201	PIP:	Performance Improvement Project
1.202	PR:	Peer Review

1.203	QA:	Quality Assurance
1.204	QAP:	Quality Assurance Plan
1.205	QAPI:	Quality Assessment and Performance Improvement
1.206	QIO:	Quality Improvement Organization
1.207	QISMC:	Quality Improvement System for Managed Care
1.208	RHC:	Rural Health Clinic
1.209	SFY:	State Fiscal Year
1.210	SLF:	Supportive Living Facility
1.211	SNF:	Skilled Nursing Facility
1.212	TDD:	Telecommunications Device for the Deaf
1.213	TTY:	Teletypewriter
1.214	UR:	Utilization Review
1.215	VPN:	Virtual Private Network
1.216	WHCP:	Women's Health Care Provider

ARTICLE II

TERMS AND CONDITIONS

2.1 **Rules of Construction**. Unless otherwise specified or the context otherwise requires:

2.1.1 Provisions apply to successive events and transactions;

2.1.2 "Or" is not exclusive;

2.1.3 References to statutes, regulations, and rules include subsequent amendments and successors thereto;

2.1.4 The various headings of this Contract are provided for convenience only and shall not affect the meaning or interpretation of this Contract or any provision hereof;

2.1.5 If any payment or delivery hereunder between Contractor and the Department shall be due on any day that is not a Business Day, such payment or delivery shall be made on the next succeeding Business Day;

2.1.6 Words in the plural that should be singular by context shall be so read, and words in the singular shall be read as plural where the context dictates;

2.1.7 Days shall mean calendar days;

2.1.8 References to masculine or feminine pronouns shall be interchangeable where the context requires;

2.1.9 References in the Contract to Potential Enrollee, Prospective Enrollee and Enrollee shall include the parent, caretaker relative or guardian where such Potential Enrollee, Prospective Enrollee or Enrollee is a minor child or an adult for whom a guardian has been named; provided, however, that this rule of construction does not require Contractor to provide Covered Services for a parent, caretaker relative or guardian who is not separately enrolled as an Enrollee with Contractor;

2.1.10 Contractor agrees that its representations regarding any service, standard or methodology that is in Contractor's response to the Request for Proposal No. 2010-24-005 (RFP), together with any best and final offers agreed to by the Parties in writing (collectively, "Proposal") and that is not otherwise excluded from, prohibited by, contrary to or materially altered by this Contract is a binding duty, responsibility or obligation on Contractor and performance of such, or similar as may be agreed to by the Parties, may be required by the Department without amending this Contract. The Parties acknowledge that Contractor specifically provided names of various programs, methodologies, strategies and coordination tools that Contractor uses in the conduct of its business separate and apart from this Contract and that these names and their descriptions are referenced from time to time throughout this Contract. The Department acknowledges that Contractor may change the names of the various programs, methodologies, strategies and coordination tools, may change its vendors providing such, and may enhance such from time to time without amending this Contract; provided, however, that at no time may Contractor diminish their functionality in the aggregate;

2.1.11 The terms of this Contract shall be interpreted if possible to be consistent with the terms of the RFP under which the Contract was awarded and with the Proposal submitted by Contractor in response to the RFP. In the event of a conflict, the order of precedence for the interpretation of this Contract is: this Contract (including amendments, schedules, attachments, addenda and exhibits), the RFP (including the Department's responses to questions submitted by potential bidders), and the Proposal submitted by Contractor in response to the RFP;

2.1.12 Whenever this Contract requires that an action be taken within a specified time period after receipt of a notice, document, report or other communication, the date the notice, document, report or other communication shall be deemed to have been received shall be in accordance with the following:

2.1.12.1 if sent by first class mail, on the date of postmark by the United States Postal Service (USPS);

2.1.12.2 if sent by registered or certified mail, on the date of signature on the USPS return receipt;

2.1.12.3 if sent by courier or hand-delivery, on the date of signature on the courier's receipt form;

2.1.12.4 if sent by e-mail, fax, or other electronic means, on the date of transmission.

2.1.13 Whenever this Contract requires that a notice, document, report or other communication be sent within a specified time period after another action, the date the notice, document, report or other communication shall be deemed to have been sent shall be in accordance with the following:

2.1.13.1 if sent by first class, registered or certified mail, on the date of postmark by the USPS;

2.1.13.2 if sent by courier, on the date of delivery to the courier;

2.1.13.3 if sent by e-mail, fax, or other electronic means, on the date of transmission.

2.2 **Performance of Services and Duties**. Contractor shall perform all services and other duties as set forth in this Contract in accordance with, and subject to, all applicable federal and State statutes, rules and regulations.

2.3 **List of Individuals in an Administrative Capacity**. Upon Execution of this Contract, Contractor shall provide to the Department a list of individuals authorized by Contractor who have responsibility for monitoring and ensuring the performance of each of the duties and obligations under this Contract, and their resumes. Contractor will maintain an administrative and organizational structure that supports a high quality, comprehensive managed care system. Contractor will fill vacant key positions in a timely manner. Contractor will employ senior level managers with sufficient experience and expertise in health care management, and employ or contract with skilled clinicians for medical management activities. This list of individuals in an administrative capacity, and their resumes, shall be updated throughout the term of this Contract as necessary and as changes

occur. Written notice of such changes shall be given to the Department no later than ten (10) Business Days after such changes occur. At a minimum, Contractor shall provide the key positions identified in this Section 2.3 (either through direct employment or contract). The Department acknowledges that the position titles in this Section 2.3 may not be the position titles that Contractor currently uses and that position titles may change from time to time. The Department further acknowledges that positions required to be full-time may also have some responsibilities for Contractor's other lines of business. Contractor warrants that such responsibilities shall never detract from or conflict with the obligation to provide the equivalent of full-time resources to ensure the Contract requirements are met. Failure to meet this requirement may result in a monetary performance penalty pursuant to Section 7.16.14 and any other applicable provision of Article VII.

2.3.1 **Chief Executive Officer.** Contractor shall have a full-time Chief Executive Officer operating within Illinois with clear authority over the general administration and implementation of requirements set forth in this Contract, including the responsibility to oversee the budget and accounting system implemented by Contractor. The Chief Executive Officer shall be responsible for the daily conduct and operations.

2.3.2 **Medical Director.** Contractor shall have a full-time Medical Director who is an Illinois licensed Physician. The Medical Director shall be actively involved in all major clinical program components of this Contract, including review of medical care provided, medical professional aspects of Provider contracts, and other areas of responsibility as may be designated by Contractor. The Medical Director shall devote sufficient time to the Contract to ensure that timely medical decisions are made, including after hours consultation as needed. The Medical Director shall be responsible for managing Contractor's QAPI Program. The Medical Director shall attend all quarterly Quality Assurance meetings.

2.3.3 **Quality Management Coordinator**. Contractor shall have a full-time Quality Management Coordinator who shall be (i) a registered nurse licensed in Illinois, or (ii) another licensed clinician as approved by the Department based on Contractor's demonstration that the clinician possesses the training and education necessary to meet the requirements for quality improvement activities required in this Contract. The Quality Management Coordinator shall be located in Illinois. The Quality Management Coordinator shall, at a minimum, be responsible for directing the activities of the quality improvement staff in monitoring and auditing Contractor's healthcare delivery system to meet the Department's goal of providing health care services that improve the health status and health outcomes of Enrollees.

2.3.4 **Utilization Management Coordinator**. Contractor shall have a full-time Utilization Management Coordinator, who shall be (i) a registered nurse licensed in Illinois, or (ii) other professional as approved by the Department based on Contractor's demonstration that the professional possesses the training and education necessary to meet the requirements for utilization review activities required in the Contract. The Utilization Management Coordinator will manage the pre-authorization and Referral functions, and

inpatient certification review staff for inpatient initial, concurrent and retrospective reviews.

2.3.5 Care Coordination and Disease Management Program Manager. Contractor shall have a full-time Care Coordination and Disease Management Program Manager who shall be (i) a registered nurse licensed in Illinois, or (ii) other professional as approved by the Department based on Contractor's demonstration that the professional possesses the training and education necessary to meet the requirements for Care Coordination and Disease Management Program activities required in this Contract. The Care Coordination and Disease Management Program Manager will direct all activities pertaining to Care Management and Care Coordination and monitor the utilization of Enrollees' physical health and behavioral health treatments.

2.3.6 Interagency Liaison. Contractor shall have an Interagency Liaison who shall be responsible for coordinating the provision of services with the HCBS Waivers, community resources, the Department and other State agencies, and any other community entity that traditionally provides services for Enrollees.

2.3.7 Chief Financial Officer. Contractor shall have a full-time Chief Financial Officer who shall be responsible for overseeing the budget and accounting systems of Contractor. The Chief Financial Officer shall, at a minimum, ensure that Contractor meets the Department's requirements for financial performance and reporting.

2.3.8 Member Services Director. Contractor shall have a full-time Member Services Director, who shall: (i) direct the community relations functions of the health plan, (ii) coordinate communications with Enrollees, and (iii) act as an Enrollee advocate, assisting Enrollees when necessary to access culturally competent, high quality integrated medical and behavioral health care.

2.3.9 Provider Service Director. Contractor shall have a full-time Provider Service Director, who shall: (i) coordinate communications between Contractor and its Subcontractors and Providers by overseeing the Provider Network, Provider Relations and Provider Service activities; (ii) serve as liaison with key Subcontractors, Providers and other key stakeholders to address Provider network issues; (iii) develop and conduct Provider education training; (iv) identify any network gaps; and, (v) oversee the Provider call center.

2.3.10 Management Information System (MIS) Director. Contractor shall have a full-time MIS Director, who shall oversee and maintain the data management system to ensure it meets the requirements of this Contract and who shall act as Contractor's primary liaison with the Department for systems compliance issues.

2.3.11 Compliance Officer. Contractor shall have a full-time Compliance Officer who shall oversee Contractor's compliance plan and the Complaint, Grievance and fair hearing process, and ensure and verify that Fraud and Abuse is reported in accordance with the guidelines in 42 C.F.R. Section

438.608. The Compliance Officer shall serve as Contractor's primary liaison with the Department to facilitate communications between the Department and Contractor's executive leadership and staff.

2.4 **Certificate of Authority**. Contractor must obtain and maintain during the term of this Contract a valid Certificate of Authority as a health maintenance organization under 215 ILCS 125/1-1, et seq. Contractor shall provide proof of Certificate of Authority upon the Department's request.

2.5 **Obligation to Comply with Other Laws**. No obligation imposed herein on Contractor shall relieve Contractor of any other obligation imposed by law or regulation, including, but not limited to, those imposed by the Managed Care Reform and Patient Rights Act (215 ILCS 134/1 et seq.), the federal Balanced Budget Act of 1997 (Public Law 105-33), and regulations promulgated by the Illinois Department of Financial and Professional Regulation, the Illinois Department of Public Health or Federal CMS. The Department shall report to the appropriate agency any information it receives that indicates a violation of a law or regulation. The Department will inform Contractor of any such report unless the appropriate agency to which the Department has reported requests that the Department not inform Contractor.

2.5.1 If Contractor believes that it is impossible to comply with a provision of this Contract because of a contradictory provision of applicable State or federal law, Contractor shall immediately notify the Department. The Department then will make a determination of whether a Contract amendment is necessary. The fact that either the Contract or an applicable law imposes a more stringent standard than the other does not, in and of itself, render it impossible to comply with both.

2.6 **Provision of Covered Services through Affiliated Providers**. Where Contractor does not employ Physicians or other Providers to provide direct health care services, every provision in this Contract by which Contractor is obligated to provide Covered Services of any type to Enrollees, including, but not limited to, provisions stating that Contractor shall "provide Covered Services," "provide quality care," or provide a specific type of health care service, such as the enumerated Covered Services in Section 5.1, shall be interpreted to mean that Contractor shall arrange for the provision of those Covered Services through its network of Affiliated Providers.

2.7 **Cultural Competence.** Contractor shall implement a Cultural Competence Plan, and Covered Services shall be provided in a culturally competent manner by ensuring the cultural competence of all Contractor staff, from clerical to executive management, and the Provider network. Contractor shall implement the NCQA Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards).

2.7.1 **Cultural Competence Plan.** Contractor's Cultural Competence Plan shall address the challenges of meeting the health care needs of Enrollees. Contractor's Cultural Competence Plan shall contain, at a minimum, the following provisions:

2.7.1.1 Involvement of executive management, support, Enrollee Care Plans, and Providers in the development and on-going operation of the Cultural Competence Plan;

2.7.1.2 The individual executive position responsible for executing and monitoring the Cultural Competence Plan;

2.7.1.3 The creation and on-going operation of a committee or group within Contractor to assist Contractor to meet the cultural needs of its Enrollees;

2.7.1.4 The assurance of cultural competence at each level of care;

2.7.1.5 Indicators within the Cultural Competence Plan to be used as benchmarks toward achieving cultural competence;

2.7.1.6 The written policies and procedures for cultural competence;

2.7.1.7 The strategy and method for recruiting staff with backgrounds representative of Enrollees served;

2.7.1.8 The availability of interpretive services;

2.7.1.9 On-going strategy and its operation to ameliorate transportation barriers;

2.7.1.10 On-going strategy and its operation to meet the unique needs of Enrollees who have Developmental Disabilities and Cognitive Disabilities;

2.7.1.11 On-going strategy and its operation to provide services for home-bound Enrollees;

2.7.1.12 On-going strategy and its operation describing how Contractor will engage local organizations to develop or provide cultural competency training and collaborate on initiatives to increase and measure the effectiveness of culturally competent service delivery; and,

2.7.1.13 Description of how cultural competence will be and is linked to health outcomes.

2.7.2 **Staff.** Contractor shall proactively hire staff who reflect the diversity of Enrollee demographics. Contractor shall require all staff to complete linguistic and cultural competency training upon hire, and no less frequently than annually thereafter. Contractor shall provide training targeted to individual staff members as necessary.

2.7.3 **Providers.** Contractor shall contract with a culturally-diverse network of Providers of both genders, and prioritize recruitment of bilingual or multi-lingual Providers. Provider contracts will require compliance with Contractor's Cultural Competence Plan. During the credentialing and recredentialing process, Contractor will confirm the languages used by Providers, including American Sign Language, and physical access to Provider office locations.

2.7.4 **Subcontractors.** Contractor will require that its Subcontractors comply with Contractor's Cultural Competence Plan and complete Contractor's initial and annual cultural competence training. Contractor's Delegated

Oversight Committee will provide oversight of subcontractors to ensure compliance with contractual and statutory requirements, including, but not limited to, the Illinois Human Rights Act, the U. S. Civil Rights Act, and Section 504 of the federal Rehabilitation Act. This oversight will occur through quarterly delegation oversight audits, monthly joint operation meetings and regular monitoring of Enrollee Complaints.

2.7.5 **Provider Monitoring.** Contractor shall perform Quality Assurance 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 **Readiness Review.** Contractor shall submit its completed Cultural Competence Plan to the Department at least one (1) week prior to the Department's Readiness Review.

2.8 **Provider Site Access.** All Provider locations where Enrollees receive services shall comply with the requirements of the Americans with Disabilities Act (ADA). Contractor's network shall have Provider locations that are able to accommodate the unique needs of Enrollees.

2.9 **BEP Goals.**

2.9.1 Contractor shall meet the BEP subcontracting goals set by the Department. The Department shall notify Contractor of the goal at least ninety (90) days prior to the start of each State Fiscal Year. The goal will be set as percentages of the administrative allowance included in Capitation payments made to Contractor as set forth in Attachment IV, multiplied by the anticipated Enrollee months during the State Fiscal Year. The calculation for State Fiscal Year 2012 is Addendum A to Attachment VII and, for subsequent State Fiscal Years, additional addenda may be appended to Attachment VII upon written notice to Contractor without amendment of this Contract. The percentages for the goals shall be as follows:

(i) 10% for minority-owned businesses;
(ii) 7% for female-owned businesses;
(iii) 3% for businesses owned by individuals with disabilities.

2.9.2 Prior to the start of each State Fiscal Year, Contractor shall submit a BEP Utilization Plan for such State Fiscal Year, in a format specified by the Department, sufficient to demonstrate compliance with the goals set by the Department for such State Fiscal Year. Contractor shall maintain a record of all relevant data with respect to the utilization of BEP certified subcontractors, including, but not limited to, payroll records, invoices, canceled checks and books of account, for a period of at least five (5) years after the completion of the Contract. Upon three (3) Business Days' written notice, Contractor shall grant full access to these records to any Authorized Person. The Department shall have the right to obtain from Contractor any additional data reasonably related or necessary to verify any representations by Contractor.

ARTICLE III

ELIGIBILITY

3.1 **Determination of Eligibility.** The State has the exclusive right to determine an individual's eligibility for the HFS Medical Program and eligibility to become an Enrollee. Such determination shall be final and is not subject to review or appeal by Contractor. Nothing in this Article III prevents Contractor from providing the Department with information Contractor believes indicates that an Enrollee's eligibility was incorrectly determined or has changed so that enrollment with Contractor is no longer appropriate or that the Capitation rate for that Enrollee should be adjusted. At the sole discretion of the Department, enrollment with Contractor may be expanded to other geographic areas or to other categories of individuals receiving health coverage from the Department upon the Department providing Contractor with written notice no fewer than one hundred eighty (180) days in advance, unless otherwise agreed to by the Parties, before the first enrollment under such expansion. Such notice shall include: (i) the definition of any new geographic area or category of individuals; (ii) the number of Potential Enrollees within any new geographic area or category of individuals; and, (iii) the Capitation rates applicable to any new geographic area or category of individuals.

3.2 **Nondiscrimination.** Contractor shall not discriminate against a Potential Enrollee, Prospective Enrollee or Enrollee on any basis prohibited by Section 9.1.22.

ARTICLE IV

ENROLLMENT, COVERAGE AND TERMINATION OF COVERAGE

4.1 **Enrollment Generally.** All Potential Enrollees who live in the Contracting Area shall be required to become an Enrollee in a plan participating in the Integrated Care Program, except those Potential Enrollees who, pursuant to federal law, are subject only to voluntary enrollment. The Illinois Client Enrollment Broker (ICEB) shall be responsible for the enrollment of Potential Enrollees, including the provision of all health care plan choice education, enrollment by active choice, and enrollment by auto-assignment. Contractor shall continue to accept Potential Enrollees for enrollment until the Department determines that any further enrollments would exceed Contractor's capacity based on a review conducted pursuant to Section 5.5.3. Contractor shall accept each Potential Enrollee whose name appears on the 834 Audit File and 834 Daily File. Enrollment shall be without restriction and shall be in the order in which Potential Enrollees apply or are assigned. Contractor shall not participate in facilitating enrollment, including during the Open Enrollment Period. Contractor may educate a Potential Enrollee regarding the specific elements of Contractor, provided that Contractor engages in no Marketing activities prohibited under Section 4.16. Contractor shall refer all requests for enrollment to the ICEB, which shall not be considered "facilitating enrollment". Nothing in this Contract shall be deemed to be a guarantee of any Potential Enrollee's enrollment with Contractor.

4.2 **Illinois Client Enrollment Broker.** All enrollments will be processed by the ICEB. The Department will provide Contractor with a reasonable opportunity to review, and Contractor may provide the Department with comments relating to, the information to be included in any enrollment packet used by the ICEB. Contractor may be asked to provide material for the enrollment packet.

4.3 **Initial Program Implementation.** Initial enrollment of Potential Enrollees in the Contracting Area will be phased according to a schedule set by the Department in order to ensure the smooth transition to the Integrated Care Program without disruption of care.

4.4 **Choice in Enrollment.** All Potential Enrollees will have an opportunity to freely choose, from among the available MCOs, the one in which they want to enroll. On a daily basis, the ICEB will inform Contractor of the Prospective Enrollees who have voluntarily chosen Contractor and the PCPs and Sites that were selected.

4.5 **Enrollment by Auto-Assignment.** A Potential Enrollee who does not select an MCO will be auto-assigned to an MCO by the ICEB. On a daily basis, the ICEB will inform Contractor of Prospective Enrollees who have been enrolled with Contractor by auto-assignment, and the PCPs and Sites that were assigned. The Department and the ICEB will design and, during the first twelve (12) month period of this Contract, shall implement an algorithm for the auto-assignment that will attempt to equalize enrollment in the participating MCOs, taking into account both Enrollees who actively choose an MCO and those who are auto-assigned. Upon request, the Department shall provide Contractor with a description of the

algorithm for the auto-assignment of Enrollees to MCOs and of the algorithm for the assignment of Enrollees to PCPs and Sites. During the second year of the Integrated Care Program, auto-assignment will occur systematically and randomly by algorithm, so that each MCO will receive approximately fifty percent (50%) of all auto-assignments. The Department reserves the right to re-evaluate and modify the auto-assignment algorithm at any time for any reason during subsequent years of this Contract, and may provide that auto-assignment will be based on Contractor's performance on quality measures. The Department shall provide written notice of any modification of the auto-assignment algorithm at least sixty (60) days before the implementation of the modification.

4.6 **Effective Date of Enrollment.** If an enrollment is entered by the ICEB and accepted by the Department's database prior to the applicable cut-off date, coverage shall begin as designated by the Department on the first day of the following calendar month. If the ICEB enters an enrollment after the applicable cut-off date, coverage shall begin no later than the first day of the second calendar month following the date the enrollment is accepted by the Department's database.

4.7 **Update of Enrollment Information.** Within five (5) Business Days after receipt of the 834 Audit File, Contractor shall update all electronic systems maintained by Contractor to reflect the information contained in the 834 Audit File received from the Department. Contractor shall use the 834 Audit File to verify Contractor's Enrollees for the subsequent calendar month. Contractor shall not wait for the 820 Payment File to update eligibility.

4.8 **Enrollee Welcome Packet.** Within five (5) Business Days after receipt of the 834 Audit File from the Department confirming that an enrollment was accepted, Contractor shall send an Enrollee welcome packet to the Enrollee. The packet shall include all Basic Information as set forth in Section 5.18.1.

4.9 **Change of MCO.**

4.9.1 **Initial Change Period.** During the initial ninety (90) calendar days after the effective date of enrollment, whether the Enrollee actively selected the MCO or was auto-assigned, the Enrollee shall have the opportunity to change MCOs. If the Enrollee makes a change of MCO during that time period, the Enrollee shall have another ninety (90) days after the effective date of enrollment in the second MCO to change back to the original MCO. Except as provided in Section 4.9.3, the Enrollee shall not be allowed to change MCOs again until the Open Enrollment Period. If the Enrollee contacts Contractor to request a change of MCOs, Contractor shall refer the Enrollee to the ICEB. The MCO to which the Enrollee changes is responsible for coordination of care and transition of care planning. Unless otherwise specified in **Section 5.16**, the MCO in which the Enrollee was first enrolled is responsible for payment for Covered Services through the disenrollment date and for cooperating with the coordination of care and transition of care planning.

4.9.2 **Open Enrollment Period**. After the initial enrollment period as set forth in Section 4.9.1, once each twelve (12) months thereafter, each Enrollee shall have a 60-day period in which to change the MCO in which the Enrollee is enrolled. The 60-day Open Enrollment Period for each Enrollee shall begin

ninety (90) calendar days prior to such Enrollee's Anniversary Date. No later than ninety-five (95) calendar days prior to each Enrollee's Anniversary Date, the ICEB shall send notice to each Enrollee of the Enrollee's opportunity to change MCOs and the 60-day deadline for doing so. If the Enrollee selects a different MCO during the Open Enrollment Period, enrollment in the new MCO will be effective on the Enrollee's Anniversary Date. Enrollees who make no selection will continue to be enrolled with the same MCO. Enrollees shall not change MCO at any time other than the Open Enrollment Period, except as provided in Section 4.9.3.

4.9.3 Disenrollment Requested by Enrollee. An Enrollee may request, orally or in writing, to disenroll from Contractor at any time for any of the following reasons: (i) the Enrollee moves out of the Contracting Area; (ii) Contractor, due to its exercise of Right of Conscience pursuant to Section 5.4, does not provide the Covered Service that the Enrollee seeks; (iii) the Enrollee needs related Covered Services to be performed at the same time, not all of the related services are available through Contractor, and the Enrollee's PCP or other Provider determines that receiving the services separately would subject the Enrollee to unnecessary risk; or (iv) other reasons, including, but not limited to, poor quality of care, lack of access to Covered Services, lack of access to Providers experienced in dealing with the Enrollee's health care needs, or, if automatically re-enrolled pursuant to Section 4.10 and such loss of coverage causes the Enrollee to miss the Open Enrollment period.

4.10 Re-Enrollment after Resumption of Eligibility. An Enrollee whose enrollment ends due to the loss of Medicaid Program coverage, but whose Medicaid Program coverage is reinstated within two (2) calendar months, will be automatically re-enrolled with the MCO with which the Enrollee was previously enrolled as long as the Enrollee's eligibility status is still valid for participation in the Integrated Care Program and, subject to Section 4.13.1.3, the Enrollee resides in the Contracting Area.

4.11 Insolvency. If Contractor becomes insolvent or is subject to insolvency proceedings as set forth in 215 ILCS 125/1-1 et seq., Contractor shall be liable for all claims for Covered Services and shall remain responsible for the provision of Covered Services and the management of care provided to all Enrollees until the Contract is terminated or expires.

4.12 Change of Site and PCP/WHCP. Contractor shall process an Enrollee's request to change PCP or WHCP within thirty (30) days after the receipt of the request. If the change of PCP or WHCP results in a Site transfer, Contractor shall submit a Site transfer record to the Department via the 834 Daily File. Contractor shall retrieve the 834 Error File made available by the Department each day. Contractor shall review this file in order to determine whether the Site transfer was rejected by the Department. If the Site transfer was rejected by the Department, Contractor must submit a corrected Site transfer record within two (2) Business Days. The Department will provide Contractor with no fewer than one hundred twenty (120) days' notification prior to imposing a requirement that Contractor electronically communicate old and new PCP numbers and old and new WHCP numbers with this record.

4.13 Termination of Coverage.

4.13.1 The Department shall terminate an Enrollee's coverage upon the occurrence of any of the following conditions:

4.13.1.1 Upon the Enrollee's death. Termination of coverage shall take effect at 11:59 p.m. on the last day of the month in which the Enrollee dies. Termination may be retroactive to this date.

4.13.1.2 When an Enrollee elects to change MCOs during the Open Enrollment Period. Termination of coverage with the previous MCO shall take effect at 11:59 p.m. on the day immediately preceding the Enrollee's effective date of enrollment with the new MCO.

4.13.1.3 When an Enrollee no longer resides in the Contracting Area, except for an Enrollee living in the Contracting Area who is admitted to a Nursing Facility outside the Contracting Area and placement is not based on the family or social situation of the Enrollee. If an Enrollee is to be disenrolled at the request of Contractor under the provisions of this Section, Contractor must first provide documentation satisfactory to the Department that the Enrollee no longer resides in the Contracting Area. Termination of coverage shall take effect at 11:59 p.m. on the last day of the month prior to the month in which the Department determines that the Enrollee no longer resides in the Contracting Area. Termination may be retroactive if the Department is able to determine the month in which the Enrollee moved from the Contracting Area.

4.13.1.4 When the Department determines that an Enrollee has other significant insurance coverage or is placed in Spend-down status. The Department shall notify Contractor of such disenrollment on the 834 Daily File. This notification shall include the effective date of termination.

4.13.1.5 When the Department is made aware that an Enrollee is incarcerated in a county jail, Illinois Department of Corrections facility, or federal penal institution. Termination of coverage shall take effect at 11:59 p.m. on the last day of the month in which the Enrollee was incarcerated.

4.13.2 The termination or expiration of this Contract terminates coverage for all Enrollees with Contractor. Termination will take effect at 11:59 p.m. on the last day of the month in which this Contract terminates or expires, unless otherwise agreed to, in writing, by the Parties.

4.13.3 Except as otherwise provided in this Article IV, termination of an Enrollee's coverage shall take effect at 11:59 p.m. on the last day of the month following the month the disenrollment is processed by the Department.

4.13.4 Disenrollment from Contractor as provided in Section 4.9.3 and Section 4.13.5, may only occur upon receipt by Contractor of written approval of such disenrollment by the Department. Disenrollment shall be effective at 11:59 p.m. on the last day of the month in which the Department approves the disenrollment, or of the next month if the Department is unable to give the Enrollee at least ten (10) days' notice before termination of coverage, as provided in Section 4.9.3 and Section 4.13.5, takes effect.

4.13.5 Contractor may request the disenrollment of an Enrollee when the Enrollee no longer resides in the Contracting Area, except as otherwise provided in Section 4.13.1.3. Contractor shall not seek to terminate enrollment because of an adverse change in an Enrollee's health status or because of the Enrollee's utilization of Covered Services, diminished mental capacity, uncooperative or disruptive behavior resulting from such Enrollee's special needs (except to the extent such Enrollee's continued enrollment with Contractor seriously impairs Contractor's ability to furnish Covered Services to the Enrollee or other Enrollees), or take an Action in connection with an Enrollee who attempts to exercise, or is exercising, his or her Appeal or Grievance rights. Any attempts to seek to terminate enrollment in violation of this Section 4.13.5 will be considered a breach of this Contract.

4.14 Capacity.

4.14.1 The number of Enrollees enrolled with Contractor will be limited to a level that will not exceed Contractor's physical and professional capacity.

4.14.2 The Department will review documentation provided by Contractor that sets forth Contractor's physical and professional capacity: (i) before the first enrollment and as regularly provided subsequently; (ii) when Contractor requests a review and the Department agrees to such review; (iii) when there is a change in Covered Services, categories of Potential Enrollees, Contracting Area or Capitation that can reasonably be expected to impact Contractor's capacity; (iv) when there is a Change of Control, or a sale or transfer of Contractor; and, (v) when the Department determines that Contractor's operating or financial performance reasonably indicates a lack of Provider or administrative capacity. Such documentation must demonstrate that Contractor offers an appropriate range of preventive, primary care and specialty services that is adequate for the anticipated number of Enrollees in the Contracting Area and that Contractor maintains a network of Affiliated Providers that is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of Enrollees in the Contracting Area. If the Department determines that Contractor does not have the necessary Provider and administrative capacity to provide Covered Services to any additional Enrollees, the Department shall provide written notice of such determination to Contractor containing an explanation of the methodology used by the Department to determine Contractor's Provider and administrative capacity. In the event the Department reasonably finds that Contractor has failed to restore Provider and administrative capacity within ninety (90) days after Contractor's receives such notice,

the Department may freeze enrollment upon written notice of such findings. Thereafter, Contractor may, at any time, submit written evidence to the Department that Contractor has increased Contractor's Provider and administrative capacity, which evidence the Department shall review in good faith. The Department shall, within thirty (30) days following the Department's receipt of such evidence, provide written notice to Contractor of its findings. The Department shall resume Contractor's enrollment in the event the Department finds that Contractor's Provider and administrative capacity has increased to the Department's satisfaction. Nothing in this Contract shall be deemed to be a guarantee of any Potential Enrollee's enrollment with Contractor.

4.15 **Identification Card.** Contractor shall send each new Enrollee an identification card bearing: (i) the name of Contractor; (ii) the effective date of enrollment; (iii) the twenty-four (24) hour telephone number to confirm eligibility for benefits and authorization for services; and (iv) the name and phone number of the PCP and, if applicable, the WHCP. Contractor shall make reasonable efforts to send the identification cards no later than five (5) Business Days after receipt of the 834 Audit File. Contractor shall send a draft of the identification card described herein to the Department for Prior Approval no fewer than five (5) Business Days prior to the Readiness Review and when the card content is revised. Contractor shall not be required to submit format changes to the card for Prior Approval, provided there is no change in the information conveyed.

4.16 **Marketing.** Contractor must comply with the requirements in 42 C.F.R. Section 438.104 regarding Marketing activities.

4.16.1 Marketing by mail, mass media advertising and community-oriented Marketing directed at Potential Enrollees will be allowed subject to the Department's Prior Approval. Contractor shall be responsible for all costs of such Marketing, including labor costs. The Department reserves the right to determine and set the sole process of, and payment for Marketing by mail, using names and addresses of Potential Enrollees supplied by the Department, including the right to limit Marketing by mail to a vendor that has entered into a confidentiality agreement with the Department and the terms and conditions set forth in that vendor agreement. Contractor must distribute any such permitted Marketing Materials throughout an entire geographic area as set forth in Attachment IV.

4.16.2 Face-to-face Marketing by Contractor directed at Participants or Potential Enrollees, including direct or indirect door-to-door contact, telephone contact, or other cold-call activities, is strictly prohibited. Events that may involve Contractor staff educating groups of Participants or Potential Enrollees shall not be considered "face-to-face" marketing.

4.16.3 Inappropriate Marketing Activities. Unless Prior Approval is provided by the Department, Contractor shall not:

4.16.3.1 Provide cash to Potential Enrollees, Prospective Enrollees or Enrollees, except for reimbursement of expenses and stipends, in an amount approved by the Department, provided to Enrollees for participation on committees or advisory groups;

4.16.3.2 Provide gifts or incentives to Potential Enrollees or Prospective Enrollees unless such gifts or incentives: (i) are also provided to the general public; and, (ii) do not exceed ten dollars ($10) in value per individual gift or incentive;

4.16.3.3 Provide gifts or incentives to Enrollees unless such gifts or incentives (i) are provided conditionally based on the Enrollee receiving preventive care or other health related activity; and, (ii) are not in the form of cash or an instrument that may be converted to cash;

4.16.3.4 Seek to influence a Potential Enrollee's enrollment with Contractor in conjunction with the sale of any other insurance;

4.16.3.5 Induce Providers or employees of the Department or DHS to reveal Confidential Information regarding Participants or otherwise use such Confidential Information in a fraudulent manner; or

4.16.3.6 Threaten, coerce or make untruthful or misleading statements to Potential Enrollees, Prospective Enrollees or Enrollees regarding the merits of enrollment with Contractor or any other MCO, including, but not limited to, any statement that the Potential Enrollee, Prospective Enrollee or Enrollee must enroll with Contractor in order to obtain benefits or in order not to lose benefits, or any statement that Contractor is endorsed by Federal CMS, by the federal or State government, or by any similar entity.

4.17 **Readiness Review.** Contractor is not entitled to any enrollment until it has passed a desk Readiness Review conducted by the Department, or otherwise received notice from the Department, indicating to the Department's satisfaction that Contractor is ready to provide services to Enrollees in a safe and efficient manner.

4.18 **Restriction.** Contractor may restrict an Enrollee for a reasonable period of time to a designated PCP, WHCP or Provider of pharmacy services when: (i) the Department indicates the Enrollee was included in the Department's Recipient Restriction Program pursuant to 89 Ill. Admin. Code 120.80 prior to enrollment with Contractor; or (ii) Contractor determines that the Enrollee is over-utilizing Covered Services. Contractor's criteria for such determination, and the conditions of the restriction, must meet the standards of 42 C.F.R. 431.54(e). Contractor's policies on restriction must receive Prior Approval and shall include the right of the Enrollee to file a Grievance or Appeal.

ARTICLE V

DUTIES OF CONTRACTOR

5.1 **Amount, Duration and Scope of Coverage**. Contractor shall comply with the terms of 42 C.F.R. §438.206(b) and provide or arrange to have provided to all Enrollees services described in 89 Ill. Adm. Code, Part 140 as amended from time to time and not specifically excluded therein in accordance with the terms of this Contract. Covered Services shall be provided in the amount, duration and scope as set forth in 89 Ill. Adm. Code, Part 140 and this Contract, and shall be sufficient to achieve the purposes for which such Covered Services are furnished. This duty shall commence at the time of initial coverage as to each Enrollee. Contractor shall, at all times, cover the appropriate level of service for all Emergency Services and non-Emergency Services in an appropriate setting. Contractor shall notify Department in writing as soon as practicable, but no later than five (5) days, following a change in Contractor's network of Affiliated Providers that renders Contractor unable to provide one (1) or more Covered Services within the access to care standards set forth in Section 5.6. Contractor shall not refer Enrollees to publicly supported health care entities to receive Covered Services for which Contractor receives payment from the Department, unless such entities are Affiliated Providers with Contractor. Such publicly supported health care entities include, but are not limited to, Chicago Department of Public Health and its clinics, Cook County Bureau of Health Services, and Certified Local Health Departments. Contractor shall provide a mechanism for an Enrollee to obtain a second opinion from a qualified Provider, whether Affiliated or non-Affiliated, at no cost to the Enrollee. Contractor will assist in coordinating obtaining any second opinion from a non-Affiliated Provider. Covered Services will be phased in as three (3) Service Packages as follows:

5.1.1 **Service Package I**. Contractor shall provide, or arrange for the provision of, Covered Services for Service Package I, which includes all of the services and benefits set forth in Attachment I, to Enrollees at all times during the term of this Contract, whenever Medically Necessary, except to the extent services are identified as excluded services pursuant to Section 5.2.

5.1.2 **Service Package II.** Upon thirty (30) days' notice from the Department, Contractor shall provide, or arrange for the provision of, Service Package II, which will include all services in Service Package I and the additional services described in Attachment II.

5.1.3 **Service Package III.** Upon thirty (30) days' notice from the Department, Contractor shall provide, or arrange for the provision of, Service Package III, which will include all services in Service Packages I and II, and the additional services described in Attachment III.

5.1.4 Contractor shall obtain Prior Approval from the Department before offering any additional service or benefit to Enrollees not required under this Contract. Contractor shall provide written notice to Enrollees and

Prospective Enrollees before discontinuing an additional service or benefit. The notice must receive Prior Approval from the Department.

5.2 **Excluded Services**. The following services are not Covered Services:

5.2.1 Services that are provided in a State Facility operated as a psychiatric hospital as a result of a forensic commitment;

5.2.2 Services that are provided through a Local Education Agency (LEA);

5.2.3 Services that are experimental or investigational in nature;

5.2.4 Services that are provided by a non-Affiliated Provider and not authorized by Contractor, unless this Contract specifically requires that such services be Covered Services;

5.2.5 Services that are provided without a required Referral or prior authorization as set forth in the Provider Handbook;

5.2.6 Medical and surgical services that are provided solely for cosmetic purposes; and

5.2.7 Diagnostic and therapeutic procedures related to infertility or sterility.

5.3 **Limitations on Covered Services**. The following services and benefits shall be limited as Covered Services:

5.3.1 Termination of pregnancy may be provided only as allowed by applicable State and federal law (42 C.F.R. Part 441, Subpart E). In any such case, the requirements of such laws must be fully complied with and HFS Form 2390 must be completed and filed in the Enrollee's medical record. Termination of pregnancy shall not be provided to Enrollees who are eligible under the State Children's Health Insurance Program (215 ILCS 106).

5.3.2 Sterilization services may be provided only as allowed by State and federal law (see 42 C.F.R. Part 441, Subpart F). In any such case, the requirements of such laws must be fully complied with and a HFS Form 2189 must be completed and filed in the Enrollee's medical record.

5.3.3 If a hysterectomy is provided, a HFS Form 1977 must be completed and filed in the Enrollee's medical record.

5.4 **Right of Conscience**. The Parties acknowledge that pursuant to 745 ILCS 70/1 et seq., Contractor may choose to exercise a right of conscience by refusing to pay or arrange for the payment of certain Covered Services. If Contractor chooses to exercise this right, Contractor must promptly notify the Department in writing of its intent to exercise its right of conscience. Such notification shall contain the services that Contractor refuses to pay or to arrange for the payment of pursuant to the exercise of the right of conscience. The Parties agree that upon such notice the Department shall adjust the Capitation payment to Contractor.

5.4.1 If Contractor chooses to exercise this right, Contractor must notify Potential Enrollees, Prospective Enrollees and Enrollees that it has chosen not to render certain Covered Services, as follows:

5.4.1.1 To Potential Enrollees, prior to enrollment;

5.4.1.2 To Prospective Enrollees, during enrollment; and

5.4.1.3 To Enrollees, within ninety (90) days after adopting a policy with respect to any particular service that previously was a Covered Service.

5.5 Provider Network.

5.5.1 Affiliated Providers.

5.5.1.1 Contractor shall establish, maintain and monitor a network of Affiliated Providers, including PCPs, WHCPs, mid-level practitioners, specialists, dentists, hospitals and behavioral health Providers, that is sufficient to provide adequate access to all Covered Services under the Contract, taking into consideration:

5.5.1.1.1 The anticipated number of Enrollees;

5.5.1.1.2 The expected utilization of services, in light of the characteristics and health care needs of Contractor's Enrollees;

5.5.1.1.3 The number and types of Providers required to furnish the Covered Services;

5.5.1.1.4 The number of Affiliated Providers who are not accepting new patients; and

5.5.1.1.5 The geographic location of Providers and Enrollees, taking into account distance, travel time, the means of transportation and whether the location provides physical access for Enrollees with disabilities.

5.5.2 Affiliated Provider Enrollment. Contractor shall assure that all Affiliated Providers, including out-of-State Affiliated Providers, are enrolled in the HFS Medical Program, if such enrollment is required by the Department's rules or policy in order to submit claims for reimbursement or otherwise participate in the HFS Medical Program. Contractor shall make a good faith effort to give written notice of termination of a Provider as soon as practicable, but in no event later than fifteen (15) days following such termination, to each Enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated Provider.

5.5.3 Network Adequacy Analysis. Contractor shall analyze the geographic distribution of the Provider network on a quarterly basis. Contractor shall also monitor other network adequacy indicators, such as Enrollee and Provider complaints related to access; call center requests from Enrollees, Providers, advocates and external organizations for help with access; and

the percentage of completely open PCP panels versus percentage open only to existing patients. Contractor shall generate geographical distribution tables and maps to plot Enrollee and Affiliated Provider locations by zip code and analyze the information, considering the prevalent modes of transportation available to Enrollees, Enrollees' ability to travel, and Enrollees' ability to be in an office setting. When material gaps in the Contracting Area are identified, Contractor will within five (5) Business Days develop and implement a recruitment strategy to fill the gaps and immediately thereafter submit its strategy and proposed timeline to the Department.

5.5.4 **Safety Net Providers**. Contractor will prioritize recruiting safety net Providers, such as FQHCs and CMHCs, as Affiliated Providers. Contractor shall not refuse to contract with an FQHC, RHC or CMHC that is willing to accept Contractor's standard rates and contractual requirements and meets Contractor's quality standards.

