FY16

STATE OF ILLINOIS

CONTRACT-OBLIGATION DOCUMENT

Agency No. 478

PLEASE TYPE

Fiscal Year	Transaction Code	Contract/Obligation No.	Transaction Date	Nine Digit Taxpayer ID. Number	Legal Status
2016	28 10	16M0000023	01/06/16	[redacted]	04

Contract Action	Class Code	Governors Release No.	Vendors Name and Address
1. X New 2. ___ Change	25	POSTED 2	NL merger Sub Inc DBA NextLevel Health Partners 303 W. Madison St. Ste 1150 Chicago IL 60606

Appropriation Account Code	Obligation Amount
001-47865-4900-61-00	5,000,000.00
793-47865-4900-00-00	45,000,000.00

Multiple Year Contract	Maximum Contract Amount
From 12/31/15 (MO/DAY/YR) To 12/30/20 (MO/DAY/YR)	500,000,000.00
Current Fiscal Year of Contract	**Annual Contract Amount**
From 12/31/15 (MO/DAY/YR) To 06/30/16 (MO/DAY/YR)	50,000,000.00 Reimbursement Expenses Included

Multiple Year Contract Amounts Year 2-7(and over)

2	3	4
100,000,000.00	100,000,000.00	100,000,000.00
5	**6**	**7**
100,000,000.00	50,000,000.00	

Description 4460 Medical Serv Pa Recip-Vendor

RECEIVED
JAN 25 2016
State Comptroller
Obligations Section

CONTRACTOR WILL PROVIDE INTEGRATED CARE SERVICES TO ADULT AGED, BLIND AND DISABLED NON-MEDICARE ELIGIBLE MEDICARE BENEFICIARIES THE FULL SPECTRUM OF MEDICAID COVERED SERVICES.
MULTI YEAR CONTRACT - YEAR 1 OF 5

Obligations to the state will cease immediately without penalty of further payment being require if, in any fiscal year, the Illinois GeneralAssembly or federal funding source fails to appropriate or otherwise make available sufficientfunds for this agreement.

Method of Compensation	Procurement Information	Travel Expense
(If Multiple Rates, Specify) 0.00 Rate Per MR Time	Award Code P Publication Date / / Reference Subcontractor Utilization (y/n) N Subcontractor Disclosure (y/n) N	YES ___ NO X Amount Advance Payment YES X NO ___

CATHY NEFF 524-7301 01/12/16
Prepared By / Phone Number Date

HFS /Bureau of Managed Care
Contracting Agency/Division

FELICIA F NORWOOD 01/12/16
Authorized By Date

HFS /BUREAU OF FISCAL OPERATIONS
Filing Agency/Division

C-23.1(R-6-07)

HFS Illinois Department of Healthcare and Family Services

CONTRACT APPROVAL DOCUMENT

Procurement Tracking # 2016-24-004-K (NLH)

The attached (select one) contract with (Enter Contractor's Name below)

NEXTLEVEL HEALTH - ICP

in the amount of $ 50,000,000.00 for FY16; 100,000,000.00 for FY17; 100,000,000.00 for FY18; 100,000,000.00 for FY19; 50,000,000.00 for FY21; is approved.

Michelle Mahon KM 12.30.15
Bureau Chief (or nearest organizational equivalent) — Date: 12-30-15

Teresa T. Hung
Division Administrator — Date: 12/30/15

Deputy / Assistant Director — Date

Division of Finance — Date: 12/31/2015

The contract is subject to the CMS Procurement Business Case process. Yes ◉ No ○

All applicable approvals have been obtained by the Department. Yes ◉ No ○

If the contract equals or exceeds $250,000 in a fiscal year, or the amendment or renewal results in a contract that equals or exceeds $250,000 in a fiscal year, the following signatures are needed:

Chief Legal Counsel — Date

Chief Fiscal Officer — Date: 31 Dec 15

STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FELICIA NORWOOD, DIRECTOR
WORD PROCUREMENT BUSINESS CASE TEMPLATE

Project Title: NextLevel Health ICP Contract
Agency Reference Number: 2016-24-004-K (NLH)
Status: Final Date: December 9, 2015

Request ID	16-000000096377
Creator Name	Michelle Maher & Lauren Polite
Procurement End User	Division of Medical Services, Bureau of Managed Care (BMC)
Relevant Category	Health and Medical Services
Detail Object Code	4460 Medical Services Public Assist Recipients Payment Provider
Will a solicitation be posted to IPB?	NO
Will a Notice be Posted to IPB?	NO
In which fiscal year is procurement to begin?	FY 2016
Contract for legal related services (CPO #33)	NO
Nature of Request	Purchase of Care Contract
Procurement Approach	Purchase of Care pursuant to the Illinois Procurement Code, Section 30 ILCS 500/1-10(b)(3) and the Standard Procurement Rules, Section 44 IL Admin Code 1.10(d)(3).
Potential Small Business Set Aside?	NO
Potential BEP Participation Goal?	Yes. The BEP goal will be set at 20% of the administrative allowance included in the capit ation rate.
Potential Veterans Business Program Participation Goal?	NO
Type of Contract	Agency Specific Contract
Expected Start Date	01/01/2016
Expected End Date	12/31/2020
Initial Value	$500,000,000.00 for five (5) years; (Estimating $500,000,000.00 for five (5) year Renewal Term)
Number of Renewals	The contract will include an option to renew for up to an additional 5 years (60 months), not to exceed 10 years in total length of the contract term.
Total Term (in Months)	The contract is for five (5) years or 60 months and will include the option to renew up to an additional 5 years (60 months) for a total of 120 months
Total Value for Maximum Length of Contract	$1 Billion

Project Title: NextLevel Health ICP Contract
Agency Reference Number: Date: December 9, 2015
Status: Final

Total Value Funding Sources	001 – General Revenue Fund 793 – HealthCare Provider Relief Fund
These Values are:	Estimated
Programmatic Objective	The Illinois Department of Healthcare and Family Services (HFS) is seeking approval to enter into a new purchase of care contract with NextLevel Health (ICP) to operate as a Managed Care Community Network (MCCN) care coordination plan for participants in the Seniors and Persons with Disabilities (SPD) Population for the term of January 1, 2016 through December 31, 2020. This new purchase of care contract, which covers the SPD population, will be referred to as the NextLevel Health ICP contract. Currently NextLevel Health is serving as a Care Coordination Entity (CCE) for both the Integrated Care Plan population and the ACA adult population and is providing care coordination services to these populations under the Department's fee-for-service reimbursement processes. Through this new purchase of care contract, NextLevel Health will convert from a CCE to a MCCN on January 1, 2016 and will become a risk based capitation health plan serving the Integrated Care Plan population. A separate purchase of care contract will be signed for NextLevel Health to serve the FHP and ACA populations. This contract will allow the Department to provide continuity of care to the ICP members currently enrolled in their CCE by moving these members over to the NextLevel Health (ICP) MCCN risk based plan and will allow for enrollment of additional ICP members over the term of the contract. As an MCCN, NextLevel Health will manage the care of their members through contracted primary care providers (PCPs), specialty referrals, case and utilization management and outreach programs on a risk based basis. Care Coordination, aligned with the Illinois Medicaid reform law (Public Acts 096-1501 and 097-0689) and the ACA continues to be one of the many efforts under the Illinois Department of Healthcare and Family Services Medicaid reform. Therefore, the Department is committed to continuing to support the original intention of the ACE/CCE programs for an integrated care delivery system to become a risk based entity. As such, the Department is seeking approval to change NextLevel Health from a non-risk based CCE program to a risk based MCCN health plan.
Economic Justification	The ICP MCCNs are providing covered services to the targeted population whose care is coordinated under the ICP Program, Seniors and Persons with Disabilities (SPDs). SPDs have the highest healthcare needs and service utilization of any population covered by Medicaid. It is anticipated that Managed Care Organizations, including MCCNs,

will deliver better access to and quality of care more cost effectively than the traditional fee-for-service system. The medical network included in an MCCN offers comprehensive health services which eliminate fee-for-service costs incurred from other medical provider line items.

The State represents that capitation rates were developed by the Department of Healthcare and Family Services' contracted actuarial firm and that the rates proposed 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.

It is not anticipated that there will be a need for additional procurements in support of or in conjunction with this procurement.

Fiscal Year	Cost
FY16	$ 50,000,000
FY17	$100,000,000
FY18	$100,000,000
FY19	$100,000,000
FY20	$100,000,000
FY21	$ 50,000,000
Total	**$500,000,000**

ICP expenditures are claimable for federal matching funds at the appropriate federal financial participation Rate (FFP) rate. FFP will be up to 100% depending on defined eligibility for each applicant. Although funding has been included in the FY'16 budget request, please note that the FY'16 budget is subject to General Assembly approval and any subsequent changes of the Governor.

History/Background

The ICP is a mandatory managed care program for Seniors and Persons with Disabilities in part, to assist the Department in complying with Public Act 96-1501, which required 50% of Medicaid clients to be enrolled in a form of Care Coordination by January 2015.

The ICP addresses the medical and psychosocial needs of clients, focuses on wellness and prevention, and manages covered services. Integrated managed care for this population provides a much greater capacity to measure performance that goes beyond traditional quality measurement systems to reflect the complexity of chronic conditions common among seniors and people with disabilities.

In 2012, HFS developed the concept of Accountable Care Entities (ACEs) and Care Coordination Entities (CCEs). These are provider-sponsored, integrated delivery systems designed initially, to focus on care coordination. The program was developed with the intent that ACEs and

	CCES would eventually be in a position to move to a risk based capitated payment system and become a Medicaid Managed Care Community Network (MCCN). This contract is consistent with the vision of an ACE or CCE moving to a risk based capitation plan by becoming a Medicaid MCCN under this purchase of care contract that serves the ICP population. The Governor's proposed fiscal year 2016 budget eliminates funding for the ACE and CCE programs and enrolls Medicaid beneficiaries who reside in the mandatory managed care service areas into risk-based managed care delivery systems. As a result, the Department provided all CCEs with the option to: accelerate their transition to a risk based capitated payment arrangement, subcontract with a MCO to continue to provide care coordination services to the ACE's existing membership through the partner MCO, or close their plan and allow clients to select a new health plan for care coordination services. NextLevel Health chose to accelerate their transition to a capitated payment arrangement by becoming an MCCN (2013-24-002-KA3-DM) effective January 1, 2016. As such, the current NextLevel CCE contract will end December 31, 2015 and the new MCCN contract will begin January 1, 2016. The ICP members under their CCE will be moved to the NextLevel Health (ICP) MCCN risk based plan on January 1, 2016.
Cost Cutting Justification	The procurement is time-sensitive and critical to the mission of the Department, and special consideration is required due to the best interests of the State. *Providing ICP Medicaid clients with coordinated care is a key component to the Department's goal of increasing the health of Medicaid clients while lowering healthcare costs to the state. NextLevel Health is currently coordinating the care of approximately 4,700 ICP Medicaid clients under the CCE program and will continue to do so when they convert to an MCCN on January 1, 2016. If the NextLevel Health (ICP) contract is not approved, approximately 4,700 Medicaid clients will go without care coordination services until such time as they can be enrolled in a new health plan. This could lead to healthcare delivery system inefficiencies and may lead to members not receiving care at the right time in the right healthcare setting, which could result in unnecessarily higher healthcare claim costs for the state.*

Reviewed By:

This PBC request has been reviewed by the Division of Finance, Office of Inspector General, Office of General Counsel, Office of Procurement Management, and Medical Programs, Bureau of Professional and Ancillary Services. All comments received have been addressed or incorporated.

Project Title: NextLevel Health ICP Contract
Agency Reference Number: Date: December 9, 2015
Status: Final

Reviewed and Approved By:

Michelle Maher, Bureau Chief — 12-9-15 — Date

Robert Mendosa, Deputy Administrator — 12-10-15 — Date

Teresa Hursey, Division Administrator — 12-14-15 — Date

Michael Casey, Administrator
Division of Finance — 12-18-15 — Date

Project Title: NextLevel Health ICP Contract
Agency Reference Number: Date: December 9, 2015
Status: Final

Director's Action:

I approve of the procurement and request that the PBC be submitted to CMS.

Felicia Norwood, Director — 12-22-15 Date

I request additional information on this procurement and request that the PBC be held until further direction.

Felicia Norwood, Director — Date

I do not approve this procurement and request that the PBC be rejected.

Felicia Norwood, Director — Date

STATE OF ILLINOIS

CONTRACT

Between the

DEPARTMENT OF HEALTHCARE
AND FAMILY SERVICES

and

NEXTLEVEL HEALTH PARTNERS, INC., AN ILLINOIS CORPORATION

for

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

2016-24-004K(NLH)

Table of Contents

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 **NextLevel Health Partners, Inc., an Illinois corporation** ("Contractor"), which certifies that it is a Managed Care Organization and whose principal office is located at 3019 West Harrison Street, Chicago, Illinois 60612.

RECITALS

WHEREAS, Contractor is a Managed Care Community Network operating pursuant to a Certificate of Authority issued by the Illinois Department of Healthcare and Family Services 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, including such Provider of only those services available under one or more HCBS Waivers. 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

1.42 **DHS-DDD** means the Division of Developmental Disabilities within DHS that operates programs for individuals with Developmental Disabilities.

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

1.44 **DHS-DRS** means the Division of Rehabilitation Services within DHS that operates the home services programs for individuals with disabilities (Persons with Disabilities HCBS Waiver), brain injury (Persons with Brain Injury HCBS Waiver) and HIV/AIDS (Persons with HIV/AIDS HCBS Waiver).

1.45 **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

1.46 **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.

1.47 **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.

1.48 **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.

1.49 **DoA** means the Illinois Department on Aging, and any successor agency, that operates the HCBS Waiver for the elderly (Persons who are Elderly HCBS Waiver).

1.50 **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.

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

1.52 **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.

1.53 **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.

1.54 **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.

1.55 **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.

1.56 **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.

1.57 **Enrollee Care Plan** means an Enrollee-centered, goal-oriented, culturally relevant, and logical, written plan of care with a service plan component that assures that the Enrollee receives, to the extent applicable, medical, medically-related, social, behavioral, and necessary Covered Services in a supportive, effective, efficient, timely and cost-effective manner that emphasizes prevention and continuity of care.

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

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

1.60 **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.

1.61 **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.

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

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

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

1.65 **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.

1.66 **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.

1.67 **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.

1.68 **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.

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

1.70 **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).

1.71 **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".

1.72 **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.)

1.73 **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, or who are elderly, who qualify for the level of care provided in an institution but who, with special services, may remain in their homes and communities. In this Contract, references to HCBS Waivers relate only to those HCBS Waivers for which a Service Package under Section 5.1 is then in effect.

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

1.75 **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.

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

1.77 **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.

1.78 **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.

1.79 **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.

1.80 **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.

1.81 **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.

1.82 **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).

1.83 **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.

1.84 **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.

1.85 **Managed Care Community Network (MCCN)** means an entity, other than a Health Maintenance Organization, that is owned, operated, or governed by providers of health care services within Illinois and that provides or arranges primary, secondary and tertiary managed health care services under contract with the Department exclusively to persons participating in programs administered by the Department.

1.86 **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.

1.87 **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. .

1.88 **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.

1.89 **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.

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

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

1.92 **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.

1.93 **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.

1.94 **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.

1.95 **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.

1.96 **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.

1.97 **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.

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

1.99 **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.

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

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

1.102 **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.

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

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

1.105 **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.

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

1.107 **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.

1.108 **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.

1.109 **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.

1.110 **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.

1.111 **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.

1.112 **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.

1.113 **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.

1.114 **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.

1.115 **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.

1.116 **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.

1.117 **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.

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

1.119 **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.

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

1.121 **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.

1.122 **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.

1.123 **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.

1.124 **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.

1.125 **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.

1.126 **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.

1.127 **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.

1.128 **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.

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

1.130 **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.

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

1.132 **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.

1.133 **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.

1.134 **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.

1.135 **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.

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

1.137 **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.

1.138 **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.

1.139 **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.

1.140 **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.

1.141 **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.

1.142 **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.

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

1.144 **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.

1.144A **State Operated Hospital (SOH)** means a hospital operated, owned, and managed by the Department of Human Services, Division of Mental Health, that serves adults with serious mental illness who require inpatient treatment.

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

1.146 **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.

1.147 **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; (iii) encourages family and community involvement; and, (iv) administered by HFS under the Supportive Living Program HCBS Waiver.

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

1.149 **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.

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

1.150a ***Williams* Provider** means the mental health Provider having a contract with the Mental Health Division of DHS to implement the consent decree entered in ***Williams v. Quinn***, No. 05 C 4673 (N.D. Ill.) (***Williams*** consent decree).

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

1.152 **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

1.153	AES:	Advanced Encryption Standard
1.154	APN:	Advanced Practice Nurse
1.155	BEP:	Business Enterprise Program Act for Minorities, Females and Persons with Disabilities
1.156	CAHPS:	Consumer Assessment of Healthcare Providers and Systems
1.157	CART:	Computer Aided Real-time Translation
1.158	C.F.R.:	Code of Federal Regulations
1.159	CMHC:	Community Mental Health Center
1.160	DD:	Developmental Disability
1.161	DHHS:	The United States Department of Health and Human Services
1.162	DHS:	The Illinois Department of Human Services
1.163	DHS-DASA:	The Division of Alcohol and Substance Abuse within DHS
1.164	DHS-DDD:	The Division of Developmental Disabilities within DHS
1.165	DHS-DMH:	The Division of Mental Health within DHS
1.166	DHS-DRS:	The Division of Rehabilitation Services within DHS
1.167	DHS-OIG:	The Department of Human Services Office of Inspector General
1.168	DoA:	The Illinois Department on Aging
1.169	DOC:	The Illinois Department of Corrections
1.170	DON:	Determination of Need
1.171	DPH:	The Illinois Department of Public Health
1.172	DRG:	Diagnostic Related Grouping
1.173	DSCC:	Division of Specialized Care for Children
1.174	EQRO:	External Quality Review Organization
1.175	Federal CMS:	Centers for Medicare & Medicaid Services
1.176	FQHC:	Federally Qualified Health Center
1.177	HCBS Waivers:	Home and Community-Based Services Waivers
1.178	HCP:	Home Care Program
1.179	HEDIS®:	Health Plan Employer Data and Information Set
1.180	HFS:	The Illinois Department of Healthcare and Family Services
1.181	HIPAA:	Health Insurance Portability and Accountability Act
1.182	HMO:	Health Maintenance Organization
1.183	HSP:	Home Services Program
1.184	IBNP:	Incurred But Not Paid

1.185	ICEB:	Illinois Client Enrollment Broker
1.186	ICF:	Intermediate Care Facility
1.187	ICF/DD:	Intermediate Care Facility for the Developmentally Disabled
1.188	ICF/MR:	Intermediate Care Facility for the Mentally Retarded
1.189	ILCS:	Illinois Compiled Statutes
1.190	IPSEC:	Internet Protocol Security
1.191	LTC:	Long-Term Care
1.192	MCO:	Managed Care Organization
1.193	MFTD:	Medically Fragile/Technology Dependent
1.194	MI:	Mental Illness
1.195	MIS:	Management Information System
1.196	NCQA:	National Committee for Quality Assurance
1.197	NF:	Nursing Facility
1.198	OIG:	Office of Inspector General
1.199	PCCM:	Primary Care Case Management
1.200	PCP:	Primary Care Provider
1.201	PERS:	Personal Emergency Response System
1.202	PHI:	Protected Health Information
1.203	PIP:	Performance Improvement Project
1.204	PR:	Peer Review
1.205	QA:	Quality Assurance
1.206	QAP:	Quality Assurance Plan
1.207	QAPI:	Quality Assessment and Performance Improvement
1.208	QIO:	Quality Improvement Organization
1.209	QISMC:	Quality Improvement System for Managed Care
1.210	RHC:	Rural Health Clinic
1.211	SFY:	State Fiscal Year
1.212	SLF:	Supportive Living Facility
1.213	SNF:	Skilled Nursing Facility
1.214	TDD:	Telecommunications Device for the Deaf
1.215	TTY:	Teletypewriter
1.216	UR:	Utilization Review
1.217	VPN:	Virtual Private Network
1.218	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.** If organized as a HMO, Contractor must obtain and maintain during the term of this Contract a valid Certificate of Authority as a HMO under 215 ILCS 125/1-1, et seq. Contractor shall provide proof of Certificate of Authority upon the Department's request. If organized as a MCCN, for so long as Contractor meets the requirements of 89 Ill. Admin. Code Part 143, Contractor may be deemed by the Department to be a certified MCCN.

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 On an annual basis, Contractor shall meet the BEP subcontracting goals set by the Department. 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 2015 is twenty percent (20%). 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 subgoals shall be as follows:

(i) 11% for minority-owned businesses;
(ii) 7% for female-owned businesses;
(iii) 2% for businesses owned by individuals with disabilities.

2.9.2 Contractor shall report quarterly to the Illinois Department of Central Management Services (State CMS) on BEP vendor payments and goal attainment during each State Fiscal Year, in a format specified by State CMS, with a copy to the Department's BEP Liaison. 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.

2.9.3 Contractor shall submit to the Department's BEP Liaison its initial BEP utilization plan and related letters of intent no later than 60 days from the effective date. After submission, Contractor shall work and cooperate with the Department to achieve a BEP utilization plan that is acceptable to the State. Any approved BEP utilization plan shall be incorporated as part of this Contract as Attachment VII.

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 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 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. 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 PCP/WHCP. Contractor shall process an Enrollee's request to change PCP or WHCP within thirty (30) days after the receipt of the request.

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, if an Enrollee is to be disenrolled at the request of Contractor under the provisions of this Section 4.13.1.3, Contractor must first provide documentation satisfactory to the Department that the Enrollee no longer resides in the Contracting Area. Termination of coverage shall take effect at 11:59 p.m. on the last day of the month prior to the month in which the Department determines that the Enrollee no longer resides in the Contracting Area. Termination may be

retroactive if the Department is able to determine the month in which the Enrollee moved from the Contracting Area.

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 with respect to a service package, as set forth in Section 5.1, 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. A Readiness Review will be conducted prior to implementation of any service package set forth in Section 5.1.

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. Personal Assistant services in Service Package II shall be considered Covered Services only if such services can be included in a manner consistent with any existing collective bargaining agreement, or pertinent side letter, between the Illinois Department of Central Management Services and SEIU.

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.

5.1.5 Contractor shall implement any behavioral service plan developed by DHS contractors for an Enrollee who is a class member under the ***Williams*** consent decree unless the Enrollee and the Enrollee's ***Williams*** Provider consent to a modification of such plan. Contractor is responsible for payment of services under such plan only to the extent the services are Covered Services. The State, or its designee, will provide Contractor with a timely copy of any such plan. To the extent that Covered Services in such plan would not have been paid by Contractor due to Contractor's utilization controls, Contractor is not obligated to pay until Contractor has received a copy of the plan.

5.1.6 In fulfilling the requirements of the American Recovery and Reinvestment Act of 2009:

5.1.6.1 The Department shall notify Contractor through the 834 Audit File which Enrollees have been identified as American Indian/Alaskan Native.

5.1.6.2 The Department shall notify Contractor which Providers have been designated as Indian Health Care Providers.

5.1.6.3 Contractor shall notify American Indian Enrollees upon enrollment, and annually thereafter, of their right to receive services at an Indian Health Care Provider.

5.1.6.4 Contractor shall reimburse an Indian Health Provider at least the full encounter rate or fee-for-service rate established by the Department for that Provider, regardless of whether the Provider is an Affiliated Provider.

5.1.6.5 Contractor shall not impose any co-payment on Enrollees identified as American Indian for a Covered Service received from an Indian Health Care Provider or any Medicaid Provider.

5.1.6.6 Contractor shall not impose cost sharing on Enrollees identified as American Indian if the Enrollees have ever received services from an Indian Health Provider.

5.1.6.7 An Enrollee identified as an American Indian is exempt from all cost sharing if the Enrollee has ever received a Referral from an Indian Tribe, Tribal Organization or Urban Indian Organization (I/T/U).

5.1.6.8 Contractor shall not limit an Enrollee identified as an American Indian to I/T/U Providers in the State of Illinois.

5.1.6.9 Contractor shall permit any Indian who is enrolled in a non-Indian MCO and eligible to receive services from a participating I/T/U provider, to elect that I/T/U as his or her primary care provider, if that I/T/U provider participates in the network as a Primary Care Provider and has capacity to provide the services.

5.1.6.10 Contractor shall demonstrate that there are sufficient I/T/U providers in the network to ensure timely access to services

available under the contract for Indian Enrollees who are eligible to receive services from such providers.

5.1.7 Contractor shall submit its Pharmacy Formulary for Prior Approval initially and annually thereafter.

5.1.7.1 Contractor shall provide coverage of drugs in all classes of drugs for which the Department's FFS program provides coverage.

5.1.7.2 Contractor shall cover only drugs made by manufacturer who participate in the Federal Medicaid drug rebate program, which applies to both prescription and over-the-counter drugs, but does not apply to non-drug items such as blood sugar test strips. The department will provide a listing of manufacturers that participate in the federal Medicaid drug rebate program.

5.1.7.3 Contractor may determine its own utilization controls, including, but not limited to, step therapy and prior approval, unless otherwise prohibited under this Contract, to ensure appropriate utilization. Contractor shall utilize the Department's step therapy and prior authorization requirements for family planning drugs and devices pursuant to Attachment XXI.

5.1.7.4 Contractor shall ensure that it requires pharmacy, medical, and hospital providers to identify 340B-purchased drugs on pharmacy, medical, and hospital claims following the Department billing guidelines applied in the fee-for-service program. Contractor shall ensure that its encounter claims to the Department also identify these drugs.

5.1.7.5 Contractor shall establish and maintain a generic drug Maximum Allowable Cost (MAC) dispute resolution process, subject to approval by the Department. The MAC dispute resolution process shall enable pharmacies to report pricing disputes to the Contractor up to 60 days from the claim date and the Contractor is required to resolve the pricing dispute within 21 days by adjusting the reimbursement rate to represent the average acquisition cost of the drug, or by informing the pharmacy of alternative generic equivalent products that can be purchased at or below the Contractor's existing MAC price.

5.1.7.6 Contractor shall develop and implement a system, including policies and procedures, coverage criteria and processes for their Drug Utilization Review (DUR) program. The DUR program shall include a prospective review process for all drugs prior to dispensing and all non-formulary drug request; and a retrospective drug utilization review process to detect patterns in prescribing, dispensing, or administration of medication and to prevent inappropriate use or abuse. The Contractor is required to report prospective and retrospective DUR activities to HFS quarterly, and assist in

data collection and reporting to the Department of data necessary to complete the CMS DUR annual report.

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 hospitals, PCPs, WHCPs, specialist Physicians in individual and group practices, clinical laboratories, dentists, including oral surgeons, pharmacies, behavioral health Providers, substance abuse Providers, CMHCs, and all other Provider types, 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.

5.5.1.2 During the first year in which the services in Service Package II, as set forth in Section 5.1.2, are Covered Services (Service Package II First Year), Contractor shall enter into a contract with any willing and qualified Provider in the Contracting Area that renders such Covered Services so long as the Provider agrees to the Contractor's rate and adheres to Contractor's QA requirements. Contractor may establish quality standards in addition to those State and federal requirements and, after the Service Package II First Year, contract with only those Providers that meet such standards, provided that all of the contracting Providers are informed of any such additional standards no later than ninety (90) days after the start of the Service Package II First Year and that the State has given Prior Approval. Any such standards that are not established within ninety (90) days after the start of the Service Package II First Year, must be in effect for one (1) year before Contractor may terminate a contract of a Provider based on a failure to meet such standards.

5.5.1.2.1 For NFs and SLFs, Contractor must maintain the adequacy of its Provider network, sufficient to provide Enrollees with reasonable choice, within each county of the Contracting Area provided that each Affiliated Provider meets all applicable State and federal requirements for participation in the Medicaid Program. Contractor may require as a condition for participation in its network that a NF agree to provide access to Contactor's Care Management team by acting upon the team's credentialing applications in accordance with generally applicable standards, to permit qualified members of the team to write medication and lab orders, to access Enrollees in order to conduct physical examinations, and to serve as PCP for an Enrollee.

5.5.1.2.2 For Providers of each of the following Covered Services under a HCBS Waiver, Contractor must enter into contracts with a sufficient number of such Providers within each county in the Contracting Area to assure that the Affiliated Providers served at least eighty percent (80%) of the number of Participants in each county who were receiving such services on the day immediately preceding the day such services became Covered Services. For counties served by more than one (1) Provider of such Covered Services, Contractor shall enter into contracts with at least two (2) of such Providers, so long as such Providers accept Contractor's rates, even if one (1) served more than eighty percent (80%) of the Participants, unless the Department grants Contractor an exception.

5.5.1.2.2.1 Adult Day Care
5.5.1.2.2.2 Homemaker/In-Home Services
5.5.1.2.2.3 Day Habilitation
5.5.1.2.2.4 Supported Employment
5.5.1.2.2.5 Home Delivered Meals
5.5.1.2.2.6 Home Health Aides
5.5.1.2.2.7 Nursing Services
5.5.1.2.2.8 Occupational Therapy
5.5.1.2.2.9 Speech Therapy
5.5.1.2.2.10 Physical Therapy

5.5.1.2.3 For the following Covered Services that are services under a HCBS Waiver, the requirements are as follows:

5.5.1.2.3.1 Environmental Accessibility Adaptations - Home: Contractor will use its best efforts, and document those efforts, to ensure that the work necessary to meet the need for the Covered Service is satisfactorily completed by a qualified provider within ninety (90) days after Contractor becomes aware of the need.

5.5.1.2.3.2 Personal Assistants: Contractor will refer Enrollees, as necessary and appropriate,

to the Centers for Independent Living, or other available resources, for assistance in locating potential Personal Assistants.

5.5.1.2.3.3 Personal Emergency Response System (PERS): Contractor will enter into contracts that meet the requirements of 89 Ill. Admin. Code 240.235 with no fewer than two (2) providers of PERS within a Contracting Area.

5.5.1.2.4 In arranging for Covered Services for Enrollees under the DoA Persons who are Elderly HCBS Waiver for such Enrollees who do not express a choice of a Provider of such Covered Services, Contractor shall fairly distribute such Enrollees, taking into account all relevant factors, among those Affiliated Providers who are willing and able to accept such Enrollees and who meet applicable quality standards.

5.5.1.3 Contractor shall enter into a contract with any willing and qualified Community Mental Health Center (Medicaid Provider Type 36) in the Contracting Area so long as the Provider agrees to the Contractor's rate and adheres to Contractor's QA requirements. Contractor may establish quality standards in addition to those State and federal requirements and, after the first year of contracting, contract with only those Community Mental Health Centers that meet such standards, provided that each the contracting Provider is informed of any such additional standards no later than ninety (90) days after the start of its contract and that the State has given Prior Approval. Any such standards that are not established within ninety (90) days after the start of the contract with the Community Mental Health Center must be in effect for one (1) year before Contractor may terminate a contract of a Provider based on a failure to meet such standards.

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.

5.5.7 Medical Home. Contractor's Affiliated Provider network shall include Providers that serve as Medical Homes, which may include FQHCs, CMHCs and multi-specialty PCP-centered medical groups, private practice PCP offices and nurse practitioner-led clinics. Medical Homes will be patient-centered in approach with the capacity to provide access to a personal clinician and care team that offers individualized, high quality comprehensive primary care and coordinates specialty and other needed services. Medical Homes will demonstrate competence in the following areas: effective care coordination; family and caregiver involvement; health promotion and Wellness Programs; self-management strategies; 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 at FQHCs, CMHCs and high volume Providers that agree to this approach.

5.5.7.1 Medical Home Development Advisory Council. Contractor shall establish a Medical Home Development Advisory Council, including a Council Charter that defines the mission and purpose of the Council. The Council will partner with key community stakeholders to develop a plan to promote patient-centered Medical Home (PCMH) principles and the transformation and adoption of the PCMH model within the Provider community.

5.5.7.2 Assessing Medical Homes. Contractor shall provide a PCP self-assessment tool to PCP practices to self-assess the following:

5.5.7.2.1 Organizational capacity;

5.5.7.2.2 Chronic Health Condition management approaches;

5.5.7.2.3 Coordination and continuity of care processes;

5.5.7.2.4 Community outreach knowledge and connections;

5.5.7.2.5 Data management; and,

5.5.7.2.6 Quality Improvement/change.

5.5.7.3 Ranking Medical Homes. Contractor will rank PCP practices into four (4) Medical Home levels and provide incentives for those practices to become highly functioning comprehensive Medical Homes.

5.5.7.3.1 Level 1 – Basic Medical Home

5.5.7.3.2 Level 2 – Intermediate Medical Home

5.5.7.3.3 Level 3 – Advanced Medical Home

5.5.7.3.4 Level 4 – Comprehensive Medical Home

5.5.7.4 Medical Home Education. Contractor shall educate Medical Homes on methods to improve care capacity and capabilities to provide Wellness Programs, preventive care, management of Chronic Health Conditions and coordination and continuity of care through office visits, Provider manuals, Provider newsletters, Provider mailings and website updates.

5.5.7.5 Medical Home Monitoring. Contractor will provide general monitoring and support to assess Medical Home performance based on the standard and accepted PCMH criteria. Upon request by the Provider, Contractor will provide general guidance or access to resources each individual practice may choose to utilize as part of its PCMH transformation and improvement efforts.

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 in accordance with recognized Medically Necessary criteria.

5.5.9 Hospitalist Program. Contractor shall provide Hospitalist services, either through direct employment or a sub-contractual relationship.

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 either telephonic or field-based Registered Nurses or licensed clinical social workers 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. Contractor shall collect sufficient information from Providers to assess compliance with the Americans With Disabilities Act. As necessary to serve Enrollees, Provider locations where Enrollees receive services shall be ADA compliant. In addition, Contractor shall include within its network Provider locations that are able to accommodate the unique needs of Enrollees.

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 or appropriate, immediately referred for urgent Medically Necessary care or provided with an appointment within one (1) Business Day of the request. Enrollees with problems or complaints that are not deemed serious shall be seen within three (3) weeks from the date of request for such care. Initial prenatal visits without expressed problems shall be made available 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. 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 or Medical Home. 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 or Medical Home.

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, except as provided in Section 5.7.5, in accordance with National Committee for Quality Assurance (NCQA) credentialing standards as well as applicable HFS, DHS, DoA, Illinois Department of Insurance and federal requirements. Re-credentialing shall occur every three (3) years. At re-credentialing and on a continuing basis, 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. Contractor utilizes a single-tiered credentialing process, and shall not assign Enrollees to a PCP or WHCP until such Provider has been fully credentialed. Contractor must notify the Department when the credentialing process is completed and provide the results of the process.

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.

5.7.5 Verification of Qualifications of Providers of Covered Services under HCBS Waivers. Contractor shall ensure that only those Providers of Covered Services under HCBS Waivers that are approved and authorized by the State are providing such Covered Services, and that those Providers are providing only such Covered Services for which they are approved and authorized, to Enrollees. The Department will provide Contractor with a

weekly State extract file containing the list of such approved and authorized Providers. Contractor is not required to credential Providers of Covered Services under HCBS Waivers.

5.8 **This section intentionally left blank.**

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 online reference tool for the Provider and staff regarding, but not limited to, administrative, prior authorization, and Referral processes, claims and encounter submission processes, and plan benefits. The Provider Manual shall also address topics such as clinical practice guidelines, availability and access standards, Care Management Programs and Enrollee rights.

5.9.5 **Provider Directory.** Contractor shall make its Provider Directory available to Providers via Contractor's web-portal.

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.

5.9.7 **Health, Safety and Welfare Education.** As part of its Provider education, Contractor shall include information related to identifying, preventing and reporting Abuse, Neglect, exploitation, and critical incidents.

5.9.8 **DHS HCBS Waiver Provider Education.** Contractor shall distribute Provider packets, which the State or its designee will provide, to Enrollees and educate each Enrollee regarding the Enrollee's responsibility to provide the Provider packets to Personal Assistants and all other individual providers who provide Covered Services under the Persons with Disabilities HCBS Waiver, Persons with HIV/AIDS HCBS Waiver, or Persons with Brain Injury HCBS Waiver. Contractor shall further educate Enrollees that such Providers may not begin providing Covered Services until the fully and correctly completed packets have been returned to and accepted by the local DHS-DRS office.

5.10 **Coordination Tools.** Contractor shall have in place the following technology 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 Contractor's sources to profile, measure and monitor Enrollee Profiles. Profiles will include demographics, eligibility data, claims data, pharmacy data, assessment results, authorizations and Care Coordinator assignments.

5.10.2 **Care Management System.** Contractor's Care Coordinators will use the Care Management system to review assessments, interventions, and management of Chronic Health Conditions to gather information to support Enrollee Care Plans and identification of Enrollees' needs. No later than twelve (12) months after the first enrollment, Contractor shall update the Care Management system to extend its functionality to provide Enrollees and Providers with web-based access to Contractor's Care Management system.

5.10.3 **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.

5.11 **Care Management.** Contractor shall offer Care Management to Enrollees based upon each Enrollee's individual risk level. Contractor shall offer Care Management to all Enrollees who receive Covered Services under a HCBS Waiver.

5.11.1 **Provision of Care Management.**

5.11.1.1 Contractor shall offer Care Management through a Care Coordinator who participates in an Interdisciplinary Care Team for all medical, behavioral health and Covered Services under Service Package I and II, including assessment of the Enrollee's clinical risks and needs, medication management, and health education on complex clinical conditions, as appropriate to the individual needs and preferences of the Enrollee.

5.11.1.2 If Contractor enters into any contract with any entity that also administers the DON or prescreening required under the HCBS Waivers, Contractor shall immediately provide the name of that Provider to the Department.

5.11.1.3 Contractor shall maximize opportunities for an Enrollee's independence in the community by ensuring the coordination of referrals for other necessary services that are not Covered Services, such as supportive housing and other social services.

5.11.1.4 Contractor shall have the capacity to perform the full range of Care Management prior to implementation of each Service Package as set forth in Section 5.1, and the State will monitor Contractor's performance throughout the term of the Contract.

5.11.2 **Care Coordinators.** Each Enrollee identified as requiring Care Management, and any other Enrollee who agrees or wishes to receive Care Management, will be assigned a Care Coordinator.

5.11.2.1 **Qualifications.** Care Coordinators who serve Enrollees within the DoA Persons who are Elderly HCBS Waiver, DHS-DRS

Persons with a Brain Injury HCBS Waiver, DHS-DRS Persons with HIV/AIDS HCBS Waiver, or DHS-DRS Persons with Disabilities HCBS Waiver must meet the applicable qualifications set forth in Attachment XVI.

5.11.2.2 **Training Requirements.** Care Coordinators who serve Enrollees within the DoA Persons who are Elderly HCBS Waiver, DHS-DRS Persons with a Brain Injury HCBS Waiver, DHS-DRS Persons with HIV/AIDS HCBS Waiver, DHS-DRS Persons with Disabilities HCBS Waiver, or HFS Supportive Living Program HCBS Waiver must meet the applicable training requirements set forth in Attachment XVI.

5.12 **Caseload Requirements.** Contractor shall assign each Enrollee identified as requiring Care Management, and any other Enrollee who agrees or wishes to receive Care Management, to a Care Coordinator as provided in Section 5.11.2. Care Coordinators responsible for Enrollees with varying risk levels shall have their overall caseload weighted and a blended overall caseload limit set, taking into account the location of the Enrollee. The maximum weighted caseload for a Care Coordinator is 600 with low risk weighted as one (1), moderate risk weighted as four (4), and high risk weighted as eight (8). The Department may review existing caseloads at any time and require a change in methodology or an Enrollee's assignment to a caseload.

5.12.1 **Caseload Standards.** Effective April 1, 2013, Caseloads of Care Coordinators shall not exceed the following standards on average during the calendar year:

5.12.1.1 High Risk Enrollees: 75

5.12.1.2 Moderate Risk Enrollees: 150

5.12.1.3 Low Risk Enrollees: 600

5.12.1.4 For Enrollees in the Persons with Brain Injury Waiver or the Persons with HIV/AIDS Waiver, the caseloads shall not exceed 30.

5.12.2 **Contact Standards.** Care Coordinators who provide Care Management shall maintain contact with Enrollees as frequently as appropriate. Care Coordinators who provide Care Management to High Risk Enrollees shall have contact with such Enrollees at least once every ninety (90) days. Care Coordinators providing Care Management to Enrollees receiving HCBS Waiver services shall maintain contact as follows:

5.12.2.1 Persons who are Elderly Waiver: The Care Coordinator shall have a face-to-face contact with the Enrollee not less often than once every ninety (90) days.

5.12.2.2 Persons with Brain Injury: The Care Coordinator shall have contact with the Enrollee not less often than one (1) time per month.

5.12.2.3 Persons with HIV/AIDS: The Care Coordinator shall contact the Enrollee not less than one (1) time per month, and not less than one (1) face-to-face contact every 2 months.

5.12.2.4 Persons with Disabilities: The Care Coordinator shall have a face-to-face contact with the Enrollee no less often than once every ninety (90) days in the Enrollee's home.

5.12.2.5 Supportive Living Program: The Care Coordinator shall contact the Enrollee no less often than one (1) time per year.

5.13 Interdisciplinary Care Team. Contractor will support an Interdisciplinary Care Team (ICT) for each Enrollee that will ensure the integration of the Enrollee's medical, behavioral health, and Service Package II care.

5.13.1 Each ICT will be person-centered, built on each Enrollee's specific preferences and needs, and delivering services with transparency, individualization, respect, linguistic and cultural competence, and dignity. Each ICT shall consist of clinical and non-clinical staff whose skills and professional experience will complement and support each other in the oversight of each Enrollee's needs.

5.13.2 ICT functions shall include, but not be limited to:

5.13.2.1 Supporting medical homes, assisting in the development, implementation, and monitoring of Individualized Care Plans, including HCBS Service Plans where applicable, assisting in assuring integration of services and coordination of care across the spectrum of the healthcare system, and providing Care Management for Enrollees who have complex needs;

5.13.2.2 Including a primary Care Coordinator who is responsible for coordination of all benefits and services the Enrollee may need. Care Coordinators will have prescribed caseload limits as set forth in Section 5.12.1;

5.13.2.3 Assigning a Care Coordinator who has the experience most appropriate to support the Enrollee;

5.13.2.4 Using motivational interviewing techniques;

5.13.2.5 Explaining alternative care options to the Enrollee;

5.13.2.6 Maintaining frequent contact with the Enrollee through various methods including face-to-face visits, email, and telephone options, as appropriate to the Enrollee's needs and risk-level, or upon the Enrollee's request; and,

5.13.2.7 Ensuring that the Enrollee Care Plan is communicated to the appropriate Person when the Enrollee changes Providers, Contractor or setting and as provided in Sec. 5.15.1.

5.14 Assessments and Care Planning

5.14.1 Identifying Need for Care Management. Contractor's goals, benchmarks and strategies for managing the care of Enrollees in its traditional Disease Management Programs shall be incorporated in, and included as part of, Contractor's Care Management program. Contractor shall use population and individual-based tools and real-time Enrollee data to identify an Enrollee's risk level. These tools and data shall include, but not be limited to, the following:

5.14.1.1 **Health Risk Screening.** Contractor shall have a Health Risk Screening, and make its best efforts to administer the Health Risk Screening and, if needed, a behavioral health risk assessment to all new Enrollees within sixty (60) days after enrollment, to collect information about the Enrollee's physical, psychological and social health. Contractor will use the results to guide the administration of more in-depth health assessments. Contractor may administer a health risk assessment in place of the Health Risk Screening provided that it is administered within sixty (60) days after enrollment. Contractor shall notify PCPs of enrollment of any new Enrollee who has not completed a Health Risk Screening within the time period set forth above and whom Contractor has been unable to contact. Contractor shall encourage PCPs to conduct outreach to their Enrollees and to schedule visits.

5.14.1.2 **Predictive Modeling.** Upon availability of Enrollee claims data.

5.14.1.3 **Surveillance Data.** Contractor shall identify Enrollees through referrals, transition information, service authorizations, alerts, memos, results of the DON, and from families, caregivers, Providers, community organizations and Contractor personnel.

5.14.2 **Stratification.** Based upon an analysis of the information gathered through the process in Section 5.14.1, Contractor shall stratify all Enrollees identified for its Care Management Program to determine the appropriate level of intervention. Enrollees shall be assigned to one (1) of three (3) levels:

5.14.2.1 Low or no risk – Contractor provides prevention and wellness messaging and condition-specific education materials.

5.14.2.2 Moderate risk – Contractor provides problem-solving interventions. Contractor shall assign no less than twenty percent (20%) of its Enrollees to moderate risk and high risk levels combined.

5.14.2.3 High risk – Contractor provides intensive Care Management for reasons such as ameliorating past ineffective health care or addressing lack of social support. Contractor shall assign no less than five percent (5%) of its Enrollees to this level.

5.14.3 **Outreach.** Contractor shall use its best efforts to locate all Enrollees who are identified through risk stratification as being high risk or moderate risk.

5.14.4 **Enrollee Engagement and Education.** Contractor shall use a multifaceted approach to locate, engage and educate Enrollees and shall capitalize on every Enrollee contact to obtain and update Enrollee information. Contractor shall solicit input from Enrollees and other stakeholders to help develop strategies to increase motivation for enhanced independent and healthy living.

5.14.5 **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.

5.14.6 **Health Risk Assessment.** Contractor shall use its best efforts to complete a health risk assessment and develop an Enrollee Care Plan within ninety (90) days after enrollment for Enrollees stratified as high or moderate risk, except as follows:

5.14.6.1 For those Enrollees receiving HCBS Waiver Services or residing in NFs as of the date that the services in Service Package II become Covered Services, the assessment relating to those Covered Services must be face-to-face and completed within the 180-day transition period. For all other Enrollees eligible for HCBS Services or transitioning to NFs, such an assessment must be face-to-face and completed within ninety (90) days after enrollment.

5.14.7 Enrollee Care Plan Reassessment. Contractor will analyze predictive modeling reports and other surveillance data of all Enrollees monthly to identify risk level changes. As risk levels change, reassessments will be completed as necessary and Enrollee Care Plans and interventions updated. Contractor will review Enrollee Care Plans and intervention of Enrollees at high-risk at least every thirty (30) days, and Enrollees at moderate-risk at least every ninety (90) days, and conduct reassessments as necessary based upon such reviews. At a minimum, Contractor shall conduct a reassessment annually for each Enrollee. In addition, Contractor will conduct a face-to-face reassessment for Enrollees receiving HCBS Waiver services or residing in NFs each time there is a significant change in the Enrollee's condition or an Enrollee requests reassessment.

5.14.8 Individualized Care Plans/Service Plans.

5.14.8.1 Following stratification under Section 5.14.2, Contractor shall assign an ICT, with a Care Coordinator, to the Enrollee and the ICT will develop a comprehensive person-centered Enrollee Care Plan for Enrollees stratified as high or moderate risk and for Enrollees in a HCBS Waiver. The Enrollee Care Plan must be developed within ninety (90) days after enrollment. The Enrollee Care Plan must:

5.14.8.1.1 Incorporate an Enrollee's medical, behavioral health, Service Package II care, social, and functional needs;

5.14.8.1.2 Include identifiable short- and long-term treatment and service goals to address the Enrollee's needs and preferences and to facilitate monitoring of the Enrollee's progress and evolving service needs;

5.14.8.1.3 Include, in the development, implementation, and ongoing assessment of the care plan, an opportunity for Enrollee participation and an opportunity for input from the PCP, other providers, and a legal or personal representative and the family or caregiver if appropriate; and,

5.14.8.1.4 Contractor shall identify and evaluate risks associated with the Enrollee's care. Factors considered include, but are not limited to, the potential for deterioration of the Enrollee's health status; the Enrollee's ability to comprehend risk; caregiver qualifications; appropriateness of the residence for the Enrollee; and, behavioral or other compliance risks. Contractor shall incorporate the results of the risk assessment into the 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.

5.14.8.1.5 Include, as appropriate, the following elements:

5.14.8.1.5.1 The Enrollee's personal or cultural preferences, such as types or amounts of services;

5.14.8.1.5.2 The Enrollee's preference of Providers and any preferred characteristics, such as gender or language;

5.14.8.1.5.3 The Enrollee's living arrangements;

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

5.14.8.1.5.5 Actions and interventions necessary to achieve the Enrollee's objectives;

5.14.8.1.5.6 Follow-up and evaluation;

5.14.8.1.5.7 Collaborative approaches to be used;

5.14.8.1.5.8 Desired outcome and goals, both clinical and non-clinical;

5.14.8.1.5.9 Barriers or obstacles;

5.14.8.1.5.10 Responsible parties;

5.14.8.1.5.11 Standing Referrals;

5.14.8.1.5.12 Community resources;

5.14.8.1.5.13 Informal supports;

5.14.8.1.5.14 Timeframes for completing actions;

5.14.8.1.5.15 Status of the Enrollee's goals;

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

5.14.8.1.5.17 Back-up plan arrangements for critical services;

5.14.8.1.5.18 Crisis plans for an Enrollee with Behavioral Health conditions; and,

5.14.8.1.5.19 Wellness Program plans.

5.14.8.1.6 Include a HCBS Waiver service plan (Service Plan) for Enrollees receiving HCBS Waiver services.

Contractor shall develop the Service Plan as follows:

5.14.8.1.6.1 For an Enrollee who is not receiving HCBS Waiver services on the date that such services become Covered Services, Contractor shall ensure that the Service Plan is developed within fifteen (15) days after the Contractor is notified that the Enrollee is determined eligible for HCBS Waiver services. Contractor is responsible for actual HCBS Waiver service planning, including the development, implementation, and monitoring of the Service Plan, and updating the Service Plan when an Enrollee's needs change. The Service Plan Care Coordinator will lead HCBS Waiver service planning through coordination with the Enrollee and the ICT.

5.14.8.1.6.2 For an Enrollee who is receiving HCBS Waiver Services on the date that such services become Covered Services, Contractor will use the Enrollee's existing Service Plan, and that Service Plan will remain in effect for at least a 180-day transition period unless changed with the input and consent of the Enrollee and only after completion of a face-to-face comprehensive needs assessment. The Service Plan will be transmitted to Contractor prior to the effective date of enrollment. The Service Plan Care Coordinator will lead the process for changing or updating the HCBS Waiver service planning, as appropriate, through coordination with the Enrollee and the ICT.

5.14.8.1.6.3 For an Enrollee who begins receiving HCBS Waiver Services after such services become Covered Services but before the Enrollee is eligible for Contractor services, the Enrollee's existing Service Plan will remain in effect for at least a ninety (90) day transition period unless changed with the input and consent of the Enrollee as in 5.14.8.1.6.2 above. The State shall be responsible for providing the Service Plan to Contractor upon enrollment.

5.14.8.1.6.4 For an Enrollee who is receiving HCBS Waiver Services through the Contractor and who ceases to be eligible for Contractor services, but continues to be eligible for HCBS Waiver or equivalent home care services, the Contractor shall transmit the Enrollee's existing Service Plan to the applicable State agency within fifteen (15) days after new coverage information is reflected in MEDI.

5.15 Transition of Care.

5.15.1 Transition of Care Process. Contractor will manage transition of care and continuity of care for new Enrollees and for Enrollees moving from an institutional setting to a community living arrangement. Contractor's process for facilitating continuity of care will include:

5.15.1.1 Identification of Enrollees deemed critical for continuity of care.

5.15.1.2 Communication with entities involved in Enrollees' transition.

5.15.1.3 Stabilization and provision of uninterrupted access to Covered Services.

5.15.1.4 Assessment of Enrollees' ongoing care needs.

5.15.1.5 Monitoring of continuity and quality of care, and services provided.

5.15.2 Transition of Care Plan. Contractor shall, initially, and as revised, submit to the Department for the Department's review and Prior Approval, a transition of care plan that shall include transition of care policies and procedures and a staffing model designed to achieve a seamless, efficient transition with minimal impact to an Enrollee's care.

5.15.3 Transition of Care Team. Contractor shall have an interdisciplinary transition of care team to design and implement the transition of care plan and provide oversight and management of all transition of care processes. The team will consist of skilled personnel with extensive knowledge and experience transitioning Enrollees with special health care needs.

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

5.15.4.1 Use of predictive modeling and CORE tools;

5.15.4.2 Review of Enrollee Information from current Providers; and

5.15.4.3 Identification of an Enrollee's current placement as a guide for addressing needs.

5.15.5 Outreach. Contractor's community based ICT will interact with Enrollees whose needs are deemed critical for transition of care in order to assess the Enrollees' service needs, identify Enrollees' current Providers, and identify gaps in care. The ICT shall coordinate the provision of Medically Necessary Covered Services.

5.15.6 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, a Covered Service, and Medically Necessary. Contractor shall evaluate the appropriateness of integrated Care Management and education for each Enrollee who it determines to have a pre-existing condition.

5.15.7 Money Follows the Person. Contractor shall use the MFP web referral form for members residing in Nursing Facilities who are interested in returning to a community based setting. The web referral form is available at https://mfp.hfs.illinois.gov/mfpreferral.aspx.

5.15.7.1 Contractor shall follow MFP program processes, procedures, and coordination requirements provided by the Department.

5.15.7.1.1 Contractor shall coordinate with the Department, DOA, and DHS and their community based provider agencies and contractors working to transition individuals through the MFP program, including but not limited to Care Coordination Units, Center's for Independent Living, Aging and Disability Resource Centers, Community Mental Health Centers, and the University of Illinois at Chicago College of Nursing.

5.15.7.2 Contractor shall provide an incentive payment to MFP community based providers under contract with DOA and DHS when they transition an MCO enrollee through the MFP program that remains in the community at the specified intervals as follows:

5.15.7.2.1 Contractor shall provide a $1,000 incentive payment to the MFP provider that is the lead transition coordinator on the case for each Enrollee who transitions to the community and remains in the community for 3 months;

5.15.7.2.2 Contractor shall provide a $1,000 incentive payment to the MFP provider that is the lead transition coordinator on the case for each Enrollee who transitions to the community and remains in the community for 12 months; and

5.15.7.2.3 If an Enrollee switches health plans during this period, the MCO the individual is enrolled with at the 3 or 12 month mark is responsible for making the incentive payment to the MFP provider.

5.15.7.3 Contractor shall continue to meet all other responsibilities outlined in this Contract for their Enrollees when the MFP period ends after 12 months in the community.

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 The Contractor must develop policies and procedures to ensure continuity of care for all Enrollees upon initial enrollment, as follows:

5.16.2.1 The Contractor must offer an initial ninety (90)-day transition period for Enrollees new to the health plan in which Enrollees may maintain a current course of treatment with a Provider who is currently out of the Contractor's network. The Contractor must offer a ninety (90)-day transition period for Enrollees switching from another health plan to the Contractor. The ninety (90)-day transition period is applicable to all Providers, including behavioral health Providers and Providers of LTSS. Out-of-network PCPs and specialists providing an ongoing course of treatment will be offered Single Case Agreements to continue to care for that Enrollee beyond the transition period if the Enrollee remains outside the network or until a qualified Affiliated Provider is available.

5.16.2.2 The Contractor may choose to transition Enrollees to a network PCP during the transition period only if:

5.16.2.2.1 The Enrollee is assigned to a medical home that is capable of serving the Enrollee's needs appropriately;

5.16.2.2.2 A health screening and a comprehensive assessment, if necessary, is complete;

5.16.2.2.3 The Contractor consulted with the new medical home and determined that the medical home is accessible, competent, and can appropriately meet the Enrollee's needs;

5.16.2.2.4 A transition of care plan is in place (to be updated and agreed to with the new PCP, as necessary); and

5.16.2.2.5 The Enrollee agrees to the transition prior to the expiration of the transition period.

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, which require prior authorization as expeditiously as the Enrollee's health condition requires.

Ordinarily, requests for authorizations shall be reviewed and decided within ten (10) days after receiving the request for authorization from a Provider, with a possible extension of up to ten (10) additional days, if the Enrollee requests the extension or Contractor informs the Provider that there is a need for additional written justification demonstrating that the Covered Service is Medically Necessary and the Enrollee will not be harmed by the extension. If the Physician indicates, or Contractor determines, that following the ordinary review and decision time frame could seriously jeopardize the Enrollee's life or health, Contractor shall authorize or deny the Covered Service no later than seventy-two (72) hours after receipt of the request for authorization. Contractor shall authorize or deny a prior authorization request for pharmacy services no later than twenty-four (24) hours after receipt of the request for authorization.

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.

5.17.4 State Operated Hospitals. Contractor shall cover admissions to State Operated Hospitals for all enrollees admitted under civil status, at Medicaid established rates, whether that State Operated Hospital is an Affiliated or non-Affiliated Provider. MCOs shall be required to reimburse state operated hospitals for all enrollees admitted under civil status at Medicaid established rates for providing inpatient psychiatric care. Payment shall be made for all days utilized as determined by DMH and is not subject to the utilization review determinations or admission authorization standards of the MCO.

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;Cost sharing, if any;

5.18.1.7 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;

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

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

5.18.1.10 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;

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

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

5.18.1.14 Contractor shall provide information on NF Covered Services and HCBS Waiver Covered Services to Enrollees receiving or determined to be in need of Covered Services under Service Package II.

5.18.1.15 Contractor shall distribute Enrollee packets, which the State or its designee will provide, to those Enrollees receiving Covered Services from Personal Assistants or all other individual providers under the Persons with Disabilities HCBS Waiver, Persons with HIV/AIDS HCBS Waiver, or Persons with Brain Injury HCBS Waiver.

Contractor shall educate Enrollees regarding the content of the Enrollee packets.

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. All Contractor staff will receive training on all Contractor policies and procedures during new hire orientation and ongoing job-specific training to ensure effective communication with 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 at the close of each contact to inquire if the Enrollee's needs or issues have been resolved. Contractor shall conduct targeted Enrollee focus groups to obtain additional input on Contractor materials and program information, and shall also seek input from local organizations that serve Enrollees.

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.

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, Exercise the Enrollee's rights, and that the exercise of those rights 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 State's Appeal and fair hearing process, including how to register a 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 PCP changes, to file Complaints or Grievances, to request disenrollment, to ask questions or to obtain other administrative information.

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

5.18.6.4 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.

5.18.6.5 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.

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

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.

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

5.18.7.3 Enrollee Portal. No later than twelve (12) months after the first enrollment, Contractor shall establish and maintain a secure Enrollee Web Portal which shall include, at a minimum, the following functions or capabilities:

5.18.7.3.1 Information about Contractor;

5.18.7.3.2 "Contact Us" information;

5.18.7.3.3 Local health events and news; and

5.18.7.3.4 Provider search.

5.18.7.4 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 **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.

5.18.8.3 **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.

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

5.18.8.5 **Welcome Calls.** Contractor will conduct Welcome Calls to each new Enrollee within thirty (30) days after the effective date of enrollment. For those new Enrollees who Contractor successfully contacts, 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.

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

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

5.18.8.8 **Enrollee Support to Ensure Compliance.** To the extent possible, Contractor shall involve the Enrollee in 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 **Web Portal.** Providing educational materials on the Enrollee Web Portal.

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

5.18.9.3 **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 for 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.

5.19.2 Contractor shall ensure Affiliated labs are capable of reporting lab values to Contractor directly. Contractor shall use the electronic lab values to calculate HEDIS® performance measures.

5.19.3 Contractor shall adopt practice guidelines that meet, at a minimum, the following criteria:

5.19.3.1 Contractor shall adopt practice guidelines that meet the Minimum Standards of Care set forth in Attachment XXI.

5.19.3.2 Contractor agrees to comply with the Minimum Standards of Care attached hereto as Attachment XXI.

5.19.3.2 Consider the needs of the Enrollees;

5.19.3.3 Are adopted in consultation with Affiliated Providers;

5.19.3.4 Are reviewed and updated periodically, as appropriate; and

5.19.3.5 Are available to all affected Affiliated Providers, non-Affiliated Providers, Enrollees and Potential Enrollees.

5.19.4 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.

5.19.5 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.

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

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

5.19.8 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.

5.19.9 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 Health, Safety and Welfare Monitoring. Contractor shall comply with all health, safety and welfare monitoring and reporting required by State or federal statute or regulation, or that is otherwise a condition for a HCBS Waiver, including, but not limited to, the following: critical incident reporting regarding Abuse, Neglect, and exploitation; critical incident reporting regarding any incident that has the potential to place an Enrollee, or an Enrollee's services, at risk, but which does not rise to the level of Abuse, Neglect, or exploitation; and performance measures relating to the areas of health, safety and welfare and required for operating and maintaining a HCBS Waiver.

5.20.1 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.), the Elder Abuse and Neglect Act (320 ILCS 20/1 et seq.), the Abused and Neglected Child Reporting Act (325 ILCS 5/1 et seq.) and any other similar or related applicable federal and State laws.

5.20.2 Contractor shall comply with critical incident reporting requirements of the DHS-DRS, DoA, and HFS HCBS Waivers for incidents and events that do not rise to the level of Abuse, Neglect or exploitation. Such reportable incidents include, but are not limited to, the incidents identified in Attachments XVII, XVIII, and XIX for the appropriate HCBS Waivers.

5.20.3 Contractor shall comply with HCBS Waiver reporting requirements to assure compliance with Federal Waiver Assurances for Health Safety, and Welfare as set forth in the approved HCBS Waivers. Contractor, on an ongoing basis, shall identify, address, and seek to prevent the occurrence of Abuse, Neglect and exploitation. Performance measures regarding health, safety, welfare and critical incident reporting are included in Table 2 to Attachment XI.

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

5.20.5 Contractor shall train Providers, Enrollees and Enrollees' family members about the signs of Abuse, Neglect and exploitation, what to do if they suspect Abuse, Neglect or exploitation, and Contractor's responsibilities. Training sessions will be customized to the target audience. Training will

include general indicators of Abuse, Neglect and exploitation and the timeframe requirements for reporting suspected Abuse, Neglect and exploitation.

5.20.6 Reports regarding Enrollees who are age eighteen (18) and older and living in the to be made to the Illinois Department on Aging by utilizing the Adult Protective Services (APS) Hotline number at 1-866-800-1409 (voice) and 1-800-206-1327 (TTY).

5.20.7 Reports regarding Enrollees aged 18-59 receiving mental health or developmental disability services in DHS operated, licensed, certified or funded programs are to be made to the Illinois Department of Human Services Office of the Inspector General Hotline at 1-800-368-1463 (voice and TTY).

5.20.8 Reports regarding Enrollees in Supportive Living Facilities (SLF) must be made to the Department of Healthcare and Family Services' SLF Complaint Hotline at 1-800-226-0768.

5.20.9 Contractor shall provide the Department, upon request, with its protocols for reporting suspected Abuse, Neglect and exploitation and other critical incidents that are reportable.

5.20.10 Contractor shall provide the Department, upon request, with its protocols for assuring the health and safety of the Enrollee after an allegation of Abuse, Neglect or exploitation, or a critical incident, is reported.

5.20.11 Critical Incident Reporting

5.20.11.1 Contractor shall have processes and procedures in place to receive reports of critical incidents. Critical events and incidents must be reported and issues that are identified must be routed to the appropriate department within Contractor and, when required or otherwise appropriate, to the investigating authority.

5.20.11.2 Contractor shall maintain an internal reporting system for tracking the reporting and responding to critical incidents, and for analyzing the event to determine whether individual or systemic changes are needed.

5.20.11.3 Contractor shall have systems in place to report, monitor, track, and resolve critical incidents concerning restraints and restrictive interventions.

5.20.11.3.1 Contractor shall make reasonable efforts to detect unauthorized use of restraint or seclusion. Contractor shall require that events involving the use of restraint or seclusion are reported to Contractor as a reportable incident, and reported to the investigating authority as indicated if it rises to the level of suspected Abuse, Neglect, or exploitation.

5.20.11.3.2 Contractor shall make reasonable efforts to detect unauthorized use of restrictive interventions. Contractor shall require that events involving the use of restrictive interventions are reported to Contractor as a reportable incident, and reported to the investigating authority if it rises to the level of Abuse, Neglect or exploitation.

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 this Section and 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. Any Contractor obligation(s) to provide reporting to the Department shall be contingent on the Department's ability to deliver to Contractor the information or necessary business specifications reasonably required by Contractor to complete its reporting requirements, as applicable.

5.25 **Timely Payments to Providers.** Contractor shall make payments to Providers (including the fiscal agent making payments to Personal Assistants under the HCBS waivers. See Attachment XX) for Covered Services on a timely basis consistent with the Claims Payment Procedure described at 42 U.S.C. § 1396a(a)(37)(A) and 215 ILCS 5/368a. Complaints or disputes concerning payments for the provision of services as described in this Section 5.25 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. For purposes of an Enrollee's admission to a NF, a "Clean Claim" means that the admission is reflected on the patient credit file that Contractor receives from the Department. Contractor will not be considered to be in breach of this Section, 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, unless a different rate was agreed upon by Contractor and the non-Affiliated Provider.

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.

5.25.5 Contractor shall pay all Providers of HCBS Waiver services at a rate no less than the State Medicaid rate for such Covered Services.

5.25.5.1 Contractor shall pay Provider agencies that provide in-home services under the Persons who are Elderly HCBS Waiver, and that also offer health insurance to their in-home service workers, at a rate that includes the enhanced rate set forth at 89 Ill. Admin. Code 240.1970. In the event that any other HCBS Waiver becomes subject to a duly promulgated State rule that includes a similar enhanced rate, Contractor shall pay the affected Provider agencies at a rate that includes such enhanced rate.

5.25.5.2 Contractor shall not discriminate against Providers of HCBS Waiver services that offer health insurance to their in-home services workers.

5.25.6 For Covered Services rendered during calendar years 2013 and 2014, Contractor shall ensure that each Physician and each APN working under the supervision of a Physician, who meets the requirements of 42 C.F.R. 447.400(a), is paid at the Medicare rate, as calculated pursuant to the State Plan, for the provision of primary care services that are Covered Services as defined in 42 C.F.R. 447.400(c). To the extent Contractor's existing rates for primary care services, as determined pursuant to 42 C.F.R. 447.400, are less than the required Medicare rates, the Department will send a supplemental payment to Contractor for each month with documentation detailing specific supplemental payments to be paid to specific Providers. Contractor shall use this supplemental payment and documentation to comply with its payment requirement under this Section 5.25.6. Contractor shall have no obligation to pay any amount greater than the Medicare rates for these primary care services, and shall not be required to pay any supplemental payments to the applicable Providers until Contractor has received such supplemental payments from the Department. The Department will calculate the supplemental payment by identifying Encounter Data, or other mutually agreed upon file format, for the specified primary care services that are Covered Services relating to qualifying Physicians and APNs and multiplying such Encounter Data by the appropriate add-on payment under the State Plan. Contractor shall pay this incremental amount to such qualifying Physicians and APNs within thirty (30) days after it receives the supplemental payment from the Department. No later than ninety (90) days after the receipt of each supplemental payment from the Department, Contractor shall provide to the Department documentation of the additional amounts paid to qualifying Physicians and APNs in order to comply with this Section 5.25.6. The Department will be responsible for the collection of any self-attestations required to be submitted by Physicians and APNs.

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

5.26 Grievance System. Contractor shall have a formally structured Grievance system that is compliant with Sections 45 of the Managed Care Reform and Patient Rights Act, 215 ILCS 134, and 42 C.F.R. Parts 431 Subpart E and 438 Subpart F to handle all Grievances and Appeals subject to the provisions of such sections of the Act and regulations.

5.26.1 Grievances. Contractor shall establish and maintain a procedure for reviewing Grievances by an Enrollee or an Enrollee's authorized representative. A Grievance may be submitted orally or in writing, and all Grievances shall be registered with Contractor. 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. At a minimum, the following elements must be included in the Grievance process:

5.26.1.1 Contractor shall attempt to resolve all Grievances as soon as possible but no later than ninety (90) calendar days from receipt of a Grievance. Contractor may inform an Enrollee of the resolution orally or in writing.

5.26.1.2 An Enrollee may appoint any individual, including a guardian, caretaker relative, or Provider, to represent the Enrollee

throughout the Grievance process as an authorized representative. Contractor shall provide a form and instructions on how an Enrollee may appoint an authorized representative.

5.26.1.3 Contractor shall submit to the Department, in the format required by the Department, a quarterly report summarizing all Grievances and the responses to and disposition of those matters.

5.26.2 Appeals. Contractor shall establish and maintain a procedure for reviewing Appeals by Enrollees or an Enrollee's authorized representative. An Appeal may be submitted orally or in writing, and all Appeals shall be registered initially with Contractor and may later be appealed to the State, as provided herein. Contractor's procedures must: (i) be submitted to the Department in writing and approved in writing by the Department; (ii) provide for resolution within the times specified herein, 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 Enrollees. At a minimum, the following elements must be included in the Appeal process:

5.26.2.1 An Enrollee may file an oral or written Appeal within sixty (60) calendar days following the date of the notice of Action that generates such Appeal. If the Enrollee does not request an expedited Appeal pursuant to 42 CFR 438.410, Contractor may require the Enrollee to follow an oral Appeal with a written, signed Appeal.

5.26.2.2 An Enrollee may appoint any authorized representative, including a guardian, caretaker relative, or Provider, to represent the Enrollee throughout the Appeal process. Contractor shall provide a form and instructions on how an Enrollee may appoint a representative.

5.26.2.3 If an Enrollee requests an expedited Appeal pursuant to 42 CFR 438.410, Contractor shall notify the Enrollee within twenty-four (24) hours after the submission of the Appeal, of all information from the Enrollee that Contractor requires to evaluate the Appeal. Contractor shall render a decision on an expedited Appeal within twenty-four (24) hours after receipt of the required information.

5.26.2.4 If an Enrollee does not request an expedited Appeal, Contractor shall make its decision on the Appeal within fifteen (15) business days after submission of the Appeal. Contractor may extend this timeframe for up to fourteen (14) calendar days if the Enrollee requests an extension, or if Contractor demonstrates to the satisfaction of the appropriate state agency's Hearing Office that there is a need for additional information and the delay is in the Enrollee's interest.

5.26.2.5 Final decisions of Appeals not resolved wholly in favor of the Enrollee may be appealed by the Enrollee to the State under its Fair Hearings system within thirty (30) calendar days after the date of the Contractor's Decision Notice.

5.26.2.6 Except for a denial of Waiver services, which may not be reviewed by an external independent entity, Contractor shall have procedures allowing an Enrollee to request an external independent review, both standard and expedited timeframes, of Appeals that are denied by Contractor within thirty (30) calendar days after the date of the Contractor's Decision Notice.

5.26.2.7 If an Appeal is filed with the State Fair Hearing system, Contractor will participate in the pre-hearing process, including scheduling coordination and submission of documentary evidence at least three (3) business days prior to the hearing, and shall participate in the hearing, including providing a witness to offer testimony supporting the decision of Contractor.

5.26.2.8 If Contractor or the State Fair Hearing Officer reverses a decision to deny, limit, or delay services, and those services were not furnished while the Appeal was pending, Contractor must authorize or provide the disputed services as expeditiously as the Enrollee's health condition requires.

5.26.2.9 If Contractor or the State Fair Hearing Officer reverses a decision to deny authorization of services, and the Enrollee received the disputed services while the Appeal was pending, Contractor must pay for those services, in accordance with State policy and regulations.

5.26.2.10 If an Enrollee files an Appeal within ten (10) calendar days after the date of a notice of Action from Contractor and the Enrollee asks to have their benefits continued during the Appeal process, Contractor must continue the Enrollee's benefits during the Appeal process. Pursuant to 42 CFR 438.420, if the final resolution of the Appeal is adverse to the Enrollee, Contractor may recover the cost of the services that were furnished to the Enrollee.

5.26.2.11 Contractor shall submit to the Department, in the format required by the Department, a quarterly report summarizing all Appeals filed by Enrollees and the responses to and disposition of those matters (including decisions made following an external independent review).

5.26.3 Contractor shall review its Grievance and Appeal procedures at least annually for the purpose of amending such procedures when necessary. Contractor shall amend its procedures only upon receiving the written Prior Approval of the Department. This information shall be furnished to the Department.

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.

5.27.1 Contractor shall administer DoA's "Participant Outcomes and Status Measures (POSM) Quality of Life Survey" to each DoA Persons who are elderly HCBS Waiver Enrollee and Supportive Living Program HCBS Waiver Enrollee at each annual reassessment in order to determine each Enrollee's perception of the quality of life.

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 sub contractual 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.

5.28.1.3 Contractor shall require each Affiliated Provider that provides Covered Services under a DHS HCBS Waiver, under the Medicaid Clinic Option, or under the Medicaid Rehabilitation Option, or subacute alcoholism and substance abuse treatment services pursuant to 89 Ill. Admin. Code 148.340-148.390 and 77 Ill. Admin. Code Part 2090 to enter any data regarding Enrollees that is required under State rules, or a contract between the Provider and DHS, into any subsystem maintained by DHS, including, but not limited to, the Department's (DHS) Automated Reporting and Tracking System (DARTS).

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, Abuse or misconduct 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 HIPAA Requirements 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.

5.35 Pursuant to 305 ILCS 5/5-30 (a) and (h), any MCO serving at least 5,000 seniors, or, people with disabilities, or, 15,000 individuals in other populations covered by the Medical Assistance Program that have been receiving full-risk capitation for at least one year are considered eligible for accreditation and shall be accredited by the NCQA within two years after the date it was eligible for accreditation.

5.35.1 The Contractor must achieve and/or maintain a status of "Excellent," "Commendable," or "Accredited." If the Contractor receives a "Provisional" accreditation status, the MCO will be required to complete a "re-survey" within 12 months after the accreditation determination.

5.35.2 During this provisionary period, enrollment may be limited. If the subsequent "re-survey" results in a "Provisional" or "Denied" status, the Department will regard this finding as a breach of contract. In such an event, the Contractor's failure to achieve accreditation may result in the termination for the contract.

5.35.3 Upon completion of the accreditation survey, the Contractor must submit to the Department a copy of the "Final Decision Letter" no later than 10 calendar days upon receipt from NCQA. Thereafter and on an annual basis between accreditation surveys, the Contractor must submit a copy of the "Accreditation Summary Report" issued as a result of the Annual Healthcare Effectiveness Data and Information Set (HEDIS) Update no later than 10 calendar days upon receipt from NCQA. Upon the Department's request, the Contractor must provide any and all documents related to achieving accreditation. Compliance will be assessed annually based on the Contractor's accreditation status as of September 15th of each subsequent year.

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 **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. The Capitation rates for the Nursing Facility rate cell and the HCBS Other Waivers rate cell will include a component for Service Package I and Service Package II. Except as provided in Subsections 7.1.1 through 7.1.4, an Enrollee's rate cell will be determined by his or her residential status as of the first day of the month (e.g., NF resident, HCBS Waiver Enrollee). The Department will use its eligibility system to determine an Enrollee's rate cell. Delays in changes to an Enrollee's residential status being reflected in the Department's eligibility system will cause adjustments to past Capitation payments to be made. 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.

7.1.1 Effective September 2014, the Department will pay a supplemental capitation payment in the amount shown in the table on attachment IV to allow contractor to preserve access to hospital services for Enrollees. Contractor shall only expend the amount of this supplemental capitation to support the availability of hospital services and to ensure access to hospital services. Such expenditures shall be made within 15 days of receipt of the supplemental capitation payment. Contractor shall obtain a surety bond payable to the Department in an amount estimated by the Department to equal the aggregate monthly amount Contractor shall receive as a supplemental payment under this subparagraph within forty (40) days of the Department's notification to Contractor of the estimated amount. The Department shall notify contractor on an annual basis of the estimated amount of the required surety bond. The supplemental capitation payment made pursuant to this paragraph shall not be subject to risk adjustment pursuant to Section 7.4 or to the quality withhold pursuant to Section 7.10.1.

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 risk adjusted using a standard industry risk adjustment tool, such as the Chronic Illness and Disability Payment System (CDPS), Medicaid Rx (MRx), or a combination of the two (CDPS+Rx). The version of the risk adjustment tool will not be modified during a calendar year, but may be updated annually with the most recent version publicly available. The Department will either use standard weights as published by the University of California in San Diego or develop custom weights using Illinois-specific data, where 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 across all rate cells. The risk scores may be established using a credibility formula for each MCO and rate cell if enrollment is not sufficiently large enough to assume full credibility. The credibility formula to be used will be determined by an independent actuary. Encounter records will not be supplemented by medical record data. Diagnoses must be recorded in the patient's record prior to claim submission and may not be retroactively adjusted through appropriate encounter submission 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 Initial Risk Adjustment Period. [This Section Intentionally Blank.]

7.4.2.1 [This Section Intentionally Blank.]

7.4.2.2 [This Section Intentionally Blank.]

7.4.3 For every calendar year, Enrollee risk scores shall be calculated using both the Department's Fee-For-Service claims data and all MCO Encounter Data, in all Contracting Areas, for claims with dates of service during a twelve-month experience period preceding the year of payment adjustment with four (4) months of paid claims run-out (each such one year 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 sixty (60) days following the claims run-out 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. The application of risk scores is intended to be budget neutral to the

Department across the Integrated Care Program, or normalized to a 1.0000 value among the MCOs.

7.4.4 [This Section Intentionally Blank]

7.4A Stop Loss Insurance.

7.4A.1 Provision of Stop Loss Insurance. The Department shall provide stop loss insurance to Contractor as described in this Section 7.4A for the calendar year 2016 or for such time as determined by the Department in its sole discretion. The projected cost of stop loss insurance has been determined by the Department's actuary. The premiums for the cost of stop loss insurance will be withheld from Capitation rates that otherwise would be paid to Contractor. At the Contractor's request, the Department may extend, at the Department's sole discretion, stop loss insurance as described in this Section 7.4A to additional service areas and for additional contract periods. In the event that Contractor obtains a suitable private market replacement for the stop loss insurance described in this Section 7.4A, Contractor shall notify the Department immediately in writing, the Department will cancel the stop loss insurance effective as of the date the private market insurance takes effect, and Contractor shall have no further obligations to pay premiums to the Department with respect to such stop loss insurance.

7.4A.2 Description of Stop Loss Insurance. The terms of this Section 7.4.2A shall apply while the stop loss insurance in Section 7.4.1A is in effect. For dates of service during any calendar year, for any single Enrollee, Contractor will be at risk for one hundred percent (100%) of any Service Package 1 medical costs up to eighty thousand dollars ($80,000). Contractor will be at risk for twenty percent (20%) of the Service Package 1 medical costs in excess of $80,000 for such calendar year and the Department will be at risk for the remaining eighty percent (80%) of Service Package 1 medical costs in excess of $80,000 for such calendar year (the "State Reinsurance Portion"). Claims for any hospital stay that occurs in two (2) calendar years and that is reimbursed through the DRG methodology will be attributed to the calendar year in which the admission occurred. Contractor will be at risk for one hundred percent (100%) of Service Package 2 Costs at all times. Commencing in the month immediately following the month in which the Service Package 1 medical costs for an Enrollee during a calendar year exceed $80,000, Contractor will invoice the Department on a monthly basis for the State Reinsurance Portion to the extent incurred in the prior month. The Department shall use best efforts to process such invoice for payment within thirty (30) days of receipt or as soon as practicable thereafter. The Parties shall conduct a final reconciliation each calendar year that will allow for a 180 day claims run-out period and Contractor shall provide the Department with a final invoice no later than July 31, 2017, that sets forth each claim that Contractor paid during the applicable calendar year and a detailed statement of the State Reinsurance Portion, including a statement of such amounts that have been reimbursed to Contractor.

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 disenrollment 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 disenrollment of Enrollees shall not exceed two (2) months except in instances of the death of an Enrollee or when the Enrollee moves out of the State. 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 Pay for Performance.

7.10.1 Contractor may earn a percentage of payments based on its performance with respect to those quality metrics set forth in Attachment XI, Table 1. Each month the Department shall withhold a portion of the 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 and subsequent measurement years. An equal portion of the incentive payment will be allocated to each P4P Metric. If Contractor reaches the target goal on a P4P Metric, Contractor will earn the withhold percentage of the incentive payment assigned to that P4P Metric. Withholds of Contractor's Capitation payment for the purposes of funding the incentive payments shall commence with the January Capitation payment of the first measurement year.

7.10.2 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 approval of the calculations for payment by Contractor and the Department. 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 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 payments under this Section 7.10.

7.10.3 [This Section Intentionally Blank.]

7.10.4 Effective for HEDIS® 2017 (measurement year January 1, 2016 through December 31, 2016), the Department will provide the P4P measures and target goals prior to the beginning of the measurement year. 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 a payment, then the Parties will negotiate, and the resolution will be memorialized 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 may adopt NAIC reporting standards and protocols after giving written notice to Contractor.

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. The annual fee pursuant to Section 7.14.1 will not be included as revenue for the MLR calculation. Payments made to Contractor pursuant to Section 7.1.5 shall not be included as revenue for the MLR calculation.

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. Expenditures pursuant to Section 7.1.5 will not be included as a 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.

7.14.1 Health Insurance Provider Annual Fee. Section 9010 of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (124 Stat. 119 (2010)), as amended by Section 10905 of PPACA, and as further amended by Section 1406 of the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (124 Stat. 1029 (2010)) imposes an annual fee on health insurance providers beginning in 2014 ("Annual Fee"). Contractor is responsible for a percentage of the Annual Fee for all health insurance providers as determined by the ratio of Contractor's net written premiums for the preceding year compared to the total net written premiums of all entities subject to the Annual Fee for the same year. The State shall reimburse the Contractor for the amount of the Annual Fee specifically allocable to the premiums paid pursuant to this Contract, for each calendar year or part thereof, including an adjustment for the full impact of the non-deductibility of the Annual Fee for Federal and state tax purposes, including income and excise taxes ("Contractor's Adjusted Fee"). The Contractor's Adjusted Fee shall be determined based on the final notification of the Annual Fee amount Contractor or Contractor's parent receives from the United States Internal Revenue Service. To claim reimbursement for the Contractor's Adjusted Fee the Contractor must submit a certified copy of its full Annual Fee assessment within sixty (60) days of receipt, together with the allocation of the Annual Fee attributable specifically to its premiums under this Contract. The Contractor must also submit the calculated adjustment for the impact of non-deductibility of the Annual Fee attributable specifically to its premiums under this Contract, and any other data deemed necessary by the State to validate the reimbursement amount. These materials shall be submitted under the signatures of either its Financial Officer or Executive leadership (e.g., President, Chief Executive Office, Executive Director), certifying the accuracy, truthfulness and completeness of the data provided.

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.

7.15A Repayment of Advance. Pursuant to Section 7.9 ("Advance") under the contract entered into by Contractor as a Care Coordination Entity (2013-24-002, as amended), the Department advanced Contractor the amount of three hundred thousand dollars ($300,000.00) for use in establishing the Contractor's Care Coordination model, including hiring necessary care coordination and administrative staff, under that Contract. Beginning with the Capitation payment due under this Contract for January 2016, the Department shall deduct $16,670.00 from the Capitation payment due for each month through the Capitation payment

due for May 2017, and the Department shall deduct $16,610.00 from the Capitation payment due for June 2017. If this Contract terminates before the Department has recovered the three hundred thousand dollars ($300,000.00), the Department may deduct any unpaid balance of the advance from any other contract Contractor may have with the Department at the same rate as provided in this Section 7.15A. If this Contract terminates before the full amount of the advance is recovered, and the remainder cannot be recovered from Capitation payments due from the Department and there are no other contracts between the Parties from which the remainder can be recovered, then Contractor shall immediately reimburse the Department in full for the portion of the advance which has not been recovered by the Department. Nothing in this Section 7.15A shall prohibit the Parties from agreeing to an increase in the amounts of the deductions, provided that such agreement is in a letter signed by the Parties, whereupon such written agreement shall be incorporated into this Contract.

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 Appropriations (30 ILCS 500/20-60); Sufficiency of Funds. This contract is contingent upon and subject to the availability of sufficient funds. The Department may terminate or suspend this contract, in whole or in part, without penalty or further payment being required, if (i) sufficient State funds have not been appropriated to the Department or sufficient Federal funds have not been made available to the Department by the Federal funding source, (ii) the Governor or the Department reserves appropriated funds, or (iii) the Governor or the Department determines that appropriated funds or Federal funds may not be available for payment. The Department shall provide notice, in writing, to Contractor of any such funding failure and its election to terminate or suspend this contract as soon as practicable. Any suspension or termination pursuant to this Section will be effective upon Contractor's receipt of notice.

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 HIPAA Requirements set forth in Attachment VI. Upon the Department's learning of a material breach of the terms of the HIPAA Requirements, 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 the HIPAA Requirements and cure is not possible.

9.1.34 **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).

9.1.35 **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.

9.1.36 **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.

9.1.37 **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.

9.1.38 Contractor shall consult and cooperate with the State in meeting any obligations the State may have under any consent decree, including, but not limited to, the ***Colbert v. Quinn***, No. 07 C 4735 (N.D. Ill.) and ***Williams*** consent decrees. Contractor shall modify its business practices, as required by the State, in performing under the Contract in order for the State to comply with such consent decrees and, if necessary, enter into any amendments to the Contract. If compliance with Section 9.1.39 necessitates the expenditure of additional material resources, then the Department will address adjustments of the Capitation rates as set forth in Section 7.6.

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.

9.2.34 The Contractor shall comply with the disclosure requirements specified in 42 C.F.R. Part 455, including, but not limited to, filing with the Department upon the execution of this Contract and within thirty-five (35) days after a change occurring, a disclosure statement containing the following:

9.2.34.1 The name, FEIN and address of each Person with an Ownership or Controlling Interest in the Contractor, and for individuals include home address, work address, date of birth, Social Security number and gender.

9.2.34.2 Whether any of the individuals so identified are related to another so identified as the individual's spouse, child, brother, sister or parent.

9.2.34.3 The name of any Person With an Ownership or Controlling Interest in the Contractor who also is a Person With an Ownership or Controlling Interest in another managed care organization that has a contract with the Department to furnish services under the HFS Medical Program, and the name or names of the other managed care organization.

9.2.34.4 The name and address of any Person With an Ownership or Controlling Interest in the Contractor or who is an agent or employee of the Contractor who has been convicted of a criminal offense related to that Person With an Ownership or Controlling Interest's involvement in any program under Federal law including any program under Titles XVIII, XIX, XX or XXI of the Social Security Act, since the inception of such programs.

9.2.34.5 Whether any Person identified in subsections (1) through (4) of this section, is currently terminated, suspended, barred or otherwise excluded from participation, or has voluntarily withdrawn as the result of a settlement agreement, in any program under Federal

law including any program under Titles XVIII, XIX, XX or XXI of the Social Security Act or has within the last five (5) years been reinstated to participation in any program under Federal law including any program under Titles XVIII, XIX, XX or XXI of the Social Security Act and prior to said reinstatement had been terminated, suspended, barred or otherwise excluded from participation or has voluntarily withdrawn as the result of a settlement agreement in such programs.

9.2.34.6 Whether the Medical Director of the Plan is a Person with an Ownership or Controlling Interest.

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

NEXTLEVEL HEALTH PARTNERS, INC., ILLINOIS CORPORATION

By: _____
Official Signature

Cheryl Rucker-Whitaker
Printed Name

CEO
Title

Date: Dec 28, 2015

Address:
3019 West Harrison St.
Chicago, IL 60612

Phone: 312 601 0249
Fax: 312 324 0665
E-mail: cheryl@nlhpartners.com

STATE OF ILLINOIS
Department of Healthcare and Family Services

By: _____
Felicia F. Norwood, Director

Date: 12-31-15

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 Audiology services;
1.4 Chiropractic services for Enrollees under age twenty-one (21);
1.5 Dental services, including oral surgeons;
1.6 Preventive dental services for Enrollees under age twenty-one (21);
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; (drugs used in the treatment of Hepatitis C are covered only if dispensed in accordance with Contractor's coverage criteria approved by the Department);
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 Renal Dialysis services;
1.28 Services to prevent illness and promote health in accordance with Attachment XXI.
1.29 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
1.30 Transplants covered under 89 Ill. Admin. Code Section 148.82 (using transplant providers certified by the Department)
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. Adult preventive dental care - two cleanings per year
2. Transportation to provider appointments and pharmacy for prescription fill
3. $50 allowance toward a pair of upgraded eyeglass frames every two years

Attachment II
Service Package II Covered Services

Service	DoA	DHS-DRS			HFS	Definition	Standards	HFS Fee-For-Service Service Limits
	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury	Supportive Living Facility			
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		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			HFS	Definition	Standards	HFS Fee-For-Service Service Limits
	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury	Supportive Living Facility			
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			HFS	Definition	Standards	HFS Fee-For-Service Service Limits
	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury	Supportive Living Facility			
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	DRSThe 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			HFS	Definition	Standards	HFS Fee-For-Service Service Limits
	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury	Supportive Living Facility			
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	DRSAll 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			HFS	Definition	Standards	HFS Fee-For-Service Service Limits
	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury	Supportive Living Facility			
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						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						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 59 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			HFS	Definition	Standards	,HFS Fee-For-Service Service Limits
	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury	Supportive Living Facility			
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 Assistant (Contingent upon compliance with collective bargaining agreement and accompanying side letter between SEIU and the State.)		x	x	x		Personal Assistants provide assistance with eating, bathing, personal hygiene, and other activities of daily living in the home and at work (if applicable). When specified in the Enrollee Care Plan, this service may also include such housekeeping chores as bed making, dusting, vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the consumer, rather than the consumer's family. Personal Care Providers must meet State standards for this service. The Personal Assistant is the employee of the consumer. The State acts as fiscal agent for the Enrollee.	89 Il. Adm. Code 686.10	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 as determined by the DON score. These services may include assistance with preparation of meals, but does not include the cost of the meals themselves. Personal Care will only be provided when it has been determined by the case manager that the consumer has the ability to supervise the Personal Care Provider and the service is not otherwise covered.

Service	DoA	DHS-DRS			HFS	Definition	Standards	HFS Fee-For-Service Service Limits
	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury	Supportive Living Facility			
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			HFS	Definition	Standards	HFS Fee-For-Service Service Limits
	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury	Supportive Living Facility			
Respite		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 250 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						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			HFS	Definition	Standards	HFS Fee-For-Service Service Limits
	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury	Supportive Living Facility			
Family Training						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		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			HFS	Definition	Standards	HFS Fee-For-Service Service Limits
	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury	Supportive Living Facility			
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
Nursing Facility Services over the first ninety (90) days								

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 (HRS 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	DDThere 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 Waiver Manual	DDThis 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.

NEXTLEVEL HEALTH PARTNERS, INC.

Contracting Areas	Effective January 1, 2016: Region IV (Suburban Cook) Region VI (City of Chicago)
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 unless they voluntarily enroll in an MCO; • 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	See below

All capitation rates listed are 100% of actuarially certified rates, but only a percentage may be paid in accordance with Section 7.10.1.

Service Package 1 Rates effective January 1, 2016:						
Rate Cell	Region I (N.W. Illinois) PMPM	Region II (Central Illinois) PMPM	Region III (Southern Illinois) PMPM	Region IV (Suburban Cook Co) PMPM	Region V (Collar Counties) PMPM	Region VI (City of Chicago) PMPM
Community Residents	NA	NA	NA	$940.26	NA	$1,053.55
HCBS DD Waiver	NA	NA	NA	$614.21	NA	$581.16
ICF/MR Other	NA	NA	NA	$789.04	NA	$702.18
Nursing Facility	NA	NA	NA	$1,446.66	NA	$1,599.71
HCBS Other Waivers	NA	NA	NA	$1,729.19	NA	$1,897.50
ICF/MR State Op Facility	NA	NA	NA	$115.70	NA	$154.11

Service Package 2 Rates effective January 1, 2016						
Rate Cell	Region I (N.W. Illinois) PMPM	Region II (Central Illinois) PMPM	Region III (Southern Illinois) PMPM	Region IV (Suburban Cook Co) PMPM	Region V (Collar Counties) PMPM	Region VI (City of Chicago)
Nursing Facility	NA	NA	NA	$4,404.35	NA	$4,283.48
HCBS Other Waivers	NA	NA	NA	$1,492.43	NA	$1,531.96
Other Waivers Plus	NA	NA	NA	NA	NA	NA
Community Plus	NA	NA	NA	NA	NA	NA

Supplemental Capitation Payment for Hospital Services effective January 2016 through June 2016:						
Rate Cell	Region I (N.W. Illinois) PMPM	Region II (Central Illinois) PMPM	Region III (Southern Illinois) PMPM	Region IV (Suburban Cook Co) PMPM	Region V (Collar Counties) PMPM	Region VI (City of Chicago)
All rate cells except ICF/MR State Op Facility	NA	NA	NA	$309.46	NA	$309.46

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 NEXTLEVEL HEALTH PARTNERS, INC., AN ILLINOIS CORPORATION.

Signature of Authorized Representative

2016-24-004K(NLH)
Contract ID Number

CEO Cheryl Rucker Whitaker
Printed Name and Title

Dec. 28, 2015
Date

Attachment VI

HIPAA Requirements

A. **Definitions.**

1. "Designated Record Set" shall have the same meaning as the term "designated record set" in 45 CFR Section 164.501.
2. "Individual" shall have the same meaning as the term "individual" in 45 CFR Section 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR Section 164.502(g).
3. "PHI" means Protected Health Information, which shall have the same meaning as the term "protected health information" in 45 CFR Section 160.103, limited to the information created or received by Contractor from or on behalf of the Agency in connection with Contractor's performance of the Services.
4. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 Subpart A and 45 CFR Part 164 subparts A and E, as amended.
5. "Required by law" shall have the same meaning as the term "required by law" in 45 CFR Section 164.103.
6. "Services" shall have the meaning set forth in this Contract, and, if not therein defined, shall mean the services described in this Contract to be performed by Contractor for the Agency.
7. "Contractor" shall mean NextLevel Health Partners, Inc., an Illinois corporation.
8. All capitalized terms used in this Attachment shall have the meanings established for purposes of HIPAA or the HITECH Act, as amended.

B. **Contractor's Permitted Uses and Disclosures.**

1. Except as limited by the Contract, Contractor may use or disclose PHI to perform functions, activities, or services for, or on behalf of, the Agency as specified in the Contract, or otherwise as permitted by applicable law, provided that such use or disclosure would not violate the Privacy Rule.
2. Contractor may disclose PHI for the proper management and administration of the contract, provided that the disclosures are required by law, or Contractor 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. Contractor shall require the person to whom the PHI was disclosed to notify Contractor of any instances of which the person is aware in which the confidentiality of the PHI has been breached.
3. Contractor may use PHI to report violations of law to appropriate federal and state authorities, consistent with 45 CFR Section 164.502(j)(1).

C. **Limitations on Contractor's Uses and Disclosures. Contractor 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;
   i. PHI in paper media shall not be disclosed and must be de-identified, and information stripped of identifiers;
   ii. PHI in electronic media shall be encrypted and secured;

iii.email transmissions containing PHI shall meet the standards for transmission security encrypted and secured pursuant to 45 CFR § 164.312(e) standards specifications for integrity controls and encryption.

3. Mitigate, to the extent practicable, any harmful effect that is known to Contractor of a use or disclosure of PHI 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 Contractor becomes aware;
5. Ensure that any agents, including a subcontractor, to whom Contractor provides PHI received from the Agency or created or received by Contractor on behalf of the Agency in connection with its performance of the Services, agree to the same restrictions and conditions that apply through this Attachment to Contractor with respect to such information;
6. Provide access to PHI maintained by Contractor in a Designated Record Set to the Agency or to another individual whom the Agency names, in order to meet the requirements of 45 CFR Section 164.524, at the Agency's written request, and in the time and manner reasonably specified by the Agency;
7. Make Contractor'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 Contractor 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. To the extent permitted by law, Vendor shall provide the Agency with a copy of such internal policies or documentation that Vendor provides to the Secretary pursuant to this Section.
8. 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 CFR Section 164.528;
9. Return or destroy all PHI received from the Agency or created or received by Contractor on behalf of the Agency that Contractor 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, Contractor 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, Contractor 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.

D. Breach Requirements. As a HIPAA covered entity, Contractor shall comply with provisions of the HIPAA, Security, Privacy and Breach Notification Rules Sections 164.308, 164.310, 164.312 and 164.316 of title 45, Code of Federal Regulations as of their respective compliance dates and provisions related to the handling of a breach of protected health information.

E. Breach Notification. In the event that the Contractor discovers a Breach of Unsecured Protected Health Information, Contractor agrees to comply with the terms of HIPAA breach provisions. For purposes of this Contract, Contractor acknowledges it is a HIPAA covered entity and will be bound by the HIPAA requirements for purposes of breach notification.

F. Contractor will notify the Agency of the Breach of Unsecured PHI involving the acquisition, access, use or disclosure of the Unsecured PHI involving Medicaid clients. Contractor will comply with all HIPAA breach notification requirements under HIPAA,

including notifying the affected individuals, conducting assessments of the breach, and notifying the necessary governmental entities of such breach.

G. Costs/Fines. Contractor agrees to be responsible for all costs associated with any breach, invalid access, use or disclosure of PHI involving Medicaid clients. Contractor is directly and solely responsible for all costs for providing Breach notification to affected individuals who are required by law to receive such notifications. In the event that Contractor breaches Medicaid client protected health information, Contractor shall provide all reasonable remedies, including, but not limited to, credit monitoring services of one year. Contractor is solely responsible for payment of any fines levied by an investigatory body or governmental entity as a result of a breach of protected health information.

H. Indemnification for Breach. Contractor is responsible for indemnifying the Agency for any and all costs, fines, fees associated with any incident caused by the Contractor, its employees, subcontractors or business associates, 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, as amended.

I. Security Rule Compliance. Contractor shall comply with the Security Rule's administrative, physical and technical safeguard requirements as set forth in 45 CFR Part 164 Sections 164.308, 164.310, 164.312, and 164.316. As part of compliance with the Security Rule, Contractor shall develop and implement written security policies and procedures with respect to the PHI, including Electronic PHI it has in its possession and control. Contractor agrees that the Electronic PHI that it transmits will be encrypted and that Contractor will adopt internal procedures for reporting breaches and mitigating potential damages associated with Breaches of Unsecured PHI.

J. Contractor shall ensure minimum necessary policies are adhered to by all individuals accessing the PHI, irrespective of the medium (i.e, paper, electronic, etc.) PHI is stored or maintained.

K. Interpretation. Any ambiguity in this Attachment shall be resolved in favor of a meaning that permits the Agency to comply with HIPAA, the HITECH Act and the Privacy Rule.

L. Third Party Beneficiary. Nothing contained in this Attachment is intended to confer upon any person (other than the parties hereto) any rights, benefits, or remedies of any kind or character whatsoever, whether in contract, statute, tort (such as negligence), or otherwise, and no person shall be deemed a third-party beneficiary under or by reason of this Attachment.

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: [signature]

Business Name: NextLevel Health Partners, INC

Taxpayer Identification Number:
Social Security Number _____
or
Employer Identification Number [redacted]

Legal Status (check one):

☐ Individual	☐ Governmental
☐ Sole Proprietor	☐ Nonresident alien
☐ Partnership	☐ Estate or trust

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: N L Sub Merger Inc DBA Next Level Health Partners Inc

Taxpayer Identification Number:
Social Security Number _____
or
Employer Identification Number [redacted]

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: _____ Date: 12/28/2015

☐ 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: Dec. 28, 2015

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 this Contract. Failure to fully disclose shall render the Contract voidable by the Department. There are five sections to this form and each must be completed to meet full disclosure requirements. The requested disclosures are a continuing obligation and must be promptly supplemented for accuracy throughout the term of the Contract. Contractor 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. If a Contractor submits a 10K, however, it 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: NextLevel Health Partners Inc.
D/B/A (if used): _____

Name of any Parent Organization: None

Section 1. Disclosure of Financial Interest in Contractor. Contractor must complete one of subsections (a), (b) or (c) below.

(a) If Contractor is a publicly traded corporation subject to SEC reporting requirements, Contractor shall submit its 10K disclosure (include proxy if referenced in 10k). 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 a 10K disclosure.

Check here if submitting a 10k☐, 20f☐, or 40f☐.

OR

(b) If Contractor is a privately held corporation with more than 400 shareholders, Contractor may submit the information identified in 17 CFR 229.401 and list the names of any person or entity holding any ownership share in excess of 5%.

OR

(c) If Contractor is an individual, sole proprietorship, partnership or any other entity not qualified to use subsections (a) or (b); Contractor shall 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.

Name: Cheryl Whitaker

address: 7030 S Euclid Ave Chicago Il 60649

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: 35.203%. 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): _____

ii. With regard to each individual identified in (i), above, indicate whether any of the following potential conflict of interest relationships apply. Use a separate form for each individual. If the answer to any question is "Yes," please describe each situation (label with appropriate number). If no individual has been identified above, mark not applicable (N/A) here: _____

1. State employment, currently or in the previous three 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 ☒

2. State employment of spouse, father, mother, son, or daughter, including contractual employment for services in the previous two years.
   Yes ☐ No ☒

3. 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 three years.
   Yes ☐ No ☒

4. Relationship to anyone holding elective office currently or in the previous two years; spouse, father, mother, son, or daughter.
   Yes ☐ No ☒

5. 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 three years.
   Yes ☐ No ☒

6. Relationship to anyone holding appointive office currently or in the previous two years; spouse, father, mother, son, or daughter.
   Yes ☐ No ☒

7. Employment, currently or in the previous three years, as or by any registered lobbyist of the State government.
   Yes ☐ No ☒

8. Relationship to anyone who is or was a registered lobbyist in the previous two years; spouse, father, mother, son, or daughter.
   Yes ☐ No ☒

9. Compensated employment, currently or in the previous three 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 ☒

10. Relationship to anyone; spouse, father, mother, son, or daughter; who is or was a compensated employee in the last two 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: Conflicts of Interest

(a) Prohibition. Pursuant to 30 ILCS 500/50-13(a), 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 for 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.