5.5.5 **Non-Affiliated Providers**. It is understood that in some instances Enrollees will require specialty care not available from an Affiliated Provider and that Contractor will arrange that such services be provided by a non-Affiliated Provider. In such event, Contractor will promptly negotiate an agreement ("Single Case Agreement") with a non-Affiliated Provider to treat the Enrollee until a qualified Affiliated Provider is available. Contractor shall make best efforts to have any non-Affiliated Provider billing for services rendered in Illinois be enrolled in the HFS Medical Program prior to paying a claim.

5.5.6 **Initial Provider Reimbursement.** All of Contractor's initial Provider compensation models shall be structured on a Fee-For-Service basis. Contractor shall give the Department advance written notice of all Provider agreements reimbursed on a sub-capitated basis. Contractor shall give the Department advance notice of any agreement that pays an FQHC on a basis other than the Department's cost-based Encounter rate, including the details of the reimbursement methodology to be used. Notwithstanding the above, the Department acknowledges and agrees that Contractor may reimburse various vendors on a sub-capitated basis to provide, or arrange for the provision of, vision, dental, behavioral health, pharmacy, nurse telephone triage, transportation and radiology.

5.5.7 **Medical Home.** Contractor's Affiliated Provider network shall include Providers that act as Medical Homes, with a focus on FQHCs, CMHCs and multi-specialty PCP-centered medical groups and private practice PCP offices. Medical Homes shall be patient-centered medical homes that provide and coordinate high quality, planned, family-centered health promotion; Wellness Programs; acute illness care; and Chronic Health Condition management. Medical Homes shall provide all PCP services and be supported by Integrated Care Teams and Health Information Technology. Contractor will support Medical Homes and the integration of behavioral and physical health care by providing embedded Care Coordinators, as appropriate, onsite at FQHCs, CMHCs and high volume Providers that agree to this approach.

5.5.8 **Specialty Care.** Contractor shall establish a comprehensive network to ensure the availability and accessibility of specialists and subspecialists to meet the needs of Enrollees. Care Coordinators shall have authority to authorize services and will not require approval by Contractor's Medical Director for the majority of services.

5.5.9 **Hospitalist Program.** Contractor shall encourage hospitals to provide Hospitalist services, and shall support and coordinate care with the Hospitalists employed by, or that subcontract with, Affiliated Providers.

5.5.10 **SNFist Program.** Contractor shall provide SNFist services, either through direct employment or a sub-contractual relationship. The SNFist program shall provide intensive clinical management of Enrollees in Nursing Facilities. Contractor shall implement one of the following for each Enrollee in a Nursing Facility:

5.5.10.1 When appropriate or necessary, the Care Management team will include an additional facility-based Provider (Physician or nurse practitioner) who will deliver care in identified Nursing Facilities.

5.5.10.2 For all other Enrollees, Care Management through the SNFist program shall be performed by field-based Registered Nurses who will work within each assigned Nursing Facility to provide Care Management and care coordination activities.

5.6 Access to Care Standards.

5.6.1 **Travel Time and Distance Standards**. Enrollees shall not be required to travel more than thirty (30) minutes or thirty (30) miles to receive primary health care services in urban areas, or sixty (60) minutes or sixty (60) miles to receive primary health care services in rural areas. An Enrollee may elect to travel beyond the distance standards when the Enrollee exercises choice in selecting a PCP or specialty care Provider. The free exercise of such choice by the Enrollee will not negatively impact the results of any reporting by Contractor on access to care.

5.6.2 **Access to Provider Locations.** Provider locations shall be accessible for Enrollees with disabilities. During the credentialing process, Contractor shall collect sufficient information from Providers to assess compliance with the Americans With Disabilities Act. As necessary to serve Enrollees, Provider locations where Enrollees receive services shall be ADA compliant. In addition, Contractor's network shall have Provider locations that are able to accommodate the unique needs of Enrollees. Examples of such accommodations may include separate entrances for Enrollees with developmental and cognitive conditions and diagnoses.

5.6.3 **Appointments.** Contractor shall require that time specific appointments for routine, preventive care are available within five (5) weeks from the date of request for such care. Enrollees with more serious problems not deemed Emergency Medical Conditions shall be triaged and, if necessary, Medically Necessary care will be provided within twenty-four (24) hours. Enrollees with problems or complaints that are not deemed serious shall be

seen within three (3) weeks from the date of request for such care. Initial prenatal visits without expressed problems shall be made available within two (2) weeks after a request for an Enrollee in her first trimester, within one (1) week for an Enrollee in her second trimester, and within three (3) days for an Enrollee in her third trimester. Contractor shall have an established policy that scheduled Enrollees shall not routinely wait for more than one (1) hour to be seen by a Provider and that no more than six (6) scheduled appointments shall be made for each PCP per hour. Notwithstanding this limit, the Department recognizes that Physicians supervising other licensed health care Providers may routinely account for more than six (6) appointments per hour. Affiliated Providers shall offer hours of operation that are no less than the hours of operation offered to persons who are not Enrollees.

5.6.4 **After Hours.** PCPs and specialty Provider contracts shall provide coverage for their respective practices twenty-four (24) hours a day, seven (7) days a week and have a published after hours telephone number; voicemail alone after hours is not acceptable.

5.6.5 **Choice of Primary Care Provider.** Contractor shall afford to each Enrollee a choice of PCP, which may be, where appropriate, a WHCP.

5.6.6 **Specialists As PCPs**. Contractor shall offer pregnant Enrollees and Enrollees with Chronic Health Conditions, disabilities, or special health care needs the option of choosing a specialist to be their PCP. Such Enrollees or their Providers may request a specialist as a PCP at any time. Contractor shall contact the Enrollee promptly after the request to schedule an assessment. Contractor's Medical Director will approve or deny requests after determining that the Enrollee meets criteria and whether the specialist is willing to fulfill the role and all the obligations of PCP.

5.6.7 **Homebound.** If an Enrollee is homebound or has significant mobility limitations, Contractor shall provide access to primary care through home visits by nurse practitioners or Physicians to support the Enrollee's ability to live as independently as possible in the community.

5.6.8 **Primary Care Provider to Enrollee Ratio.** Contractor's maximum PCP panel size shall be six hundred (600) Enrollees. If Contractor does not satisfy the PCP requirements set forth above, Contractor may demonstrate compliance with these requirements by demonstrating that (i) Contractor's full time equivalent PCP ratios exceed ninety percent (90%) of the requirements set forth above, and (ii) that Covered Services are being provided in the Contracting Area in a manner which is timely and otherwise satisfactory. Contractor shall comply with Section 1932(b)(7) of the Social Security Act.

5.7 Provider Credentialing and Re-credentialing.

5.7.1 **Credentialing and Re-credentialing.** Contractor shall credential Providers in accordance with National Committee for Quality Assurance (NCQA) credentialing standards as well as applicable HFS, Illinois Department of Insurance and federal requirements. Re-credentialing shall occur every three (3) years. At re-credentialing and in between credentialing cycles,

Contractor shall verify minimum credentialing requirements and monitor Enrollee Complaints and Appeals, quality of care and quality of service events, and medical record review.

5.7.2 **Credentialing of Primary Care Providers**. All PCPs, WHCPs, and specialists who agree to be PCPs must be credentialed by Contractor. The credentialing process may be two-tiered, and Contractor may assign Enrollees to a PCP or WHCP following preliminary credentialing, provided that full credentialing is completed within a reasonable time following the assignment of Enrollees to the PCP or WHCP. Contractor must notify the Department when the credentialing process is completed and provide the results of the process. If Contractor utilizes a single-tiered credentialing process, Contractor shall not assign Enrollees to a PCP or WHCP until such Provider has been fully credentialed.

5.7.3 **Quality Assurance Plan Committee.** Contractor shall have a Quality Assurance Plan Committee that meets quarterly and is responsible for oversight of Contractor's credentialing process.

5.7.4 **Delegated Credentialing.** Contractor may subcontract or delegate all or part of its credentialing functions when the subcontractor or delegate, such as a Provider organization, maintains a formal credentialing program in compliance with Contractor, NCQA, the Department and applicable regulatory agency standards. Contractor shall remain responsible for Provider credentialing and re-credentialing.

5.8 **Site Registration.** Contractor will register all FQHCs and RHCs as unique Sites, and all Enrollees receiving Covered Services at those unique Sites must be reflected in those Sites in the Department's system. A fully executed Provider agreement must be in place between Contractor and the Site prior to registration of the Site. Contractor must give advance notice to the Department as soon as practicable of the anticipated closing of a Site. If it is not possible to give advance notice of a closing of a Site, Contractor shall notify the Department immediately when a Site is closed. The Department, at its sole discretion, may eliminate or modify the requirement for Site reporting at any time during the term of this Contract.

5.9 **Provider Education.** Prior to any enrollment of Enrollees under this Contract and thereafter, Contractor shall conduct Affiliated Provider education regarding Contractor policies and procedures as well as the Integrated Care Program.

5.9.1 **Provider Orientation.** Contractor shall conduct orientation sessions for Affiliated Providers and their office staff.

5.9.2 **Medical Home**. Contractor shall educate Affiliated Providers about the Medical Home model and the importance of using it to integrate all aspects of each Enrollee's care, as well as how to become a Medical Home.

5.9.3 **Cultural Competency.** Contractor will provide the cultural competency requirements at orientation, training sessions, and updates as needed.

5.9.4 **Provider Manual.** The Provider Manual shall be a comprehensive reference for administrative, prior authorization, and Referral processes, claims, and

plan benefits. The Provider Manual shall also address topics such as clinical practice guidelines, availability and access standards, Disease Management Programs, and Enrollee rights.

5.9.5 **Provider Directory.** Contractor shall make its Provider Directory available to Providers.

5.9.6 **Provider-based Health Education for Enrollees.** Contractor shall encourage PCPs to provide health education to Enrollees. Contractor shall ensure that Providers have the preventive care, disease-specific and plan services information necessary to support Enrollee education in an effort to promote compliance with treatment directives and to encourage self-directed care.

5.10 **Coordination Tools.** Contractor shall have in place the technology identified in this Section 5.10 to assist with Care Coordination and Provider/Enrollee communication.

5.10.1 **Enrollee Profile.** Contractor shall use technology and processes that effectively integrate data from a variety of sources to profile, measure and monitor Enrollee Profiles. Profiles will include demographics, claims payment information, care opportunities, care gap alerts and Enrollee preferences.

5.10.2 **MemberConnect.** Contractor shall use MemberConnect, or similar technology, for Member Relationship Management's use for inbound Enrollee contact and query management.

5.10.3 **MemberReach.** Contractor will automate, manage, track and report on Contractor's workflows for outbound and outreach Enrollee campaigns as well as targeted outbound interventions (such as engaging high-risk Enrollees in care or Disease Management Programs).

5.10.4 **TruCare.** Contractor shall have a clinical information system that will incorporate clinical, evidence-based criteria, standard assessments and customized Enrollee Care Plans, with stratification of risk for tracking and reporting data. This process shall be accessible only by appropriate clinical operations staff.

5.10.5 **Predictive Modeling.** Contractor shall have a predictive modeling and health risk stratification engine that Contractor will use to proactively identify high-risk Enrollees and monitor gaps in care. Contractor will use clinical, risk, and administrative profile information, based on information received through Health Risk Screenings and Assessments, claims and lab data.

5.10.6 **Health Passport**. Contractor shall use a web-based secure application for Enrollees and Providers that: (i) organizes Enrollee records from claims, demographics, data, lab results, immunization data, Enrollee Care Plans and other information, and (ii) allows for the entry of clinical information by Providers at the point of service. Contractor's technology shall provide robust, multi-layered security functionality to protect patient privacy.

5.11 Health Risk Screening, Stratification and Assessment.

5.11.1 Health Risk Screening. Contractor will use best efforts to obtain a completed Health Risk Screening for each new Enrollee within ninety (90) days after the effective date of enrollment. PCPs will be notified of enrollment of all new Enrollees who have not completed a Health Risk Screening within the time period set forth above and whom Contractor has been unable to contact. PCPs will be encouraged to conduct outreach to their Enrollees and to schedule visits.

5.11.2 Identifying Need for Care Management or Disease Management Programs. Contractor will use a variety of methods to identify Enrollees who may need Care Management or Disease Management Programs, including, but not limited to, the following:

5.11.2.1 Predictive modeling. When Enrollee claims data are available, Contractor will use predictive modeling to stratify Enrollees for its Disease Management Program and assist in identifying and prioritizing for Care Management.

5.11.2.2 Referrals. Contractor may identify Enrollees through referrals from families, caregivers, Providers, community organizations and Contractor personnel.

5.11.2.3 Stratification. Contractor shall stratify all Enrollees identified for its Disease Management Program or Care Management to determine the appropriate level of intervention. In general, Enrollees shall be stratified into three levels: low, moderate and high risk. Contractor shall develop outreach and intervention for each risk level.

5.11.3 Health Risk Assessment. Contractor will use best efforts to complete a Health Risk Assessment and develop an Enrollee Care Plan no later than ninety (90) days after the Enrollee is identified as high-risk or moderate-risk.

5.11.4 Outreach and Intervention. Contractor shall utilize multiple communication strategies to perform Enrollee outreach and intervention for Enrollees receiving Care Management or its Disease Management Program. Each such Enrollee shall be provided with written educational materials about the condition(s) for which the Enrollee is receiving Care Management. The frequency of providing materials will be based on the level of intervention, but shall be no less frequent than semi-annually. All Enrollees enrolled in Contractor's Disease Management Program shall be provided reminders about preventive care and screenings for their conditions.

5.11.5 Enrollee Engagement and Education. Contractor shall use a multifaceted approach to locate, engage and educate Enrollees and shall capitalize on every Enrollee contact to obtain and update Enrollee information. Input will be solicited from Enrollees and other stakeholders to help develop strategies to increase motivation.

5.11.6 Contractor will offer a set of health education programs that use comprehensive outreach and communication methods to effectively

educate Enrollees and, to the extent permitted by applicable State and federal confidentiality requirements, their families about health and self-care and how to access Plan benefits and supports. Such programs may include:

5.11.6.1 Offering restricted-use cell phones to select high-risk Enrollees participating in Care Management.

5.11.6.2 Programs aimed at promoting healthy lifestyles.

5.11.6.3 Welcome calls to provide health education and respond to questions about Covered Services and how to access them.

5.11.6.4 Enrollee incentive programs to promote personal health responsibility.

5.11.6.5 Newsletters.

5.11.6.6 On-hold messaging that includes health education briefs and general reminders and Contractor benefits and services information.

5.11.6.7 An Enrollee portal on Contractor's website.

5.12 Care Management and Disease Management.

5.12.1 Enrollee Care Plan. Contractor shall develop a single comprehensive Enrollee Care Plan for moderate-risk and high-risk Enrollees, as provided in Section 5.11.3, that incorporates Enrollee goals and preferences for each Enrollee who requires Care Management or Disease Management services. The Enrollee Care Plan will facilitate monitoring of an Enrollee's progress and evolving service needs by establishing the Enrollee's goals as well as benchmarks against which to monitor progress.

5.12.2 Elements of Enrollee Care Plan. The Enrollee Care Plan may include the following, based on the needs and preferences of the Enrollee identified through the Health Risk Assessment:

5.12.2.1 Personal or cultural preferences, such as types or amounts of services;

5.12.2.2 Providers and their characteristics, such as preferred gender or language;

5.12.2.3 Enrollee's living arrangements;

5.12.2.4 Covered Services and non-Covered Services to address each identified need, provided that Contractor shall not be required to pay for any non-Covered Services;

5.12.2.5 Short- and long-term treatment and service goals and objectives;

5.12.2.6 Actions and interventions necessary to achieve such objectives;

5.12.2.7 Follow-up and evaluation;

5.12.2.8 Timeframes;

5.12.2.9 Collaborative approaches to be used;

5.12.2.10 Desired outcomes and goals, both clinical and non-clinical;

5.12.2.11 Standing Referrals;

5.12.2.12 Community resources;

5.12.2.13 Informal supports;

5.12.2.14 Home visits as necessary and appropriate for Enrollees who are homebound (as defined in 42 U.S.C. 1395n(a)(2)), who have physical or Cognitive Disabilities, or who may be at increased risk for Abuse and Neglect; and,

5.12.2.15 Wellness Programs plan.

5.12.3 **Enrollee Care Plan Development.** Contractor will use the information gathered through Health Risk Assessments and during Enrollee interactions in developing the Enrollee Care Plan. To the extent permitted by applicable State and federal confidentiality requirements, Enrollees and their families and other caregivers, the Enrollee's PCP, and other treating Providers will be provided the opportunity to be involved in Enrollee Care Plan development. Contractor shall give Enrollees the opportunity to approve the Enrollee Care Plans.

5.12.4 **Non-Covered Services.** Contractor will use assessments and input from the Enrollee, the Enrollee's family and other caregivers, and Providers to determine the need for non-Covered Services and community resources, and shall ensure all identified services are fully integrated into the Enrollee Care Plan, provided that Contractor shall not be required to pay for non-Covered Services.

5.12.5 **Enrollee Care Plan Implementation.** Contractor will review the Enrollee Care Plan with the Enrollee and, as appropriate, any other caregivers, family members and Providers with the Enrollee's permission. Contractor will utilize all appropriate methods of communication to ensure that all identified parties understand the Enrollee Care Plan. Contractor will coordinate services as agreed upon in the Enrollee Care Plan.

5.12.6 **Self-directed Care.** Contractor will encourage Providers to support Enrollees in directing their own care and Enrollee Care Plan development. This will include giving PCPs a copy of the Enrollee Care Plan.

5.12.7 **Enrollee Care Plans with Negotiated Risk.** Contractor shall have as a goal that an Enrollee has an Enrollee Care Plan for services under HCBS Waivers that allows the Enrollee to have choice while also protecting the Enrollee's

safety. When a situation arises that requires Negotiated Risk for an Enrollee, Contractor will work with the Enrollee to make the Enrollee aware of potential risks and make appropriate referrals if safety is a concern.

5.12.8 **Assessing Risk.** Contractor shall identify and evaluate risks associated with the Enrollee's care. Factors considered include the potential for deterioration of the Enrollee's health status; the Enrollee's ability to comprehend risk; caregiver qualifications; appropriateness of the residence for the Enrollee; and behavioral or other compliance risks.

5.12.9 **Negotiating and Documenting Risk.** Contractor shall incorporate the results of the risk assessment into the Enrollee Care Plan. Enrollee Care Plans that include Negotiated Risks shall be submitted to Contractor's Medical Director for review. Negotiated Risks shall not allow or create a risk for other Residents in a group setting.

5.13 **Integrated Care Team (ICT).** Contractor will establish a multidisciplinary ICT for those Enrollees identified as requiring Care Management or Disease Management services. The ICT shall consist of clinical and non-clinical staff whose skills and professional experience will complement and support each other in the oversight of Enrollees' needs. ICT functions will include, but are not limited to:

5.13.1 Conducting individualized Enrollee assessments and coordination of care.

5.13.2 Developing an Enrollee Care Plan for Enrollees, as set forth in Section 5.11.3, receiving Care Management or Disease Management services, in collaboration with the Enrollee, family and other caregivers, and Providers;

5.13.3 Communicating and coordinating care in a manner that reasonably ensures Enrollees' behavioral and physical health needs are met, including the following care integration services:

5.13.3.1 **Specialty Care**. ICTs and embedded Care Coordinators will be available to assist Medical Home Providers in referring Enrollees for specialty care.

5.13.3.2 **Medication Management**. Care Coordinators will facilitate communication between the Medical Home and other Providers concerning Enrollees' medication.

5.13.3.3 **Institutional Care.** The ICT will promptly identify Enrollees who are in SNFs and ICFs on the effective date of enrollment. Subsequent to the initial assessment, Care Coordinators will visit onsite to re-assess the Enrollee's health and functional status and other elements such as informal supports, the extent to which established goals are being met as judged by the Enrollee, the Enrollee's satisfaction with current Providers, and the utilization of acute services and timeliness of preventive care services. Contractor may arrange for onsite SNFist coordination services for Enrollees in Nursing Facilities who are the most medically complex, chronically ill, frail and elderly.

5.13.4 Engaging representatives of external programs and services that support Enrollees' needs as needed.

5.13.5 Coordinating with first responders, inpatient facilities, emergency rooms and Long-Term Care Facilities to support the effective coordination of services and assist stakeholders in working effectively with the Enrollee. The ICT will receive notification of preauthorized or emergency inpatient admissions from the Utilization Management staff. The ICT will ensure the Enrollee's Medical Home is aware of such admissions and will coordinate to provide the Enrollee's medical and behavioral health history and Enrollee Care Plan, including current medication list, to Contractor's discharge planning staff for use by hospital medical, nursing, social service, and discharge planning staff.

5.13.6 Monitoring the day-to-day delivery of community-based services to reasonably ensure these services support recovery and resiliency principles for Enrollees.

5.14 **Care Coordinators.** Each Enrollee will be assigned a Care Coordinator as part of the Enrollee's Integrated Care Team. Care Coordinators assigned to Enrollees with varying risk levels shall have their overall caseload weighted and a blended overall case load limit set, taking into account the location of the Enrollee. Contractor will provide the Department with its methodology for assigning Enrollees with varying risk levels for Prior Approval. The Department may review existing caseloads at any time and require a change in methodology or an Enrollee's assignment to a caseload. Case loads of Care Coordinators shall not exceed the following standards, on average, during a calendar year:

5.14.1 High Risk Enrollees. Care Coordinator caseload for high risk Enrollees shall not exceed:

5.14.1.1 Forty-five (45) Enrollees with a Serious Mental Illness;

5.14.1.2 Sixty (60) Enrollees with a Developmental Disability; and

5.14.1.3 Sixty (60) Enrollees with a physical disability or Chronic Health Condition.

5.14.2 Moderate Risk Enrollees. Care Coordinator caseload for moderate risk Enrollees shall not exceed:

5.14.2.1 One hundred (100) Enrollees with a Serious Mental Illness;

5.14.2.2 One hundred fifty (150) Enrollees with a Developmental Disability; and

5.14.2.3 One hundred fifty (150) Enrollees with a physical disability or Chronic Health Condition.

5.14.3 Low Risk Enrollees. Care Coordinator shall contact low risk Enrollees whenever such an Enrollee's condition worsens, but at least every six (6) months, for reassessment. Care Coordinator caseload for low risk Enrollees shall not exceed:

5.14.3.1 One hundred fifty (150) Enrollees with a Serious Mental Illness;

5.14.3.2 Two hundred (200) Enrollees with a Developmental Disability; and

5.14.3.3 Three hundred (300) Enrollees with a physical disability or Chronic Health Condition

5.15 Transition of Care.

5.15.1 Contractor shall manage transition of care and continuity of care for new Enrollees and for Enrollees moving from an institutional setting to a community living arrangement. Transition coordinators will be members of the ICT, will be physically located with other ICT staff and will share systems with Care Coordinators embedded in FQHCs, CMHCs and large medical groups to optimize integration of the transition process.

5.15.2 Transition of New Enrollees. Contractor will identify new Enrollees who require transition services by using a variety of sources, including, but not limited to:

5.15.2.1 Prior claim history as provided by the Department;

5.15.2.2 Health Risk Screenings completed by new Enrollees;

5.15.2.3 Providers requesting information and service authorizations for Enrollees (existing prior authorizations for new Enrollees shall be honored by Contractor);

5.15.2.4 Communications from Enrollees; and

5.15.2.5 Communication with existing agencies or service Providers that are supporting Enrollees at the time of transition.

5.15.3 Pre-existing Conditions. Upon the effective date of enrollment, Contractor shall assume full responsibility for any Covered Services necessary to treat medical conditions that may have existed prior to an Enrollee's enrollment with Contractor. Contractor shall support the continuation of any existing treatment plan provided that the Enrollee's treatment plan is current and the Enrollee's current PCP and Contractor's Medical Director determine that it is Medically Necessary. Contractor shall evaluate the appropriateness of Care Management, Disease Management and education for each Enrollee who it determines to have a pre-existing condition.

5.16 Continuity of Care. If an Enrollee is receiving medical care or treatment as an inpatient in an acute care hospital on the effective date of enrollment, Contractor shall assume responsibility for the management of such care and shall be liable for all claims for Covered Services from that date. For hospital stays that would otherwise be reimbursed under the HFS Medical Program on a per diem basis, Contractor's liability shall begin on the effective date of enrollment. Notwithstanding the foregoing, for hospital stays that would otherwise be

reimbursed under the HFS Medical Program on a DRG basis, Contractor will have no liability for the hospital stay.

5.16.1 If an Enrollee is receiving medical care or treatment as an inpatient in an acute care hospital at the time coverage under this Contract is terminated, Contractor shall arrange for the continuity of care or treatment for the current episode of illness until such medical care or treatment has been fully transferred to a treating Provider who has agreed to assume responsibility for such medical care or treatment for the remainder of that hospital episode and subsequent follow-up care. Contractor must maintain documentation of such transfer of responsibility of medical care or treatment. For hospital stays that would otherwise be reimbursed under the Department's Medical Program on a per diem basis, Contractor shall be liable for payment for any medical care or treatment provided to an Enrollee until the effective date of disenrollment. For hospital stays that would otherwise be reimbursed under the Department's Medical Program on a DRG basis, Contractor shall be liable for payment for any inpatient medical care or treatment provided to an Enrollee where the discharge date is after the effective date of disenrollment.

5.16.2 Contractor shall provide for the transition of services in accordance with Section 25 of the Managed Care and Patients Rights Act (215 ILCS 134/25).

5.16.3 **Coordination of Care.** Contractor shall provide coordination of care assistance to Prospective Enrollees to access a PCP or WHCP, or to continue a course of treatment, before Contractor's coverage becomes effective, if requested to do so by Prospective Enrollees, or if Contractor has knowledge of the need for such assistance. The Care Coordinator assigned to the Prospective Enrollee shall attempt to contact the Prospective Enrollee no later than two (2) Business Days after the Care Coordinator is notified of the request for coordination of care.

5.16.4 **Out-of-Network Providers.** In the event that the Physician of a new Enrollee who is in an active, ongoing course of treatment or is in the third trimester of pregnancy is not an Affiliated Provider, Contractor will permit such Enrollee to continue an ongoing course of treatment with such Physician for up to ninety (90) days or through the postpartum period, or as otherwise required by Section 25 of the Managed Care Reform and Patients Rights Act only if the out-of-network Physician agrees to provide such ongoing course of treatment, and if such out-of-network Physician agrees to: (i) accept reimbursement at Contractor's established rates based on a review of the level of services provided, (ii) adhere to Contractor's QA requirements, (iii) provide necessary medical information related to health care, and (iv) adhere to Contractor's policies and procedures, including, but not limited to, procedures regarding Referrals.

5.16.5 **Authorization of Services.** Contractor shall have in place and follow written policies and procedures when processing requests for initial and continuing authorizations of Covered Services. Such policies and

procedures shall provide for consistent application of review criteria for authorization decisions by a health care professional or professionals with expertise in treating the Enrollee's condition or disease and provide that Contractor shall consult with the Provider requesting such authorization when appropriate. If Contractor declines to authorize Covered Services that are requested by a Provider or authorizes one or more services in an amount, scope, or duration that are less than that requested, Contractor shall notify the Provider orally or in writing and shall furnish the Enrollee with written notice of such decision. Such notice shall meet the requirements set forth in 42 C.F.R. 438.404.

5.16.6 **Services Requiring Prior Authorization**. Contractor shall authorize or deny Covered Services, including pharmacy services, that require prior authorization as expeditiously as the Enrollee's health condition requires. Ordinarily, authorizations or denials shall be provided within fourteen (14) days after receiving the request for authorization from a Provider, with a possible extension of up to fourteen (14) additional days, if the Enrollee requests the extension or Contractor provides written justification to the Department that there is a need for additional information and the Enrollee will not be harmed by the extension. If the Physician indicates, or Contractor determines, that following the ordinary time frame could seriously jeopardize the Enrollee's life or health, Contractor shall authorize or deny the Covered Service no later than seventy-two (72) hours after receipt of the request for authorization, with a possible extension of up to fourteen (14) days, if the Enrollee requests the extension or Contractor provides written justification to the Department that there is a need for additional information and the Enrollee will not be harmed by the extension.

5.17 Direct Access Services

5.17.1 **Emergency Services.** Contractor shall cover Emergency Services for all Enrollees whether the Emergency Services are provided by an Affiliated or non-Affiliated Provider.

5.17.1.1 Contractor shall not impose any requirements for prior approval of Emergency Services.

5.17.1.2 Contractor shall cover Emergency Services provided to Enrollees who are temporarily away from their residence and outside the Contracting Area to the extent that the Enrollees would be entitled to the Emergency Services if they still were within the Contracting Area.

5.17.1.3 Contractor shall have no obligation to cover medical services provided on an emergency basis that are not Covered Services under this Contract.

5.17.1.4 Elective care or care required as a result of circumstances that could reasonably have been foreseen prior to the Enrollee's departure from the Contracting Area is not covered. Unexpected hospitalization due to complications of pregnancy shall be covered. Routine delivery at term outside

the Contracting Area, however, shall not be covered if the Enrollee is outside the Contracting Area against medical advice unless the Enrollee is outside of the Contracting Area due to circumstances beyond her control. Contractor must educate the Enrollee regarding the medical and financial implications of leaving the Contracting Area and the importance of staying near the treating Provider throughout the last month of pregnancy.

5.17.1.5 Contractor shall provide ongoing education to Enrollees regarding the appropriate use of Emergency Services. Contractor shall use a range of management techniques, policies and Enrollee or Provider initiatives to avoid unnecessary utilization of Emergency Services and to promote Care Management through an Enrollee's PCP or Medical Home.

5.17.1.6 Contractor shall not condition coverage for Emergency Services on the treating Provider notifying Contractor of the Enrollee's screening and treatment within ten (10) days after presentation for Emergency Services.

5.17.1.7 The determination of the attending emergency Physician, or the Provider actually treating the Enrollee, of whether an Enrollee is sufficiently Stabilized for discharge or transfer to another facility, shall be binding on Contractor.

5.17.2 **Post-Stabilization Services.** Contractor shall cover Post-Stabilization Services provided by an Affiliated or non-Affiliated Provider in any of the following situations: (i) Contractor authorized such services; (ii) such services were administered to maintain the Enrollee's Stabilized condition within one (1) hour after a request to Contractor for authorization of further Post-Stabilization Services; or (iii) Contractor does not respond to a request to authorize further Post-Stabilization Services within one (1) hour, Contractor could not be contacted, or Contractor and the treating Provider cannot reach an agreement concerning the Enrollee's care and an Affiliated Provider is unavailable for a consultation, in which case the treating Provider must be permitted to continue the care of the Enrollee until an Affiliated Provider is reached and either concurs with the treating Provider's plan of care or assumes responsibility for the Enrollee's care.

5.17.3 **Family Planning Services.** Subject to Section 5.3 hereof, Contractor shall cover family planning services for all Enrollees whether the family planning services are provided by an Affiliated or non-Affiliated Provider.

5.18 Member Services

5.18.1 **Basic Information.** "Basic information" as used herein shall mean information regarding:

5.18.1.1 The types of benefits, and amount, duration and scope of such benefits available under this Contract with sufficient

detail to ensure that Enrollees understand the Covered Services that they are entitled to receive, including behavioral health services;

5.18.1.2 The procedures for obtaining Covered Services, including authorization and Referral requirements, and any restrictions Contractor may place on an Enrollee pursuant to Section 4.18;

5.18.1.3 Information, as provided by the Department, regarding any benefits to which an Enrollee may be entitled under the HFS Medical Program that are not provided under Contractor's plan and specific instructions on where and how to obtain those benefits, including any restrictions on an Enrollee's freedom of choice among Affiliated Providers;

5.18.1.4 The extent to which after-hours coverage and Emergency Services are provided, including the following specific information: (i) definitions of "Emergency Medical Condition," "Emergency Services," and "Post-Stabilization Services" that are consistent with the definitions set forth herein; (ii) the fact that prior authorization is not required for Emergency Services; (iii) the fact that, subject to the provisions of this Contract, an Enrollee has a right to use any hospital or other setting to receive Emergency Services; (iv) the process and procedures for obtaining Emergency Services; and (v) the location of Emergency Services and Post-Stabilization Services Providers that are Affiliated Providers;

5.18.1.5 The procedures for obtaining Post-Stabilization Services in accordance with the terms set forth in Section 5.17.2;

5.18.1.6 The policy on Referrals for specialty care and for Covered Services not furnished by an Enrollee's PCP;

5.18.1.7 Cost sharing, if any;

5.18.1.8 The rights, protections, and responsibilities of an Enrollee as specified in 42 C.F.R. Section 438.100, such as those pertaining to enrollment and disenrollment and those provided under State and Federal law;

5.18.1.9 Grievance and fair hearing procedures and timeframes, provided that such information must be submitted to the Department for Prior Approval before distribution;

5.18.1.10 Appeal rights and procedures and timeframes, provided that such information must be submitted to the Department for Prior Approval before distribution;

5.18.1.11 Contractor's website address and the types of information contained on the website, including Certificate of Coverage

or Document of Coverage, Provider directory and the ability to request a hard copy of these through member services;

5.18.1.12 A copy of Contractor's Certificate of Coverage or Document of Coverage;

5.18.1.13 Names, locations, telephone numbers, and non-English languages spoken by current Affiliated Providers, including identification of those who are not accepting new Enrollees.

5.18.2 **Obligation to Provide Basic Information**. Contractor shall have written policies and provide Basic Information to the following Participants, and shall notify such Participants that translated materials in Spanish and prevalent languages are available and how to obtain them, at the times described below:

5.18.2.1 To each Enrollee or Prospective Enrollee within thirty (30) days after Contractor receives notice of the Enrollee's enrollment and within thirty (30) days before a significant change to the Basic Information;

5.18.2.2 To any Potential Enrollee who requests it; or

5.18.2.3 Once each year Contractor must notify Enrollees of their right to request and obtain Basic Information.

5.18.3 **Other Information:** Contractor shall provide the following additional information when requested by any Enrollee, Prospective Enrollee, or Potential Enrollee:

5.18.3.1 MCO and health care facility licensure;

5.18.3.2 Practice guidelines maintained by Contractor in accordance with 42 C.F.R. 438.236; and,

5.18.3.3 Information about Affiliated Providers of health care service, including education, Board certification and recertification, if appropriate.

5.18.4 **Communications with Prospective Enrollees, Potential Enrollees, and Enrollees**. The requirements outlined in this Section 5.18.4 apply to all Key Oral Contacts and Written Materials. Contractor shall promote the hiring of staff from in and around the Contracting Area to ensure cultural competence. Member Services staff, Member Connections staff, care coordination and Care Management staff and nurse advice line staff will receive training on all Contractor policies and procedures during new hire orientation and ongoing job-specific training to ensure effective communication with the diverse Enrollee population, including translation assistance, assistance to the hearing impaired and those with limited English proficiency. Contractor shall meet quarterly with its Enrollee Advisory Committee to assess the results of Enrollee calls. Enrollee feedback will be sought during all Enrollee interactions to improve service delivery. Contractor shall conduct targeted Enrollee focus

groups to obtain additional input on Contractor materials and program information, and shall also seek input from local organizations that serve Enrollees.

5.18.4.1 Interpretive Services. Contractor shall make oral interpretation services available free of charge in all languages to all Potential Enrollees, Prospective Enrollees or Enrollees who need assistance understanding Key Oral Contacts or Written Materials. Contractor must include in all Key Oral Contacts and Written Materials notification that such oral interpretation services are available and how to obtain such services. Contractor shall conduct Key Oral Contacts with Potential Enrollees, Prospective Enrollees or Enrollees in a language the Potential Enrollees, Prospective Enrollees and Enrollees understand. If such Participant requests interpretive services by a family member or acquaintance, Contractor shall not allow such services by anyone who is under the age of eighteen (18). Contractor shall accept such Participant's verification of the age of the individual providing interpretive services unless Contractor has a valid reason for requesting further verification.

5.18.4.2 Reading Level. All of Contractor's written communications with Potential Enrollees, Prospective Enrollees and Enrollees must be easily understood by individuals with, and produced at, a sixth grade reading level. Contractor will use the Flesch Reading Ease and Flesch-Kincaid Grade level tests, or other reading level test as approved by the Department, to ensure appropriate reading level. Written Materials will be presented in a layout and manner that enhances Enrollees' understanding in a culturally competent manner.

5.18.4.3 Alternative Methods of Communication. Contractor shall make Key Oral Contacts and Written Materials available in such alternative formats as large print, Braille, sign language interpreters in accordance with the Interpreters for the Deaf Act (225 ILCS 442), CART reporters, audio CDs, TDD/TTY, Video Relay Interpretation or Video Relay Services, and in a manner that takes into consideration the special needs of those who are visually impaired, hearing-impaired or have limited reading proficiency. Contractor shall inform Potential Enrollees, Prospective Enrollees and Enrollees, as appropriate, that information is available in alternative formats and how to access those formats. Contractor must provide TDD/TTY service upon request for communicating with Potential Enrollees, Prospective Enrollees and Enrollees who are deaf or hearing impaired. Contractor shall arrange interpreter services through Contractor's Member Services Department when necessary (such as for Provider visits or consultations). These services will be made available at no cost to the Enrollee.

5.18.4.4 Translated Materials. Translated Written Materials and scripts for translated Key Oral Contacts require Prior Approval and must

be accompanied by Contractor's certification that its certified translator certifies that the translation is accurate and complete, and that the translation is easily understood by individuals with a sixth grade reading level and is culturally appropriate. Contractor's first submittal of the translated materials to the Department for Prior Approval must be accompanied by a copy of the Department's approval of the English version and the required translation certification. Contractor shall make all Written Materials distributed to English-speaking Potential Enrollees, Prospective Enrollees and Enrollees, as appropriate, available in Spanish and other prevalent languages, as determined by the Department. Where there is a prevalent single-language minority within the low income households in the relevant DHS local office area (which for purposes of this Contract shall exist when five percent (5%) or more such households speak a language other than English, as determined by the Department according to published Census Bureau data), Contractor's Written Materials provided to Potential Enrollees, Prospective Enrollees or Enrollees must be available in that language as well as in English. Contractor's policies and processes regarding Enrollee materials will also apply to the reviewing and developing of recorded scripts, on-hold messages and podcasts. The Department may require that Contractor provide Written Materials in additional languages at any time with written notice to Contractor and without requiring additional payment from the Department or a Contract amendment. Most Enrollee materials shall include instructions to call Contractor if the information is needed in another format.

5.18.5 **Enrollee Handbook**. Contractor shall submit an Enrollee Handbook to the Department for Prior Approval before the first enrollment, when revised, and upon the Department's request. Contractor shall not be required to submit format changes for Prior Approval, provided there is no change in the information conveyed. Contractor shall mail an Enrollee Handbook to new Enrollees no later than five (5) Business Days following receipt of the Enrollee's initial enrollment record on the 834 Audit File. At a minimum, the Enrollee Handbook must contain:

5.18.5.1 Contractor's contact information.

5.18.5.2 The Enrollee's rights and responsibilities and the Enrollee's freedom to exercise those rights without negative consequences. The Enrollee's rights include the right to:

5.18.5.2.1 Be treated with respect and with due consideration for the Enrollee's dignity and privacy;

5.18.5.2.2 Receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's condition and ability to understand;

5.18.5.2.3 Participate in decisions regarding the Enrollee's health care, including the right to refuse treatment;

5.18.5.2.4 Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;

5.18.5.2.5 Request and receive a copy of the Enrollee's medical records, and to request that they be amended or corrected; and

5.18.5.2.6 Exercise the Enrollee's rights, and that the exercise of those rights will not adversely affect the way the Enrollee is treated.

5.18.5.3 The PCP Network and the PCP's role in directing and managing the Enrollee's care.

5.18.5.4 An explanation of Open Enrollment and the Open Enrollment Period.

5.18.5.5 How to select and change a PCP, change "for cause", whether Contractor may impose a restriction on the number of times the Enrollee can change PCPs during the Enrollment Period, and the circumstances under which an Enrollee may select a specialist as a PCP.

5.18.5.6 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.

5.18.5.7 How and the extent to which the Enrollee may obtain direct access services, including family planning services.

5.18.5.8 The policies and procedures for obtaining services, including self-referred services, services requiring prior authorization and services requiring a Referral.

5.18.5.9 How to access after-hours, non-emergency care.

5.18.5.10 The procedures for obtaining Emergency Services. The information shall specify that Emergency Services do not require a Referral; provide information about the 911 telephone system; and refer the Enrollee to the Provider Directory or the Call Center for a list of facilities providing Emergency Services and Post-Stabilization Services. The information shall clearly communicate that the Enrollee has a right to use any hospital or other setting for Emergency Services.

5.18.5.11 How to identify what constitutes an Emergency Medical Condition, Emergency Services or the need for Post-

Stabilization Services, as defined by 42 C.F.R. Section 438.114(a).

5.18.5.12 Contractor's Grievance and Appeals process and the Department's Appeal and fair hearing process, including how to register a Complaint, Grievance or Appeal.

5.18.5.13 How to access and receive written and oral information in languages other than English and in alternate language formats, including TDD/TTY.

5.18.5.14 The preferred drug list and how to obtain prescription drugs.

5.18.5.15 The Disease Management Program and the services offered, and how to access these services.

5.18.5.16 Care Coordination and services provided by a Care Coordinator.

5.18.5.17 Any Basic Information, as set forth in Section 5.18.1, that is not otherwise specifically set forth in this Section 5.18.5.

5.18.6 Telephone Access.

5.18.6.1 **Twenty-Four Hour Telephone Access.** Contractor shall establish a toll-free telephone number, available twenty-four (24) hours, seven (7) days a week, for Enrollees to confirm eligibility for benefits and seek prior approval for treatment where required by Contractor, and shall assure twenty-four (24) hour access, via telephone(s), to medical professionals, either to Contractor directly or to the PCPs, for consultation to obtain medical care.

5.18.6.2 Contractor shall establish a toll-free number available, at a minimum during the hours of 8:30 a.m. until 5:00 p.m. Central Time on Business Days. This number will be used: (i) to confirm eligibility for benefits, (ii) for approval for non-emergency services, and (iii) for Enrollees to call to request Site or PCP changes, to file Complaints or Grievances, to request disenrollment, to ask questions or to obtain other administrative information.