(b) Interests. Pursuant to 30 ILCS 500/50-13(b), 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 7½% 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. Pursuant to 30 ILCS 500/50-13(c), 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 two times the salary of the Governor [$354,824.00], to have or acquire any such contract or direct pecuniary interest therein.

Contractor has (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. Each person 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 describe the nature of the debarment or legal proceeding. The State reserves the right to request more information for further clarification.

_____

_____

_____

_____

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.

Name: Michael Kinne

Address: 1879 Snead St., Bolingbrook, IL 60490

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: 18.528%. 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): _____

ii. With regard to each individual identified in (i), above, indicate whether any of the following potential conflict of interest relationships apply. Use a separate form for each individual. If the answer to any question is "Yes," please describe each situation (label with appropriate number). If no individual has been identified above, mark not applicable (N/A) here: _____

1. State employment, currently or in the previous three 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 ☒

2. State employment of spouse, father, mother, son, or daughter, including contractual employment for services in the previous two years.
   Yes ☐ No ☒

3. 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 three years.
   Yes ☐ No ☒

4. Relationship to anyone holding elective office currently or in the previous two years; spouse, father, mother, son, or daughter.
   Yes ☐ No ☒

5. 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 three years.
   Yes ☐ No ☒

6. Relationship to anyone holding appointive office currently or in the previous two years; spouse, father, mother, son, or daughter.
   Yes ☐ No ☒

7. Employment, currently or in the previous three years, as or by any registered lobbyist of the State government.
   Yes ☐ No ☒

8. Relationship to anyone who is or was a registered lobbyist in the previous two years; spouse, father, mother, son, or daughter.
   Yes ☐ No ☒

9. Compensated employment, currently or in the previous three 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 ☒

10. Relationship to anyone; spouse, father, mother, son, or daughter; who is or was a compensated employee in the last two 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: Conflicts of Interest

(a) Prohibition. Pursuant to 30 ILCS 500/50-13(a), 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 for 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.

(b) Interests. Pursuant to 30 ILCS 500/50-13(b), 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 7½% 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. Pursuant to 30 ILCS 500/50-13(c), 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 two times the salary of the Governor [$354,824.00], to have or acquire any such contract or direct pecuniary interest therein.

Contractor has (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. Each person 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 describe the nature of the debarment or legal proceeding. The State reserves the right to request more information for further clarification.

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.

Name: Keith Wolski

Address: 16568 Pasture Dr. Lemont, IL. 60439

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: 11.117%. 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): _____

ii. With regard to each individual identified in (i), above, indicate whether any of the following potential conflict of interest relationships apply. Use a separate form for each individual. If the answer to any question is "Yes," please describe each situation (label with appropriate number). If no individual has been identified above, mark not applicable (N/A) here: _____

1. State employment, currently or in the previous three 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 ☒

2. State employment of spouse, father, mother, son, or daughter, including contractual employment for services in the previous two years.
   Yes ☐ No ☒

3. 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 three years.
   Yes ☐ No ☒

4. Relationship to anyone holding elective office currently or in the previous two years; spouse, father, mother, son, or daughter.
   Yes ☐ No ☒

5. 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 three years.
   Yes ☐ No ☒

6. Relationship to anyone holding appointive office currently or in the previous two years; spouse, father, mother, son, or daughter.
   Yes ☐ No ☒

7. Employment, currently or in the previous three years, as or by any registered lobbyist of the State government.
   Yes ☐ No ☒

8. Relationship to anyone who is or was a registered lobbyist in the previous two years; spouse, father, mother, son, or daughter.
   Yes ☐ No ☒

9. Compensated employment, currently or in the previous three 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 ☒

10. Relationship to anyone; spouse, father, mother, son, or daughter; who is or was a compensated employee in the last two 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: Conflicts of Interest

(a) Prohibition. Pursuant to 30 ILCS 500/50-13(a), 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 for 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.

(b) Interests. Pursuant to 30 ILCS 500/50-13(b), 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 7½% 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. Pursuant to 30 ILCS 500/50-13(c), 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 two times the salary of the Governor [$354,824.00], to have or acquire any such contract or direct pecuniary interest therein.

Contractor has (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. Each person 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 describe the nature of the debarment or legal proceeding. The State reserves the right to request more information for further clarification.

_____

_____

_____

_____

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.

Name: Brett Benson

Address: 1435 South Prairie Ave, Unit G, Chicago, IL 60605

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: 1.901%. 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): _____

ii. With regard to each individual identified in (i), above, indicate whether any of the following potential conflict of interest relationships apply. Use a separate form for each individual. If the answer to any question is "Yes," please describe each situation (label with appropriate number). If no individual has been identified above, mark not applicable (N/A) here: _____

1. State employment, currently or in the previous three 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 ☒

2. State employment of spouse, father, mother, son, or daughter, including contractual employment for services in the previous two years.
   Yes ☐ No ☒

3. 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 three years.
   Yes ☐ No ☒

4. Relationship to anyone holding elective office currently or in the previous two years; spouse, father, mother, son, or daughter.
   Yes ☐ No ☒

5. 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 three years.
   Yes ☐ No ☒

6. Relationship to anyone holding appointive office currently or in the previous two years; spouse, father, mother, son, or daughter.
   Yes ☐ No ☒

7. Employment, currently or in the previous three years, as or by any registered lobbyist of the State government.
   Yes ☐ No ☒

8. Relationship to anyone who is or was a registered lobbyist in the previous two years; spouse, father, mother, son, or daughter.
   Yes ☐ No ☒

9. Compensated employment, currently or in the previous three 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 ☒

10. Relationship to anyone; spouse, father, mother, son, or daughter; who is or was a compensated employee in the last two 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: Conflicts of Interest

(a) Prohibition. Pursuant to 30 ILCS 500/50-13(a), 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 for 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.

(b) Interests. Pursuant to 30 ILCS 500/50-13(b), 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 7½% 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. Pursuant to 30 ILCS 500/50-13(c), 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 two times the salary of the Governor [$354,824.00], to have or acquire any such contract or direct pecuniary interest therein.

Contractor has (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. Each person 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 describe the nature of the debarment or legal proceeding. The State reserves the right to request more information for further clarification.

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.

Name: Justin Dearborn

Address: 329 Fairview Avenue, Winnetka, IL 60093

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: ___ 2.266% . 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): _____

ii. With regard to each individual identified in (i), above, indicate whether any of the following potential conflict of interest relationships apply. Use a separate form for each individual. If the answer to any question is "Yes," please describe each situation (label with appropriate number). If no individual has been identified above, mark not applicable (N/A) here: _____

1. State employment, currently or in the previous three 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 ☒

2. State employment of spouse, father, mother, son, or daughter, including contractual employment for services in the previous two years.
   Yes ☐ No ☒

3. 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 three years.
   Yes ☐ No ☒

4. Relationship to anyone holding elective office currently or in the previous two years; spouse, father, mother, son, or daughter.
   Yes ☐ No ☒

5. 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 three years.
   Yes ☐ No ☒

6. Relationship to anyone holding appointive office currently or in the previous two years; spouse, father, mother, son, or daughter.
   Yes ☐ No ☒

7. Employment, currently or in the previous three years, as or by any registered lobbyist of the State government.
   Yes ☐ No ☒

8. Relationship to anyone who is or was a registered lobbyist in the previous two years; spouse, father, mother, son, or daughter.
   Yes ☐ No ☒

9. Compensated employment, currently or in the previous three 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 ☒

10. Relationship to anyone; spouse, father, mother, son, or daughter; who is or was a compensated employee in the last two 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: Conflicts of Interest

(a) Prohibition. Pursuant to 30 ILCS 500/50-13(a), 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 for 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.

(b) Interests. Pursuant to 30 ILCS 500/50-13(b), 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 7½% 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. Pursuant to 30 ILCS 500/50-13(c), 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 two times the salary of the Governor [$354,824.00], to have or acquire any such contract or direct pecuniary interest therein.

Contractor has (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. Each person 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 describe the nature of the debarment or legal proceeding. The State reserves the right to request more information for further clarification.

_____

_____

_____

_____

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.

Name: Frank Borges_____
Address: 12250 Tillinghast Circle, Palm Beach Gardens, FL 33418_____

_____

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: ____ 2.437%. 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): _____

ii. With regard to each individual identified in (i), above, indicate whether any of the following potential conflict of interest relationships apply. Use a separate form for each individual. If the answer to any question is "Yes," please describe each situation (label with appropriate number). If no individual has been identified above, mark not applicable (N/A) here: _____

1. State employment, currently or in the previous three 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 ☒

2. State employment of spouse, father, mother, son, or daughter, including contractual employment for services in the previous two years.
   Yes ☐ No ☒

3. 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 three years.
   Yes ☐ No ☒

4. Relationship to anyone holding elective office currently or in the previous two years; spouse, father, mother, son, or daughter.
   Yes ☐ No ☒

5. 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 three years.
   Yes ☐ No ☒

6. Relationship to anyone holding appointive office currently or in the previous two years; spouse, father, mother, son, or daughter.
   Yes ☐ No ☒

7. Employment, currently or in the previous three years, as or by any registered lobbyist of the State government.
   Yes ☐ No ☒

8. Relationship to anyone who is or was a registered lobbyist in the previous two years; spouse, father, mother, son, or daughter.
   Yes ☐ No ☒

9. Compensated employment, currently or in the previous three 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 ☒

10. Relationship to anyone; spouse, father, mother, son, or daughter; who is or was a compensated employee in the last two 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: Conflicts of Interest

(a) Prohibition. Pursuant to 30 ILCS 500/50-13(a), 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 for 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.

(b) Interests. Pursuant to 30 ILCS 500/50-13(b), 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 7½% 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. Pursuant to 30 ILCS 500/50-13(c), 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 two times the salary of the Governor [$354,824.00], to have or acquire any such contract or direct pecuniary interest therein.

Contractor has (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. Each person 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 describe the nature of the debarment or legal proceeding. The State reserves the right to request more information for further clarification.

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.

Name: Matthew Stonestreet

Address: 1435 South Prairie Ave Unit H Chicago Il 60605

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: 3.802%. 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): _____

ii. With regard to each individual identified in (i), above, indicate whether any of the following potential conflict of interest relationships apply. Use a separate form for each individual. If the answer to any question is "Yes," please describe each situation (label with appropriate number). If no individual has been identified above, mark not applicable (N/A) here: _____

1. State employment, currently or in the previous three 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 ☒

2. State employment of spouse, father, mother, son, or daughter, including contractual employment for services in the previous two years.
   Yes ☐ No ☒

3. 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 three years.
   Yes ☐ No ☒

4. Relationship to anyone holding elective office currently or in the previous two years; spouse, father, mother, son, or daughter.
   Yes ☐ No ☒

5. 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 three years.
   Yes ☐ No ☒

6. Relationship to anyone holding appointive office currently or in the previous two years; spouse, father, mother, son, or daughter.
   Yes ☐ No ☒

7. Employment, currently or in the previous three years, as or by any registered lobbyist of the State government.
   Yes ☐ No ☒

8. Relationship to anyone who is or was a registered lobbyist in the previous two years; spouse, father, mother, son, or daughter.
   Yes ☐ No ☒

9. Compensated employment, currently or in the previous three 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 ☒

10. Relationship to anyone; spouse, father, mother, son, or daughter; who is or was a compensated employee in the last two 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: Conflicts of Interest

(a) Prohibition. Pursuant to 30 ILCS 500/50-13(a), 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 for 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.

(b) Interests. Pursuant to 30 ILCS 500/50-13(b), 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 7½% 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. Pursuant to 30 ILCS 500/50-13(c), 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 two times the salary of the Governor [$354,824.00], to have or acquire any such contract or direct pecuniary interest therein.

Contractor has (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. Each person 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 describe the nature of the debarment or legal proceeding. The State reserves the right to request more information for further clarification.

_____

_____

_____

_____

Section 4: Disclosure of Business Operations with Iran. Contractor shall disclose whether it, or any of its corporate parents or subsidiaries, within the 24 months prior to the submission of Contractor's response to the Solicitation, 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 twelve-month period, that directly or significantly contributes to the enhancement of Iran's ability to develop petroleum resources of Iran.

Check one of the following items, and disclose as necessary.

☒ There are no business operations that must be disclosed.

☐ The following business operations are disclosed:

_____

_____

_____

_____

Section 5: Current and Pending Contracts.

Contractor has 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 or other ongoing procurement relationship by stating the agency name and other descriptive information such as bid number, project title, purchase order number or contract reference number:

_____

Section 6: Representative Lobbyist or Other Agent.

Is Contractor represented by or does Contractor 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 this Contract?

Yes ☒ No ☐

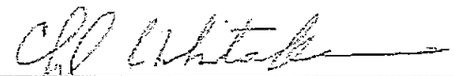
If "Yes":

1. State the name and address of each agent or lobbyist:
Jessica A. Pickens 63 Buckhorn Dr. Springfield, Il 62707

2. Describe the costs, fees, compensation or reimbursements paid for assistance to obtain this Contract:
Jessica Pickens was a contractual lobbyist from June 2014 to Nov. 1 2015. She was paid a monthly retainer of $4500/month inclusive of expenses. She joined NextLevel Health as a full time employee on November 15th. She was paid $ 18,000 total over November and December as a full time employee.

3. Contractor certifies that none of these costs will be billed to the State. Contractor must file this information with the Secretary of State. None of these costs are billed to the state.

The information contained on this Attachment is submitted on behalf of:



Signature of Authorized Representative

Cheryl Whitaker CEO
Name and Title of Authorized Representative

Date: December 29, 2015

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.

Attachment XI
Quality Assurance

1. Contractor shall establish procedures such that Contractor shall be able to demonstrate that it has an ongoing fully implemented Quality Assurance Program for health services that meets the requirements of the HMO Federal qualification regulations (42 CFR 417.106), the Medicare HMO/CMP regulations (42 CFR 417.418(c)), and the regulations promulgated pursuant to the Balanced Budget Act of 1997 (42 CFR 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 nationally-recognized standards 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 in this Attachment XI), 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 from in patient care for Behavioral Health, with a Behavioral Health provider; follow up for inpatient medical care, including delivery care, to assure women have access to contraception and postpartum care, or follow up after an emergency room visit.

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. Detail any 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. childhood immunizations, well child visits, prenatal care, obesity, 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 and the Behavioral Health services rendered.

2. Contractor shall provide to the Department a written description of its Quality Assurance Plan (QAP) for the provision of Care Coordination services including intensive care management, perinatal care management, and disease management. This written description must meet federal and State requirements, as outlined below:

   a. Goals and objectives — The written description shall contain a detailed set of Quality Assurance 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 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, pharmacy, and ancillary services) are included in the scope of the review. Documentation of the monitoring and evaluation plan shall be provided to the Department upon request.

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 and social service agencies.
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 enrollees (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.
12. Utilization of behavioral health benefits.

b) For pregnant women:

1. Timeliness and frequency of prenatal visits.
2. Provision of American Congress of Obstetricians and Gynecologists (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/Pediatrician for the infant.

c) For individuals, ages nineteen (19) and twenty (20):

1. number of well-child visits appropriate for age.
2. Immunization status.
3. Number of hospitalization
4. Length of hospitalization

5. Medical management for a limited number of medically complicate conditions as agreed to by Contractor and Department.

d) For Chronic Health Conditions (such conditions specifically including, without limitation, diabetes, asthma, congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease, Behavioral Health, including those with one or more co-morbidities).

1. Appropriate treatment, follow-up care, and coordination of care, for all Enrollees.
2. Identification of Enrollees with special health care needs and processes in place to assure adequate, ongoing risk assessments, care plan developed with the Enrollee's participation in consultation with any specialists caring for the Enrollee, to the extent possible, the appropriateness and quality of care, and if approval is required, such approval occurs in a timely manner.
3. Care coordination, Care Management, Disease Management, and Chronic Health Conditions action plan, as appropriate.

e) 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 but not limited to transportation.
3. Enrollee access to timely Behavioral Health services.
4. An Enrollee Care or Service Plan 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.

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 hospitalization.
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 including those specified in this Attachment XI.

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.

   i. Multi-disciplinary teams shall be used, where indicated, to analyze and address systems issues.

   ii. 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 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 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) QA/UR/PR Plan with overview of goal areas;

b) Major Initiatives to comply with the State Quality Strategy,

c) Quality Improvement and work plan monitoring;

d) Contractor Network Access and Availability and Service Improvements, including access and utilization of dental services;

e) Cultural Competency;

f) Fraud and Abuse Monitoring;

g) Population Profile;

h) Improvements in Care Coordination/Care Management and Clinical Services/Programs;

i) Effectiveness of Care Coordination Model of Care;;

j) Effectiveness of Quality Program Structure;

k) Comprehensive Quality Improvement Work Plans;

l) Chronic Conditions;

m) Behavioral Health;

n) Dental care

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 Board has approved the overall Quality Assurance Program and an annual QAP.

   b. Oversight Entity — The Governing Board shall document that it has formally designated an accountable entity or entities within the organization to provide oversight of QA, or has formally decided to provide such oversight as a committee of the whole.

   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 meaningful participation in the QAP Committee by the Medical Director, practicing physicians, senior leadership and other appropriate personnel.

f. Enrollee Advisory Committee and Community Stakeholder Committee – There shall be an Enrollee Advisory Committee and a Community Stakeholder Committee that will provide feedback to the QAP Committee on the Plan's performance from Enrollee and community perspectives. The committee shall recommend program enhancements based on Enrollee and community needs; review Provider and Enrollee satisfaction survey results; evaluate performance levels and telephone response timelines; evaluate access and provider feedback on issues requested by the QAP Committee; identify key program issues; such as disparities, that may impact community groups; and offer guidance on reviewing Enrollee materials and effective approaches for reaching enrollees. The Committee will be comprised of randomly selected Enrollees, family members and other caregivers, local representation from key community stakeholders such as churches, advocacy groups, and other community-based organizations. Contractor will educate Enrollees and community stakeholders about the committee through materials such as handbooks, newsletters, websites and communication events.

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, and/or training, to effectively carry out its specified activities.

   b. Provider Participation in the QAP

      i. Affiliated Providers shall be kept informed about the written QAP.

      ii. Contractor shall include in all agreements with Affiliated Providers and Subcontractors a requirement securing cooperation with the QAP.

iii. Contracts shall specify that Affiliated Providers and Subcontractors shalll 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 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 recurring. Evidence of ongoing monitoring of the delegated activities sufficient to assure corrective action shall be provided to the Department through quarterly or annual reporting.

8. The QAP shall contain provisions to assure that 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 coordinated by Contractor shall be in accordance with Departmental policies and 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 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. Pharmacy services;
o. Community reintegration and support;
p. Long-term Care (LTC) residential coordination of services; and
q. Prenatal, obstetrical, postpartum and reproductive health care.

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, pharmacy 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. Contractor shall ensure that data received from Providers and included in reports are accurate and complete by (1) verifying the accuracy and timeliness of reported data; (2) screening the data for completeness, logic, and consistency; and (3) collecting service information in standardized formats to the extent feasible and appropriate. Contractor shall have in effect a program consistent with the utilization control requirements of 42 CFR Part 456. This program will include, when required by the regulations, written plans of care and certifications of need of care.

14. Contractor shall perform and report the quality and utilization measures identified in Attachment XI – Quality Measures using the HEDIS® and HEDIS®-like Quality Measure Specifications methodology, as provided by the Department. Contractor shall not modify the reporting specifications methodology prescribed by the Department without first obtaining the Department's written approval. Contractor must obtain an independent validation of its HEDIS® and HEDIS®-like findings by a recognized entity, e.g., NCQA-certified auditor, as approved by the Department. The Department's

External Quality Review Organization will perform an independent validation of at least a sample of Contractor's findings.

15. Contractor shall monitor other Performance Measures as required by CMS in accordance with notification by the Department.

16. Contractor shall perform and report the performance measures in Table 2 – HCBS Waiver Performance Measures for ICP. Contractor shall not modify the reporting specifications methodology prescribed by the Department without first obtaining the Department's written approval.

Table 1 to Attachment XI

Health and Quality of Life (HQOL) Performance Measures: Seniors and People with Disabilities

For Reporting in 2017 on 2016 CY Data

Acronym	Performance Measure	Further Description	Specification Source	2017 P4P	Target Goal
Access/Utilization of Care					
AAP	**Adult's Access to Preventive/Ambulatory Health Services**	Percentage of members 20 years and older who had an ambulatory or preventive care visit.	HEDIS®		
AMB	**Ambulatory Care** 1) Outpatient Visits 2) ED Visits	Visits per 1,000 Member Months	HEDIS®		
PPC	**Prenatal and Postpartum Care** (Timeliness of Prenatal Care and Postpartum Care)	Measures timely access to network providers. Percentage of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year.	HEDIS®		
IET	**Initiation and Engagement of Alcohol and Other Drug Dependence Treatment**	Percentage of members age ≥13 years with new episode of alcohol or other drug (AOD) dependence who received initiation and engagement of AOD treatment. Report two age stratifications and a total rate: 13-17 years, 18 + years and total.	HEDIS®		
Prevention/Screening Services					
ABA	**Adult BMI Assessment**	Percentage of members 18-74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measure year or the year prior; measure age populations 18-64 and 65-74. The age groups apply to reporting for the Adult Core Set.	HEDIS®		

Acronym	Performance Measure	Further Description	Specification Source	2017 P4P	Target Goal
Prevention/Screening Services					
BCS	**Breast Cancer Screening**	Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer; measure age populations 50-64 and 65-74. The woman must be 52-74 years of age as of 12/31 of the measurement year. The look back period for the screening is two years (actually 27 months). The age groups apply to reporting for the Adult Core Set.	HEDIS®		
CCS	**Cervical Cancer Screening**	Percentage of women who were screened for cervical cancer using either of the following criteria: Women 21-64 who had cervical cytology performed every 3 years or women age 30-64 who had cervical cytology/human papillomavirus co-testing performed every 5 years.	HEDIS®		
CHL	**Chlamydia Screening in Women**	Percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for Chlamydia during the measurement year.	HEDIS®		
CBP	**Controlling High Blood Pressure**	Percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled during the measurement year.	HEDIS®		
Appropriate Care					
CDC	**Comprehensive Diabetes Care**	Percentage of members18-75 years of age with diabetes.	HEDIS®		
SPD	**Statin Therapy for Patients With Diabetes**	Who remained on the indicated medications for 80% of the treatment period during the measurement year; age 40-75.	HEDIS®		

Acronym	Performance Measure	Further Description	Specification Source	2017 P4P	Target Goal
Medication Management					
MPM	**Annual Monitoring for Patients on Persistent Medications**	Percentage of members ≥18 years who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent and at least one therapeutic monitoring event for the therapeutic agent in the measurement year; measure age populations 18-64 and 65+. The age groups apply to reporting for the Adult Core Set.	HEDIS®		
MMA	**Medication Management for People With Asthma**	Percentage of members 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period.	HEDIS®		
Behavioral Health					
FUH	**Follow-up after hospitalization for Mental Illness**	Percentage of members ≥6 years who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner as follow-up; measure age populations 6 – 20, 21 – 64, and 65+. The age groups apply to reporting for the Child Core Set and the Adult Core Set.	HEDIS®		

Table 2 to Attachment XI
HCBS Waiver Performance Measures

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection / Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
	Appendix C- Qualified Providers							
	Subassurance C **The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver**							
29 C	*# and % of case managers who meet waiver provider training requirements.* N: # of MCO case managers reviewed who meet waiver provider training requirements. --- D: Total # of MCO case managers reviewed.	EQRO/ MCO	Quarterly and Annually	100%	MA/MCO	Quarterly and Annually	MCO Reports	Completion of case manager training; Moratorium of new waiver cases to non-certified MCO case managers. Remediation within 60 days.
	Appendix D- Service Plan Development							

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection / Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
	Subassurance A **Service plans address all participants' assessed needs (including health and safety factors) and personal goals, either by the provision of waiver services or through other means**							
31 D	*# and % of MCO participants' care plans/service plans that address all personal goals identified by the assessment.* N: # of MCO care plans/service plans reviewed that address all personal goals identified by the assessment. --- D: Total # of MCO care plans/service plans reviewed.	EQRO /MCO	Quarterly and Ongoing	Representative Sample	MA/MCO	Quarterly and Annually	MCO Reports; EQRO Reviews	If plans do not address required items, the MA will require the plans be corrected and will provide training of case managers. Remediation must be completed within 60 days.
32 D	*# and % of MCO participants' care plans/service plans that address all participant needs identified by the assessment.* N: # of MCO care plans/service plans reviewed that address all participant needs identified by	EQRO /MCO	Quarterly and Ongoing	Representative Sample	MA/MCO	Quarterly and Annually	MCO Reports; EQRO Reviews	If plans do not address required items, the MA will require the plans be corrected and will provide training of case managers. Remediation must be

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection / Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
	the assessment. ---------- D: Total # of MCO care plans/service plans reviewed.							completed within 60 days.
33 D	*# and % of MCO participants' care plans/service plans that address risks identified in the assessment.* N: # of MCO care plans/service plans reviewed that address risks identified in the assessment. ---------- D: Total # of MCO care plans/service plans reviewed.	EQRO /MCO	Quarterly and Ongoing	Representative Sample	MA/MCO	Quarterly and Annually	MCO Reports; EQRO Reviews	If plans do not address required items, the MA will require the plans be corrected and will provide training of case managers. Remediation must be completed within 60 days.
34 D	*# and % of MCO survey respondents in the sample who reported they receive services they need when they need them.* N: # of MCO survey respondents who reported they receive services when needed. ----------D: # of MCO survey respondents in the sample.	MCO	Annually	CAHPS Guidelines (BI, HIV, PD)	MA/MCO	Quarterly and Annually	CAHPS Survey (BI, HIV, PD)	If identifying information is available for individual surveys the MCO case managers will follow up on non-favorable surveys. Resolution or remediation will be based on the nature of the concern.
			Quarterly and Annually	100% (Elderly)			POSM Survey question A.2. (Elderly)	

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection / Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
								Anonymous survey responses will be used to identify need for system improvement.
	Subassurance B **The State monitors service plan development in accordance with its policies and procedures**							
35 D	*# and % of MCO participants' care plans/service plans that were signed and dated by the waiver participant and the case manager.* N: # of MCO care plans/service plans that were signed by the waiver participant and the case manager. --- D: Total # of MCO care plans/service plans reviewed.	EQRO /MCO	Quarterly and Ongoing	Representative Sample	MA/MCO	Quarterly and Annually	MCO Reports; EQRO Reviews	If plans are not signed by appropriate parties, the MA will require the plans be corrected. The MCO may also provide training in both cases. Remediation must be completed within 60 days.

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection / Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
36 D	*# and % of MCO participants who received contact by their case manager every 12 months for Persons with Disabilities and Elderly; monthly for BI and HIV, with a bi-monthly contact being face-face for HIV, in an effort to monitor service provision and to address potential gaps in service delivery.* N: # of MCO participants reviewed who received contact by their case manager every 12 months for Persons with Disabilities and Elderly; monthly for BI and HIV; with a bi-monthly contact being face-to-face, for HIV. --- D: Total # of MCO participants reviewed.	EQRO /MCO	Quarterly and Ongoing	Representative Sample	MA/MCO	Quarterly and Annually	MCO Reports; EQRO Reviews	If participants do not receive the required contact by case manager, the MA will require the participant be contacted and provide training of case managers. Remediation must be completed within 60 days.
	Subassurance CService plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs							

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection / Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
37 D	*# and % of MCO waiver participants who have their care plan/service plan updated every 12 months for Persons with Disabilities and Elderly; every 6 months for BI and HIV.* N: # of MCO waiver participants reviewed who have their care plan/service plan updated every 12 months for Persons with Disabilities and Elderly; every 6 months for BI and HIV. --- D: Total # of MCO waiver participants with care plan/service plan due during the period reviewed.	EQRO /MCO	Quarterly and Ongoing	100%	MA/MCO	Quarterly and Annually	MCO Reports; EQRO Reviews	If service plans are untimely, the MA will require completion of overdue service plans and justification from the case manager. If service plans are not updated when there is documentation that a participant's needs changed, the MCO will require an update. In both cases the MCO may also provide training of case managers. Remediation within 60 days.
38 D	*# and % of MCO waiver participants that received updates to care plans/service plans when participants needs*	EQRO /MCO	Quarterly and Ongoing	Subset of Representative Sample	MCO	Quarterly and Annually	MCO Reports; EQRO Reviews	If plans do not address required items, the MCO will require that the plans

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection / Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
	changed. N: # of MCO waiver participants reviewed that received updates to care plans/service plans when participants' needs changed. --- D: Total # of MCO waiver participants identified whose needs changed.							be corrected and provide training of case managers. Remediation must be completed within 60 days.
	<u>Subassurance D</u> **Services are delivered in accordance with the service plan, including type, scope, amount, duration, and frequency specified in the service plan**							
39 D	*# and % of MCO participants who received services in the type, scope, amount, duration, and frequency as specified in the care plan/service plan.* N: # of MCO participants reviewed who received services as specified in the care plan/service plan.	EQRO /MCO	Quarterly and Ongoing	Representative Sample	MA/MCO	Quarterly and Annually	MCO Reports; EQRO Reviews	If a participant does not receive services as specified in the service plan, the MCO will determine if a correction or adjustment of service plan, services authorized, or services vouchered is

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection / Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
	--- D: Total # of MCO participants reviewed.							needed. If not, services will be implemented as authorized. The MCO may also provide training to case managers. If the issue appears to be fraudulent, it will be reported by the MA to fraud control. Remediation must be completed within 60 days.
40 D	*# and % of MCO survey respondents in the sample who reported the receipt of all services listed in the plan of care.* N: # of MCO survey respondents who reported the receipt of all services listed in the plan of care. --- D: # of MCO survey respondents in the sample.	MCO	Annually	CAHPS Guidelines	MA/MCO	Quarterly and Annually	CAHPS Survey	If identifying information is available for individual surveys the MCO case managers will follow up on non-favorable surveys. Resolution or remediation will be based on the nature of the concern. Anonymous survey responses will be used to identify need

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection / Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
								for system improvement
	Subassurance E **Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers**							
41 D	*# and % of MCO participants records with the most recent plan of care indicating the participant had choice between/among services and providers.* N:# of MCO participant records reviewed with a signed POC that indicates participant had choice between services and providers. --- D:Total # of MCO participant records reviewed.	EQRO /MCO	Quarterly and Ongoing	Representative Sample	MA/MCO	Quarterly and Annually	MCO Reports; EQRO Reviews	The MCO will assure that choice was provided as shown by the correction of documentation to indicate customer choice. The MCO may also provide training to case managers. Remediation must be completed within 60 days.
	Appendix G- Health Safety & Welfare		-	-	-	-	-	

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection / Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
	Subassurance **The State , on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation**		-	-	-	-	-	
42 G	*# and % of participants who received information from the MCO about how and to whom to report abuse, neglect, exploitation at the time of assessment/reassessment.* N: # of participant records reviewed where the participant received information from the MCO about how and to whom to report abuse, neglect exploitation at the time of assessment/reassessment. --- D: Total # of MCO participant records reviewed.	EQRO /MCO	Quarterly and Ongoing	Represent -ative Sample	MA/MCO	Quarterly and Annually	MCO Reports; EQRO Reviews	The MCO will assure that customers know how to report abuse, neglect or exploitation. This will be demonstrated by correction of case work documentation reflecting customers awareness, including evidence of steps taken to educate the customer. Remediation must be completed within 30 days.
43 G	*# and % of participants' DHS-OIG substantiated incidents that were reported to the MCO and resolved within recommended OIG timelines.*	MCO	Quarterly and Ongoing	100%	MCO	Quarterly and Annually	MCO Reports	The MCO will follow up all outstanding APS referrals and Unusual Incident Reports. Changes in

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

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

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection / Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
	D: Total # of MCO restraint applications, seclusion, or other restrictive intervention.							determined based on circumstances and identified trends and patterns.
47 G	*# and % of participant survey respondents who reported to the MCO of being treated well by direct support staff.* N: # of participant satisfaction survey respondents who reported to the MCO of being treated well by direct support staff. --- D: Total # of MCO participant satisfaction survey respondents.	MCO	Annually	CAHPS Guidelines (BI, HIV, PD)	MA/MCO	Quarterly and Annually	CAHPS Survey (BI, HIV, PD)	If identifying information is available for individual surveys the MCO case managers will follow up on non-favorable surveys. Resolution or remediation will be based on the nature of the concern. Anonymous survey responses will be used to identify need for system improvement.
			Quarterly and Annually	100% (Elderly)			POSM Survey question E.1.a. (Elderly)	
48 G	*# and % of participants for whom identified critical incidents other than A/N/E were reviewed and corrective measures were appropriately taken by the MCO.*	MCO	Quarterly and Ongoing	100%	MCO	Quarterly and Annually	MCO Reports	The MCO will follow up on identified critical incidents, other than A/N/E, to ensure information

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection / Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
	N:# of participants for whom identified critical incidents other than A/N/E were reviewed and corrective measures were appropriately taken by the MCO. --- D:Total # of MCO participants for whom identified critical incidents were reviewed.							was reviewed and corrective measures were appropriately taken. Resolution or remediation will be based on the nature of the concern. Survey responses will be used to identify need for system improvement.
49 G	*# and % of MCO participants who have personal assistant or other independently employed services whose care plan/service plan included back up plans.* N: # of MCO participants reviewed who have personal assistant or other independently employed services whose care plan/service plan included back up plans. --- D: Total MCO participants reviewed who have personal assistant or other independently employed services.	MCO	Quarterly and Ongoing	Representative Sample	MCO	Quarterly and Annually	EQRO Reviews	The MCO would develop and implement PA back up plans and revisions to customers' service plans. Timeline for remediation would be within 30 days.

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection / Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
Appendix I- Financial Accountability								
Subassurance A The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered								
501	*# and % of payments that were paid for participants who were enrolled in the waiver on the date the service was delivered.* N: # of MCO payments made for participants who were enrolled in the waiver on the date the service was delivered. --- D: Total # of MCO payments.	MCO	Quarterly and Annually	100%	MCO	Semi-Annually	Encounter Data	The MA will adjust the federal claim for services provided by the MCO prior to the customers' waiver enrollment. Remediation must be completed within 30 days.
511	*# and % of payments there were paid for services that were specified in the participant's service plan.* N: # of MCO payments made that are specified in the participant's service plan. --- D: Total # of MCO payments.	MCO	Quarterly and Annually	Non-Representative Sample	MCO	Semi-Annually	MCO Reports	The MCO will determine whether the service was authorized. If authorized, the MCO will revise customer service plan; If not authorized, the MA will void the federal claims that were not consistent with

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection / Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
								service plans. Remediation must be completed within 30 days.
Subassurance B The State provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.								
521	*# and % of payments that were paid using the correct rate as specified in the waiver application.* N: # of MCO payments using the correct rate as specified in the waiver application. --- D: Total # of MCO payments.	MCO	Quarterly and Annually	100%	MA and MCO	Semi-Annually	Encounter Data	The MA will require the MCO to recoup the overpayment or repay at correct rate. Remediation must be completed within 30 days.

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 twenty (120) days after the date of service. Any claims processed by Contractor for services provided subsequent to submission of an Encounter Data file shall be reported on the next Encounter Data file. **Testing.** Upon receipt of each submitted Encounter Data file, the Department shall perform two distinct levels of review:

Name of Report/Submission	Frequency	HFS Prior Approval	Report Description and Requirements
			The first level of review and edits performed by the Department shall check the data file format. These edits shall include, but are not limited to the following: check the data file for completeness of records; correct 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 the Contractor for correction. Corrected Encounter Data must be returned to

Name of Report/Submission	Frequency	HFS Prior Approval	Report Description and Requirements
			the Department for reprocessing. **Electronic Data Certification.** In a format determined by the Department, Contractor shall certify by the 5th day of each month that all electronic data submitted during the previous calendar month is accurate, complete and true.
Disclosure Statements	Initially, annually, on request and as changes occur	No	Contractor shall submit disclosure statements as specified in 42 CFR, Part 455.
Financial Reports	Quarterly and annually	No	Contractor shall provide the Department with copies of all financial reports Contractor is required to file with the Department of Insurance. In the event Contractor is an MCCN, Contractor shall provide the Department with copies of its financial statements on a quarterly and annual basis prescribed by the Department.
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	or shall report the number of claims Contractor adjudicated by claim type, in-network and out-of-network break out, and the number of days the claims took to process.

Name of Report/Submission	Frequency	HFS Prior Approval	Report Description and Requirements
Compliance Certification	Annually, no later than July 1	No	or shall submit a Certification confirming that Contractor and its subcontractors are in compliance with Section 9.2 and each subsection thereof.
			Enrollee Materials.
Certificate of Coverage, Description of Coverage, and Any Changes or Amendments	Initially and as revised	Yes	Contractor shall submit the Certificate of Coverage and Description of Coverage for Prior Approval that comply with the Managed Care Reform and Patient Rights Act (215 ILCS 134) and the Illinois Administrative Code, Title 50, Chapter I, Subchapter kkk, Part 5421.
Enrollee Handbook	Initially and as revised	Yes	Contractor shall submit an Enrollee Handbook for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed.
Identification Card	Initially and as revised	Yes	Contractor shall submit the Enrollee identification card for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed.

Name of Report/Submission	Frequency	HFS Prior Approval	Report Description and Requirements
Provider Directory	Initially and as changes occur	Yes	Contractor shall submit separate Provider Directories that are on Contractor's website for Prior Approval. For example, the FHP Provider Directory shall include only those Providers that provide Covered Services to FHP population. Provider updates shall not be required to be submitted for Prior Approval.
Fraud and Abuse			
Fraud and Abuse Referral	Immediately upon notification or knowledge of suspected Fraud and Abuse	N/A	Contractor shall report all suspected Fraud and Abuse to the Department as required in Article V and Article IX of this Contract. Contractor shall provide a preliminary investigation report as each occurrence is identified.
Fraud and Abuse Report	Quarterly	No	Contractor shall provide a summary report of referrals made and program integrity activities conducted in the previous quarter.
Recipient Verification Procedure	Initially, annually and as revised	Yes	Contractor shall submit Contractor's plan for verifying with Enrollees whether services billed by Providers were received, as required by 42 CFR 455.20, for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in information conveyed.

Name of Report/Submission	Frequency	HFS Prior Approval	Report Description and Requirements
Recipient Verification Results	Annually and within ten (10) Business Days after the Department's request	No	Contractor shall submit a summary of the results of the Recipient Verification Procedure.
Fraud and Abuse Compliance Plan	Initially and annually	Yes	Per CFR, 438.608, Contractor shall submit its compliance plan designed to guard against Fraud and Abuse to the Department for Prior Approval.
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.

Name of Report/Submission	Frequency	HFS Prior Approval	Report Description and Requirements
Community Outreach Events	Monthly, by the last day of the reporting month	No	Contractor shall submit to the Department a list of all previously approved community outreach events that occurred during the submission month. The report must include the Event name, date, time, address/location, county, audience type, estimated number of attendees and date of Department approval.
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 Site Closures/Terminations	As each occurs	No	Contractor shall submit Provider Site Closures/termination reports, in a format and medium designated by the Department.

Name of Report/Submission	Frequency	HFS Prior Approval	Report Description and Requirements
ACA Primary Physician Services Reimbursement Requirement	No later than ninety (90) days after the receipt of each supplemental payment from the Department	No	Contractor shall provide to the Department documentation of the additional amounts paid to qualifying Physicians and APNs in accordance with Section 5.25.6 of the contract.
Quality Assurance/Medical			
Grievance and Appeals Procedures	Initially and as revised	Yes	Contractor shall submit Grievance and Appeals Procedures for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed.

Name of Report/Submission	Frequency	HFS Prior Approval	Report Description and Requirements
Summary of Grievances, Appeals and Resolutions and External Independent Reviews and Resolutions – Summary Report	Quarterly	No	Contractor shall submit a summary of the Grievances and Appeals filed by Enrollees, organized by categories of quality of care, access to care, medical necessity reviews, transportation, Long Term Services and Supports (LTSS), and "Other" issues. Reporting shall include total Grievances and Appeals per/1,000 Enrollees. The report shall include a summary count of any such Grievances or Appeals received during the reporting period including those that go through fair hearings and external independent reviews. Contractor shall report on Covered Services and include Appeals and Grievances outcomes and the levels at which the Grievances or Appeals were resolved, and whether the Appeals were upheld or overturned. Contractor shall provide this report for each population for which it provides Covered Services. Contractor shall also report Grievances and Appeals separately for the categories of: Nursing Facility Services; Persons who are Elderly; Assisted Living, Supportive Living Program; Persons with Physical Disabilities; Persons with HIV/AIDS; and Persons with Brain Injury. The report shall only include Grievances and Appeals related specifically to LTC and Waiver services and providers.
Quality Assurance, Utilization Review and Peer Review (QA/UR/PR) Annual Report / Program Evaluation	Annually, no later than ninety (90) days after close of reporting period	No	Contractor shall submit a QA/UR/PR Annual Report/Program Evaluation reviewing the effectiveness of Contractor's QAP. The summary shall contain Contractor's processes for Quality Assurance, utilization review and peer review. This report shall include a comprehensive description of Contractor's network and an annual work-plan outlining Contractor's intended activities relating to QA, utilization review, peer review and health education.

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

Name of Report/Submission	Frequency	HFS Prior Approval	Report Description and Requirements
Care Management/ Disease Management Summary Report	Monthly	No	Contractor shall track Enrollees based on enrollment date and show the data points of initial screenings completed, comprehensive assessments completed, Enrollee care plans completed, opt outs (Enrollees who declined Care Management), and attempting to locate. Contractor shall report separately for the categories of: FHP; Persons with Developmental Disabilities; Persons with Disabilities; Persons with Brain Injury; Persons with HIV/AIDS; Persons who are Elderly; Assisted Living, Supportive Living Program; LTC; Behavioral Health (by primary diagnoses, including Substance Abuse); and ACA Adult. Contractor shall also report on all Enrollees who are assigned to Contractor's Care Management and Disease Management interventions, including a count of those who are risk-stratified, in process of stratification, attempting to locate, opt out of care management, and the percentage of Enrollees at each level. Contractor shall provide summary data for each of the categories listed above.
Care Gap Plan	Annually	No	Contractor shall submit its plan for ensuring provision of services missed by Enrollees, including, but not limited to, annual preventive exams, immunizations, women's healthcare, PAP and missed services for Chronic Health Conditions and behavioral health follow-up.
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 which level they are in at the end of the quarter. Contractor shall report separately for the categories of: Persons with Disabilities; Persons with Brain Injury; Persons with HIV/AIDS; Persons who are Elderly; LTC; and Assisted Living, Supportive Living Program.

Name of Report/Submission	Frequency	HFS Prior Approval	Report Description and Requirements
Prior Authorization Report	Monthly	No	Contractor shall submit turnaround times for routine and expedited prior authorizations, as well as pharmacy authorizations, for its 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.
Enrollee Profiles/Statistics for Care Integration	As needed, and within ten (10) Business Days after the Department's request	No	Contractor shall submit a report that provides comprehensive information on Contractor's care integration systems for Enrollees' care. This report shall include, but not be limited to, an annual summary of physical and behavioral health conditions, service utilization such as PCP and specialist visits, Emergency Services, inpatient hospitalizations and pharmacy utilization.
Processes and Procedures to Receive Reports of Critical Incidents	Initially and as revised	Yes	Contractor shall submit Critical Incident Processes and Procedures for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed.

Name of Report/Submission	Frequency	HFS Prior Approval	Report Description and Requirements
Critical Incidents – Detail Report	Monthly	No	Contractor shall submit a detailed report on Critical Incidents providing Enrollee name, Enrollee Medicaid number, incident summary, date received, source, incident date, date referred, referral entity, date resolved, and resolution summary, grouped by incident type. Contractor shall report Critical Incidents using the following values for waiver type: Persons with Physical Disabilities; Persons with Brain Injury; Persons with HIV/AIDS; Persons who are Elderly; Assisted Living, Supportive Living Program; Nursing Facility Services; and Non-Waiver.
Critical Incidents – Summary Report	Quarterly	No	Contractor shall submit a summary report on Critical Incidents providing a count of Critical Incidents in the following categories: Abuse, Neglect, Exploitation, Other, total and total referred. Contractor shall report Critical Incidents separately for each population group: Persons who are Elderly; Assisted Living, Supportive Living Program; Persons with Physical Disabilities; Persons with HIV/AIDS; Persons with Brain Injury; Nursing Facility Services; and Non-Waiver/Non-LTC (all others).

Name of Report/Submission	Frequency	HFS Prior Approval	Report Description and Requirements
LTSS Assessments Completed	Monthly	No	Contractor shall provide a monthly report to the Department showing the following information for Enrollees receiving HCBS Waiver Services or residing in Nursing Facilities: Total Enrollment by HCBS Waiver Type and LTC; and Total Assessments, Service Plans and Care Plans completed, partially completed, not completed, and remaining to be completed. The report must include this information for the following populations: Total FHP, ACA Adult, Nursing Facility Services; HCBS Waiver for Persons who are Elderly; HCBS Waiver for Assisted Living, Supportive Living Program; HCBS Waiver for Persons with Physical Disabilities; HCBS Waiver for Persons with HIV/AIDS; and HCBS Waiver for Persons with Brain Injury. This report must also be broken out by service area (e.g., Central Illinois, Greater Chicago) for the following categories: • *Waiver Eligible Enrollees:* Managed Care Enrollees Not Receiving HCBS Waiver Services Who then Become Eligible for HCBS Waiver Services (within 15 Day Transition Period). • *Transition Enrollees:* Completed within 180 Day Transition Period. • *Transfer Enrollees:* Managed Care Enrollees Receiving HCBS Waiver Services Who Transfer to a New MCO (within 90 Day Transition Period). • *MC to FFS Enrollees:* Enrollees Receiving HCBS Waiver Services Who Transition from Managed Care to FFS and Are Still Eligible for HCBS Services (within 15 Day Transition Period).

Name of Report/Submission	Frequency	HFS Prior Approval	Report Description and Requirements
Transition of Care Plan	Initially and as revised	Yes	Contractor shall submit its Transition of Care Plan to the Department for review and Prior Approval. The Transition of Care Plan shall include policies and procedures and a staffing model designed to achieve a seamless, efficient transition with minimal impact to an Enrollee's care.
Cultural Competence Plan	At least one (1) week prior to the Department's Readiness Review	No	Contractor shall submit its Cultural Competence Plan that addresses the challenges of meeting the health care needs of Enrollees. Contractor's Cultural Competence Plan shall contain, at a minimum, the provisions listed in Section 2.7.1 of the Contract.
Executive Summary	Quarterly	No	Contractor shall submit an Executive Summary that summarizes the data within the reports submitted to the Department for that quarter (including monthly and quarterly reports). The Executive Summary shall contain, at a minimum, an analysis of the reports submitted during the quarter, an explanation of the data submitted, and highlights from the reports.
Children with Special Health Care Needs (CSHCN) Plan	Initially and as revised	No	Contractor shall submit the Children with Special Health Care Needs Plan to conduct timely identification and screening, comprehensive assessments, and appropriate case management services for any CSHCN.
Provider-preventable Conditions Report	Quarterly	No	Contractor shall report provider-preventable conditions that are identified in the State Plan to the Department.

Name of Report/Submission	Frequency	HFS Prior Approval	Report Description and Requirements
			Utilization Review
Utilization Management Report	Monthly	No	Contractor shall submit an analysis of Inpatient and Emergency Services utilization. Inpatient services shall be based on inpatient days and be categorized as follows: Utilization for total Inpatient, Medical/Surgical, Rehabilitation, Mental Health including Substance Abuse, Emergency Services, and Outpatient visits. Data will be based on utilization per 1,000 Enrollees and Total utilization. Reporting for Inpatient, Emergency Services, and Outpatient visits utilization shall be divided into separate worksheets for LTC, HCBS Waiver for Persons with Developmental Disabilities, HCBS Waiver for Persons with Disabilities, HCBS Wavier for Persons with Brain Injury, HCBS Waiver for Persons with HIV/AIDS, HCBS Waiver for Persons who are Elderly, HCBS Waiver for Assisted Living, Supportive Living Program, and total population as defined by Department standards.
			Pharmacy Reports
Pharmacy Rebate Report	Quarterly	N/A	Contractor shall submit a 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	No	Contractor shall submit pharmacy data utilization reports based on total utilization, claims summaries, cost summaries and cost per claim.

Name of Report/Submission	Frequency	HFS Prior Approval	Report Description and Requirements
Psychotropic Review Reports	Monthly	No	Contractor shall submit a summary report of Enrollees' Psychotropic medication utilization and the prescribing patterns of providers. The report must include information on the following criteria: use of 5 or more psychotropics for 60 or more days, use of 2 or more ADHD medications for 60 or more days, use of 3 or more antidepressants for 60 or more days, use of 5 or more drugs for bipolar disorder (mood stabilizers, atypical antipsychotics, antidepressants) for 60 or more days, use of 2 or more SSRIs for 60 or more days, use of 2 or more antipsychotics for 60 or more days, use of 2 or more atypical antipsychotics for 60 or more days, and use of 2 or more benzodiazepine or benzodiazepine hypnotics for 60 or more days.
Pharmacy Formulary	Initially and annually	Yes	Contractor shall submit its Pharmacy Formulary to the Department for review and Prior Approval.
Drug Utilization Review Report	Quarterly	No	Contractor shall report its prospective and retrospective Drug Utilization Review activities to the Department.
Outpatient Drug Utilization Report	Quarterly	No	Contractor shall report to the Department, in a format and in the detail specified by the Department, information on the total number of units of each dosage form and strength and package size by National Drug Code of each covered outpatient drug identified in Section 5.2.5.4.1 dispensed to Enrollees.

Name of Report/Submission	Frequency	HFS Prior Approval	Report Description and Requirements
Subcontracts and Provider Agreements			
Executed Subcontracts	Initially and as revised	N/A	Contractor shall submit copies of each executed subcontract relating to an arrangement for the provision of Covered Services, but not those subcontracts for the direct provision of Covered Services. For example, a subcontract with a behavioral health or dental administrator shall be submitted to the Department, but an agreement with a therapist or dentist providing direct care to an Enrollee need not be submitted unless otherwise required or requested by the Department.
Executed Provider Agreements	Within ten (10) Business Days after the Department's request	N/A	Contractor shall submit copies of executed Provider agreements to the Department upon request.
Model Subcontracts and Provider Agreements	Initially and as revised	N/A	Contractor shall submit copies of model subcontracts and Provider agreements related to Covered Services, assignment of risk and data reporting functions, inclusive of all proposed schedules or exhibits intended to be used therewith. Contractor shall provide the Department with any substantial revisions to, or deviations from, these model subcontracts and Provider agreements.

Name of Report/Submission	Frequency	HFS Prior Approval	Report Description and Requirements
Business Enterprise Program Act for Minorities, Females and Persons with Disabilities			
Business Enterprise Program (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, prior to the start of each State Fiscal Year, and as revised. Refer to Section 2.9 of the Contract.
BEP Report	Quarterly	N/A	Contractor shall submit, in a format specified by the Illinois Department of Central Management Services, its expenditures for BEP-certified subcontractors and goal attainment as provided in Section 2.9 of the Contract.