5.18.6.3 **Nurse Advice Line.** Contractor shall establish a toll-free advice line, available twenty-four (24) hours a day, seven (7) days a week, through which Enrollees may obtain medical guidance and support from a nurse. Contractor shall ensure that the nurses staffing the nurse advice line will be able to obtain Physician support and advice by contacting Contractor's Medical Director if needed.

5.18.6.4 Contractor may use one (1) toll-free number for these purposes or may establish separate numbers.

5.18.6.5 The Member Services telephone line on-hold messaging will include health education briefs and general reminders and Contractor benefits and services information. The messaging will be changed periodically to meet identified Enrollee trends or topical issues.

5.18.6.6 Contractor's administrative QA and improvement policies and procedures shall contain standards and a monitoring plan for all telephone access and call center performance on an ongoing basis, and Contractor shall take immediate corrective action when standards are not met. Contractor shall analyze data collected from its phone system as requested by the Department and as necessary to perform QA and improvement tasks, monitor compliance with performance standards, and ensure adequate staffing of the call centers. Upon request from the Department, Contractor shall document compliance in these areas.

5.18.6.7 **Call Recording and Monitoring.** Contractor shall record all incoming calls received by any call center for quality control, program integrity and training purposes. Staff at any Member Services call center and nurse advice line shall advise callers that calls may be monitored and recorded for QA purposes. Administrative lines do not need to be recorded. Contractor shall archive the recordings for no fewer than twelve (12) months or as otherwise required by law.

5.18.7 **Engaging Enrollees.** Contractor shall use a multifaceted approach to locate and engage Enrollees and shall capitalize on every Enrollee contact to obtain and update Enrollee contact information and engage the Enrollees in their own care. Input will be solicited from Contractor's Enrollee Advisory Committee and Community Stakeholder Committee to help develop strategies to increase motivation of Enrollees in participating in their own care.

5.18.7.1 **Member Relationship Management System.** Contractor shall have a system dedicated to the management of information about Enrollees, specifically designed to collect Enrollee-related data and processing workflow needs in health care administration. The system shall have, at a minimum, three (3) core integrated components:

5.18.7.1.1 Member demographics tracking and information;

5.18.7.1.2 Means to automate, manage, track and report on Contractor's workflows for outbound and outreach Enrollee campaigns as well as targeted outbound interventions (such as engaging high-risk Enrollees in care or disease management programs); and,

5.18.7.1.3 Technology for use for inbound Enrollee contact and query management.

5.18.7.2 **MemberConnections.** Contractor shall have representatives who are locally hired and familiar with the communities and service challenges encountered by Enrollees and whose function is to assist in locating and engaging Enrollees.

5.18.7.3 **Telephonic Outreach.** Contractor will implement a telephonic outreach program to educate and assist Enrollees in accessing services and managing their care. Calls will be made by Contractor staff, or by the nurse advice line, to new Enrollees and to targeted populations such as Enrollees who are identified or enrolled in Disease or Care Management, who have frequent emergency room utilization or who are due or past due for services.

5.18.7.4 **Enrollee Portal.** Contractor shall develop and maintain a secure Enrollee Web Portal which shall include, at a minimum, the following functions or capabilities:

5.18.7.4.1 Information about Contractor;

5.18.7.4.2 "Contact Us" information;

5.18.7.4.3 Secure messaging;

5.18.7.4.4 Enrollee incentive account status;

5.18.7.4.5 Podcasts;

5.18.7.4.6 Local health events and news;

5.18.7.4.7 Health Passport;

5.18.7.4.8 Health Risk Screening;

5.18.7.4.9 Gaps in care;

5.18.7.4.10 Provider search; and

5.18.7.4.11 Compliance with Section 508 of the Rehabilitation Act of 1973.

5.18.7.5 **Distribution of Written Material.** Contractor shall produce mailings to all Enrollees enrolled in Care Management that will include reminders about the benefits of participating in the Care Management program and of receiving the screenings and preventive care required for their particular condition. The mailing shall include Contractor's toll-free phone number and invite Enrollees to contact ICT or the nurse advice line with any questions. Contractor mailings shall include reminders about needed preventive services or screenings, whether in writing or by telephone, a reminder about the risks associated with progression of the Enrollee's disease and

about any available incentives for receiving a needed service.

5.18.8 **Enrollee Health Education.** Contractor will offer an expansive set of health education programs that use comprehensive outreach and communication methods to effectively educate Enrollees, and their families and other caregivers, about health and self-care and how to access plan benefits and supports.

5.18.8.1 **Collaborative Education Development and Oversight.** Contractor's Medical Management Department and Medical Director shall be responsible for development, maintenance and oversight of Enrollee health education programs.

5.18.8.2 **Cell Phone Program.** Contractor shall offer restricted-use cell phones to select high-risk Enrollees participating in Care Management. The phones will be pre-programmed with numbers for the Care Coordinators, the nurse advice line, 911, and the PCP and other treating Providers. ICT staff will use the phones to contact Enrollees for education, appointment reminders and ongoing coaching and support for wellness and compliance. Contractor shall send text messages with health information targeted to the Enrollee's condition. Phone models shall be available with options such as large print and numbers and Spanish translation.

5.18.8.3 **MP3 Players**. Contractor shall offer MP3 players loaded with podcasts relevant to an Enrollee's condition to certain Enrollees. Podcasts will also be available to download from the Enrollee Portal.

5.18.8.4 **Health Education Outreach**. Contractor will identify regional community health education opportunities, improve outreach and communication with Enrollees and community-based organization members, and actively promote healthy lifestyles such as disease prevention and health promotion. This outreach will include, but is not limited to, the following:

5.18.8.4.1 Contractor staff will visit local group homes and day programs to teach Enrollees about healthy eating (including cooking demonstrations) and other healthy habits such as safety and hygiene education.

5.18.8.4.2 Contractor staff will assist Enrollees who live in low-income or public housing to identify and address health hazards in the home, particularly the presence of lead.

5.18.8.5 **Flu Prevention Program.** Contractor shall make a flu prevention program available for all Enrollees and will provide targeted outreach to high-risk Enrollees. The program will educate Enrollees about preventing the transmission of the influenza virus.

5.18.8.6 **New Enrollee Welcome Packet.** Contractor shall send to each new Enrollee a welcome packet that contains the Enrollee Handbook and a quick reference guide that shall provide a summary of important topics, such as how to get needed care, a benefits summary, and information about the Complaint, Grievance and Appeal processes. This may be combined with the Enrollee welcome packet required in Section 4.8.

5.18.8.7 **Welcome Calls**. Contractor will conduct Welcome Calls to each new Enrollee within thirty (30) days after the effective date of enrollment. Contractor will provide health education and respond to questions about Covered Services and how to access them, and conduct a Health Risk Screening to identify an Enrollee's potential need for services and Care Management.

5.18.8.8 **Enrollee Incentive Account Program.** Contractor shall offer an Enrollee incentive account program to promote personal health responsibility and ownership by offering financial incentives loaded onto a Contractor-issued Enrollee incentive account debit card. The incentives offered by Contractor to eligible Enrollees may include rewards for completing annual preventive health visits; attending a follow-up visit within seven (7) days after discharge of an admission for Mental Illness; and, completing other recommended preventive health and Chronic Health Condition care screenings. Contractor shall inform Enrollees of this program through Contractor's New Enrollee Welcome Packet, Enrollee Handbook and websites, and other appropriate means.

5.18.8.9 **Enrollee Newsletters.** Contractor will distribute quarterly Enrollee Newsletters that include health education and a Contractor events calendar listing health fairs, screening days and other Contractor-sponsored or organized health activities.

5.18.8.10 **Education through Care Coordinators.** Contractor's Care Coordinators will contact all Enrollees who frequently use or recently visited an emergency room to determine whether the Enrollees are experiencing barriers to primary and preventive care, to help resolve those barriers, if any, and to educate Enrollees on the appropriate use of emergency room services and the Enrollees' health home.

5.18.8.11 **Enrollee Support to Ensure Compliance.** To the extent possible, Contractor shall involve the Enrollee in Enrollee Care Plan development. Enrollee education will occur through telephone contact, face-to-face contact, education groups, and educational mailings. Education shall include information about monitoring daily disease-specific indicators. If appropriate, the Care Coordinator will link the Enrollee with

available community-based disease-specific educational programs and support groups.

5.18.9 **Transient Enrollees.** Contractor shall utilize various strategies and methodologies, as appropriate, to connect with transient Enrollees including, but not limited to, the following.

5.18.9.1 **Connections Plus.** Providing pre-programmed restricted use cell phones to selected Enrollees.

5.18.9.2 **Web Portal.** Providing educational materials on the Enrollee Web Portal.

5.18.9.3 **Enrollee Contact.** Verifying Enrollee address and phone numbers during each contact.

5.18.9.4 **Other Methods.** Contractor shall use other methods available to locate and educate transient Enrollees such as community organizations, Physicians, family, Internet and reverse phone number look-up systems to locate active phone numbers, and Enrollee demographics on paid claims. Contractor representatives may be dispatched to an Enrollee's home when a valid phone number is not found.

5.19 Quality Assurance, Utilization Review and Peer Review.

5.19.1 All services provided or arranged to be provided by Contractor shall be in accordance with prevailing community standards. Contractor must have in effect a program consistent with the utilization control requirements of 42 C.F.R. Part 456. This program will include, when so required by the regulations, written plans of care and certifications of need of care.

5.19.1.1 Contractor shall adopt practice guidelines that, at a minimum:

5.19.1.1.1 Are based on valid and reliable clinical evidence or a consensus of health care professionals in a particular field;

5.19.1.1.2 Consider the needs of the Enrollees;

5.19.1.1.3 Are adopted in consultation with Affiliated Providers;

5.19.1.1.4 Are reviewed and updated periodically, as appropriate; and

5.19.1.1.5 Are disseminated to all affected Affiliated Providers and, upon request, to Enrollees and Potential Enrollees.

5.19.2 Contactor shall use electronic lab value results to support clinical management activities and for HEDIS® reporting and shall incorporate use of this data in stratifying and managing Enrollees for Care Management services and measuring clinical outcomes. Contractor shall encourage Providers to use labs that are capable of reporting electronic lab values directly to Contractor.

5.19.3 Contractor shall have a Utilization Review Program that includes a utilization review plan, a utilization review committee that meets quarterly and appropriate mechanisms covering preauthorization and review requirements.

5.19.4 Contractor shall establish and maintain a Peer Review Program approved by the Department to review the quality of care being offered by Contractor and its employees, Subcontractors, and Affiliated Providers.

5.19.5 Contractor agrees to comply with the QA standards attached hereto as Attachment XI.

5.19.6 Contractor agrees to comply with the utilization review standards and peer review standards attached hereto as Attachment XII.

5.19.7 Contractor agrees to conduct a program of ongoing review that evaluates the effectiveness of its QA and performance improvement strategies designed in accordance with the terms of this Section 5.19.

5.19.8 Contractor shall not compensate individuals or entities that conduct utilization review activities on its behalf in a manner that is structured to provide incentives for the individuals or entities to deny, limit, or discontinue Covered Services that are Medically Necessary for any Enrollee.

5.20 Abuse and Neglect. Contractor shall comply with the Department of Human Services Act (20 ILCS 1305/1-1 et seq.), the Abuse of Adults with Disabilities Intervention Act (20 ILCS 2435/1 et seq.), and the Abused and Neglected Child Reporting Act (325 ILCS 5/1 et seq.). Contractor shall have a formal process for reporting incidents that may indicate Abuse, Neglect or exploitation of an Enrollee.

5.20.1 Contractor shall train all of Contractor's employees to recognize potential concerns related to Abuse and Neglect, and on their responsibility to report suspected or alleged Abuse or Neglect. Contractor's employees who, in good faith, report suspicious or alleged Abuse or Neglect shall not be subjected to any adverse Action from Contractor, its Affiliated Providers, Affiliates or subcontractors.

5.20.2 Providers, Enrollees and Enrollees' family members will be trained about the signs of Abuse and Neglect, what to do if they suspect Abuse or Neglect, and Contractor's responsibilities. Training sessions will be customized to the target audience. Training will include general indicators of Abuse and Neglect and the timeframe requirements for reporting suspected Abuse, Neglect and exploitation.

5.20.3 Reports regarding Enrollees who are age eighteen (18) through fifty-nine (59) will be reported to the Illinois Department of Human Services Office of the Inspector General Hotline at 1-800-368-1465.

5.20.4 Reports regarding Enrollees who are age sixty (60) or older will be reported to the Illinois Department on Aging by utilizing the Elder Abuse Hotline number at 1-866-800-1409.

5.20.5 Contractor shall provide the Department with its protocols for reporting suspected Abuse and Neglect at the Readiness Review.

5.21 Physician Incentive Plan Regulations. Contractor shall comply with the provisions of 42 C.F.R. 422.208 and 422.210. If, to conform to these regulations, Contractor performs Enrollee satisfaction surveys, such surveys may be combined with those otherwise required by the Department pursuant to Section 5.27 of this Contract.

5.22 Prohibited Relationships.

5.22.1 Contractor shall not employ, subcontract with, or affiliate itself with or otherwise accept any Excluded Person into its network.

5.22.2 Contractor shall screen all current and prospective employees, contractors, and sub-contractors, prior to engaging their services under this Contract by: (i) requiring them to disclose whether they are Excluded Persons; and (ii) reviewing the OIG's list of sanctioned Persons (available at http://www.arnet.gov/epls) and the HHS/OIG List of Excluded Individuals/Entities (available at http://www.dhhs.gov/oig). Contractor shall annually screen all of its then-current employees, contractors and sub-contractors providing services under this Contract. Contractor shall screen out-of-State non-Affiliated Providers billing for Covered Services prior to payment and shall not pay such Providers who are Excluded Persons.

5.22.3 Contractor shall terminate its relations with any Excluded Person immediately upon learning that such Person or Provider meets the definition of an Excluded Person and notify the OIG of the termination.

5.23 Records.

5.23.1 Maintenance of Business Records. Contractor shall maintain all business and professional records that are required by the Department in accordance with generally accepted business and accounting principles. Such records shall contain all pertinent information about the Enrollee including, but not limited to, the information required under this Section 5.23.

5.23.2 Availability of Business Records. Records shall be made available in Illinois to the Department and Authorized Persons for inspection, audit, and reproduction as required in Section 9.1.2. These records will be maintained as required by 45 C.F.R. Part 74. As a part of these requirements, Contractor will retain one copy in any format of all records for at least six (6) years after final payment is made under the Contract. If an audit, litigation or other action involving the records is started before

the end of the six-year (6 year) period, the records must be retained until all issues arising out of the action are resolved.

5.23.3 **Patient Records**. Contractor shall require that a permanent medical record shall be maintained by each Enrollee's PCP. The medical record shall be available to the PCP, WHCP and other Providers. Copies of the medical record shall be sent to any new PCP or Medical Home to which the Enrollee transfers. Contractor shall require that the medical record contain documented efforts to obtain the Enrollee's consent when required by law. Contractor shall require that copies of records shall be released only to Authorized Persons upon request. Original medical records shall be released only in accordance with Federal or State law, court orders, subpoenas, or a valid records release form executed by an Enrollee. Contractor shall assist Enrollees in accessing their records in a timely manner. Contractor shall protect the confidentiality and privacy of minors, and abide by all Federal and State laws regarding the confidentiality and disclosure of medical records, mental health records, and any other information about Enrollee. Contractor shall require that Affiliated Providers produce such records for the Department upon request. Medical records must include Provider 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 the following, where applicable, shall be included:

5.23.3.1 Enrollee identification;

5.23.3.2 personal health, social history and family history, with updates as needed;

5.23.3.3 risk assessment;

5.23.3.4 obstetrical history and profile;

5.23.3.5 hospital admissions and discharges;

5.23.3.6 relevant history of current illness or injury and physical findings;

5.23.3.7 diagnostic and therapeutic orders;

5.23.3.8 clinical observations, including results of treatment;

5.23.3.9 reports of procedures, tests and results;

5.23.3.10 diagnostic impressions;

5.23.3.11 Enrollee disposition and pertinent instructions to the Enrollee for follow-up care;

5.23.3.12 immunization record;

5.23.3.13 allergy history;

5.23.3.14 periodic exam record;

5.23.3.15 weight and height information and, as appropriate, growth charts;

5.23.3.16 Referral information;

5.23.3.17 health education and anticipatory guidance provided; and,

5.23.3.18 family planning and counseling.

5.24 **Regular Information Reporting Requirements**. Contractor shall submit to the Department, or its designee, regular reports and additional information as set forth in Attachment XIII. Contractor shall ensure that data received from Providers and included in reports are accurate and complete by (i) verifying the accuracy and timeliness of reported data; (ii) screening the data for completeness, logic, and consistency; and (iii) collecting service information in standardized formats to the extent feasible and appropriate. All data collected by Contractor shall be available to the Department and, upon request, to Federal CMS. Such reports and information shall be submitted in a format and medium designated by, or having received Prior Approval from, the Department. A schedule of all reports and information submissions and the frequency required for each under this Contract is provided in Attachment XIII. For purposes of this Section, the following terms shall have the following meanings: "initially" means upon Execution of this Contract; "annual" means the State Fiscal Year; and "quarter" means three (3) consecutive calendar months of the State Fiscal Year beginning with the first day of July. Unless otherwise specified, Contractor shall submit all reports to the Department or its designee within thirty (30) days from the last day of the reporting period or as defined in Attachment XIII. The Department shall advise Contractor in writing of the appropriate format for such reports and information submissions. The Department will provide adequate notice before requiring production of any new reports or information, and will consider concerns raised by Contractor about potential burdens associated with producing the proposed additional reports. The Department will provide the reason for any such request. Failure of Contractor to materially comply with reporting requirements may subject Contractor to any of the applicable monetary sanctions in Article VII.

5.25 **Timely Payments to Providers.** Contractor shall make payments to Providers for Covered Services on a timely basis consistent with the Claims Payment Procedure described at 42 U.S.C. § 1396a(a)(37)(A) and Illinois Public Act 91-0605. Complaints or disputes concerning payments for the provision of services as described in this Section 5.25 shall be subject to Contractor's Provider grievance resolution system. Contractor must pay 90 percent (90%) of all Clean Claims from Providers for Covered Services within thirty (30) days following receipt. Contractor must pay 99 percent (99%) of all Clean Claims from Providers for Covered Services within ninety (90) days following receipt. For purposes of this Section, 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. Contractor will not be considered to be in breach of this Section, and the

Department will not impose a monetary sanction pursuant to Section 7.16.14 for Contractor's failure to meet the requirements of this Section, if such purported breach or failure occurs at a time when the Department has not paid any of the required Capitation to Contractor for two (2) consecutive months.

5.25.1 Contractor shall pay for all appropriate Emergency Services rendered by a non-Affiliated 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-Affiliated Provider within thirty (30) days of receiving the claim, and shall pay the non-Affiliated Provider within thirty (30) days after receiving such information. Such payment shall be made at the same rate the Department would pay for such services according to the level of services provided and exclusive of disproportionate share payments and Medicaid percentage adjustments. 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-Affiliated 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-Affiliated Providers.

5.25.2 Contractor shall pay for all Post-Stabilization Services as a Covered Service in any the following situations: (i) Contractor authorized such services; (ii) such services were administered to maintain the Enrollee's Stabilized condition within one (1) hour after a request to Contractor for authorization of further Post-Stabilization Services; or (iii) Contractor did not respond to a request to authorize such services within one (1) hour, Contractor could not be contacted, or, if the treating Provider is a non-Affiliated Provider, Contractor and the treating Provider could not reach an agreement concerning the Enrollee's care and an Affiliated Provider was unavailable for a consultation, in which case Contractor must pay for such services rendered by the treating non-Affiliated Provider until an Affiliated Provider was reached and either concurred with the treating non-Affiliated Provider's plan of care or assumed responsibility for the Enrollee's care. Such payment shall be made at the same rate the Department would pay for such services according to the level of services provided and exclusive of disproportionate share payments and Medicaid percentage adjustments.

5.25.3 Contractor shall pay for family planning services, subject to Section 5.3 hereof, rendered by a non-Affiliated Provider, for which Contractor would pay if rendered by an Affiliated Provider, at the same rate Department would pay for such services exclusive of disproportionate share payments and Medicaid percentage adjustments.

5.25.4 Contractor shall accept claims from non-Affiliated Providers for at least one (1) year after the date the services are provided. Contractor shall not be required to pay for claims initially submitted by such non-Affiliated Providers more than one (1) year after the date of service.

5.26 Grievance Procedure and Appeal Procedure.

5.26.1 **Grievance**. Contractor shall establish and maintain a procedure for reviewing Grievances registered by Enrollees. All Grievances shall be registered initially with Contractor and may later be appealed to the Department. Contractor's procedures must: (i) be submitted to the Department in writing and approved in writing by the Department; (ii) provide for prompt resolution, and (iii) assure the participation of individuals with authority to require corrective action. Contractor must have a Grievance Committee for reviewing Grievances registered by its Enrollees, and Enrollees must be represented on the Grievance Committee. At a minimum, the following elements must be included in the Grievance process:

5.26.1.1 An informal system, available internally, to attempt to resolve all Grievances;

5.26.1.2 A formally structured Grievance system that is compliant with Section 45 of the Managed Care Reform and Patient Rights Act and 42 C.F.R. Part 438 Subpart F to handle all Grievances subject to the provisions of such sections of the Act and regulations (including, without limitation, procedures to ensure expedited decision making when an Enrollee's health so necessitates);

5.26.1.3 A formally structured Grievance Committee that is available for Enrollees whose Grievances cannot be handled informally and are not appropriate for the procedures set up under the Managed Care Reform and Patient Rights Act. All Enrollees must be informed that such a process exists. Grievances at this stage must be in writing and sent to the Grievance Committee for review;

5.26.1.3.1 The Grievance Committee must have at least one (1) Enrollee on the Committee. The Department may require that one (1) member of the Grievance Committee be a representative of the Department;

5.26.1.4 Final decisions under the Managed Care Reform and Patient Rights Act procedures and those of the Grievance Committee may be appealed by the Enrollee to the Department under its Fair Hearings system;

5.26.1.5 A summary of all Grievances heard by the Grievance Committee and by independent external reviewers and the responses and disposition of those matters must be submitted to the Department quarterly; and

5.26.1.6 An Enrollee may appoint a guardian, caretaker relative, PCP, WHCP, or other Physician treating the Enrollee to represent the Enrollee throughout the Grievance process.

5.26.2 **Appeals**. Contractor shall establish and maintain a procedure for reviewing Appeals made by Enrollees or Providers on behalf of Enrollees. All Appeals shall be registered initially with Contractor and may later be appealed to the Department. Contractor's procedures must: (i) be submitted to the Department in writing and approved in writing by the Department; (ii) provide for prompt resolution, and (iii) assure the participation of individuals with authority to require corrective action. Contractor must have a committee in place for reviewing Appeals made by its Enrollees. At a minimum, the following elements must be included in the Appeal process:

5.26.2.1 A system that allows an Enrollee or Provider to file an Appeal either orally or in writing, within a reasonable period of time following the date of the notice of Action that generates such Appeal, which reasonable period of time shall not be less than twenty (20) days or more than ninety (90) days; provided that, unless the Enrollee or Provider has requested review on an expedited basis, Contractor may require an Enrollee or Provider to follow an oral Appeal with a written, signed Appeal;

5.26.2.2 A formally structured Appeal system that complies with Section 45 of the Managed Care Reform and Patient Rights Act and 42 C.F.R. 438 to handle all Appeals subject to the provisions of such sections of the Act and C.F.R. (including, without limitation, procedures to ensure expedited decision making when an Enrollee's health so necessitates and procedures allowing for an external independent review of Appeals that are denied by Contractor);

5.26.2.3 Final decisions of Appeals not resolved wholly in favor of the Enrollee may be appealed by the Enrollee to the Department under its Fair Hearings system;

5.26.2.4 A summary of all Appeals filed by Enrollees and the responses and disposition of those matters (including decisions made following an external independent review) must be submitted to the Department quarterly; and,

5.26.2.5 An Enrollee may appoint a guardian, caretaker relative, PCP, WHCP, or other Physician treating the Enrollee to represent the Enrollee throughout the Appeal process.

5.26.3 Contractor shall submit its Grievance and Appeals procedures to the Department for Prior Approval before any enrollment. The granting of Prior Approval will be contingent on the procedures meeting all Federal CMS requirements, including those at required by 42 C.F.R. 438.400. Contractor agrees to review its Grievance and Appeal procedures at regular intervals for the purpose of amending such procedures when necessary. Contractor shall amend the procedures only upon receiving the Prior Approval of the Department. Contractor further agrees to supply the Department, or its designee, with the information and reports

prescribed in its approved procedure. This information shall be furnished to the Department upon its request.

5.26.4 Contractor shall establish a complaint and resolution system for Providers that includes a Provider dispute process.

5.27 **Enrollee Satisfaction Survey.** Contractor shall conduct an annual Consumer Assessment of Health Plans (CAHPS) survey as approved by the Department. The survey sampling and administration must follow specifications contained in the most current HEDIS® volume. Contractor must contract with an NCQA-Certified HEDIS® Survey Vendor to administer the survey and submit results according to the HEDIS® survey specifications. Contractor shall submit its findings and explain what actions it will take on its findings as part of the comprehensive Annual QA/UR/PR Report.

5.28 **Provider Agreements and Subcontracts.** Contractor may provide or arrange to provide any Covered Services with Affiliated Providers, or fulfill any other obligations under this Contract, by means of subcontractual relationships.

5.28.1 All Provider agreements and subcontracts entered into by Contractor must be in writing and are subject to the following conditions:

5.28.1.1 The Affiliated Providers and Subcontractors shall be bound by the terms and conditions of this Contract that are appropriate to the service or activity delegated under the agreement or subcontract. Such requirements include, but are not limited to, the record keeping and audit provisions of this Contract, such that the Department or Authorized Persons shall have the same rights to audit and inspect Affiliated Providers and Subcontractors as they have to audit and inspect Contractor; and

5.28.1.2 All Physicians who are Affiliated Providers shall have and maintain admitting privileges and, as appropriate, delivery privileges at a hospital that is an Affiliated Provider; or, in lieu of these admitting and delivery privileges, the Physician shall have a written Referral agreement with a Physician who is an Affiliated 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.

5.28.2 Contractor shall remain responsible for the performance of any of its responsibilities delegated to Affiliated Providers or subcontractors.

5.28.3 No Provider agreement or subcontract can terminate the legal responsibilities of Contractor to the Department to assure that all the activities under this Contract will be carried out.

5.28.4 All Affiliated Providers providing Covered Services for Contractor under this Contract must be enrolled as Providers in the HFS Medical Program. Contractor shall not contract or subcontract with an Excluded Person or

a Person who has voluntarily withdrawn from the HFS Medical Program as the result of a settlement agreement.

5.28.5 All Provider agreements and subcontracts must comply with the Lobbying Certification contained in Article IX of this Contract.

5.28.6 All Affiliated Providers shall be furnished with information about Contractor's Grievance and Appeal procedures at the time the Provider enters into an agreement with Contractor and within fifteen (15) days following any substantive change to such procedures.

5.28.7 Contractor must retain the right to terminate any Provider agreement or subcontract, or impose other sanctions, if the performance of the Affiliated Provider or Subcontractor is inadequate.

5.28.8 Provider compensation modes shall reimburse for Covered Services provided and may reimburse for performance.

5.28.9 With respect to all Provider agreements and subcontracts made by Contractor, Contractor further warrants:

5.28.9.1 That such Provider agreements and subcontracts are binding;

5.28.9.2 That it will promptly terminate all contracts with Providers and Subcontractors, or impose other sanctions, if the performance of the Affiliated Provider or Subcontractor is inadequate;

5.28.9.3 That it will promptly terminate contracts with Providers that are terminated, barred, suspended, or have voluntarily withdrawn as a result of a settlement agreement, under either Section 1128 or Section 1128A of the Social Security Act, from participating in any program under federal law including any program under Titles XVIII, XIX, XX or XXI of the Social Security Act or are otherwise excluded from participation in the HFS Medical Program;

5.28.9.4 That all laboratory testing Sites providing services under this Contract must possess a valid Clinical Laboratory Improvement Amendments ("CLIA") certificate and comply with the CLIA regulations found at 42 C.F.R. Part 493; and

5.28.9.5 That it will monitor the performance of all Affiliated Providers and Subcontractors on an ongoing basis, subject each Affiliated Provider and subcontractor to formal review on a triennial basis, and, to the extent deficiencies or areas for improvement are identified during an informal or formal review, require that the Affiliated Provider or Subcontractor take appropriate corrective action.

5.28.10 Contractor will submit to the Department those Provider agreements and subcontracts as provided in Attachment XIII. The Department reserves the right to require Contractor to amend any Provider agreement or

subcontract as reasonably necessary to conform to Contractor's duties and obligations under this Contract.

5.28.11 Contractor may designate in writing certain information disclosed under this Section 5.28 as confidential and proprietary. If Contractor makes such a designation, the Department shall consider said information exempt from copying and inspection under Section 7(1)(b) or (g) of the State Freedom of Information Act (5 ILCS 140/1 et seq.). If the Department receives a request for said information under the State Freedom of Information Act, however, it may require Contractor to submit justification for asserting the exemption. The Department may honor a properly executed criminal or civil subpoena for such documents without such being deemed a breach of this Contract or any subsequent amendment hereto.

5.28.12 Prior to entering into a Provider agreement or subcontract, Contractor shall submit a disclosure statement to the Department specifying any Provider agreement or subcontract and Providers or subcontractors in which any of the following have a five percent (5%) or more financial interest:

5.28.12.1 any Person also having a five percent (5%) or more financial interest in Contractor or its Affiliates as defined by 42 C.F.R. 455.101;

5.28.12.2 any director, officer, trustee, partner or employee of Contractor or its Affiliates; or

5.28.12.3 any member of the immediate family of any Person designated above.

5.28.13 Any contract or subcontract between Contractor and a FQHC or a RHC shall be executed in accordance with 1902(a)(13)(C) and 1903(m)(2)(A)(ix) of the Social Security Act, as amended by the Balanced Budget Act of 1997 and shall provide payment that is not less than the level and amount of payment which Contractor would make for the Covered Services if the services were furnished by a Provider which is not an FQHC or a RHC.

5.29 **Advance Directives.** Contractor shall comply with all rules concerning the maintenance of written policies and procedures with respect to Advance Directives as set forth in 42 C.F.R. §422.128. Contractor shall provide adult Enrollees with oral and written information on Advance Directives policies, and include a description of applicable State law. Such information shall reflect changes in State law as soon as possible, but no later than ninety (90) days after the effective date of the change.

5.30 **Fees to Enrollees Prohibited.** Neither Contractor, its Affiliated Providers, nor non-Affiliated Providers shall seek or obtain funding through fees or charges to any Enrollee receiving Covered Services pursuant to this Contract, except as permitted or required by the Department in 89 Ill. Adm. Code 125 and the Department's Fee-For-Service copayment policy then in effect, and subject to Section 7.8. Contractor acknowledges that imposing charges in excess of those permitted

under this Contract is a violation of §1128B(d) of the Social Security Act and subjects Contractor to criminal penalties. Contractor shall have language in all of its Provider agreements or subcontracts reflecting this requirement.

5.31 Fraud and Abuse Procedures

5.31.1 Contractor shall have an affirmative duty to timely report, as provided in Section 9.1.29, suspected Fraud, Abuse or misconduct in the HFS Medical Program by Participants, Providers, Contractor's employees, or the Department employees to the OIG. To this end, Contractor shall establish the following procedures, in writing:

5.31.1.1 Contractor shall form a compliance committee that meets monthly and appoint a single individual to serve as liaison to the Department regarding the reporting of suspected Fraud, Abuse or misconduct;

5.31.1.2 Contractor's procedure shall require that any of Contractor's personnel, Affiliated Providers or Subcontractors who identify suspected Fraud, Abuse or misconduct shall immediately make a report to Contractor's liaison;

5.31.1.3 Contractor's procedure shall require that Contractor's liaison shall provide notice of any suspected Fraud, Abuse or misconduct to the OIG within three (3) days after receiving such report;

5.31.1.4 Contractor shall submit a quarterly report certifying that the report includes all instances of suspected Fraud, Abuse and misconduct, or shall certify that there was no suspected Fraud, Abuse or misconduct during that quarter. The inclusion of a report of suspected Fraud or Abuse on a quarterly report shall be considered timely if the report of suspected Fraud, Abuse or misconduct is made as soon as Contractor knew or should have known of the suspected Fraud, Abuse or misconduct and the certification is received within thirty (30) days after the end of the quarter; and,

5.31.1.5 Contractor shall ensure that all its personnel, Affiliated Providers and Subcontractors receive notice of, and are educated on, these procedures and require adherence to them.

5.31.2 Contractor shall not conduct any investigation of suspected Fraud, Abuse or misconduct of the Department personnel, but shall report all incidents immediately to the OIG.

5.31.3 Contractor may conduct investigations of suspected Fraud or Abuse of its personnel, Providers, Subcontractors, or Enrollees only to the extent necessary to determine if reporting to the OIG is required or if Contractor has the express concurrence of the OIG. If the investigation discloses potential criminal acts, Contractor shall immediately notify the OIG.

5.31.4 Contractor shall cooperate with all OIG investigations of suspected Fraud, Abuse or misconduct. Nothing in this Section 5.31 precludes Contractor or subcontractors from establishing measures to maintain quality of services and control costs that are consistent with their usual business practices, conducting themselves in accordance with their respective legal or contractual obligations or taking internal personnel-related actions.

5.32 **Enrollee-Provider Communications.** Subject to this Section and in accordance with the Managed Care Reform and Patient Rights Act, Contractor shall not 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 Contract, if the Provider is acting within the lawful scope of practice, and Contractor shall not retaliate against a Provider for so advising Enrollee.

5.33 **HIPAA Compliance.** Contractor shall comply with the terms of Sections B and C of the HIPAA Compliance Obligations set forth in Attachment VI.

5.34 **Independent Evaluation.** Contractor will cooperate in the conduct of any independent evaluation of the Integrated Care Program performed by the Illinois Department of Public Health, its designee or its subcontractor.

ARTICLE VI

DUTIES OF THE DEPARTMENT

6.1 **Enrollment.** Once the Department has determined that a Participant is a Potential Enrollee, and after the Potential Enrollee has selected, or been auto-assigned to, Contractor, such Participant shall become a Prospective Enrollee. A Prospective Enrollee shall become an Enrollee on the effective date of enrollment. Coverage shall begin as specified in Section 4.6. The Department shall make an 834 Audit File available to Contractor prior to the first day of each month.

6.2 **Payment**. The Department shall pay Contractor for the performance of Contractor's duties and obligations hereunder. Such payment amounts shall be as set forth in Article VII of this Contract and Attachment IV hereto. Unless specifically provided herein, no payment shall be made by the Department for extra charges, supplies or expenses, including, but not limited to, Marketing costs incurred by Contractor.

6.3 **Department Review of Marketing Materials**. Review of all Marketing Materials required by this Contract to be submitted to the Department for Prior Approval shall be completed by the Department on a timely basis, not to exceed thirty (30) days after the date of receipt by the Department; provided, however, that if the Department fails to notify Contractor of approval or disapproval of submitted materials within thirty (30) days after receiving such materials, Contractor may begin to use such materials. The Department, at any time, reserves the right to disapprove any materials that Contractor used or distributed prior to receiving the Department's express written approval. In the event the Department disapproves any materials, Contractor shall immediately cease use and distribution of such materials.

6.4 **HIPAA Compliance**. The Department shall comply with the terms of Section D of the HIPAA Compliance Obligations set forth in Attachment VI.

6.5 **Historical Claims Data.** The Department shall provide Contractor with available historical claims data for each new Enrollee monthly.

ARTICLE VII

PAYMENT AND FUNDING

7.1 **Capitation Payment.** The Department shall pay Contractor on a Capitation basis, based on the rate cell of the Enrollee as shown on the table in Attachment IV, a sum equal to the product of the approved Capitation rate and the number of Enrollees enrolled in that category as of the first day of that month. An Enrollee's rate cell shall be determined by the Department at the time of the Enrollee's enrollment and the Enrollee's rate cell shall not change during the first year of the Enrollee's enrollment, regardless of any change in the Enrollee's circumstances, except as provided in Section 7.3. Capitation is due to Contractor by the fifteenth day of the service month. Rates reflected in Attachment IV are for the period as set forth in said Attachment, except as adjusted pursuant to this Article VII. Rates may be updated periodically to reflect future time periods, additional Service Packages and additional populations. The Department will provide Contractor with an opportunity to review, comment and accept in writing any such update, including supporting data, before such update is implemented. The Parties will work together to resolve any discrepancies.

7.2 **820 Payment File**. For each payment made, the Department will make available an 820 Payment File. This file will include, but is not limited to, identification of each Enrollee for whom payment is being made and the rate cell that the Enrollee is in. Contractor shall electronically retrieve this file.

7.3 **Payment File Reconciliation.** Within thirty (30) days after the 820 Payment File is made available, Contractor shall notify the Department of any discrepancies, including Enrollees who Contractor believes are in its plan and not on the 820 Payment File, Enrollees included on the 820 Payment File who Contractor believes have not been enrolled with Contractor, and Enrollees included on the 820 Payment File who Contractor believes are in a different rate cell. Contractor and the Department will work together to resolve these discrepancies.

7.4 **Risk Adjustment.**

7.4.1 Capitation rates calculated under this Agreement will be adjusted in accordance with the Chronic Illness and Disability Payment System ("CDPS") using the CDPS + Rx version 5.2 and standard weights. The version of the risk adjustment tool will not be modified during a calendar year, but will be updated annually with the most recent version publicly available. In order for an Enrollee's individual claims data to be the basis for a risk adjustment score hereunder, such Enrollee must have been enrolled in the State Medicaid Program (i.e. either managed care or Fee-For-Service) for at least six (6) full months during the time period from which claims data are used to calculate the adjustment. In the event an Enrollee has not been enrolled in the State Medicaid Program for at least six (6) full months, then such Enrollee shall receive a risk score equal to Contractor's average risk score. The risk scores shall be established for each MCO by rate cell. The risk scores will be established using a credibility formula for each MCO and rate cell. The credibility formula to be used will be determined by an independent actuary. All diagnoses codes submitted by

Contractor shall be included in calculations of risk scoring irrespective of placement of such diagnoses codes in the encounter records. Encounter records may not be supplemented by medical record data. Diagnosis codes may only be recorded by the Provider at the time of the creation of the medical record and may not be retroactively adjusted except to correct errors. A significant increase in risk scores by an MCO may warrant an audit of the diagnosis collection and submission methods.

7.4.2 For the time period commencing with the first date on which Enrollees have been enrolled with Contractor (e.g., May 1, 2011) through December 31, 2011, two risk adjustment factors shall be calculated: (i) an initial calculation using enrollment figures from September 15, 2011 ("Initial"), and (ii) an adjusted calculation using enrollment figures from December 15, 2011 ("Adjusted"). The risk scores for the period of May 1, 2011 through December 31, 2011 will be based on a weighted average of the number of months each Enrollee is enrolled with the specific MCO. The claims data to be used for such calculations shall be the Department's Fee-For-Service claims data for claims with dates of service from January 1, 2010, through December 31, 2010, and that were paid through April 30, 2011.

7.4.2.1 The Department shall provide written notification to Contractor of: (i) Contractor's Initial risk adjustment factor, along with sufficient detail supporting the calculations, no later than October 31, 2011, and (ii) Contractor's Adjusted risk adjustment factor, along with sufficient detail supporting the calculations, no later than January 31, 2012. Contractor shall have thirty (30) days from receipt of the Department's notice to review the calculations regarding the Adjusted risk adjustment factor and detail provided and to submit questions, if any, to the Department regarding the same. No modification to Contractor's Capitation payment may be made during such thirty (30) day review period. If during the thirty (30) day review period Contractor disputes the Adjusted risk adjustment factor, the Department shall agree to meet with Contractor within a reasonable time frame to achieve a good faith resolution of the disputed matter.

7.4.2.2 Modifications to Contractor's Capitation payment resulting from the application of the Adjusted risk adjustment factor, if any, shall be effective May 1, 2011. All risk scores shall be budget neutral to the Department or normalized to a 1.0000 value between the MCOs. The risk scores shall also be budget neutral to the Department within each individual rate cell.

7.4.3 For calendar year 2012 and every calendar year thereafter, Enrollee risk scores shall be re-calculated using Enrollee claims or Encounter Data, as applicable, from the Department's most recent State Fiscal Year, including a four (4) month period for claims payment run-out. For the first six (6) months of calendar year 2012, and every six (6) month period thereafter (each such six (6) month period being an "Adjustment Period"), Contractor's risk adjustment factor will be calculated using enrollment figures from the month immediately preceding the Adjustment Period. The

Department shall provide written notification to Contractor of Contractor's risk adjustment factor, along with sufficient detail supporting the calculations, no later than the last day of the first month of the Adjustment Period. Contractor shall have thirty (30) days from receipt of the Department's notice to review the calculations and detail provided and to submit questions, if any, to the Department regarding the same. No modification to Contractor's Capitation payment may be made during such thirty (30) day review period. If during the review period Contractor disputes the risk adjustment factor, the Department shall agree to meet with Contractor within a reasonable time frame to achieve a good faith resolution of the disputed matter. Modifications to Contractor's Capitation payment resulting from the application of the applicable risk adjustment factor, if any, shall be effective for the duration of the applicable Adjustment Period, effective as of the first day thereof. Enrollee risk scores will be established by the Department on or before December 31, 2011, using Department fiscal year 2011 claim and encounter information, and such risk scores shall be applicable to Enrollees throughout calendar year 2012, irrespective of to which MCO an Enrollee is assigned. For example, the Department will calculate Contractor's risk adjustment factor for the first six (6) months of calendar year 2012 using Contractor's enrollment figures as of December 15, 2011, and shall provide written notification to Contractor of such risk adjustment factor no later than January 31, 2012. Any modification of Contractor's Capitation payment due to its risk adjustment factor shall be applied effective January 1, 2012, and shall be in effect for the time period from January 1, 2012, through June 30, 2012. All risk scores shall be budget neutral to the Department or normalized to a 1.0000 value between the MCOs. The risk scores shall also be budget neutral to the Department within each individual rate cell.