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:

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Bureau of Managed Care
Illinois Department of Healthcare and Family Services
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For Contractor:

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ATTACHMENT XVI

Qualifications and Training Requirements of Certain Care Coordinators

A. Qualifications of Certain Care Coordinators

Persons who are Elderly Waiver

Care Coordinators must meet one (1) of the four (4) following requirements:

1. RN licensed in Illinois
2. Bachelor's degree in nursing, social sciences, social work, or related field
3. LPN with one (1) year experience in conducting comprehensive assessments and provision of formal service for the elderly
4. One (1) year of satisfactory program experience may replace one year of college education, at least four (4) years of experience replacing baccalaureate degree

Persons with Disabilities Waiver

Care Coordinators must meet one (1) of the nine (9) following requirements:

1. Registered Nurse (RN)
2. Licensed Clinical Social Worker (LCSW)
3. Licensed Marriage and Family Therapist (LMFT)
4. Licensed Clinical Professional Counselor (LCPC)
5. Licensed Professional Counselor (LPC)
6. PhD
7. Doctorate in Psychology (PsyD)
8. Bachelor or Master's Degree prepared in human services related field
9. Licensed Practical Nurse (LPN)

Persons with Brain Injury Waiver

Care Coordinators must meet one (1) of the seven (7) following requirements:

1. Registered Nurse (RN) licensed in Illinois
2. Certified or Licensed social worker
3. Unlicensed social worker: minimum of bachelor's degree in social work, social sciences or counseling
4. Vocational specialist: certified rehabilitation counselor or at least three (3) years experience working with people with disabilities
5. Licensed Clinical Professional Counselor (LCPC)
6. Licensed Professional Counselor (LPC)
7. Certified Case Manager (CCM)

Persons with HIV/AIDS Waiver

Care Coordinators must meet one (1) of the three (3) following requirements:

1. A Registered Nurse (RN) licensed in Illinois and a Bachelor's degree in nursing, social work, social sciences or counseling or four (4) years of case management experience.
2. A Social worker with a bachelor's degree in either social work, social sciences or counseling (A Bachelor's of social work or a Masters of social

work from a school accredited by any organization nationally recognized for the accreditation of schools of social work is preferred).

3. Individual with a bachelor's degree in a human services field with a minimum of five (5) years of case management experience.

In addition, it is mandatory that the Care Coordinator for Enrollees within the Persons with HIV/AIDS Waiver have experience working with:

- Addictive and dysfunctional family systems
- Racial and ethnic minorities
- Homosexuals and bisexuals
- Persons with AIDS, and
- Substance abusers

B. Training Requirements of Certain Care Coordinators

Care Coordinators for HCBS Waiver Enrollees shall receive a minimum of 20 hours in-service training initially and annually. For partial years of employment, training shall be prorated to equal one-and-a-half (1.5) hours for each full month of employment. Care Coordinators must be trained on topics specific to the type of HCBS Waiver Enrollee they are serving. Training must include the following:

Persons who are Elderly Waiver

- Aging related subjects

Persons with Brain Injury Waiver

- Training relevant to the provision of services to persons with brain injuries.

Persons with HIV/AIDS Waiver

- Training relevant to the provision of services to persons with AIDS (e.g., infectious disease control procedures, sensitivity training, and updates on information relating to treatment procedures).

Supportive Living Program Waiver

- Training on the following subjects: resident rights; prevention and notification of Abuse, Neglect, and exploitation; behavioral intervention, techniques for working with the elderly and persons with disabilities; and, disability sensitivity training.

Attachment XVII
Illinois Department of Human Services, Division of Rehabilitation Services
Critical Incident Definitions

Death, HSP customer	All deaths will be reported via incident reporting, and will be reported to the DHS Office of Inspector General. Follow-up will be provided on deaths of an unusual nature per OIG direction. Criteria for investigating such incidents and reporting via the Incident reporting system may include a recent allegation or abuse/neglect/exploitation, customer was receiving home health services at time of passing, etc.
Death, Other parties	Events that result in significant event for customer. For example, customer's caregiver dies in the process of giving customer bath, thereby leaving customer stranded in home without care for several days. Passing of immediate family members is not necessary unless the passing creates a resulting turn events that are harmful to customer.
Physical abuse of customer	Non-accidental use of force that results in bodily injury, pain or impairment. Includes but not limited to being slapped, burned, cut, bruised or improperly physically restrained.
Verbal/Emotional abuse of customer	Includes but is not limited to name calling, intimidation, yelling and swearing. May also include ridicule, coercion, and threats.
Sexual abuse of customer	Unwanted touching, fondling, sexual threats, sexually inappropriate remarks or other sexual activity with an adult with disabilities.
Exploitation of Customer	The illegal use of assets or resources of an adult with disabilities. It includes, but is not limited to , misappropriation of assets or resources of the alleged victim by undue influence, by breach of fiduciary relationship, by fraud, deception, extortion, or in any manner contrary to law.
Neglect of customer	The failure of another individual to provide an adult with disabilities with, or the willful withholding from an adult with disabilities of the necessities of life including but not limited to food, clothing, shelter, or medical care

Sexual Harassment by provider	Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature that tends to create a hostile or offensive work environment.
Sexual Harassment by customer	Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature that tends to create a hostile or offensive work environment.
Sexually problematic behavior	Inappropriate sexual behaviors exhibited by either the customer or individual provider which impacts the work environment adversely.
Significant Medical event of Provider	A recent event to a provider that has the potential to impact upon a customer's care.
Significant Medical Event of Customer	This includes a recent event or new diagnosis that has the potential to impact on the customer's health or safety. Also included are unplanned hospitalizations or errors in medication administration by provider.
Customer arrested, charged with or convicted of a crime	In instance where the arrest, charge, or conviction has a risk or potential risk upon the customer's health and safety should be reported.
Provider arrested, charged with or convicted of a crime	In instance where the arrest, charge, or conviction has a risk or potential risk upon the customer's health and safety should be reported.
Fraudulent activities or theft on the part of the Customer or the Provider	Executing or attempting to execute a scheme or ploy to defraud the Home Services program, or obtaining information by means of false pretenses, deception, or misrepresentation in order to receive services from our program. Theft of customer property by a provider, as well as theft of provider property by a customer is included.

Self-Neglect	Individual neglects to attend to their basic needs, such as personal hygiene, appropriate clothing, feeding, or tending appropriately to medical conditions.
Customer is missing	Customer is missing or whereabouts are unknown for provision of services.
Problematic possession or use of a weapon by a customer.	Customers should never display or brandish a weapon in staff's presence. Any perceived threat through use of weapons should be reported. In some cases, persons with SMI are not allowed to possess firearms and this should be documented if observed.
Customer displays physically aggressive behavior	Customer uses physical violence that results in harm or injury to the provider.
Property damage by customer of $50 or more	Customer causes property damage to in the amount of $50 or more to provider property.
Suicide attempt by customer	Customer attempts to take own life.
Suicide ideation/ threat by customer	An act of intended violence or injurious behavior towards self, even if the end result does not result in injury.
Suspected alcohol or substance abuse by customer	Use of alcohol or other substances that appears compulsive and uncontrolled and is detrimental to customer's health, personal relationships, safety of self and others. Social and legal status.

Seclusion of a customer	Seclusion is defined as placing a person in a locked or barricaded area that prevents contact with others.
Unauthorized Restraint of a customer	Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely.
Media involvement/media inquiry	Any inquiry or report/article from a media source concerning any aspect of a customer's case should be reported via an incident report. Additionally, all media requests will be forwarded to the DHS Office of Communications for response.
Threats made against DRS/HSP Staff	Threats and/or intimidation manifested in electronic, written, verbal, physical acts of violence, or other inappropriate behavior
Falsification of credentials or records	To falsify medical documents or other official papers for the expressed interest of personal gain, either monetary or otherwise.
Report against DHS/HSP employee	Deliberate and unacceptable behavior initiated by an employee of DRS against a customer or provider in HSP.
Bribery or attempted bribery of a HSP Employee	Money or favor given to an HSP employee in exchange to influence the judgment or conduct of a person in a position of authority.
Fire / Natural Disaster	Any event or force of nature that has catastrophic consequences, such as flooding, tornados, or fires.
please specify:	

Attachment XVIII
Illinois Department on Aging
Elder Abuse and Neglect Program

Elder abuse refers to the following types of mistreatment to any Illinois resident 60 years of age or older who lives in the community and must be committed by another person on the elder:

- **Physical Abuse** means causing the inflictions of physical pain or injury to an older person.
- **Sexual Abuse** means touching fondling, sexual threats, sexually inappropriate remarks, or any other sexual activity with an older person when the older person is unable to understand, unwilling to consent, threatened, or physically forced to engage in sexual activity.
- **Emotional Abuse** means verbal assaults, threats of maltreatment, harassment, or intimidation intended to compel the older person to engage in conduct from which he or she wishes and has a right to abstain, or to refrain from conduct in which the older person whishes and has a right to engage.
- **Confinement** means restraining or isolating, without legal authority, an older person for other than medical reasons, as ordered by a physician.
- **Passive Neglect** means a caregiver's failure to provide an eligible adult with the necessities of life including, but not limited to, food, clothing, shelter, or medical care. This definition does not create any new affirmative duty to provide support to eligible adults; nor shall it be construed to mean that an eligible adult is a victim of neglect because of health care services provided or not provided by licensed health care professionals.
- **Willful Deprivation** means willfully denying medications, medical care, shelter, food, therapeutic devices, or other physical assistance to a person who, because of age, health, or disability, requires such assistance and thereby exposes that person to the risk of physical, mental, or emotions harm because of such denial; except with respect to medical care or treatment when the dependent person has expressed an intent to forego such medical care or treatment and has the capacity to understand the consequences.
- **Financial Exploitation** means the misuse or withholding of an older person's resources by another person to the disadvantage of the older person or the profit or advantage of a person other than the older person.

Attachment XIX
Illinois Department of Healthcare and Family Services
Incident Reporting for Supportive Living Facilities

Examples of incidents that must be reported to the Department include, but are not limited to the following:

- Abuse or suspected abuse of any nature by anyone, including another resident, staff, volunteer, family, friend, etc.
- Allegations of theft when a resident chooses to involve local law enforcement.
- Elopement of residents/missing residents.
- Any crime that occurs on facility property.
- Fire alarm activation for any reason that results in on-site response by local fire department personnel. This does **NOT** include fire department response that is a result of resident cooking mishaps that only cause minimal smoke limited to a resident's apartment and that do not result in any injuries or damage to the apartment. Examples of what do not need to be reported include, but are not limited to: burnt toast or burnt popcorn.
- Physical injury suffered by residents during a mechanical failure or force of nature.
- Loss of electrical power in excess of an hour.
- Evacuation of residents for any reason.

Contractor has subcontracted back to DHS-DRS for payroll functions to compensate Personal Assistants providing services in the DRS waivers. DHS-DRS and the Enrollee shall remain the co-employers of the Personal Assistant. DHS-DRS shall be responsible for making payment, and for the performance of related payroll and employment functions, for the Personal Assistants. After the one hundred eighty (180) day transition period that begins on the date the services included in Service Package II are Covered Services, Contractor shall be responsible to provide DHS-DRS with data, in a mutually agreed upon format, that indicates the approved hours of Personal Assistant services. The State will provide invoices to Contractor, in a mutually agreed upon format, within sixty (60) days after DHS-DRS has paid for Personal Assistants' for Enrollees of Contractor. Contractor shall reimburse DHS-DRS for these services either by agreeing to have the amounts due to the state deducted from future capitation payments due to Contractor, or by direct payment to the state. In the event that the Contract terminates and no further payments to Contractor are to be made from which monies can be deducted, Contractor shall reimburse the state directly. At any time during the course of this Contract the parties may decide to use an entity other than DHS-DRS as the fiscal agent responsible for Personal Assistant payroll functions.

The State is a party to a collective bargaining agreement with SEIU covering Personal Assistants in certain HCBS Waivers. Services provided by Personal Assistants are included in Service Package II. Wages agreed to pursuant to the collective bargaining agreement constitute the Medicaid rate for Personal Assistant services, which Contractor is obligated to pay pursuant to Section 5.25.5. Contractor shall have no obligation to become party to such agreement, or have any liability under such agreement, as a result of entering into this Contract. If the parties to the SEIU agreement negotiate terms that Contractor reasonably demonstrates materially increases Contractor's cost of providing, or arranging for the provision of, Covered Services or otherwise meeting its obligations under this Contract, the Department will address adjustments of the Capitation rates as set forth in Section 7.6. Nothing in this Contract shall impair or diminish DHS-DRS' status as co-employer of the Personal Assistants working under the Home Services Program under Section 3 of the Disabled Persons Rehabilitation Act (5 ILCS 315). Nothing in this Contract shall diminish the effect of the collective bargaining agreement covering Personal Assistants' employment.

1. Contractor shall provide or arrange to provide to all Enrollees Covered Services at locations serving the Contracting Area that assure availability and accessibility to Enrollees.
2. Contractor will provide a system to notify Enrollees on an ongoing basis of the need for and benefits of health screenings and physical examinations. Contractor will provide or arrange to provide such examinations to all of its Enrollees.
3. All Covered Services provided by or arranged to be provided by Contractor shall be in accordance with current Departmental policies and 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 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. These services include:

   a. EPSDT Services to Enrollees Under Twenty-One (21) Years. All Enrollees under twenty-one (21) years of age should receive screening examinations including appropriate childhood immunizations at intervals as specified by the EPSDT Program as set forth in §§1902(a)(43)and 1905(a)(4)(B) of the Social Security Act and 89 Ill. Adm. Code 140.485. Contractor shall provide EPSDT services in conformance with the *Handbook for Providers of Healthy Kids Services* including future revisions.
      i. Contractor shall employ strategies to ensure that children receive comprehensive child health services, according to the Department's recommended periodicity schedule or more frequently, as needed, and shall perform provider training to ensure that best practice guidelines are followed in relation to well child services and care for acute and chronic health care needs.
      ii. Any condition discovered during the screening examination or screening test requiring further diagnostic study or treatment must be provided if within the scope of Covered Services. Contractor shall refer the Enrollee to an appropriate source of care for any required services that are not Covered Services. If, as a result of EPSDT services, Contractor determines an Enrollee is in need of services that are not Covered Services but are services otherwise provided for under the HFS Medical Program, Contractor will ensure that the Enrollee is referred to an appropriate source of care. Contractor shall have no obligation to pay for services that are not Covered Services.

   b. Preventive Medicine Schedule (Services to Enrollees Twenty-One (21) Years of Age and Over). The following preventive medicine services and age schedule is the minimum acceptable range and scope of required services for the average risk patient. These guidelines do not supplant clinical judgment of the licensed professional and the individual patient. Contractor may substitute an alternate schedule for adult preventive medicine services as long as such schedule is based upon recognized guidelines such as those recommended by the current United States Preventive Service Task Force.

Contractor shall ensure that a complete health history and physical examination is provided to each Enrollee initially within the first twelve (12) months of enrollment. Thereafter, for Enrollees between ages twenty-one (21) and sixty-four (64), Contractor shall ensure that a complete health history and physical examination is conducted every 1-3 years, as indicated by Enrollee's need and clinical care guidelines. For Enrollees aged sixty-five (65) and older, Contractor shall ensure that a complete health history and physical examination is conducted annually. With each health history and physical examination, screening, counseling and immunization should be provided in accordance with national medical organizations' guidelines.

For purposes of this section, a "complete health history and physical examination" shall include, at a minimum, the following health services regardless of age and gender of each Enrollee.

Initial and interval history;

- Height and weight measurement for Body Mass Index (BMI);
- Blood pressure;
- Nutrition and physical activity assessment and counseling;
- Alcohol, tobacco, substance abuse, intimate partner violence, and depression screening and counseling;
- Health promotion and anticipatory guidance;
- Any known condition or condition discovered during the complete health history and physical examination requiring further Medically Necessary diagnostic study or treatment must be provided if within the scope of Covered Services.

i. The following are cancer screenings for healthy adults with recommended age and intervals:

A. Cervical Cancer- Women aged 21-29 should have cytology (pap smear) every three (3) years. For women 30-65, extended screening to every five years (5) is appropriate after three satisfactory normal cytology results and a negative human papillomavirus (HPV) test. Women over 65 with adequate screening or women of any age who have had a hysterectomy with removal of the cervix for benign reasons and without a history of high grade lesion or at low risk for cervical cancer do not need screening. The HPV vaccine series should also be offered for those up to age 26 years old, if not already immunized.

B. Breast Cancer- Women aged 40 to 49 are recommended to have biennial mammogram screenings and annual screenings begin at age 50. Clinical breast exams are recommended every one (1) to three (3) years from 20 to 40 years old and annually thereafter. Breast self-awareness to recognize changes can be discussed from age 20 years old. Using one of several tools, women with a family history of breast, ovarian, tubal, or peritoneal cancer should be offered the gene mutation screening for BRCA1 and BRCA2. Subsequent positive testing should be offered genetic counseling. Women who are at

increased risk for breast cancer should be counseled and offered risk reducing medication such as selective estrogen response modulators.

C. Colorectal Cancer- Colonoscopy at age 50, every ten (10) years OR fecal occult blood test (FOBT) every three years with flexible sigmoidoscopy every five (5) years OR annual FOBT until age 75 years.

D. Prostate Cancer- There is no recommendation to screen for prostate cancer with prostate specific antigen (PSA) testing for the asymptomatic, low risk man. Along the same line, digital rectal exam (DRE) is at the discretion of the provider and after informed discussion with the patient. Screening with both PSA and DRE may be considered at age 40 for African American ancestry or family history risk of a first degree relative diagnosed at younger than 65 years of age.

E. Skin Cancer- No specific age or interval recommendations, but general preventive exams should include examination of the skin with attention to those with family history of skin cancer or considerable exposure to sun and sunburns. Fair skinned men and women aged 65 and older or people with atypical moles or greater than 50 moles may be at greater risk for melanoma.

ii. The following are recommended other screenings with age and intervals:

A. Type 2 Diabetes Mellitus- Screening should start at 45 years old at three (3) year intervals for the Enrollee with normal weight and no other risk factors. Those with first degree relatives with diabetes mellitus, clinical signs and symptoms consistent with glucose intolerance, or with sustained blood pressure greater than 135/80, screening may be earlier. Fasting plasma glucose is the preferred screening method, however the two hour oral glucose tolerance or a hemoglobin A1C are considered appropriate.

B. Lipid Disorder- Cholesterol screening for men should begin at 35 years old and at five (5) year intervals. For women and men at risk of coronary artery disease (CAD) screening should start at 20 years old. Risk of coronary artery disease may include family history of CAD, obesity, hypertension, diabetes, and current tobacco use.

C. Osteoporosis- Screen all women 65 years and older for bone mineral density with dual energy x-ray absorptiometry. For those with one risk factor or having a fracture risk equivalent to a 65 year old white woman, screening may begin earlier. An interval of two (2) years is usually sufficient for clinical changes. Risk factor may include certain ethnicities, very low BMI, history of fractures, tobacco use, limited exercise, and other chronic diseases.

D. Sexually Transmitted Infections- See Family Planning and Reproductive Health Care section herein.

E. Tuberculosis- annual tuberculin (Mantoux) skin testing for all at risk Enrollees. At risk may include signs and symptoms of tuberculosis, recent contact with someone diagnosed with tuberculosis, occupational or living hazard of close quarters, recent immigrants from county with high prevalence of tuberculosis, illicit drug use, compromised immune system, or healthcare workers.

iii. The following are recommended immunizations by age and interval for both male and female Enrollees, unless contraindicated:

A. Influenza- one (1) dose annually

B. Tetanus/ Diphtheria (Tdap/Td)- One tdap and one td booster every ten (10) years

C. Varicella- One (1) two dose series for all adults without previous evidence of immunity

D. Human Papilloma Virus (HPV) - one (1) three dose series up through age 26.

E. Shingles (zoster)- one (1) dose at 60 years of age and older

F. Hepatitis A & B – combined Hepatitis A and Hepatitis B one (1) three dose series or Hepatitis A one (1) two dose series or Hepatitis B one (1) three dose series provided at any age for any Enrollee requesting protection.

c. Family Planning and Reproductive Health Care

Contractor shall ensure that the full spectrum of family planning options and reproductive health services are appropriately provided within the Provider's scope of practice and competence. The Contractor shall follow Federal and State laws regarding minor consents and confidentiality. The family planning and reproductive health services are defined as those services offered, arranged, or furnished for the purpose of preventing an unintended pregnancy, or to improve maternal health and birth outcomes. The Contractor must follow nationally recognized standards of care and guidelines for sexual and reproductive health, such as those established by the Centers of Disease Control and Prevention (CDC) or the American Congress of Obstetricians and Gynecologists (ACOG) and comply with the requirements of the Affordable Care Act.

Contractor policies shall not present barriers or restrictions to access to care, such as prior authorizations or step-failure therapy requirements. Contractor shall cover and offer all FDA-approved birth control methods with education and counseling on the most effective methods first, specifically long acting reversible contraception (LARC). Enrollees have the freedom to choose the preferred birth control method that is most appropriate for them.

Contractor shall provide the following family planning and reproductive health services:

- A reproductive life plan, which may include a preconception care risk assessment and preconception and interconception care discussions.

- Education and counseling on all contraceptive methods with emphasis on presenting the most effective methods first, specifically long acting reversible contraceptives (LARC) such as intrauterine devices (IUD) and the implantable rod.

- Contraceptive methods must also include over-the-counter and prescription emergency contraception, including the provision of the copper IUD for emergency contraception.

- Permanent methods of birth control: tubal ligation, transcervical sterilization and vasectomy.

- Basic infertility counseling, consisting of medical/sexual history review and fertility awareness education. Infertility medications and procedures are NOT covered.

- Reproductive health exam, with pelvic exam decoupled from the provision of contraception.

- Sexually active female Enrollees under 26 years of age should be screened annually for chlamydia and gonorrhea. Male Enrollees under 26 years of age should be screened for chlamydia and gonorrhea if in clinical settings with a high prevalence of sexually transmitted infections (STI) such as STD clinics, adolescent health centers, and family planning clinics. For all Enrollees who are 26 years of age or older, screening should base on risk factors such as symptoms, new partner, multiple partners, or recent history of another STI. For all Enrollees, syphilis screening is recommended if infected with another STI or has risk factors such as men having sex with men, recent incarceration, IV drug use, or commercial sex workers. CDC recommends a one-time screening for Hepatitis C for all Enrollees born in 1945 through1965 regardless of risk factors. Blanket screening is not recommended because testing low risk individuals may increase the risk of false positives.

- Universal HIV testing, counseling, and screening.

- Testing and treatment for genital and related infections and other pathological conditions.

- Lab test or screening necessary for family planning and reproductive health services.

- Cervical cancer screening, management, and early treatment.

- Vaccines for preventable reproductive health related conditions (i.e., HPV, Hepatitis B).

- Mammography referral and BRCA genetic counseling and testing.
  Refer to the Department's Provider notices relating to family planning and reproductive health care as they become available.

i. Maternity Care. Contractor shall provide evidence-based care for pregnant Enrollees. At a minimum, Contractor shall provide the following services:

A. A comprehensive prenatal evaluation and care in accordance with the latest standards as recommended by the American Congress of Obstetricians and Gynecology or the American Academy of Family Physicians, including ongoing risk assessment and development of individualized care plans that take into consideration the medical, psychosocial, cultural/linguistic, and educational needs of the patient and her family.

B. Contractor shall have systems and protocols in place to handle regular appointments, early entry to care appointments, after hours care with emergency appointment slots, seamless process for transmitting prenatal records to the delivering facility, and a referral network for mental health, social services and specialty care. Contractor must refer all pregnant Enrollees to the Women, Infants and Children's (WIC) Supplemental Nutrition Program and have or be linked to case management services for identified high risk Enrollees. Contractor must be able to provide equal, high quality obstetrical care to special populations such as adolescent, homeless, developmentally and intellectually disabled pregnant patients.

C. The specific areas to be addressed in regard to the provision of prenatal care include but are not limited to the following items:

- Risk counseling for STI /HIV, intimate partner violence, teratogen exposure, substance use and abuse and potential for pre-term delivery screenings, and education on use of 17 P, if appropriate.

- Screening for, diagnosing, and treating depression before, during and after pregnancy with any number of tested screening tools (refer to the Healthy Kids Handbook for a list of approved screening tools)

- Health maintenance promotion includes nutrition, exercise, dental care, immunizations, management of current chronic disease, over the counter and prescription medication, breastfeeding counseling and recommendation, appropriate weight gain in pregnancy, obesity counseling, managing signs and symptoms of common pregnancy ailments, and referral to breastfeeding, childbirth classes, and text4baby. The influenza vaccine should be offered to all pregnant women during influenza season regardless of gestational age. Tdap should be provided regardless of prior interval of Td or Tdap.

- Routine laboratory screening and physical exam, which includes dating by ultrasound for accurate gestational age. Every prenatal exam at minimum should include blood pressure check, fetal growth assessment, and fetal heart rate check. In the absence of patient symptoms and/or suspicion for preeclampsia, renal disease, or urinary tract infection, a urine analysis and culture is only required at the initial visit. Routine laboratory screening should include the following: blood type, Rh type, antibody, CBC (routine screening for anemia), rubella, hepatitis B, syphilis/gonorrhea/chlamydia/HIV, varicella, diabetes, and tuberculosis to applicable populations.

- Genetic screening should be counseled and offered depending on patient's age, medical/ family history, and ethnic background.

- Visits approximate to the third trimester should include labor preparation, education regarding preeclampsia, warning signs of miscarriage, fetal movements/kick count, preterm labor and labor, options for intrapartum care, breastfeeding encouragement, postpartum family planning including LARC or permanent sterilization with informed consent done prior to labor and delivery, circumcision, newborn provider care, car seat, SIDS, the importance of waiting at least 39 weeks to deliver, referral to parenting classes and WIC, and transition of maternal healthcare after the postpartum visit. Contractor shall have protocols in place to facilitate the continuum of care after the obstetric period.

D. Contractor shall require all Providers to timely identify high-risk pregnancies and arrange for maternal fetal medicine specialist or transfer to Level III perinatal facilities in accordance with ACOG guidelines and the Illinois Perinatal Act requirements for referral and/or transfer of high-risk women. Risk appropriate care shall be ongoing during the perinatal period. Contractor shall provide a plan to the Department on how it will ensure that maternity care is received at the appropriate perinatal facility for the level of risk associated with each pregnancy.

E. Contractor shall provide evidence-based postpartum care for Enrollees. At a minimum, Contractor shall provide and document the following services:

- Immediate and subsequent postpartum visits, in accordance with the Department's approved schedule, to assess and provide education on areas such as perineum care, breastfeeding/feeding practices, nutrition, exercise, immunization, sexual activity, effective family planning, pregnancy intervals, physical activity, SIDS, and the importance of ongoing well woman care, and referral to parenting classes, text4baby and WIC.

- Postpartum depression screening during the one year period after delivery to identify high risk mothers who have an acute or long term history of depression, using an HFS-approved screening tool. After delivery and discharge, the Enrollee shall have a mechanism to readily communicate with her health team and not be limited to a single "six week" postpartum visit.

- Contractor must continue to engage the Enrollee in health promotion and chronic disease maintenance by supporting the postpartum mother with seamless referrals to avoid interruption of care.

- Contractor shall assure that Enrollees are transitioned to the medical home for ongoing well woman care. Enrollees who delivered and who are at risk of or diagnosed with diabetes, hypertension, heart disease, depression, substance use, obesity or renal disease shall be identified and followed closely after the postpartum period.

- Contractor shall provide or arrange for interconception care management services for these high risk women for 24 months following delivery.

ii. Well Woman Exam. Contractor shall provide evidence-based annual preventive well woman care to female Enrollees.

A. At a minimum, Contractor shall provide and document the following:

- Preconception and interconception care and reproductive life planning.

- The annual exam should include screening, counseling, evaluation, education, and immunizations based on age.

- The examination may vary but at minimum should include the following: routine vital signs, body mass index, palpation of abdominal and inguinal lymph nodes, and visual inspection of breast and genital.

- The components of the exam are based on Enrollee's age, medical history, symptoms and provider findings.

B. Exams shall include age appropriate discussions and anticipatory guidance related to reproductive health issues. Education shall include, but not be limited to chronic disease management, breastfeeding reinforcement, reproductive life planning, and emphasis on the most effective method of family planning, specifically intrauterine devices or the implant.

C. Appropriate referrals should be made to support services including WIC, interconception care management and parenting classes.

D. A routine pelvic exam is not required for Enrollees less than 21 years of age unless there is a clinical indication. A pelvic examination is an appropriate component of a comprehensive evaluation of any patient who reports or exhibits symptoms suggestive of female genital tract, pelvic, urologic, or rectal problems.

E. Cervical cytology screening every three years from 21 years of age regardless of sexual debut and every 3-5 years after 29 years of age.

F. Annual clinical breast examination for women aged 40 years and older; and in women aged 20-39 years, every 1-3 years.

d. Complex and Serious Medical Conditions.

i. Contractor shall provide or arrange to provide quality care for Enrollees with complex and serious medical conditions. At a minimum, Contractor shall provide and document the following:

1. Timely identification of Enrollees with complex and serious medical conditions.

2. Assessment of such conditions and identification of appropriate medical procedures for monitoring or treating them.

3. A Chronic Care Action Plan that is symptom-based and developed in conjunction with the Enrollee and a copy of this Chronic Care Action Plan shall be provided to the Enrollee.

ii. Contractor shall have procedures in place to identify Enrollees with special health care needs in order to identify any ongoing special conditions of the Enrollee that require a course of treatment or regular care monitoring. Appropriate health care professionals shall make such assessments. Such procedures must be delineated in Contractor's Quality Assurance Plan, and ongoing monitoring shall occur in compliance with Attachment XI, sections 3.a.iv(b) and (c) ("For pregnant women" and "For children, ages birth through twenty(20)", respectively).

iii. Contractor shall have a mechanism in place to allow Enrollees with special health care needs as defined by Contractor to have direct access to a specialist as appropriate for each Enrollee's condition and identified needs.

e. Coordination with Other Service Providers.

i. Contractor shall encourage Affiliated Providers and subcontractors to cooperate and communicate with other service providers who serve Enrollees. Such other service providers may include: Special Supplemental Nutrition Programs for Women, Infants, and Children (commonly referred to as "WIC" programs); Head Start programs; Early

Intervention programs; and, school systems. Such cooperation may include performing annual physical examinations for school and the sharing of information (with the consent of the Enrollee).

ii. Contractor shall coordinate with the Family Case Management Program, which shall include, but is not limited to:

1. Coordinating services and sharing information with existing Family Case Management Providers for its Enrollees;

2. Developing internal policies, procedures, and protocols for the organization and its provider network for use with Family Case Management Providers serving Enrollees; and

3. Conducting periodic meetings with Family Case Management Providers performing problem resolution and handling of grievances and issues, including policy review and technical assistance.

IRS DEPARTMENT OF THE TREASURY
INTERNAL REVENUE SERVICE
CINCINNATI OH 45999-0023

Date of this notice: 12-17-2015

Employer Identification Number: [redacted]

Form: SS-4

Number of this notice: CP 575 A

NL MERGER SUB INC
303 W MADISON ST STE 1110
CHICAGO, IL 60606

For assistance you may call us at:
1-800-829-4933

IF YOU WRITE, ATTACH THE
STUB AT THE END OF THIS NOTICE.

WE ASSIGNED YOU AN EMPLOYER IDENTIFICATION NUMBER

Thank you for applying for an Employer Identification Number (EIN). We assigned you EIN [redacted]. This EIN will identify you, your business accounts, tax returns, and documents, even if you have no employees. Please keep this notice in your permanent records.

When filing tax documents, payments, and related correspondence, it is very important that you use your EIN and complete name and address exactly as shown above. Any variation may cause a delay in processing, result in incorrect information in your account, or even cause you to be assigned more than one EIN. If the information is not correct as shown above, please make the correction using the attached tear off stub and return it to us.

Based on the information received from you or your representative, you must file the following form(s) by the date(s) shown.

Form 941	04/30/2016
Form 940	01/31/2017
Form 1120	03/15/2016

If you have questions about the form(s) or the due date(s) shown, you can call us at the phone number or write to us at the address shown at the top of this notice. If you need help in determining your annual accounting period (tax year), see Publication 538, *Accounting Periods and Methods*.

We assigned you a tax classification based on information obtained from you or your representative. It is not a legal determination of your tax classification, and is not binding on the IRS. If you want a legal determination of your tax classification, you may request a private letter ruling from the IRS under the guidelines in Revenue Procedure 2004-1, 2004-1 I.R.B. 1 (or superseding Revenue Procedure for the year at issue). Note: Certain tax classification elections can be requested by filing Form 8832, *Entity Classification Election*. See Form 8832 and its instructions for additional information.

IMPORTANT INFORMATION FOR S CORPORATION ELECTION:

If you intend to elect to file your return as a small business corporation, an election to file a Form 1120-S must be made within certain timeframes and the corporation must meet certain tests. All of this information is included in the instructions for Form 2553, *Election by a Small Business Corporation*.

(IRS USE ONLY) 575A 12-17-2015 NLME B 9999999999 SS-4

If you are required to deposit for employment taxes (Forms 941, 943, 940, 944, 945, CT-1, or 1042), excise taxes (Form 720), or income taxes (Form 1120), you will receive a Welcome Package shortly, which includes instructions for making your deposits electronically through the Electronic Federal Tax Payment System (EFTPS). A Personal Identification Number (PIN) for EFTPS will also be sent to you under separate cover. Please activate the PIN once you receive it, even if you have requested the services of a tax professional or representative. For more information about EFTPS, refer to Publication 966, *Electronic Choices to Pay All Your Federal Taxes.* If you need to make a deposit immediately, you will need to make arrangements with your Financial Institution to complete a wire transfer.

The IRS is committed to helping all taxpayers comply with their tax filing obligations. If you need help completing your returns or meeting your tax obligations, Authorized e-file Providers, such as Reporting Agents (payroll service providers) are available to assist you. Visit the IRS Web site at www.irs.gov for a list of companies that offer IRS e-file for business products and services. The list provides addresses, telephone numbers, and links to their Web sites.

To obtain tax forms and publications, including those referenced in this notice, visit our Web site at www.irs.gov. If you do not have access to the Internet, call 1-800-829-3676 (TTY/TDD 1-800-829-4059) or visit your local IRS office.

IMPORTANT REMINDERS:

* Keep a copy of this notice in your permanent records. **This notice is issued only one time and the IRS will not be able to generate a duplicate copy for you.** You may give a copy of this document to anyone asking for proof of your EIN.
* Use this EIN and your name exactly as they appear at the top of this notice on all your federal tax forms.
* Refer to this EIN on your tax-related correspondence and documents.

If you have questions about your EIN, you can call us at the phone number or write to us at the address shown at the top of this notice. If you write, please tear off the stub at the bottom of this notice and send it along with your letter. If you do not need to write us, do not complete and return the stub.

Your name control associated with this EIN is NLME. You will need to provide this information, along with your EIN, if you file your returns electronically.

Thank you for your cooperation.

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Keep this part for your records. CP 575 A (Rev. 7-2007)

Return this part with any correspondence so we may identify your account. Please correct any errors in your name or address.

CP 575 A

9999999999

Your Telephone Number
( ) -

Best Time to Call

DATE OF THIS NOTICE: 12-17-2015
EMPLOYER IDENTIFICATION NUMBER: [redacted]
FORM: SS-4 NOBOD

INTERNAL REVENUE SERVICE
CINCINNATI OH 45999-0023

NL MERGER SUB INC
303 W MADISON ST STE 1110
CHICAGO, IL 60606

OFFICE OF THE SECRETARY OF STATE

JESSE WHITE • Secretary of State

DECEMBER 30, 2015 7032-280-3

ILLINOIS CORPORATION SERVICE COMPANY
801 ADLAI STEVENSON DR
SPRINGFIELD, IL 62703

RE NL MERGER SUB, INC.

DEAR SIR OR MADAM:

ENCLOSED YOU WILL FIND THE ARTICLES OF MERGER REGARDING THE ABOVE NAMED CORPORATION.

FEES IN THIS CONNECTION HAVE BEEN RECEIVED AND CREDITED.

THE SURVIVING CORPORATION SHALL EXECUTE A REPORT FOLLOWING MERGER (FORM BCA 14.35) AND FILE IT IN THIS OFFICE WITHIN SIXTY (60) DAYS OF THE EFFECTIVE DATE OF THE MERGER. THIS FORM IS AVAILABLE ON OUR WEBSITE AT WWW.CYBERDRIVEILLINOIS.COM. CLICK ON PUBLICATIONS ON THE MENU BAR.

SINCERELY,

JESSE WHITE
SECRETARY OF STATE
DEPARTMENT OF BUSINESS SERVICES
CORPORATION DIVISION
TELEPHONE (217) 782-6961

FORM **BCA-14.35** (rev. Dec. 2014)
Report Following Merger or Consolidation
Business Corporation Act

Department of Business Services
501 S. Second St., Rm. 350
Springfield, IL 62756
217-782-6961
www.cyberdriveillinois.com

Payment must be made by check or money order payable to Secretary of State.

File #: _____ Approved: _____

Franchise Tax: $_____ **Filing Fee: $5** Penalty: $_____ Interest: $_____ Total: $_____

Type or Print clearly in black ink — Do not write above this line

1. Corporate Name: _____

2. State or Country of Incorporation: _____

3. Issued shares of each corporation party to the merger prior to the merger:

Corporation	Class	Series	Par Value	Number of Shares

4. Paid-in Capital of each corporation party to the merger prior to the merger:

Corporation	Paid-in Capital
	$
	$
	$
	$

5. Description of merger: (Include effective date and brief explanation of the conversion as stated in the plan of merger.)

6. Issued shares after merger:

Class	Series	Par Value	Number of Shares

7. Paid-in Capital of the surviving or new corporation: $ _____

("Paid-In Capital" replaces the terms Stated Capital and Paid-in Surplus and is equal to the total of these accounts.)

ITEM 8 MUST BE SIGNED

8. The undersigned corporation has caused this statement to be signed by a duly authorized officer who affirms, under penalties of perjury, that the facts stated herein are true and correct.

Dated _____ (Month & Day), _____ (Year) _____ (Exact Name of Corporation)

_____
Any Authorized Officer's Signature

_____
Name and Title (type or print)

Printed by authority of the State of Illinois. October 2015— 1 — C 243.5

FORM **BCA 11.39** (rev. Dec. 2003)
ARTICLES OF MERGER
BETWEEN ILLINOIS CORPORATIONS
AND LIMITED LIABILITY COMPANIES
Business Corporation Act

Secretary of State
Department of Business Services
501 S. Second St., Rm. 350
Springfield, IL 62756
217-782-6961
www.cyberdriveillinois.com

Remit payment in the form of a check or money order payable to Secretary of State.

The filing fee is $100, but if merger involves more than two corporations, submit $50 for each additional corporation.

FILED

DEC 30 2015

JESSE WHITE
SECRETARY OF STATE

EFT: 11/16 File #[redacted] Filing Fee: $100.00 Approved:

———— Submit in duplicate ———— Type or Print clearly in black ink ———— Do not write above this line ————

1. Names of Corporations and Limited Liability Companies proposing to merge and State or Country of organization or incorporation:

Name of Corporation or Limited Liability Company	State or Country of Organization/Incorporation	Corporation File Number
Next Level Health Partners, LLC	Illinois	[redacted]
NL Merger Sub, Inc.	Illinois	[redacted]

2. The laws of the state or country under which each Corporation and Limited Liability Company are organized, permit such merger.

3. a. Name of Surviving Party: NL Merger Sub, Inc.

   b. Corporation or Limited Liability Company shall be governed by the laws of: Illinois

For more space, attach additional sheets of this size.

4. Plan of merger is as follows:
   See Exhibit A attached hereto.

Printed by authority of the State of Illinois. January 2015 — 1 — C 294.6

5. Plan of merger was approved, as to each Limited Liability Company, in compliance with the laws of the state under which it is organized, and (b) as to each Illinois corporation, as follows:

Mark an "X" in one box only for each Illinois Corporation.

Name of Corporation:	By the shareholders, a resolution of the board of directors having been duly adopted and submitted to a vote at a meeting of shareholders. Not less than the minimum number of votes required by statute and by the Articles of Incorporation voted in favor of the action taken. **(§11.20)**	By written consent of the shareholders having not less than the minimum number of votes required by statute and by the Articles of Incorporation. Shareholders who have not consented in writing have been given notice in accordance with §7.10. **(§11.20)**	By written consent of ALL the shareholders entitled to vote on the action, in accordance with §7.10 and §11.20.
NL Merger Sub, Inc.	☐	☐	☑
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐

6. **Not applicable if survivor is an Illinois Corporation or an Illinois Limited Liability Company.**

It is agreed that, upon and after the filing of Articles of Merger by the Secretary of State of the State of Illinois:

a. The surviving Limited Liability Company may be served with process in the State of Illinois in any proceeding for the enforcement of any obligation of any Corporation organized under the laws of the State of Illinois which is a party to the merger and in any proceeding for the enforcement of the rights of a dissenting shareholder of any such Corporation organized under the laws of the State of Illinois against the surviving Limited Liability Company.

b. The Secretary of State of the State of Illinois shall be and is hereby irrevocably appointed as the agent of the surviving Limited Liability Company to accept service of process in any such proceedings, and

c. The surviving Limited Liability Company will promptly pay to the dissenting shareholders of any Corporation organized under the laws of the State of Illinois which is a party to the merger the amount, if any, to which they shall be entitled under the provisions of The Business Corporation Act of 1983 of the State of Illinois with respect to the rights of dissenting shareholders.

7. a. The undersigned Corporations have caused this statement to be signed by their duly authorized officers, each of whom affirms, under penalties of perjury, that the facts stated herein are true and correct. **All signatures must be in BLACK INK.**

Dated December 29, 2015 — NL Merger Sub, Inc.
(Month & Day, Year) (Exact Name of Corporation)

Any Authorized Officer's Signature

Cheryl Whitaker -- Chief Executive Officer
Name and Title (type or print)

Dated _____, _____ — _____
(Month & Day, Year) (Exact Name of Corporation)

Any Authorized Officer's Signature

Name and Title (type or print)

7. b. The undersigned Limited Liability Companies have caused this statement to be signed by their duly authorized person, who affirms, under penalties of perjury, that the facts stated herein are true and correct. **All signatures must be in BLACK INK.**

Dated December 29, 2015 — Next Level Health Partners, LLC
(Month & Day, Year) (Exact Name of Limited Liability Company)

Signature

Cheryl Whitaker -- Manager
Name and Title (type or print)

Dated _____, _____ — _____
(Month & Day, Year) (Exact Name of Limited Liability Company)

Name and Title (type or print)

PLAN OF MERGER

OF

NL MERGER SUB INC.
(an Illinois corporation)

and

NEXT LEVEL HEALTH PARTNERS, LLC
(an Illinois limited liability company)

THIS PLAN OF MERGER, dated as of January 1, 2016 (the "Plan of Merger"), governs the merger of NL Merger Sub Inc., an Illinois corporation (the "Corporation"), and Next Level Health Partners, LLC, an Illinois limited liability company (the "LLC"). The Corporation and the LLC are sometimes referred to herein as the "Constituent Entities".

RECITALS

A. Each of the Constituent Entities have determined that it is advisable and in its best interests that the LLC merge with and into the Corporation upon the terms and conditions herein provided, and this Plan of Merger shall be submitted to them for their consideration and approval.

B. The Board of Directors of the Corporation has approved this Plan of Merger in accordance with 805 ILCS 5/11.05, and the sole shareholder of the Corporation has approved the Plan of Merger in accordance with 805 ILCS 5/11.20.

C. The members of the LLC have approved this Plan of Merger in accordance with 805 ILCS 180/37-20.

NOW, THEREFORE, in consideration of the mutual agreements and covenants set forth herein, the Constituent Entities hereby agree, subject to the terms and conditions hereinafter set forth, as follows:

ARTICLE I

MERGER

1.1 MERGER. In accordance with the provisions of this Plan of Merger, Section 11.39 of the Business Corporation Act of 1983 of the State of Illinois, as amended ("BCA"), and Section 37-25 of the Illinois Limited Liability Company Act, as amended ("LLCA"), the LLC shall be merged with and into the Corporation (the "Merger"), the separate existence of the LLC shall cease and the Corporation shall survive the Merger and shall continue to be governed by the laws of the State of Illinois. The Corporation shall be, and is herein sometimes referred to as, the "Surviving Company". The name of the Surviving Company shall be NextLevel Health Partners, Inc.

1.2 FILING AND EFFECTIVENESS. Except as otherwise provided herein, the Merger shall become effective when the following actions shall have been completed:

(a) The Plan of Merger shall have been adopted and approved by the sole director and sole shareholder of the Corporation and the members of the LLC in accordance with the requirements of Illinois law.

(b) All of the conditions precedent to the consummation of the Merger shall have been satisfied or duly waived by the party entitled to satisfaction thereof.

(c) The Articles of Merger meeting the requirements of Section 11.25 of the BCA and 37-25 of the LLCA shall be filed with the Illinois Secretary of State and the effective time shall be 12:00 AM on the date hereof (the "Effective Time").

1.3 EFFECT OF THE MERGER. As of the Effective Time, the separate existence of the LLC shall cease and the Corporation, as the Surviving Company shall, without any further action by the Board of Directors, Board of Managers, shareholder, or members of the Constituent Entities (i) continue to possess all of its assets, rights, powers and property as constituted immediately prior to the Effective Time, (ii) assume, accept, adopt, ratify and confirm, as if taken by the Surviving Company, and thereby shall become subject to, all actions previously taken by its and the LLC, as the case may be, (iii) succeed, without other transfer, to all of the assets, rights, powers and property of the LLC in the manner more fully set forth in the applicable provisions of Illinois law, (iv) continue to be subject to all of the debts, liabilities and obligations of the Corporation as constituted immediately prior to the Effective Time, and (v) succeed, without other transfer, to all of the debts, liabilities and obligations of the Corporation in the same manner as if the Corporation had itself incurred them, all as more fully provided under the applicable provisions of the BCA and the LLCA.

ARTICLE 2

CHARTER DOCUMENTS, MANAGEMENT

2.1 ARTICLES OF INCORPORATION. The Articles of Incorporation of the Corporation as in effect immediately prior to the Effective Time shall continue in full force and effect as the Articles of Incorporation of the Surviving Company, except that the name of the Surviving Company shall be changed to NextLevel Health Partners, Inc., until duly amended in accordance with the provisions thereof and applicable law.

2.2 BY-LAWS. The By-Laws of the Corporation as in effect immediately prior to the Effective Time shall continue in full force and effect as the By-Laws of the Surviving Company until duly amended in accordance with the provisions thereof and applicable law.

2.3 LLC AGREEMENT. The Second Amended and Restated Limited Liability Company Operating Agreement of the LLC shall be terminated and be of no further force or effect as of the Effective Time.

2.4 MANAGEMENT. The members of the board of managers of and officers of the LLC as in effect immediately prior to the Effective Time shall serve as the members of the board and directors and officers of the Surviving Company, respectively, until their successors shall have been duly qualified and elected in accordance with the provisions of the Surviving Company's By-Laws and the Shareholders' Agreement entered into by and among the Surviving Company and its shareholders effective as of the Effective Time, and applicable law.

ARTICLE 3

MANNER OF CONVERSION OF MEMBERSHIP INTERESTS

3.21 CANCELLATION OF EXISTING SHARES. As of the Effective Time, each share of common stock of the Corporation issued and outstanding immediately prior thereto shall, by virtue of the Merger and without any action by the Constituent Entities or any other person, be cancelled and retired and shall cease to exist, and no consideration shall be delivered in exchange therefor.

3.2 CONVERSION OF UNITS INTO SHARES. As of the Effective Time, each Voting Common Unit of the LLC issued and outstanding immediately prior thereto shall, by virtue of the Merger and without any action by the Constituent Entities or any other person, be converted into one validly issued, fully paid and non-assessable share of Voting Common Stock of the Surviving Company. As of the Effective Time, each Non-voting Common Unit of the LLC issued and outstanding immediately prior thereto shall, by virtue of the Merger and without any action by the Constituent Entities or any other person, be converted into one validly issued, fully paid and non-assessable share of Non-voting Common Stock of the Surviving Company. As of the Effective Time, each Series A Preferred Unit of the LLC issued and outstanding immediately prior thereto shall, by virtue of the Merger and without any action by the Constituent Entities or any other person, be converted into one validly issued, fully paid and non-assessable share of Series A Preferred Stock of the Surviving Company. As of the Effective Time, each Series B Preferred Unit of the LLC issued and outstanding immediately prior thereto shall, by virtue of the Merger and without any action by the Constituent Entities or any other person, be converted into one validly issued, fully paid and non-assessable share of Series B Preferred Stock of the Surviving Company.

ARTICLE 4

GENERAL

4.1 ABANDONMENT. At any time before the Effective Time, this Plan of Merger may be terminated and the Merger may be abandoned for any reason whatsoever by the Board of Managers of the LLC.

4.2 AMENDMENT. At any time before the Effective Time, this Plan of Merger may be amended by the incorporator or sole director of the Corporation.

4.3 GOVERNING LAW. This Plan of Merger shall in all respects be construed, interpreted and enforced in accordance with and governed by the laws of the State of Illinois, excluding its choice of law rules.

4.4 SERVICE OF PROCESS. The Surviving Company shall file with the Illinois Secretary of State in the Articles of Merger an agreement that it may be served with process in Illinois in any proceeding for enforcement of any obligation of the LLC, as well as for enforcement of any obligation of the Surviving Company arising from the Merger, including any suit or other proceeding to enforce the shareholders right to dissent as provided in Section 11.70 of the BCA.

4.5 FURTHER ASSURANCES. From time to time, as and when required by the LLC or by its successors or assigns, there shall be executed and delivered on behalf of the Corporation such deeds and other instruments, and there shall be taken or caused to be taken by the Constituent Entities such further and other actions as shall be appropriate or necessary in order to vest or perfect in or conform of record or otherwise by the Surviving Company the title to and possession of all the property, interest, assets, rights, privileges, immunities, powers, franchises and authority of the LLC and otherwise to carry

out the purpose of this Plan of Merger, and the directors and officers of the Corporation or otherwise are authorized and directed to take any and all such action and to execute and deliver any and all such deeds and other instruments.

Form **LLC-37.25**
May 2012

Secretary of State
Department of Business Services
Limited Liability Division
501 S. Second St., Rm. 351
Springfield, IL 62756
217-524-8008
www.cyberdriveillinois.com

Payment may be made by check payable to Secretary of State. If check is returned for any reason this filing will be void.

Illinois
Limited Liability Company Act
Articles of Merger

SUBMIT IN DUPLICATE

Type or print clearly.

Filing Fee: $
(Filing fee $100 plus $50 each entity more than two)

Approved:

FILE #

This space for use by Secretary of State.

1. Names of Entities proposing to merge:

Name of Entity	Type of Entity (Corporation, Limited Liability Company, Limited Partnership, General Partnership or other permitted entity)	Domestic State or Jurisdiction	Date of Organization or Admission to Illinois	Illinois Secretary of State File Number (if any)
NL Merger Sub, Inc.	Corporation	Illinois	12/16/2015	[redacted]
Next Level Health Partners, LLC	LLC	Illinois	5/28/2013	[redacted]

2. **A copy of the plan as approved must be attached to these Articles of Merger.**

3. a. Name of Surviving Entity: NL Merger Sub, Inc.

   b. Address of Surviving Entity: 303 W. Madison, Suite 1110, Chicago, IL 60606

   c. File Number (if any): [redacted]

   d. Jurisdiction: Illinois

4. Effective date of merger: (check one)
   a. ☐ the filing date, or
   b. ☑ a later date, but not more than 30 days subsequent to the filing date: January 1, 2016
   Month, Day, Year

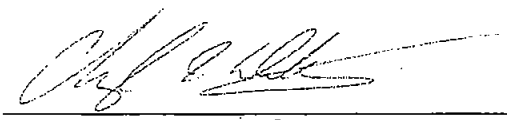
5. If the survivor is a Limited Liability Company, indicate changes that are necessary to its Articles of Organization as stated in the plan of merger:

LLC-37.25

If the surviving entity is not a Limited Liability Company, the entity agrees that it may be served with process in Illinois and is subject to liability in any action or proceeding for the enforcement of any liability or obligation of a Limited Liability Company previously subject to suit in this State, which is to merge, and for the enforcement, as provided in this Act, of the right of members of any Limited Liability Company to receive payment for their interest against the surviving entity.

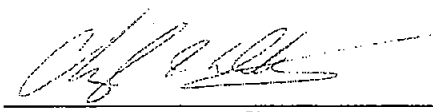
6. The plan of merger has been approved and each LLC or other entity that is party to this Merger has signed below and affirms, under penalty of perjury, that the facts stated herein are true, correct and complete.

Dated December 29 (Month & Day), 2015 (Year)

1. 
Signature

Cheryl Whitaker, Manager
Name and Title (type or print)

Name if a Corporation or other Entity

2. 
Signature

Cheryl Whitaker, Chief Executive Officer
Name and Title (type or print)

NL Merger Sub, Inc.
Name if a Corporation or other Entity

3. Signature

Name and Title (type or print)

Name if a Corporation or other Entity

4. Signature

Name and Title (type or print)

Name if a Corporation or other Entity

If more space is needed, please attach additional sheets of this size.

Signatures must be in black ink on an original document. Carbon copy, photocopy or rubber stamp signatures may only be used on conformed copies.

PLAN OF MERGER

OF

NL MERGER SUB INC.
(an Illinois corporation)

and

NEXT LEVEL HEALTH PARTNERS, LLC
(an Illinois limited liability company)

THIS PLAN OF MERGER, dated as of January 1, 2016 (the "Plan of Merger"), governs the merger of NL Merger Sub Inc., an Illinois corporation (the "Corporation"), and Next Level Health Partners, LLC, an Illinois limited liability company (the "LLC"). The Corporation and the LLC are sometimes referred to herein as the "Constituent Entities".

RECITALS

A. Each of the Constituent Entities have determined that it is advisable and in its best interests that the LLC merge with and into the Corporation upon the terms and conditions herein provided, and this Plan of Merger shall be submitted to them for their consideration and approval.

B. The Board of Directors of the Corporation has approved this Plan of Merger in accordance with 805 ILCS 5/11.05, and the sole shareholder of the Corporation has approved the Plan of Merger in accordance with 805 ILCS 5/11.20.

C. The members of the LLC have approved this Plan of Merger in accordance with 805 ILCS 180/37-20.

NOW, THEREFORE, in consideration of the mutual agreements and covenants set forth herein, the Constituent Entities hereby agree, subject to the terms and conditions hereinafter set forth, as follows:

ARTICLE 1

MERGER

1.1 MERGER. In accordance with the provisions of this Plan of Merger, Section 11.39 of the Business Corporation Act of 1983 of the State of Illinois, as amended ("BCA"), and Section 37-25 of the Illinois Limited Liability Company Act, as amended ("LLCA"), the LLC shall be merged with and into the Corporation (the "Merger"), the separate existence of the LLC shall cease and the Corporation shall survive the Merger and shall continue to be governed by the laws of the State of Illinois. The Corporation shall be, and is herein sometimes referred to as, the "Surviving Company". The name of the Surviving Company shall be NextLevel Health Partners, Inc.

1.2 FILING AND EFFECTIVENESS. Except as otherwise provided herein, the Merger shall become effective when the following actions shall have been completed:

(a) The Plan of Merger shall have been adopted and approved by the sole director and sole shareholder of the Corporation and the members of the LLC in accordance with the requirements of Illinois law.

(b) All of the conditions precedent to the consummation of the Merger shall have been satisfied or duly waived by the party entitled to satisfaction thereof.

(c) The Articles of Merger meeting the requirements of Section 11.25 of the BCA and 37-25 of the LLCA shall be filed with the Illinois Secretary of State and the effective time shall be 12:00 AM on the date hereof (the "Effective Time").

1.3 EFFECT OF THE MERGER. As of the Effective Time, the separate existence of the LLC shall cease and the Corporation, as the Surviving Company shall, without any further action by the Board of Directors, Board of Managers, shareholder, or members of the Constituent Entities (i) continue to possess all of its assets, rights, powers and property as constituted immediately prior to the Effective Time, (ii) assume, accept, adopt, ratify and confirm, as if taken by the Surviving Company, and thereby shall become subject to, all actions previously taken by its and the LLC, as the case may be, (iii) succeed, without other transfer, to all of the assets, rights, powers and property of the LLC in the manner more fully set forth in the applicable provisions of Illinois law, (iv) continue to be subject to all of the debts, liabilities and obligations of the Corporation as constituted immediately prior to the Effective Time, and (v) succeed, without other transfer, to all of the debts, liabilities and obligations of the Corporation in the same manner as if the Corporation had itself incurred them, all as more fully provided under the applicable provisions of the BCA and the LLCA.

ARTICLE 2

CHARTER DOCUMENTS. MANAGEMENT

2.1 ARTICLES OF INCORPORATION. The Articles of Incorporation of the Corporation as in effect immediately prior to the Effective Time shall continue in full force and effect as the Articles of Incorporation of the Surviving Company, except that the name of the Surviving Company shall be changed to NextLevel Health Partners, Inc., until duly amended in accordance with the provisions thereof and applicable law.

2.2 BY-LAWS. The By-Laws of the Corporation as in effect immediately prior to the Effective Time shall continue in full force and effect as the By-Laws of the Surviving Company until duly amended in accordance with the provisions thereof and applicable law.

2.3 LLC AGREEMENT. The Second Amended and Restated Limited Liability Company Operating Agreement of the LLC shall be terminated and be of no further force or effect as of the Effective Time.

2.4 MANAGEMENT. The members of the board of managers of and officers of the LLC as in effect immediately prior to the Effective Time shall serve as the members of the board and directors and officers of the Surviving Company, respectively, until their successors shall have been duly qualified and elected in accordance with the provisions of the Surviving Company's By-Laws and the Shareholders' Agreement entered into by and among the Surviving Company and its shareholders effective as of the Effective Time, and applicable law.

ARTICLE 3

MANNER OF CONVERSION OF MEMBERSHIP INTERESTS

3.21 CANCELLATION OF EXISTING SHARES. As of the Effective Time, each share of common stock of the Corporation issued and outstanding immediately prior thereto shall, by virtue of the Merger and without any action by the Constituent Entities or any other person, be cancelled and retired and shall cease to exist, and no consideration shall be delivered in exchange therefor.

3.2 CONVERSION OF UNITS INTO SHARES. As of the Effective Time, each Voting Common Unit of the LLC issued and outstanding immediately prior thereto shall, by virtue of the Merger and without any action by the Constituent Entities or any other person, be converted into one validly issued, fully paid and non-assessable share of Voting Common Stock of the Surviving Company. As of the Effective Time, each Non-voting Common Unit of the LLC issued and outstanding immediately prior thereto shall, by virtue of the Merger and without any action by the Constituent Entities or any other person, be converted into one validly issued, fully paid and non-assessable share of Non-voting Common Stock of the Surviving Company. As of the Effective Time, each Series A Preferred Unit of the LLC issued and outstanding immediately prior thereto shall, by virtue of the Merger and without any action by the Constituent Entities or any other person, be converted into one validly issued, fully paid and non-assessable share of Series A Preferred Stock of the Surviving Company. As of the Effective Time, each Series B Preferred Unit of the LLC issued and outstanding immediately prior thereto shall, by virtue of the Merger and without any action by the Constituent Entities or any other person, be converted into one validly issued, fully paid and non-assessable share of Series B Preferred Stock of the Surviving Company.

ARTICLE 4

GENERAL

4.1 ABANDONMENT. At any time before the Effective Time, this Plan of Merger may be terminated and the Merger may be abandoned for any reason whatsoever by the Board of Managers of the LLC.

4.2 AMENDMENT. At any time before the Effective Time, this Plan of Merger may be amended by the incorporator or sole director of the Corporation.

4.3 GOVERNING LAW. This Plan of Merger shall in all respects be construed, interpreted and enforced in accordance with and governed by the laws of the State of Illinois, excluding its choice of law rules.

4.4 SERVICE OF PROCESS. The Surviving Company shall file with the Illinois Secretary of State in the Articles of Merger an agreement that it may be served with process in Illinois in any proceeding for enforcement of any obligation of the LLC, as well as for enforcement of any obligation of the Surviving Company arising from the Merger, including any suit or other proceeding to enforce the shareholders right to dissent as provided in Section 11.70 of the BCA.

4.5 FURTHER ASSURANCES. From time to time, as and when required by the LLC or by its successors or assigns, there shall be executed and delivered on behalf of the Corporation such deeds and other instruments, and there shall be taken or caused to be taken by the Constituent Entities such further and other actions as shall be appropriate or necessary in order to vest or perfect in or conform of record or otherwise by the Surviving Company the title to and possession of all the property, interest, assets, rights, privileges, immunities, powers, franchises and authority of the LLC and otherwise to carry

out the purpose of this Plan of Merger, and the directors and officers of the Corporation or otherwise are authorized and directed to take any and all such action and to execute and deliver any and all such deeds and other instruments.

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.
NL Merger Sub, Inc.

2 Business name/disregarded entity name, if different from above
NextLevel Health Partners, Inc.

3 Check appropriate box for federal tax classification; check only **one** of the following seven boxes:
☐ Individual/sole proprietor or single-member LLC ☑ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate
☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶
Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.
☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):
Exempt payee code (if any) 5
Exemption from FATCA reporting code (if any)
(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)
303 W. Madison St., Suite 1110

Requester's name and address (optional)

6 City, state, and ZIP code
Chicago, IL 60606

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number
[ ][ ][ ] - [ ][ ] - [ ][ ][ ][ ]

or

Employer Identification number
[redacted]

Part II Certification

Under penalties of perjury, 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. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here Signature of U.S. person ▶ [signature] M.D. Date ▶ 12-31-2015

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

STATE OF ILLINOIS

CONTRACT-OBLIGATION DOCUMENT

FY16
2 transactions
1 of 2

Agency No. 478

PLEASE TYPE

Fiscal Year	Transaction Code	Contract/Obligation No.	Transaction Date	Nine Digit Taxpayer ID. Number	Legal Status
2016	28 20	16M0000023	01/27/16	[redacted]	04

Contract Action	Class Code	Governors Release No.
1. ___ New 2. X Change	___ ___	POSTED 2

Vendors Name and Address

N L MERGER SUB INC
DBA NEXT LEVEL HEALTH PRTNRS
303 W MADISON STREET STE 1150
CHICAGO IL 60606

Appropriation Account Code	Obligation Amount
001-47865-4900-61-00	0.00
346-47865-4400-00-00	10,000,000.00

Multiple Year Contract: From 12/31/15 (MO/DAY/YR) To 12/30/20 (MO/DAY/YR)

Maximum Contract Amount: 500,000,000.00

Current Fiscal Year of Contract: From 12/31/15 (MO/DAY/YR) To 06/30/16 (MO/DAY/YR)

Annual Contract Amount: 50,000,000.00 Reimbursement Expenses Included

Multiple Year Contract Amounts Year 2-7(and over)

2	3	4
100,000,000.00	100,000,000.00	100,000,000.00
5	**6**	**7**
100,000,000.00	50,000,000.00	

Description 4460 Medical Serv Pa Recip-Vendor

RECEIVED
JAN 28 2016
State Comptroller
Obligations Section

CONTRACTOR WILL PROVIDE INTEGRATED CARE SERVICES TO ADULT AGED, BLIND AND DISABLED NON-MEDICARE ELIGIBLE MEDICARE BENEFICIARIES THE FULL SPECTRUM OF MEDICAID COVERED SERVICES.
MULTI YEAR CONTRACT - YEAR 1 OF 5
DECREASE LINE 2 & CREATE LINE 3 FOR MCO/ICP PER FINANCE & BUDGET

Obligations to the state will cease immediately without penalty of further payment being require if, in any fiscal year, the Illinois GeneralAssembly or federal funding source fails to appropriate or otherwise make available sufficientfunds for this agreement.

Method of Compensation

(If Multiple Rates, Specify)

0.00 Rate Per MR Time

Procurement Information

Award Code P
Publication Date / /
Reference
Subcontractor Utilization (y/n) N
Subcontractor Disclosure (y/n) N

Travel Expense

YES ___ NO X
Amount
Advance Payment
YES X NO ___

CATHY NEFF 524-7301 01/27/16
Prepared By / Phone Number Date

HFS /Bureau of Managed Care
Contracting Agency/Division

FELICIA F NORWOOD 01/27/16
Authorized By Date

HFS /BUREAU OF FISCAL OPERATIONS
Filing Agency/Division

C-23.1(R-6-07)

STATE OF ILLINOIS

FY16

CONTRACT-OBLIGATION DOCUMENT

2of2

Agency No. 478

PLEASE TYPE

Fiscal Year	Transaction Code	Contract/Obligation No.	Transaction Date	Nine Digit Taxpayer ID. Number	Legal Status
2016	28 25	16MO000023	01/27/16	[redacted]	04

Contract Action	Class Code	Governors Release No.	Vendors Name and Address
1. ___ New 2. X Change	___ ___	POSTED 2	N L MERGER SUB INC DBA NEXT LEVEL HEALTH PRTNRS 303 W MADISON STREET STE 1150 CHICAGO IL 60606

Appropriation Account Code	Obligation Amount
793-47865-4900-00-00	10,000,000.00

Multiple Year Contract	Maximum Contract Amount
From 12/31/15 (MO/DAY/YR) To 12/30/20 (MO/DAY/YR)	500,000,000.00
Current Fiscal Year of Contract	**Annual Contract Amount**
From 12/31/15 (MO/DAY/YR) To 06/30/16 (MO/DAY/YR)	50,000,000.00 Reimbursement Expenses Included

Multiple Year Contract Amounts Year 2-7(and over)

2	100,000,000.00	3	100,000,000.00	4	100,000,000.00
5	100,000,000.00	6	50,000,000.00	7	

Description 4460 Medical Serv Pa Recip-Vendor

CONTRACTOR WILL PROVIDE INTEGRATED CARE SERVICES TO ADULT AGED, BLIND AND DISABLED NON-MEDICARE ELIGIBLE MEDICARE BENEFICIARIES THE FULL SPECTRUM OF MEDICAID COVERED SERVICES.
MULTI YEAR CONTRACT - YEAR 1 OF 5
DECREASE LINE 2 & CREATE LINE 3 FOR MCD/ICP PER FINANCE & BUDGET

Obligations to the state will cease immediately without penalty of further payment being require if, in any fiscal year, the Illinois GeneralAssembly or federal funding source fails to appropriate or otherwise make available sufficientfunds for this agreement.

Method of Compensation	Procurement Information	Travel Expense
(If Multiple Rates, Specify) 0.00 Rate Per MR Time	Award Code P Publication Date / / Reference Subcontractor Utilization (y/n) N Subcontractor Disclosure (y/n) N	YES ___ NO X Amount Advance Payment YES X NO ___

CATHY NEFF 524-7301 01/27/16
Prepared By / Phone Number Date

HFS /Bureau of Managed Care
Contracting Agency/Division

FELICIA F NORWOOD 01/27/16
Authorized By Date

HFS /BUREAU OF FISCAL OPERATIONS
Filing Agency/Division

C-23.1(R-6-07)

STATE OF ILLINOIS

CONTRACT-OBLIGATION DOCUMENT

FY16
2 transactions
1 of 2

Agency No. 478

PLEASE TYPE

Fiscal Year	Transaction Code	Contract/Obligation No.	Transaction Date	Nine Digit Taxpayer ID. Number	Legal Status
2016	28 20	16M0000023	02/17/16	[redacted]	04

Contract Action	Class Code	Governors Release No.
1. ___ New 2. X Change	___ ___	POSTED 2

Vendors Name and Address

N L MERGER SUB INC
DBA NEXT LEVEL HEALTH PRTNRS
303 W MADISON STREET STE 1150
CHICAGO IL 60606

Appropriation Account Code	Obligation Amount
001-47865-4900-61-00	30,000,000.00
346-47865-4400-00-00	0.00

Multiple Year Contract: From 12/31/15 (MO/DAY/YR) To 12/30/20 (MO/DAY/YR)

Maximum Contract Amount: 500,000,000.00

Current Fiscal Year of Contract: From 12/31/15 (MO/DAY/YR) To 06/30/16 (MO/DAY/YR)

Annual Contract Amount: 50,000,000.00 Reimbursement Expenses Included

Multiple Year Contract Amounts Year 2-7(and over)

2	3	4
100,000,000.00	100,000,000.00	100,000,000.00
5	**6**	**7**
100,000,000.00	50,000,000.00	

Description 4460 Medical Serv Pa Recip-Vendor

CONTRACTOR WILL PROVIDE INTEGRATED CARE SERVICES TO ADULT AGED, BLIND AND DISABLED NON-MEDICARE ELIGIBLE MEDICARE BENEFICIARIES THE FULL SPECTRUM OF MEDICAID COVERED SERVICES.
MULTI YEAR CONTRACT - YEAR 1 OF 5
DECREASE LINE 2 & CREATE LINE 3 FOR MCO/ICP PER FINANCE & BUDGET
DECREASE LINE 2 AND INCREASE LINE 1 PER FINANCE & BUDGET

Obligations to the state will cease immediately without penalty of further payment being require if, in any fiscal year, the Illinois GeneralAssembly or federal funding source fails to appropriate or otherwise make available sufficientfunds for this agreement.

RECEIVED
FEB 19 2016
State Comptroller
Obligations Section

Method of Compensation	Procurement Information	Travel Expense
0.00 Rate Per MR Time (If Multiple Rates, Specify)	Award Code P Publication Date / / Reference Subcontractor Utilization (y/n) N Subcontractor Disclosure (y/n) N	YES ___ NO X Amount Advance Payment YES X NO ___

CATHY NEFF 524-7301 02/18/16
Prepared By / Phone Number Date

HFS /Bureau of Managed Care
Contracting Agency/Division

FELICIA F NORWOOD 02/18/16
Authorized By Date

HFS /BUREAU OF FISCAL OPERATIONS
Filing Agency/Division

C-23.1(R-6-07)

FY16

2of2

STATE OF ILLINOIS

CONTRACT-OBLIGATION DOCUMENT

Agency No. 478

PLEASE TYPE

Fiscal Year	Transaction Code	Contract/Obligation No.	Transaction Date	Nine Digit Taxpayer ID. Number	Legal Status
2016	28 25	16M0000023	02/17/16	[redacted]	04

Contract Action	Class Code	Governors Release No.	Vendors Name and Address
1. ___ New 2. X Change	___ ___		N L MERGER SUB INC DBA NEXT LEVEL HEALTH PRTNRS 303 W MADISON STREET STE 1150 CHICAGO IL 60606

Appropriation Account Code	Obligation Amount
793-47865-4900-00-00	30,000,000.00

Multiple Year Contract	Maximum Contract Amount
From 12/31/15 (MO/DAY/YR) To 12/30/20 (MO/DAY/YR)	500,000,000.00
Current Fiscal Year of Contract	**Annual Contract Amount**
From 12/31/15 (MO/DAY/YR) To 06/30/16 (MO/DAY/YR)	50,000,000.00 Reimbursement Expenses Included

Multiple Year Contract Amounts Year 2-7(end over)

2	3	4
100,000,000.00	100,000,000.00	100,000,000.00
5	**6**	**7**
100,000,000.00	50,000,000.00	

Description 4460 Medical Serv Pa Recip-Vendor

CONTRACTOR WILL PROVIDE INTEGRATED CARE SERVICES TO ADULT AGED, BLIND AND DISABLED NON-MEDICARE ELIGIBLE MEDICARE BENEFICIARIES THE FULL SPECTRUM OF MEDICAID COVERED SERVICES.
MULTI YEAR CONTRACT - YEAR 1 OF 5
DECREASE LINE 2 & CREATE LINE 3 FOR MCO/ICP PER FINANCE & BUDGET
DECREASE LINE 2 AND INCREASE LINE 1 PER FINANCE & BUDGET

Obligations to the state will cease immediately without penalty of further payment being require if, in any fiscal year, the Illinois GeneralAssembly or federal funding source fails to appropriate or otherwise make available sufficientfunds for this agreement.

Method of Compensation	Procurement Information	Travel Expense
(If Multiple Rates, Specify) 0.00 Rate Per MR Time	Award Code P Publication Date / / Reference Subcontractor Utilization (y/n) N Subcontractor Disclosure (y/n) N	YES ___ NO X Amount Advance Payment YES X NO ___

CATHY NEFF 524-7301 02/18/16
Prepared By / Phone Number Date

HFS /Bureau of Managed Care
Contracting Agency/Division

FELICIA F NORWOOD 02/18/16
Authorized By Date

HFS /BUREAU OF FISCAL OPERATIONS
Filing Agency/Division

C-23.1(R-6-07)

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FY16

STATE OF ILLINOIS

CONTRACT-OBLIGATION DOCUMENT

Agency No. 478

PLEASE TYPE

Fiscal Year	Transaction Code	Contract/Obligation No.	Transaction Date	Nine Digit Taxpayer ID. Number	Legal Status
2016	28 20	16M0000023	03/04/16	[redacted]	04

Contract Action	Class Code	Governors Release No.
1. ___ New 2. X Change	___ ___ POSTED 2	

Vendors Name and Address:

N L MERGER SUB INC
DBA NEXT LEVEL HEALTH PRTNRS
303 W MADISON STREET STE 1150
CHICAGO IL 60606

Appropriation Account Code	Obligation Amount
001-47865-4900-61-00	0.00
346-47865-4400-00-00	0.00
793-47865-4900-00-00	1,000,000.00

Multiple Year Contract: From 12/31/15 (MO/DAY/YR) To 12/30/20 (MO/DAY/YR)

Maximum Contract Amount: 500,000,000.00

Current Fiscal Year of Contract: From 12/31/15 (MO/DAY/YR) To 06/30/16 (MO/DAY/YR)

Annual Contract Amount: 50,000,000.00 Reimbursement Expenses Included

Multiple Year Contract Amounts Year 2-7(and over)

2	3	4
100,000,000.00	100,000,000.00	100,000,000.00
5	**6**	**7**
100,000,000.00	50,000,000.00	

Description 4460 Medical Serv Pa Recip-Vendor

RECEIVED
MAR 11 2016
State Comptroller
Obligations Section

CONTRACTOR WILL PROVIDE INTEGRATED CARE SERVICES TO ADULT AGED, BLIND AND DISABLED NON-MEDICARE ELIGIBLE MEDICARE BENEFICIARIES THE FULL SPECTRUM OF MEDICAID COVERED SERVICES.
MULTI YEAR CONTRACT - YEAR 1 OF 5
DECREASE LINE 2 & CREATE LINE 3 FOR MCO/ICP PER FINANCE & BUDGET
DECREASE LINE 2 AND INCREASE LINE 1 PER FINANCE & BUDGET
DECREASE LINE 1 AND INCREASE LINE 2 PER FINANCE & BUDGET
Obligations to the state will cease immediately without penalty of further payment being require if, in any fiscal year, the Illinois GeneralAssembly or federal funding source fails to appropriate or otherwise make available sufficientfunds for this agreement.

Method of Compensation

(If Multiple Rates, Specify)

0.00 Rate Per MR Time

Procurement Information

Award Code P
Publication Date / /
Reference
Subcontractor Utilization (y/n) N
Subcontractor Disclosure (y/n) N

Travel Expense

YES ___ NO X
Amount
Advance Payment
YES X NO ___

CATHY NEFF 524-7301 03/08/16
Prepared By / Phone Number Date

HFS /Bureau of Managed Care
Contracting Agency/Division

FELICIA F NORWOOD 03/08/16
Authorized By Date

HFS /BUREAU OF FISCAL OPERATIONS
Filing Agency/Division

C-23.1(R-6-07)

2042

STATE OF ILLINOIS

CONTRACT - OBLIGATION DOCUMENT

FY16

Agency No. 478

PLEASE TYPE

Fiscal Year	Transaction Code	Contract/ Obligation No	Transaction Date	Nine Digit Taxpayer ID Number	Legal Status
2016	28 25	16M0000023	3/4/2016	[redacted]	04

Contract Action	Class Code	Governor's Release No.	Vendor's Name and Address
1 ___ New 2 X Change		POSTED 2	N L MERGER SUB INC DBA NEXT LEVEL HEALTH PRTNRS 303 W MADISON STREET STE 1150 CHICAGO IL 60606

Appropriation Account Code	Obligation Amount
001-47865-4900-61-00	8,000,000.00

Multiple Year Contract	Maximum Contract Amt
From 12/31/2015 (MO/DAY/YR) To 12/30/2020 (MO/DAY/YR)	500,000,000.00
Current Fiscal Year of Contract	**Annual Contract Amt**
From 12/31/2015 (MO/DAY/YR) To 6/30/2016 (MO/DAY/YR)	50,000,000.00 Reimbursement Exp Included

Multiple Year Contract Amts						Year 2 - 7 (and over)
2		3		4		
5		6		7		

4460 MEDICAL SERV PA RECIP-VENDOR

Description

CONTRACTOR WILL PROVIDE INTEGRATED CARE SERVICES TO ADULT AGED, BLIND AND DISABLED NON-MEDICARE ELIGIBLE MEDICARE BENEFICIARES THE FULL SPECTRUM OF MEDICAID COVERED SERVICES.
MULTI YEAR CONTRACT, YEAR 1 OF 5

RECEIVED
MAR 11 2016
State Comptroller
Obligations Section

Method of Compensation	Procurement Information	Travel Expenses
(If Multiple Rates, Specify)	Award Code P	Yes ___ No X
0.00 Per MR	Publication Date	Amount
Rate Time	Reference #	
	Subcontractor Utilization (Y/N) N	Advance Payment
	Subcontractor Disclosure (Y/N) N	Yes X No ___

CATHY NEFF	524-7301	##	HFS / BUREAU OF MANAGED CARE
Prepared by	Phone	Date	Contracting Agency/Division
FELCIIA F NORWOOD		##	HFS / BUREAU OF FISCAL OPEARTIONS
Authorized by		Date	Filing Agency/Division

C-23 6/07

FY16

STATE OF ILLINOIS

CONTRACT-OBLIGATION DOCUMENT

Agency No. 478

PLEASE TYPE

Fiscal Year	Transaction Code	Contract/Obligation No.	Transaction Date	Nine Digit Taxpayer ID. Number	Legal Status
2016	28 00	16M0000023	03/18/16	[redacted]	04

Contract Action	Class Code	Governors Release No.
1. ___ New 2. X Change	___ ___	POSTED 2

Vendors Name and Address

N L MERGER SUB INC
DBA NEXT LEVEL HEALTH PRTNRS
303 W MADISON STREET STE 1150
CHICAGO IL 60606

Appropriation Account Code	Obligation Amount
001-47865-4900-61-00	0.00
346-47865-4400-00-00	0.00
793-47865-4900-00-00	0.00

Multiple Year Contract: From 12/31/15 (MO/DAY/YR) To 12/30/20 (MO/DAY/YR)

Maximum Contract Amount: 500,000,000.00

Current Fiscal Year of Contract: From 12/31/15 (MO/DAY/YR) To 06/30/16 (MO/DAY/YR)

Annual Contract Amount: 50,000,000.00 Reimbursement Expenses Included

Multiple Year Contract Amounts Year 2-7(and over)

2	3	4
100,000,000.00	100,000,000.00	100,000,000.00
5	**6**	**7**
100,000,000.00	50,000,000.00	

Description 4460 Medical Serv Pa Recip-Vendor

RECEIVED
MAR 24 2016
State Comptroller
Obligations Section

CONTRACTOR WILL PROVIDE INTEGRATED CARE SERVICES TO ADULT AGED, BLIND AND DISABLED NON-MEDICARE ELIGIBLE MEDICARE BENEFICIARIES THE FULL SPECTRUM OF MEDICAID COVERED SERVICES.
MULTI YEAR CONTRACT - YEAR 1 OF 5
DECREASE LINE 2 & CREATE LINE 3 FOR MCO/ICP PER FINANCE & BUDGET
DECREASE LINE 2 AND INCREASE LINE 1 PER FINANCE & BUDGET
DECREASE LINE 1 AND INCREASE LINE 2 PER FINANCE & BUDGET
Obligations to the state will cease immediately without penalty of further payment being require if, in any fiscal year, the Illinois GeneralAssembly or federal funding source fails to appropriate or otherwise make available sufficientfunds for this agreement.

Method of Compensation

(If Multiple Rates, Specify)

0.00 Rate Per MR Time

Procurement Information

Award Code P
Publication Date / /
Reference
Subcontractor Utilization (y/n) N
Subcontractor Disclosure (y/n) N

Travel Expense

YES ___ NO X
Amount
Advance Payment
YES X NO ___

CATHY NEFF 524-7301 03/23/16
Prepared By / Phone Number Date

HFS /Bureau of Managed Care
Contracting Agency/Division

FELICIA F NORWOOD 03/23/16
Authorized By Date

HFS /BUREAU OF FISCAL OPERATIONS
Filing Agency/Division

C-23.1(R-6-07)

Illinois Department of Healthcare and Family Services

CONTRACT APPROVAL DOCUMENT

Procurement Tracking # 2015-24-004-KA1 (NLH)

The attached (select one) amendment with (Enter Contractor's Name below)

NextLevel Health Partners - ICP

in the amount of $ 0 for FY'16 is approved.

Michelle Maher RM 2.18.16 — Bureau Chief (or nearest organizational equivalent) — Date: 2-18-16

[signature] — Division Administrator — Date: 2-19-16

Deputy / Assistant Director — Date

Michael P. Casey RM — Division of Finance — Date: 2/5/16

The amendment is subject to the CMS Procurement Business Case process. Yes ○ No ◉

All applicable approvals have been obtained by the Department. Yes ○ No ○

If the amendment equals or exceeds $250,000 in a fiscal year, or the amendment or renewal results in a contract that equals or exceeds $250,000 in a fiscal year, the following signatures are needed:

Chief Legal Counsel — Date

Chief Fiscal Officer — Date

STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

and

NEXTLEVEL HEALTH PARTNERS, INC.

AMENDMENT NO. 1 TO THE
CONTRACT FOR FURNISHING HEALTH SERVICES
IN AN INTEGRATED CARE PROGRAM BY A
MANAGED CARE ORGANIZATION
2015-24-004-KA1 (NLHP)

WHEREAS, the Parties to the Contract for Furnishing Health Services in an Integrated Care Program by a Managed Care Organization ("Contract"), the **Illinois Department of Healthcare and Family Services**, 201 South Grand Avenue East, Springfield, Illinois 62763-0001 ("Department"), acting by and through its Director, and NextLevel Health Partners, Inc., an Illinois Corporation ("Contractor"), desire to amend the Contract; and

WHEREAS, pursuant to Section 9.1.18, the Contract may be modified or amended by the mutual consent of the Parties; and

WHEREAS, the Contract was been previously amended;

NOW THEREFORE, the Parties agree to amend the Contract further as follows:

1. Section 7.16.3 is deleted in its entirety and replaced with the following:

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. Contractor shall submit complete and accurate data quarterly to the Department in accordance with the Illinois Medicaid Health Plan Encounter Utilization Monitoring (EUM) Requirements document, as set forth in Attachment XXIII, for each evaluation period. If Contractor does not meet the standards by the evaluation date as set forth in Attachment XXIII, the Department, without further notice, may:

7.16.3.1 Impose a quarterly monetary penalty,

7.16.3.2 Suspend auto-assignment of Potential Enrollees with Contractor, or

7.16.3.3 Impose both.

2. The Table of Contents is amended by adding Attachment XXIII, Illinois Medicaid Health Plan Encounter Utilization Monitoring (EUM) Requirements, is attached hereto and hereby incorporated into this Amendment No. 1.

All other terms and conditions of the Contract shall remain in full force and effect.

IN WITNESS WHEREOF, the Parties have hereunto caused this agreement to amend the Contract to be executed by their duly authorized representatives, effective as of the date of last signature.

CONTRACTOR

By: _____

Printed Name: Cheryl R. Whitaker

Title: Chairman and CEO

Date: 02/05/16

Fein: [redacted]

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

By: _____

Printed Name: Felicia F. Norwood

Title: Director

Date: 3-1-16

Attachment XXIII

Illinois Medicaid Health Plan Encounter Utilization Monitoring (EUM) Requirements:
General Process (Page 1 of 2)

Evaluation Period	Final date for MCO to submit encounter claims to be included in the evaluation	Final date for MCO to e-mail EUM spend data to HFS (See #2 below)	Evaluation Date	Service Dates Measured (Calendar Year)	Cumulative Percentage Difference between Plan Reported and Encounter Reported Service Cost PMPM (Encounter/Plan-1)	
					$50,000 Financial Penalty If at or above:	Auto-Assignment Shut-Off If at or above:
1	1/15/2016	1/15/2016	2/29/2016	Q3 2014	20%	Test Period – measured at 30%
2	4/15/2016	4/15/2016	5/20/2016	Q3 2014 – Q2 2015	20%	30%
3	7/15/2016	7/15/2016	8/19/2016	Q3 2014 – Q4 2015	15%	25%
4	10/14/2016	10/14/2016	11/18/2016	Q3 2014 – Q1 2016	10%	20%

General Implementation Procedures:

1. The Department will inform Contractor in writing what spend data is to be included and provided. Failure to send accurate spend data by the deadline will result in both the Financial Penalty and Auto-Assignment Shut-Off to occur.

When Medicaid spend data is sent, it must be accompanied by an attestation letter signed by Contractor's Executive Director/CEO.

2. If Contractor has more than one contract as a MCO with the Department, each contract will be measured separately and sanctions will be imposed by contract.
3. Auto-Assignment will not be shut-off for the first Evaluation Period as this will be treated as a test period. Contractor will be measured at 30% for this test period.
4. Note that the Financial Penalty will apply for the first Evaluation Period. Please see the *Auto-Assignment Specific Process* for additional information about Auto-Assignment shut-off.
5. For contracts that have an Initial Effective Date on or after December 1, 2015, the Department will implement the EUM Requirements on the first Evaluation Date that occurs twelve (12) months after enrollment begins.
6. Contractor shall email all related data to the Department's designated Contract Monitor and Paul Stieber (paul.stieber@illinois.gov), with Bhavin Shah (bhavin.shah@illinois.gov) and Robert Mendonsa (robert.mendonsa@illinois.gov) copied.

Illinois Medicaid Health Plan Encounter Utilization Monitoring (EUM) Requirements:
Auto-Assignment Specific Process (Page 2 of 2)

Evaluation Period	HFS to communicate any Auto-Assignment Shut-Off to Client Enrollment Broker by this date:	Date Auto-Assignment Shut-Off occurs	30 Day Re-Evaluation date	Final date for MCO to submit data for 30 Day Re-Evaluation	If Auto-Assignment Re-Evaluation is positive, Auto-Assignment re-start date	If Auto-Assignment remains off, 60 Day Re-Evaluation date	Final date for MCO to submit data for 60 Day Re-Evaluation	If Auto-Assignment Re-Evaluation is positive, Auto-Assignment re-start date
1	3/18/2016	4/1/2016	4/19/2016	4/5/2016	5/1/2016	5/19/2016	5/5/2016	6/1/2016
2	6/17/2016	7/1/2016	7/19/2016	7/5/2016	8/1/2016	8/19/2016	8/5/2016	9/1/2016
3	9/16/2016	10/1/2016	10/19/2016	10/5/2016	11/1/2016	11/18/2016	11/4/2016	12/1/2016
4	12/16/2016	1/1/2017	1/19/2017	1/5/2017	2/1/2017	2/20/2017	2/6/2017	3/1/2017

Auto-Assignment Shut-Off Implementation Procedures:

1. If Auto-Assignment is shut-off, it will be re-evaluated at 30 days. If Contractor meets or exceeds the objective, Auto-Assignment will be re-started on the first of the following month. If Contractor does not reach the objective at the 30 day re-evaluation, it will be re-assessed at 60 days.

2. Contractor shall email all related data to the Department's designated Contract Monitor and Paul Stieber (paul.stieber@illinois.gov), with Bhavin Shah (bhavin.shah@illinois.gov) and Robert Mendonsa (robert.mendonsa@illinois.gov) copied.

STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
Felicia F. Norwood, Director
DECISION MEMORANDUM
2015-24-004-KA4 DM2 ICP

Issue:
Should the Department of Healthcare and Family Services (Department) amend nine (9) Integrated Care Program (ICP) Managed Care Organizations (MCO) contracts to amend the encounter data requirements by adding greater specificity as to the requirements and to the sanctions that may be imposed if those requirements are not met, and to make such requirements and sanctions consistent with those in the FHP/ACA contracts; and correctly reflect IlliniCare Health Plan and Health Alliance Connect Attachment IV contracting area?

Background:
The ICP is a mandatory managed care program for Seniors and Persons with Disabilities that began as a pilot program in the greater Chicago region including suburban Cook, DuPage, Kane, Kankakee, Lake and Will counties, and has been expanded into the Central Illinois, Quad Cities, Rockford and Metro East Regions. The ICP was expanded to assist the Department in complying with Public Act 96-1501, which required 50% of Medicaid clients to be enrolled in a form of Care Coordination by January 2015. As of February 2015, in the 29 counties in which the ICP operates, there were 119,747 participants enrolled in an MCO health plan under the ICP.

The ICP addresses the medical and psychosocial needs of clients, focuses on wellness and prevention, and manages covered services. Integrated managed care for this population provides a much greater capacity to measure performance that goes beyond traditional quality measurement systems to reflect the complexity of chronic conditions common among seniors and people with disabilities.

Discussion:
The Department of Healthcare and Family Services (Department) is seeking approval to amend the nine (9) Integrated Care Program (ICP) Managed Care Organizations (MCO) contracts to amend the encounter data requirements by adding greater specificity as to the requirements and to the sanctions that may be imposed if those requirements are not met. The plans participating are Aetna, BlueCross/Blue Shield, Community Care Alliance, Health Alliance Connect, HealthSpring/CIGNA, Humana, IlliniCare, Molina and Meridian. There are $0 (zero) dollar values projected for this amendment. An identical amendment was recently approved (2015-24-002-KA3 FHP/ACA) and added to the FHP/ACA contracts. These changes are required to structure the expectations of encounter data more clearly and ensure the MCOs are motivated to submit timely and accurate encounter data. The IlliniCare Health Plan Attachment IV rate sheet will be amended only to include three contracting county names (Rock Island, Mercer and Henry) that were left off previous amendments inadvertently due to a drafting error; and Health Alliance Connect Attachment IV rate sheet to include the expansion into the Quad Cities (Rock Island, Mercer and Henry counties).

Options:
Option 1: Amend the nine (9) Integrated Care Program (ICP) Managed Care Organizations (MCO) contracts to add encounter data requirements and sanction specificity.

Felicia F. Norwood, Director — 1-23-16 Date

Option 2: Do not amend the nine (9) MCO contracts.

Felicia F. Norwood, Director — Date

Option 3: I request additional information on this matter and request that action be held until further direction.

Felicia F. Norwood, Director _____ Date

Recommendation:
The ICP MCOs are providing covered services to the targeted population whose care is coordinated under the ICP Program, Seniors and Persons with Disabilities (SPDs). SPDs have the highest healthcare needs and service utilization of any population covered by Medicaid. It is imperative that the department receive complete and accurate encounter data from the MCOs.

Fiscal Note:
This amendment adds encounter data requirements and sanction specificity; there are $0 (zero) dollar values projected for this amendment. The procurement is time-sensitive and critical to the mission of the Department, and special consideration is required due to the best interests of the State. This procurement is also critical to the life, health and safety of the citizens of Illinois to allow continuity of care. Coordinated managed care has the potential to provide a better standard and quality of care at a reduced and more predictable cost.

Federal Matching:
This is a no cost amendment; however, ICP contract expenditures are claimable for matching funds at the appropriate Federal Financial Participation rate.

Review:
This Decision Memorandum has been reviewed by the Office of General Counsel, the Office of the Inspector General, the Division of Finance, the Office of Procurement Management and the Division of Medical Programs including the Bureau of Managed Care, the Bureau of Professional and Ancillary Services, the Bureau of Eligibility Integrity, and the Bureau of Policy and Program Coordination. All comments received have been addressed and incorporated as appropriate.

Prepared by:
Michelle Maher, Division of Medical Programs, January 21, 2016.

Approved by:

Michelle Maher, Bureau Chief — 1-21-16 Date

Robert Mendonsa, Deputy Administrator — 1-21-16 Date

Theresa Hursey, Administrator — 1-22-16 Date

FY16

STATE OF ILLINOIS

CONTRACT-OBLIGATION DOCUMENT

1of2

Agency No. 478

PLEASE TYPE

Fiscal Year	Transaction Code	Contract/Obligation No.	Transaction Date	Nine Digit Taxpayer ID. Number	Legal Status
2016	28 20	16M0000023	05/11/16	[redacted]	04

Contract Action	Class Code	Governors Release No.	Vendors Name and Address
1. ___ New 2. X Change	___ ___	POSTED 2	N L MERGER SUB INC DBA NEXT LEVEL HEALTH PRTNRS 303 W MADISON STREET STE 1150 CHICAGO IL 60606

Appropriation Account Code	Obligation Amount
001-47865-4900-61-00	0.00
✓ 793-47865-4900-00-00	1,000,000.00

Multiple Year Contract	Maximum Contract Amount
From 12/31/15 MO/DAY/YR To 12/30/20 MO/DAY/YR	500,000,000.00
Current Fiscal Year of Contract	**Annual Contract Amount**
From 12/31/15 MO/DAY/YR To 06/30/16 MO/DAY/YR	50,000,000.00 Reimbursement Expenses Included

Multiple Year Contract Amounts Year 2-7(and over)		
2 100,000,000.00	3 100,000,000.00	4 100,000,000.00
5 100,000,000.00	6 50,000,000.00	7

Description 4460 Medical Serv Pa Recip-Vendor

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Obligations Section

CONTRACTOR WILL PROVIDE INTEGRATED CARE SERVICES TO ADULT AGED, BLIND AND DISABLED NON-MEDICARE ELIGIBLE MEDICARE BENEFICIARIES THE FULL SPECTRUM OF MEDICAID COVERED SERVICES.
MULTI YEAR CONTRACT - YEAR 1 OF 5
DECREASE LINE 2 & CREATE LINE 3 FOR MCO/ICP PER FINANCE & BUDGET
DECREASE LINE 2 AND INCREASE LINE 1 PER FINANCE & BUDGET
DECREASE LINE 1 AND INCREASE LINE 2 PER FINANCE & BUDGET
Obligations to the state will cease immediately without penalty of further payment being require if, in any fiscal year, the Illinois GeneralAssembly or federal funding source fails to appropriate or otherwise make available sufficientfunds for this agreement.

Method of Compensation	Procurement Information	Travel Expense
0.00 Rate Per MR Time (If Multiple Rates, Specify)	Award Code P Publication Date / / Reference Subcontractor Utilization (y/n) N Subcontractor Disclosure (y/n) N	YES ___ NO X Amount Advance Payment YES X NO ___

CATHY NEFF 524-7301 05/11/16
Prepared By / Phone Number Date

HFS /Bureau of Managed Care
Contracting Agency/Division

FELICIA F NORWOOD 05/11/16
Authorized By Date

HFS /BUREAU OF FISCAL OPERATIONS
Filing Agency/Division

C-23.1(R-6-07)

FY16

STATE OF ILLINOIS

CONTRACT-OBLIGATION DOCUMENT

2072

Agency No. 478

PLEASE TYPE

Fiscal Year	Transaction Code	Contract/Obligation No.	Transaction Date	Nine Digit Taxpayer ID. Number	Legal Status
2016	28 25	16M0000023	05/11/16	[redacted]	04

Contract Action	Class Code	Governors Release No.	Vendors Name and Address
1. ___ New 2. X Change	___ ___ POSTED 2		N L MERGER SUB INC DBA NEXT LEVEL HEALTH PRTNRS 303 W MADISON STREET STE 1150 CHICAGO IL 60606

Appropriation Account Code	Obligation Amount
346-47865-4400-00-00	1,000,000.00

Multiple Year Contract	Maximum Contract Amount
From 12/31/15 (MO/DAY/YR) To 12/30/20 (MO/DAY/YR)	500,000,000.00
Current Fiscal Year of Contract	**Annual Contract Amount**
From 12/31/15 (MO/DAY/YR) To 06/30/16 (MO/DAY/YR)	50,000,000.00 Reimbursement Expenses Included

Multiple Year Contract Amounts Year 2-7(and over)

2	3	4
100,000,000.00	100,000,000.00	100,000,000.00
5	**6**	**7**
100,000,000.00	50,000,000.00	

Description 4460 Medical Serv Pa Recip-Vendor

CONTRACTOR WILL PROVIDE INTEGRATED CARE SERVICES TO ADULT AGED, BLIND AND DISABLED NON-MEDICARE ELIGIBLE MEDICARE BENEFICIARIES THE FULL SPECTRUM OF MEDICAID COVERED SERVICES.
MULTI YEAR CONTRACT - YEAR 1 OF 5
DECREASE LINE 2 & CREATE LINE 3 FOR MCO/ICP PER FINANCE & BUDGET
DECREASE LINE 2 AND INCREASE LINE 1 PER FINANCE & BUDGET
DECREASE LINE 1 AND INCREASE LINE 2 PER FINANCE & BUDGET
Obligations to the state will cease immediately without penalty of further payment being require if, in any fiscal year, the Illinois GeneralAssembly or federal funding source fails to appropriate or otherwise make available sufficientfunds for this agreement.

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Method of Compensation	Procurement Information	Travel Expense
(if Multiple Rates, Specify) 0.00 Per MR Rate Time	Award Code P Publication Date / / Reference Subcontractor Utilization (y/n) N Subcontractor Disclosure (y/n) N	YES___ NO X Amount Advance Payment YES X NO___

CATHY NEFF 524-7301 05/11/16 HFS /Bureau of Managed Care
Prepared By / Phone Number Date Contracting Agency/Division

FELICIA F NORWOOD 05/11/16 HFS /BUREAU OF FISCAL OPERATIONS
Authorized By Date Filing Agency/Division

C-23.1(R-6-07)

FY17

STATE OF ILLINOIS

CONTRACT-OBLIGATION DOCUMENT

Agency No. 478

PLEASE TYPE

Fiscal Year	Transaction Code	Contract/Obligation No.	Transaction Date	Nine Digit Taxpayer ID. Number	Legal Status
2017	28 10	16M0000023	07/11/16	[redacted]	04

Contract Action	Class Code	Governors Release No.	Vendors Name and Address
1. X New 2. ___ Change	25K	POSTED 2	N L MERGER SUB INC DBA NEXT LEVEL HEALTH PRTNRS 303 W MADISON STREET STE 1150 CHICAGO IL 60606

Appropriation Account Code	Obligation Amount
001-47865-4900-61-00	27,000,000.00
346-47865-4400-00-00	9,000,000.00
793-47865-4900-00-00	14,000,000.00

Multiple Year Contract: From 12/31/15 (MO/DAY/YR) To 12/30/20 (MO/DAY/YR)

Maximum Contract Amount: 400,000,000.00

Current Fiscal Year of Contract: From 07/01/16 (MO/DAY/YR) To 06/30/17 (MO/DAY/YR)

Annual Contract Amount: 50,000,000.00 Reimbursement Expenses Included

Multiple Year Contract Amounts Year 2-7(and over)

2	3	4
100,000,000.00	100,000,000.00	100,000,000.00
5	**6**	**7**
50,000,000.00		

Description 4460 Medical Serv Pa Recip-Vendor

ICP/CONTRACTOR WILL ADMINISTER THE DEPARTMENT'S INTEGRATED CARE PROGRAM SERVICES TO SENIORS, BLIND & DISABLED NON-MEDICARE ELIGIBLE MEDICARE BENEFICIARIES THRU THE FULL SPECTRUM OF MEDICAID COVERED SERVICES.
MULTI-YEAR CONTRACT - YEAR 2 OF 5

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Obligations to the state will cease immediately without penalty of further payment being require if, in any fiscal year, the Illinois GeneralAssembly or federal funding source fails to appropriate or otherwise make available sufficientfunds for this agreement.

Method of Compensation	Procurement Information	Travel Expense
0.00 Rate Per MR Time (If Multiple Rates, Specify)	Award Code P Publication Date / / Reference Subcontractor Utilization (y/n) N Subcontractor Disclosure (y/n) N	YES ___ NO X Amount Advance Payment YES X NO ___

CATHY NEFF 524-7301 07/15/16
Prepared By / Phone Number Date

HFS /Bureau of Managed Care
Contracting Agency/Division

FELICIA F NORWOOD 07/15/16
Authorized By Date

HFS /BUREAU OF FISCAL OPERATIONS
Filing Agency/Division

C-23.1(R-6-07)

HFS Illinois Department of Healthcare and Family Services

CONTRACT APPROVAL DOCUMENT

Procurement Tracking # 2016-24-004-K (NLH)

The attached (select one) contract with (Enter Contractor's Name below)

NEXTLEVEL HEALTH - ICP

in the amount of $ 50,000,000.00 for FY16; 100,000,000.00 for FY17; 100,000,000.00 for FY18; 100,000,000.00 for FY19; 100,000,000.00 FY20; 50,000,000.00 for FY21. is approved.