7.4.4 The Department shall provide the MCOs with written notice of the Department's intent to modify the CDPS version or the standard weights no fewer than ninety (90) days before implementing any such modification.

7.5 **Actuarially Sound Rate Representation**. The Department represents that actuarially sound Capitation rates were developed by the Department's contracted actuarial firm and that Capitation rates paid hereunder are actuarially sound. The rates were developed from the Fee-For-Service equivalent values to be consistent with the Federal regulations promulgated pursuant to the Balanced Budget Act of 1997. The Fee-For-Service equivalent values were modified to reflect the following adjustments: (i) completion factors, (ii) inpatient outlier adjustments, (iii) managed care adjustments, (iv) contractual adjustments, (v) trend rates, (vi) administrative allowance, (vii) Third Party liability recoveries, and (viii) PCP management fee adjustment.

7.6 **New Covered Services**. The financial impact of any Covered Services added to Contractor's responsibilities under this Contract will be evaluated from an actuarial perspective by the Department, and rates will be adjusted accordingly to reflect the changes made by the Department. At least one hundred eighty (180) days, unless otherwise agreed to by the Parties, before the effective date of the addition of such Covered Services, the Department shall provide written notice to Contractor of such new Covered Services and any adjustment to the Capitation

rates herein as a result of such new Covered Services. This notice shall include: (i) an explanation of the new Covered Services; (ii) the amount of any adjustment to the Capitation rates herein as a result of such new Covered Services; and, (iii) the methodology for any such adjustment.

7.7 **Adjustments.** Payments to Contractor will be adjusted for retroactive disenrollments of Enrollees, changes to Enrollee information that affect the Capitation rates (e.g., eligibility classification), monetary sanctions imposed in accordance with Section 7.16, rate changes in accordance with updates to Attachment IV, or other miscellaneous adjustments provided for herein. Adjustments shall be retroactive no more than eighteen (18) months, unless otherwise agreed to by the Parties. Notwithstanding the foregoing, any adjustment for retroactive disenrollments of Enrollees shall not exceed two (2) months. The Department will make retroactive enrollments only in accordance with Section 4.6.

7.8 **Copayments**. Contractor may charge copayments to Enrollees, but in no instance may the copayment for a type of service exceed the Department's Fee-For-Service copayment policy then in effect. Any copayment requirement must comply with the restrictions in Sections 1916 and 1916A of the Social Security Act. If Contractor desires to charge such copayments, Contractor shall provide written notice to the Department before charging such copayments. Such written notice to the Department shall include a copy of the policy Contractor intends to distribute to its Affiliated Providers. This policy must set forth the amount, manner, and circumstances in which copayments may be charged. Such policy is subject to the Prior Approval of the Department. In the event Contractor wishes to make a change in its copayment policy, it shall first provide at least sixty (60) days' prior written notice, subject to the Department's Prior Approval, to Enrollees. Contractor shall be responsible for promptly refunding to an Enrollee any copayment that, in the sole discretion of the Department, has been inappropriately collected for Covered Services.

7.9 **Availability of Funds**. Payments of obligations of the Department under this Contract are subject to the availability of funds and the appropriation authority as provided by law. Obligations of the State will cease immediately without penalty of further payment being required if in any State Fiscal Year the Illinois General Assembly or federal funding source fails to appropriate or otherwise make available sufficient funds for this Contract within thirty (30) days before the end of the State Fiscal Year.

7.9.1 If State funds become unavailable, as set forth herein, to meet the Department's obligations under this Contract in whole or in part, the Department will provide Contractor with written notice thereof prior to the unavailability of such funds, or as soon thereafter as the Department can provide written notice.

7.9.2 In the event that funds become unavailable to fund this Contract in whole, this Contract may be terminated in accordance with Section 8.9.7 of this Contract. In the event that funds become unavailable to fund this Contract in part, it is agreed by both Parties that this Contract may be renegotiated as to Capitation rate or scope of services or amended in accordance with Section 9.1.18. If Contractor is unable or unwilling to

provide fewer Covered Services at a reduced Capitation rate, or otherwise is unwilling or unable to amend this Contract within ten (10) Business Days after receipt of a proposed amendment, the Contract shall be terminated on a date set by the Department not to exceed thirty (30) days after the date of a termination notice.

7.10 Incentive Pool Payments:

7.10.1 The Department will establish an incentive pool from which Contractor may earn payments based on its performance with respect to those quality metrics set forth in Attachment XI of this Agreement (P4P Metrics). To fund the pool, each month the Department shall withhold a portion of the contractual Capitation rate. The withheld amount will be one percent (1%) in the first measurement year, one and a half percent (1.5%) in the second measurement year and two percent (2%) in the third measurement year. Subsequent withheld amounts will be negotiated and agreed to by the Parties. The withheld amount will be combined with an additional bonus amount funded by the Department so that total funding of the incentive pool shall be equal to five percent (5%) of the Capitation rate. An equal portion of the incentive pool will be allocated to each P4P Metric. If Contractor reaches the target goal on a P4P Metric, Contractor will earn the percentage of the incentive pool assigned to that P4P Metric. Withholds of Contractor's Capitation payment for the purposes of funding the incentive pool shall commence with the January 15, 2012 Capitation payment for the January 2012 service month. For purposes of measuring P4P Metrics, calendar year 2010 will be considered the initial baseline year and calendar year 2012 will be considered the initial measurement year. All measurement years will be calendar years. In subsequent measurement years, the previous year's performance will be the baseline for that measurement year unless the previous year's performance was below the initial baseline, in which case the initial baseline remains the baseline.

7.10.2 **Minimum Performance Standard.** Contractor will not be eligible to receive any Incentive Pool payments if it fails to meet a minimum performance standard. The minimum performance standard will require Contractor's measurement year performance to be no lower than one percent (1%) below that year's baseline on all P4P measures, except that Contractor may regress more than one percent (1%) in three (3) P4P quality metrics in the first measurement year.

7.10.3 Attachment XI shows the P4P metrics for each of the first three (3) years. Collection of data and calculation of Contractor's performance against the P4P Metrics will be in accordance with national HEDIS® timelines and specifications. In the event any P4P Metrics are not HEDIS® but are distinct measures established by the Department ("HEDIS®-Like"), then the methodology for calculating such metrics shall be detailed in a separate document sent to Contractor. Contractor must obtain an independent validation of its HEDIS® and HEDIS®-Like results by an NCQA certified auditor, with such results submitted to the Department within thirty (30) days after Contractor's receipt of its audited results. Upon receipt of Contractor's certified results, the Department shall compare Contractor's performance against the P4P Metrics and Encounter Data received and

accepted by the Department. If the Department approves Contractor's submitted results and an incentive payment is due, then such payment shall be made within sixty (60) days after such approval. If there is a discrepancy, the Department shall notify Contractor in writing within 30 days after receiving Contractor's results that a discrepancy exists and further investigation is needed. Any significant discrepancies between Contractor's audited results and the Encounter Data received by the Department, or any audit of the measures by the Department, will be resolved in a manner mutually agreeable to the Parties following good faith negotiations before the Department will distribute any incentive pool payments earned by Contractor. Once resolution of any discrepancy is agreed upon by the Parties, the Department shall initiate such payment within thirty (30) days after such agreement. Contractor's audited results will be used to determine eligibility for incentive pool payments unless it is determined through the process outlined in this paragraph that other data are more accurate. Final 2010 baseline data (i.e., to be used as the baseline for 2012) will be set in consultation with Contractor and confirmed by a countersigned letter no later than August 1, 2011.

7.10.4 For the P4P Metrics set forth in Attachment XI, for the first two (2) years of this Contract, the target goal will be set at a percentage above the baseline equal to ten percent (10%) of the difference between the baseline score and one hundred percent (100%). For example, if the baseline is fifty percent (50%), ten percent (10%) of the difference between fifty percent (50%) and one hundred percent (100%) is five percent (5%); therefore the goal will be set at fifty-five percent (55%).

7.10.5 P4P metrics, baselines and goals for future years will be negotiated and established through countersigned letters. If any coding or data specifications are modified and a Party has a reasonable basis to believe that the modification will have an impact on an incentive pool payment, then the Parties will negotiate, and the resolution will be established through countersigned letters.

7.11 **Medical Loss Ratio Guarantee:** Contractor has a Target Medical Loss Ratio of eighty-eight percent (88%). If the Medical Loss Ratio calculated as set forth below is less than the Target Medical Loss Ratio, Contractor shall refund to the State an amount equal to the difference between the calculated Medical Loss Ratio and the Target Medical Loss Ratio (expressed as a percentage) multiplied by the Coverage Year Revenue. The Department shall prepare a Medical Loss Ratio Calculation which shall summarize Contractor's Medical Loss Ratio for Enrollees under this Contract for each Coverage Year. The Medical Loss Ratio Calculation shall be determined as set forth below; however, the Department will use best efforts to evaluate the use of the National Association of Insurance Commissioner ("NAIC") definition of medical loss ratio for the purpose of calculating the Medical Loss Ratio, with the goal being adoption of as much of the NAIC definition as is consistent with the Department's policy goals and interests prior to the initial calculation of Contractor's Medical Loss Ratio. In the event the Department adopts some or all of NAIC guidelines for the calculation of the Medical Loss Ratio, the Department shall notify Contractor in writing. Notwithstanding the foregoing and independent of such evaluation of the NAIC definition of medical loss ratio, prior to the initial calculation of Contractor's Medical Loss Ratio, the parties will

work in good faith to detail the basis of calculating the Medical Loss Ratio including establishing sample calculations to demonstrate what is included and excluded from the Medical Loss Ratio.

7.11.1 Revenue. The revenue used in the Medical Loss Ratio calculation will consist of the Capitation payments, as adjusted pursuant to Section 7.4, due from the Department for services provided during the Coverage Year, including amounts withheld pursuant to Section 7.10.1.

7.11.2 Benefit Expense. The Department shall determine the Benefit Expense using the following data:

7.11.2.1 Paid Claims. Paid Claims shall be included in Benefit Expense. The Department shall use Encounter Data claims for all dates of service during the Coverage Year and accepted by the Department within six (6) months after the end of the Coverage Year. If the Parties are unable to resolve Encounter Data systems issues prior to calculation of the MLR, the Parties will agree on an alternative method of calculating paid claims expense. Encounter Data claims covered by sub-capitation contracts shall be priced at Contractor's Fee-For-Service rate for Covered Services. If Contractor does not have a published fee schedule for a Covered Service, the price on the sub-capitated service may not exceed one hundred ten percent (110%) of the Department's Medicaid rate.

7.11.2.2 Incurred But Not Paid Claims. Claims that have been incurred but not paid (IBNP), as determined by the Department's actuary based on Encounter Data and made available for review by Contractor, shall be included in Benefit Expense.

7.11.2.3 Provider Incentive Payments. Incentive payments to Affiliated Providers paid within six (6) months after the end of the Coverage Year for performance measured during the Coverage Year provided the payments are made pursuant to agreements in place at the start of the measurement period under which the benchmarks triggering payments and the methodology for determining payments amounts are clearly set forth shall be included in Benefit Expense. Litigation reserves and payments in settlement of claims disputes, excluding legal fees, shall be included in Benefit Expense. Such amounts shall be recorded by Contractor for the Coverage Year.

7.11.2.4 Care Coordination Expense. That portion of the personnel costs for Care Coordinators whose primary duty is direct Enrollee contact that is attributable to this Contract shall be included as a Benefit Expense. That portion of the personnel costs for Contractor's Medical Director that is attributable to this Contract shall be included as a Benefit Expense.

7.11.2.5 Other Benefit Expense. Any service provided directly to an Enrollee not capable of being sent as Encounter Data due to there not being appropriate codes or similar issues may be sent

to the Department on a report identifying the Enrollee, the service and the cost. Such costs will be included in Benefit Expense.

7.11.3 Data Submission. Contractor shall submit to the Department, in the form and manner prescribed by the Department, the data described in Sections 7.11.2.3, 7.11.2.4 and 7.11.2.5 within seven (7) months after the end of the Coverage Year. Encounter Data must be submitted as required under this Contract.

7.11.4 Medical Loss Ratio Calculation. Within ninety (90) days following the six (6) month claims run-out period following the Coverage Year, the Department shall calculate the Medical Loss Ratio by dividing the Benefit Expense by the Revenue. The Medical Loss Ratio shall be expressed as a percentage rounded to the second decimal point. Contractor shall have sixty (60) days to review the Department's Medical Loss Ratio Calculation. Each Party shall have the right to review all data and methodologies used to calculate the Medical Loss Ratio.

7.11.5 Coverage Year. The Coverage Year shall be the calendar year. The Medical Loss Ratio Calculation shall be prepared using all data available from the Coverage Year, including IBNP and six (6) months of run-out for Benefit Expense (excluding sub-capitation paid during the run-out months).

7.12 Denial of Payment Sanction by Federal CMS. The Department shall deny payments otherwise provided for under this Contract for new Enrollees when, and for so long as, payment for those Enrollees is denied by Federal CMS under 42 C.F.R. §438.726.

7.13 Hold Harmless. Contractor shall indemnify and hold the Department harmless from any and all claims, complaints or causes of action which arise as a result of: (i) Contractor's failure to pay any Provider for rendering Covered Services to Enrollees, or failure to pay any subcontractor, either on a timely basis or at all, regardless of the reason; or, (ii) any dispute arising between Contractor and a Provider or subcontractor; provided, however, the preceding provision will not affect any obligation that the Department may have to pay for services that are not Covered Services under this Contract, but that are eligible for payment by the Department. Contractor warrants that Enrollees will not be liable for any of Contractor's debts if Contractor becomes insolvent or subject to insolvency proceedings as set forth in 215 ILCS 125/1-1 et seq.

7.14 Payment in Full. Acceptance of payment of the rates specified in this Article VII for any Enrollee is payment in full for all Covered Services provided to that Enrollee, except to the extent Contractor charges such Enrollee a copayment as permitted in this Contract.

7.15 Prompt Payment. Payments, including late charges, will be paid in accordance with the State Prompt Payment Act (30 ILCS 540) and rules (74 Ill. Adm. Code 900) when applicable, except as otherwise provided in this Section 7.15. Interest shall accrue at an annual rate of nine percent (9%), beginning on the sixteenth day of the month immediately following the service month in which Capitation is due as provided in Section 7.1. Collection of underlying amounts owed plus interest shall be Contractor's sole remedy for late payments by the State, except as set forth in

Section 8.12. Payment terms contained on Contractor's invoices shall have no force and effect.

7.16 **Sanctions**. The Department may impose civil money penalties, late fees, and performance penalties (collectively, "monetary sanction"), and other sanctions, on Contractor for Contractor's failure to substantially comply with the terms of this Contract. Monetary sanctions imposed pursuant to this Section may be collected by deducting the amount of the monetary sanction from any payments due to Contractor or by demanding immediate payment by Contractor. The Department, at its sole discretion, may establish an installment payment plan for payment of any monetary sanction. The determination of the amount of any monetary sanction shall be at the sole discretion of the Department, within the ranges set forth below. Self-reporting by Contractor will be taken into consideration in determining the amount of any monetary sanction. The Department shall not impose any monetary sanction where the noncompliance is directly caused by the Department's action or failure to act or where a *force majeure* delays performance by Contractor. The Department, in its sole discretion, may waive the imposition of a monetary sanction for failures that it judges to be minor or insignificant. Upon determination of substantial noncompliance, the Department shall give written notice to Contractor describing the noncompliance, the opportunity to cure the noncompliance where a cure is not otherwise disallowed under this Contract, and the monetary sanction that the Department will impose hereunder. The Department may disallow an opportunity to cure when noncompliance is willful, egregious, persistent, part of a pattern of noncompliance, is incapable of being cured, or a cure is otherwise not allowed under this Contract. The Department reserves the right to terminate this Contract as provided in Article VIII in addition to, or in lieu of, imposing one or more monetary sanctions.

7.16.1 **Failure to Report or Submit.** If Contractor fails to submit any report or other material required by this Contract to be submitted to the Department, other than Encounter Data, by the date due, the Department will give notice to Contractor of the late report or material and Contractor must submit it within thirty (30) days following the notice. If the accurate and complete report or other material has not been submitted within thirty (30) days following the notice, the Department may, at its sole discretion and without further notice, impose a late fee of $1,000.00 to $5,000.00 for the late report. At the end of each subsequent period of thirty (30) days during which the specific report is not submitted, the Department may, without further notice, impose an additional late fee equal to the amount of the original late fee.

7.16.2 **Failure to Comply with BEP Requirements.** If the Department determines that Contractor has not met, and has not made good faith efforts to meet, the goals for BEP subcontracting established in Section 2.9, or has provided false or misleading information or statements concerning compliance, certification status or eligibility of certified contractors, its good faith efforts to meet the BEP goal, or any other material fact or representation, the Department will send Contractor a notice of noncompliance. If Contractor has not met these requirements or demonstrated good cause for not meeting them by the end of the thirty (30) day period following the notice, the Department may, without further notice, (i) impose a performance

penalty of $10,000.00 to $25,000.00, or (ii) withhold payment to Contractor in an amount equal to the difference between the BEP goal and the amount of money paid to BEP certified subcontractors during the State Fiscal Year. The Department may withhold whichever is the larger amount.

7.16.3 Failure to Submit Encounter Data. The Department and Contractor acknowledge and agree that they will work in good faith to implement mutually agreed upon system requirements resulting in the complete and comprehensive transfer and acceptance of Encounter Data and that such mutual agreement shall not be unreasonably withheld. The Department and Contractor further acknowledge and agree that such implementation shall be satisfactorily completed no later than January 1, 2012, unless the failure to do so is the fault of the Department. Thereafter, if the Department determines that Contractor has not met the requirements of Attachment XIII and this Section 7.16.3 regarding Encounter Data, the Department will send Contractor a notice of non-compliance. If Contractor does not demonstrate compliance with these requirements by the end of the thirty (30) day period following the notice, the Department, without further notice, may impose a late fee of $10,000.00 to $50,000.00. At the end of each subsequent period of thirty (30) days in which Contractor is out of compliance, the Department may, without further notice, impose an additional late fee of $10,000.00 to $50,000.00.

7.16.4 Failure to Submit Quality and Performance Measures. If the Department determines that Contractor has not accurately conducted and submitted quality and performance measures as required in Attachment XI, the Department will send Contractor a notice of noncompliance. If Contractor has not met these requirements by the end of the sixty (60) day period following the notice, and the Department reasonably determines the failure warrants imposing a late fee, the Department may, without further notice, impose a late fee of $10,000.00 for each measure not accurately conducted or submitted.

7.16.5 Failure to Participate in the Performance Improvement Projects. If the Department determines that Contractor has not fully participated in the Performance Improvement Project, the Department will send Contractor a notice of noncompliance. If Contractor does not demonstrate progress towards substantial compliance with these requirements by the end of the thirty (30) day period following the notice, and the Department reasonably determines the failure warrants imposing a performance penalty, the Department, without further notice, may impose a performance penalty of $1,000.00 to $5,000.00. At the end of each subsequent period of thirty (30) days in which no demonstrated progress is made towards full compliance, the Department may, without further notice, impose an additional performance penalty of $1,000.00 to $5,000.00.

7.16.6 Failure to Demonstrate Improvement in Areas of Deficiencies.

7.16.6.1 If the Department determines that Contractor has not made significant progress in monitoring or carrying out its QAP, including quality improvement plan or demonstrating improvement in areas of deficiencies, as identified in its HEDIS®

results, quality monitoring, or Performance Improvement Project, the Department will provide notice to Contractor that Contractor shall be required to develop a formal Corrective Action Plan (CAP) to remedy the breach of Contract. The CAP must be submitted with the signature of Contractor's Chief Executive Officer and is subject to approval by the Department. The CAP must include, but is not be limited to, the following:

(i) the specific problems that requires corrective action;

(ii) the type of corrective action to be taken for improvement for each specific problem;

(iii) the goals of the corrective action;

(iv) the time-table and work plan for action;

(v) the identified changes in processes, structure, and internal and external education;

(vi) the type of follow-up monitoring, evaluation and improvement; and,

(vii) the identified improvements and enhancements of existing outreach and Care Management activities, if applicable.

7.16.6.2 Contractor shall submit a CAP within thirty (30) days after the date of notification by the Department. Contractor's CAP will be evaluated by the Department to determine whether it satisfactorily addresses the actions needed to correct the deficiencies. If Contractor's CAP is unsatisfactory, the Department will indicate the sections requiring revision and any necessary additions, and request that another CAP be submitted by Contractor, unless otherwise specified, within thirty (30) days after receipt of the Department's second notice. If Contractor's second CAP is unsatisfactory, the Department may declare a material breach.

7.16.6.3 Within ninety (90) days after Contractor has submitted an acceptable CAP, Contractor must demonstrate progress towards improvement. The Department, or its designee, may review Contractor's progress through an onsite or offsite process. Thereafter, Contractor must show improvement for each ninety (90) day period until Contractor is in compliance with the applicable requirements of this Contract.

7.16.6.4 If Contractor does not submit a satisfactory CAP within the required timeframes, or show the necessary improvements, the Department, without further notice, may impose a performance penalty of $1,000.00 to $5,000.00 for each thirty (30) day period thereafter.

7.16.7 Imposition of Prohibited Charges. If the Department determines that Contractor has imposed a charge on an Enrollee that is prohibited, or otherwise not allowed, by this Contract, the Department may impose a civil money penalty of $10,000.00 to $25,000.00.

7.16.8 Misrepresentation or Falsification of Information. If the Department determines that Contractor has misrepresented or falsified information furnished to a Potential Enrollee, Prospective Enrollee, Enrollee, or Provider, the Department may impose a civil money penalty of $10,000.00 to $25,000.00. If the Department determines that Contractor has misrepresented or falsified information furnished to the Department or Federal CMS, the Department may impose a civil money penalty of $10,000.00 to $50,000.00.

7.16.9 Failure to Comply with the Physician Incentive Plan Requirements. If the Department determines that Contractor has failed to comply with the Physician Incentive Plan requirements of Section 5.21, the Department may impose a civil money penalty of $10,000.00 to $25,000.00.

7.16.10 Failure to Meet Access and Provider Ratio Standards. If the Department determines that Contractor has not met the Provider to Enrollee access standards established in Sections 5.5.3 and 5.6 the Department will send Contractor a notice of noncompliance. If Contractor has not met these requirements by the end of the thirty (30) day period following the notice, the Department may, without further notice, (i) impose a performance penalty of $1,000.00 to $5,000.00, (ii) suspend enrollment of Potential Enrollees with Contractor, or (iii) impose both. At the end of each subsequent period of thirty (30) days in which no demonstrated progress is made toward compliance, the Department may, without further notice, impose additional performance penalties of $1,000.00 to $5,000.00.

7.16.11 Failure to Provide Covered Services. If the Department determines that Contractor has substantially failed to provide, or arrange to provide, a Medically Necessary service that Contractor is required to provide under law or this Contract, the Department may:

7.16.11.1 impose a civil money penalty of $5,000.00 to $25,000.00,

7.16.11.2 suspend enrollment of Potential Enrollees with Contractor, or

7.16.11.3 impose both.

7.16.12 Discrimination Related to Pre-Existing Conditions or Medical History. If the Department determines that discrimination has occurred in relation to an Enrollee's pre-existing condition or medical history indicating a probable need for substantial medical services in the future, the Department may:

7.16.12.1 impose a civil money penalty of $5,000.00 to $25,000.00,

7.16.12.2 suspend enrollment of Potential Enrollees with Contractor, or

7.16.12.3 impose both.

7.16.13 Pattern of Marketing Failures. If the Department determines that there is Marketing Misconduct or a pattern of Marketing failures, the Department may:

7.16.13.1 impose a civil money penalty of $5,000.00 to $25,000.00,

7.16.13.2 suspend enrollment of Potential Enrollees with Contractor, or

7.16.13.3 impose both.

7.16.14 Other Failures. If the Department determines that Contractor is in substantial noncompliance with any material terms of this Contract, or any State or federal laws affecting Contractor's conduct under this Contract, that are not specifically enunciated in this Article VII, but for which the Department reasonably determines imposing a performance penalty or other sanction is warranted, the Department shall provide written notice to Contractor setting forth the specific failure or noncompliant activity. If Contractor does not cure the failure or noncompliance to the Department's satisfaction within thirty (30) days after the notice, the Department, without further notice, may:

7.16.14.1 impose a performance penalty of $1,000.00 to $25,000.00,

7.16.14.2 suspend enrollment of Potential Enrollees with Contractor, or

7.16.14.3 impose both.

7.17 Retention of Payments. In addition to the assessment of monetary sanctions, if applicable, pursuit of actual damages, or termination of this Contract:

7.17.1 Pursuant to 44 Ill. Admin. Code 1.5530, the Department may deduct from whatever is owed Contractor on this or any other Contract an amount sufficient to compensate the State for any damages suffered by it because of Contractor's breach of Contract or other unlawful act by Contractor, including, but not limited to:

7.17.1.1 The additional cost of supplies or services bought elsewhere;

7.17.1.2 The cost of repeating the procurement procedure;

7.17.1.3 Any expenses incurred because of delay in receipt of supplies or services; and,

7.17.1.4 Any other damages caused by Contractor's breach of Contract or unlawful act.

7.17.2 If any failure of Contractor to meet any requirement of this Contract results in the withholding of federal funds from the State, the Department may withhold and retain an equivalent amount from payments to Contractor until such federal funds are released, in whole or in part, to the State, at which time the Department will release to Contractor an amount equivalent to the amount of federal funds received by the State.

7.18 Deductions from Payments. Any payment to Contractor may be reduced or suspended when a provision of this Contract requires a payment or refund to the Department or an adjustment of a payment to Contractor.

7.19 Computational Error. The Department reserves the right to correct any mathematical or computational error in payment subtotals or total contractual obligation. The Department will notify Contractor of any such corrections.

7.20 Notice for Retentions and Deductions. Prior to making an adjustment pursuant to Section 7.17, Section 7.18 or Section 7.19, except for routine systematic adjustments, the Department will provide Contractor with a notice and explanation of the adjustment. Contractor may provide written objections regarding the adjustment to the Department within fifteen (15) days after the Department sends the notice. No adjustment will be made until the Department responds in writing to the objections or, if no timely objections are made, on or after the sixteenth day after sending the notice.

7.21 Recoveries from Providers. If the Department requires Contractor to recover established overpayments made to a Provider by the Department for performance or non-performance of activities not governed by this Contract, Contractor shall immediately notify the Department of any amount recovered and, as agreed to by the Parties, (i) Contractor will immediately provide the amount recovered to the Department, or (ii) the Department will withhold the amount recovered from a payment otherwise owed to Contractor.

ARTICLE VIII

TERM, RENEWAL AND TERMINATION

8.1 **Term of this Contract.** This Contract shall take effect on the Effective Date and shall continue for a period of five (5) years.

8.2 **Renewal.** If the Contract is renewed, the renewal shall be subject to the same terms and conditions as the original Contract unless otherwise stated. The Contract may not renew automatically, nor may the Contract renew solely at Contractor's option. The Department reserves the right to renew for a total of five (5) years in any of the following manners or combination thereof.

8.2.1 One renewal covering the entire renewal allowance,

8.2.2 Individual one-year renewals up to and including the entire renewal allowance, or

8.2.3 Any combination of multi-year renewals up to and including the entire renewal allowance.

8.3 **Continuing Duties in the Event of Termination.** Upon termination of this Contract, the Parties are obligated to perform those duties which survive under this Contract. Such duties include, but are not limited to, payment to Affiliated or non-Affiliated Providers, completion of Enrollee satisfaction surveys, cooperation with medical records review, all reports for periods of operation, including Encounter Data, and retention of records. 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, which is necessary for the orderly transition of Enrollees and completion of all Contract responsibilities.

8.4 **Immediate Termination for Cause.** In addition to any other termination rights under this Contract, the Department may terminate this Contract, in whole or in part, immediately upon notice to Contractor if it is determined that the actions, or failure to act, of Contractor, its agents, employees or subcontractors have caused, or reasonably could cause, jeopardy to health, safety, or property. This Contract may be terminated immediately if the Department determines that Contractor fails to meet the financial requirements established by the Illinois Department of Insurance pursuant to the Health Maintenance Organization Act.

8.5 **Termination for Cause.** In addition to any other termination rights under this Contract, if Contractor fails to perform to the Department's satisfaction any material requirement of this Contract or is in violation of a material provision of this Contract, the Department shall provide written notice to Contractor requesting that the breach or noncompliance be remedied within the period of time specified in the Department's written notice, which shall be no fewer than sixty (60) days. If the breach or noncompliance is not remedied by that date, the

Department may: (i) immediately terminate the Contract without additional written notice, or (ii) enforce the terms and conditions of the Contract. In either event, the Department may also seek any available legal or equitable remedies and damages.

8.6 **Social Security Act**. This Contract may be terminated by the Department with cause upon at least fifteen (15) days' written notice to Contractor for any reason set forth in Section 1932(e)(4)(A) of the Social Security Act. In the event such notice is given, Contractor may request in writing a hearing, in accordance with Section 1932 of the Social Security Act by the date specified in the notice. If such a request is made by the date specified, then a hearing under procedures determined by the Department will be provided prior to termination. The Department reserves the right to notify Enrollees of the hearing and its purpose and inform them that they may disenroll from Contractor, and to suspend further enrollment with Contractor during the pendency of the hearing and any related proceedings.

8.7 **Temporary Management.** While one (1) or more agencies of the State have the authority and retain the power under 42 C.F.R. 438.702 to impose temporary management upon Contractor for repeated violations of the Contract, the Department may exercise its option to terminate the Contract prior to imposition of temporary management. This does not preclude other State agencies from exercising such power at their discretion.

8.8 **Termination for Convenience.** Following ninety (90) days' written notice, the Department may terminate this Contract in whole or in part without the payment of any penalty or incurring any further obligation to Contractor. Following one hundred eighty (180) days' written notice, Contractor may terminate this Contract in whole or in part without the payment of any penalty or incurring any further obligation to the Department.

8.9 **Other Termination Rights.** This Contract may be terminated immediately or upon notice by the Department, in its sole discretion, in the event of the following:

8.9.1 Material failure of Contractor to maintain the representations, warranties and applicable certifications set forth in Section 9.2.

8.9.2 Failure of Contractor to maintain general liability insurance coverage as required in this Contract.

8.9.3 Any case or proceeding is commenced by or against Contractor seeking a decree or order with respect to the other party under the United States Bankruptcy Code or any other applicable bankruptcy or other similar law, including, without limitation, laws governing liquidation and receivership, and such proceeding is not dismissed within ninety (90) days after its commencement.

8.9.4 Material misrepresentation or falsification of any information provided by Contractor in the course of dealings between the Parties.

8.9.5 Contractor takes any action to sell, transfer, dissolve, merge, or liquidate its business.

8.9.6 Failure of the Parties to negotiate an amendment necessary for statutory or regulatory compliance as provided in this Contract.

8.9.7 Funds for this Contract become unavailable as set forth in Section 7.9 or Section 9.1.1.

8.9.8 The Department does not receive Federal CMS approval of this Contract, in which event the Department shall provide at least thirty (30) days' prior written notice to Contractor. The effective date of any termination under this Section 8.9.8 shall be the earliest date that is at least thirty (30) days following the date the notice is sent and occurs on the last day of a calendar month. Neither Party shall be relieved of its obligations under this Contract, including the Department's obligation to pay Contractor, for the period from the date of the first enrollment through the effective termination date.

8.10 **Automatic Termination.** This Contract shall automatically terminate on a date set by the Department upon the conviction of a felony of Contractor, or a Person with an Ownership or Controlling Interest in Contractor.

8.11 **Reimbursement in the Event of Termination.** In the event of termination of this Contract, Contractor shall be responsible and liable for payment to Providers for any and all claims for Covered Services rendered to Enrollees prior to the effective termination date.

8.12 **Termination by Contractor.** If the Department fails to pay Contractor the entire Capitation due under Section 7.1 for three (3) consecutive months, Contractor may provide written notice to the Department that Contractor wishes to terminate the Contract. If none of the Capitation attributable to those three (3) consecutive months has been paid at the time the notice is sent, and at least fifty percent (50%) of such Capitation is not paid within three (3) days after such notice is received by the Department, or the Parties do not otherwise agree, the Contract will terminate at 11:59 p.m. on the last day of the calendar month immediately following the month in which the notice is sent.

ARTICLE IX

GENERAL TERMS

9.1 Standard Business Terms and Conditions

9.1.1 Availability of Appropriation (30 ILCS 500/20-60): This Contract is contingent upon and subject to the availability of funds. The Department, at its sole option, may terminate or suspend this Contract, in whole or in part, without penalty or further payment being required, if: (i) the Illinois General Assembly or the federal funding source fails to make an appropriation sufficient to pay such obligation, or if funds needed are insufficient for any reason; (ii) the Governor decreases the Department's funding by reserving some or all of the Department's appropriation(s) pursuant to power delegated to the Governor by the Illinois General Assembly; or (iii) the Department determines, in its sole discretion or as directed by the Office of the Governor, that a reduction is necessary or advisable based upon actual or projected budgetary considerations. Contractor will be notified in writing of the failure of appropriation or of a reduction or decrease.

9.1.2 Audit/Retention Of Records (30 ILCS 500/20-65): Unless otherwise required by this Contract, Contractor and its subcontractors shall maintain books and records relating to the performance of the Contract or any subcontract and necessary to support amounts charged to the State under the Contract or subcontract. Books and records, including information stored in databases or other computer systems, shall be maintained by Contractor for a period of three (3) years from the later of the date of final payment under the Contract or completion of the Contract, and by a subcontractor for a period of three (3) years from the later of the date of final payment under the subcontract or completion of the subcontract. If federal funds are used to pay Contract costs, Contractor and its subcontractors must retain the books and records for five (5) years. Books and records required to be maintained under this Section 9.1.2 shall be available for review or audit by representatives of the Department, the Auditor General, the Executive Inspector General, the Chief Procurement Officer, State of Illinois internal auditors or other governmental entities with monitoring authority, upon reasonable notice and during normal business hours. Contractor and its subcontractors shall cooperate fully with any such audit and with any investigation conducted by any of these entities. Failure to maintain the books and records required by this Section 9.1.2 shall establish a presumption in favor of the State for the recovery of any funds paid by the State under the Contract for which adequate books and records are not available to support the purported disbursement. Contractor or its subcontractors shall not impose a charge for audit or examination of Contractor's books and records.

9.1.3 Time Is Of The Essence: Time is of the essence with respect to Contractor's performance of this Contract. Unless otherwise directed by the Department, Contractor shall continue to perform its obligations while any dispute concerning the Contract is being resolved.

9.1.4 No Waiver Of Rights: Except as specifically waived in writing, failure by a Party to exercise or enforce a right does not waive that Party's right to exercise or enforce that or other rights in the future.

9.1.5 Force Majeure: Failure by either Party to perform its duties and obligations will be excused by unforeseeable circumstances beyond its reasonable control and not due to its negligence, including acts of nature, acts of terrorism, riots, labor disputes, fire, flood, explosion, and governmental prohibition. The non-declaring Party may cancel the Contract without penalty if performance does not resume within thirty (30) days after the declaration.

9.1.6 Confidential Information: It is understood that each Party to this Contract, including its agents and subcontractors, may have or gain access to confidential data or information owned or maintained by the other Party in the course of carrying out its responsibilities under this Contract. Contractor shall presume all information received from the State or to which it gains access pursuant to this Contract is confidential. Contractor's information (excluding information regarding rates paid by Contractor to its Providers and subcontractors), unless clearly marked as confidential and exempt from disclosure under the Illinois Freedom of Information Act, shall be considered public. No confidential data collected, maintained, or used in the course of performance of the Contract shall be disseminated except as authorized by law and with the written consent of the disclosing Party, either during the term of the Contract or thereafter, or as otherwise set forth in this Contract. The receiving Party must return any and all data collected, maintained, created or used in the course of the performance of the duties of this Contract, in whatever form it is maintained, promptly at the end of the term of this Contract, or earlier at the request of the disclosing Party, or notify the disclosing Party in writing of its destruction. The foregoing obligations shall not apply to confidential data or information that is: (i) lawfully in the receiving Party's possession prior to its acquisition from the disclosing Party; (ii) received in good faith from a third-party not subject to any confidentiality obligation to the disclosing Party; (iii) now is or later becomes publicly known through no breach of confidentiality obligation by the receiving Party; or (iv) is independently developed by the receiving Party without the use or benefit of the disclosing Party's Confidential Information.

9.1.7 Use And Ownership: Excluding all materials, information, processes, and programs that are owned by or proprietary to Contractor or that are licensed to Contractor by a Third Party, including any modifications or enhancements thereto, all work performed or supplies created by Contractor under this Contract, whether written documents or data, goods or deliverables of any kind, shall be deemed work-for-hire under copyright law and all intellectual property and other laws, and the State is granted sole and exclusive ownership to all such work, unless otherwise agreed in writing. Contractor hereby assigns to the State all right, title, and interest in and to such work including any related intellectual property rights, and waives any and all claims that Contractor may have to such work including any so-called "moral rights" in connection with the work. Contractor acknowledges the State may use the work product for any

purpose. Confidential data or information contained in such work shall be subject to confidentiality provisions of this Contract.

9.1.8 Indemnification And Liability: Contractor shall indemnify and hold harmless the State, its agencies, officers, employees, agents and volunteers from any and all costs, demands, expenses, losses, claims, damages, liabilities, settlements and judgments, including in-house and contracted attorneys' fees and expenses, arising out of: (i) any breach or violation by Contractor of any of its certifications, representations, warranties, covenants or agreements; (ii) any actual or alleged death or injury to any individual, damage to any property or any other damage or loss claimed to result in whole or in part from Contractor's negligent performance; or (iii) any act, activity or omission of Contractor or any of its employees, representatives, subcontractors or agents. Neither Party shall be liable for incidental, special, consequential or punitive damages.

9.1.9 Insurance: Contractor shall, at all times during the term of this Contract and any renewals thereof, maintain and provide a Certificate of Insurance naming the State as additional insured for all required bonds and insurance. Certificates may not be modified or canceled until at least thirty (30) days' notice has been provided to the State. Contractor shall provide: (i) General Commercial Liability-occurrence form in amount of $1,000,000 per occurrence (Combined Single Limit Bodily Injury and Property Damage) and $2,000,000 Annual Aggregate; (ii) Auto Liability, including Hired Auto and Non-owned Auto, (Combined Single Limit Bodily Injury and Property Damage) in amount of $1,000,000 per occurrence; and (iii) Worker's Compensation Insurance in amount required by law. Insurance shall not limit Contractor's obligation to indemnify, defend, or settle any claims.

9.1.10 Independent Contractor: Contractor shall act as an independent contractor and not an agent or employee of, or joint venturer with, the State. All payments by the State shall be made on that basis.

9.1.11 Solicitation and Employment: Contractor shall give notice immediately to the Department's Ethics Officer if Contractor solicits or intends to solicit State employees to perform any work under this Contract.

9.1.12 Compliance with the Law: Contractor, its employees, agents, and subcontractors shall comply with all applicable federal, State, and local laws, rules, ordinances, regulations, orders, federal circulars and license and permit requirements in the performance of this Contract. Contractor shall be in compliance with applicable tax requirements and shall be current in payment of such taxes. Contractor shall obtain at its own expense, all licenses and permissions necessary for the performance of this Contract.

9.1.13 Background Check: Whenever the State deems it reasonably necessary for security reasons, the State may conduct, at its expense, criminal and driver history background checks of Contractor's and its subcontractors' officers, employees or agents. Contractor or the subcontractor shall reassign immediately any such individual who, in the opinion of the State, does not pass the background checks.

9.1.14 Applicable Law: This Contract shall be construed in accordance with and is subject to the laws and rules of the State. The applicable provisions of the Department of Human Rights' Equal Opportunity requirements (44 Ill. Adm. Code 750) are incorporated by reference. Any claim against the State arising out of this Contract must be filed exclusively with the Illinois Court of Claims (705 ILCS 505/1). The State shall not enter into binding arbitration to resolve any contract dispute. The State does not waive sovereign immunity by entering into this Contract. The applicable provisions of the official text of cited statutes are incorporated by reference. In compliance with the Illinois and federal Constitutions, the Illinois Human Rights Act, the U. S. Civil Rights Act, and Section 504 of the federal Rehabilitation Act and other applicable laws and rules, the State does not unlawfully discriminate in employment, contracts, or any other activity.

9.1.15 Anti-Trust Assignment: If Contractor does not pursue any claim or cause of action it has arising under federal or State antitrust laws relating to the subject matter of the Contract, then upon request of the Illinois Attorney General, Contractor shall assign to the State rights, title and interest in and to the claim or cause of action.

9.1.16 Contractual Authority: The agency that signs for the State shall be the only State entity responsible for performance and payment under the Contract.

9.1.17 Notices: Notices and other communications provided for herein shall be given in writing by first class, registered or certified mail, return receipt requested, by receipted hand delivery, by courier (UPS, Federal Express or other similar and reliable carrier), or by e-mail, fax or other electronic means, showing the date and time of successful receipt as provided in Sections 2.1.12 and 2.1.13. Except as otherwise provided herein, notices shall be sent to the Contract Monitors set forth on Attachment XV using the contact information in that Attachment. By giving notice, either Party may change the Contract Monitor or his or her contact information.

9.1.18 Modifications And Survival: Amendments, modifications and waivers must be in writing and signed by authorized representatives of the Parties. Any provision of this Contract officially declared void, unenforceable, or against public policy, shall be ignored and the remaining provisions shall be interpreted, as far as possible, to give effect to the Parties' intent. All provisions that by their nature would be expected to survive, shall survive termination.

9.1.19 Performance Record / Suspension: Upon request of the State, Contractor shall meet to discuss performance or provide contract performance updates to help ensure proper performance of the Contract. The State may consider Contractor's performance under this Contract and compliance with law and rule to determine whether to continue the Contract, suspend Contractor from doing future business with the State for a specified period of time, or to determine whether Contractor can be considered responsible on specific future contract opportunities.

9.1.20 Freedom Of Information Act (FOIA): This Contract and all related public records maintained by, provided to or required to be provided to the State are subject to the Illinois Freedom of Information Act notwithstanding any

provision to the contrary that may be found in this Contract. If the Department receives a request for a record relating to Contractor under this Contract, or Contractor's provision of services, or the arranging of the provision of services, under this Contract, the Department shall provide notice to Contractor as soon as practicable and, within the period available under FOIA, Contractor may identify those records, or portions thereof, that it in good faith believes to be exempt from production and the justification for such exemption. The Department shall make good faith efforts to notify Contractor regarding a request for a record that has been the subject of a previous request under FOIA.