Michelle Maher KM 12.30.15
Bureau Chief (or nearest organizational equivalent) — Date: 12-30-15

Jesse T. Hoy
Division Administrator — Date: 12/30/15

Deputy / Assistant Director — Date

Division of Finance — Date: 12/31/2015

The contract is subject to the CMS Procurement Business Case process. Yes ◉ No ○

All applicable approvals have been obtained by the Department. Yes ◉ No ○

If the contract equals or exceeds $250,000 in a fiscal year, or the amendment or renewal results in a contract that equals or exceeds $250,000 in a fiscal year, the following signatures are needed:

Chief Legal Counsel — Date

David Vincent
Chief Fiscal Officer — Date: 31 Dec 15

HFS Illinois Department of Healthcare and Family Services

CONTRACT APPROVAL DOCUMENT

Procurement Tracking # 2016-24-004-K (NLH)

The attached (select one) contract with (Enter Contractor's Name below)

NEXTLEVEL HEALTH - ICP

in the amount of $ 500,000,000.00 for FY'16 - 21 is approved.
100,000,000.00 for FY 17; 100,000,000.00 for FY 19;
100,000,000.00 for FY 18; 100,000,000.00 for FY 20; and 50,000,000.00 for FY 21.

Bureau Chief (or nearest organizational equivalent) Date

Division Administrator Date

Deputy / Assistant Director Date

Division of Finance Date

The contract is subject to the CMS Procurement Business Case process. Yes ◉ No ○

All applicable approvals have been obtained by the Department. Yes ◉ No ○

If the contract equals or exceeds $250,000 in a fiscal year, or the amendment or renewal results in a contract that equals or exceeds $250,000 in a fiscal year, the following signatures are needed:

Chief Legal Counsel 12/28/15
Date

Chief Fiscal Officer Date

1 of 2 Transactions

STATE OF ILLINOIS

CONTRACT-OBLIGATION DOCUMENT

Agency No. 478

PLEASE TYPE

Fiscal Year	Transaction Code	Contract/Obligation No.	Transaction Date	Nine Digit Taxpayer ID. Number	Legal Status
2017	28 25	16M0000023	09/02/16	[redacted]	04

Contract Action	Class Code	Governors Release No.	Vendors Name and Address
1. ___ New 2. X Change	___ ___	POSTED 2	N L MERGER SUB INC DBA NEXT LEVEL HEALTH PRTNRS 303 W MADISON STREET STE 1150 CHICAGO IL 60606

Appropriation Account Code	Obligation Amount
001-47865-4900-61-00	12,000,000.00

Multiple Year Contract	Maximum Contract Amount
From 12/31/15 MO/DAY/YR To 12/30/20 MO/DAY/YR	400,000,000.00
Current Fiscal Year of Contract	**Annual Contract Amount**
From 07/01/16 MO/DAY/YR To 06/30/17 MO/DAY/YR	50,000,000.00 Reimbursement Expenses Included

Multiple Year Contract Amounts Year 2-7(and over)

2	3	4
100,000,000.00	100,000,000.00	100,000,000.00
5	**6**	**7**
50,000,000.00		

Description 4460 Medical Serv Pa Recip-Vendor

ICP/CONTRACTOR WILL ADMINISTER THE DEPARTMENT'S INTEGRATED CARE PROGRAM SERVICES TO SENIORS, BLIND & DISABLED NON-MEDICARE ELIGIBLE MEDICARE BENEFICIARIES THRU THE FULL SPECTRUM OF MEDICAID COVERED SERVICES.
MULTI-YEAR CONTRACT - YEAR 2 OF 5

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Obligations Section

Obligations to the state will cease immediately without penalty of further payment being require if, in any fiscal year, the Illinois GeneralAssembly or federal funding source fails to appropriate or otherwise make available sufficientfunds for this agreement.

Method of Compensation	Procurement Information	Travel Expense
(If Multiple Rates, Specify) 0.00 Rate Per MR Time	Award Code P Publication Date / / Reference Subcontractor Utilization (y/n) N Subcontractor Disclosure (y/n) N	YES ___ NO X Amount Advance Payment YES X NO ___

LATOYA CRAWFORD 217-524-7330 09/06/16
Prepared By / Phone Number Date

HFS /Bureau of Managed Care
Contracting Agency/Division

FELICIA F NORWOOD 09/06/16
Authorized By Date

HFS /BUREAU OF FISCAL OPERATIONS
Filing Agency/Division

C-23.1(R-6-07)

2 of 2 Transactions

STATE OF ILLINOIS

CONTRACT-OBLIGATION DOCUMENT

Agency No. 478

PLEASE TYPE

Fiscal Year	Transaction Code	Contract/Obligation No.	Transaction Date	Nine Digit Taxpayer ID. Number	Legal Status
2017	28 20	16M0000023	09/02/16	[redacted]	04

Contract Action	Class Code	Governors Release No.	Vendors Name and Address
1. ___ New 2. X Change	___ ___	POSTED 2	N L MERGER SUB INC DBA NEXT LEVEL HEALTH PRTNRS 303 W MADISON STREET STE 1150 CHICAGO IL 60606

Appropriation Account Code	Obligation Amount
346-47865-4400-00-00	0.00
793-47865-4900-00-00	12,000,000.00

3

Multiple Year Contract	Maximum Contract Amount
From 12/31/15 MO/DAY/YR To 12/30/20 MO/DAY/YR	400,000,000.00
Current Fiscal Year of Contract	**Annual Contract Amount**
From 07/01/16 MO/DAY/YR To 06/30/17 MO/DAY/YR	50,000,000.00 Reimbursement Expenses Included

Multiple Year Contract Amounts Year 2-7(and over)

2	3	4
100,000,000.00	100,000,000.00	100,000,000.00
5	**6**	**7**
50,000,000.00		

Description 4460 Medical Serv Pa Recip-Vendor

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Obligations Section

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MULTI-YEAR CONTRACT - YEAR 2 OF 5

Obligations to the state will cease immediately without penalty of further payment being require if, in any fiscal year, the Illinois GeneralAssembly or federal funding source fails to appropriate or otherwise make available sufficientfunds for this agreement.

Method of Compensation	Procurement Information	Travel Expense
(If Multiple Rates, Specify) 0.00 Rate Per MR Time	Award Code P Publication Date / / Reference Subcontractor Utilization (y/n) N Subcontractor Disclosure (y/n) N	YES ___ NO X Amount Advance Payment YES X NO ___

LATOYA CRAWFORD 217-524-7330 09/06/16
Prepared By / Phone Number Date

HFS /Bureau of Managed Care
Contracting Agency/Division

FELICIA F NORWOOD 09/06/16
Authorized By Date

HFS /BUREAU OF FISCAL OPERATIONS
Filing Agency/Division

C-23.1(R-6-07)

STATE OF ILLINOIS

CONTRACT-OBLIGATION DOCUMENT

Agency No. 478

PLEASE TYPE

Fiscal Year	Transaction Code	Contract/Obligation No.	Transaction Date	Nine Digit Taxpayer ID. Number	Legal Status
2017	28 20	16M0000023	09/07/16	[redacted]	04

Contract Action	Class Code	Governors Release No.	Vendors Name and Address
1. ___ New 2. X Change	___ ___	POSTED 2	N L MERGER SUB INC DBA NEXT LEVEL HEALTH PRTNRS 303 W MADISON STREET STE 1150 CHICAGO IL 60606

Appropriation Account Code	Obligation Amount
001-47865-4900-61-00	0.00
346-47865-4400-00-00	0.00
793-47865-4900-00-00	0.00

Multiple Year Contract — From 12/31/15 (MO/DAY/YR) To 12/30/20 (MO/DAY/YR)

Maximum Contract Amount: 400,000,000.00

Current Fiscal Year of Contract — From 07/01/16 (MO/DAY/YR) To 06/30/17 (MO/DAY/YR)

Annual Contract Amount: 50,000,000.00 Reimbursement Expenses Included

Multiple Year Contract Amounts Year 2-7(and over)

2	3	4
100,000,000.00	100,000,000.00	100,000,000.00
5	**6**	**7**
50,000,000.00		

Description 4460 Medical Serv Pa Recip-Vendor

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State Comptroller
Obligations Section

ICP/CONTRACTOR WILL ADMINISTER THE DEPARTMENT'S INTEGRATED CARE PROGRAM SERVICES TO SENIORS, BLIND & DISABLED NON-MEDICARE ELIGIBLE MEDICARE BENEFICIARIES THRU THE FULL SPECTRUM OF MEDICAID COVERED SERVICES.
MULTI-YEAR CONTRACT - YEAR 2 OF 5

Obligations to the state will cease immediately without penalty of further payment being require if, in any fiscal year, the Illinois GeneralAssembly or federal funding source fails to appropriate or otherwise make available sufficientfunds for this agreement.

Method of Compensation	Procurement Information	Travel Expense
(If Multiple Rates, Specify) 0.00 Rate Per MR Time	Award Code P Publication Date / / Reference Subcontractor Utilization (y/n) N Subcontractor Disclosure (y/n) N	YES ___ NO X Amount Advance Payment YES X NO ___

LATOYA CRAWFORD 217-524-7330 09/13/16
Prepared By / Phone Number Date

HFS /Bureau of Managed Care
Contracting Agency/Division

FELICIA F NORWOOD 09/13/16
Authorized By Date

HFS /BUREAU OF FISCAL OPERATIONS
Filing Agency/Division

C-23.1(R-6-07)

HFS Illinois Department of Healthcare and Family Services

CONTRACT APPROVAL DOCUMENT

Procurement Tracking # 2015-24-004-PBC4

The attached (select one) amendment with (Enter Contractor's Name below)

NEXTLEVEL HEALTH PARTNERS - ICP

in the amount of $ 0.00 for FY'16 is approved.

Bureau Chief (or nearest organizational equivalent) — Date 8/16/16

Division Administrator — Date 8.17.16

Deputy / Assistant Director — Date

Division of Finance — Date 08-29-16

The amendment is subject to the CMS Procurement Business Case process. Yes ◉ No ○

All applicable approvals have been obtained by the Department. Yes ◉ No ○

If the amendment equals or exceeds $250,000 in a fiscal year, or the amendment or renewal results in a contract that equals or exceeds $250,000 in a fiscal year, the following signatures are needed:

Chief Legal Counsel — Date

Chief Fiscal Officer — Date

STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

and

NEXTLEVEL HEALTH PARTNERS, INC., AN ILLINOIS CORPORATION

AMENDMENT NO. 3 TO THE CONTRACT FOR FURNISHING HEALTH SERVICES IN AN INTEGRATED CARE PROGRAM BY A MANAGED CARE ORGANIZATION 2016-24-004-KA3 (NLHP)

WHEREAS, the Parties to the Contract for Furnishing Health Services in an Integrated Care Program by a Managed Care Organization ("Contract"), the **Illinois Department of Healthcare and Family Services**, 201 South Grand Avenue East, Springfield, Illinois 62763-0001 ("Department"), acting by and through its Director, and Community Care Alliance, Inc. ("Contractor"), desire to amend the Contract; and

WHEREAS, pursuant to Section 9.1.18, the Contract may be modified or amended by the mutual consent of the Parties; and

WHEREAS, the Contract has been previously amended;

NOW THEREFORE, the Parties agree to amend the Contract further as follows:

1. Section 5.5 is amended by adding new Section 5.5.11, to read as follows:

   5.5.11 Governmental Provider Entities Contracting Requirement. Contractor shall contract with the University of Illinois, Cook County, by and through its Cook County Health and Hospitals System, and Southern Illinois University (collectively, governmental Provider entities) in order to provide certain Covered Services to Enrollees if such governmental Provider entity is located within Contractor's geographic area set forth in Attachment IV. Contractor shall reimburse the University of Illinois and Cook County for inpatient hospital, outpatient hospital, and physician services at no less than their rates as determined by the Medicaid approved reimbursement methodologies. Contractor shall reimburse Southern Illinois University for physician services at no less than its rate as determined by the Medicaid approved reimbursement methodologies. Contractor shall not limit equal access to such Providers.

2. Section 7.1 is deleted in its entirety and replaced with the following:

   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. The Capitation rates for the Nursing Facility rate cell and the HCBS Other Waivers rate cell will include a component for Service Package I and Service Package II. Except as provided in Subsections 7.1.1 through 7.1.4, an Enrollee's rate cell will be determined by his or her residential status as of the first day of the month (e.g., NF resident, HCBS Waiver

Enrollee). The Capitation rates provided under Subsections 7.1.1 through 7.1.4 are applicable through December 31, 2015 and are eliminated as of January 1, 2016. The Department will use its eligibility system to determine an Enrollee's rate cell. Delays in changes to an Enrollee's residential status being reflected in the Department's eligibility system will cause adjustments to past Capitation payments to be made. 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.

3. Section 7.9 and the subsections are deleted in its entirety and replaced with the following:

7.9 Availability of Appropriation; Sufficiency of Funds.
This Agreement is contingent upon and subject to the availability of sufficient funds. The Department may terminate or suspend this Agreement, in whole or in part, without penalty or further payment being required, if (i) sufficient funds for this Agreement have not been appropriated or otherwise made available to the Department by the State or the Federal funding source, (ii) the Governor or the Department reserves funds, or (iii) the Governor or the Department determines that funds will not or may not be available for payment. The Department shall provide notice, in writing, to Contractor of any such funding failure and its election to terminate or suspend this Agreement as soon as practicable. Any suspension or termination pursuant to this Section will be effective upon the date of the written notice unless otherwise indicated.

4. Attachment IV is deleted in its entirety and replaced with Attachment IV-A, which is attached hereto and hereby incorporated into this Amendment. As of the effective date of this Amendment, all references in the Contract to Attachment IV shall be interpreted as references to Attachment IV-A.

All other terms and conditions of the Contract shall remain in full force and effect.

IN WITNESS WHEREOF, the Parties have hereunto caused this agreement to amend the Contract to be executed by their duly authorized representatives, effective as of the date of last signature.

NEXTLEVEL HEALTH PARTNERS INC.	**DEPARTMENT OF HEALTHCARE & FAMILY SERVICES**
By:	By:
Printed Name: Cheryl R. Whitaker	Printed Name: Felicia F. Norwood
Title: Chairwoman & CEO	Title: Director
Date: 8.15.2016	Date: 9-1-16
FEIN: [redacted]	

Attachment IV-A
Rate Sheet

NEXTLEVEL HEALTH PARTNERS, INC.

Contracting Areas	Effective January 1, 2016: Region IV (Suburban Cook) Region VI (City of Chicago)
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 unless they voluntarily enroll in an MCO; • 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	See below

All capitation rates listed are 100% of actuarially certified rates, but only a percentage may be paid in accordance with Section 7.10.1.

Service Package 1 Rates effective January 1, 2016 through December 31, 2016:						
Rate Cell	Region I (N.W. Illinois) PMPM	Region II (Central Illinois) PMPM	Region III (Southern Illinois) PMPM	Region IV (Suburban Cook Co) PMPM	Region V (Collar Counties) PMPM	Region VI (City of Chicago) PMPM
Community Residents	$882.44	$879.05	$784.84	$1,035.00	$907.03	$1,035.00
HCBS DD Waiver	$652.22	$708.96	$615.88	$693.92	$658.00	$693.92
ICF/MR Other	$769.92	$786.39	$760.52	$919.75	$909.45	$919.75
Nursing Facility	$1,879.79	$1,936.00	$2,080.38	$1,901.59	$1,798.52	$1,901.59
HCBS Other Waivers	$1,727.53	$1,984.78	$1,677.27	$1,737.58	$1,647.05	$1,737.58
ICF/MR State Op Facility	$357.97	$357.97	$357.97	$367.97	$367.97	$367.97

Service Package 2 Rates effective January 1, 2016 through December 31, 2016:						
Rate Cell	Region I (N.W. Illinois) PMPM	Region II (Central Illinois) PMPM	Region III (Southern Illinois) PMPM	Region IV (Suburban Cook Co) PMPM	Region V (Collar Counties) PMPM	Region VI (City of Chicago)
Nursing Facility	NA	NA	NA	$2,587.28	NA	$2,587.28
HCBS Other Waivers	NA	NA	NA	$2,587.28	NA	$2,587.28

***Nursing Facility and HCBS Other Waiver LTSS rates are blended into one rate and will vary by health plan.**

Supplemental Capitation Payment for Hospital Services effective January 1, 2016 through December 31, 2016:						
Rate Cell	**Region I (N.W. Illinois) PMPM**	**Region II (Central Illinois) PMPM**	**Region III (Southern Illinois) PMPM**	**Region IV (Suburban Cook Co) PMPM**	**Region V (Collar Counties) PMPM**	**Region VI (City of Chicago)**
All rate cells except ICF/MR State Op Facility	$450.79	$483.02	$365.49	309.46	$309.46	309.46

STATE OF ILLINOIS

CONTRACT-OBLIGATION DOCUMENT

Agency No. 478

PLEASE TYPE

Fiscal Year	Transaction Code	Contract/Obligation No.	Transaction Date	Nine Digit Taxpayer ID. Number	Legal Status
2017	28 20	16M0000023	11/10/16	[redacted]	04

Contract Action	Class Code	Governors Release No.	Vendors Name and Address
1. ___ New 2. X Change	25	POSTED 3	N L MERGER SUB INC DBA NEXT LEVEL HEALTH PRTNRS 303 W MADISON STREET STE 1150 CHICAGO IL 60606

	Appropriation Account Code	Obligation Amount
01	001-47865-4900-61-00	25,000,000.00
02	346-47865-4400-00-00	5,000,000.00
03	793-47865-4900-00-00	15,000,000.00

Multiple Year Contract: From 12/31/15 (MO/DAY/YR) To 12/30/20 (MO/DAY/YR)

Maximum Contract Amount: 445,000,000.00

Current Fiscal Year of Contract: From 07/01/16 (MO/DAY/YR) To 06/30/17 (MO/DAY/YR)

Annual Contract Amount: 95,000,000.00 Reimbursement Expenses Included

Multiple Year Contract Amounts Year 2-7(and over)

2	3	4
100,000,000.00	100,000,000.00	100,000,000.00
5	**6**	**7**
50,000,000.00		

Description 4460 Medical Serv Pa Recip-Vendor

RECEIVED
DEC 14 2016
State Comptroller
Obligations Section

ICP/CONTRACTOR WILL ADMINISTER THE DEPARTMENT'S INTEGRATED CARE PROGRAM SERVICES TO SENIORS, BLIND & DISABLED NON-MEDICARE ELIGIBLE MEDICARE BENEFICIARIES THRU THE FULL SPECTRUM OF MEDICAID COVERED SERVICES.
MULTI-YEAR CONTRACT - YEAR 2 OF 5
INCREASE LINES 1, 3, AND 2 PER FINANCE AND BUDGET.
INCREASE OBLIGATION BY $45M OF THE $50M REMAINING AUTHORIZATION OF THE
Obligations to the state will cease immediately without penalty of further payment being require if, in any fiscal year, the Illinois GeneralAssembly or federal funding source fails to appropriate or otherwise make available sufficientfunds for this agreement.

Method of Compensation	Procurement Information	Travel Expense
(If Multiple Rates, Specify) 0.00 Rate Per MR Time	Award Code P Publication Date / / Reference Subcontractor Utilization (y/n) N Subcontractor Disclosure (y/n) N	YES ___ NO X Amount Advance Payment YES X NO ___

LATOYA CRAWFORD 217-524-7330 12/12/16
Prepared By / Phone Number Date

HFS /Bureau of Managed Care
Contracting Agency/Division

FELICIA F NORWOOD 12/12/16
Authorized By Date

HFS /BUREAU OF FISCAL OPERATIONS
Filing Agency/Division

C-23.1(R-6-07)

HFS Illinois Department of Healthcare and Family Services

CONTRACT APPROVAL DOCUMENT

Procurement Tracking # 2016-24-004-K (NLH)

The attached (select one) contract with (Enter Contractor's Name below)

NEXTLEVEL HEALTH - ICP

in the amount of $ 500,000,000.00 for FY'16 - 21 is approved.

100,000,000.00 for FY 17; 100,000,000.00 for FY 19;
100,000,000.00 for FY 18; 100,000,000.00 for FY 20; and 50,000,000.00 for FY 21.

Bureau Chief (or nearest organizational equivalent) Date

Division Administrator Date

Deputy / Assistant Director Date

Division of Finance Date

The contract is subject to the CMS Procurement Business Case process. Yes ◉ No ○

All applicable approvals have been obtained by the Department. Yes ◉ No ○

If the contract equals or exceeds $250,000 in a fiscal year, or the amendment or renewal results in a contract that equals or exceeds $250,000 in a fiscal year, the following signatures are needed:

Chief Legal Counsel 12/28/15 Date

Chief Fiscal Officer Date

Illinois Department of Healthcare and Family Services

CONTRACT APPROVAL DOCUMENT

Procurement Tracking # 2016-24-004-K (NLH)

The attached (select one) contract with (Enter Contractor's Name below)

NEXTLEVEL HEALTH - ICP

in the amount of $ 50,000,000.00 for FY16; 100,000,000.00 for FY17; 100,000,000.00 for FY18; 100,000,000.00 for FY19; 100,000,000.00 for FY20; 50,000,000.00 for FY21; is approved.

KM 12.30.15

Michelle Maher
Bureau Chief (or nearest organizational equivalent) — Date: 12-30-15

Teresa T. Hung
Division Administrator — Date: 12/30/15

Deputy / Assistant Director — Date

Division of Finance — Date: 12/31/2015

The contract is subject to the CMS Procurement Business Case process. Yes ◉ No ○

All applicable approvals have been obtained by the Department. Yes ◉ No ○

If the contract equals or exceeds $250,000 in a fiscal year, or the amendment or renewal results in a contract that equals or exceeds $250,000 in a fiscal year, the following signatures are needed:

Chief Legal Counsel — Date

David Vincent
Chief Fiscal Officer — Date: 31 Dec 15

STATE OF ILLINOIS

CONTRACT-OBLIGATION DOCUMENT

Agency No. 478

PLEASE TYPE

Fiscal Year	Transaction Code	Contract/Obligation No.	Transaction Date	Nine Digit Taxpayer ID. Number	Legal Status
2017	28 20	16M0000023	01/10/17	[redacted]	06

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Appropriation Account Code	Obligation Amount
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346-47865-4400-00-00	0.00
793-47865-4900-00-00	0.00

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Maximum Contract Amount: 445,000,000.00

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Multiple Year Contract Amounts Year 2-7(and over)

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100,000,000.00	100,000,000.00	100,000,000.00
5	**6**	**7**
50,000,000.00		

Description 4460 Medical Serv Pa Recip-Vendor

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JAN 18 2017
State Comptroller
Obligations Section

ICP/CONTRACTOR WILL ADMINISTER THE DEPARTMENT'S INTEGRATED CARE PROGRAM SERVICES TO SENIORS, BLIND & DISABLED NON-MEDICARE ELIGIBLE MEDICARE BENEFICIARIES THRU THE FULL SPECTRUM OF MEDICAID COVERED SERVICES.
MULTI-YEAR CONTRACT - YEAR 2 OF 5
$O AMENDMENT #2 TO ADD NECESSARY CHANGES FOR FEDERAL REGULATION REQUIREMENTS AND/OR COMPLIANCE
Obligations to the state will cease immediately without penalty of further payment being require if, in any fiscal year, the Illinois GeneralAssembly or federal funding source fails to appropriate or otherwise make available sufficientfunds for this agreement.

Method of Compensation	Procurement Information	Travel Expense
(If Multiple Rates, Specify) 0.00 Rate Per MR Time	Award Code P Publication Date / / Reference Subcontractor Utilization (y/n) N Subcontractor Disclosure (y/n) N	YES___ NO X Amount Advance Payment YES X NO___

LATOYA CRAWFORD 217-524-7330 01/11/17
Prepared By / Phone Number Date

HFS /Bureau of Managed Care
Contracting Agency/Division

FELICIA F NORWOOD 01/11/17
Authorized By Date

HFS /BUREAU OF FISCAL OPERATIONS
Filing Agency/Division

C-23.1(R-6-07)

Illinois

Integrated Care Program (ICP) Contract Amendment – KA2, KA5, KA6 **FINAL** 11/16/2016

Note: Paragraphs and Contract Sections may slightly vary depending on individual MCO contracts and all changes may not affect every plan.

Amendment Paragraph	Contract Section	Reason	Change
1.	Article 1	Contract updates	Adds or modifies definition of Effective Enrollment Date, Family Planning, Individual Provider, LTSS, WHCP, adds acronyms. Consistent with ICP & FHP-ACA Contracts.
2.	2.5	Final MMC Reg	Adds "section 1557 of the Patient Protection and Affordable Care Act" as a specifically cited law that must be complied with
3.	4.9.1	Policy Clarification	Initial Change Period - removes the second 90 day switch period after October 1, 2016.
4.	4.9.3	Final MMC Reg	Add additional reason for enrollee requested disenrollment - disruption to LTSS residential and/or employment services
5.	4.13.1.5	Policy Clarification	Termination of coverage due to incarceration takes effect on last day of the month prior to the month of incarceration. Consistent with FHP/ACA contracts.
6.	4.16.2	Final MMC Reg	Add to prohibited marketing activities direct or indirect texting and emailing
7.	5.1	Update	Amount, Duration and Scope of Coverage paragraph is revised to replace Cook County Bureau of Health with Cook County Health and Hospital Systems.
8.	5.1.6.9 5.1.6.10	Federal requirement	Adds CMS required American Indian language. Consistent with FHP/ACA Contracts.
9.	5.1.7.4.1 5.1.7.4.2	Federal requirement	Adds language required by CMS for outpatient drug reporting. Consistent with FHP/ACA Contracts.
10.	5.3.4 5.3.5	Federal requirement	Adds language required by CMS on: • assisted suicide funding restriction act language; and • restriction on capitation payment to fund roads, bridges, stadiums or other services or items that are not Covered Services. Consistent with FHP/ACA Contracts.
11.	Section 5.5.1.4	CMHC policy and federal requirement	Adds, as required by federal law and CMS, that upon implementation of federal law, home health agencies must provide the state with a surety bond. Consistent with FHP/ACA Contracts.
12.	5.5.7	Policy Clarification	Modifies Medical Home language to specify that the MCOs' education to their Providers about medical homes include resources, support, and incentives, both financial and non-financial, available for becoming a Medical Home and receiving applicable recognition. Consistent with FHP/ACA Contracts.
13.	5.6.5	Policy Clarification	Choice of Primary Care Provider – Adds language to provide direct access to WHCP when the PCP is not the WHCP.
14.	5.8.8	Update	DHS HCBS Provider Education – adds acronym IP after Individual Providers

Amendment Paragraph	Contract Section	Reason	Change
15.	5.9.2	Policy Update	Adds Care Plan maintenance to Care Management System, and removes requirement to establish web-based access to Care Management System by enrollees and providers.
16.	5.9.3	Policy Update	Updates Predictive Modeling to utilize claims and CCCD data
17.	5.10	Policy Clarification	Expands population that must be offered care management to include pregnant Enrollees and Enrollees with complex conditions (was previously only HCBS Waiver enrollees). Consistent with FHP/ACA Contracts.
18. (NEW)	5.10	Renumbering	Care Management and/or Care Coordinators renumbered correctly.
19.	5.11.2	Policy Update	Adds to Contact Standards requirement of a face-to-face contact every 6 months with High Risk, non-HCBS Enrollees
20.	5.11.2	Renumbering	Contact Standards renumbered correctly.
21. (NEW)	5.13	Renumbering	Assessment and Care Planning and/or Identifying Need for Care Management renumbered correctly.
22.	5.13.6	Policy Clarification	Sets specific Health Risk Assessment timeframes based on LTSS status
23.	5.13.7	Policy Clarification	Clarifies Enrollee Care Plan annual reassessment is for those with a care plan.
24.	5.13.8.1.6	Policy Clarification	Adds new language regarding development of Enrollee Care Plan for those receiving HCBS Waiver Services or residing in a Nursing Facility
25.	5.13.9	Policy Clarification	New section 5.13.9 is added to require review and signature of Care Plan by Enrollee or Authorized Representative
26.	5.14.1	Policy Clarification	Adds medication reconciliation to duties of continuity of care transitions. Consistent with FHP/ACA Contracts.
27.	5.14.4	Policy Update	Updates and adds sources to be used to identify new Enrollees who need transition services
28.	5.14.7	Policy Clarification	Clarifies Money Follows the Person process and language. Consistent with FHP/ACA Contracts.
29. (NEW)	5.15	Policy Update	Entire Section deleted and replaced to be consistent with other ICP contracts language. (IlliniCare update only)
30.	5.15.2.1.1	Policy Update	New sections added regarding NF Continuity of Care
31.	5.15.6.1	Policy Update	Adds NF prior authorization 24-hour response time requirement
32.	5.16.4	Policy Clarification	Adds specificity already required in operations on the requirements for plans to cover inpatient psychiatric care at State Operated Hospitals for enrollees admitted under civil status at Medicaid established rates, whether that SOH is an Affiliated or non-Affiliated Provider, for all days utilized as determined by DMH, and is not subject to the utilization review determinations or admission authorization standards of the MCO. Consistent with FHP/ACA Contracts.
33.	5.17.1.15	Update	Changes "individual providers" to "IPs"

Amendment Paragraph	Contract Section	Reason	Change
34.	5.17.5.9	Policy Clarification	Adds "clinical advice" to those items that must be in member handbook policies and procedures as it relates to obtaining services
35.	5.17.7.4	Policy Update	Adds specificity to Enrollee Portal - specifies access to the Enrollee's care plan, care gaps and health education material. Consistent with ICP & FHP/ACA Contracts.
36.	5.22.2	MMC Final Reg	Increases record retention timeframe and right to audit from six to ten years
37.	5.23	Policy Update	Specifies that Department will provide notice before requiring any new *regular* reports/information; Removes sanction language for failing to comply with reporting requirements which moves to new 5.23.2
38.	5.23.1 5.23.2	Policy Update	Adds requirements for Contractor response to ad hoc requests; Sanction language moved from 5.23 to new 5.23.2
39.	5.24.7 5.24.8	Policy Update Federal Requirement	Adds specific response requirements to Provider dispute process and Provider complaint portal. Adds provider-preventable conditions reporting and payment limitations as required by CMS. Consistent with FHP/ACA Contracts.
40.	5.25.1.1 – 5.25.1.3	Policy Clarification	Updates Grievance process language. Consistent with FHP/ACA Contracts.
41.	5.25.2.3	Federal Requirement	Adds, as required by CMS, Contractor shall not discriminate or take punitive action against a Provider who either requests an expedited resolution of appeal or supports an enrollee's appeal pursuant to 42 CFR 438.410(b).
42.	5.26.1	Policy Clarification	Updates DOA's (POSM) Quality of Life Survey language to apply only to IDoA Waiver enrollees.
43.	7.10	Policy Update	Changes language from "incentive pool" to "Pay for Performance" and updates P4P requirements, including adding CY16 (HEDIS 17). Consistent with FHP/ACA Contracts.
44. (NEW)	7.16.1 & 7.16.1.1	Policy Update	Adds new language under 7.16.1.1 for monetary sanctions related to ad to ad hoc reports.
45.	9.1.2	Final MMC Reg	Increases record retention timeframe and right to audit from six to ten years
46.	9.1.22	Final MMC Reg	Adds sexual orientation and gender identity to non-discrimination clause
47.	Attachment I	Policy Update	Updates Covered Services. Consistent with ICP & FHP/ACA Contracts.
48. (NEW)	Attachment XI	Policy Update	Updates Quality Assurance. Consistent with FHP/ACA Contracts.
49.	Table 1, Attachment XI	Policy Update	Updates Health and Quality of Life Performance Measures
50.	Table 2, Attachment XI	Policy Update	Updates HCBS Waiver Performance Measures
51.	Attachment XIII	Policy Update	Updates Required Deliverables, Submissions and Reporting Consistent with ICP & FHP/ACA Contracts.
52.	Attachment XV	Update	Attachment XV, Contract Monitor Form, included again to be completed by the Health Plan

Amendment Paragraph	Contract Section	Reason	Change
53.	Attachment XXIII	Policy Decisions	Chart of Encounter Data/Encounter Utilization Management requirements (Health Alliance correction only)

STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

and

NEXTLEVEL HEALTH PARTNERS, INC., AN ILLINOIS CORPORATION

AMENDMENT NO. 2 TO THE CONTRACT FOR FURNISHING HEALTH SERVICES IN AN INTEGRATED CARE PROGRAM BY A MANAGED CARE ORGANIZATION 2016-24-004-KA2 (NLHP) (F/K/A 2013-24-005)

WHEREAS, the Parties to the Contract for Furnishing Health Services in an Integrated Care Program by a Managed Care Organization ("Contract"), the **Illinois Department of Healthcare and Family Services**, 201 South Grand Avenue East, Springfield, Illinois 62763-0001 ("Department"), acting by and through its Director, and NextLevel Health Partners, Inc. ("Contractor"), desire to amend the Contract; and

WHEREAS, pursuant to Section 9.1.18, the Contract may be modified or amended by the mutual consent of the Parties; and

WHEREAS, the Contract was been previously amended;

NOW THEREFORE, the Parties agree to amend the Contract further as follows:

1. Article I is amended by inserting new Sections 1.51A, 1.60A, 1.77A and 1.84A, by deleting and replacing Section 1.151, and by inserting new Sections 1.174A, 1.188A, 1.191A and 1.211A as follows:

1.51A **Effective Enrollment Date** means the date on which an Enrollee becomes a member of the Contractor's Plan.

1.60A **Family Planning (FP)** means a full spectrum of family planning options (all FDA-approved birth control methods) and reproductive health services appropriately provided within the Provider's scope of practice and competence. The family planning and reproductive health services are defined as those services offered, arranged, or furnished for the purpose of preventing an unintended pregnancy, or to improve maternal health and birth outcomes.

1.77A **Individual Provider (IP)** means an individual co-employed by the DHS-DRS Home Services Program Enrollee and DHS who provides care to the Enrollee according to the HCBS Waiver service plan (Service Plan). Such individuals include, but are not limited to: Personal Assistants, certified nursing assistants, licensed practical nurses, registered nurses, physical therapists, occupational therapists, and speech therapists.

1.84A **Long-Term Services and Supports (LTSS)** means those Covered Services provided in a NF or under a HCBS Waiver intended to help an Enrollee with a disability, or who is

elderly, to meet the Enrollee's daily needs for assistance and improve the quality of life.

1.151 **Women's Health Care Provider (WHCP)** means a Physician or other health care Provider, who within the Provider's scope of practice and in accordance with State certification requirements or State licensure requirements, specializes by certification or training in obstetrics, gynecology or family practice.

1.174A FP: Family Planning

1.188A IP: Individual Provider

1.191A LTSS: Long-Term Supports and Services

1.211A SOH: State Operated Hospital

2. Section 2.5 but not the subsections, which remain unchanged, is deleted in its entirety and replaced with the following:

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), Section 1557 of the Patient Protection and Affordable Care Act, 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.

3. Section 4.9.1 is deleted in its entirety and replaced with the following:

4.9.1 **Initial Change Period.** During the initial ninety (90) calendar days after the Effective Enrollment Date, 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 and such time period is before October 1, 2016, the Enrollee shall have another ninety (90) days after the Effective Enrollment Date 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. Section 4.9.3 is deleted in its entirety and replaced with the following:

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; (iv) when a change in Enrollee's LTSS provider from in-network to out-of-network results in a disruption to residence or employment; or (v) 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.

5. Section 4.13.1.5 is deleted in its entirety and replaced with the following:

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 prior to the month in which the Enrollee was incarcerated.

6. Section 4.16.2 is deleted in its entirety and replaced with the following:

4.16.2 Face-to-face Marketing by Contractor directed at Participants or Potential Enrollees, including email, texting, 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.

7. Section 5.1, but not its subsections, which shall be unchanged except as otherwise provided in this Amendment, is deleted in its entirety and replaced with the following:

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 Health and Hospitals System, 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:

8. Section 5.1.7.4 is amended by adding new Section 5.1.7.4.1 and Section 5.1.7.4.2, to read as follows:

5.1.7.4.1 For outpatient drugs not identified in Section 5.1.7.4, Contractor shall collect information on the total number of units of each dosage form and strength and package size by National Drug Code of each covered outpatient drug dispensed to Enrollees.

5.1.7.4.2 Contractor shall report to the Department quarterly, in a format and in the detail specified by the Department, information on the total number of units of each dosage form and strength and package size by National Drug Code of each covered outpatient drug identified in Section 5.1.7.4.1 dispensed to Enrollees.

9. Section 5.3 is amended by adding new Section 5.3.4 and Section 5.3.5, to read as follows:

5.3.4 Services or items furnished for the purpose of causing, or for the purpose of assisting in causing, the death of an Enrollee, such as by assisted suicide, euthanasia, or mercy killing, except as otherwise permitted by P. L. 105-12, Section 3(b), which is incorporated by Section 1903(i)(16) of the Social Security Act.

5.3.5 Services for which Contractor uses any portion of a Capitation payment to fund roads, bridges, stadiums or any other items or services that are not Covered Services, except such items or services that are Emergency Services or included as additional Covered Services in an addendum to Attachment I.

10. Section 5.5 is amended by adding a new Section 5.5.1.4, to read as follows:

5.5.1.4 Upon the implementation of Section 1861(o)(7) of the Social Security Act by Federal CMS, Contractor will not pay for a service or item (other than an Emergency Service or item furnished in an emergency room of a hospital) for home health care services provided by an agency or organization, unless the agency or organization provides the State with a surety bond as specified in Section 1861(o)(7) of the Act.

11. Section 5.5.7, but not its subsections, is deleted in its entirety and replaced with the following:

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. Contractor shall educate Affiliated Providers about the Medical Home model, the importance of using it to integrate all aspects of each Enrollee's care, and how to become a Medical Home, including educating Affiliated Providers about resources, support, and incentives, both financial and non-financial, available for becoming a Medical Home and receiving applicable recognition.

12. Section 5.6.5 is deleted in its entirety and replaced with the following:

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. Contractor shall provide direct access to a WHCP for routine and preventative women's health care Covered Services when a female Enrollee's PCP is not a WCHP.

13. Section 5.9.8 is deleted in its entirety and replaced with the following:

5.9.8 DHS HCBS Provider Education. Contractor shall distribute Provider packets, which the State or its designee will provide, to Enrollees and educate each Enrollee regarding the Enrollee's responsibility to provide the Provider packets to Personal Assistants and all other Individual Providers (IP) who provide Covered Services under the Persons with Disabilities HCBS Waiver, Persons with HIV/AIDS HCBS Waiver, or Persons with Brain Injury HCBS Waiver. Contractor shall further educate Enrollees that such Providers may not begin providing Covered Services until the fully and correctly completed packets have been returned to and accepted by the local DHS-DRS office.

14. Section 5.10.2 is deleted in its entirety and replaced with the following:

5.10.2 Care Management System. Contractor's Care Coordinators will use the Care Management system to review assessments, interventions, and management of Chronic Health Conditions to gather information to support Enrollee Care Plans, maintain Enrollee Care Plans, and identify Enrollees' needs.

15. Section 5.10.3 is deleted in its entirety and replaced with the following:

5.10.3 Predictive Modeling. Contractor shall utilize claims and Care Coordination Claims Database (CCCD) data to risk stratify the population and to identify high risk conditions needing immediate care management.

16. Section 5.11, but not its subsections, is deleted in its entirety and replaced with the following:

5.11 Care Management. Contractor shall offer Care Management to Enrollees based upon each Enrollee's individual risk level. Contractor shall offer Care Management to all

pregnant Enrollees, Enrollees with complex conditions, and Enrollees who receive Covered Services under a HCBS Waiver.

17. Section 5.12.2, but not its subsections, is deleted in its entirety and replaced with the following:

5.12.2 Contact Standards. Care Coordinators who provide Care Management shall maintain contact with Enrollees as frequently as appropriate. Care Coordinators who provide Care Management to High Risk Enrollees shall have contact with such Enrollees at least once every ninety (90) days. The Care Coordinator or a member of the Enrollee's ICT shall have a face-to-face contact at least once every six (6) months with each High Risk Enrollee who is not receiving HCBS Waiver services. Care Coordinators providing Care Management to Enrollees receiving HCBS Waiver services shall maintain contact as follows:

18. Section 5.14 is amended by deleting and replacing Section 5.14.6 through 5.14.6.1 and by adding new Sections 5.14.6.2 through 5.14.6.4, to read as follows:

5.14.6 Health Risk Assessment. Contractor shall use its best efforts to complete a health risk assessment and develop an Enrollee Care Plan within ninety (90) days after enrollment for Enrollees stratified as high or moderate risk, except as follows. Contractor shall ensure each enrollee has a risk assessment and make its best efforts to complete a health risk assessment, by following the procedures outlined in this section:

5.14.6.1 For those Enrollees receiving HCBS Waiver services or residing in NFs as of their Effective Enrollment Date with Contractor, the health risk assessment must be face-to-face and completed within one hundred eighty (180) days of the Effective Enrollment Date.

5.14.6.2 For those Enrollees receiving HCBS Waiver services or residing in NFs as of the Effective Enrollment Date, who were enrolled in another MCO, but are transitioning to the Contractor's Plan, the health risk assessment relating to those Covered Services must be face-to-face and completed within the first 90-days after the Effective Enrollment Date.

5.14.6.3 For those Enrollees transitioning to NFs, the health risk assessment relating to those Covered Services must be face-to-face and completed within the first 90-days after the Effective Enrollment Date.

5.14.6.4 For those Enrollees deemed newly eligible for HCBS Waiver services, the health risk assessment must be face-to-face and completed within fifteen (15) days after Contractor is notified that the Enrollee is determined eligible for HCBS Waiver services.

19. Section 5.14.7 is deleted in its entirety and replaced with the following:

5.14.7 Enrollee Care Plan Reassessment. Contractor will analyze predictive modeling reports and other surveillance data of all Enrollees monthly to identify risk level changes. As risk levels change, reassessments will be completed as necessary and Enrollee Care

Plans and interventions updated. Contractor will review Enrollee Care Plans and intervention of Enrollees at high-risk at least every thirty (30) days, and Enrollees at moderate-risk at least every ninety (90) days, and conduct reassessments as necessary based upon such reviews. At a minimum, Contractor shall conduct a reassessment annually for each Enrollee who has an Enrollee Care Plan. In addition, Contractor will conduct a face-to-face reassessment for Enrollees receiving HCBS Waiver services or residing in NFs each time there is a significant change in the Enrollee's condition or an Enrollee requests reassessment.

20. Section 5.14.8.1.6 is amended by adding a new Section 5.14.8.1.6.5 and subsections 5.14.8.1.6.5.1 and 5.14.8.1.6.5.2, to read as follows:

5.14.8.1.6.5 For Enrollees changing enrollment from another MCO to the Contractor's Plan who are receiving HCBS Waiver services or residing in Nursing Facilities as of their Effective Enrollment Date, the Enrollee Care Plan must be developed within ninety (90) days after the Effective Enrollment Date. For those Enrollees, any existing Enrollee Care Plan will remain in effect for a transition period spanning at least ninety (90) days, unless that period is changed with the input and consent of the Enrollee after completion of a health risk assessment.

5.14.8.1.6.5.1 For Enrollees transitioning to NFs, the Enrollee Care Plan must be developed within ninety (90) days after the Effective Enrollment Date. For those Enrollees, any existing Enrollee Care Plan will remain in effect for a transition period spanning at least ninety (90) days, unless that period is changed with the input and consent of the Enrollee after completion of a health risk assessment.

5.14.8.1.6.5.2 For Enrollees deemed newly eligible for HCBS Waiver services, the Enrollee Care Plan must be developed within fifteen (15) days after the Contractor is notified that the Enrollee is determined eligible for HCBS Waiver services.

21. Section 5.14 is amended by adding new section 5.14.9, to read as follows:

5.14.9 The Enrollee or their authorized representative must review and sign the care plan and all subsequent revisions. Acceptable forms of signature include but are not limited to electronic forms such as e-signatures and voice recordings. In the event the Enrollee refuses to sign the care plan, the Contractor shall:

5.14.9.1 Document in detail the specific reasons why the Enrollee refuses to sign the care plan;

5.14.9.2 Document actions taken by the care manager to address Enrollee's concerns.

22. Section 5.15.1 is amended by adding a new Section 5.15.1.6, to read as follows:

5.15.1.6 Medication reconciliation.

23. Section 5.15.4 is amended by deleting Sections 5.15.4.1 through 5.15.4.3 in their entirety and replacing with the following:

5.15.4.1 Prior claim history as provided by the Department;

5.15.4.2 Health Risk Screenings completed by new Enrollees;

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

5.15.4.4 Communications from Enrollees; and

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

24. Section 5.15.7 is deleted in its entirety and replaced with the following:

5.15.7 Money Follows the Person. Contractor shall use the MFP web referral form for members residing in Nursing Facilities who are interested in returning to a community based setting. The web referral form is available at https://mfp.hfs.illinois.gov/mfpreferral.aspx.

5.15.7.1 Contractor shall follow MFP program processes, procedures, and coordination requirements provided by the Department.

5.15.7.1.1 Contractor shall coordinate with the Department, DOA, and DHS and their community based provider agencies and contractors working to transition individuals through the MFP program, including but not limited to Care Coordination Units, Center's for Independent Living, Aging and Disability Resource Centers, Community Mental Health Centers, and the University of Illinois at Chicago College of Nursing.

5.15.7.2 Contractor shall provide an incentive payment to MFP community based providers under contract with DOA or DHS when they transition an MCO enrollee through the MFP program that remains in the community at the specified intervals as follows:

5.15.7.2.1 Contractor shall provide a $1,000 incentive payment to the MFP provider that is the lead transition coordinator on the case for each Enrollee who transitions to the community and remains in the community for ninety (90) consecutive days;

5.15.7.2.2 Contractor shall provide a $1,000 incentive payment to the MFP provider that is the lead transition coordinator on the case for

each Enrollee who transitions to the community and remains in the community for 365 consecutive days; and

5.15.7.2.3 If an Enrollee changes the Enrollee's MCO during either of the periods set forth in 5.15.7.2.1 or Section 5.15.7.2.2, the MCO in which the Enrollee is enrolled with at the conclusion of either such period is responsible for making the incentive payment to the MFP provider.

5.15.7.3 Contractor shall continue to meet all other responsibilities outlined in this Contract for their Enrollees when the MFP period ends after 365 consecutive days in the community.

25. Section 5.16 is amended by adding new Sections 5.16.2.1.1 and sub-sections 5.16.2.1.1.1 through 5.16.2.1.1.2:

5.16.2.1.1 Continuity of Care for NF Residents. When a resident in a NF first transitions to the Contractor from the fee-for-service system or from another plan, the Contractor shall honor the existing Enrollee Care Plan and any necessary changes to that Enrollee Care Plan until it has completed a comprehensive assessment and new Enrollee Care Plan, to the extent such services are covered benefits under the Contract, which shall be consistent with the requirements of the Resident Assessment Instrument (RAI) Manual.

5.16.2.1.1.1 When an Enrollee is moving from a community setting to a NF, and the Contractor is properly notified of the proposed admission by a network NF, and the Contractor fails to participate in developing an Enrollee Care Plan within the time frames required by NF regulations and this Contract, the Contractor must honor an Enrollee Care Plan developed by the NF until the Contractor has completed a comprehensive assessment and a new Enrollee Care Plan to the extent such services are covered benefits under the contract, consistent with the requirements of the RAI Manual.

5.16.2.1.1.2 A NF shall have the ability to refuse admission of an Enrollee for whom care is required that the NF determines is outside the scope of its license and healthcare capabilities.

26. Section 5.16.6 is amended by adding new Section 5.16.6.1, to read as follows:

5.16.6.1 For authorizations for Enrollees residing in a NF, if a response to the authorization is not provided within twenty-four (24) hours of the request and the NF is required by regulation to provide a service because a Physician ordered it, the Contractor must pay for the service if it is a Covered Service, provided that the request is consistent with the policies and procedures of the Contractor.

27. Section 5.17.4 is deleted in its entirety and replaced with the following:

5.17.4 State Operated Hospitals. Contractor shall provide inpatient psychiatric care to a SOH for an Enrollee admitted under civil status, at Medicaid established rates, whether that SOH is an Affiliated or non-Affiliated Provider. Payment shall be made for all days utilized as determined by DMH and is not subject to the utilization review determinations or admission authorization standards of Contractor.

28. Section 5.18.1.15 is deleted in its entirety and replaced with the following:

5.18.1.15 Contractor shall distribute Enrollee packets, which the State or its designee will provide, to those Enrollees receiving Covered Services from Personal Assistants or all other IPs under the Persons with Disabilities HCBS Waiver, Persons with HIV/AIDS HCBS Waiver, or Persons with Brain Injury HCBS Waiver. Contractor shall educate Enrollees regarding the content of the Enrollee packets.

29. Section 5.18.5.8 is deleted in its entirety and replaced with the following:

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

30. Section 5.18.7.3 is amended by adding new Sections 5.18.7.3.5, 5.18.7.3.6, and 5.18.7.3.7 to read as follows:

5.18.7.3.5 Access to the Enrollee's Care Plan;

5.18.7.3.6 Access to the Enrollee's care gaps; and

5.18.7.3.7 Access to health education materials.

31. Section 5.23.2 is deleted in its entirety and replaced with the following:

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 ten (10) 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 ten-year (10 year) period, the records must be retained until all issues arising out of the action are resolved.

32. Section 5.24 is deleted in its entirety and replaced with the following:

5.24 Regular Information Reporting Requirements. Contractor shall submit to the Department, or its designee, regular reports and additional information as set forth in this Section and 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 regular 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.

33. Section 5.24 is further amended by adding new Section 5.24.1 and Section 5.24.2, to read as follows:

5.24.1 Contractor shall submit to the Department accurate and complete responses to any ad hoc request received from the Department by the due date given by the Department. If Contractor cannot meet the due date, Contractor shall request an extension no later than forty-eight (48) hours before such due date. The Department may approve, deny or allow for such shorter extension within its sole discretion.

5.24.2 Failure of Contractor to materially comply with reporting requirements may subject Contractor to any of the applicable monetary sanctions in Article VII. Any Contractor obligation(s) to provide reporting to the Department shall be contingent on the Department's ability to deliver to Contractor the information or necessary business specifications reasonably required by Contractor to complete its reporting requirements, as applicable.

34. Section 5.25 is amended by deleting and replacing section 5.25.7 and by adding a new Section 5.25.8, to read as follows:

5.25.7 Contractor shall establish a complaint and resolution system for Providers that includes a Provider dispute process. Contractor shall provide a substantive response intended to resolve a complaint received through the Department's Provider complaint portal on the Department's website within two (2) business days if the complaint is categorized as urgent and within fifteen (15) business days if it is not categorized as urgent.

5.25.8 Contractor shall require that Providers agree to the reporting requirements in 42 C.F.R. 447.26(d) as a condition of receiving payment from Contractor. Contractor shall report identified provider-preventable conditions to the Department as required in Attachment XIII. Contractor shall not pay a Provider for provider-preventable conditions that are identified in the State Plan. Contractor, however, is not prohibited from paying a Provider for such provider-preventable conditions that existed prior to

the initiation of treatment for an Enrollee with a provider-preventable condition by that Provider.

35. Section 5.26.2.3 is deleted in its entirety and replaced with the following:

5.26.2.3 If an Enrollee requests an expedited Appeal pursuant to 42 CFR 438.410, Contractor shall notify the Enrollee within twenty-four (24) hours after the submission of the Appeal, of all information from the Enrollee that Contractor requires to evaluate the Appeal. Contractor shall render a decision on an expedited Appeal within twenty-four (24) hours after receipt of the required information. Contractor shall not discriminate or take punitive action against a Provider who either requests an expedited resolution of appeal or supports an enrollee's appeal pursuant to 42 CFR 438.410(b).