9.1.21 Confidentiality Of Program Recipient Identification: Contractor shall ensure that all information, records, data, and data elements pertaining to applicants for and recipients of public assistance, or to Providers, facilities, and associations, shall be protected from unauthorized disclosure by Contractor and Contractor's employees, by Contractor's corporate Affiliates and their employees, and by Contractor's subcontractors and their employees, pursuant to 305 ILCS 5/11-9, 11-10, and 11-12; 42 USC 654(26); 42 C.F.R. Part 431, Subpart F; and 45 C.F.R. Part 160 and 45 C.F.R. Part 164, Subparts A and E. To the extent that Contractor, in the course of performing the Contract, serves as a business associate of the Department, as "business associate" is defined in the HIPAA Privacy Rule (45 C.F.R. 160.103), Contractor shall assist the Department in responding to the client as provided in the HIPAA Privacy Rule, and shall maintain for a period of six (6) years any records relevant to an individual's eligibility for services under the HFS Medical Program.

9.1.22 Nondiscrimination: (i) Contractor shall abide by all Federal and State laws, regulations, and orders that prohibit discrimination because of race, color, religion, sex, national origin, ancestry, age, physical or mental disability, including, but not limited to, the Federal Civil Rights Act of 1964, the Americans with Disabilities Act of 1990, the Federal Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, the Illinois Human Rights Act, and Executive Orders 11246 and 11375. (ii) Contractor further agrees to take affirmative action to ensure that no unlawful discrimination is committed in any manner including, but not limited to, the delivery of services under this Contract. (iii) Contractor will not discriminate against Potential Enrollees, Prospective Enrollees, or Enrollees on the basis of health status or need for health services. (iv)Contractor may not discriminate against any Provider who is acting within the scope of his/her licensure solely on the basis of that licensure or certification. (v) Contractor will provide each Provider or group of Providers whom it declines to include in its network written notice of the reason for its decision. (vi) Nothing in subsection (iv) or (v), above, may be construed to require Contractor to contract with Providers beyond the number necessary to meet the needs of its Enrollees; precludes Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or precludes Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to Enrollees.

9.1.23 **Child Support**: Contractor shall ensure that it is in compliance with paying, or any other obligations it may have in enforcing, child support payments pursuant to a court or administrative order of this or any other State. Contractor will not be considered out of compliance with the requirements of this Section 9.1.23 if, upon request by the Department, Contractor provides:

9.1.23.1 Proof of payment of past-due amounts in full;

9.1.23.2 Proof that the alleged obligation of past-due amounts is being contested through appropriate court or administrative proceedings and Contractor provides proof of the pendency of such proceedings; or

9.1.23.3 Proof of entry into payment arrangements acceptable to the appropriate State agency.

9.1.24 **Notice Of Change In Circumstances**: In the event Contractor, Contractor's parent, or an Affiliate, becomes a party to any litigation, investigation or transaction that may reasonably be considered to have a material impact on Contractor's ability to perform under this Contract, Contractor will immediately notify the Department in writing.

9.1.25 **Performance Of Services And Duties**: Contractor shall perform all services and other duties as set forth in this Contract in accordance with, and subject to, applicable Administrative Rules and Department policies including rules and regulations which may be issued or promulgated from time to time during the term of this Contract. Contractor shall be provided copies of such upon Contractor's written request.

9.1.26 **Consultation**: Upon request, Contractor shall promptly furnish the Department with copies of all relevant correspondence and all documents prepared in connection with the services rendered under this Contract.

9.1.27 **Employee Handbook**: Contractor shall require that its employees and subcontractors who provide services under this Contract at a location controlled by the Department, or any other State agency, abide by applicable provisions of the controlling agency's Employee Handbook.

9.1.28 **Disputes Between Contractor And Other Parties**: Any dispute between Contractor and any Third Party, including any subcontractor, shall be solely between such Third Party and Contractor, and the Department shall be held harmless by Contractor. Contractor agrees to assume all risk of loss and to indemnify and hold the Department and its officers, agents, and employees harmless from and against any and all liabilities, demands, claims, suits, losses, damages, causes of action, fines or judgments, including costs, attorneys' and witnesses' fees, and expenses incident thereto, for Contractor's failure to pay any subcontractor, either timely or at all, regardless of the reason.

9.1.29 **Fraud And Abuse**: Contractor shall report in writing to the Department's Office of Inspector General (OIG) any suspected Fraud, Abuse or misconduct associated with any service or function provided for under this

Contract by any parties directly or indirectly affiliated with this Contract, including but not limited to, Contractor's staff, Contractor's subcontractors, the Department's employees or the Department's contractors. Contractor shall make this report within three (3) days after first suspecting Fraud, Abuse or misconduct. Contractor shall not conduct any investigation of the suspected Fraud, Abuse or misconduct without the express concurrence of the OIG; the foregoing notwithstanding, Contractor may conduct and continue investigations necessary to determine whether reporting is required under this Section 9.1.29. Contractor must report the results of such an investigation to OIG as described in the first sentence above. Contractor shall cooperate with all investigations of suspected Fraud, Abuse or misconduct reported pursuant to this paragraph. Contractor shall require adherence with these requirements in any contracts it enters into with subcontractors. Nothing in this Section precludes Contractor or subcontractors from establishing measures to maintain quality of services and control costs that are consistent with their usual business practices, conducting themselves in accordance with their respective legal or contractual obligations or taking internal personnel-related actions.

9.1.30 **Gifts**: Contractor and Contractor's principals, employees and subcontractors are prohibited from giving gifts to Department employees, and from giving gifts to, or accepting gifts from, any Person who has a contemporaneous contract with the Department involving duties or obligations related to this Contract.

9.1.31 **Media Relations And Public Information**: Subject to any disclosure obligations of Contractor under applicable law, rule, or regulation, news releases pertaining to this Contract or the services or project to which it relates shall only be made with Prior Approval by, and in coordination with, the Department. Contractor shall not disseminate any publication, presentation, technical paper, or other information related to Contractor's duties and obligations under this Contract unless such dissemination has received Prior Approval from the Department.

9.1.32 **Excluded Individuals/Entities:** Contractor shall screen all current and prospective employees, contractors and subcontractors prior to engaging their services under this Contract and at least annually thereafter, by:

9.1.32.1 Requiring that current or prospective employees, contractors or sub-contractors to disclose whether they are Excluded Individuals/Entities; and

9.1.32.2 Reviewing the list of sanctioned Persons maintained by the OIG (available at http://www.state.il.us/agency/oig), and the Excluded Parties List System maintained by the U.S. General Services Administration (available at http://epls.arnet.gov/).

9.1.32.3 For purposes under this Section, "Excluded Individual/Entity" shall mean a Person which:

9.1.32.3.1 Under Section 1128 of the Social Security Act, is or has been terminated, barred, suspended or

otherwise excluded from participation in, or as the result of a settlement agreement has voluntarily withdrawn from participation in, any program under federal law, including any program under Titles IV, XVIII, XIX, XX or XXI of the Social Security Act;

9.1.32.3.2 Has not been reinstated in the program after a period of exclusion, suspension, debarment, or ineligibility; or

9.1.32.3.3 Has been convicted of a criminal offense related to the provision of items or services to a federal, State or local government entity within the last ten (10) years.

9.1.32.4 Contractor shall terminate its relations with any employee, contractor or subcontractor immediately upon learning that such employee, contractor or subcontractor meets the definition of an Excluded Individual/Entity, and shall notify the OIG of the termination.

9.1.33 Termination For Breach Of HIPAA Compliance Obligations: Contractor shall comply with the terms of the HIPAA Compliance Obligations set forth in Attachment VI. Upon the Department's learning of a material breach of the terms of the HIPAA Compliance Obligations set forth in Attachment VI, the Department shall:

9.1.33.1 Provide Contractor with an opportunity to cure the breach or end the violation, and terminate this Contract if Contractor does not cure the breach or end the violation within the time specified by the Department; or

9.1.33.2 Immediately terminate this Contract if Contractor has breached a material term of the HIPAA Compliance Obligations and cure is not possible; or

9.1.33.3 Report the violation to the Secretary of DHHS, if neither termination nor cure by Contractor is feasible.

9.1.34 HIPAA Compliance Obligations: Contractor and the Department shall comply with the terms of the HIPAA Compliance Obligations set forth in Attachment VI. If Contractor materially breaches the terms of the HIPAA Compliance Obligations, the Department may require a cure or terminate this Contract, as provided herein.

9.1.35 Retention Of HIPAA Records: Contractor shall maintain, for a minimum of six (6) years, documentation of the PHI disclosed by Contractor, and all requests from individuals for access to records or amendment of records, pursuant to Attachment VI, paragraphs C.6 and C.7, of this Contract, in accordance with 45 C.F.R. 164.530(j).

9.1.36 Sale or Transfer: Contractor shall provide the Department with the earliest possible advance notice of any sale or transfer of Contractor's business.

The Department has the right to terminate this Contract upon notification of such sale or transfer.

9.1.37 Coordination of Benefits for Enrollees. Money that Contractor receives as a result of Third Party liability collection activities may be retained by Contractor to the extent, as permitted by law, Contractor has paid any claim or incurred any expense. Upon the Department's verification that an Enrollee has Third Party coverage for major medical benefits, the Department shall disenroll such Enrollee from Contractor. Contractor shall be notified of the disenrollment on the 834 Daily File. Contractor shall report any and all Third Party liability collections it makes with Contractor's Encounter Data. Contractor shall report to the Department those Enrollees who Contractor discovers to have any Third Party health insurance coverage.

9.1.38 Subrogation. If an Enrollee is injured by an act or omission of a Third Party, Contractor shall have the right to pursue subrogation and recover reimbursement from the Third Party for all Covered Services that Contractor provided to the Enrollee in exchange for the Capitation paid hereunder.

9.2 Certifications

9.2.1 General. Contractor acknowledges and agrees that compliance with this Section 9.2 and each subsection thereof is a material requirement and condition of this Contract, including renewals. By executing this Contract, Contractor certifies compliance, as applicable, with this Section and is under a continuing obligation to remain in compliance and report any non-compliance. This Section applies to subcontractors used on this Contract. Contractor shall include these Standard Certifications in any subcontract used in the performance of the Contract using the Standard Subcontractor Certification form provided by the State. If this Contract extends over multiple fiscal years, including the initial term and all renewals, Contractor and its subcontractors shall confirm compliance with this Section in the manner and format determined by the State by the date specified by the State and in no event later than July 1 of each year that this Contract remains in effect. If the Parties determine that any certification in this Section is not applicable to this Contract it may be stricken without affecting the remaining subsections.

9.2.1.1 As part of each certification, Contractor acknowledges and agrees that if Contractor or its subcontractors provide false information, or fail to be or remain in compliance with the Standard Certification requirements, one (1) or more of the sanctions listed below will apply. Identifying a sanction or failing to identify a sanction in relation to any of the specific certifications does not waive imposition of other sanctions or preclude application of sanctions not specifically identified.

9.2.1.1.1 the Contract may be void by operation of law,

9.2.1.1.2 the State may void the Contract, and

9.2.1.1.3 Contractor and it subcontractors may be subject to one or more of the following: suspension, debarment, denial of payment, civil fine, or criminal penalty.

9.2.2 Contractor certifies that it and its employees will comply with applicable provisions of the U.S. Civil Rights Act, Section 504 of the Federal Rehabilitation Act, the Americans with Disabilities Act (42 U.S.C. § 12101 et seq.) and applicable rules in performance under this Contract.

9.2.3 Contractor certifies that it is not in default on an educational loan (5 ILCS 385/3). This applies to individuals, sole proprietorships, partnerships and individuals as members of LLCs.

9.2.4 Contractor (if an individual, sole proprietor, partner or an individual as member of a LLC) certifies that it has not received an (i) an early retirement incentive prior to 1993 under Section 14-108.3 or 16-133.3 of the Illinois Pension Code, 40 ILCS 5/14-108.3 and 40 ILCS 5/16-133.3, or (ii) an early retirement incentive on or after 2002 under Section 14-108.3 or 16-133.3 of the Illinois Pension Code, 40 ILCS 5/14-108.3 and 40 ILCS 5/16-133, (30 ILCS 105/15a).

9.2.5 Contractor certifies that it is a properly formed and existing legal entity (30 ILCS 500/1.15.80, 20-43); and as applicable has obtained an assumed name certificate from the appropriate authority, or has registered to conduct business in Illinois and is in good standing with the Illinois Secretary of State.

9.2.6 To the extent there was an incumbent contractor providing the services covered by this Contract and the employees of that contractor that provide those services are covered by a collective bargaining agreement, Contractor certifies (i) that it will offer to assume the collective bargaining obligations of the prior employer, including any existing collective bargaining agreement with the bargaining representative of any existing collective bargaining unit or units performing substantially similar work to the services covered by the Contract subject to its bid or offer; and (ii) that it shall offer employment to all employees currently employed in any existing bargaining unit performing substantially similar work that will be performed under this Contract (30 ILCS 500/25-80). This does not apply to heating, air conditioning, plumbing and electrical service contracts. There is no incumbent contractor contracted with the State that is providing the services covered by this Contract.

9.2.7 Contractor certifies that it has not been convicted of bribing or attempting to bribe an officer or employee of the State or any other state, nor has Contractor made an admission of guilt of such conduct that is a matter of record (30 ILCS 500/50-5).

9.2.8 If Contractor has been convicted of a felony, Contractor certifies at least five (5) years have passed after the date of completion of the sentence for such felony, unless no Person held responsible by a prosecutor's office for the facts upon which the conviction was based continues to have any involvement with the business (30 ILCS 500/50-10).

9.2.9 If Contractor, or any officer, director, partner, or other managerial agent of Contractor, has been convicted of a felony under the Sarbanes-Oxley Act of 2002, or a Class 3 or Class 2 felony under the Illinois Securities Law of 1953, Contractor certifies that at least five (5) years have passed since the date of the conviction. Contractor further certifies that it is not barred from being awarded a contract and acknowledges that the State shall declare the Contract void if this certification is false (30 ILCS 500/50-10.5).

9.2.10 Contractor certifies that it is not barred from having a contract with the State based on violating the prohibition on providing assistance to the State in identifying a need for a contract (except as part of a public request for information process) or by reviewing, drafting or preparing a solicitation or similar documents for the State (30 ILCS 500/50-10.5e).

9.2.11 Contractor certifies that it and its Affiliates are not delinquent in the payment of any debt to the State (or if delinquent has entered into a deferred payment plan to pay the debt), and Contractor and its affiliates acknowledge the State may declare the Contract void if this certification is false (30 ILCS 500/50-11) or if Contractor or an Affiliate later becomes delinquent and has not entered into a deferred payment plan to pay off the debt (30 ILCS 500/50-60).

9.2.12 Contractor certifies that it and all Affiliates shall collect and remit Illinois Use Tax on all sales of tangible personal property into the State in accordance with provisions of the Illinois Use Tax Act (30 ILCS 500/50-12) and acknowledges that failure to comply can result in the Contract being declared void.

9.2.13 Contractor certifies that it has not been found by a court or the Pollution Control Board to have committed a willful or knowing violation of the Environmental Protection Act within the last five (5) years, and is therefore not barred from being awarded a contract (30 ILCS 500/50-14).

9.2.14 Contractor certifies that it has not paid any money or valuable thing to induce any Person to refrain from bidding on a State contract, nor has Contractor accepted any money or other valuable thing, or acted upon the promise of same, for not bidding on a State contract (30 ILCS 500/50-25).

9.2.15 Contractor certifies that it is not in violation of the "Revolving Door" section of the Illinois Procurement Code (30 ILCS 500/50-30).

9.2.16 Contractor certifies that it has not retained a Person to attempt to influence the outcome of a procurement decision for compensation contingent in whole or in part upon the decision or procurement (30 ILCS 500/50-38).

9.2.17 Contractor certifies that it will report to the Illinois Attorney General and the Chief Procurement Officer any suspected collusion or other anti-competitive practice among any bidders, offerors, contractors, proposers or employees of the State (30 ILCS 500/50-40, 50-45, 50-50).

9.2.18 In accordance with the Steel Products Procurement Act, Contractor certifies that steel products used or supplied in the performance of a

contract for public works shall be manufactured or produced in the United States, unless the executive head of the procuring agency grants an exception (30 ILCS 565).

9.2.19 If Contractor employs twenty-five (25) or more employees and this Contract is worth more than $5000, Contractor certifies that it will provide a drug free workplace pursuant to the Drug Free Workplace Act (30 ILCS 580).

9.2.20 Contractor certifies that neither Contractor nor any substantially owned Affiliate is participating or shall participate in an international boycott in violation of the U.S. Export Administration Act of 1979 or the applicable regulations of the U.S. Department of Commerce. This applies to contracts that exceed $10,000 (30 ILCS 582).

9.2.21 Contractor certifies that it has not been convicted of the offense of bid rigging or bid rotating or any similar offense of any state or of the United States (720 ILCS 5/33E-3, E-4).

9.2.22 Contractor certifies that it complies with the Illinois Department of Human Rights Act and rules applicable to public contracts, including equal employment opportunity, refraining from unlawful discrimination, and having written sexual harassment policies (775 ILCS 5/2-105).

9.2.23 Contractor certifies that it does not pay dues to or reimburse or subsidize payments by its employees for any dues or fees to any "discriminatory club" (775 ILCS 25/2).

9.2.24 Contractor certifies that it complies with the State Prohibition of Goods from Forced Labor Act, and certifies that no foreign-made equipment, materials, or supplies furnished to the State under the Contract have been or will be produced in whole or in part by forced labor, or indentured labor under penal sanction (30 ILCS 583).

9.2.25 Contractor certifies that no foreign-made equipment, materials, or supplies furnished to the State under this Contract have been produced in whole or in part by the labor or any child under the age of twelve (12) (30 ILCS 584).

9.2.26 Contractor certifies that it is not in violation of Section 50-14.5 of the Illinois Procurement Code (30 ILCS 500/50-14.5) that states: "Owners of residential buildings who have committed a willful or knowing violation of the Lead Poisoning Prevention Act (410 ILCS 45) are prohibited from doing business with the State until the violation is mitigated".

9.2.27 Contractor warrants and certifies that it and, to the best of its knowledge, its subcontractors have and will comply with Executive Order No. 1 (2007). The Order generally prohibits contractors and subcontractors from hiring the then-serving Governor's family members to lobby procurement activities of the State, or any other unit of government in Illinois including local governments if that procurement may result in a contract valued at over $25,000. This prohibition also applies to hiring for that same purpose any former State employee who had procurement authority at any time during the one-year period preceding the procurement lobbying activity.

9.2.28 Contractor certifies that information technology, including electronic information, software, systems and equipment, developed or provided under this Contract will comply with the applicable requirements of the Illinois Information Technology Accessibility Act Standards as published at www.dhs.state.il.us/iitaa. (30 ILCS 587)

9.2.29 Non-Exclusion:

9.2.29.1 Contractor certifies that it is not currently barred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal or State department or agency, and is not currently barred or suspended from contracting with the State under Section 50-35(f), 50-35(g) or 50-65 of the Illinois Procurement Code, 30 ILCS 500/1-1 et seq.

9.2.29.2 If at any time during the term of this Contract, Contractor becomes barred, suspended, or excluded from participation in this transaction, Contractor shall, within thirty (30) days after becoming barred, suspended or excluded, provide to the Department a written description of each offense causing the exclusion, the date(s) of the offense, the action(s) causing the offense(s), any penalty assessed or sentence imposed, and the date any penalty was paid or sentence complete.

9.2.30 Conflict Of Interest: In addition to any other provision in this Contract governing conflicts of interest, Contractor certifies that neither Contractor, nor any party directly or indirectly affiliated with Contractor, including, but not limited to, Contractor's officers, directors, employees and subcontractors, and the officers, directors and employees of Contractor's subcontractors, shall have or acquire any Conflict of Interest in performance of this Contract.

9.2.30.1 For purposes of this Section 9.2.30, "Conflict of Interest" shall mean an interest of Contractor, or any entity described above, which may be direct or indirect, professional, personal, financial, or beneficial in nature that, in the sole discretion of the Department, compromises, appears to compromise, or gives the appearance of impropriety with regard to Contractor's duties and responsibilities under this Contract. This term shall include potential Conflicts of Interest. A Conflict of Interest may exist even if no unethical or improper act results from it or may arise where Contractor becomes a party to any litigation, investigation, or transaction that materially impacts Contractor's ability to perform under this Contract. Any situation where Contractor's role under the Contract competes with Contractor's professional or personal role may give rise to an appearance of impropriety. Any conduct that would lead a reasonable individual, knowing all the circumstances, to a conclusion that bias may exist or that improper conduct may occur, or that gives the appearance of the existence of bias or improper conduct, is a Conflict of Interest.

9.2.30.2 Contractor shall disclose in writing any Conflicts of Interest to the Department no later than seven (7) days after learning of the Conflict of Interest. The Department may initiate any inquiry as to the existence of a Conflict of Interest. Contractor shall cooperate with all inquiries initiated pursuant to this Section 9.2.30. Contractor shall have an opportunity to discuss the Conflict of Interest with the Department and suggest a remedy under this Section.

9.2.30.3 Notwithstanding any other provisions in this Contract, the Department shall, in its sole discretion, determine whether a Conflict of Interest exists or whether Contractor failed to make any required disclosure. This determination shall not be subject to appeal by Contractor. If the Department concludes that a Conflict of Interest exists, or that Contractor failed to disclose any Conflict of Interest, the Department may impose one or more remedies, as set forth below.

9.2.30.4 The appropriate remedy for a Conflict of Interest shall be determined in the sole discretion of the Department and shall not be subject to appeal by Contractor. Available remedies shall include, but not be limited to, the elimination of the Conflict of Interest or the non-renewal or termination of the Contract.

9.2.31 Clean Air Act And Clean Water Act: Contractor certifies that it is in compliance with all applicable standards, orders or regulations issued pursuant to the federal Clean Air Act (42 U.S.C. 7401 et seq.) and the federal Water Pollution Control Act (33 U.S.C. 1251 et seq.). Violations shall be reported to the United States Department of Health and Human Services and the appropriate Regional Office of the United States Environmental Protection Agency.

9.2.32 Lobbying:

9.2.32.1 Contractor certifies that, to the best of its knowledge and belief, no federally appropriated funds have been paid or will be paid by or on behalf of Contractor, 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.

9.2.32.2 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, Contractor shall complete and submit Standard Form LLL, "Disclosure Forms to Report Lobbying," in accordance with its instructions. Such Form is to be obtained at Contractor's request from the Department's Bureau of Fiscal Operations.

9.2.32.3 Contractor shall require that the language of this certification be included in the award document for subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

9.2.32.4 This certification is a material representation of fact upon which reliance was placed when this Contract was executed. Submission of this certification is a prerequisite for making or entering into the transaction imposed by Section 1352, Title 31, U.S. Code. Any Person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

9.2.33 Contractor certifies that it has accurately completed the certification on Attachment X.

IN WITNESS WHEREOF, the Department and Contractor hereby execute and deliver this Contract effective as of the Effective Date.

ILLINICARE HEALTH PLAN, INC.

_____
(IlliniCare Health Plan, Inc.)

By: _____
Official Signature

_____
Printed Name

_____
Title

Date: _____

Address:
_____
_____
_____

Phone: _____

Fax: _____

E-mail: _____

STATE OF ILLINOIS
Department of Healthcare and Family Services

By: _____
Julie Hamos, Director

Date: _____

Address:
201 South Grand Avenue East
Springfield, IL 62763-0002

Phone: 217-782-1200

Fax: 217-524-7979

E-mail: HFS.Director@illinois.gov

Attachment I

Service Package I Covered Services

1. Enumerated Covered Services in Service Package I.

1.1 Advanced Practice Nurse services;

1.2 Ambulatory Surgical Treatment Center services;

1.3 Annual adult (over age twenty (20)) dental cleaning;

1.4 Audiology services;

1.5 Chiropractic services;

1.6 Dental services, including oral surgeons;

1.7 EPSDT services for Enrollees under age twenty-one (21) pursuant to 89 Ill. Admin. Code Section 140.485; excluding shift nursing for Enrollees in the MFTD HCBS Waiver for individuals who are medically fragile and technology dependent (MFTD);

1.8 Family planning services and supplies;

1.9 FQHCs, RHCs and other Encounter rate clinic visits;

1.10 Home health agency visits;

1.11 Hospital emergency room visits;

1.12 Hospital inpatient services; Hospital ambulatory services;

1.13 Laboratory and x-ray services (Contractor shall receive and transmit electronic lab values to support clinical management and for HEDIS® reporting);

1.14 Medical supplies, equipment, prostheses and orthoses, and respiratory equipment and supplies;

1.15 Mental health services provided under the Medicaid Clinic Option or Medicaid Rehabilitation Option;

1.16 Nursing care for Enrollees under age twenty-one (21) not in the HCBS Waiver for individuals who are MFTD, pursuant to 89 Ill. Admin Code Section 140.472;

1.17 Nursing care for the purpose of transitioning children from a hospital to home placement or other appropriate setting for Enrollees under age twenty-one (21), pursuant to 89 Ill. Adm. Code 146, Subpart D;

1.18 Nursing Facility services for the first ninety (90) days*;

1.19 Optical services and supplies;

1.20 Optometrist services;

1.21 Palliative and Hospice services;

1.22 Pharmacy Services;

1.23 Physical, Occupational and Speech Therapy services;

1.24 Physician services;

1.25 Podiatric services;

1.26 Post-Stabilization Services as detailed in Section 5.17.2;

1.27 Practice Visits for Enrollees with special needs;

1.28 Renal Dialysis services; ;

1.29 Respiratory Equipment and Supplies;

1.30 Subacute alcoholism and substance abuse services pursuant to 89 Ill. Admin. Code Sections 148.340 through 148.390 and 77 Ill. Admin. Code Part 2090; and

1.31 Transportation to secure Covered Services.

*Excludes Enrollees who are Residents of a Nursing Facility on the date of enrollment with Contractor.

Addendum 1 to Attachment I

Additional Covered Services

The following services shall be covered as value-added benefits:

1. Annual dental cleaning
2. Providing additional time, as needed, for dental appointments for Enrollees with Developmental Disabilities or physical disabilities
3. Practice visits for dental services as needed
4. Practice visits for gynecological visits as needed
5. Telemonitoring equipment to transmit health data electronically to Contractor for Enrollees determined eligible for the telemonitoring program.

Attachment II
Service Package II Covered Services

Service	DoA	DHS-DRS			DSCC	HFS			
	Persons who are Elderly	**Persons with Disabilities**	**Persons with HIV/AIDS**	**Persons with Brain Injury**	**Children who are Medically Fragile, Technology Dependent**	**Supportive Living Facility**	**Definition**	**Standards**	**HFS Fee-For-Service Service Limits**
Adult Day Service	x	x	x	x			Adult day service is the direct care and supervision of adults aged 60 and over in a community-based setting for the purpose of providing personal attention; and promoting social, physical and emotional well-being in a structured setting.	**DOA:** 89 Il.Adm.Code 240.1505-1590 Contract with DoA, Contract requirements, **DRS:** 89 Il.Adm.Code 686.100	**DOA, DRS** The amount, duration, and scope of services is based on the service plan and is included in the service cost maximum/monthly cost limit. This service will not be duplicative of other services in the HCBS Waiver.
Adult Day Service Transportation	x	x	x	x				**DOA:** 89 Il.Adm.Code 240.1505-1590 **DRS:** 89 Il.Adm.Code 686.100	No more than two units of transportation shall be provided per MFP Enrollee in a 24 hour period, and shall not include trips to a Physician, shopping, or other miscellaneous trips.
Environmental Accessibility Adaptations-Home		x	x	x	x		Those physical adaptations to the home, required by the Enrollee Care Plan, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require Institutionalization. Excluded are those adaptations or improvements to the home that are of general utility and are not of direct remedial benefit to the Enrollee. **DSCC** Vehicle modifications (wheelchair lifts and tie downs) are also provided under environmental modifications.	**DRS:** 89 Il.Adm.Code 686.608 **DSCC:** DSCC Home Care Manual, 53.20.30, (Rev.9/01) &53.43 (Rev.9/01)	**DRS** The cost of environmental modification, when amortized over a 12 month period and added to all other monthly service costs, may not exceed the service cost maximum. **DSCC** All environmental modifications will be limited in scope to the minimum necessary to meet the Enrollee's medical needs.

Service	DoA	DHS-DRS			DSCC	HFS			
	Persons who are Elderly	**Persons with Disabilities**	**Persons with HIV/AIDS**	**Persons with Brain Injury**	**Children who are Medically Fragile, Technology Dependent**	**Supportive Living Facility**	**Definition**	**Standards**	**HFS Fee-For-Service Service Limits**
Supported Employment				x			Supported employment services consist of intensive, ongoing supports that enable Enrollees, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need supports, to perform in a regular work setting. It may include assisting the Enrollee to locate a job or develop a job on behalf of the Enrollee, and is conducted in a variety of settings; including work sites where persons without disabilities are employed.	**DHS:** 89 Il.Adm.Code 530 89 Il.Admin.Code 686.1400	**BI** When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by Enrollees receiving HCBS Waiver services as a result of their disabilities and will not include payment for the supervisory activities rendered as a normal part of the business setting. The amount, duration, and scope of services are based on the determination of need assessment conducted by the case manager and the service cost maximum determined by the DON score.
Home Health Aide		x	x	x			Service provided by an individual that meets Illinois licensure standards for a Certified Nursing Assistant (CNA) and provides services as defined in 42C.F.R. 440.70, with the exception that limitations on the amount, duration, and scope of such services imposed by the State's approved Medicaid State Plan shall not be applicable.	**DRS:** Individual: 210 ILCS 45/3-206 Agency: 210 ILCS 55	Services provided are in addition to any services provided through the State Plan. The amount, duration, and scope of services are based on the determination of need assessment conducted by the case manager and the service cost maximum determined by the DON.

Service	DoA	DHS-DRS			DSCC	HFS			
	Persons who are Elderly	**Persons with Disabilities**	**Persons with HIV/AIDS**	**Persons with Brain Injury**	**Children who are Medically Fragile, Technology Dependent**	**Supportive Living Facility**	**Definition**	**Standards**	**HFS Fee-For-Service Service Limits**
Nursing, Intermittent		x	x	x			Nursing services that are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or a licensed practical nurse, licensed to practice in the State. Nursing through the HCBS Waiver focuses on long term habilitative needs rather than short-term acute restorative needs. HCBS Waiver intermittent nursing services are in addition to any Medicaid State Plan nursing services for which the Enrollee may qualify.	**DRS:** Home Health Agency: 210 ILCS 55 Licensed Practical Nurse: 225 ILCS 65 Registered Nurse: 225 ILCS 65	The amount, duration, and scope of services are based on the determination of need assessment conducted by the case manager and the service cost maximum determined by the DON score. All HCBS Waiver clinical services require a prescription from a Physician. The duration and/or frequency of these services are dependent on continued authorization of the Physician, and relevance to the Enrollee's service plan.
Nursing,Skilled (RN and LPN)		x	x	x			Service provided by an individual that meets Illinois licensure standards for nursing services and provides shift nursing services.	**DRS:**Home Health Agency: 210 ILCS 55 Licensed Practical Nurse: 225 ILCS 65 Registered Nurse: 225 ILCS 65	**DRS**The amount, duration, and scope of services is based on the service plan and is included in the service cost maximum/monthly cost limit. This service will not be duplicative of other services in the HCBS Waiver.
Occupational Therapy		x	x	x			Service provided by a licensed occupational therapist that meets Illinois standards. Services are in addition to any Medicaid State Plan services for which the Enrollee may qualify. Occupational therapy through the HCBS Waiver focuses on long term habilitative needs rather than short-term acute restorative needs.	**DRS:** Occupational Therapist: 225 ILCS 75 Home Health Agency: 210 ILCS 55	**DRS** All HCBS Waiver clinical services require a prescription from a Physician. The duration and/or frequency of these services are dependent on continued authorization of the Physician, and relevance to the Enrollee's service plan. The amount, duration, and scope of services is based on the service plan and is included in the service cost maximum

Service	DoA	DHS-DRS			DSCC	HFS			
	Persons who are Elderly	**Persons with Disabilities**	**Persons with HIV/AIDS**	**Persons with Brain Injury**	**Children who are Medically Fragile, Technology Dependent**	**Supportive Living Facility**	**Definition**	**Standards**	**HFS Fee-For-Service Service Limits**
Physical Therapy		x	x	x			Service provided by a licensed physical therapist that meets Illinois standards. Services are in addition to any Medicaid State Plan services for which the Enrollee may qualify. Physical Therapy through the HCBS Waiver focuses on long term habilitative needs rather than short-term acute restorative needs.	**DRS:** Physical Therapist 225 ILCS 90 Home Health Agency: 210 ILCS 55	**DRS** All HCBS Waiver clinical services require a prescription from a Physician. The duration and/or frequency of these services are dependent on continued authorization of the Physician, and relevance to the Enrollee's service plan. The amount, duration, and scope of services is based on the service plan and is included in the service cost maximum.
Speech Therapy		x	x	x			Service provided by a licensed speech therapist that meets Illinois standards. Services are in addition to any Medicaid State Plan services for which the Enrollee may qualify. Speech Therapy through the HCBS Waiver focuses on long term habilitation needs rather than short-term acute restorative needs.	**DRS:** Speech Therapist 225 ILCS 110 Home Health Agency: 210 ILCS 55	**DRS**All HCBS Waiver clinical services require a prescription from a Physician. The duration and/or frequency of these services are dependent on continued authorization of the Physician, and relevance to the Enrollee's service plan. The amount, duration, and scope of services is based on the service plan and is included in the service cost maximum.
Prevocational Services				x			Prevocational services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. This can include teaching concepts such as compliance, attendance, task completion, problem solving and safety. Prevocational Services are provided to persons expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs).	89 Il.Adm.Code 530 89 il Admin Code 686.1300	The amount, duration, and scope of services are based on the determination of need assessment conducted by the case manager and the service cost maximum determined by the DON score.All prevocational services will be reflected in the Enrollee Care Plan as directed to habilitative, rather than explicit employment, objectives.

Service	DoA	DHS-DRS			DSCC	HFS			
	Persons who are Elderly	**Persons with Disabilities**	**Persons with HIV/AIDS**	**Persons with Brain Injury**	**Children who are Medically Fragile, Technology Dependent**	**Supportive Living Facility**	**Definition**	**Standards**	**HFS Fee-For-Service Service Limits**
Habilitation-Day				x			**BI** Day habilitation assists with the acquisition, retention, or improvement in self-help, socialization, and adaptive skills which takes place in a non-residential setting, separate from the home or facility which the individual resides. The focus is to enable the individual to attain or maintain his or her maximum functional level. Day habilitation shall be coordinated with any physical, occupational, or speech therapies listed in the Enrollee Care Plan. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.	**BI** 59 Il.Adm.Code 119 **IL Admin Code 686.1200**	**BI** The amount, duration, and scope of services are based on the determination of need assessment conducted by the case manager and the service cost maximum determined by the DON score. This service shall be furnished 4 or more hours per day on a regularly scheduled basis, for 1 or more days per week unless provided as an adjunct to other day activities included in the Enrollee Care Plan.
Placement Maintenance Counseling					x		This service provides short-term, issue-specific family or individual counseling for the purpose of maintaining the Enrollee in the home placement. This service is prescribed by a Physician based upon his or her judgment that it is necessary to maintain the child in the home placement.	Licensed Clinical Social Worker 225 ILCS 20 Medicaid Rehabilitation Option 59 Il.Adm.Code 132 Licensed Clinical Psychologist 225 ILCS 15	Services will require pr-authorization by HFS and will be limited to a maximum of twelve sessions per calendar year.
Medically Supervised Day Care					x		This service offers the necessary technological support and nursing care provided in a licensed medical day care setting as a developmentally appropriate adjunct to full time care in the home. Medically supervised day care serves to normalize the child's environment and provide an opportunity for interaction with other children who have similar medical needs.	Licensed Day Care Facility 89 Il.Adm.Code 407 Health Care Center 77 Il.Adm.Code 260	This service cannot exceed more than 12 hours per day, five days per week.

Service	DoA	DHS-DRS			DSCC	HFS			
	Persons who are Elderly	**Persons with Disabilities**	**Persons with HIV/AIDS**	**Persons with Brain Injury**	**Children who are Medically Fragile, Technology Dependent**	**Supportive Living Facility**	**Definition**	**Standards**	**HFS Fee-For-Service Service Limits**
Homemaker	x	x	x	x			Homemaker service is defined as general non-medical support by supervised and trained homemakers. Homemakers are trained to assist individuals with their activities of daily living, including Personal Care, as well as other tasks such as laundry, shopping, and cleaning. The purpose of providing homemaker service is to maintain, strengthen and safeguard the functioning of Enrollees in their own homes in accordance with the authorized Enrollee Care Plan. (a.k.a. In home care)	**DOA:** 89 Il.Adm.Code 240 **DRS:** 89 Il. Adm. Code 686.200	**DOA, DRS:** The amount, duration, and scope of services are based on the determination of need assessment conducted by the case manager and the service cost maximum determined by the DON score.
Home Delivered Meals		x	x	x			Prepared food brought to the client's residence that may consist of a heated luncheon meal and/or a dinner meal which can be refrigerated and eaten later. This service is designed primarily for the client who cannot prepare his/her own meals but is able to feed him/herself.	89 Il. Adm. Code 686.500	The amount, duration, and scope of services is based on the determination of need assessment conducted by the case manager and the service cost maximum. This service will be provided as described in the service plan and will not duplicate any other services.
Personal Emergency Response System (PERS)	x	x	x	x			PERS is an electronic device that enables certain individuals at high risk of Institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. Trained professionals staff the response center.	**DOA:** Standards for Emergency Home Response 89 Il.Adm.Code 240 **DRS:** 89 Il. Adm. Code 686.300	PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

Service	DoA	DHS-DRS			DSCC	HFS			
	Persons who are Elderly	**Persons with Disabilities**	**Persons with HIV/AIDS**	**Persons with Brain Injury**	**Children who are Medically Fragile, Technology Dependent**	**Supportive Living Facility**	**Definition**	**Standards**	**HFS Fee-For-Service Service Limits**
Respite		x	x	x	x		**DRS** Respite services provide relief for unpaid family or primary care givers, who are currently meeting all service needs of the Enrollee. Services are limited to Personal Assistant, homemaker, nurse, adult day care, and provided to a consumer to provide his or her activities of daily living during the periods of time it is necessary for the family or primary care giver to be absent. **DSCC** Respite care services allow for the needed level of care and supportive services to enable the Enrollee to remain in the community, or home-like environment, while periodically relieving the family of care-giving responsibilities. These services will be provided in the Enrollee'ss home or in a Children's Community-Based Health Care Center Model, licensed by the Illinois Department of Public Health.	Adult Day Care 89 Il. Adm.Code 686.100 Home Health Aide 210 ILCS 45/3-206 RN/LPN 225 ILCS 65 Home Health Agency: 210 ILCS 55 Homemaker 89 Il.Adm.Code 686.200 PA 89 Il.Adm.Code 686.10 **DSCC:** Health Care Center 77 Il.Adm.Code 260 Nursing Agency: Meet DSCC nursing agency requirements-DSCC Home Care Manual, 53.09	**DRS** The amount, duration, and scope of services is based on the determination of need assessment conducted by the case manager and the service cost maximum determined by the DON score **DSCC** Respite care services will be limited to a maximum of 14 days or 336 hour annual limit. Exceptions may be made on an individual basis based on extraordinary circumstances.
Nurse Training					x		This service provides child specific training for nurses, under an approved nursing agency, in the use of new or unique prescribed equipment, or special care needs of the child.	DSCC Nursing agency requirements-DSCC Home Care Manual, 53.09.	This service cannot exceed the maximum of four hours per nurse, per HCBS Waiver year.

Service	DoA	DHS-DRS			DSCC	HFS			
	Persons who are Elderly	**Persons with Disabilities**	**Persons with HIV/AIDS**	**Persons with Brain Injury**	**Children who are Medically Fragile, Technology Dependent**	**Supportive Living Facility**	**Definition**	**Standards**	**HFS Fee-For-Service Service Limits**
Family Training					x		Training for the families of Enrollees served on this HCBS Waiver. Training includes instruction about treatment regimens and use of equipment specified in the Enrollee Care Plan and shall include updates as necessary to safely maintain the Enrollee at home. It may also include training such as Cardiopulmonary Resuscitation (CPR).	Nursing Agency: Meet DSCC nursing agency requirements-DSCC Home Care Manual, 53.09 Service Agency: Qualify to provide the service.	All Family Training must be included in the Enrollee Care Plan.
Specialized Medical Equipment and Supplies		x	x	x	x		Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the Enrollee Care Plan, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. All items shall meet applicable standards of manufacture, design and installation.	**DRS:** 68 Il. Adm. Code 1253 Pharmacies 225.ILCS.85 Medical Supplies 225.ILCS.51 **DSCC:** 225.ILCS.51 If not licensed under 225 ILCS 51, must be accredited by the Joint Commission on Accreditation of Healthcare Organizations, or other accrediting organization. Meet DSCC Home Medical Equipment requirements for the HCBS Waiver. A Medicaid enrolled pharmacy or durable medical equipment provider that provides items not available from a DSCC approved home medical equipment (HME) provider,(such as special formula).	Items reimbursed with HCBS Waiver funds shall be in addition to any medical equipment and supplies furnished under the State Plan and shall exclude those items, which are not of direct medical or remedial benefit to the individual. **DSCC:** Medical supplies, equipment and appliances are provided only on the prescription of the PCP as specified in the Enrollee Care Plan.

Service	DoA	DHS-DRS			DSCC	HFS			
	Persons who are Elderly	**Persons with Disabilities**	**Persons with HIV/AIDS**	**Persons with Brain Injury**	**Children who are Medically Fragile, Technology Dependent**	**Supportive Living Facility**	**Definition**	**Standards**	**HFS Fee-For-Service Service Limits**
Behavioral Services (M.A. and PH.D)				x			Behavioral Services provide remedial therapies to decrease maladaptive behaviors and/or to enhance the cognitive functioning of the recipient. These services are designed to assist Enrollees in managing their behavior and cognitive functioning and to enhance their capacity for independent living.	Speech Therapist 225 ILCS 110/ Social Worker 225 ILCS 20/ Clinical Psychologist 225 ILCS 15/ Licensed Counselor 225 ILCS 107/ 89 IL Admin Code 686.1100	The amount, duration, and scope of services are based on the determination of need assessment conducted by the case manager and the service cost maximum determined by the DON score. The services are based on a clinical recommendation and are not covered under the State Plan.
Assisted Living						x	The Supportive Living Program serves as an alternative to Nursing Facility (NF) placement, providing an option for seniors 65 years of age or older and persons with physical disabilities between 22 and 64 years of age who require assistance with activities of daily living, but not the full medical model available through a nursing facility. Enrollees reside in their own private apartment with kitchen or kitchenette, private bath, individual heating and cooling system and lockable entrance. Supportive Living Facilities (SLFs) are required to meet the scheduled and unscheduled needs of Residents 24 hours a day	Supportive Living Facilities 89 Il. Adm.Code 146 SupPart B	SLFs are reimbursed through a global rate which includes the following Covered Services: • Nursing Services • Personal Care • Medication administration, oversight and assistance in self-administration • Laundry • Housekeeping • Maintenance • Social and recreational programming • Ancillary Services • 24 Hour Response/Security staff • Health Promotion and Exercise • Emergency call System • Daily Checks • Quality Assurance Plan • Management of Resident Funds, if applicable

Attachment III
Service Package III Covered Services

Service	DHS-DDD			Definition	Standards	Service Limits
	Adults with DD	Children's Residential	Children's Support			
Adult Day Service	x			Adult day service is the direct care and supervision of adults aged 60 and over in a community-based setting for the purpose of providing personal attention; and promoting social, physical and emotional well-being in a structured setting. Transportation is included in the rate for ADS under DD.	**DD:** 59 Il.Adm.Code 120.70 Contract with DoA, Contract requirements, **DD Waiver Manual**	**DD** For Enrollees who chose home-based supports, this service is included in the Enrollee's monthly cost limit. The annual rate is spread over a State Fiscal Year maximum of 1,100 hours for any combination of day programs.
Service Facilitation	X (HBS only)		x	Service Facilitation includes services that assist Enrollees in gaining access to needed HCBS Waiver and other State Plan services, as well as medical, social, educational and other services, regardless of the funding source for the services. Responsibilities include assisting the Enrollee and/or guardian in convening a support planning team, choosing services and service Providers to meet the Enrollee's needs, and ensuring Enrollee's health and welfare through ongoing monitoring of the provision of services.	Entity under contract with the Operating Agency that does not also provide Individual Service and Support Advocacy. Services must be provided personally by a professional defined in federal regulations as a Qualified Mental Retardation Professional. 59 Il.Adm.Code 120.70 DD Waiver Manual	This service will not be duplicative of other services in the HCBS Waiver. For example, case management/care coordination services are a component of residential services. This service is included in the Enrollee's monthly cost limit. No specific service maximum. The support plan/Service Agreement must set aside at least two hours per month to allow for routine required administrative activities.

Service	DHS-DDD			Definition	Standards	Service Limits
	Adults with DD	**Children's Residential**	**Children's Support**			
Environmental Accessibility Adaptations-Home	X (HBS only)		x	Those physical adaptations to the home, required by the Enrollee Care Plan, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require Institutionalization. Excluded are those adaptations or improvements to the home that are of general utility and are not of direct remedial benefit to the Enrollee.	**DD:** 59 Il.Adm.Code 120.70 Independent contractor -Enrolled vendor approved by the Service Facilitator and Enrollee/ guardian Construction companies-Enrolled vendor approved by the Service Facilitator and Enrollee/ guardian. DD Waiver Manual	**DD** This service is subject to pre-authorization by the Operating Agency.
Environmental Accessibility Adaptations-Vehicle	x (HBS only)		x	Vehicle Modifications are adaptations or alterations to an automobile or van that is the Enrollee's primary means of transportation in order to accommodate the special needs of the Enrollee. Vehicle adaptations are specified by the support plan as necessary to enable the Enrollee to integrate more fully into the community and to ensure the health, welfare and safety of the Enrollee. The vehicle that is adapted must be owned by the Enrollee, a family member with whom the Enrollee lives or has consistent and on-going contact, or a non-relative who provides primary long-term support to the Enrollee and is not a paid provider of such services.	59 Il.Adm.Code 120.70 DD Waiver Manual	This service will not be duplicative of other services in the HCBS Waiver. This service requires pre-authorization by the Operating Agency.The following are specifically excluded:1. Adaptations or improvements to the vehicle that are of general utility, and are not of direct remedial benefit to the Enrollee;2. Purchase or lease of a vehicle; 3. Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.

Service	DHS-DDD			Definition	Standards	Service Limits
	Adults with DD	Children's Residential	Children's Support			
Supported Employment	x			Supported employment services consist of intensive, ongoing supports that enable Enrollees, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need supports, to perform in a regular work setting. It may include assisting the Enrollee to locate a job or develop a job on behalf of the Enrollee, and is conducted in a variety of settings; including work sites where persons without disabilities are employed.	**DD:** 59 Il.Adm.Code 120.70 DD Waiver Manual	**DD** For Enrollees who chose home-based supports, this service is included in the Enrollee's monthly cost limit. Services are subject to pre-authorization.
Nursing,Skilled (RN and LPN)	x (HBS only)			Service provided by an individual that meets Illinois licensure standards for nursing services and provides shift nursing services.	**DD:** Registered Nurse or Licensed Practical Nurse, under supervision by a registered nurse: 225 ILCS 65 68 Il.Adm.Code 1300 59 Il.Adm.Code 120.70 DD Waiver Manual	**DD**There is a State Fiscal Year maximum of 365 hours of service by a registered nurse and 365 hours of service by a licensed practical nurse.For Enrollees who chose home-based supports, this service is included in the Enrollee's monthly cost limit.
Occupational Therapy	x			Service provided by a licensed occupational therapist that meets Illinois standards. Services are in addition to any Medicaid State Plan services for which the Enrollee may qualify. Occupational therapy through the HCBS Waiver focuses on long term habilitative needs rather than short-term acute restorative needs	**DD:** Occupational Therapist may directly supervise a Certified Occupational Therapist Assistant 225 ILCS 75 68 Il.Adm.Code 1315 59 Il.Adm.Code 120.70 DD Waiver Manual	**DD** This service is included in the Enrollee's monthly cost limit for home-based supports. Services are subject to pre-authorization by the Operating Agency.

Service	DHS-DDD			Definition	Standards	Service Limits
	Adults with DD	Children's Residential	Children's Support			
Physical Therapy	x			Service provided by a licensed physical therapist that meets Illinois standards. Services are in addition to any Medicaid State Plan services for which the Enrollee may qualify. Physical Therapy through the HCBS Waiver focuses on long term habilitative needs rather than short-term acute restorative needs.	**DD:** Physical Therapist may directly supervise a certified physical therapist assistant. 225 ILCS 90 68 Il.Adm.Code 1340 59 Il.Adm.Code 120.70 DD Waiver Manual	**DD** This service is included in the Enrollee's monthly cost limit for home-based supports. Services are subject to pre-authorization by the Operating Agency.
Speech Therapy	x			Service provided by a licensed speech therapist that meets Illinois standards. Services are in addition to any Medicaid State Plan services for which the Enrollee may qualify. Speech Therapy through the HCBS Waiver focuses on long term habilitation needs rather than short-term acute restorative needs.	**DD:** Speech/Language Pathologist 225 ILCS 110 68 Il.Adm.Code 1465 59 Il.Adm.Code 120.70 DD Wiaver Manual	**DD**This service is included in the Enrollee's monthly cost limit for home-based supports. Services are subject to pre-authorization by the Operating Agency.

Service	DHS-DDD			Definition	Standards	Service Limits
	Adults with DD	Children's Residential	Children's Support			
Habilitation - Residential	x			Residential habilitation means individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community in the most integrated setting appropriate to the individual's needs. It includes case management, adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill development, personal support, protective oversight and supervision, and reduction of maladaptive behaviors through positive supports and other methods. It may also include necessary nursing assessment, direction and monitoring by a registered professional nurse (RN), and support services and assistance by an RN or a licensed practical nurse (LPN) to ensure the Enrollee's health and welfare. These include monitoring of health status, medication monitoring, administration of injections or suctioning, administration and/or oversight of the administration of oral and topical medications as appropriate under Illinois law.	59 Il.Adm.Code 115 (DD Comm. Integrated Living Arrangements CILA) 77 Adm. Code 370 (Community Living Facilities - CLF) 59 Il.Adm.Code 50 (DHS OIG) 59 Il.Adm.Code 120.70 (DD Waiver rule) 59 Il.Adm.Code 116 (Med. Administration) Contract requirements DD Waiver Manual	This service will not be duplicative of other services in the HCBS Waiver. Residential Habilitation services are available to Enrollees who request this service, require this intensity of service and meet the priority population criteria for residential services. Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement, other than such costs for modification or adaptations to a facility required to assure the health and safety of Residents, or to meet the requirements of the applicable life safety code. Payment is not made, directly or indirectly, to members of the Enrollee's immediate family. Nursing supports are part-time and limited; 24-hour nursing supports are not available to Enrollees in the HCBS Waiver.

Service	DHS-DDD			Definition	Standards	Service Limits
	Adults with DD	Children's Residential	Children's Support			
Child Group Home (Residential Habilitation)		x		Residential habilitation means case management and individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, and social and leisure skill development that assist the Enrollee to reside in the most integrated setting appropriate to his/her needs. Residential habilitation also includes Personal Care and protective oversight and supervision.	59 Il.Adm.Code 120.70 Unusual Incidents 89 Il.Adm.Code 331 Behavior Treatment Contract Requirements 89 Il.Adm.Code 384 Child Welfare Agencies 89 Il.Adm.Code 401 Group Homes 89 Il.Adm.Code 403 DD Waiver Manual	Services are available to Enrollees who request this service and meet the priority population criteria for residential services. Payment is not made for the cost of room and board. Payment is not made, directly or indirectly, to members of the Enrollee's immediate family.
Habilitation-Day	x			**DD** Assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that takes place in a non-residential setting, separate from the Enrollee's private residence or other residential living arrangement. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. Services are furnished four or more hours per day on a regularly scheduled basis for one or more days per week or as specified in the Enrollee's support plan.	**DD** Community-Based Agencies: 59 Il.Adm.Code 119 (Developmental Training); 59 Il. Adm. Code 50 (DHS-OIG) 59 Il.Adm.Code 120.70 (DD Waiver Rule) Contract requirements Special Recreation Associations 59 Il.Adm.Code 119 59 Il.Adm.Code 50 59 Il.Adm.Code 120 Contract requirements DD Waiver Manual	**DD** The annual rate is spread over a State Fiscal Year maximum of 1,100 hours for any combination of day programs. Monthly payment is limited to a maximum of 115 hours for any combination of day programs. Day Habilitation does not include special education and related services which otherwise are available to the Enrollee through a local education agency or vocational Rehabilitation services which otherwise are available to the Enrollee through a program funded under Section 110 of the Rehabilitation Act of 1973.

Service	DHS-DDD			Definition	Standards	Service Limits
	Adults with DD	**Children's Residential**	**Children's Support**			
Personal Support	x (HBS only)		x	Personal Support includes: Teaching adaptive skills, personal assistance in activities of daily living (ADLs), and Respite services provided on a short-term basis.Personal Support may be provided in the Enrollee's home and may include supports necessary to participate in other community activities outside the home. The need for Personal Support and the scope of the needed services must be documented in the Enrollee Care Plan. The amount of Personal Support must be specified in the support plan/Service Agreement.	**Personal Support Worker:** 18+ and is deemed by the Enrollee / guardian to be qualified and competent. If hired on or after July 1, 2007, must have passed criminal background and Health Care Worker Registry (HCWR) checks prior to employment.**Community-Based Agencies and Special Recreation Associations:** The Agency must be under contract with the Operating Agency. Employees must complete training, pass training assessments and be certified.All employees must have passed criminal background and HCWR checks prior to employment. 59 Il.Adm.Code 120.70 **DD Waiver Manual**	Personal Support will not be duplicative of other services in the HCBS Waiver.For Enrollees who chose home-based supports, this service is included in the Enrollee's monthly cost limit. For Enrollees still enrolled in school, no Personal Support services may be delivered during the typical school day relative to the age of the Enrollee or during times when educational services are being provided.
Personal Emergency Response System (PERS)	x (HBS only)			PERS is an electronic device that enables certain individuals at high risk of Institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. Trained professionals staff the response center.	**DD:** Vendor certified by the DoA to provide this service or approved by the Department of Human Services with a current written rate agreement. **DD Waiver Manual**	PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

Service	DHS-DDD			Definition	Standards	Service Limits
	Adults with DD	Children's Residential	Children's Support			
Assistive Technology	x	x	x	Assistive technology device means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of Enrollees. Assistive technology service means a service that directly assists an Enrollee in the selection, acquisition, or use of an assistive technology device. All items shall meet applicable standards of manufacture, design and installation. All purchased items shall be the property of the Enrollee or the Enrollee's family.	Equipment vendor - Enrolled vendor approved by the Service Facilitator and Enrollee/guardian 59 Il.Adm.Code 120.70	Items reimbursed with HCBS Waiver funds do not include any assistive technology furnished by the Medicaid State Plan and exclude those items that are not of direct remedial benefit to the Enrollee. This service is subject to pre-authorization by the Operating Agency.

Service	DHS-DDD			Definition	Standards	Service Limits
	Adults with DD	Children's Residential	Children's Support			
Adaptive Equipment	x	x	x	Adaptive equipment, as specified in the Enrollee Care Plan, includes devices, controls, or appliances that enable Enrollees to increase their ability to perform activities of daily living or perceive and interact with the environment in which they live.; It also includes such other durable equipment not available under the State Plan that is necessary to address Enrollee's functional limitations; and necessary initial training from the vendor to use the adaptive equipment. All items shall meet applicable standards of manufacture, design and installation. All purchased items shall be the property of the Enrollee or the Enrollee's family.	Equipment vendors - Enrolled vendor approved by the Service Facilitator and Enrollee/guardian 59 Il.Adm.Code 120.70 DD Waiver Manual	Items reimbursed with HCBS Waiver funds do not include any medical equipment and supplies furnished under the State Plan and exclude those items that are not of direct remedial benefit to the Enrollee.This service is subject to pre-authorization by the Operating Agency.
Transportation - Non-Medical	x (HBS only)			Non-Medical Transportation is a service offered in order to enable Enrollees served under the HCBS Waiver to gain access to HCBS Waiver and other community services, activities and resources, as specified by the support plan. Transportation services under the HCBS Waiver are offered in accordance with the Enrollee's support plan. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge are utilized.	Drivers must have appropriate State licenses and proof of insurance 59 Il.Adm.Code 120.70 DD Waiver Manual	For Enrollees who choose home-based supports, this service is included in the Enrollee's monthly cost limit. This service will not be duplicative of other HCBS Waiver services. No more than $500 of the monthly cost limit may be used for non-medical transportation services. Excluded is transportation to and from covered Medicaid State Plan services and transportation to and from day program services.

Service	DHS-DDD			Definition	Standards	Service Limits
	Adults with DD	Children's Residential	Children's Support			
Behavior Intervention and Treatment	x	x	x	Behavior intervention and treatment includes a variety of individualized, behaviorally based treatment models consistent with best practice and research on effectiveness that are directly related to the Enrollee's therapeutic goals. These services are designed to assist Enrollees to develop or enhance skills with social value, lessen behavioral excesses and improve communication skills. The strategies are a component of the Enrollee Care Plan and must be approved by the planning team. Services are provided by professionals working closely with the Enrollee's direct support staff and unpaid informal caregivers in the Enrollee's home and other natural environments.	59 Il.Adm.Code 120.70 Behavior Consultant 225 ILCS 15/1 et seq 68 Ill. Adm. Code 1400 Clinical psychologist - Services are supervised by a professional. Services are typically provided by a team of professionals. Masters level - professional who is certified as a Behavior Analyst by the Behavior Analyst Certification Board. Bachelor's level - professional who is certified as an Associate Behavior Analyst. Professional who is certified to provide Relationship Development Assessment. Professional with a Bachelor's Degree and who has completed at least 1,500 hours or training or supervised experience in the application of behaviorally-based therapy models consistent with best practice and research on individuals with Autism Spectrum Disorder. DD Waiver Manual	For Enrollees who choose home-based supports, this service is included in the Enrollee's monthly cost limit. There is a State Fiscal Year maximum of 66 hours.

Service	DHS-DDD			Definition	Standards	Service Limits
	Adults with DD	Children's Residential	Children's Support			
Behavior Services (Counseling and Therapy)	x			Psychotherapy is a treatment approach that focuses on a goal of ameliorating or reducing the symptoms of emotional, cognitive or behavioral disorder and promoting positive emotional, cognitive and behavioral development. Counseling is a treatment approach that uses relationship skills to promote the Enrollee's abilities to deal with daily living issues associated with their cognitive or behavioral problems using a variety of supportive and re-educative techniques.	59 Il.Adm.Code 120.70 Licensed Psychotherapists - 225 ILCS 15/1 et seq 68 Ill. Adm. Code 1400 225 ILCS 20/1 et seq. 68 Ill. Adm. Code 1470 Clinical Social Work 225 ILCS 55/1 et seq. 68 Ill. Adm. Code 1283 Marriage & Family Therapy 225 ILCS 107/1 et seq. Licensed Counselors - All licensure categories for psychotherapists, plus Clinical Social Worker and Counselor 225 ILCS 107/1 et seq. 68 Ill. Adm. Code 1375 DD Waiver Manual	For Enrollees who choose home-based supports, this service is included in the Enrollee's monthly cost limit. There is a State Fiscal Year maximum of 60 hours for any combination of psychotherapy and counseling services.

Service	DHS-DDD			Definition	Standards	Service Limits
	Adults with DD	Children's Residential	Children's Support			
Crisis Services	x			Crisis Services are provided on an emergency temporary basis because of the absence or incapacity of the persons who normally provide unpaid care. Absence or incapacity of the primary caregiver(s) must be due to a temporary cause. The definition of Crisis Services includes the same activities, requirements and responsibilities as Personal Support. The Enrollee, legal representative, the service Provider and the support planning team may set mutually acceptable rates for Crisis Services.	Standards are the same as for Personal Support services. 59 Il.Adm.Code 120.70 DD Waiver Manual	Crisis Services are not available for caregiver absences for vacations, educational or employment-related reasons, or other non-emergency reasons. The rates must be specified in the Service Agreements and are subject to review and approval by the Operating Agency on either a targeted or a random sample basis. The service is also subject to pre-authorization by the Operating Agency. This service will not be duplicative of other services in the HCBS Waiver. Crisis Services may not exceed $2,000 in any single month and may not be authorized for more than two consecutive months or 60 consecutive days. No Crisis Services may be delivered during the typical school day relative to the age of the Enrollee or during times when educational services are being provided.

Service	DHS-DDD			Definition	Standards	Service Limits
	Adults with DD	Children's Residential	Children's Support			
Training and Counseling for Unpaid Caregivers	x		x	Training and counseling services for individuals who provide unpaid support, training, companionship or supervision to Enrollees. All training for individuals who provide unpaid support to the Enrollee must be included in the Enrollee Care Plan. Training furnished to individuals who provide uncompensated care and support to the Enrollee must be directly related to their role in supporting the Enrollee in areas specified in the support plan. Counseling similarly must be aimed at assisting unpaid individuals who support the Enrollee to understand and address Enrollee's needs.	59 Il.Adm.Code 120.70 Clinical Psychologist 225 ILCS 15/1 et seq 68 Il.Adm.Code 1400 Clinical Social Work 225 ILCS 20/1 et seq. 68 Il.Adm.Code 1470 Marriage & Family Therapy. 225 ILCS 55/1 et seq. 68 Il.Adm.Code 1283 Counselor 225 ILCS 107/1 et seq. 68 Il.Adm.Code 1375 Specialized Training Providers - Training programs, workshops or events deemed qualified by the Enrollee/guardian and approved by the Service Facilitator. Examples include CPR instruction, first aid, and programs on disability-specific topics such as epilepsy, autism, etc.	This service will not be duplicative of other services in the HCBS Waiver. For Enrollees who choose home-based supports, this service is included in the Enrollee's monthly cost limit. This service may not be provided in order to train paid caregivers or school personnel. Caregivers who are compensated for direct services under this HCBS Waiver may not receive services under this service title.

Attachment IV
RATE SHEET

The rates in this Attachment are valid for the Potential Enrollees described below residing in the geographic area described below for the dates listed:

Geographic Areas	DuPage, Kankakee, Kane, Lake, Will and suburban Cook counties
Potential Enrollees	Aged, Blind and Disabled (AABD- Categories 01/91, 02/92, and 03/93 respectively) except: • Children under 19 years of age; • Participants eligible for Medicare Part A or enrolled in Medicare Part B; • Participants who are American Indian/Alaskan Natives; • Participants with Spend-down; • All Presumptive Eligibility categories; • Participants in the Illinois Breast and Cervical Cancer program; and, • Participants with Comprehensive Third Party Insurance.
Effective Period for Rates	May 1, 2011 through April 30, 2012

Rate Cell	Rate	Administrative Allowance (included in the Rate)
ICF/MR SOF	$269.13	$38.72
ICF/MR Other	$875.54	$73.37
Nursing Facility	$2,126.65	$159.01
HCBS DD Waiver	$741.85	$65.73
HCBS Other Waivers	$1,704.16	$134.87
Community Residents	$971.35	$78.85

Capitation rates listed are 100% of actuarially certified rates, but only a percentage may be paid in accordance with Section 7.10.1.

Attachment V

STATE OF ILLINOIS DRUG-FREE WORKPLACE CERTIFICATION

Contractor certifies that it will not engage in the unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance in the performance of the Agreement.

This business or corporation has twenty-five (25) or more employees, and Contractor certifies and agrees that it will provide a drug free workplace by:

A) Publishing a statement:
   1) Notifying employees that the unlawful manufacture, distribution, dispensation, possession or use of a controlled substance, including cannabis, is prohibited in the grantee's or contractor's workplace.
   2) Specifying the actions that will be taken against employees for violations of such prohibition.
   3) Notifying the employees that, as a condition of employment on such contract, the employee will:
      a) abide by the terms of the statement; and
      b) notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five (5) days after such conviction.

B) Establishing a drug free awareness program to inform employees about:
   1) the dangers of drug abuse in the workplace;
   2) Contractor's policy of maintaining a drug free workplace:
   3) any available drug counseling, rehabilitation, and employee assistance programs; and
   4) the penalties that may be imposed upon an employee for drug violations.

C) Providing a copy of the statement required by subparagraph (a) to each employee engaged in the performance of the contract or grant and to post the statement in a prominent place in the workplace.

D) Notifying the contracting or granting agency within ten (10) days after receiving notice under part (B) or paragraph (3) of subsection (a) above from an employee or otherwise receiving actual notice of such conviction.

E) Imposing a sanction on, or requiring the satisfactory participation in a drug abuse assistance or rehabilitation program by, any employee who is so convicted, as required by section 5 of the Drug Free Workplace Act, 1992 Illinois Compiled Statute, 30 ILCS 580/5.

F) Assisting employees in selecting a course of action in the event drug counseling, treatment, and rehabilitation is required and indicating that a trained referral team is in place.

G) Making a good faith effort to continue to maintain a drug free workplace through implementation of the Drug Free Workplace Act, 1992 Illinois Compiled Statute, 30 ILCS 580/1 *et seq*.

THE UNDERSIGNED AFFIRMS, UNDER PENALTIES OF PERJURY, THAT HE OR SHE IS AUTHORIZED TO EXECUTE THIS CERTIFICATION ON BEHALF OF ILLINICARE HEALTH PLAN, INC..

_____	2010-24-005-K
Signature of Authorized Representative	Contract ID Number
_____	_____
Printed Name and Title	Date

Attachment VI

HIPAA Compliance Obligations

A. Definitions.

1. "Designated Record Set" shall have the same meaning as the term "designated record set" in 45 C.F.R. section 164.501.
2. "Individual" shall have the same meaning as the term "individual" in 45 C.F.R. section 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. section 164.502(g).
3. "PHI" means Protected Health Information, which shall have the same meaning as the term "protected health information" in 45 C.F.R. section 164.501, limited to the information created or received by Vendor from or on behalf of the Agency.
4. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Part 160 and 45 C.F.R. Part 164 subparts A and E.
5. "Required by law" shall have the same meaning as the term "required by law" in 45 C.F.R. section 164.501.
6. "Vendor" means Contractor.

B. Vendor's Permitted Uses and Disclosures.

1. Except as otherwise limited by this Contract, Vendor may use or disclose PHI to perform functions, activities, or services for, or on behalf of, the Agency as specified in this Contract, provided that such use or disclosure would not violate the Privacy Rule if done by the Agency.
2. Except as otherwise limited by this Contract, Vendor may use PHI for the proper management and administration of Vendor or to carry out the legal responsibilities of Vendor.
3. Except as otherwise limited by this Contract, Vendor may disclose PHI for the proper management and administration of Vendor, provided that the disclosures are required by law, or Vendor obtains reasonable assurances from the person to whom the PHI is disclosed that the PHI will remain confidential and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person. Vendor shall require the person to whom the PHI was disclosed to notify Vendor of any instances of which the person is aware in which the confidentiality of the PHI has been breached.
4. Except as otherwise limited by this Contract, Vendor may use PHI to provide data aggregation services to the Agency as permitted by 45 C.F.R. section 164.504(e)(2)(i)(B).
5. Vendor may use PHI to report violations of law to appropriate federal and state authorities, consistent with 45 C.F.R. section 164.502(j)(1).

C. Limitations on Vendor's Uses and Disclosures. Vendor shall:

1. Not use or further disclose PHI other than as permitted or required by the Contract or as required by law;
2. Use appropriate safeguards to prevent use or disclosure of PHI other than as provided for by this Contract;
3. Mitigate, to the extent practicable, any harmful effect that is known to Vendor of a use or disclosure of PHI by Vendor in violation of the requirements of this Contract;
4. Report to the Agency any use or disclosure of PHI not provided for by this Contract of which Vendor becomes aware;
5. Ensure that any agents, including a subcontractor, to whom Vendor provides PHI received from the Agency or created or received by Vendor on behalf of the Agency, agree to the same restrictions and conditions that apply through this Contract to Vendor with respect to such information;
6. Provide access to PHI in a Designated Record Set to the Agency or to another individual whom the Agency names, in order to meet the requirements of 45 C.F.R. section 164.524, at the Agency's request, and in the time and manner specified by the Agency;
7. Make available PHI in a Designated Record Set for amendment and to incorporate any amendments to PHI in a Designated Record Set that the Agency directs or that Vendor agrees to pursuant to 45 C.F.R. section 164.526 at the request of the Agency or an individual, and in a time and manner specified by the Agency;

8. Make Vendor's internal practices, books, and records, including policies and procedures and PHI, relating to the use and disclosure of PHI received from the Agency or created or received by Vendor on behalf of the Agency available to the Agency and to the Secretary of Health and Human Services for purposes of determining the Agency's compliance with the Privacy Rule;
9. Document disclosures of PHI and information related to disclosures of PHI as would be required for the Agency to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. section 164.528;
10. Provide to the Agency or to an individual, in a time and manner specified by the Agency, information collected in accordance with the terms of this Contract to permit the Agency to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. section 164.528;
11. Return or destroy all PHI received from the Agency or created or received by Vendor on behalf of the Agency that Vendor still maintains in any form, and to retain no copies of such PHI, upon termination of this Contract for any reason. If such return or destruction is not feasible, Vendor shall provide the Agency with notice of such purposes that make return or destruction infeasible, and upon the parties' written agreement that return or destruction is infeasible, Vendor shall extend the protections of the Contract to the PHI and limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible. This provision shall apply equally to PHI that is in the possession of Vendor and to PHI that is in the possession of subcontractor or agents of Vendor.

D. **Agency Obligations.** The Agency shall:

1. Provide Vendor with the Agency's Notice of Privacy Practices and notify Vendor of any changes to said Notice;
2. Notify Vendor of any changes in or revocation of permission by an individual to use or disclose PHI, to the extent that such changes may affect Vendor's permitted or required uses and disclosures of PHI;
3. Notify Vendor of any restriction to the use or disclosure of PHI that the Agency had agreed to in accordance with 45 C.F.R. section 164.522, to the extent that such restriction may affect Vendor's use or disclosure of PHI;
4. Not request that Vendor use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by the Agency.

E. Breach Requirements.

1. Sections 164.308, 164.310, 164.312 and 164.316 of title 45, Code of Federal Regulations, apply to the Vendor in the same manner that such sections apply to the Agency. The Vendor's obligations include but are not limited to the following:
   a. Implementing administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic Protected Health Information that the Vendor creates, receives, maintains, or transmits on behalf of the covered entity as required by HIPAA;
   b. Ensuring that any agent, including a sub Vendor, to whom the Vendor provides such information ,agrees to implement reasonable and appropriate safeguards to protect the data; and
   c. Reporting to the Agency any security incident of which it becomes aware.
2. Privacy Obligations. To comply with the privacy obligations imposed by HIPAA, Vendor agrees to:
   a. Abide by any Individual's request to restrict the disclosure of Protected Health Information consistent with the requirements of Section 13405(a) of the HITECH Act;
   b. Use appropriate safeguards to prevent use or disclosure of the information other than as provided for by the Underlying Agreement and this Addendum;
   c. Report to the Agency any use or disclosure of the information not provided for by the Underlying Agreement of which the Vendors becomes aware;
   d. Ensure that any agents, including a sub Vendor, to whom the Vendor provides Protected Health Information received from the Agency or created or received by the Vendor on behalf of the Agency, agrees to the same restrictions and conditions that apply to the Vendor with respect to such information;

e. Make available to the Agency within ten (10) calendar days Protected Health Information to comply with an Individual's right of access to their Protected Health Information in compliance with 45 C.F.R. § 164.524 and Section 13405(f) of the HITECH Act;

f. Make available to the Agency within fifteen (15) calendar days Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with 45 C.F.R. § 164.526;

g. Make available to the Agency within fifteen (15) calendar days the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528 and Section 13405(c) of the HITECH Act;

h. To the extent practicable, mitigate any harmful effects that are known to the Vendor of a use or disclosure of Protected Health Information or a Breach of Unsecured Protected Health Information in violation of this Addendum;

i. Use and disclose an Individual's Protected Health Information only if such use or disclosure is in compliance with each and every applicable requirement of 45 C.F.R. § 164.504(e);

j. Refrain from exchanging any Protected Health Information with any entity of which the Vendor knows of a pattern of activity or practice that constitutes a material breach or violation of HIPAA;

k. To comply with Section 13405(b) of the HITECH Act when using, disclosing, or requesting Protected Health Information in relation to this Addendum by limiting disclosures as required by HIPAA.

3. Breach Notification. In the event that the Vendor discovers a Breach of Unsecured Protected Health Information, the Vendor agrees to take the following measures within 10 calendar days after the Vendor first becomes aware of the incident:

   a. To notify the Agency of any incident involving the acquisition, access, use or disclosure of Unsecured Protected Health Information in a manner not permitted under 45 C.F.R. parts D and E. Such notice by the Vendor shall be provided after the Vendor first becomes aware of the incident, except where a law enforcement official determines that a notification would impede a criminal investigation or cause damage to national security. For purposes of clarity for this provision, Vendor must notify the Agency of any such incident within the above timeframe even if Vendor has not conclusively determined within that time that the incident constitutes a Breach as defined by HIPAA. The Vendor is deemed to have become aware of the Breach as of the first day on which such Breach is known or reasonably should have been known to such entity or associate of the Vendor, including any person other than the individual committing the Breach, that is an employee, officer or other agent of the Vendor or an associate of the Vendor;

   b. To include the names of the Individuals whose Unsecured Protected Health Information has been, or is reasonably believed to have been, the subject of a Breach;

   c. To complete and submit the Breach Notice form to the Agency (see Exhibit A); and

   d. To include for the Agency a sample copy of the notice that was used to inform individuals about the breach.

4. Notification Duty. It is Vendors duty to provide the Breach notification to the affected individuals unless Agency agrees to provide the Breach notification.

5. Costs. Vendor assumes all costs for providing Breach notification unless Agency agrees to assume any costs.

6. Indemnification for Breach Notification. Vendor shall indemnify the Agency for costs associated with any incident involving the acquisition, access, use or disclosure of Unsecured Protected Health Information in a manner not permitted under 45 C.F.R. parts D and E.

7. Security Rule Compliance. Vendor shall comply with the Security Rule's administrative, physical and technical safeguard requirements. As part of compliance with the Security Rule, Vendor shall develop and implement written security policies and procedures with respect to the electronic PHI they handle. By signing this Amendment, the Vendor assures and acknowledges compliance with the requirements of HITECH including meeting the administrative, physical and technical safeguard requirements of the HIPAA Security Rule. (45 C.F.R. Part 160, 162, 164.) Vendor also assures and acknowledges that the

electronic PHI they transmit is encrypted and that it will adopt internal procedures for reporting breaches and mitigating potential damages.

F. **Interpretation.** Any ambiguity in this Contract shall be resolved in favor of a meaning that permits the Agency to comply with the Privacy Rule.

EXHIBIT A
NOTIFICATION TO THE AGENCY OF BREACH OF
UNSECURED PROTECTED HEALTH INFORMATION

Vendor must complete this form to notify HFS pursuant to the Contract for any Breach of Unsecured Protected Health Information. In accordance with the Contract, notice must occur immediately or within ten (10) days after the breach (as clarified in Section 3a of Attachment VI, "HIPAA Compliance Obligations") being discovered.

Notice shall be provided to:

(1) Contract Administrator Michelle Maher, in compliance with the Notice Requirements of the Underlying Agreement, at:

Illinois Department of Healthcare and Family Services
Attn: Michelle Maher
Bloom Building, 3rd Floor
201 South Grand Avenue East
Springfield, Illinois 62763

(2) HFS Privacy Officer, in compliance with the Notice Requirements of the Underlying Agreement at:

Illinois Department of Healthcare and Family Services
Attn: Privacy Officer
Bloom Building, 3rd Floor
201 South Grand Avenue East
Springfield, Illinois 62763

Information to be Submitted by Vendor:

Contract Information:
Contract Number:
Contract Title:
Contact Person for this Incident:
Contact Person's Title:
Contact's Address:
Contact's E-mail:
Contact's Telephone No.:

NOTIFICATON:
Vendor hereby notifies the Agency that there has been a Breach of Unsecured Protected Health Information that Vendor has used or has had access to under the terms of the Contract, as described in detail below:

Date of Discovery of Breach:
Detailed Description of the Breach:

Types of Unsecured Protected Health Information involved in the Breach (such as full name, SSN, Date of Birth, Address, Account Number, Disability Code, etc – List All).
What steps are being/have been taken to investigate the breach, mitigate losses, and protect against any further breaches?
Number of Individuals Impacted. If over 500, identify whether individuals live in multiple states.

Submitted by:
Signature: _____ **Date:** _____

Printed Name and Title: _____

Attachment VII

BEP Utilization Plan

Attachment VIII

Taxpayer Identification Number

I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and

2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and

3. I am a U.S. Person (including a U.S. resident alien).

   - *If you are an individual, enter your name and SSN as it appears on your Social Security Card.*
   - *If you are a sole proprietor, enter the owner's name on the name line followed by the name of the business and the owner's SSN or EIN.*
   - *If you are a single-member LLC that is disregarded as an entity separate from its owner, enter the owner's name on the name line and the d/b/a on the business name line and enter the owner's SSN or EIN.*
   - *If the LLC is a corporation or partnership, enter the entity's business name and EIN and for corporations, attach IRS acceptance letter (CP261 or CP277).*
   - *For all other entities, enter the name of the entity as used to apply for the entity's EIN and the EIN.*

Name: _____

Business Name: _____

Taxpayer Identification Number:
Social Security Number _____
or
Employer Identification Number _____

Legal Status (*check one*):

☐ Individual ☐ Governmental

☐ Sole Proprietor ☐ Nonresident alien

☐ Partnership ☐ Estate or trust

☐ Legal Services Corporation ☐ Pharmacy (Non-Corp.)

☐ Tax-exempt ☐Pharmacy/Funeral Home/Cemetery(Corp.)

☐Corporation providing or billing medical and/or health care services (select applicable tax classification)

☐Corporation NOT providing or billing medical and/or health care services

☐ D = disregarded entity
☐ C = corporation
☐ Limited Liability Company
☐ P = partnership

Signature: _____D**ate:** _____

Attachment IX

Disclosures and Conflicts of Interest

Instructions: Contractor shall disclose financial interests, potential conflicts of interest and contract information identified in Sections 1, 2 and 3 below as a condition of receiving an award or contract (30 ILCS 500/50-13 and 50-35). Failure to fully disclose shall render the contract, bid, proposal, subcontract, or relationship voidable by the chief procurement officer if s/he deems it in the best interest of the State of Illinois and may be cause for barring from future contracts, bids, proposals, subcontracts, or relationships with the State.

- There are five sections to this form and each must be completed to meet full disclosure requirements.
- Note: The requested disclosures are a continuing obligation and must be promptly supplemented for accuracy throughout the process and throughout the term of the resultant contract if the bid/offer is awarded. As required by 30 ILCS 500/50-2, for multi-year contracts Contractors must submit these disclosures on an annual basis.

A publicly traded entity may submit its 10K disclosure in satisfaction of the disclosure requirements set forth in Section 1 below. HOWEVER, if a Contractor submits a 10K, they must still must complete Sections 2, 3, 4 and 5 and submit the disclosure form.

If Contractor is a wholly owned subsidiary of a parent organization, separate disclosures must be made by Contractor and the parent. For purposes of this form, a parent organization is any entity that owns 100% of Contractor.

This disclosure information is submitted on behalf of (show official name of Contractor, and if applicable, D/B/A and parent):

Name of Contractor:_____

D/B/A (if used):_____

Name of any Parent Organization:_____

Section 1. Disclosure of Financial Interest in Contractor. (*All Contractors must complete this section)*

Contractors must complete subsection (a), (b) or (c) below. Please read the following subsections and complete the information requested.

a. If Contractor is a Publicly traded corporation subject to SEC reporting requirements

i. Contractor shall submit their 10K disclosure (include proxy if referenced in 10k) in satisfaction of the financial and conflict of interest disclosure requirements set forth in subsections 50-35 (a) and (b) of the Procurement Code. The SEC 20f or 40f, supplemented with the names of those owning in excess of 5% and up to the ownership percentages disclosed in those submissions, may be accepted as being substantially equivalent to 10K.

Check here if submitting a 10k☐, 20f☐, or 40f☐.

OR

b. If Contractor is a privately held corporation with more than 400 shareholders

i. These Contractors may submit the information identified in 17 C.F.R. 229.401 and list the names of any person or entity holding any ownership share in excess of 5% in satisfaction of the financial and conflict of interest disclosure requirements set forth in subsections 50-35 a and b of the Illinois Procurement Code.

OR

c. If Contractor is an individual, sole proprietorship, partnership or any other not qualified to use subsections (A) or (B), complete (i) and (ii) below as appropriate.

i. For each individual having any of the following financial interests in Contractor (or its parent), please mark each that apply and show the applicable name and address. Use a separate form for each individual.

1. Do you have an ownership share of greater than 5% of the offering entity or parent entity?
☐ Yes ☐ No

2. Do you have an ownership share of less than 5%, but which has a value greater than $106,447.20?
☐ Yes ☐ No

3. Do you receive more than $106,447.20 of the offering entity's or parent entity's distributive income? (Note: Distributive income is, for these purposes, any type of distribution of profits. An annual salary is not distributive income.)
☐ Yes ☐ No

4. Do you receive greater than 5% of the offering entity's or parent entity's total distributive income, but which is less than $106,447.20?
☐ Yes ☐ No

5. If you responded yes to any of questions 1 – 4 above, please provide either the percentage or dollar amount of your ownership or distributive share of income: _____. For partnerships with more than 50 partners, the percentage share of ownership of each individual identified above may be shown in the following ranges (dollar value fields must also be completed when applicable):
0.5% or less_____>0.5 to 1.0% _____>1.0 to 2.0%_____ >2.0 to 3.0 %_____> 3.0 to 4.0%_____%
>4.0 to 5.0%_____and in additional 1% increments as appropriate _____%

6. If you responded yes to any of the questions 1-4 above, please check the appropriate type of ownership/distributable income share:

Sole Proprietorship ☐ Stock ☐ Partnership ☐
Other (explain)_____

Name:_____

Address:_____

_____

ii. In relation to individuals identified above, indicate whether any of the following potential conflict of interest relationships apply. If "Yes," please describe each situation (label with appropriate letter) using the space at the end of this Section (attach additional pages as necessary). If no individual has been identified above, mark not applicable (N/A) here _____.