36. Section 5.27.1 is deleted in its entirety and replaced with the following:

5.27.1 Contractor shall administer DoA's "Participant Outcomes and Status Measures (POSM) Quality of Life Survey" to each DoA Person who is an elderly HCBS Waiver Enrollee at each annual reassessment in order to determine each Enrollee's perception of the quality of life.

37. Section 7.10 is deleted in its entirety and replaced with the following:

7.10 Pay for Performance

7.10.1 Contractor may earn a percentage of payments based on its performance with respect to those quality metrics set forth in Attachment XI, Table 1, First Reporting Period and Attachment XI, Table 1, Second Reporting Period. Each month the Department shall withhold a portion of the 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 and subsequent measurement years. An equal portion of the incentive payment will be allocated to each P4P Metric. If Contractor reaches the target goal on a Pay for Performance (P4P) Metric, Contractor will earn the withhold percentage of the incentive payment assigned to that P4P Metric. Withholds of Contractor's Capitation payment for the purposes of funding the incentive payments shall commence with the January Capitation payment of the first measurement year.

7.10.2 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 approval of the calculations for payment by Contractor and the Department. 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 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 payments under this Section 7.10.

7.10.3 **[This Section Intentionally Blank.]**

7.10.4 Effective for HEDIS® 2017 (measurement year January 1, 2016 through December 31, 2016), and any subsequent year, the Department will provide the P4P measures and target goals prior to the beginning of the measurement year. 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 a payment, then the Parties will negotiate, and the resolution will be memorialized through countersigned letters.

38. Section 7.16.1 is deleted in its entirety and replaced with the following:

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.

7.16.1.1 If Contractor fails to submit any ad hoc report in an accurate, complete and timely manner, as provided in Section 5.24.1, then the Department may at its sole discretion and without further notice impose a monetary sanction of $1,000.00 to $50,000.00. The Department may also, without further notice, impose an additional monetary sanction until an accurate and complete response is submitted.

39. Section 9.1.2 is deleted in its entirety and replaced with the following:

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 ten (10) 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.

40. Section 9.1.22 is deleted in its entirety and replaced with the following:

9.1.22 Non-discrimination: Contractor shall abide by all Federal and State laws, regulations, and orders that prohibit discrimination because of race, color, religion, sex, sexual orientation, gender identity, 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.

41. Attachment I, Service Package 1 Covered Services, is deleted in its entirety and replaced with Attachment I-A, Service Package 1 Covered Services, which is attached hereto and hereby incorporated into this Amendment No. 2. As of the effective date of this Amendment, all references in the Contract to Attachment I shall be interpreted as references to Attachment I-A.

42. Attachment XI, Quality Assurance (QA), is deleted in its entirety and replaced with Attachment XI-A, Quality Assurance (QA), which is attached hereto and hereby incorporated into this Amendment No. 2. As of the effective date of this Amendment, all references in the Contract to Attachment XI shall be interpreted as references to Attachment XI-A.

43. Table 1 to Attachment XI, Health and Quality of Life (HQOL) Performance Measures: Seniors and People with Disabilities, is deleted in its entirety and replaced with Table I-A, which is attached hereto and hereby incorporated into this Amendment No. 2 attached. As of the effective date of this Amendment, all references to Table 1 to Attachment XI shall be interpreted as references to Table 1-A to Attachment XI.

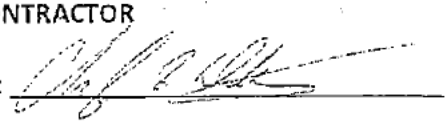
44. Table 2 to Attachment XI, HCBS Waiver Performance Measures, is deleted in its entirety and replaced with Table 2-A, which is attached hereto and hereby incorporated into this Amendment No. 2. As of the effective date of this Amendment, all references to Table 2 to Attachment XI shall be interpreted as references to Table 2-A to Attachment XI.

45. Attachment XIII, Required Deliverables, Submissions and Reporting, is deleted in its entirety and replaced with Attachment XIII-A, which is attached hereto and hereby incorporated into this Amendment No. 2. As of the effective date of this Amendment, all references in the Contract to Attachment XIII shall be interpreted as references to Attachment XIII-A.

46. Attachment XV, Contract Monitors, is deleted in its entirety and replaced with Attachment XV-A which is attached hereto and hereby incorporated into this Amendment No. 6. As of the effective date of this Amendment, all references in the Contract to Attachment XV shall be interpreted as references to Attachment XV-A.

All other terms and conditions of the Contract shall remain in full force and effect.

IN WITNESS WHEREOF, the Parties have hereunto caused this agreement to amend the Contract to be executed by their duly authorized representatives, effective as of the date of last signature.

CONTRACTOR	DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
By: 	By: _____
Printed Name: Cheryl R. Whitaker	Printed Name: Felicia F. Norwood
Title: Chairman and CEO	Title: Director
Date: 12.9.2016	Date: _____
FEIN: [redacted]	

All other terms and conditions of the Contract shall remain in full force and effect.

IN WITNESS WHEREOF, the Parties have hereunto caused this agreement to amend the Contract to be executed by their duly authorized representatives, effective as of the date of last signature.

CONTRACTOR

By: _____

Printed Name: Cheryl R. Whitaker

Title: Chairman and CEO

Date: 12.9.2016

FEIN: [redacted]

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

By: _____

Printed Name: Felicia F. Norwood

Title: Director

Date: 1-6-17

Attachment I-A
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** Audiology services;
   - **1.4** Chiropractic services;
   - **1.5** Dental services, including oral surgeons;
   - **1.6** 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);
   - **1.7** Family planning services and supplies;
   - **1.8** FQHCs, RHCs and other Encounter rate clinic visits;
   - **1.9** Home health agency visits;
   - **1.10** Hospital emergency room visits;
   - **1.11** Hospital inpatient services; Hospital ambulatory services;
   - **1.12** Laboratory and x-ray services (Contractor shall receive and transmit electronic lab values to support clinical management and for HEDIS® reporting);
   - **1.13** Medical supplies, equipment, prostheses and orthoses, and respiratory equipment and supplies;
   - **1.14** Mental health services provided under the Medicaid Clinic Option or Medicaid Rehabilitation Option;
   - **1.15** 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;
   - **1.16** 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;
   - **1.17** Nursing Facility services for the first ninety (90) days*;
   - **1.18** Optical services and supplies;
   - **1.19** Optometrist services;
   - **1.20** Palliative and Hospice services;
   - **1.21** Pharmacy Services (drugs used in the treatment of Hepatitis C are covered only if dispensed in accordance with Contractor's coverage criteria approved by the Department);
   - **1.22** Physical, Occupational and Speech Therapy services;
   - **1.23** Physician services;
   - **1.24** Podiatric services;
   - **1.25** Post-Stabilization Services as detailed in Section 5.17.2;
   - **1.26** Practice Visits for Enrollees with special needs;
   - **1.27** Renal Dialysis services;
   - **1.28** Services to prevent illness and promote health in accordance with Attachment XXI.
   - **1.29** 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;
   - **1.30** Transplants covered under 89 Ill. Admin. Code Section 148.82 (using transplant providers certified by the Department)
   - **1.31** Transportation to secure Covered Services.

*Excludes Enrollees who are Residents of a Nursing Facility on the date of enrollment with Contractor.

Attachment XI-A
Quality Assurance

1. Contractor shall establish procedures such that Contractor shall be able to demonstrate that it has an ongoing fully implemented Quality Assurance Program for health services that meets the requirements of the HMO Federal qualification regulations (42 CFR 417.106), the Medicare HMO/CMP regulations (42 CFR 417.418(c)), and the regulations promulgated pursuant to the Balanced Budget Act of 1997 (42 CFR 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 nationally-recognized standards 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 in this Attachment XI), 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. Detail any 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 and the Behavioral Health 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, as outlined below:

   a. Goals and objectives — The written description shall contain a detailed set of Quality Assurance 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 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, pharmacy, and ancillary services) are included in the scope of the review. Documentation of the monitoring and evaluation plan shall be provided to the Department upon request.

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 enrollees (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.
12. Utilization of Behavioral Health benefits.

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, congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease, Behavioral Health, including those with one or more co-morbidities).

1. Appropriate treatment, follow-up care, coordination of care, and Care Management and Disease Management, for all Enrollees.
2. Identification of Enrollees with special health care needs and processes in place to assure adequate, ongoing risk assessments, care plan developed with the

Enrollee's participation in consultation with any specialists caring for the Enrollee, to the extent possible, the appropriateness and quality of care, and if approval is required, such approval occurs in a timely manner.

3. 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 but not limited to transportation and escort services.
3. Enrollee access to timely Behavioral Health services.
4. An Enrollee Care or Service Plan 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.

   i. Multi-disciplinary teams shall be used, where indicated, to analyze and address systems issues.

   ii. 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) QA/UR/PR Plan with overview of goal areas;

b) Major Initiatives to comply with the State Quality Strategy,

c) Quality Improvement and work plan monitoring;

d) Contractor Network Access and Availability and Service Improvements, including access and utilization of dental services;

e) Cultural Competency;

f) Fraud and Abuse Monitoring;

g) Population Profile;

h) Improvements in Care Coordination/Care Management and Clinical Services/Programs;

i) Findings on Initiatives and Quality Reviews;

j) Effectiveness of Quality Program Structure;

k) Comprehensive Quality Improvement Work Plans;

l) Chronic Conditions;

m) Behavioral Health (includes mental and substance abuse services);

n) Dental care

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 Board has approved the overall Quality Assurance Program and an annual QAP.

   b. Oversight Entity — The Governing Board shall document that it has formally designated an accountable entity or entities within the organization to provide oversight of QA, or has formally decided to provide such oversight as a committee of the whole.

   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 a Community Stakeholder Committee that will provide feedback to the QAP Committee on the Plan's performance from Enrollee and community perspectives. The committee shall recommend program enhancements based on Enrollee and community needs; review Provider and Enrollee satisfaction survey results; evaluate performance levels and telephone response timelines; evaluate access and provider feedback on issues requested by the QAP Committee; identify key program issues; such as disparities, that may impact community groups; and offer guidance on reviewing Enrollee materials and effective approaches for reaching enrollees. The Committee will be comprised of randomly selected Enrollees, family members and other caregivers, local representation from key community stakeholders such as churches, advocacy groups, and other community-based organizations. Contractor will educate Enrollees and community stakeholders about the committee through materials such as handbooks, newsletters, websites and communication events.

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, and/or training, to effectively carry out its specified activities.

   b. Provider Participation in the QAP

      i. Affiliated Providers shall be kept informed about the written QAP.

      ii. Contractor shall include in all agreements with Affiliated Providers and Subcontractors a requirement securing cooperation with the QAP.

iii. Contracts shall specify that Affiliated Providers and Subcontractors shall 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 recurring. Evidence of ongoing monitoring of the delegated activities sufficient to assure corrective action shall be provided to the Department through quarterly or annual reporting.

8. The QAP shall contain provisions to assure that 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 coordinated by Contractor shall be in accordance with Departmental policies and 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. Pharmacy services;

o. Community reintegration and support;

p. Long-term Care (LTC) residential coordination of services; and

q. Prenatal, obstetrical, postpartum and reproductive health care.

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, pharmacy, 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 CFR 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 Quality Measure Specifications methodology, as provided by the Department. Contractor shall not modify the reporting specifications methodology prescribed by the Department without first obtaining the Department's written approval. Contractor must obtain an independent validation of its HEDIS® and HEDIS®-like findings by a recognized entity, e.g., NCQA-certified auditor, as approved by the Department. The

Department's External Quality Review Organization will perform an independent validation of at least a sample of Contractor's findings.

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.

16. Contractor shall perform and report the performance measures in Table 2 - HCBS Waiver Performance Measures for ICP. Contractor shall not modify the reporting specifications methodology prescribed by the Department without first obtaining the Department's written approval.

Table 1-A to Attachment XI-A

Healthcare and Quality of Life (HQOL) Performance Measures for ICP

For Reporting in 2016 on **2015 CY** Data

Acronym	Performance Measure	Further Description	Specification Source	Data Source
		Access/Utilization of Care		
AAP	**Adult's Access to Preventive/Ambulatory Health Services**	Percentage of members 20 years and older who had an ambulatory or preventive care visit.	HEDIS®	Admin
AMB	**Ambulatory Care**	Visits per 1,000 Member Months	HEDIS®	Admin
	1) Outpatient Visits			
	2) ED Visits			
IAPE	**Ambulatory Care Follow-up with a Provider within 14 Days of Emergency Department (ED) Visit**	Follow-up with any Provider within 14 days following Emergency Department visit. Exclude ED visits with a principal diagnosis of mental health or chemical dependency.	Illinois	Admin
IAPI	**Ambulatory Care Follow-up with a Provider within 14 Days of Inpatient Discharge**	Ambulatory care follow-up visit within 14 days of having an inpatient hospital stay. Exclude discharges for deliveries (births) and discharges with a principal diagnosis of mental health or chemical dependency or a principal diagnosis of poisoning with a secondary alcohol/drug related MH diagnosis.	Illinois	Admin
IIHR	**Inpatient Hospital 30-day Re-Admission Rate**	Inpatient Hospital readmission for the same discharge diagnosis (to 3rd digit) within 30 days after having an initial inpatient hospital stay	Illinois	Admin
	Non-Behavioral Health Primary Diagnosis			
	Behavioral Health Primary Diagnosis			
		Access/Utilization of Care		
IPU	**Inpatient Utilization-General Hospital/Acute Care**	Utilization of acute inpatient care and services, per 1,000 Enrollees - exclude discharges with a principal diagnosis of mental health or chemical dependency.	HEDIS®	Admin
	1) Total Inpatient			

Acronym	Performance Measure	Further Description	Specification Source	Data Source
	2) Surgery			
	3) Maternity			
	4) Medicine			
Prevention/Screening Services				
ABA	**Adult BMI Assessment**	Percentage of members 18-74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measure year or the year prior.	HEDIS®	Admin / Hybrid
BCS	**Breast Cancer Screening**	Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.	HEDIS®	Admin
CCS	**Cervical Cancer Screening**	Percentage of women who were screened for cervical cancer using either of the following criteria: Women 21-64 who had cervical cytology performed every 3 years or women age 30-64 who had cervical cytology/human papillomavirus co-testing performed every 5 years	HEDIS®	Admin / Hybrid
SCOL	**Colorectal Cancer Screening**	Percentage of members 50-75 years of age who had appropriate screening for colorectal cancer – apply to Medicaid product line.	State Modified HEDIS®	Admin / Hybrid
Appropriate Care				
MCDC	**Diabetes Care**	Percentage of members18-75 years of age with diabetes	Multiple	
	CDC – Comprehensive Diabetes Care	Who had the listed care during the measurement year.	HEDIS®	Admin / Hybrid
	1) Hemoglobin A1c (HbA1c) testing			
	2) Medical attention for nephropathy			
	3) Eye exam (retinal) performed			
	SCDC – State Defined CDC rates	Who remained on the indicated medications for 80% of the treatment period during the measurement year.	State Modified HEDIS®	Admin
	4) Statin Therapy			
	5) ACE/ARB			

Acronym	Performance Measure	Further Description	Specification Source	Data Source
PQI08	**Heart Failure Admission Rate**	Number of discharges for heart failure **per 1,000 member months** for Medicaid enrollees age 18 and older.	State Modified AHRQ	Admin
MCVC	**Cardiovascular Conditions**	Members ≥18 years	Multiple	Admin
	• **ICAD – Coronary Artery Disease**	Percentage diagnosed with CAD who had an LDL-C test during measure year; who remained on the indicated medications for 80% of the treatment period during the measurement year.	Illinois	
	1) Cholesterol testing			
	2) Statin therapy			
	3) ACE/ARB therapy			
	• **PBH – Persistence of Beta-Blocker Treatment After a Heart Attack**	Percentage hospitalized and discharged alive with a diagnosis of AMI between 7/1 prior year to 6/30 measure year and received persistent beta-blocker treatment for 6 months after discharge.	HEDIS®	
	4) Percentage who received 6 months of treatment after discharge			
MCOP	**Chronic Obstructive Pulmonary Disease**	Percentage of members ≥40 years	Multiple	Admin
	• **PCE – Pharmacotherapy Management of COPD Exacerbation**	With COPD exacerbations who had an acute hospital discharge or ED visit and who were dispensed appropriate medications.	HEDIS®	
	1) Dispensed a systemic corticosteroid within 14 days			
	2) Dispensed a bronchodilator within 30 days			
	• **SPR - Use of Spirometry testing in the Assessment and Diagnosis of COPD**	With a new diagnosis or newly active COPD who received appropriate spirometry testing to confirm diagnosis		
	Percentage who received appropriate testing			
MPM	**Annual Monitoring for Patients on Persistent Medications**	Percentage of members ≥18 years who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent and at least one therapeutic	HEDIS® - Adult Core	Admin
	1) ACE Inhibitors or ARB			

Acronym	Performance Measure	Further Description	Specification Source	Data Source
	2) Digoxin	monitoring event for the therapeutic agent in the measurement year		
	3) Diuretics			
	4) Total Rate (Sum of the three numerators divided by the sum of the three denominators)			
SDAE	**Use of High-Risk Medications in the Elderly**	Percentage of member's age ≥60 who received medications considered to be high-risk for use in the elderly population. Medicaid product line.	State Modified HEDIS®	Admin
	1) Received at least one high-risk medication			
	2) Received at least two different high-risk medications			
Movement				
IMWS	**Movement Within Service Populations**	The number and percentage of members moving from one service population (1/1/MY) to another (12/31/MY)	Illinois	Admin
Long Term Care				
IUTI	**Urinary Tract Infection Hospital Admission Rate**	Hospital Admissions due to urinary tract infections for LTC Residents.	Illinois	Admin
IBPR	**Bacterial Pneumonia Hospital Admission Rate**	Hospital Admission due to bacterial pneumonia for LTC Residents.	Illinois	Admin
IPPU	**Prevalence of Hospital Acquired Pressure Ulcers**	LTC Residents that have category / stage II or greater pressure ulcers acquired during an inpatient hospital stay.	Illinois	Admin
Behavioral Health				
AMM	**Antidepressant Medication Management**	Percentage of members ≥18 years with a diagnosis of major depression and treated with antidepressant medication, and who remained on the antidepressant treatment for the indicated phases.	HEDIS®	
	1) Effective Acute Phase Treatment. At least 84 days (12 weeks) continuous treatment			

Acronym	Performance Measure	Further Description	Specification Source	Data Source
	2) Effective Continuation Phase Treatment. At least 180 days (6 months) continuous treatment			
SAA	**Adherence to Antipsychotic Medications for Individuals With Schizophrenia**	Percentage of members 19-64 years with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.	HEDIS®	
IMMP	**Medication Monitoring for Patients with Psychotic Disorders**	Percentage of members diagnosed with specified psychotic disorders in the prior year that remained on appropriate medication for 6-months and 12-months during the measurement year.	Illinois	Admin
SSD	**Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications**	Percentage of members with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening (HbA1c) during the measurement year.	HEDIS®	
IET	**Initiation and Engagement of Alcohol and Other Drug Dependence Treatment**	Percentage of members age ≥13 years with new episode of alcohol or other drug (AOD) dependence who received initiation and engagement of AOD treatment. Report two age stratifications and a total rate: 13-17 years, 18 + years and Total.	HEDIS®	
	1) Initiation of AOD Treatment. Within 14 days of diagnosis.			
	2) Engagement of AOD Treatment. Initiation and 2 or more additional services within 30 days of initiation visit.			
FUH	**Follow-up after hospitalization for Mental Illness**	Percentage of member's ≥6 years who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner as follow-up.	HEDIS®	
	1) Follow-up within 7 days of discharge			
	2) Follow-up within 30 days of discharge			

Acronym	Performance Measure	Further Description	Specification Source	Data Source
MPT	**Mental Health Utilization**	The number and percentage of members receiving the indicated mental health services during the measurement year, per 1,000 Enrollees.	HEDIS®	
	1) Any service			
	2) Inpatient			
	3) Intensive outpatient or partial hospitalization			
	4) Outpatient or ED			
IBHR	**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.	Illinois	
	1) Behavioral Screening/ Assessment within 60 days of enrollment			
	2) Behavior Health follow-up within 30 days of screening			
	Surveys			
SCPA	**CAHPS – Consumer Assessment of Health Plan Survey**	CAHPS, Adult Version as approved by HFS. Provides information on the experiences of members with the organization and gives a general indication of how well the organization meets member's expectations. The following questions must be added for the waiver populations only. Do you receive additional care through [insert plan name] waiver service? □Yes...skip to **xx** □No Thank you for completing the survey □I do not know if I qualify for waiver services...Thank you for completing the survey Did you receive the services you needed when you needed	State Modified HEDIS®	

Acronym	Performance Measure	Further Description	Specification Source	Data Source
		them? □Yes □No □I did not need services from my plan's waiver service Did you receive all the services listed in your plan of care? □Yes □No □I have not received a plan of care. Were you treated well by your direct support staff? □Yes □No		
SFVA	**Flu Vaccinations for Adults Ages 18 and Older**	Percentage of members who received an influenza vaccination between July 1 of the measurement year and the date when the CAHPS 5.0H adult survey was completed. Report: 18-64 years, ≥65 years and Total rates. Add question to CAHPS. Have you had either a flu shot or flu spray in the nose since July 1, 2014? □Yes □No □Don't know	State Modified HEDIS®	

Acronym	Performance Measure	Further Description	Specification Source	Data Source
SFRM	Fall Risk Management	*Discussing Fall Risk:* The percentage of member's ≥60 years of age who in the past 6 months had balance or walking problems or a fall who were seen by a practitioner and discussed fall risk *Managing Fall Risk* Percentage of members ≥60 years of age who in the past 6 months had a fall or balance or walking problems who were seen by a practitioner and received fall risk intervention from their current practitioner. Medicaid product line. Add questions to CAHPS. A fall is when your body goes to the ground without being pushed. In the **past 6 months**, did you talk with your doctor or other health provider about falling or problems with balance or walking? □Yes □No □I had no visits in the past 6 months Did you fall in the **past 6 months?** □Yes □No In the **past 6 months,** have you had a problem with balance or walking? □Yes □No Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking? things they might do : ▪ Suggest that you use a cane or walker. ▪ Check your blood pressure lying or standing. ▪ Suggest that you do an exercise or physical therapy program. ▪ Suggest a vision or hearing testing. □Yes □No □I had no visits in the past 6 months	State Modified HEDIS®	

Acronym	Performance Measure	Further Description	Specification Source	Data Source
SMUI	**Management of Urinary Incontinence in Older Adults**	*Discussing:* Members who reported having a problem with urine leakage in the past six months and who discussed their urine leakage problem with their current practitioner. *Receiving Treatment:* Members who reported having a urine leakage problem in the past six months and who received treatment for their current urine leakage problem. Medicaid product line. Add questions to CAHPS. Many people experience problems with urinary incontinence, the leakage of urine. In the past 6 months, have you accidentally leaked urine? □Yes □No...Skip to xx How much of a problem, if any, was the urine leakage for you? □A big problem □A small problem □Not a problem...Skip to xx Have you talked with your current doctor or other health provider about your urine leakage problem? □Yes □No There are many ways to treat urinary incontinence including bladder training, exercises, medication and surgery. Have you received these or any other treatments for your current urine leakage problem? □Yes □No	State Modified HEDIS®	

Acronym	Performance Measure	Further Description	Specification Source	Data Source
SPAO	**Physical Activity in Older Adults**	*Discussing Physical Activity:* Members who had a doctor's visit in the past **6** months and who spoke with a doctor or other health provider about their level of exercise or physical activity. *Advising Physical Activity:* Members who had a doctor's visit in the past **6** months and who received advice to start, increase or maintain their level exercise or physical activity. Medicaid product line. Add questions to CAHPS. In the **past 6 months,** did you talk with a doctor or other health provider about your level of exercise or physical activity? For example, a doctor or other health provider may ask if you exercise regularly or take part in physical exercise. □Yes □No □I had no visits in the past 6 months...Skip to xx In the **past 6 months,** did a doctor or other health provider advise you to start, increase or maintain your level of exercise or physical activity? For example, in order to improve your health, your doctor or other health provider may advise you to start taking the stairs, increase walking from 10 to 20 minutes every day or to maintain your current exercise program. □Yes □No	State Modified HEDIS®	

Table 1-A to Attachment XI-A
Healthcare and Quality of Life (HQOL) Performance Measures for ICP
For Reporting in 2017 on **2016 CY** Data

Acronym	Performance Measure	Further Description	Specification Source	Data Source
Access/Utilization of Care				
AAP	**Adult's Access to Preventive/Ambulatory Health Services**	Percentage of members 20 years and older who had an ambulatory or preventive care visit.	HEDIS®	Admin
AMB	**Ambulatory Care**	Visits per 1,000 Member Months	HEDIS®	Admin
	1) Outpatient Visits			
	2) ED Visits			
PPC	**Prenatal and Postpartum Care**	Percentage of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year for which the Women received the proper care. Two rates reported: *Timeliness of Prenatal Care* and *Postpartum Care*.	HEDIS®	Admin / Hybrid
IET	**Initiation and Engagement of Alcohol and Other Drug Dependence Treatment**	Percentage of members age ≥13 years with new episode of alcohol or other drug (AOD) dependence who received initiation and engagement of AOD treatment.	HEDIS®	Admin
Prevention/Screening Services				
ABA	**Adult BMI Assessment**	Percentage of members 18-74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measure year or the year prior; measure ages 18-64 and 65-74.	HEDIS®	Admin / Hybrid

Acronym	Performance Measure	Further Description	Specification Source	Data Source
BCS	**Breast Cancer Screening**	Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer; measure age populations 50-64 and 65-74. The woman must be 52-74 years of age as of 12/31 of the measurement year.	HEDIS®	Admin
CCS	**Cervical Cancer Screening**	Percentage of women who were screened for cervical cancer using either of the following criteria: Women 21-64 who had cervical cytology performed every 3 years or women age 30-64 who had cervical cytology/human papillomavirus co-testing performed every 5 years.	HEDIS®	Admin / Hybrid
CHL	**Chlamydia Screening in Women**	Percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for Chlamydia during the measurement year.	HEDIS®	Admin
CBP	**Controlling High Blood Pressure**	Percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and who's BP was adequately controlled during the measurement year.	HEDIS®	Hybrid Only
Appropriate Care				
CDC	**Comprehensive Diabetes Care**	Percentage of members18-75 years of age with diabetes that had at least one HbA1c test, an Eye exam (Retinal) and Attention for nephropathy during the measure year.	HEDIS®	Admin / Hybrid
SPD	**Statin Therapy for Patients With Diabetes**	Percentage of members18-75 years of age with diabetes that remained on the indicated statin medication for 80% of the treatment period during the measurement year.	HEDIS®	Admin
Medication Management				
MPM	**Annual Monitoring for Patients on**	Percentage of member's ≥18 years who received at least	HEDIS®	Admin

Acronym	Performance Measure	Further Description	Specification Source	Data Source
	Persistent Medications	180 treatment days of ambulatory medication therapy for a select therapeutic agent and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. Includes ACE/ARB, Digoxin, Diuretics and a Total rate.		
		Respiratory Condition		
MMA	**Medication Management for People With Asthma**	Percentage of members 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period.	HEDIS®	Admin
		Behavioral Health		
FUH	**Follow-up after hospitalization for Mental Illness**	Percentage of member's ≥6 years who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner as follow-up.	HEDIS®	Admin

Table 1-A to Attachment XI-A

Healthcare and Quality of Life (HQOL) Performance Measures for ICP

Third Reporting Period

For Reporting in 2018 on **2017 CY** Data

Acronym	Performance Measure	Further Description	Specification Source	Data Source
Access/Utilization of Care				
AAP	**Adult's Access to Preventive/Ambulatory Health Services**	Percentage of members 20 years and older who had an ambulatory or preventive care visit.	HEDIS®	Admin
AMB	**Ambulatory Care** 1) Outpatient Visits 2) ED Visits	Visits per 1,000 Member Months	HEDIS®	Admin
PPC	**Prenatal and Postpartum Care**	Percentage of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year for which the Women received the proper care. Two rates reported: *Timeliness of Prenatal Care* and *Postpartum Care*.	HEDIS®	Admin / Hybrid
IET	**Initiation and Engagement of Alcohol and Other Drug Dependence Treatment**	Percentage of members age ≥13 years with new episode of alcohol or other drug (AOD) dependence who received initiation and engagement of AOD treatment.	HEDIS®	Admin
Prevention/Screening Services				
ABA	**Adult BMI Assessment**	Percentage of members 18-74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measure year or the year prior; measure ages 18-64 and 65-74.	HEDIS®	Admin / Hybrid

Acronym	Performance Measure	Further Description	Specification Source	Data Source
BCS	**Breast Cancer Screening**	Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer; measure age populations 50-64 and 65-74. The woman must be 52-74 years of age as of 12/31 of the measurement year.	HEDIS®	Admin
CCS	**Cervical Cancer Screening**	Percentage of women who were screened for cervical cancer using either of the following criteria: Women 21-64 who had cervical cytology performed every 3 years or women age 30-64 who had cervical cytology/human papillomavirus co-testing performed every 5 years.	HEDIS®	Admin / Hybrid
CHL	**Chlamydia Screening in Women**	Percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for Chlamydia during the measurement year.	HEDIS®	Admin
CBP	**Controlling High Blood Pressure**	Percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and who's BP was adequately controlled during the measurement year.	HEDIS®	Hybrid Only
Appropriate Care				
CDC	**Comprehensive Diabetes Care**	Percentage of members18-75 years of age with diabetes that had at least one HbA1c test, an Eye exam (Retinal) and Attention for nephropathy during the measure year.	HEDIS®	Admin / Hybrid
SPD	**Statin Therapy for Patients With Diabetes**	Percentage of members18-75 years of age with diabetes that remained on the indicated statin medication for 80% of the treatment period during the measurement year.	HEDIS®	Admin
Medication Management				
MPM	**Annual Monitoring for Patients on Persistent Medications**	Percentage of member's ≥18 years who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent and at least one therapeutic monitoring event for the therapeutic agent in the	HEDIS®	Admin

Acronym	Performance Measure	Further Description	Specification Source	Data Source
		measurement year. Includes ACE/ARB, Digoxin, Diuretics and a Total rate		
Respiratory Condition				
MMA	**Medication Management for People With Asthma**	Percentage of members 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period.	HEDIS®	Admin
Behavioral Health				
FUH	**Follow-up after hospitalization for Mental Illness**	Percentage of member's ≥6 years who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner as follow-up.	HEDIS®	Admin

Table 2-A to Attachment XI-A
Service Package II HCBS Waiver Performance Measures

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection / Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
Appendix C- Qualified Providers								
Subassurance C **The State implements its policies and procedures for verifying that training is provided in accordance with state requirements and the approved waiver**								
26C	*# and % of enrolled non-licensed/non-certified waiver service providers (Personal Assistants) who meet waiver provider qualifications.* N: # of enrolled waiver service providers reviewed who meet waiver provider qualifications. D: Total # of enrolled waiver service providers reviewed.	EQRO/ MCO	Annually and Ongoing	Represent ative Sample	MCO	Quarterly and Annually	MCO Reports	Obtain document; Training for MCO case managers. Change provider; remove from MMIS; disenroll from plan, Remediation within 60 days.
29C	*# and % of case managers who meet waiver provider training requirements.* N: # of MCO case managers reviewed who meet waiver provider training requirements. D: Total # of MCO case managers reviewed.	EQRO/ MCO	Quarterly and Annually	100%	MA/MCO	Quarterly and Annually	MCO Reports	Completion of case manager training; Moratorium of new waiver cases to non-certified MCO case managers. Remediation within 60 days.
Appendix D- Service Plan Development								

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection / Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
<u>Subassurance A</u> **Service plans address all participants' assessed needs (including health and safety factors) and personal goals, either by the provision of waiver services or through other means**								
31D	*# and % of MCO participants' care plans/service plans that address all personal goals identified by the assessment.* N: # of MCO care plans/service plans reviewed that address all personal goals identified by the assessment. --- D: Total # of MCO care plans/service plans reviewed.	EQRO /MCO	Quarterly and Ongoing	Representative Sample	MA/MCO	Quarterly and Annually	MCO Reports; EQRO Reviews	If plans do not address required items, the MA will require the plans be corrected and MCO will provide training of case managers. Remediation must be completed within 60 days.
32D	*# and % of MCO participants' care plans/service plans that address all participant needs identified by the assessment.* N: # of MCO care plans/service plans reviewed that address all participant needs identified by the assessment. --- D: Total # of MCO care plans/service plans reviewed.	EQRO /MCO	Quarterly and Ongoing	Representative Sample	MA/MCO	Quarterly and Annually	MCO Reports; EQRO Reviews	If plans do not address required items, the MA will require the plans be corrected and MCO will provide training of case managers. Remediation must be completed within 60 days.
33D	*# and % of MCO participants' care plans/service plans that address risks identified in the assessment.*	EQRO /MCO	Quarterly and Ongoing	Representative Sample	MA/MCO	Quarterly and Annually	MCO Reports; EQRO Reviews	If plans do not address required items, the MA will require the plans

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection / Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
	N: # of MCO care plans/service plans reviewed that address risks identified in the assessment. --- D: Total # of MCO care plans/service plans reviewed.							be corrected and MCO will provide training of case managers. Remediation must be completed within 60 days.
34D	*# and % of MCO survey respondents in the sample who reported they receive services they need when they need them.* N: # of MCO survey respondents who reported they receive services when needed. ---D: # of MCO survey respondents in the sample.	MCO	Annually	CAHPS Guidelines (BI, HIV, PD)	MA/MCO	Quarterly and Annually	CAHPS Survey (BI, HIV, PD)	If identifying information is available for individual surveys the MCO case managers will follow up on non-favorable surveys. Resolution or remediation will be based on the nature of the concern. Patterns of negative responses, including anonymous survey responses, will be used to identify need for system improvement.
			Quarterly and Annually	100% (Elderly)			POSM Survey question A.2. (Elderly)	

Subassurance B

The State monitors service plan development in accordance with its policies and procedures

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection / Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
35D	*# and % of MCO participants' care plans/service plans that were signed and dated by the waiver participant and the case manager.* N: # of MCO care plans/service plans that were signed by the waiver participant and the case manager. --- D: Total # of MCO care plans/service plans reviewed.	EQRO /MCO	Quarterly and Ongoing	Representative Sample	MA/MCO	Quarterly and Annually	MCO Reports; EQRO Reviews	If plans are not signed by appropriate parties, the MA will require the plans be signed, with a review of the plan with the participant when indicated. The MCO may also provide training in both cases. Remediation must be completed within 60 days.
36D	*# and % of MCO participants who received contact by their case manager every 12 months for Persons with Disabilities and Elderly; monthly for BI and HIV, with a bi-monthly contact being face-face for HIV, in an effort to monitor service provision and to address potential gaps in service delivery.* N: # of MCO participants reviewed who received contact by their case manager every 12 months for Persons with Disabilities and Elderly; monthly for BI and HIV; with a bi-monthly contact being face-to-face,	EQRO /MCO	Quarterly and Ongoing	Representative Sample	MA/MCO	Quarterly and Annually	MCO Reports; EQRO Reviews	If participants do not receive the required contact by case manager, the MA will require the participant be contacted and MCO will provide training of case managers. Remediation must be completed within 60 days.

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection / Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
	for HIV. --- D: Total # of MCO participants reviewed.							
Subassurance C **Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs**								
37D	*# and % of MCO waiver participants who have their care plan/service plan updated every 12 months for Persons with Disabilities, HIV and Elderly; every 6 months for BI.* N: # of MCO waiver participants reviewed who have their care plan/service plan updated every 12 months for Persons with Disabilities, HIV and Elderly; every 6 months for BI. --- D: Total # of MCO waiver participants with care plan/service plan due during the period reviewed.	EQRO /MCO	Quarterly and Ongoing	Representative Sample	MA/MCO	Quarterly and Annually	MCO Reports; EQRO Reviews	If service plans are untimely, the MA will require completion of overdue service plans and justification from the case manager. In both cases the MCO may also provide training of case managers. Remediation within 60 days.

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection / Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
38D	*# and % of MCO waiver participants that received updates to care plans/service plans when participants needs changed.* N: # of MCO waiver participants reviewed that received updates to care plans/service plans when participants' needs changed. --- D: Total # of MCO waiver participants identified whose needs changed.	EQRO /MCO	Quarterly and Ongoing	Subset of Representative Sample	MCO	Quarterly and Annually	MCO Reports; EQRO Reviews	If plans do not address required items, the MA will require that the plans be corrected and provide training of case managers. Remediation must be completed within 60 days.
Subassurance D **Services are delivered in accordance with the service plan, including type, scope, amount, duration, and frequency specified in the service plan**								
39D	*# and % of MCO participants who received services in the type, scope, amount, duration, and frequency as specified in the care plan/service plan.* N: # of MCO participants reviewed who received services as specified in the care plan/service plan. --- D: Total # of MCO participants reviewed.	EQRO /MCO	Quarterly and Ongoing	Representative Sample	MA/MCO	Quarterly and Annually	MCO Reports; EQRO Reviews	If a participant does not receive services as specified in the service plan, the MCO will determine if a correction or adjustment of service plan, services authorized, or services vouchered is needed. If not, services will be

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection / Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
								implemented as authorized. The MCO may also provide training to case managers. If the issue appears to be fraudulent, it will be reported by the MA to fraud control. Remediation must be completed within 60 days.
40D	*# and % of MCO survey respondents in the sample who reported the receipt of all services listed in the plan of care.* N: # of MCO survey respondents who reported the receipt of all services listed in the plan of care. --- D: # of MCO survey respondents in the sample.	MCO	Annually	CAHPS Guidelines	MA/MCO	Quarterly and Annually	CAHPS Survey	If identifying information is available for individual surveys the MCO case managers will follow up on non-favorable surveys. Resolution or remediation will be based on the nature of the concern. Anonymous survey responses will be used to identify need for system improvement

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection / Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
Subassurance E Participants are afforded choice between/among waiver services and providers.								
41D	*# and % of MCO participants records with the most recent plan of care indicating the participant had choice between/among services and providers.* N:# of MCO participant records reviewed with a signed POC that indicates participant had choice between services and providers. --- D:Total # of MCO participant records reviewed.	EQRO /MCO	Quarterly and Ongoing	Representative Sample	MA/MCO	Quarterly and Annually	MCO Reports; EQRO Reviews	The MCO will assure that choice was provided as shown by the correction of documentation to indicate customer choice. The MCO may also provide training to case managers. Remediation must be completed within 60 days.
Appendix G - Participant Safeguards								
Subassurance A The State demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.								
42G	*# and % of participants who received information from the MCO about how and to whom to report abuse, neglect, exploitation at the time of assessment/reassessment.*	EQRO /MCO	Quarterly and Ongoing	Represent-ative Sample	MA/MCO	Quarterly and Annually	MCO Reports; EQRO Reviews	The MCO will assure that customers know how to report abuse, neglect or exploitation. This

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection / Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
	N: # of participant records reviewed where the participant received information from the MCO about how and to whom to report abuse, neglect exploitation at the time of assessment/reassessment. --- D: Total # of MCO participant records reviewed.							will be demonstrated by correction of case work documentation reflecting customers awareness, including evidence of steps taken to educate the customer. Remediation must be completed within 30 days.
43G	*# and % of participants' substantiated incidents that were reported by the Investigative Authority to the MCO and resolved within recommended timelines.* N: # of substantiated incidents reported to the MCO that were resolved within recommended timelines: --- D: Total # of substantiated incidents reported to the MCO.	MCO	Quarterly and Ongoing	100%	MCO	Quarterly and Annually	MCO Reports	The MCO will follow up all outstanding Investigative Authority referrals and Unusual Incident Reports. Changes in customers' service plans will be made when needed. Remediation must be completed within 30 days.

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection / Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
44G	*# and % of participants' substantiated cases of abuse, neglect or exploitation received from the Investigative Authority where the MCO implemented the recommendations.* N: # of substantiated cases of abuse, neglect or exploitation received from where the MCO implemented the recommendations. --- D: Total # of substantiated cases of abuse, neglect or exploitation received by the MCO.	MCO	Quarterly and Ongoing	100%	MCO	Quarterly and Annually	MCO Reports	The MCO will implement the Investigative Authority recommenda-tions for substantiated cases of abuse, neglect or exploitation. Changes in customers' service plans will be made when needed. Remediation must be completed within 30 days.
45G	*# and % of participants' deaths as a result of substantiated case of abuse, neglect or exploitation where appropriate follow-up actions were implemented by the MCO.* N:# of deaths as a result of a substantiated case of A/N/E where appropriate follow-up actions were implemented by the MCO. --- D:Total # of MCO deaths as a result	MCO	Quarterly and Ongoing	100%	MA/MCO	Quarterly and Annually	MCO Reports	The cause of death/circumstanc es would be reviewed by the MCO and need for training or other remediation; including sanction or termination of provider, would be determined based on circumstances

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection / Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
	of a substantiated case of A/N/E.							and identified trends and patterns.
Subassurance B The State demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.								
46G	*# and % of participants for whom identified critical incidents other than A/N/E were reviewed and corrective measures were appropriately taken by the MCO.* N:# of participants for whom identified critical incidents other than A/N/E were reviewed and corrective measures were appropriately taken by the MCO. --- D:Total # of MCO participants for whom identified critical incidents were reviewed.	MCO	Quarterly and Ongoing	100%	MCO	Quarterly and Annually	MCO Reports	The MCO will follow up on identified critical incidents, other than A/N/E, to ensure information was reviewed and corrective measures were appropriately taken. Resolution or remediation will be based on the nature of the concern.

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection / Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
Subassurance C The State policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.								
47G	*# And % of restraint applications, seclusion, or other restrictive interventions where appropriate intervention by the MCO occurred.* N: # of restraint applications, seclusion, or other restrictive interventions where appropriate intervention by the MCO occurred. --- D: Total # of MCO restraint applications, seclusion, or other restrictive intervention.	MCO	Quarterly and Ongoing	100%	MA/MCO	Quarterly and Annually	MCO Reports	Restraint applications, seclusion, or other restrictive interventions will be reviewed by the MCO. The need for training or other remediation; including sanction or termination of provider, would be determined based on circumstances and identified trends and patterns.
Subassurance D The State establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.								
48G	*# and % of participant survey respondents who reported to the MCO of being treated well by direct support staff.* N: # of participant satisfaction	MCO	Annually	CAHPS Guidelines (BI, HIV, PD)	MA/MCO	Annually	CAHPS Survey (BI, HIV, PD)	If identifying information is available for individual surveys the MCO case managers will

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection / Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
	survey respondents who reported to the MCO of being treated well by direct support staff. --- D: Total # of MCO participant satisfaction survey respondents.		Quarterly and Annually	100% (Elderly)			POSM Survey Ques. E.1.a (Elderly)	follow up on non-favorable surveys. Resolution or remediation will be based on the nature of the concern. Anonymous survey responses will be used to identify need for system improvement.
49G	*# and % of MCO participants who have personal assistant or other independently employed services whose care plan/service plan included back up plans.* N: # of MCO participants reviewed who have personal assistant or other independently employed services whose care plan/service plan included back up plans. --- D: Total MCO participants reviewed who have personal assistant or other independently employed services.	MCO	Quarterly and Ongoing	Representative Sample	MCO	Quarterly and Annually	EQRO Reviews	The MCO would develop and implement PA back up plans and revisions to customers' service plans. Timeline for remediation would be within 30 days.
Appendix I- Financial Accountability								

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection / Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
Subassurance A The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered								
501	*# and % of payments that were paid for participants who were enrolled in the waiver on the date the service was delivered.* N: # of MCO payments made for participants who were enrolled in the waiver on the date the service was delivered. --- D: Total # of MCO payments.	MCO	Quarterly and Annually	100%	MCO	Semi-Annually	Encounter Data	The MA will adjust the federal claim for services provided by the MCO prior to the customers' waiver enrollment. Remediation must be completed within 30 days.
511	*# and % of payments there were paid for services that were specified in the participant's service plan.* N: # of MCO payments made that are specified in the participant's service plan. --- D: Total # of MCO payments.	MCO	Quarterly and Annually	Non-Representative Sample	MCO	Semi-Annually	MCO Reports	The MCO will determine whether the service was authorized. If authorized, the MCO will revise customer service plan; If not authorized, the MA will void the federal claims that were not consistent with service plans. Remediation must be completed

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection / Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
								within 30 days.
Subassurance B The State provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.								
521	*# and % of payments that were paid using the correct rate as specified in the waiver application.* N: # of MCO payments using the correct rate as specified in the waiver application. --- D: Total # of MCO payments.	MCO	Quarterly and Annually	100%	MA and MCO	Semi-Annually	Encounter Data	The MA will require the MCO to recoup the overpayment or repay at correct rate. Remediation must be completed within 30 days.

Attachment XIII-A
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 twenty (120) days after the date of service. Any claims processed by Contractor for services provided subsequent to submission of an Encounter Data file shall be reported on the next Encounter Data file. **Testing.** Upon receipt of each submitted Encounter Data file, the Department shall perform two distinct levels of review: The first level of review and edits performed by the Department shall check the data file format. These edits shall include, but are not limited to the following: check the data file for completeness of records; correct 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

Name of Report/Submission	Frequency	HFS Prior Approval	Report Description and Requirements
			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 the Contractor for correction. Corrected Encounter Data must be returned to the Department for reprocessing. **Electronic Data Certification.** In a format determined by the Department, Contractor shall certify by the 5th day of each month that all electronic data submitted during the previous calendar month is accurate, complete and true.
Disclosure Statements	Initially, annually, on request and as changes occur	No	Contractor shall submit disclosure statements as specified in 42 CFR, Part 455.

Name of Report/Submission	Frequency	HFS Prior Approval	Report Description and Requirements
Financial Reports	Quarterly and annually	No	Contractor shall provide the Department with copies of all financial reports Contractor is required to file with the Department of Insurance. In the event Contractor is an MCCN, Contractor shall provide the Department with copies of its financial statements on a quarterly and annual basis prescribed by the Department.
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.
Claims Report	Monthly, no later than fifteen (15) days after the close of the reporting month	No	Contractor shall report the number of claims Contractor adjudicated by claim type, in-network and out-of-network break out, and the number of days the claims took to process.
Compliance Certification	Annually, no later than July 1	No	Contractor shall submit a Certification confirming that Contractor and its subcontractors are in compliance with Section 9.2 and each subsection thereof.
Enrollee Materials.			
Certificate of Coverage, Description of Coverage, and Any Changes or Amendments	Initially and as revised	Yes	Contractor shall submit the Certificate of Coverage and Description of Coverage for Prior Approval that comply with the Managed Care Reform and Patient Rights Act (215 ILCS 134) and the Illinois Administrative Code, Title 50, Chapter 1, Subchapter kkk, Part 5421.

Name of Report/Submission	Frequency	HFS Prior Approval	Report Description and Requirements
Enrollee Handbook	Initially and as revised	Yes	Contractor shall submit an Enrollee Handbook for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed.
Identification Card	Initially and as revised	Yes	Contractor shall submit the Enrollee identification card for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed.
Provider Directory	Initially and as changes occur	Yes	Contractor shall submit 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 Referral	Immediately upon notification or knowledge of suspected Fraud and Abuse	N/A	Contractor shall report all suspected Fraud and Abuse to the Department as required in Article V and Article IX of this Contract. Contractor shall provide a preliminary investigation report as each occurrence is identified.
Fraud and Abuse Report	Quarterly	No	Contractor shall provide a summary report of referrals made and program integrity activities conducted in the previous quarter.
Recipient Verification Procedure	Initially, annually and as revised	Yes	Contractor shall submit Contractor's plan for verifying with Enrollees whether services billed by Providers were received, as required by 42 CFR 455.20, for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in information conveyed.

Name of Report/Submission	Frequency	HFS Prior Approval	Report Description and Requirements
Recipient Verification Results	Annually and within ten (10) Business Days after the Department's request	No	Contractor shall submit a summary of the results of the Recipient Verification Procedure.
Fraud and Abuse Compliance Plan	Initially and annually	Yes	Per 42 CFR 438.608, Contractor shall submit its compliance plan designed to guard against Fraud and Abuse to the Department for Prior Approval.
Marketing			
Marketing Gifts and Incentives	Initially and within ten (10) Business Days after the Department's request	Yes	Contractor shall submit all plans to distribute gifts and incentives, as well as description of gifts and incentives, for Prior Approval.
Marketing Materials	Initially and as revised	Yes	Contractor shall submit all Marketing Materials for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed.
Marketing Plans and Procedures	Initially and as revised	Yes	Contractor shall submit descriptions of proposed Marketing concepts, strategies, and procedures for Prior Approval.
Community Outreach Events	Monthly, by the last day of the reporting month	No	Contractor shall submit to the Department a list of all previously approved community outreach events that occurred during the submission month. The report must include the Event name, date, time, address/location, county, audience type, estimated number of attendees and date of Department approval.
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 Site Closures/Terminations	As each occurs	No	Contractor shall submit Provider Site Closures/termination reports, in a format and medium designated by the Department.

Name of Report/Submission	Frequency	HFS Prior Approval	Report Description and Requirements
ACA Primary Physician Services Reimbursement Requirement	No later than ninety (90) days after the receipt of each supplemental payment from the Department	No	Contractor shall provide to the Department documentation of the additional amounts paid to qualifying Physicians and APNs in accordance with Section 5.25.6 of the Contract.
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 – Summary Report	Quarterly	No	Contractor shall submit a summary of the Grievances and Appeals filed by Enrollees, organized by categories of quality of care, access to care, medical necessity reviews, transportation, Long Term Services and Supports (LTSS), and "Other" issues. Reporting shall include total Grievances and Appeals per/1,000 Enrollees. The report shall include a summary count of any such Grievances or Appeals received during the reporting period including those that go through fair hearings and external independent reviews. Contractor shall report on Covered Services and include Appeals and Grievances outcomes and the levels at which the Grievances or Appeals were resolved, and whether the Appeals were upheld or overturned. Contractor shall also report Grievances and Appeals separately for the categories of: Nursing Facility Services; Persons who are Elderly; Assisted Living, Supportive Living Program; Persons with Physical Disabilities; Persons with HIV/AIDS; and Persons with Brain Injury. The report shall only include Grievances and Appeals related specifically to LTC and Waiver services and providers.