(a) State employment, currently or in the previous 3 years, including contractual employment of services directly with the individuals identified in Section 1 in their individual capacity unrelated to Contractor's contract.
Yes ☐ No ☐

(b) State employment of spouse, father, mother, son, or daughter, including contractual employment for services in the previous 2 years.
Yes ☐ No ☐

(c) Elective status; the holding of elective office of the State of Illinois, the government of the United States, any unit of local government authorized by the Constitution of the State of Illinois or the statutes of the State of Illinois currently or in the previous 3 years.
Yes ☐ No ☐

(d) Relationship to anyone holding elective office currently or in the previous 2 years; spouse, father, mother, son, or daughter.
Yes ☐ No ☐

(e) Appointive office; the holding of any appointive government office of the State of Illinois, the United States of America, or any unit of local government authorized by the Constitution of the State of Illinois or the statutes of the State of Illinois, which office entitles the holder to compensation in excess of expenses incurred in the discharge of that office currently or in the previous 3 years.
Yes ☐ No ☐

(f) Relationship to anyone holding appointive office currently or in the previous 2 years; spouse, father, mother, son, or daughter.
Yes ☐ No ☐

(g) Employment, currently or in the previous 3 years, as or by any registered lobbyist of the State government.
Yes ☐ No ☐

(h) Relationship to anyone who is or was a registered lobbyist in the previous 2 years; spouse, father, mother, son, or daughter.
Yes ☐ No ☐

(i) Compensated employment, currently or in the previous 3 years, by any registered election or re-election committee registered with the Secretary of State or any county clerk in the State of Illinois, or any political action committee registered with either the Secretary of State or the Federal Board of Elections.
Yes ☐ No ☐

(j) Relationship to anyone; spouse, father, mother, son, or daughter; who is or was a compensated employee in the last 2 years of any registered election or reelection committee registered with the Secretary of State or any county clerk in the State of Illinois, or any political action committee registered with either the Secretary of State or the Federal Board of Elections.
Yes ☐ No ☐

Section 2: Section 50-13 Conflicts of Interest (*All Contractors must complete this section)*

(a) Prohibition. It is unlawful for any person holding an elective office in this State, holding a seat in the General Assembly, or appointed to or employed in any of the offices or agencies of State government and who receives compensation for such employment in excess of 60% of the salary of the Governor of the State of Illinois [$106,447.20], or who is an officer or employee of the Capital Development Board or the Illinois Toll Highway Authority, or who is the spouse or minor child of any such person to have or acquire any contract, or any direct pecuniary interest in any contract therein, whether for stationery, printing, paper, or any services, materials, or supplies, that will be wholly or partially satisfied by the payment of funds appropriated by the General Assembly of the State of Illinois or in any contract of the Capital Development Board or the Illinois Toll Highway Authority.

(b) Interests. It is unlawful for any firm, partnership, association, or corporation, in which any person listed in subsection (a) is entitled to receive (i) more than 7 1/2% of the total distributable income or (ii) an amount in excess of the salary of the Governor ($177,412.00], to have or acquire any such contract or direct pecuniary interest therein.

(c) Combined interests. It is unlawful for any firm, partnership, association, or corporation, in which any person listed in subsection (a) together with his or her spouse or minor children is entitled to receive (i) more than 15%, in the aggregate, of the total distributable income or (ii) an amount in excess of 2 times the salary of the Governor [$354,824.00], to have or acquire any such contract or direct pecuniary interest therein.

Check One: ☐ No Conflicts Of Interest
☐ Potential Conflict of Interest (If checked, name each conflicted individual, the nature of the conflict, and the name of the State agency that is associated directly or indirectly with the conflicted individual.)

Section 3: Debarment/Legal Proceeding Disclosure (*All Contractors must complete this section).*

Each of the persons identified in Sections 1, 2 and 3 must each identify any of the following that occurred within the previous 10 years:

Debarment from contracting with any governmental entity	Yes ☐	No ☐
Professional licensure discipline	Yes ☐	No ☐
Bankruptcies	Yes ☐	No ☐
Adverse civil judgments and administrative findings	Yes ☐	No ☐
Criminal felony convictions	Yes ☐	No ☐

If any of the above is checked yes, please identify with descriptive information the nature of the debarment and legal proceeding. The State reserves the right to request more information, should the information need further clarification.

_____
_____
_____
_____

Section 4: Disclosure of Business Operations with Iran *(All Contractors must complete this section)*.

In accordance with 30 ILCS 500/50-36, each bid, offer, or proposal submitted for a State contract, other than a small purchase defined in Section 20-20 [of the Illinois Procurement Code], shall include a disclosure of whether or not the bidder, offeror, or proposing entity, or any of its corporate parents or subsidiaries, within the 24 months before submission of the bid, offer, or proposal had business operations that involved contracts with or provision of supplies or services to the Government of Iran, companies in which the Government of Iran has any direct or indirect equity share, consortiums or projects commissioned by the Government of Iran and:

(1) more than 10% of the company's revenues produced in or assets located in Iran involve oil-related activities or mineral-extraction activities; less than 75% of the company's revenues produced in or assets located in Iran involve contracts with or provision of oil-related or mineral – extraction products or services to the Government of Iran or a project or consortium created exclusively by that Government; and the company has failed to take substantial action;

or

(2) the company has, on or after August 5, 1996, made an investment of $20 million or more, or any combination of investments of at least $10 million each that in the aggregate equals or exceeds $20 million in any 12- month period that directly or significantly contributes to the enhancement of Iran's ability to develop petroleum resources of Iran.

A bid, offer, or proposal that does not include this disclosure shall not be considered responsive. We may consider this disclosure when evaluating the bid, offer, or proposal or awarding the contract.

You must check one of the following items and if item 2 is checked you must also make the necessary disclosure:

☐ There are no business operations that must be disclosed to comply with the above cited law.

☐ The following business operations are disclosed to comply with the above cited law:

_____

_____

_____

_____

Section 5: Current and Pending Contracts (*All Contractors must complete this section)*.

Does Contractor have any contracts pending contracts, bids, proposals or other ongoing procurement relationships with units of State of Illinois government?
Yes ☐ No ☐

If yes, please identify each contract, pending contract, bid, proposal and other ongoing procurement relationship it has with units of State of Illinois government by showing agency name and other descriptive information such as bid number, project title, purchase order number or contract reference number.

_____
_____
_____
_____
_____
_____

Section 6: Representative Lobbyist/Other Agent (*All Contractors must complete this section)*.

Is Contractor represented by or employ a lobbyist or other agent who is not identified under Sections 1 and 2 and who has communicated, is communicating, or may communicate with any State officer or employee concerning the bid, offer or contract?
Yes ☐ No ☐

If yes, please identify each agent / lobbyist, including name and address.

_____
_____

Costs/Fees/Compensation/Reimbursements related to assistance to obtain contract (describe):

_____
_____

Contractor certifies that none of these costs will be billed to the State in the event of contract award. Contractor must file this information with the Secretary of State.

This Disclosure is signed and made under penalty of perjury pursuant to Sections 500/50-13 and 500/50-35(a) of the Illinois Procurement Code.

This information is submitted on behalf of: _____

_____
(Contractor/Subcontractor Name)

Name of Authorized Representative: _____

_____Date:_____
Signature of Authorized Representative

Title of Authorized Representative: _____

Attachment X

Public Act 95-971

Contractor certifies that it has read, understands, and is in compliance with the registration requirements of the Elections Code (10 ILCS 5/9-35) and the restrictions on making political contributions and related requirements of the Illinois Procurement Code (30 ILCS 500/20-160 and 50-37). Contractor will not make a political contribution that will violate these requirements. These requirements are effective for the duration of the term of office of the incumbent Governor or for a period of two (2) years after the end of the Contract term, whichever is longer.

In accordance with Section 20-160 of the Illinois Procurement Code, Contractor certifies as applicable:

- ☐ Contractor is not required to register as a business entity with the State Board of Elections,

  or

- ☐ Contractor has registered **and has attached a copy** of the official certificate of registration as issued by the State Board of Elections. As a registered business entity, Contractor acknowledges a continuing duty to update the registration as required by the Act.

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Attachment XI

Quality Assurance (QA)

1. Contractor shall establish procedures such that Contractor shall be able to demonstrate that it meets the requirements of the HMO Federal qualification regulations (42 C.F.R. 417.106), the Medicare HMO/CMP regulations (42 C.F.R. 417.418(c)), and the regulations promulgated pursuant to the Balanced Budget Act of 1997 (42 C.F.R. 438.200 et seq.). These regulations require that Contractor have an ongoing fully implemented Quality Assurance Program for health services that:

    a. incorporates widely accepted practice guidelines that meet the criteria referenced above, and are distributed to Affiliated Providers, as appropriate, and to Enrollees and Potential Enrollees, upon request, and:

        i. are based on valid and reliable clinical evidence;

        ii. consider the needs of Enrollees;

        iii. are adopted in consultation with Affiliated Providers; and

        iv. are reviewed and updated periodically as appropriate.

    b. monitors the health care services Contractor provides, including assessing the appropriateness and quality of care;

    c. stresses health outcomes and monitors Enrollee risks status and improvement in health outcomes;

    d. provides a comprehensive program of care coordination, Care Management, and Disease Management, with needed outreach to assure appropriate care utilization and community referrals;

    e. provides review by Physicians and other health professionals of the process followed in the provision of health services;

    f. includes fraud control provisions;

    g. establishes and monitors access standards;

    h. uses systematic data collection of performance and Enrollee results, provides interpretation of these data to its Affiliated Providers- (including, without limitation, Enrollee-specific and aggregate data provided by the Department, such as HEDIS® and State defined measures), and institutes needed changes;

    i. includes written procedures for taking appropriate remedial action and developing corrective action and quality improvement whenever, as determined under the Quality Assurance Program, inappropriate or

substandard services have been furnished or Covered Services that should have been furnished have not been provided;

j. describes its implementation process for reducing unnecessary emergency room utilization and inpatient services, including (thirty)30-day readmissions;

k. describes its process for obtaining clinical results, findings, including emergency room and inpatient care, pharmacy information, lab results, feedback from other care providers, etc., to provide such data and information to the PCP or specialist, or others, as determined appropriate, on a real-time basis;

l. describes its process to assure follow up services within (seven) 7 days from inpatient care for behavioral health, with a behavioral health provider, or within (fourteen)14 day follow up for inpatient medical care, with a PCP or specialist, or follow up within (fourteen)14 days following an emergency room visit.

m. details its processes for establishing Medical Homes and the coordination between the PCP and behavioral health provider, specialists and PCP, or specialists and behavioral health providers;

n. details its processes for determining and facilitating Enrollees needing nursing home, supportive living facility (SLF) or ICF/DD level of care, or to live in the community with HCBS supports;

o. describes its processes for addressing Abuse and Neglect and unusual incidents in the community setting;

p. details its compensation structure, incentives, pay-for-performance programs, value purchasing strategies, and other mechanisms utilized to promote the goals of Medical Homes and accountable, integrated care;

q. describes its health education procedures and materials for Enrollees; processes for training, monitoring, and holding providers accountable for health education; and oversight of Provider requirements to coordinate care and provide health education topics (e.g., obesity, heart smart activities, mental health and substance abuse resources) and outreach documents (e.g., about chronic conditions) using evidence based guidelines and best practice strategies; and

r. provides for systematic activities to monitor and evaluate the dental services rendered.

2. Contractor shall provide to the Department a written description of its Quality Assurance Plan (QAP) for the provision of clinical services (e.g., medical, medically related services, care coordination, Care Management, Disease Management, and behavioral health services). This written description must meet federal and State requirements:

a. Goals and objectives — The written description shall contain a detailed set of QA objectives that are developed annually and include a workplan and timetable for implementation and accomplishment.

b. Scope — The scope of the QAP shall be comprehensive, addressing both the quality of clinical care and the quality of non-clinical aspects of service, such as and including: availability, accessibility, coordination, and continuity of care.

c. Methodology — The QAP methodology shall provide for review of the entire range of care provided, by assuring that all demographic groups, care settings, (e.g., inpatient, ambulatory, and home care), and types of services (e.g., preventive, primary, specialty care, behavioral health, dental and ancillary services) are included in the scope of the review. Documentation of the monitoring and evaluation plan shall be provided to the Department.

d. Activities — The written description shall specify quality of care studies and other activities to be undertaken over a prescribed period of time, and methodologies and organizational arrangements to be used to accomplish them. Individuals responsible for the studies and other activities shall be clearly identified in the written workplan and shall be appropriately skilled or trained to undertake such tasks. The written description shall provide for continuous performance of the activities, including tracking of issues over time.

e. Provider review — The written description shall document how Physicians and other health professionals will be involved in reviewing quality of care and the provision of health services and how feedback to health professionals and Contractor staff regarding performance and Enrollee results will be provided.

f. Focus on health outcomes — The QAP methodology shall address health outcomes; a complete description of the methodology shall be fully documented and provided to Department.

g. Systematic process of quality assessment and improvement — The QAP shall objectively and systematically monitor and evaluate the quality, appropriateness of, and timely access to, care and service to Enrollees, and pursue opportunities for improvement on an ongoing basis. Documentation of the monitoring activities and evaluation plan shall be provided to the Department.

h. Enrollee and advocate input --- The QAP shall detail its operational and management plan for including Enrollee and advocate input into its QAP processes.

3. Contractor shall provide the Department with the QAP written guidelines which delineate the QA process, specifying:

   a. Clinical areas to be monitored:

i. The monitoring and evaluation of clinical care shall reflect the population served by Contractor in terms of age groups, disease categories, and special risk status, and shall include quality improvement initiatives, as determined appropriate by Contractor or as required by the Department.

ii. The QAP shall, at a minimum, monitor and evaluate care and services in certain priority clinical areas of interest specified by the Department, based on the needs of Enrollees.

iii. At its discretion or as required by the Department, Contractor's QAP must monitor and evaluate other important aspects of care and service, including coordination with community resources.

iv. At a minimum, the following areas shall be monitored:

a) For all populations:

1. Emergency room utilization.

2. Inpatient hospitalization.

3. Thirty (30)-day readmission rate.

4. Assistance to Enrollees accessing services outside the Covered Services, such as housing, social service agencies, senior center.

5. Health education provided.

6. Coordination of primary and specialty care.

7. Coordination of care, Care Management, Disease Management, and other activities.

8. Individualized Enrollee Care Plan.

9. Utilization of dental benefits.

10. Preventive health care for adults (e.g., annual health history and physical exam; mammography; papanicolaou test, immunizations).

11. PCP or behavioral health follow-up after emergency room or inpatient hospitalization.

b) For individuals ages nineteen (19) and twenty (20):

1. Number of preventive visits appropriate for age.

a. Immunization status.

b. Number of hospitalizations.

c. Length of hospitalizations.

d. Medical management for medically complicated conditions.

c) For Chronic Health Conditions (such conditions specifically including, without limitation, diabetes, asthma, CHF, CAD, COPD, Behavioral Health, including those with one or more co-morbidities). Appropriate treatment, follow-up care, and coordination of care, Care Management and Disease Management for all Enrollees.

1. Identification of Enrollees with special health care needs and processes in place to assure adequate, ongoing risk assessments, treatment plans developed with the Enrollee's participation in consultation with any specialists caring for the Enrollee, to the extent possible, the appropriateness and quality of care, and if approval is required, such approval occurs in a timely manner.

2. Care coordination, Care Management, Disease Management, and Chronic Health Conditions action plan, as appropriate.

d) For behavioral health:

1. Behavioral health network adequate to serve the behavioral health care needs of Enrollees, including mental health and substance abuse services sufficient to provide care within the community in which the Enrollee resides.

2. Assistance sufficient to access behavioral health services, including transportation and escort services.

3. Enrollee access to timely behavioral health services.

4. An Enrollee Care Plan or treatment and provision of appropriate level of care;

5. Coordination of care between Providers of medical and behavioral health services to assure follow-up and continuity of care

6. Involvement of the PCP in aftercare.

7. Enrollee satisfaction with access to and quality of behavioral health services

8. Mental health outpatient and inpatient utilization, and follow up.

9. Chemical dependency outpatient and inpatient utilization, and follow up.

e) For pregnant women:

1. Timeliness and frequency of prenatal visits.

2. Provision of ACOG recommended prenatal screening tests.

3. Birth outcomes.

4. Referral to the Perinatal Centers, as appropriate.

5. Length of hospitalization for the mother.

6. Length of newborn hospital stay for the infant.

7. Assist the Enrollee in finding an appropriate PCP for the infant.

f) For Enrollees in Nursing Facilities and Enrollees receiving HCBS Waiver services:

1. Maintenance in, or movement to, community living.

2. Number of hospitalizations and length of hospital stay.

3. Falls resulting in hospitalizations.

4. Behavior resulting in injury to self or others.

5. Enrollee non-compliance of services.

6. Medical errors resulting in hospitalizations.

7. Occurrences of pressure ulcers, weight loss, and infections.

b. Use of Quality Indicators — Quality indicators are measurable variables relating to a specified clinical area, which are reviewed over a period of

time to monitor the process of outcomes of care delivered in that clinical area:

i. Contractor shall identify and use quality indicators that are objective, measurable, and based on current knowledge and clinical experience.

ii. Contractor shall document that methods and frequency of data collected are appropriate and sufficient to detect the need for a program change.

iii. For the priority clinical areas specified by the Department, Contractor shall monitor and evaluate quality of care through studies which address, but are not limited to, the quality indicators also specified by the Department.

c. Analysis of clinical care and related services, including behavioral health, Long-Term Care and HCBS Waiver services: Appropriate clinicians shall monitor and evaluate quality through review of individual cases where there are questions about care, and through studies analyzing patterns of clinical care and related service.

ii. Multi-disciplinary teams shall be used, where indicated, to analyze and address systems issues.

iii. Clinical and related service areas requiring improvement shall be identified and documented, and a corrective action plan shall be developed and monitored.

d. Conduct Performance Improvement Projects (PIPs)/Quality Improvement Projects (QIPs) ---- PIPs/QIPs (42 C.F.R. 438.240 (1) (d)), shall be designed to achieve, through ongoing measurements and intervention, significant improvement of the quality of care rendered, sustained over time, and resulting in a favorable effect on health outcome and Enrollee satisfaction. Performance measurements and interventions shall be submitted to the Department annually as part of the QA/UR/PR Annual Report and at other times throughout the year upon request by the Department. If Contractor implements a PIP/QIP that spans more than one (1) year, Contractor shall report annually the status of such project and the results thus far. The PIPs/QIPs topics and methodology shall be submitted to the Department for Prior Approval.

e. Implementation of Remedial or Corrective Actions — The QAP shall include written procedures for taking appropriate remedial action whenever, as determined under the QAP, inappropriate or substandard services are furnished, including in the area of behavioral health, or services that should have been furnished were not. Quality Assurance actions that result in remedial or corrective actions shall be forwarded by Contractor to the Department on a timely basis. Written remedial or corrective action procedures shall include:

i. specification of the types of problems requiring remedial or corrective action;

ii. specification of the person(s) or entity responsible for making the final determinations regarding quality problems;

iii. specific actions to be taken;

iv. a provision for feedback to appropriate health professionals, providers and staff;

v. the schedule and accountability for implementing corrective actions;

vi. the approach to modifying the corrective action if improvements do not occur; and

vii. procedures for notifying a PCP group that a particular Physician is no longer eligible to provide services to Enrollees.

f. Assessment of Effectiveness of Corrective Actions — Contractor shall monitor and evaluate corrective actions taken to assure that appropriate changes have been made. Contractor shall assure follow-up on identified issues to ensure that actions for improvement have been effective and provide documentation of the same.

g. Evaluation of Continuity and Effectiveness of the QAP:

i. At least annually, Contractor shall conduct a regular examination of the scope and content of the QAP (42 C.F.R. 438.240 (1)(i)(ii)) to ensure that it covers all types of services, including behavioral health services, in all settings, through an Executive Summary and Overview of the Quality Improvement Program, including Quality Assurance (QA), Utilization Review (UR) and Peer Review (PR).

ii. At the end of each year (as specified in Attachment XIII), a written report on the QAP shall be prepared by Contractor and submitted to the Department as a component part of the QA/UR/PR Annual Report. The report shall include an Executive Summary that provides a high-level discussion/analysis of each area of the Annual Report of findings, accomplishments, barriers and continued need for quality improvement. The report shall, at a minimum, provide detailed analysis of each of the following:

a)
b) QA/UR/PR Plan with overview of goal areas;
c) Major Initiatives to comply with the State Quality Strategy,
d) Quality Improvement and work plan monitoring;
e) Provider Network Access and Availability and Service Improvements, including access and utilization of dental services;
f) Cultural Competency;

g) Fraud and Abuse Monitoring;
h) Population Profile;
i) Improvements in Care Management and Clinical Services/Programs;
j) Findings on Initiatives and Quality Reviews;
k) Effectiveness of Quality Program Structure;
l) Comprehensive Quality Improvement Work Plans;
m) Chronic Conditions;
n) Behavioral Health (includes mental health and substance abuse services);
o) Discussion of Health Education Program;
p) Member Satisfaction;
q) Enrollee Safety;
r) Fraud, Waste and Abuse and Privacy and Security; and
s) Delegation.

4. Contractor shall have a QAP Committee. Contractor shall have a governing body to which the QA Committee shall be held accountable ("Governing Body"). The Governing Body of Contractor shall be the Board of Directors or, where the Board's participation with quality improvement issues is not direct, a designated committee of the senior management of Contractor. This Board of Directors or Governing Body shall be ultimately responsible for the execution of the QAP. However, changes to the medical Quality Assurance Program shall be made by the chair of the QA Committee. Responsibilities of the Governing Body include:

   a. Oversight of QAP — Contractor shall document that the Governing Body has approved the overall Quality Assurance Program and an annual QAP.

   b. Oversight Entity — The Governing Body shall document that it has formally designated an accountable entity or entities within the organization to provide oversight of QA, or has formally decided to provide such oversight as a committee of the whole.

   c. QAP Progress Reports — The Governing Body shall routinely receive written reports from the QAP Committee describing actions taken, progress in meeting QA objectives, and improvements made.

   d. Annual QAP Review — The Governing Body shall formally review on a periodic basis (but no less frequently than annually) a written report on the QAP which includes: studies undertaken, results, subsequent actions, and aggregate data on utilization and quantity of services rendered, to assess the QAP's continuity, effectiveness and current acceptability. Behavioral health shall be included in the Annual QAP Review.

   e. Program Modification — Upon receipt of regular written reports from the QAP Committee delineating actions taken and improvements made, the Governing Body shall take action when appropriate and direct that the operational QAP be modified on an ongoing basis to accommodate review findings and issues of concern within Contractor. This activity shall be documented in the minutes of the meetings of the Governing Board in sufficient detail to demonstrate that it

has directed and followed up on necessary actions pertaining to Quality Assurance.

5. The QAP shall delineate an identifiable structure responsible for performing QA functions within Contractor. Contractor shall describe its committees' structure in its QAP and shall be submitted to the Department for approval. This committee or committees and other structure(s) shall have:

   a. Regular Meetings — The QAP Committee shall meet on a regular basis with specified frequency to oversee QAP activities. This frequency shall be sufficient to demonstrate that the structure/committee is following-up on all findings and required actions, but in no case shall such meetings be held less frequently than quarterly. A copy of the meeting summaries/minutes shall be submitted to the Department no later than thirty (30) days after the close of the quarterly reporting period.

   b. Established Parameters for Operating — The role, structure and function of the QAP Committee shall be specified.

   c. Documentation — There shall be records kept documenting the QAP Committee's activities, findings, recommendations and actions.

   d. Accountability — The QAP Committee shall be accountable to the Governing Body and report to it on a scheduled basis on activities, findings, recommendations and actions.

   e. Membership — There shall be active participation in the QAP Committee as set forth in Section 1.122.

   f. Enrollee Advisory Committee and Community Stakeholder Committee – There shall be an Enrollee Advisory Committee and Community Stakeholder Committee that will provide feedback to the QAP Committee on the Plan's performance from Enrollee and community perspectives. These committees shall recommend program enhancements based on Enrollee and community needs; review Provider and Enrollee satisfaction survey results; evaluate performance levels and telephone response timelines; evaluate access and provider feedback on issues requested by the QAP Committee; identify key program issues; such as disparities, that may impact community groups; and offer guidance on reviewing Enrollee materials and effective approaches for reaching enrollees. The Enrollee Advisory Committee will be comprised of randomly selected Enrollees, family members and other caregivers. The Community Stakeholder Committee will be comprised of local representation from key community stakeholders such as churches, advocacy groups, and other community-based organizations. Contractor will educate Enrollees and community stakeholders about these committees through materials such as handbooks, newsletters, websites and communication events.

6. There shall be a designated Quality Management Coordinator, as set forth in Section 2.3.3. Contractor's Medical Director shall have substantial involvement in QA activities and shall be responsible for the required reports.

   a. Adequate Resources — The QAP shall have sufficient material resources, and staff with the necessary education, experience, or training, to effectively carry out its specified activities.

   b. Provider Participation in the QAP

      i. Affiliated Physicians and other Affiliated Providers shall be kept informed about the written QAP.

      ii. Contractor shall include in all agreements with Affiliated Provider and Subcontractors a requirement securing cooperation with the QAP.

      iii. Contracts shall specify that Affiliated Providers and Subcontractors will allow access to the medical records of its Enrollees to Contractor.

7. Contractor shall remain accountable for all QAP functions, even if certain functions are delegated to other entities. If Contractor delegates any QA activities to subcontractors:

   a. There shall be a written description of the following: the delegated activities; the subcontractor's accountability for these activities; and the frequency of reporting to Contractor.
   b. Contractor shall have written procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the actual quality of care being provided.
   c. Contractor shall be held accountable for subcontractor's performance and must assure that all activities conform to this Contract's requirements.
   d. There shall be evidence of continuous and ongoing evaluation and oversight of delegated activities, including approval of quality improvement plans and regular specified reports, as well as a formal review of such activities. Oversight of delegated activities must include no less than an annual audit, analyses of required reports and Encounter Data, a review of Enrollee complaints, grievances, Provider complaints and appeals, and quality of care concerns raised through Encounter Data, monitoring activities, or other venues. Outcomes of the annual audit shall be submitted to the Department as part of the QA/UR/PR Annual Report.
   e. Contractor shall be responsible for, directly or through monitoring of delegated activities, credentialing and re-credentialing, and shall review such credentialing files performed by the delegated entity no less than annually, as part of the annual audit.
   f. If Contractor or subcontractor identifies areas requiring improvement, Contractor and subcontractor, as appropriate, shall take corrective action and implement a quality improvement initiative. If one or more deficiencies are identified, the subcontractor must develop and implement a corrective action plan, with protections put in place by

Contractor to prevent such deficiencies from reoccurring. Evidence of ongoing monitoring of the delegated activities sufficient to assure corrective action shall be provided to the Department through quarterly or annual reporting.

8. The QAP shall contain provisions to assure that Affiliated Physicians and other Affiliated Providers, are qualified to perform their services and are credentialed by Contractor. Recredentialing shall occur at least once every three (3) years. Contractor's written policies shall include procedures for selection and retention of Physicians and other Providers.

9. All services provided by or arranged to be provided by Contractor shall be in accordance with prevailing professional community standards. All clinical practice guidelines shall be based on established evidence-based best practice standards of care, promulgated by leading academic and national clinical organizations, and shall be adopted by Contractor's QAP Committee with sources referenced and guidelines documented in Contractor's QAP. Contractor's QAP shall be updated no less than annually and when new significant findings or major advancements in evidence-based best practices and standards of care are established. Contractor shall provide ongoing education to Affiliated Providers on required clinical guideline application and provide ongoing monitoring to assure that its Affiliated Providers are utilizing them. At a minimum, clinical practice guidelines and best practice standards of care shall be adopted by Contractor for the following conditions and services:
    a. Asthma;
    b. Congestive Heart Failure (CHF);
    c. Coronary Artery Disease (CAD);
    d. Chronic Obstructive Pulmonary Disease (COPD);
    e. Diabetes;
    f. Adult Preventive Care;
    g. EPSDT for individuals 19 and 20;
    h. Smoking Cessation;
    i. Behavioral Health (mental health and substance abuse) screening, assessment, and treatment, including medication management and PCP follow-up;
    j. Psychotropic medication management;
    k. Clinical Pharmacy Medication Review;
    l. Coordination of community support and services for Enrollees in HCBS Waivers;
    m. Dental services;
    n. Community reintegration and support; and
    o. Long-term Care (LTC) residential coordination of services.

10. Contractor shall put a basic system in place which promotes continuity of Care Management. Contractor shall provide documentation on:

a. Monitoring the quality of care across all services and all treatment modalities.

b. Studies, reports, protocols, standards, worksheets, minutes, or such other documentation as may be appropriate, concerning its QA activities and corrective actions and make such documentation available to the Department upon request.

11. The findings, conclusions, recommendations, actions taken, and results of the actions taken as a result of QA activity, shall be documented and reported to appropriate individuals within the organization and through the established QA channels. Contractor shall document coordination of QA activities and other management activities.

    a. QA information shall be used in recredentialing, recontracting and annual performance evaluations.

    b. QA activities shall be coordinated with other performance monitoring activities, including utilization management, risk management, and resolution and monitoring of Enrollee complaints and grievances.

    c. There shall be a linkage between QA and the other management functions of Contractor such as:

        i. network changes.

        ii. benefits redesign.

        iii. medical management systems (e.g., pre-certification).

        v. practice feedback to Physicians.

        vi. other services, such as dental, vision, etc.

        vii. member services.

        viii. care management, disease management.

        ix. Enrollee education.

    d. In the aggregate, without reference to individual Physicians or Enrollee identifying information, all Quality Assurance findings, conclusions, recommendations, actions taken, results or other documentation relative to QA shall be reported to Department on a quarterly basis or as requested by the Department. The Department shall be notified of any Provider or Subcontractor who ceases to be an Affiliated Provider or Subcontractor for a quality of care issue.

12. Contractor shall, at the direction of the Department, cooperate with the external, independent quality review process conducted by the EQRO. Contractor shall address the findings of the external review through its Quality Assurance Program

by developing and implementing performance improvement goals, objectives and activities, which shall be documented in the next quarterly report submitted by Contractor following the EQRO's findings.

13. Contractor's Quality Assurance Program shall systematically and routinely collect data to be reviewed for quality oversight, monitoring of performance, and Enrollee care outcomes. The Quality Assurance Program shall include provision for the interpretation and dissemination of such data to Contractor's Affiliated Providers. The Quality Assurance Program shall be designed to perform quantitative and qualitative analytical activities to assess opportunities to improve efficiency, effectiveness, appropriate health care utilization, and Enrollee health status, per 42 C.F.R. 438.242 (2). Contractor shall ensure that data received from Providers and included in reports are accurate and complete by (1) verifying the accuracy and timeliness of reported data; (2) screening the data for completeness, logic, and consistency; and (3) collecting service information in standardized formats to the extent feasible and appropriate. Contractor shall have in effect a program consistent with the utilization control requirements of 42 C.F.R. Part 456. This program will include, when required by the regulations, written plans of care and certifications of need of care.

14. Contractor shall perform and report the quality and utilization measures identified in Table 1 – Performance Measures using the HEDIS® and HEDIS®-like Performance Measure Specifications methodology, as provided by the Department. Contractor shall not modify the reporting specifications methodology prescribed by the Department without first obtaining the Department's written approval. Contractor must obtain an independent validation of its HEDIS® and HEDIS®-like findings by a recognized entity, e.g., NCQA-certified auditor, as approved by the Department. The Department's External Quality Review Organization will perform an independent validation of at least a sample of Contractor's findings.

15. Contractor shall monitor other performance measures not specifically stated in Attachment XI that are required by Federal CMS. The Department will use its best efforts to notify Contractor of new Federal CMS requirements.

Table 1 – Performance Measures

#	Category	Performance Measure	Specification Source	Quality Monitoring	P4P	Yr1	Yr2	Yr3
1	**Behavioral Health Risk Assessment and Follow-up**	New Enrollees who completed a behavioral health assessment (BHRA) within 60 days of enrollment. Also measures percent of Enrollees with a positive finding on BHRA who receive follow-up with MH provider within 30 days of assessment						
	1) Behavioral Screening/ Assessment within 60 days of enrollment		State	X				
	2) Behavior Health follow-up within 30 days of screening		State	X				
2	**Alcohol and other Drug Dependence Treatment**	Enrollees with new episode of alcohol or other drug (AOD) dependence who received initiation and engagement of AOD treatment.	HEDIS®	X				
3	**Behavioral Health Support**	Appropriate follow-up with any Provider within 30 days after initial BH diagnosis.	State	X	X	X	X	X
4	**Behavioral Health Support**	Follow-up after hospitalization for Mental Illness						

#	Category	Performance Measure	Specification Source	Quality Monitoring	P4P	Yr1	Yr2	Yr3
	1) Follow-up in 7 days		HEDIS®	X				
	2) Follow-up in 30 days		HEDIS®	X	X	X	X	X
5	**Care Coordination Influenza Immunization Rate**	Enrollees who received at least one influenza immunization annually.	State	X				
6	**Dental Utilization**	Enrollees who receive an annual dental visit						
	1) Annual Dental Visit –All		State	X				
	2) Annual Dental Visit – DD only		State		X	X	X	X
7	**Dental ER Utilization**	Emergency room visits for Enrollees with dental primary diagnoses.	State	X				
8	**Diabetes Care**	Increased utilization of disease specific therapies. Meet two of numbers 1, 2, and 3 and one of numbers 4 and 5.						
	1) HbA1c testing 1x per year		HEDIS®	X	X	X	X	X
	2) Microalbuminuria testing 1 X per year		HEDIS®	X	X	X	X	X
	3) Cholesterol testing 1X per year		HEDIS®	X	X	X	X	X
	4) Statin Therapy 80% of the time		State	X	X	X	X	X
	5) ACE/ARB 80% of		State	X	X	X	X	X

#	Category	Performance Measure	Specification Source	Quality Monitoring	P4P	Yr1	Yr2	Yr3
	the time							
	6) DD Waiver Program Support	Services for Enrollees in DD Waiver and Enrollees with DD Diagnostic History - HbA1c testing 1x per year	HEDIS®	X				
9	**Congestive Heart Failure**	Increased utilization of disease specific therapies (meet 2 of 3).						
	1) ACE/ARB 80% of the time		State	X	X	X	X	X
	2) Beta Blocker 80% of the time		State	X	X	X	X	X
	3) Diuretic 80% of the time		State	X	X	X	X	X
10	**Coronary Artery Disease**	Increased utilization of disease specific therapies (meet 2 of 4).						
	1) Cholesterol testing 1X per year		HEDIS®	X	X	X	X	X
	2) Statin Therapy 80% of the time		State	X	X	X	X	X
	3) ACE/ARB 80% of the time		State	X	X	X	X	X

#	Category	Performance Measure	Specification Source	Quality Monitoring	P4P	Yr1	Yr2	Yr3
	4) Beta Blocker Post MI for 6 months following MI		HEDIS®	X	X	X	X	X
11	**Chronic Obstructive Pulmonary Disease**	Increased utilization of disease specific therapies (meet 2 of 3).						
	1) Acute COPD Exacerbation w/corticosteroid		HEDIS®	X	X	X	X	X
	2) History of hospitalizations for COPD with a bronchiodilator medications		HEDIS®	X	X	X	X	X
	3) Spirometry testing (1 time in last three years)		HEDIS®	X	X	X	X	X
12	**Ambulatory Care**	Emergency Department visits per 1,000 Enrollees	HEDIS®	X	X	X	X	X
	1) Waiver Program Support	Services for Population in DD Waiver and Clients with Diagnostic History - Emergency Department Utilization Rate per 1,000	HEDIS®	X				
13	**Ambulatory Care follow-up after Emergency Department Visit**	Follow-up with any Provider within 14 days following Emergency Department visit	State	X	X	X	X	X

#	Category	Performance Measure	Specification Source	Quality Monitoring	P4P	Yr1	Yr2	Yr3
14	**Inpatient Utilization-General Hospital/ Acute Care**	General Hospital Inpatient Utilization Admits per 1,000 Enrollees	HEDIS®	X				
15	**Mental Health Utilization**	Mental Health services utilization per 1,0000 Enrollees	HEDIS®	X				
16	**Ambulatory Care Follow-up after Inpatient Discharge**	Ambulatory care follow-up visit within 14 days of every inpatient discharge	State	X	X	X	X	X
17	**Inpatient Hospital Re-Admission**	Inpatient Hospital 30 day readmissions. In addition, Mental Health readmissions reported separately	State	X				
18	**Long Term Care Residents – Urinary Tract Infection Hospital Admission**	Hospital Admissions due to urinary tract infections for LTC Residents	AHRQ	X				
19	**Long Term Care Residents – Bacterial Pneumonia Hospital Readmission**	Hospital Admission due to bacterial pneumonia for LTC Residents	HSAG	X				
20	**Long Term Care Residents – Prevalence of Pressure Ulcers**	LTC Residents that have category/ stage II or greater pressure ulcers.	State	X	X			X

#	Category	Performance Measure	Specification Source	Quality Monitoring	P4P	Yr1	Yr2	Yr3
21	**Medication Reviews**	Annual monitoring for Enrollees on persistent medications	HEDIS®	X				
22	**Medication Reviews**	Antidepressant Medication Management - At least 84 days continuous treatment with antidepressant medication during 114 day period following Index Episode Start Date (IESD)	HEDIS®	X	X	X	X	X
23	**Medication Reviews**	Antidepressant Medication Management - At least 180 days continuous treatment with antidepressant medication during 231 day period following IESD	HEDIS®	X	X	X	X	X
24	**Medication Reviews**	Percentage of Enrollees diagnosed with schizophrenia who maintain medication adherence at 6 months and 12 months	State	X				
25	**Preventive Services**	Colorectal Cancer Screening	HEDIS®	X				
26	**Preventive Services**	Breast Cancer Screening	HEDIS®	X				
27	**Preventive Services**	Cervical Cancer Screening	HEDIS®	X				
28	**Preventive Services**	Adult BMI Assessment	HEDIS®	X				
29	**Access to Enrollee's Assigned PCP**	Enrollees who had an annual ambulatory or preventive care visit with Enrollee's assigned PCP.	State	X	X	X	X	X

#	Category	Performance Measure	Specification Source	Quality Monitoring	P4P	Yr1	Yr2	Yr3
30	**Retention Rate for LTC and HCBS Waiver Enrollees Service in the Community**	LTC and HCBS Waiver Enrollees served in the community at the beginning of the year and continued to be served in the community during the year.	State	X	X		X	X

Attachment XII

Utilization Review/Peer Review

1. Contractor shall have a utilization review and peer review committee(s) whose purpose will be to review data gathered and the appropriateness and quality of care. The committee(s) shall review and make recommendations for changes when problem areas are identified and report suspected Fraud and Abuse in the HFS Medical Program to the Department's Office of Inspector General. The committees shall keep minutes of all meetings, the results of each review and any appropriate action taken. A copy of the minutes shall be submitted to the Department no later than thirty (30) days after the close of the quarterly reporting period. At a minimum, these programs must meet all applicable federal and State requirements for utilization review. Contractor and the Department may further define these programs.

2. Contractor shall implement a Utilization Review Plan, including medical and dental peer review as required. Contractor shall provide the Department with documentation of its utilization review process. The process shall include:

    a. Written program description — Contractor shall have a written Utilization Management Program description which includes, at a minimum, procedures to evaluate medical necessity criteria used and the process used to review and approve the provision of medical services.

    b. Scope — The program shall have mechanisms to detect under-utilization as well as over-utilization.

    c. Preauthorization and concurrent review requirements — For organizations with preauthorization and concurrent review programs:

        i. Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions;

        ii. Utilize practice guidelines that have been adopted, pursuant to Exhibit XIII

        iii. Review decisions shall be supervised by qualified medical professionals and any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested must be made by a health care professional who has appropriate clinical expertise in treating the Enrollee's condition or disease;

        iv. Efforts shall be made to obtain all necessary information, including pertinent clinical information, and consultation with the treating Physician, as appropriate;

v. The reasons for decisions shall be clearly documented and available to the Enrollee and the requesting Provider, provided, however, that any decision to deny a service request or to authorize a service in an amount, duration or scope that is less than requested shall be furnished in writing to the Enrollee;

vi. There shall be written well-publicized and readily available Appeal mechanisms for both Providers and Enrollees;

vii. Decisions and appeals shall be made in a timely manner as required by the circumstances and shall be made in accordance with the timeframes specified in this Contract for standard and expedited authorizations;

viii. There shall be mechanisms to evaluate the effects of the program using data on Enrollee satisfaction, Provider satisfaction or other appropriate measures;

ix. If Contractor delegates responsibility for utilization management, it shall have mechanisms to ensure that these standards are met by the subcontractor.

3. Contractor further agrees to review the utilization review procedures, at regular intervals, but no less frequently than annually, for the purpose of amending same, as necessary in order to improve said procedures. All amendments must receive Prior Approval. Contractor further agrees to supply the Department and its designee with the utilization information and data, and reports prescribed in its approved utilization review system or the status of such system. This information shall be furnished in accordance to Attachment XIII of this Contract or upon request by the Department.

4. Contractor shall establish and maintain a peer review program, subject to Prior Approval, to review the quality of care being offered by Contractor, employees and subcontractors. This program shall provide, at a minimum, the following:

   a. A peer review committee comprised of Physicians and dentists, formed to organize and proceed with the required reviews for both the health professionals of Contractor's staff and any Affiliated Providers which include:

      i. A regular schedule for review;

      ii. A system to evaluate the process and methods by which care is given; and

      iii. A medical record review process.

   b. Contractor shall maintain records of the actions taken by the peer review committee with respect to Providers and those records shall be available to the Department upon request.

c. A system of internal medical review, including behavioral health services, waiver and long term care services, medical evaluation studies, peer review, a system for evaluating the processes and outcomes of care, health education, systems for correcting deficiencies, and utilization review.

d. At least two (2) medical evaluation studies must be completed annually that analyze pressing problems identified by Contractor, the results of such studies and appropriate action taken. One of the studies may address an administrative problem noted by Contractor and one may address a clinical problem or diagnostic category. One brief follow-up study shall take place for each medical evaluation study in order to assess the actual effect of any action taken. Contractor's medical evaluation studies' topic and design must receive Prior Approval.

e. Contractor shall participate in the annual collaborative PIPS/QIPs, as mutually agreed upon and directed by the Department.

5. Contractor further agrees to review the peer review procedures, at regular intervals, but no less frequently than annually, for the purpose of amending same in order to improve said procedures. All amendments must be approved by the Department. Contractor shall supply the Department and its designee with the information and reports related to its peer review program upon request.

6. The Department may request that peer review be initiated on specific Providers.

7. The Department may conduct its own peer reviews at its discretion.

Attachment XIII

Required Deliverables, Submissions and Reporting

Name of Report/Submission	Frequency	HFS Prior Approval	Report Description and Requirements
Administrative			
Encounter Data	At least monthly.	No	**Submission.** Contractor shall submit Encounter Data as provided herein. This shall include all services received by Enrollees, including services reimbursed by Contractor through a Capitation arrangement. The report must provide the Department with HIPAA Compliant transactions, including the NCPDP, 837D File, 837I File and 837P File, prepared with claims level detail, as required herein, for all institutional and non-institutional Provider services received by Enrollee and paid by or on behalf of Contractor during a given month. Contractor shall submit administrative denials in the format and medium designated by the Department. Beginning in Phase 2, the report must include all institutional and HCBS Waiver Services. Contractor shall submit Encounter Data such that it is accepted by the Department within one hundred twenty (120) days after Contractor's payment or final rejection of the claim or, for services paid through a Capitation arrangement, within one hundred fifty (150) days after the date of service. Any claims processed by Contractor for services provided subsequent to submission of an Encounter Data file shall be reported on the next Encounter Data file. **Testing.** Upon receipt of each submitted Encounter Data file, the Department shall perform two distinct levels of review: The first level of review and edits performed by the Department shall check the data file format. These edits shall include, but are not limited to the following:

Name of Report/Submission	Frequency	HFS Prior Approval	Report Description and Requirements
			check the data file for completeness of records; correct sort order of records; proper field length and composition; and correct file length. To be accepted by the Department, the format of the file must be correct. Once the format is correct, the Department shall then perform the second level of review. This second review shall be for standard claims processing edits. These edits shall include, but are not limited to, the following: correct Provider numbers; valid Enrollee numbers; valid procedure and diagnosis codes; and cross checks to assure Provider and Enrollee numbers match their name. The acceptable error rate of claims processing edits of the Encounter Data provided by Contractor shall be determined by the Department. Once an acceptable error rate has been achieved, as determined by the Department, Contractor shall be instructed that the testing phase is complete and that data must be sent in production. **Production.** Once Contractor's testing of data specified above is completed, Contractor will be certified for production. Once certified for production, Contractor shall continue to submit Encounter Date in accordance with these requirements. The Department will continue to review the Encounter Data for correct format and quality. Contractor shall submit as many files as necessary, in a time frame agreed upon by the Department and Contractor, to ensure all Encounter Data are current. Records that fail the edits described above will be returned to Contractor for correction. Corrected Encounter Data must be returned to the Department for re-processing. **Electronic Data Certification.** In a format determined by the Department, Contractor shall certify by the 5th day of each month that all electronic data submitted during the previous calendar month is accurate, complete and true.

Name of Report/Submission	Frequency	HFS Prior Approval	Report Description and Requirements
Disclosure Statements	Initially, annually, on request and as changes occur.	No	Contractor shall submit disclosure statements as specified in 42 C.F.R., Part 455.
Financial Reports	Concurrent with submission to Department of Insurance	No	Contractor shall provide the Department with copies of all financial reports Contractor is required to file with the Department of Insurance and the Department of Financial and Professional Regulation.
Report of Transactions with Parties of Interest	Annually	No	Contractor shall report all "transactions" with a "party of interest" (as such terms are defined in Section 1903(m)(4)(A) of the Social Security Act and SMM 2087.6(A-B)), as required by Section 1903(m)(4)(A) of the Social Security Act.
Adjudicated Claims Inventory Summary	Monthly, no later than fifteen (15) days after the close of the reporting month	No	Contractor shall report the number of claims Contractor adjudicated by claim type for both paper and electronic claims, in-network and out-of-network break out, and the number of days the claims took to process.
Enrollee Materials.			
Certificate of Coverage, Description of Coverage, and Any Changes or Amendments	Initially and as revised	Yes	Contractor shall submit the Certificate of Coverage and Description of Coverage for Prior Approval that comply with the Managed Care Reform and Patient Rights Act (215 ILCS 134) and the Illinois Administrative Code, Title 50, Chapter 1, Subchapter kkk, Part 5421.
Enrollee Handbook	Initially and as revised	Yes	Contractor shall submit an Enrollee Handbook for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed.

Name of Report/Submission	Frequency	HFS Prior Approval	Report Description and Requirements
Identification Card	Initially and as revised	Yes	Contractor shall submit the Enrollee identification card for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed.
Provider Directory	Initially and as changes occur	Yes	Contractor shall submit the Provider Directory that is on Contractor's website for Prior Approval. Provider updates shall not be required to be submitted for Prior Approval.
Fraud and Abuse			
Fraud and Abuse Report	Immediately upon notification or knowledge of suspected Fraud and Abuse; and quarterly.	N/A	Contractor shall report all suspected Fraud and Abuse to the Department as required in Article V and Article IX of this Contract. Contractor shall provide a preliminary investigation report as each occurrence is identified and a quarterly summary report of activities conducted in the previous quarter.
Recipient Verification Procedure	Initially, annually and as revised	Yes	Contractor shall submit Contractor's plan for verifying with Enrollees whether services billed by Providers were received, as required by 42 C.F.R. 455.20, for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in information conveyed.
Recipient Verification Results	Annually and within ten (10) Business Days after the Department's request	No	Contractor shall submit a summary of the results of the Recipient Verification Procedure.

Name of Report/Submission	Frequency	HFS Prior Approval	Report Description and Requirements
Marketing			
Marketing Gifts and Incentives	Initially and within ten (10) Business Days after the Department's request	Yes	Contractor shall submit all plans to distribute gifts and incentives, as well as description of gifts and incentives, for Prior Approval.
Marketing Materials	Initially and as revised	Yes	Contractor shall submit all Marketing Materials for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed.
Marketing Plans and Procedures	Initially and as revised	Yes	Contractor shall submit descriptions of proposed Marketing concepts, strategies, and procedures for Prior Approval.
Provider Network			

Name of Report/Submission	Frequency	HFS Prior Approval	Report Description and Requirements
PCP, Hospital, and Affiliated Specialist File. (CEB Provider File)	No less often than weekly	Yes	Contractor shall submit to the Department or its designee, in a format and medium designated by the Department, an electronic file of Contractor's PCPs, Hospitals and Affiliated Specialists. The PCPs must include, but not limited to, the following information: • Provider name, Provider number, office address, and telephone number; • Type of specialty (e.g., family practitioner, internist, oncologist, etc.), subspecialty if applicable, and treatment age ranges; • Identification of Group Practice, if applicable; • Geographic service area, if limited; • Areas of board-certification, if applicable; • Language(s) spoken by Provider and office staff; • Office hours and days of operation; • Special services offered to the deaf or hearing impaired (i.e., sign language, TDD/TTY, etc.); • Wheelchair accessibility status (e.g., parking, ramps, elevators, automatic doors, personal transfer assistance, etc.); • PCP indicator; • PCP gender and panel status (open or closed); and • PCP hospital affiliations, including information about where the PCP has admitting privileges or admitting arrangements and delivery privileges (as appropriate).
Provider Affiliation with Sites	Monthly by the first business day of the month	Yes	Contractor shall submit the Provider Affiliation with Sites report in the format given to Contractor by the Department, which shall include monthly updating of those Providers who have either become a Provider in Contractor's network or who have left the network since the last report.
Provider Site Requests	As each occurs	No	Contractor shall submit the Provider Site Requests, in a format and medium designated by the Department, as new Sites are added.

Name of Report/Submission	Frequency	HFS Prior Approval	Report Description and Requirements
Enrollee Site Transfers	As each occurs	No	Contractor shall submit Enrollee Site Transfer files to the Department, using the HIPAA compliant 834 transaction.
Provider Site Closures/Terminations	As each occurs	No	Contractor shall submit Provider Site Closures/termination reports, in a format and medium designated by the Department.
Quality Assurance/Medical			
Grievance and Appeals Procedures	Initially and as revised	Yes	Contractor shall submit Grievance and Appeals Procedures for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed.
Summary of Grievances, Appeals and Resolutions and External Independent Reviews and Resolutions – Detail Report	Monthly	No	Contractor shall submit a detailed report on Grievances and Appeals providing Enrollee Medicaid number, Enrollee name, description of Grievance, date received, incident date, date resolved, source of Grievance, status (open or closed), reason closed, incident summary and resolution summary, grouped by incident type. Reporting will be limited to quality of care (as defined by: misdiagnosis, bad prescription, quality of service, balance billing, poor office conditions, poor treatment by staff), access to care (as defined by: cannot find provider, inconvenient hours, Provider capacity, out of area Providers, refusal to take Medicaid, ADA non-compliance, unable to address language needs, not meeting appointment times requirements), medical necessity, transportation and dental issues. All other issues shall only be categorized and reported as "Other" as part of the quarterly summary report.

Name of Report/Submission	Frequency	HFS Prior Approval	Report Description and Requirements
Summary of Grievances, Appeals and Resolutions and External Independent Reviews and Resolutions – Summary Report	Quarterly	No	Contractor shall submit a summary of the Grievances and Appeals filed by Enrollees, organized by categories of quality of care, access to care, medical necessity reviews, transportation, dental and "Other" issues. Reporting shall include total grievance and appeals per/1,000 Enrollees. The report shall include a summary count of any such Grievances or Appeals resolved during the reporting period including any resolution by external independent reviews, types of Grievances and Appeals and the levels at which the Grievances or Appeals were resolved, the types of resolutions and the number pending resolution by category
Quality Assurance, Utilization Review and Peer Review Annual Report (QA/UR/PR Annual Report/Program Evaluation)	Annually, no later than ninety (90) days after close of reporting period	No	Contractor shall submit a QA/UR/PR Annual Report/Program Evaluation reviewing the effectiveness of Contractor's QAP. The summary shall contain Contractor's processes for Quality Assurance, utilization review and peer review. This report shall include a comprehensive description of Contractor's network and an annual work-plan outlining Contractor's intended activities relating to QA, utilization review, peer review and health education.
QA/UR/PR Committee Meeting Minutes	Quarterly	No	Contractor shall submit the minutes of the QA/UR/PR meetings.
Quality Assurance, Utilization Review, Peer Review and Health Education Plans	Initially and as revised	Yes	Contractor shall submit the Quality Assurance, Utilization Review, Peer Review and Health Education Plans for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed.
Conditions Report	Semi-annually	No	Contractor shall submit the aggregate count of the primary health conditions of its Enrollees and their associated risk levels. These reports may be generated utilizing Contractor's unique internal algorithms and systems to determine primary conditions and risk level of Enrollees.

Name of Report/Submission	Frequency	HFS Prior Approval	Report Description and Requirements
Care Management and Disease Management Program Descriptions	Initially and as revised.	Yes	Contractor shall submit the descriptions of its Care Management and Disease Management programs for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed.
Care Management/ Disease Management Summary Report	Monthly	No	Contractor shall submit an aggregate report of all Enrollees who are assigned to Contractor's Care Management and Disease Management interventions, including risk stratification count and percent of Enrollees at each level. Contractor shall also provide summary data for the categories of (i) Aged, Blind and Disabled, (ii) HCBS Developmentally Disabled Waiver, (iii) Long Term Care, and, (iv) Behavioral Health (by primary diagnoses, including Substance Abuse). These reports may be generated utilizing Contractor's unique internal algorithms and systems to determine primary conditions and risk level of Enrollees.
Case Management/Disease Management Active Participants Report	Monthly	No	Contractor shall submit the risk stratification levels for all Enrollees in an aggregate report. This report shall track Enrollees based on enrollment date and show the data points of initial screening completed, stratification level and assessment and Enrollee Care Plan developed for the first twelve (12) months of enrollment. Stratification levels are to be reported as follows: Active (moderate and high risk); Attempting to locate (moderate and high risk); Light condition support (low risk) and opt out (moderate or high risk who refused Care Management). Contractor shall report separately for the categories of (i) Aged, Blind and Disabled, (ii) HCBS Developmentally Disabled Waiver, (iii) Long Term Care and (iv) Behavioral Health (by primary diagnoses, including Substance Abuse).
Care Gap Plan	Annually	No	Contractor shall submit its plan for ensuring provision of services missed by Enrollees, including, but not limited to, annual preventive exams, immunizations, women's healthcare, PAP and missed services for Chronic Health Conditions and behavioral health follow-up.

Name of Report/Submission	Frequency	HFS Prior Approval	Report Description and Requirements
Outreach Summary Report	Quarterly	No	Contractor shall submit a summary report that shows Enrollee outreach for each level of stratification. Enrollees' risk levels will be determined by what level they are in the end of the quarter. Inclusive in this report are Enrollees who were unable to be contacted and those who were contacted but refused to be in Care Management.
Risk Stratification Trend Report	Monthly	No	Contractor shall submit aggregate Enrollees' risk group assignments and shall analyze movement and trends. These reports may be generated utilizing Contractor's unique internal algorithms and systems to determine primary conditions and risk level of Enrollees.
Prior Authorization and Pre-Certification Report	Monthly	No	Contractor shall submit turnaround times for routine and expedited prior authorizations and pre-certifications for Enrollees.
HEDIS® and State-Defined Plan Goals	Quarterly	No	Contractor shall submit a HEDIS® measures report that is based on the performance measures required by this Contract, and that includes HEDIS® measures, modified HEDIS® measures, and State defined measures. This report shall include the numerator, denominator and rate for each measure and will display information in a manner that includes trending data, based on previous quality indicators.
Physician Quality Measurement Report	As needed, and within ten (10) Business Days after the Department's request	No	Contractor shall submit a report for each Provider or Provider group that shows actual performance relative to measures of performance.

Name of Report/Submission	Frequency	HFS Prior Approval	Report Description and Requirements
Executive Summary on Enrollee Profiles/Statistics for Care Integration	Annually	No	Contractor shall submit an executive summary that provides comprehensive information on Contractor's care integration systems for Enrollees' care. This report shall include, but not be limited to, an annual summary of physical and behavioral health conditions, service utilization such as PCP and specialist visits, Emergency Services, inpatient hospitalizations and pharmacy utilization.
Utilization Review			
Utilization Management Report	Monthly	No	Contractor shall submit an analysis of inpatient and Emergency Service utilization. Inpatient services shall be based on inpatient days and be categorized as follows: utilization for total inpatient, medical/surgical, Rehabilitation, and mental health including substance abuse. Emergency Services will be based on utilization per 1000 Enrollees. Reporting for inpatient and Emergency Service utilization shall be divided into separate worksheets for long term care, the population served in the HCBS Waiver for persons with DD, and total population as defined by Department standards.
Pharmacy Reports			
Pharmacy Rebate Report	Quarterly	N/A	Contractor shall submit a pharmacy rebates report that sets forth the pharmaceutical rebates received by it or its Pharmacy Benefit Manager (PBM) from pharmaceutical manufacturers or labelers for the drug utilization covered under this Contract. Rebates include all revenue or credits from manufacturers or labelers that is paid or credited as a result of formulary placement or that is paid or credited based on the volume of drugs sold.
Pharmacy Monitoring Reports	Monthly	Yes	Contractor shall submit pharmacy data utilization reports (to be determined, in a format that has received Prior Approval.
Psychotropic Review Reports	Monthly	No	Contractor shall submit summary reports of Enrollees Psychotropic medication utilization and the prescribing patterns of Providers, including efforts to change unsafe, redundant or atypical prescribing patterns, as decided by all parties.

Name of Report/Submission	Frequency	HFS Prior Approval	Report Description and Requirements
Subcontracts and Provider Agreements			
Executed Subcontracts	Upon execution and as revised;	N/A	Contractor shall submit copies of each executed subcontract relating to an arrangement for the provision of Covered Services, but not those subcontracts for the direct provision of Covered Services. For example, a subcontract with a behavioral health or dental administrator shall be submitted, but an agreement with a therapist or dentist providing direct care to an Enrollee need not be submitted unless otherwise required or requested by the Department.
Executed Provider Agreements	Within ten (10) Business Days after the Department's request	N/A	Contractor shall submit copies of an executed Provider agreement to the Department upon request.
Model Subcontracts and Provider Agreements	Initially and as revised	N/A	Contractor shall submit copies of model subcontracts and Provider agreements related to Covered Services, assignment of risk and data reporting functions, including the form of all proposed schedules or exhibits, intended to be used therewith. Contractor shall provide the Department with any substantial revisions to, or deviations from, these model subcontracts and Provider agreements.
Business Enterprise Program Act for Minorities, Females and Persons with Disabilities			
Business Enterprise Program Act (BEP) Plan	Initially, prior to the start of each State Fiscal Year, and as revised	Yes	Contractor shall submit the Business Enterprise Program Plan specifying how Contractor will meet the goals set forth in the Contract relating to expenditures for BEP certified subcontractors for Prior Approval initially and as revised. Refer to Section 2.9.
Business Enterprise Program Reports	Quarterly	N/A	Contractor shall submit, in a format specified by the Department, its expenditures for BEP certified sub-contractors.

Attachment XIV
Data Security Connectivity Specifications

As used in this Attachment, "CMS" means the Illinois Department of Central Management Services, and "Vendor" means Contractor.

Third Party Network (TPN) or Internet Connection

The line connection to the CMS data center must either be through the private State telecommunications network to the CMS Third Party Network (TPN) or through a secure connection via the Internet. A secure connection over the Internet will require a Site-to-Site Virtual Private Network (VPN) or the use of SSL sessions depending upon the communication requirements.

Private State Telecommunications Network Requirements

If the Vendor chooses to connect through the private State telecommunications network, Contractor site terminating dedicated network connection must be located within the State of Illinois. HFS must submit the orders to CMS for processing, design, installation and configuration of the connection for the Vendor. The Vendor must supply information concerning the circuit termination point, onsite contact, and other information required for the order to be submitted to CMS for processing and installation by the appropriate CMS contractor. The Vendor must provide authorized HFS' personnel access to the location and the phone demark for the location where the circuit is to be installed. The vendor must provide space and power for a State of Illinois managed router to be installed at the site.

Internet Site-to-Site VPN Requirements

If the Vendor chooses to connect through secure connections via the Internet, the connection may be made using a Site-to-Site VPN. In this type of connection, the Vendor will be responsible for the cost of the connection between the Vendor and its Internet Service Provider (ISP), troubleshooting and any redundancy requirements associated with the Vendor's connection to the Internet or for Disaster recovery. The vendor will also be responsible to procure, install, and support, any VPN equipment required at the Vendor's location to support secure Site-to-Site VPN communications via the Internet with CMS.

HFS will coordinate with the Vendor to ensure that any authorization/certificate paperwork required for the establishment of the VPN connection is completed. CMS currently utilizes a Cisco 7600 series router with IPSEC accelerators to provide VPN connections to the CMS data center. For VPN authentication, CMS uses "pre-shared keys". Only STATIC IP addresses, no subnet pool addresses, from the Vendor's network are allowed by CMS.

CMS Supported Encryption Configurations

Phase 1 IKE Properties (ISAKMP Protection Suites)

- Encryption Algorithm.

- Triple-DES (3DES).
- Advanced Encryption Standard (AES) preferred
- Data Integrity.
- Hashing Algorithm: SHA or MD5 supported (MD5 is preferred).
- Diffie-Hellman Group: Group 5 supported only.
- Security Association Lifetime: 86400 seconds.

Phase 2 IPSEC Properties:

- Encryption Algorithm.
- Triple-DES (3DES).
- Advanced Encryption Standard (AES) preferred
- Data Integrity.
- Hashing Algorithm: SHA or MD5 supported (MD5 is preferred).
- Perfect Forward Secrecy: Disabled.

Internet SSL/TLS Requirements for File Transfer Protocol

If the Vendor's only communication requirement is to send or receive data files, the connection may be made using secure FTP (FTPS) via the Internet. The Vendor will be responsible for the cost of the connection between the Vendor and its Internet Service Provider (ISP), troubleshooting and any redundancy requirements associated with the Vendor's connection to the Internet or for Disaster recovery. The Vendor is responsible for any costs associated with obtaining a secure FTP client that supports SSL/TLS. The Vendor will be responsible for initiating the secure FTP sessions to the CMS Data Center and perform any necessary firewall changes to reach the provided IP address and ftp control and data ports.

Exchanging Configuration Information

HFS will work with the Vendor to determine the configuration and define any connection parameters between the Vendor and the CMS data center. This will include any security requirements CMS requires for the specific connection type the Vendor is using. The Vendor is required to work with both HFS and CMS in exchanging configuration information required to make the connection secure and functional for all parties.

Transmission Control Protocol/Internet Protocol (TCP/IP)

The Vendor shall cooperate in the coordination of the interface with CMS and HFS. TCP/IP (Transmission Control Protocol/Internet Protocol) must be used for all connections from the Vendor to the CMS data center.

Firewall Devices

The Vendor shall be responsible for the installation, configuration, and troubleshooting of any firewall devices required on the Vendor's side of the data communication link.

Attachment XV
Contract Monitors

For the Department:

Michelle Maher
Bureau of Managed Care
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East
Springfield, IL 62763

Telephone: 217-524-7478
Fax: 217-524-7535
Email: Michelle.Maher@Illinois.gov

For Contractor:

Michael Kinne
President
IlliniCare Health Plan, Inc.
999 Oakmont Plaza Drive
Westmont, IL 60559

Telephone: 866-329-4701
Fax: 855-707-5478
Email: MKINNE@CENTENE.COM

Attachment V

STATE OF ILLINOIS DRUG-FREE WORKPLACE CERTIFICATION

Contractor certifies that it will not engage in the unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance in the performance of the Agreement.

This business or corporation has twenty-five (25) or more employees, and Contractor certifies and agrees that it will provide a drug free workplace by:

A) Publishing a statement:
   1) Notifying employees that the unlawful manufacture, distribution, dispensation, possession or use of a controlled substance, including cannabis, is prohibited in the grantee's or contractor's workplace.
   2) Specifying the actions that will be taken against employees for violations of such prohibition.
   3) Notifying the employees that, as a condition of employment on such contract, the employee will:
      a) abide by the terms of the statement; and
      b) notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five (5) days after such conviction.

B) Establishing a drug free awareness program to inform employees about:
   1) the dangers of drug abuse in the workplace;
   2) Contractor's policy of maintaining a drug free workplace:
   3) any available drug counseling, rehabilitation, and employee assistance programs; and
   4) the penalties that may be imposed upon an employee for drug violations.

C) Providing a copy of the statement required by subparagraph (a) to each employee engaged in the performance of the contract or grant and to post the statement in a prominent place in the workplace.

D) Notifying the contracting or granting agency within ten (10) days after receiving notice under part (B) or paragraph (3) of subsection (a) above from an employee or otherwise receiving actual notice of such conviction.

E) Imposing a sanction on, or requiring the satisfactory participation in a drug abuse assistance or rehabilitation program by, any employee who is so convicted, as required by section 5 of the Drug Free Workplace Act, 1992 Illinois Compiled Statute, 30 ILCS 580/5.

F) Assisting employees in selecting a course of action in the event drug counseling, treatment, and rehabilitation is required and indicating that a trained referral team is in place.

G) Making a good faith effort to continue to maintain a drug free workplace through implementation of the Drug Free Workplace Act, 1992 Illinois Compiled Statute, 30 ILCS 580/1 *et seq.*

THE UNDERSIGNED AFFIRMS, UNDER PENALTIES OF PERJURY, THAT HE OR SHE IS AUTHORIZED TO EXECUTE THIS CERTIFICATION ON BEHALF OF ILLINICARE HEALTH PLAN, INC..

Signature of Authorized Representative

2010-24-005-K
Contract ID Number

Michael Kinne, President
Printed Name and Title

04/25/2011
Date

Attachment VII

BEP Utilization Plan

Illinois Department of Healthcare and Family Services

Business Enterprise Program Utilizaton Plan Summary Sheet

For Integrated Care Program Contract

Name of the Prime Vendor :	Centene Corporation (Illinicare Health Plan)
Name of Contact Person :	Michael Kinne
Phone & Email Address :	(866) 329-4701 X 47823, Cell : 312 - 330 - 2919 (mkinne@centene.com)
Date Completed :	04 - 04 - 2011

Total Minimum Dollar Amount Subject to BEP Goal (Estimated @ 20 % of Administrative Cost)	**= $3,600,000 (per Year for Duration of Contract)**

Initial Contract Period (May 2011 - June 2011)

Minimum Required Split Goal			Vendor's Commitment for BEP Split Goal Dollar Amounts	Difference in Split Goal Dollars (Required vs. Commitment)	Commitment of BEP Split Goal Percent	BEP Split Goal Dollars Achieved to-Date	Difference in Split Goal Dollars (Required vs. Achieved)	BEP Split Goal Percentage Achieved to-Date	# of BEP Sub Contractors
BEP Category	BEP Goal %	Split Goal Dollars							
			1	2	3	4	5	6	7
MBE	10%	$300,000	24,000	(276,000)	0.80%				1
FBE	7%	$210,000	445,307	235,307	14.84%				8
PBE	3%	$90,000	20,350	(69,650)	0.68%				1
Total	20%	$600,000	489,657	(110,343)	16.32%				10

Contract Year - 2 (July 2011 - June 2012)

Minimum Required Split Goal			Vendor's Commitment for BEP Split Goal Dollar Amounts	Difference in Split Goal Dollars (Required vs. Commitment)	Commitment of BEP Split Goal Percent	BEP Split Goal Dollars Achieved to-Date	Difference in Split Goal Dollars (Required vs. Achieved)	BEP Split Goal Percentage Achieved to-Date	# of BEP Sub Contractors
BEP Category	BEP Goal %	Split Goal Dollars							
			1	2	3	4	5	6	7
MBE	10%	$1,800,000	2,389,000	589,000	13.27%				4
FBE	7%	$1,260,000	1,300,000	40,000	7.22%				9
PBE	3%	$540,000	20,350	(519,650)	0.11%				1
Total	20%	$3,600,000	3,709,350	109,350	20.61%				14

Centene Corporation (Illinicare Health Plan) Utilization Plan for Integrated Care Program

BEP Vendors / Companies - Projected Spend
Plan: IlliniCare Health Plan
Last Updated: 4/4/2011

Sub-Contractors	Address	Vendor Description				SFY 2011 Total	SFY 2012 Total
		Description	TYPE	Current	Relationship In Place		
Facilities / Real Estate							
Louer Facility Planning		Chairs	FBE	YES	YES	$ 35,952	$ -
Louer Facility Planning		Est. Office Furnature	FBE	YES	YES	$ -	$ 310,000
Arcturis Inc Architects		Architectural Drawings	FBE	YES	YES	$ 60,726	$ -
Forrest Contruction Group-Porposal		Office Space Buildout	FBE	YES	YES	$ 171,000	$ 399,000
SEICO		Security system and monitoring	PBE	YES	06/01/11	$ 20,350	$ 20,350
GMB Group INC		Vending /coffee services	MBE	YES	YES	$ -	$ 4,000
Douc-Shred INC		Shredding	FBE	YES	YES	$ -	$ 1,000
Shanes Office Supply		Office supplies	FBE	YES	YES	$ 2,363	$ 20,000
Medical Management							
1st Metroplitan Traslation Servcies		Interpreter services	FBE	YES	YES	$ -	$ 80,000
[illegible]kened Alternatives		High Risk Homebound Case Management	MBE	YES	YES	$ -	$ 2,300,000
Human Resources / Recruiting							
One Course Inc		Search Firm Temp Staffing services	FBE	YES	YES	$ 56,240	$ 100,000
Information System - IT							
Livetek Communications, LLC		Est. wiring- temp space (2011) / Perm Space (2012)	MBE	Application Submitted	YES	$ 24,000	$ 35,000
Legal							
Gonzalez, Saggio and Harlan, L.L.C.		Legal counsel	MBE	YES	YES	$ -	$ 50,000
Marketing							
Beaman Incorporated		Company is on a $16K Retainer through Nov '11- Per Mike Hoffman	FBE	YES	YES	$ 114,000	$ 80,000
1st Metroplitan Traslation Servcies		Translation services	FBE	YES	YES	$ 3,700	$ 10,000
B.P. Direct Inc.		Printing services - speciality items (give aways) and marketing support	FBE	YES	YES	$ 1,326	$ 300,000
Total Projected Spend						**$ 489,657**	**$ 3,709,350**

* **Corrected by HFS**

Attachment VIII

Taxpayer Identification Number

I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and

2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and

3. I am a U.S. Person (including a U.S. resident alien).

   - *If you are an individual, enter your name and SSN as it appears on your Social Security Card.*
   - *If you are a sole proprietor, enter the owner's name on the name line followed by the name of the business and the owner's SSN or EIN.*
   - *If you are a single-member LLC that is disregarded as an entity separate from its owner, enter the owner's name on the name line and the d/b/a on the business name line and enter the owner's SSN or EIN.*
   - *If the LLC is a corporation or partnership, enter the entity's business name and EIN and for corporations, attach IRS acceptance letter (CP261 or CP277).*
   - *For all other entities, enter the name of the entity as used to apply for the entity's EIN and the EIN.*

Name: Michael Kinne

Business Name: IlliniCare Health Plan, Inc.

Taxpayer Identification Number:
Social Security Number _____
or
Employer Identification Number 27-2186150

Legal Status (*check one*):

- ☐ Individual
- ☐ Sole Proprietor
- ☐ Partnership
- ☐ Governmental
- ☐ Nonresident alien
- ☐ Estate or trust

☐ Legal Services Corporation ☐ Pharmacy (Non-Corp.)

☐ Tax-exempt ☐ Pharmacy/Funeral Home/Cemetery(Corp.)

☒ Corporation providing or billing medical and/or health care services (select applicable tax classification)

☐ Corporation NOT providing or billing medical and/or health care services

☐ D = disregarded entity
☒ C = corporation
☐ Limited Liability Company
☐ P = partnership

Signature: _____ **Date:** 04/25/2011

Attachment IX

Disclosures and Conflicts of Interest

Instructions: Contractor shall disclose financial interests, potential conflicts of interest and contract information identified in Sections 1, 2 and 3 below as a condition of receiving an award or contract (30 ILCS 500/50-13 and 50-35). Failure to fully disclose shall render the contract, bid, proposal, subcontract, or relationship voidable by the chief procurement officer if s/he deems it in the best interest of the State of Illinois and may be cause for barring from future contracts, bids, proposals, subcontracts, or relationships with the State.

- There are five sections to this form and each must be completed to meet full disclosure requirements.
- Note: The requested disclosures are a continuing obligation and must be promptly supplemented for accuracy throughout the process and throughout the term of the resultant contract if the bid/offer is awarded. As required by 30 ILCS 500/50-2, for multi-year contracts Contractors must submit these disclosures on an annual basis.

A publicly traded entity may submit its 10K disclosure in satisfaction of the disclosure requirements set forth in Section 1 below. HOWEVER, if a Contractor submits a 10K, they must still must complete Sections 2, 3, 4 and 5 and submit the disclosure form.

If Contractor is a wholly owned subsidiary of a parent organization, separate disclosures must be made by Contractor and the parent. For purposes of this form, a parent organization is any entity that owns 100% of Contractor.

This disclosure information is submitted on behalf of (show official name of Contractor, and if applicable, D/B/A and parent):

Name of Contractor: IlliniCare Health Plan, Inc.

D/B/A (if used): N/A

Name of any Parent Organization: Centene Corporation

Section 1. Disclosure of Financial Interest in Contractor. *(All Contractors must complete this section)*

Contractors must complete subsection (a), (b) or (c) below. Please read the following subsections and complete the information requested.

a. If Contractor is a Publicly traded corporation subject to SEC reporting requirements

i. Contractor shall submit their 10K disclosure (include proxy if referenced in 10k) in satisfaction of the financial and conflict of interest disclosure requirements set forth in subsections 50-35 (a) and (b) of the Procurement Code. The SEC 20f or 40f, supplemented with the names of those owning in excess of 5% and up to the ownership percentages disclosed in those submissions, may be accepted as being substantially equivalent to 10K.

Check here if submitting a 10k[X], 20f[ ], or 40f[ ].

IlliniCare Health Plan is a wholly owned subsidiary of Centene Corporation. Centene Corporation is a publicly traded corporation subject to SEC reporting requirements. IlliniCare Health Plan's financial information will be incorporated in Centene Corporation's 10K. In addition, following commencement of operations IlliniCare Health Plan will also supply IlliniCare-specific audited financial statements.

OR

b. If Contractor is a privately held corporation with more than 400 shareholders

i. These Contractors may submit the information identified in 17 C.F.R. 229.401 and list the names of any person or entity holding any ownership share in excess of 5% in satisfaction of the financial and conflict of interest disclosure requirements set forth in subsections 50-35 a and b of the Illinois Procurement Code.

OR

c. If Contractor is an individual, sole proprietorship, partnership or any other not qualified to use subsections (A) or (B), complete (i) and (ii) below as appropriate.

i. For each individual having any of the following financial interests in Contractor (or its parent), please mark each that apply and show the applicable name and address. Use a separate form for each individual.

1. Do you have an ownership share of greater than 5% of the offering entity or parent entity?
☐ Yes ☐ No

2. Do you have an ownership share of less than 5%, but which has a value greater than $106,447.20?
☐ Yes ☐ No

3. Do you receive more than $106,447.20 of the offering entity's or parent entity's distributive income? (Note: Distributive income is, for these purposes, any type of distribution of profits. An annual salary is not distributive income.)
☐ Yes ☐ No

4. Do you receive greater than 5% of the offering entity's or parent entity's total distributive income, but which is less than $106,447.20?
☐ Yes ☐ No

5. If you responded yes to any of questions 1 – 4 above, please provide either the percentage or dollar amount of your ownership or distributive share of income: _____. For partnerships with more than 50 partners, the percentage share of ownership of each individual identified above may be shown in the following ranges (dollar value fields must also be completed when applicable):
0.5% or less____ >0.5 to 1.0% ____ >1.0 to 2.0%____ >2.0 to 3.0 %_____ > 3.0 to 4.0%____%
>4.0 to 5.0%____and in additional 1% increments as appropriate _____%

6. If you responded yes to any of the questions 1-4 above, please check the appropriate type of ownership/distributable income share:

Sole Proprietorship ☐ Stock ☐ Partnership ☐
Other (explain)_____

Name:_____

Address:_____

_____

ii. In relation to individuals identified above, indicate whether any of the following potential conflict of interest relationships apply. If "Yes," please describe each situation (label with appropriate letter) using the space at the end of this Section (attach additional pages as necessary). If no individual has been identified above, mark not applicable (N/A) here _____.

(a) State employment, currently or in the previous 3 years, including contractual employment of services directly with the individuals identified in Section 1 in their individual capacity unrelated to Contractor's contract.
Yes ☐ No ☐

(b) State employment of spouse, father, mother, son, or daughter, including contractual employment for services in the previous 2 years.
Yes ☐ No ☐

(c) Elective status; the holding of elective office of the State of Illinois, the government of the United States, any unit of local government authorized by the Constitution of the State of Illinois or the statutes of the State of Illinois currently or in the previous 3 years.
Yes ☐ No ☐

(d) Relationship to anyone holding elective office currently or in the previous 2 years; spouse, father, mother, son, or daughter.
Yes ☐ No ☐

(e) Appointive office; the holding of any appointive government office of the State of Illinois, the United States of America, or any unit of local government authorized by the Constitution of the State of Illinois or the statutes of the State of Illinois, which office entitles the holder to compensation in excess of expenses incurred in the discharge of that office currently or in the previous 3 years.
Yes ☐ No ☐

(f) Relationship to anyone holding appointive office currently or in the previous 2 years; spouse, father, mother, son, or daughter.
Yes ☐ No ☐

(g) Employment, currently or in the previous 3 years, as or by any registered lobbyist of the State government.
Yes ☐ No ☐

(h) Relationship to anyone who is or was a registered lobbyist in the previous 2 years; spouse, father, mother, son, or daughter.
Yes ☐ No ☐

(i) Compensated employment, currently or in the previous 3 years, by any registered election or re-election committee registered with the Secretary of State or any county clerk in the State of Illinois, or any political action committee registered with either the Secretary of State or the Federal Board of Elections.
Yes ☐ No ☐

(j) Relationship to anyone; spouse, father, mother, son, or daughter; who is or was a compensated employee in the last 2 years of any registered election or reelection committee registered with the Secretary of State or any county clerk in the State of Illinois, or any political action committee registered with either the Secretary of State or the Federal Board of Elections.
Yes ☐ No ☐

Section 2: Section 50-13 Conflicts of Interest (*All Contractors must complete this section)*

(a) Prohibition. It is unlawful for any person holding an elective office in this State, holding a seat in the General Assembly, or appointed to or employed in any of the offices or agencies of State government and who receives compensation for such employment in excess of 60% of the salary of the Governor of the State of Illinois [$106,447.20], or who is an officer or employee of the Capital Development Board or the Illinois Toll Highway Authority, or who is the spouse or minor child of any such person to have or acquire any contract, or any direct pecuniary interest in any contract therein, whether for stationery, printing, paper, or any services, materials, or supplies, that will be wholly or partially satisfied by the payment of funds appropriated by the General Assembly of the State of Illinois or in any contract of the Capital Development Board or the Illinois Toll Highway Authority.

(b) Interests. It is unlawful for any firm, partnership, association, or corporation, in which any person listed in subsection (a) is entitled to receive (i) more than 7 1/2% of the total distributable income or (ii) an amount in excess of the salary of the Governor ($177,412.00], to have or acquire any such contract or direct pecuniary interest therein.

(c) Combined interests. It is unlawful for any firm, partnership, association, or corporation, in which any person listed in subsection (a) together with his or her spouse or minor children is entitled to receive (i) more than 15%, in the aggregate, of the total distributable income or (ii) an amount in excess of 2 times the salary of the Governor [$354,824.00], to have or acquire any such contract or direct pecuniary interest therein.

Check One: ☒ No Conflicts Of Interest
☐ Potential Conflict of Interest (If checked, name each conflicted individual, the nature of the conflict, and the name of the State agency that is associated directly or indirectly with the conflicted individual.)

Section 3: Debarment/Legal Proceeding Disclosure (*All Contractors must complete this section).*

Each of the persons identified in Sections 1, 2 and 3 must each identify any of the following that occurred within the previous 10 years:

Debarment from contracting with any governmental entity	Yes ☐	No ☒
Professional licensure discipline	Yes ☐	No ☒
Bankruptcies	Yes ☐	No ☒
Adverse civil judgments and administrative findings	Yes ☐	No ☒
Criminal felony convictions	Yes ☐	No ☒

If any of the above is checked yes, please identify with descriptive information the nature of the debarment and legal proceeding. The State reserves the right to request more information, should the information need further clarification.

_____
_____
_____
_____

Section 4: Disclosure of Business Operations with Iran *(All Contractors must complete this section).*

In accordance with 30 ILCS 500/50-36, each bid, offer, or proposal submitted for a State contract, other than a small purchase defined in Section 20-20 [of the Illinois Procurement Code], shall include a disclosure of whether or not the bidder, offeror, or proposing entity, or any of its corporate parents or subsidiaries, within the 24 months before submission of the bid, offer, or proposal had business operations that involved contracts with or provision of supplies or services to the Government of Iran, companies in which the Government of Iran has any direct or indirect equity share, consortiums or projects commissioned by the Government of Iran and:

(1) more than 10% of the company's revenues produced in or assets located in Iran involve oil-related activities or mineral-extraction activities; less than 75% of the company's revenues produced in or assets located in Iran involve contracts with or provision of oil-related or mineral – extraction products or services to the Government of Iran or a project or consortium created exclusively by that Government; and the company has failed to take substantial action;

or

(2) the company has, on or after August 5, 1996, made an investment of $20 million or more, or any combination of investments of at least $10 million each that in the aggregate equals or exceeds $20 million in any 12- month period that directly or significantly contributes to the enhancement of Iran's ability to develop petroleum resources of Iran.

A bid, offer, or proposal that does not include this disclosure shall not be considered responsive. We may consider this disclosure when evaluating the bid, offer, or proposal or awarding the contract.

You must check one of the following items and if item 2 is checked you must also make the necessary disclosure:

☒ There are no business operations that must be disclosed to comply with the above cited law.

☐ The following business operations are disclosed to comply with the above cited law:

_____

_____

_____

_____

Section 5: Current and Pending Contracts *(All Contractors must complete this section).*

Does Contractor have any contracts pending contracts, bids, proposals or other ongoing procurement relationships with units of State of Illinois government?
Yes ☐ No ☒

If yes, please identify each contract, pending contract, bid, proposal and other ongoing procurement relationship it has with units of State of Illinois government by showing agency name and other descriptive information such as bid number, project title, purchase order number or contract reference number.

Section 6: Representative Lobbyist/Other Agent (*All Contractors must complete this section*).

Is Contractor represented by or employ a lobbyist or other agent who is not identified under Sections 1 and 2 and who has communicated, is communicating, or may communicate with any State officer or employee concerning the bid, offer or contract?
Yes ☐ No ☒

If yes, please identify each agent / lobbyist, including name and address.

Costs/Fees/Compensation/Reimbursements related to assistance to obtain contract (describe):

Contractor certifies that none of these costs will be billed to the State in the event of contract award. Contractor must file this information with the Secretary of State.

This Disclosure is signed and made under penalty of perjury pursuant to Sections 500/50-13 and 500/50-35(a) of the Illinois Procurement Code.

This information is submitted on behalf of: IlliniCare Health Plan, Inc.

(Contractor/Subcontractor Name)

Name of Authorized Representative: Michael Kinne

Signature of Authorized Representative Date: 04/25/2011

Title of Authorized Representative: President

Attachment X

Public Act 95-971

Contractor certifies that it has read, understands, and is in compliance with the registration requirements of the Elections Code (10 ILCS 5/9-35) and the restrictions on making political contributions and related requirements of the Illinois Procurement Code (30 ILCS 500/20-160 and 50-37). Contractor will not make a political contribution that will violate these requirements. These requirements are effective for the duration of the term of office of the incumbent Governor or for a period of two (2) years after the end of the Contract term, whichever is longer.

In accordance with Section 20-160 of the Illinois Procurement Code, Contractor certifies as applicable:

☐ Contractor is not required to register as a business entity with the State Board of Elections,
or

☒ Contractor has registered **and has attached a copy** of the official certificate of registration as issued by the State Board of Elections. As a registered business entity, Contractor acknowledges a continuing duty to update the registration as required by the Act.

IN WITNESS WHEREOF, the Department and Contractor hereby execute and deliver this Contract effective as of the Effective Date.

ILLINICARE HEALTH PLAN, INC.

(IlliniCare Health Plan, Inc.)

By: _____
Official Signature

Michael Kinne
Printed Name

President
Title

Date: 04/27/2011

Address:
999 Oakmont Plaza Dr.
Suite 400
Westmont, IL 60559

Phone: (312) 330-2919
Fax: (855) 707-5478
E-mail: mKinne@centene.com

STATE OF ILLINOIS
Department of Healthcare and Family Services

By: Julie Hamos
Julie Hamos, Director

Date: 4/28/11

Address:
201 South Grand Avenue East
Springfield, IL 62763-0002

Phone: 217-782-1200
Fax: 217-524-7979
E-mail: HFS.Director@illinois.gov