Name of Report/Submission	Frequency	HFS Prior Approval	Report Description and Requirements
Quality Assurance, Utilization Review and Peer Review (QA/UR/PR) Annual Report / Program Evaluation	Annually, no later than ninety (90) days after close of reporting period	No	Contractor shall submit a QA/UR/PR Annual Report/Program Evaluation reviewing the effectiveness of Contractor's QAP. The summary shall contain Contractor's processes for Quality Assurance, utilization review and peer review. This report shall include a comprehensive description of Contractor's network and an annual work-plan outlining Contractor's intended activities relating to QA, utilization review, peer review and health education. Contractor may submit one report that includes all care coordination programs in which it participates; however, Contractor must clearly identify program-specific activities.
QA/UR/PR Committee Meeting Minutes	As needed, and within ten (10) Business Days after the Department's request	No	Contractor shall submit the minutes of its QA/UR/PR Committee meetings.
QA/UR/PR and Health Education Plans	Initially and as revised	Yes	Contractor shall submit the Quality Assurance, Utilization Review, Peer Review and Health Education Plans for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed.
Conditions Report	As needed, and within ten (10) Business Days after the Department's request	No	Contractor shall submit the aggregate count of the primary health conditions of its Enrollees and their associated risk levels. These reports may be generated utilizing Contractor's unique internal algorithms and systems to determine primary conditions and risk level of Enrollees.
Care Management and Disease Management Program Descriptions	Initially and as revised	Yes	Contractor shall submit the descriptions of its Care Management and Disease Management programs for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed.

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

Name of Report/Submission	Frequency	HFS Prior Approval	Report Description and Requirements
Prior Authorization Report	Monthly	No	Contractor shall submit turnaround times for routine and expedited prior authorizations, as well as pharmacy authorizations, for its Enrollees.
HEDIS® Measures Report	Quarterly	No	Contractor shall submit a HEDIS® measures report that is based on the Performance Measures required by this Contract, inclusive of HEDIS® measures and modified HEDIS® measures. This report shall include the numerator, denominator and rate for each measure and will display information in a manner that includes trending data, based on previous quality indicators.
Physician Quality Measurement Report	As needed, and within ten (10) Business Days after the Department's request	No	Contractor shall submit a report for each Provider or Provider group that shows actual performance relative to measures of performance.
Enrollee Profiles/Statistics for Care Integration	As needed, and within ten (10) Business Days after the Department's request	No	Contractor shall submit a report that provides comprehensive information on Contractor's care integration systems for Enrollees' care. This report shall include, but not be limited to, an annual summary of physical and behavioral health conditions, service utilization such as PCP and specialist visits, Emergency Services, inpatient hospitalizations and pharmacy utilization.
Processes and Procedures to Receive Reports of Critical Incidents	Initially and as revised	Yes	Contractor shall submit Critical Incident Processes and Procedures for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed.

Name of Report/Submission	Frequency	HFS Prior Approval	Report Description and Requirements
Critical Incidents – Detail Report	Monthly	No	Contractor shall submit a detailed report on Critical Incidents providing Enrollee name, Enrollee Medicaid number, incident summary, date received, source, incident date, date referred, referral entity, date resolved, and resolution summary, grouped in the following categories: Abuse, Neglect, Exploitation and Other. Contractor shall report Critical Incidents for each of the following: Nursing Facility Services; HCBS Waiver for Persons who are Elderly; HCBS Waiver for Assisted Living, Supportive Living Program; HCBS Waiver for Persons with Physical Disabilities; HCBS Waiver for Persons with HIV/AIDS; and HCBS Waiver for Persons with Brain Injury.
Critical Incidents – Summary Report	Quarterly	No	Contractor shall submit a summary report on Critical Incidents that includes the total number of Critical Incidents and the total number of Critical Incidents referred in the following categories: Abuse, Neglect, Exploitation and Other. Contractor shall report Critical Incidents separately for each of the following: Nursing Facility Services; HCBS Waiver for Persons who are Elderly; HCBS Waiver for Assisted Living, Supportive Living Program; HCBS Waiver for Persons with Physical Disabilities; HCBS Waiver for Persons with HIV/AIDS; and HCBS Waiver for Persons with Brain Injury. This report shall only include Critical Incidents specifically related to Enrollees receiving Long-Term Services and Supports (LTSS).
Transition of Care Plan	Initially and as revised	Yes	Contractor shall submit its Transition of Care Plan to the Department for review and Prior Approval. The Transition of Care Plan shall include policies and procedures and a staffing model designed to achieve a seamless, efficient transition with minimal impact to an Enrollee's care.
Cultural Competence Plan	At least one (1) week prior to the Department's Readiness Review	No	Contractor shall submit its Cultural Competence Plan that addresses the challenges of meeting the health care needs of Enrollees. Contractor's Cultural Competence Plan shall contain, at a minimum, the provisions listed in Section 2.7.1 of the Contract.

Name of Report/Submission	Frequency	HFS Prior Approval	Report Description and Requirements
Executive Summary	Quarterly	No	Contractor shall submit an Executive Summary that summarizes the data within the reports submitted to the Department for that quarter (including monthly and quarterly reports). The Executive Summary shall contain, at a minimum, an analysis of the reports submitted during the quarter, an explanation of the data submitted, and highlights from the reports.
Provider-preventable Conditions Report	Quarterly	No	Contractor shall report provider-preventable conditions that are identified in the State Plan.
			Utilization Review
Utilization Management Report	Monthly	No	Contractor shall submit an analysis of Inpatient and Emergency Services utilization. Inpatient services shall be based on inpatient days and be categorized as follows: Utilization for total Inpatient, Medical/Surgical, Rehabilitation, Mental Health including Substance Abuse, Emergency Services, and Outpatient visits. Data will be based on utilization per 1,000 Enrollees and Total utilization. Reporting for Inpatient, Emergency Services, and Outpatient visits utilization shall be divided into separate worksheets for LTC, HCBS Waiver for Persons with Developmental Disabilities, HCBS Waiver for Persons with Disabilities, HCBS Wavier for Persons with Brain Injury, HCBS Waiver for Persons with HIV/AIDS, HCBS Waiver for Persons who are Elderly, HCBS Waiver for Assisted Living, Supportive Living Program, and total population as defined by Department standards.
			Pharmacy
Pharmacy Monitoring Report	Monthly	No	Contractor shall submit pharmacy data utilization reports based on total utilization, claims summaries, cost summaries and cost per claim.

Name of Report/Submission	Frequency	HFS Prior Approval	Report Description and Requirements
Psychotropic Review Report	Monthly	No	Contractor shall submit a summary report of Enrollees' Psychotropic medication utilization and the prescribing patterns of providers. The report must include information on the following criteria: use of 5 or more psychotropics for 60 or more days, use of 2 or more ADHD medications for 60 or more days, use of 3 or more antidepressants for 60 or more days, use of 5 or more drugs for bipolar disorder (mood stabilizers, atypical antipsychotics, antidepressants) for 60 or more days, use of 2 or more SSRIs for 60 or more days, use of 2 or more antipsychotics for 60 or more days, use of 2 or more atypical antipsychotics for 60 or more days, and use of 2 or more benzodiazepine or benzodiazepine hypnotics for 60 or more days.
Pharmacy Formulary	Initially and annually, no later than October 1	Yes	Contractor shall submit its Pharmacy Formulary to the Department for review and Prior Approval.
Drug Utilization Review Report	Quarterly	No	Contractor shall report its prospective and retrospective Drug Utilization Review activities to the Department. Contractor shall also report to the Department, in a format and in the detail specified by the Department, information on the total number of units of each dosage form and strength and package size by National Drug Code of each covered outpatient drug identified in Section 5.1.7.4.1 dispensed to Enrollees.
Subcontracts and Provider Agreements			
Executed Subcontracts	Initially and as revised	N/A	Contractor shall submit copies of each executed subcontract relating to an arrangement for the provision of Covered Services, but not those subcontracts for the direct provision of Covered Services. For example, a subcontract with a behavioral health or dental administrator shall be submitted to the Department, but an agreement with a therapist or dentist providing direct care to an Enrollee need not be submitted unless otherwise required or requested by the Department.

Name of Report/Submission	Frequency	HFS Prior Approval	Report Description and Requirements
Executed Provider Agreements	Within ten (10) Business Days after the Department's request	N/A	Contractor shall submit copies of executed Provider agreements to the Department upon request.
Model Subcontracts and Provider Agreements	Initially and as revised	N/A	Contractor shall submit copies of model subcontracts and Provider agreements related to Covered Services, assignment of risk and data reporting functions, inclusive of all proposed schedules or exhibits intended to be used therewith. Contractor shall provide the Department with any substantial revisions to, or deviations from, these model subcontracts and Provider agreements.
Business Enterprise Program Act for Minorities, Females and Persons with Disabilities			
Business Enterprise Program (BEP) Utilization Plan	Initially 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 of the Contract.
BEP Report	Quarterly	No	Contractor shall submit, in a format specified by the Illinois Department of Central Management Services, its expenditures for BEP-certified subcontractors and goal attainment as provided in Section 2.9 of the Contract.

Attachment XV-A
Contract Monitors

For the Department:

Michelle Maher
Bureau of Managed Care
Illinois Department of Healthcare and Family Services
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Springfield, IL 62763

Telephone: 217-524-7478
Fax: 217-524-7535
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For Contractor:

Tanya Ford
Compliance Director
NextLevel Health Partners
3019 W. Harrison St.
Chicago, Il 60612

Contract Monitor Phone #: 312-878-2778
Contract Monitor FAX #:
tford@nlhpartners.com

STATE OF ILLINOIS

FY17

CONTRACT-OBLIGATION DOCUMENT

Agency No. 478

PLEASE TYPE

Fiscal Year	Transaction Code	Contract/Obligation No.	Transaction Date	Nine Digit Taxpayer ID. Number	Legal Status
2017	28 25	16M0000023	05/10/17	[redacted]	06

Contract Action	Class Code	Governors Release No.	Vendors Name and Address
1. ___ New 2. X Change		POSTED 2	N L MERGER SUB INC DBA NEXT LEVEL HEALTH PRTNRS 303 W MADISON STREET STE 1150 CHICAGO IL 60606

Appropriation Account Code	Obligation Amount
001-47865-4900-61-00	8,660,936.61

Multiple Year Contract	Maximum Contract Amount
From 12/31/15 MO/DAY/YR To 12/30/20 MO/DAY/YR	436,339,063.39
Current Fiscal Year of Contract	Annual Contract Amount
From 07/01/16 MO/DAY/YR To 06/30/17 MO/DAY/YR	86,339,063.39 Reimbursement Expenses Included

Multiple Year Contract Amounts Year 2-7(and over)

2	3	4
100,000,000.00	100,000,000.00	100,000,000.00
5	**6**	**7**
50,000,000.00		

Description 4460 Medical Serv Pa Recip-Vendor

RECEIVED
MAY 12 2017
State Comptroller
Obligations Section

ICP/CONTRACTOR WILL ADMINISTER THE DEPARTMENT'S INTEGRATED CARE PROGRAM SERVICES TO SENIORS, BLIND & DISABLED NON-MEDICARE ELIGIBLE MEDICARE BENEFICIARIES THRU THE FULL SPECTRUM OF MEDICAID COVERED SERVICES.
MULTI-YEAR CONTRACT - YEAR 2 OF 5
$O AMENDMENT #2 TO ADD NECESSARY CHANGES FOR FEDERAL REGULATION REQUIREMENTS AND/OR COMPLIANCE
Obligations to the state will cease immediately without penalty of further payment being require if, in any fiscal year, the Illinois GeneralAssembly or federal funding source fails to appropriate or otherwise make available sufficientfunds for this agreement.

Method of Compensation	Procurement Information	Travel Expense
(If Multiple Rates, Specify) 0.00 Per MR Rate Time	Award Code P Publication Date / / Reference Subcontractor Utilization (y/n) N Subcontractor Disclosure (y/n) N	YES ___ NO X Amount Advance Payment YES X NO ___

ADEFENBAUGH/CG 2175586720 05/11/17
Prepared By / Phone Number Date

HFS /Bureau of Managed Care
Contracting Agency/Division

FELICIA F NORWOOD 05/11/17
Authorized By Date

HFS /BUREAU OF FISCAL OPERATIONS
Filing Agency/Division

C-23.1(R-5-07)

STATE OF ILLINOIS

FY17

CONTRACT-OBLIGATION DOCUMENT

Agency No. 478

PLEASE TYPE

Fiscal Year	Transaction Code	Contract/Obligation No.	Transaction Date	Nine Digit Taxpayer ID. Number	Legal Status
2017	28 25	16M0000023	05/10/17	[redacted]1	06

Contract Action	Class Code	Governors Release No.	Vendors Name and Address
1. ___ New 2. _X_ Change	___ ___		N L MERGER SUB INC DBA NEXT LEVEL HEALTH PRTNRS 303 W MADISON STREET STE 1150 CHICAGO IL 60606

Appropriation Account Code	Obligation Amount
001-47865-4900-61-00	8,660,936.61

Multiple Year Contract	Maximum Contract Amount
From 12/31/15 MO/DAY/YR To 12/30/20 MO/DAY/YR	436,339,063.39
Current Fiscal Year of Contract	**Annual Contract Amount**
From 07/01/16 MO/DAY/YR To 06/30/17 MO/DAY/YR	86,339,063.39 Reimbursement Expenses Included

Multiple Year Contract Amounts Year 2-7(and over)

2	3	4
100,000,000.00	100,000,000.00	100,000,000.00
5	**6**	**7**
50,000,000.00		

Description 4460 Medical Serv Pa Recip-Vendor

RECEIVED
MAY 12 2017
State Comptroller
Obligations Section

ICP/CONTRACTOR WILL ADMINISTER THE DEPARTMENT'S INTEGRATED CARE PROGRAM SERVICES TO SENIORS, BLIND & DISABLED NON-MEDICARE ELIGIBLE MEDICARE BENEFICIARIES THRU THE FULL SPECTRUM OF MEDICAID COVERED SERVICES.
MULTI-YEAR CONTRACT - YEAR 2 OF 5
$O AMENDMENT #2 TO ADD NECESSARY CHANGES FOR FEDERAL REGULATION REQUIREMENTS AND/OR COMPLIANCE
Obligations to the state will cease immediately without penalty of further payment being require if, in any fiscal year, the Illinois GeneralAssembly or federal funding source fails to appropriate or otherwise make available sufficientfunds for this agreement.

Method of Compensation	Procurement Information	Travel Expense
(If Multiple Rates, Specify) 0.00 Per MR Rate Time	Award Code P Publication Date / / Reference Subcontractor Utilization (y/n) N Subcontractor Disclosure (y/n) N	YES___ NO_X_ Amount Advance Payment YES_X_ NO___

ADEFENBAUGH/CG 2175586720 05/11/17
Prepared By / Phone Number Date

HFS /Bureau of Managed Care
Contracting Agency/Division

FELICIA F NORWOOD 05/11/17
Authorized By Date

HFS /BUREAU OF FISCAL OPERATIONS
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C-23.1(R-8-07)

FY17

2 transactions
lot 2

STATE OF ILLINOIS

CONTRACT-OBLIGATION DOCUMENT

Agency No. 478

PLEASE TYPE

Fiscal Year	Transaction Code	Contract/Obligation No.	Transaction Date	Nine Digit Taxpayer ID. Number	Legal Status
2017	28 20	16M0000023	05/18/17	[redacted]	06

Contract Action	Class Code	Governors Release No.	Vendors Name and Address
1. ___ New 2. X Change	___ ___	POSTED 3	Nextlevel Health Partners Inc 303 W MADISON STREET STE 1150 CHICAGO IL 60606

Appropriation Account Code	Obligation Amount	Multiple Year Contract	Maximum Contract Amount
001-47865-4900-61-00	15,000,000.00		
346-47865-4400-00-00	0.00	From 12/31/15 MO/DAY/YR To 12/30/20 MO/DAY/YR	436,339,063.39
		Current Fiscal Year of Contract	Annual Contract Amount
		From 07/01/16 MO/DAY/YR To 06/30/17 MO/DAY/YR	86,339,063.39 Reimbursement Expenses Included

Multiple Year Contract Amounts Year 2-7(and over)

2	100,000,000.00	3	100,000,000.00	4	100,000,000.00
5	50,000,000.00	6		7	

Description 4460 Medical Serv Pa Recip-Vendor

RECEIVED
MAY 19 2017
State Comptroller
Obligations Section

ICP/CONTRACTOR WILL ADMINISTER THE DEPARTMENT'S INTEGRATED CARE PROGRAM SERVICES TO SENIORS, BLIND & DISABLED NON-MEDICARE ELIGIBLE MEDICARE BENEFICIARIES THRU THE FULL SPECTRUM OF MEDICAID COVERED SERVICES.
MULTI-YEAR CONTRACT - YEAR 2 OF 5
DECREASE LINE 2, INCREASE LINE 1 PER FINANCE AND BUDGET

Obligations to the state will cease immediately without penalty of further payment being require if, in any fiscal year, the Illinois GeneralAssembly or federal funding source fails to appropriate or otherwise make available sufficientfunds for this agreement.

Method of Compensation	Procurement Information	Travel Expense
(If Multiple Rates, Specify) 0.00 Rate Per MR Time	Award Code P Publication Date / / Reference Subcontractor Utilization (y/n) N Subcontractor Disclosure (y/n) N	YES ___ NO X Amount Advance Payment YES X NO ___

LATOYA CRAWFORD 217-524-7330 05/18/17
Prepared By / Phone Number Date

HFS /Bureau of Managed Care
Contracting Agency/Division

FELICIA F NORWOOD 05/18/17
Authorized By Date

HFS /BUREAU OF FISCAL OPERATIONS
Filing Agency/Division

C-23.1(R-6-07)

STATE OF ILLINOIS

CONTRACT-OBLIGATION DOCUMENT

FY17

2 of 2

Agency No. 478

PLEASE TYPE

Fiscal Year	Transaction Code	Contract/Obligation No.	Transaction Date	Nine Digit Taxpayer ID. Number	Legal Status
2017	28 25	16M0000023	05/18/17	[redacted]	06

Contract Action	Class Code	Governors Release No.	Vendors Name and Address
1. ___ New 2. X Change	___ ___		Nextlevel Health Partners Inc 303 W MADISON STREET STE 1150 CHICAGO IL 60606

Appropriation Account Code	Obligation Amount
793-47865-4900-00-00	15,000,000.00

Multiple Year Contract	Maximum Contract Amount
From 12/31/15 MO/DAY/YR To 12/30/20 MO/DAY/YR	436,339,063.39
Current Fiscal Year of Contract	**Annual Contract Amount**
From 07/01/16 MO/DAY/YR To 06/30/17 MO/DAY/YR	86,339,063.39 Reimbursement Expenses Included

Multiple Year Contract Amounts Year 2-7(and over)

2	3	4
100,000,000.00	100,000,000.00	100,000,000.00
5	**6**	**7**
50,000,000.00		

Description 4460 Medical Serv Pa Recip-Vendor

RECEIVED
MAY 19 2017
State Comptroller
Obligations Section

ICP/CONTRACTOR WILL ADMINISTER THE DEPARTMENT'S INTEGRATED CARE PROGRAM SERVICES TO SENIORS, BLIND & DISABLED NON-MEDICARE ELIGIBLE MEDICARE BENEFICIARIES THRU THE FULL SPECTRUM OF MEDICAID COVERED SERVICES.
MULTI-YEAR CONTRACT - YEAR 2 OF 5
DECREASE LINE 2, INCREASE LINE 1 PER FINANCE AND BUDGET

Obligations to the state will cease immediately without penalty of further payment being require if, in any fiscal year, the Illinois GeneralAssembly or federal funding source fails to appropriate or otherwise make available sufficientfunds for this agreement.

Method of Compensation	Procurement Information	Travel Expense
(If Multiple Rates, Specify) 0.00 Rate Per MR Time	Award Code P Publication Date / / Reference Subcontractor Utilization (y/n) N Subcontractor Disclosure (y/n) N	YES ___ NO X Amount Advance Payment YES X NO ___

LATOYA CRAWFORD 217-524-7330 05/18/17
Prepared By / Phone Number Date

HFS /Bureau of Managed Care
Contracting Agency/Division

FELICIA F NORWOOD 05/18/17
Authorized By Date

HFS /BUREAU OF FISCAL OPERATIONS
Filing Agency/Division

C-23.1(R-6-07)

STATE OF ILLINOIS

FY17

CONTRACT-OBLIGATION DOCUMENT

Agency No. 478

PLEASE TYPE

Fiscal Year	Transaction Code	Contract/Obligation No.	Transaction Date	Nine Digit Taxpayer ID. Number	Legal Status
2017	28 20	16M0000023	05/24/17	[redacted]	06

Contract Action	Class Code	Governors Release No.	Vendors Name and Address
1. ___ New 2. X Change	___ ___	POSTED 3	NEXTLEVEL HEALTH PARTNERS INC 303 W MADISON STREET STE 1150 CHICAGO IL 60606

Appropriation Account Code	Obligation Amount
001-47865-4900-61-00	0.00
346-47865-4400-00-00	0.00
793-47865-4900-00-00	0.00

Multiple Year Contract	Maximum Contract Amount
From 12/31/15 MO/DAY/YR To 12/30/20 MO/DAY/YR	442,464,063.39
Current Fiscal Year of Contract	**Annual Contract Amount**
From 07/01/16 MO/DAY/YR To 06/30/17 MO/DAY/YR	86,339,063.39 Reimbursement Expenses Included

Multiple Year Contract Amounts	Year 2-7(and over)		
2	3	4	
101,750,000.00	101,750,000.00	101,750,000.00	
5	6	7	
50,875,000.00			

Description 4460 Medical Serv Pa Recip-Vendor

RECEIVED
MAY 30 2017
State Comptroller
Obligations Section

ICP/CONTRACTOR WILL ADMINISTER THE DEPARTMENT'S INTEGRATED CARE PROGRAM SERVICES TO SENIORS, BLIND & DISABLED NON-MEDICARE ELIGIBLE MEDICARE BENEFICIARIES THRU THE FULL SPECTRUM OF MEDICAID COVERED SERVICES.
MULTI-YEAR CONTRACT - YEAR 2 OF 5
FILING AMENDMENT #4

Obligations to the state will cease immediately without penalty of further payment being require if, in any fiscal year, the Illinois GeneralAssembly or federal funding source fails to appropriate or otherwise make available sufficientfunds for this agreement.

Method of Compensation	Procurement Information	Travel Expense
(If Multiple Rates, Specify)	Award Code P	YES ___ NO X
0.00 Rate Per MR Time	Publication Date / /	Amount
	Reference	Advance Payment
	Subcontractor Utilization (y/n) N	YES X NO ___
	Subcontractor Disclosure (y/n) N	

LATOYA CRAWFORD 217-524-7330 05/25/17
Prepared By / Phone Number Date

HFS /Bureau of Managed Care
Contracting Agency/Division

FELICIA F NORWOOD 05/25/17
Authorized By Date

HFS /BUREAU OF FISCAL OPERATIONS
Filing Agency/Division

C-23.1(R-6-07)

Illinois Department of Healthcare and Family Services

CONTRACT APPROVAL DOCUMENT

Procurement Tracking # 2016-24-004-PBC5

The attached (select one) amendment with (Enter Contractor's Name below)

NEXTLEVEL HEALTH PARTNERS - ICP

in the amount of $ 1.5m FY17; $1.75m FY18; $1.75m FY19; $1.75m FY20 and $875,000.00 FY21. is approved.

Bureau Chief (or equivalent) signature — Date: 4-5-17

Michelle Maher

Bureau Chief (or equivalent) printed name

Division Administrator signature — Date: 4-12-17

Teresa T. Hussey

Division Administrator printed name

Deputy / Assistant Director signature — Date

Deputy / Assistant Director printed name

Division of Finance signature — Date: 04-21-17

Michael T. Casey

Division of Finance printed name

The amendment is subject to the CMS Procurement Business Case process. Yes ◉ No ○

All applicable approvals have been obtained by the Department. Yes ◉ No ○

If the amendment equals or exceeds $250,000 in a fiscal year, or the amendment or renewal results in a contract that equals or exceeds $250,000 in a fiscal year, the following signatures are needed:

Chief Legal Counsel signature — Date: 4/25/17

Chief Legal Counsel printed name

Chief Fiscal Officer signature — Date: 4-27-17

JACK DODDS

Chief Fiscal Officer printed name

F/T not used at this time

Illinois Department of Healthcare and Family Services

CONTRACT APPROVAL DOCUMENT

Procurement Tracking # 2016-24-004-PBC5

The attached (select one) amendment with (Enter Contractor's Name below)

NEXTLEVEL HEALTH PARTNERS - ICP

in the amount of $ 1.5mil FY17; $1.75mil FY18; $1.75mil FY19; $1.75mil FY20 and $875,000.00 FY21. is approved.

Michelle Maher — 4-5-17

Bureau Chief (or equivalent) signature — Date

Michelle Maher

Bureau Chief (or equivalent) printed name

Teresa T. Hursey — 4-12-17

Division Administrator signature — Date

Teresa T. Hursey

Division Administrator printed name

Deputy / Assistant Director signature — Date

Deputy / Assistant Director printed name

Michael R. Casey — 04-21-17

Division of Finance signature — Date

Michael R. Casey

Division of Finance printed name

The amendment is subject to the CMS Procurement Business Case process. Yes ◉ No ○

All applicable approvals have been obtained by the Department. Yes ◉ No ○

If the amendment equals or exceeds $250,000 in a fiscal year, or the amendment or renewal results in a contract that equals or exceeds $250,000 in a fiscal year, the following signatures are needed:

Chief Legal Counsel signature — Date

Chief Legal Counsel printed name

Chief Fiscal Officer signature — Date

Chief Fiscal Officer printed name

STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

and

NEXTLEVEL HEALTH PARTNERS, INC., AN ILLINOIS CORPORATION

AMENDMENT NO. 4 TO THE CONTRACT FOR FURNISHING HEALTH SERVICES IN AN INTEGRATED CARE PROGRAM BY A MANAGED CARE ORGANIZATION 2016-24-004-KA4 (NLHP)

WHEREAS, the Parties to the Contract for Furnishing Health Services in an Integrated Care Program by a Managed Care Organization ("Contract"), the **Illinois Department of Healthcare and Family Services**, 201 South Grand Avenue East, Springfield, Illinois 62763-0001 ("Department"), acting by and through its Director, and **NextLevel Health Partners, Inc.** ("Contractor"), desire to amend the Contract; and

WHEREAS, pursuant to Section 9.1.18, the Contract may be modified or amended by the mutual consent of the Parties; and

WHEREAS, the Contract has been previously amended;

NOW THEREFORE, the Parties agree to amend the Contract further as follows:

1. Attachment IV-A is deleted in its entirety and replaced with Attachment IV-B, which is attached hereto and hereby incorporated into this Amendment. As of the effective date of this Amendment, all references in the Contract to Attachment IV shall be interpreted as references to Attachment IV-B.

All other terms and conditions of the Contract shall remain in full force and effect.

IN WITNESS WHEREOF, the Parties have hereunto caused this agreement to amend the Contract to be executed by their duly authorized representatives, effective as of the date of last signature.

NEXTLEVEL HEALTH PARTNERS INC.

By: _____

Printed Name: KEITH WOLSKI

Title: CFO

Date: 3/23/17

FEIN: [redacted]

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

By: _____

Printed Name: Felicia F. Norwood

Title: Director

Date: _____

IN WITNESS WHEREOF, the Parties have hereunto caused this agreement to amend the Contract to be executed by their duly authorized representatives, effective as of the date of last signature.

NEXTLEVEL HEALTH PARTNERS INC.

By: _____

Printed Name: KEITH WOLSKI

Title: CFO

Date: 3/23/17

FEIN: [redacted]

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

By: _____

Printed Name: Felicia F. Norwood

Title: Director

Date: 5-1-17

Attachment IV-B
Rate Sheet

NEXTLEVEL HEALTH PARTNERS, INC.

Contracting Areas	Effective January 1, 2016: Region IV (Suburban Cook) Region VI (City of Chicago)
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 unless they voluntarily enroll in an MCO; • 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	See below

All capitation rates listed are 100% of actuarially certified rates, but only a percentage may be paid in accordance with Section 7.10.1.

Service Package 1 Rates effective January 1, 2016 through June 30, 2016:						
Rate Cell	Region I (N.W. Illinois) PMPM	Region II (Central Illinois) PMPM	Region III (Southern Illinois) PMPM	Region IV (Suburban Cook Co) PMPM	Region V (Collar Counties) PMPM	Region VI (City of Chicago) PMPM
Community Residents	$882.44	$879.05	$784.84	$1,035.00	$907.03	$1,035.00
HCBS DD Waiver	$652.22	$708.96	$615.88	$693.92	$658.00	$693.92
ICF/MR Other	$769.92	$786.39	$760.52	$919.75	$909.45	$919.75
Nursing Facility	$1,879.79	$1,936.00	$2,080.38	$1,901.59	$1,798.52	$1,901.59
HCBS Other Waivers	$1,727.53	$1,984.78	$1,677.27	$1,737.58	$1,647.05	$1,737.58
ICF/MR State Op Facility	$357.97	$357.97	$357.97	$367.97	$367.97	$367.97

Service Package 2 Rates effective January 1, 2016 through June 30, 2016:						
Rate Cell	Region I (N.W. Illinois) PMPM	Region II (Central Illinois) PMPM	Region III (Southern Illinois) PMPM	Region IV (Suburban Cook Co) PMPM	Region V (Collar Counties) PMPM	Region VI (City of Chicago)
Nursing Facility	NA	NA	NA	$2,587.28	NA	$2,587.28
HCBS Other Waivers	NA	NA	NA	$2,587.28	NA	$2,587.28

***Nursing Facility and HCBS Other Waiver LTSS rates are blended into one rate and will vary by health plan.**

Service Package 1 Rates effective July 1, 2016:						
Rate Cell	Region I (N.W. Illinois) PMPM	Region II (Central Illinois) PMPM	Region III (Southern Illinois) PMPM	Region IV (Suburban Cook Co) PMPM	Region V (Collar Counties) PMPM	Region VI (City of Chicago) PMPM
Community Residents	$918.88	$916.45	$819.07	$1,071.64	$937.46	$1,071.64
HCBS DD Waiver	$653.45	$710.30	$617.03	$696.29	$662.64	$696.29
ICF/MR Other	$770.86	$787.35	$761.45	$922.81	$912.49	$922.81
Nursing Facility	$1,881.75	$1,938.01	$2,082.55	$1,898.98	$1,780.13	$1,898.98
HCBS Other Waivers	$1,732.18	$1,994.19	$1,685.19	$1,747.29	$1,658.60	$1,747.29
ICF/MR State Op Facility	$357.97	$357.97	$357.97	$367.97	$367.97	$367.97

Service Package 2 Rates effective July 1, 2016:						
Rate Cell	Region I (N.W. Illinois) PMPM	Region II (Central Illinois) PMPM	Region III (Southern Illinois) PMPM	Region IV (Suburban Cook Co) PMPM	Region V (Collar Counties) PMPM	Region VI (City of Chicago)
Nursing Facility	NA	NA	NA	$2,278.27	NA	$2,278.27
HCBS Other Waivers	NA	NA	NA	$2,278.27	NA	$2,278.27

***Nursing Facility and HCBS Other Waiver LTSS rates are blended into one rate and will vary by health plan.**

Supplemental Capitation Payment for Hospital Services effective January 1, 2016 through September 30, 2016:						
Rate Cell	**Region I (N.W. Illinois) PMPM**	**Region II (Central Illinois) PMPM**	**Region III (Southern Illinois) PMPM**	**Region IV (Suburban Cook Co) PMPM**	**Region V (Collar Counties) PMPM**	**Region VI (City of Chicago)**
All rate cells except ICF/MR State Op Facility	$450.79	$483.02	$365.49	309.46	$309.46	309.46

Supplemental Capitation Payment for Hospital Services effective October 1, 2016:						
Rate Cell	**Region I (N.W. Illinois) PMPM**	**Region II (Central Illinois) PMPM**	**Region III (Southern Illinois) PMPM**	**Region IV (Suburban Cook Co) PMPM**	**Region V (Collar Counties) PMPM**	**Region VI (City of Chicago)**
All rate cells except ICF/MR State Op Facility	$308.78	$377.26	$303.58	$230.91	$331.85	$230.91

FY17

STATE OF ILLINOIS

CONTRACT-OBLIGATION DOCUMENT

2 Transactions

Agency No. 478

PLEASE TYPE

Fiscal Year	Transaction Code	Contract/Obligation No.	Transaction Date	Nine Digit Taxpayer ID. Number	Legal Status
2017	28 25	16M0000023	07/18/17	[redacted]	06

Contract Action	Class Code	Governors Release No.	Vendors Name and Address
1. ___ New 2. X Change	___ ___	POSTED 4	NEXTLEVEL HEALTH PARTNERS INC 303 W MADISON STREET STE 1150 CHICAGO IL 60606

Appropriation Account Code	Obligation Amount
001-47885-4900-81-00	14,013,929.81

Multiple Year Contract	Maximum Contract Amount
From 12/31/15 MO/DAY/YR To 12/30/20 MO/DAY/YR	442,464,063.39
Current Fiscal Year of Contract	**Annual Contract Amount**
From 07/01/16 MO/DAY/YR To 06/30/17 MO/DAY/YR	86,339,063.39 Reimbursement Expenses Included

Multiple Year Contract Amounts Year 2-7(and over)

2	3	4
101,750,000.00	101,750,000.00	101,750,000.00
5	**6**	**7**
50,875,000.00		

Description 4460 Medical Serv Pa Recip-Vendor

RECEIVED
JUL 20 2017
State Comptroller
Obligations Section

ICP/CONTRACTOR WILL ADMINISTER THE DEPARTMENT'S INTEGRATED CARE PROGRAM SERVICES TO SENIORS, BLIND & DISABLED NON-MEDICARE ELIGIBLE MEDICARE BENEFICIARIES THRU THE FULL SPECTRUM OF MEDICAID COVERED SERVICES.
MULTI-YEAR CONTRACT - YEAR 2 OF 5
DECREASE LINE 1 AND CREATE LINE 5 PER FINANCE/BUDGET

Obligations to the state will cease immediately without penalty of further payment being require if, in any fiscal year, the Illinois GeneralAssembly or federal funding source fails to appropriate or otherwise make available sufficientfunds for this agreement.

Method of Compensation	Procurement Information	Travel Expense
0.00 Rate Per MR Time (If Multiple Rates, Specify)	Award Code P Publication Date / / Reference Subcontractor Utilization (y/n) N Subcontractor Disclosure (y/n) N	YES ___ NO X Amount Advance Payment YES X NO ___

LATOYA CRAWFORD 217-524-7330 07/19/17
Prepared By / Phone Number Date

HFS /Bureau of Managed Care
Contracting Agency/Division

FELICIA F NORWOOD 07/19/17
Authorized By Date

HFS /BUREAU OF FISCAL OPERATIONS
Filing Agency/Division

C-23.1(R-6-07)

FY17

STATE OF ILLINOIS

CONTRACT-OBLIGATION DOCUMENT

Agency No. 478

PLEASE TYPE

Fiscal Year	Transaction Code	Contract/Obligation No.	Transaction Date	Nine Digit Taxpayer ID. Number	Legal Status
2017	28 20	16M0000023	07/18/17	[redacted]	06

Contract Action	Class Code	Governors Release No.
1. ___ New 2. X Change	___ ___	POSTED 4

Vendors Name and Address

NEXTLEVEL HEALTH PARTNERS INC
303 W MADISON STREET STE 1150
CHICAGO IL 60606

Appropriation Account Code	Obligation Amount
346-47865-4400-00-00	0.00
793-47865-4900-00-00	0.00
728-47865-4900-20-00	14,013,929.81

Multiple Year Contract — From 12/31/15 (MO/DAY/YR) To 12/30/20 (MO/DAY/YR)

Maximum Contract Amount: 442,464,063.39

Current Fiscal Year of Contract — From 07/01/16 (MO/DAY/YR) To 06/30/17 (MO/DAY/YR)

Annual Contract Amount: 86,339,063.39 Reimbursement Expenses Included

Multiple Year Contract Amounts Year 2-7(and over)

2	3	4
101,750,000.00	101,750,000.00	101,750,000.00
5	**6**	**7**
50,875,000.00		

Description 4460 Medical Serv Pa Recip-Vendor

RECEIVED
JUL 20 2017
State Comptroller
Obligations Section

ICP/CONTRACTOR WILL ADMINISTER THE DEPARTMENT'S INTEGRATED CARE PROGRAM SERVICES TO SENIORS, BLIND & DISABLED NON-MEDICARE ELIGIBLE MEDICARE BENEFICIARIES THRU THE FULL SPECTRUM OF MEDICAID COVERED SERVICES.
MULTI-YEAR CONTRACT - YEAR 2 OF 5
DECREASE LINE 1 AND CREATE LINE 5 PER FINANCE/BUDGET

Obligations to the state will cease immediately without penalty of further payment being require if, in any fiscal year, the Illinois GeneralAssembly or federal funding source fails to appropriate or otherwise make available sufficientfunds for this agreement.

Method of Compensation	Procurement Information	Travel Expense
0.00 Rate Per MR Time (If Multiple Rates, Specify)	Award Code P Publication Date / / Reference Subcontractor Utilization (y/n) N Subcontractor Disclosure (y/n) N	YES ___ NO X Amount Advance Payment YES X NO ___

LATOYA CRAWFORD 217-524-7330 07/19/17
Prepared By / Phone Number Date

HFS /Bureau of Managed Care
Contracting Agency/Division

FELICIA F NORWOOD 07/19/17
Authorized By Date

HFS /BUREAU OF FISCAL OPERATIONS
Filing Agency/Division

C-23.1(R-6-07)

FY18

STATE OF ILLINOIS

CONTRACT-OBLIGATION DOCUMENT

Agency No. 478

PLEASE TYPE

Fiscal Year	Transaction Code	Contract/Obligation No.	Transaction Date	Nine Digit Taxpayer ID. Number	Legal Status
2018	28 10	16M0000023	06/19/17	[redacted]	08

Contract Action	Class Code	Governors Release No.	Vendors Name and Address
1. X New 2. ___ Change	25 K	POSTED 3	NEXTLEVEL HEALTH PARTNERS INC 303 W MADISON STREET STE 1150 CHICAGO IL 60606

Appropriation Account Code	Obligation Amount
001-47865-4900-70-00	35,000,000.00
346-47865-4400-00-00	10,000,000.00
793-47865-4900-00-00	10,000,000.00

Multiple Year Contract: From 12/31/15 (MO/DAY/YR) To 12/30/20 (MO/DAY/YR)

Maximum Contract Amount: 309,375,000.00

Current Fiscal Year of Contract: From 07/01/17 (MO/DAY/YR) To 12/31/17 (MO/DAY/YR)

Annual Contract Amount: 55,000,000.00 Reimbursement Expenses Included

Multiple Year Contract Amounts Year 2-7(and over)

2	3	4
101,750,000.00	101,750,000.00	50,875,000.00
5	6	7

Description 4460 Medical Serv Pa Recip-Vendor

RECEIVED
JUL 20 2017
State Comptroller
Obligations Section

ICP/CONTRACTOR WILL ADMINISTER THE DEPARTMENT'S INTEGRATED CARE PROGRAM SERVICES TO SENIORS, BLIND & DISABLED NON-MEDICARE ELIGIBLE MEDICARE BENEFICIARIES THRU THE FULL SPECTRUM OF MEDICAID COVERED SERVICES.
MULTI-YEAR CONTRACT - YEAR 3 OF 6
FILING FY18 PORTION

Obligations to the state will cease immediately without penalty of further payment being require if, in any fiscal year, the Illinois GeneralAssembly or federal funding source fails to appropriate or otherwise make available sufficientfunds for this agreement.

Method of Compensation	Procurement Information	Travel Expense
0.00 Per MR Rate Time (If Multiple Rates, Specify)	Award Code P Publication Date / / Reference Subcontractor Utilization (y/n) N Subcontractor Disclosure (y/n) N	YES ___ NO X Amount Advance Payment YES X NO ___

LATOYA CRAWFORD 217-524-7330 07/17/17
Prepared By / Phone Number Date

HFS /Bureau of Managed Care
Contracting Agency/Division

FELICIA F NORWOOD 07/17/17
Authorized By Date

HFS /BUREAU OF FISCAL OPERATIONS
Filing Agency/Division

C-23.1(R-8-07)

STATE OF ILLINOIS

CONTRACT-OBLIGATION DOCUMENT

FY18

Agency No. 478

PLEASE TYPE

Fiscal Year	Transaction Code	Contract/Obligation No.	Transaction Date	Nine Digit Taxpayer ID. Number	Legal Status
2018	28 20	16M0000023	10/17/17	[redacted]	06

Contract Action	Class Code	Governors Release No.	Vendors Name and Address
1. ___ New 2. X Change	___ ___	POSTED 3	NEXTLEVEL HEALTH PARTNERS INC 303 W MADISON STREET STE 1150 CHICAGO IL 60606

Appropriation Account Code	Obligation Amount
001-47865-4900-70-00	0.00
346-47865-4400-00-00	0.00
793-47865-4900-00-00	0.00

Multiple Year Contract: From 12/31/15 MO/DAY/YR To 12/30/20 MO/DAY/YR

Maximum Contract Amount: 309,375,000.00

Current Fiscal Year of Contract: From 07/01/17 MO/DAY/YR To 12/31/17 MO/DAY/YR

Annual Contract Amount: 55,000,000.00 Reimbursement Expenses Included

Multiple Year Contract Amounts Year 2-7(and over)

2	3	4
101,750,000.00	101,750,000.00	50,875,000.00
5	**6**	**7**

Description 4460 Medical Serv Pa Recip-Vendor

RECEIVED
NOV 02 2017
State Comptroller
Obligations Section

ICP/CONTRACTOR WILL ADMINISTER THE DEPARTMENT'S INTEGRATED CARE PROGRAM SERVICES TO SENIORS, BLIND & DISABLED NON-MEDICARE ELIGIBLE MEDICARE BENEFICIARIES THRU THE FULL SPECTRUM OF MEDICAID COVERED SERVICES.
MULTI-YEAR CONTRACT - YEAR 3 OF 6
TO FILE AMENDMENT #7

Obligations to the state will cease immediately without penalty of further payment being require if, in any fiscal year, the Illinois GeneralAssembly or federal funding source fails to appropriate or otherwise make available sufficientfunds for this agreement.

Method of Compensation	Procurement Information	Travel Expense
(If Multiple Rates, Specify) 0.00 Rate Per MR Time	Award Code P Publication Date / / Reference Subcontractor Utilization (y/n) N Subcontractor Disclosure (y/n) N	YES ___ NO X Amount Advance Payment YES X NO ___

LATOYA CRAWFORD 217-524-7330 10/19/17
Prepared By / Phone Number Date

HFS /Bureau of Managed Care
Contracting Agency/Division

FELICIA F NORWOOD 10/19/17
Authorized By Date

HFS /BUREAU OF FISCAL OPERATIONS
Filing Agency/Division

C-23.1(R-6-07)

RECEIVED

OCT 19 2017

EXPENDITURE ACCOUNTING

Illinois Department of Healthcare and Family Services

CONTRACT APPROVAL DOCUMENT

Procurement Tracking # 2016-24-004-DM3 KA5

The attached (select one) amendment with (Enter Contractor's Name below)

NextLevel Health Partners - ICP

in the amount of $ 0 for FY'2018 is approved.

Michelle Maher RM 10/4/17 JS — 10-4-17

Bureau Chief (or equivalent) signature — Date

Michelle Maher

Bureau Chief (or equivalent) printed name

[signature] — 10-7-17

Division Administrator signature — Date

Teresa T. Hursey

Division Administrator printed name

Deputy / Assistant Director signature — Date

Deputy / Assistant Director printed name

Michael Casey — 10-06-17

Division of Finance signature — Date

Michael Casey

Division of Finance printed name

The amendment is subject to the CMS Procurement Business Case process. Yes ○ No ◉

All applicable approvals have been obtained by the Department. Yes ◉ No ○

If the amendment equals or exceeds $250,000 in a fiscal year, or the amendment or renewal results in a contract that equals or exceeds $250,000 in a fiscal year, the following signatures are needed:

Chief Legal Counsel signature — Date

N/A

Chief Legal Counsel printed name

Chief Fiscal Officer signature — Date

N/A

Chief Fiscal Officer printed name

STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

and

NEXTLEVEL HEALTH PARTNERS, INC., AN ILLINOIS CORPORATION

AMENDMENT NO. 7 TO THE
CONTRACT FOR FURNISHING HEALTH SERVICES
IN AN INTEGRATED CARE PROGRAM BY A
MANAGED CARE ORGANIZATION
2016-24-004-KA7 (NLHP)

WHEREAS, the Parties to the Contract for Furnishing Health Services in an Integrated Care Program by a Managed Care Organization ("Contract"), the Illinois Department of Healthcare and Family Services, 201 South Grand Avenue East, Springfield, Illinois 62763-0001 ("Department"), acting by and through its Director, and NextLevel Health Partners, Inc. ("Contractor"), desire to amend the Contract; and

WHEREAS, pursuant to Section 9.1.18, the Contract may be modified or amended by the mutual consent of the Parties; and

WHEREAS, the Contract has been previously amended;

NOW THEREFORE, the Parties agree to amend the Contract further as follows:

1. Section 6.2 is amended by adding new Section 6.2.1, to read as follows:

   6.2.1 Funding for Dialysis Centers
   In order to comply with Illinois Public Act 100-0023, for dates of service for the period of July 1, 2015 through August 4, 2017, the Illinois Department of Healthcare and Family Services will directly pay hospital and freestanding chronic dialysis centers an additional payment of $60.00 per treatment day for outpatient renal dialysis treatments or home dialysis treatments.

All other terms and conditions of the Contract shall remain in full force and effect.

IN WITNESS WHEREOF, the Parties have hereunto caused this agreement to amend the Contract to be executed by their duly authorized representatives, effective as of the date of last signature.

NEXTLEVEL HEALTH PARTNERS INC.	**DEPARTMENT OF HEALTHCARE & FAMILY SERVICES**
By:	By:
Printed Name: CHERYL R. WHITAKER	Printed Name: Felicia F. Norwood
Title: CEO	Title: Director
Date: 9/27/2017	Date: 10-11-17
FEIN: [redacted]	

2 transactions

STATE OF ILLINOIS

CONTRACT-OBLIGATION DOCUMENT

FY18

1 of 2

Agency No. 478

PLEASE TYPE

Fiscal Year	Transaction Code	Contract/Obligation No.	Transaction Date	Nine Digit Taxpayer ID. Number	Legal Status
2018	28 20	16M0000023	11/03/17	[redacted]	06

Contract Action	Class Code	Governors Release No.	Vendors Name and Address
1. ___ New 2. X Change		POSTED 3	NEXTLEVEL HEALTH PARTNERS INC 303 W MADISON STREET STE 1150 CHICAGO IL 60606

Appropriation Account Code	Obligation Amount
001-47865-4900-70-00	6,000,000.00
346-47865-4400-00-00	0.00

Multiple Year Contract	Maximum Contract Amount
From 12/31/15 MO/DAY/YR To 12/30/20 MO/DAY/YR	309,375,000.00
Current Fiscal Year of Contract	**Annual Contract Amount**
From 07/01/17 MO/DAY/YR To 12/31/17 MO/DAY/YR	55,000,000.00 Reimbursement Expenses Included

Multiple Year Contract Amounts Year 2-7(and over)

2	3	4
101,750,000.00	101,750,000.00	50,875,000.00
5	**6**	**7**

Description 4460 Medical Serv Pa Recip-Vendor

RECEIVED
NOV 13 2017
State Comptroller
Obligations Section

ICP/CONTRACTOR WILL ADMINISTER THE DEPARTMENT'S INTEGRATED CARE PROGRAM SERVICES TO SENIORS, BLIND & DISABLED NON-MEDICARE ELIGIBLE MEDICARE BENEFICIARIES THRU THE FULL SPECTRUM OF MEDICAID COVERED SERVICES.
MULTI-YEAR CONTRACT - YEAR 3 OF 6
TO INCREASE LINE 1 AND DECREASE LINE 2 PER FINANCE/BUDGET

Obligations to the state will cease immediately without penalty of further payment being require if, in any fiscal year, the Illinois GeneralAssembly or federal funding source fails to appropriate or otherwise make available sufficientfunds for this agreement.

Method of Compensation	Procurement Information	Travel Expense
(If Multiple Rates, Specify) 0.00 Rate Per MR Time	Award Code P Publication Date / / Reference Subcontractor Utilization (y/n) N Subcontractor Disclosure (y/n) N	YES ___ NO X Amount Advance Payment YES X NO ___

LATOYA CRAWFORD 217-524-7330 11/08/17
Prepared By / Phone Number Date

HFS /Bureau of Managed Care
Contracting Agency/Division

FELICIA F NORWOOD 11/08/17
Authorized By Date

HFS /BUREAU OF FISCAL OPERATIONS
Filing Agency/Division

C-23.1(R-G-07)

2 transactions

STATE OF ILLINOIS

CONTRACT-OBLIGATION DOCUMENT

FY18

2 of 2

Agency No. 478

PLEASE TYPE

Fiscal Year	Transaction Code	Contract/Obligation No.	Transaction Date	Nine Digit Taxpayer ID. Number	Legal Status
2018	28 25	16M0000023	11/03/17	[redacted]	06

Contract Action	Class Code	Governors Release No.	Vendors Name and Address
1. ___ New 2. X Change	___ ___		NEXTLEVEL HEALTH PARTNERS INC 303 W MADISON STREET STE 1150 CHICAGO IL 60606

Appropriation Account Code	Obligation Amount
793-47865-4900-00-00	6,000,000.00

Multiple Year Contract	Maximum Contract Amount
From 12/31/15 MO/DAY/YR To 12/30/20 MO/DAY/YR	309,375,000.00
Current Fiscal Year of Contract	**Annual Contract Amount**
From 07/01/17 MO/DAY/YR To 12/31/17 MO/DAY/YR	55,000,000.00 Reimbursement Expenses Included

Multiple Year Contract Amounts Year 2-7(and over)

2	3	4
101,750,000.00	101,750,000.00	50,875,000.00
5	**6**	**7**

Description 4460 Medical Serv Pa Recip-Vendor

ICP/CONTRACTOR WILL ADMINISTER THE DEPARTMENT'S INTEGRATED CARE PROGRAM SERVICES TO SENIORS, BLIND & DISABLED NON-MEDICARE ELIGIBLE MEDICARE BENEFICIARIES THRU THE FULL SPECTRUM OF MEDICAID COVERED SERVICES.
MULTI-YEAR CONTRACT - YEAR 3 OF 6
TO INCREASE LINE 1 AND DECREASE LINE 2 PER FINANCE/BUDGET

RECEIVED
NOV 13 2017
State Comptroller
Obligations Section

Obligations to the state will cease immediately without penalty of further payment being require if, in any fiscal year, the Illinois GeneralAssembly or federal funding source fails to appropriate or otherwise make available sufficientfunds for this agreement.

Method of Compensation	Procurement Information	Travel Expense
(If Multiple Rates, Specify) 0.00 Rate Per MR Time	Award Code P Publication Date / / Reference Subcontractor Utilization (y/n) N Subcontractor Disclosure (y/n) N	YES ___ NO X Amount Advance Payment YES X NO ___

LATOYA CRAWFORD 217-524-7330 11/08/17
Prepared By / Phone Number Date

HFS /Bureau of Managed Care
Contracting Agency/Division

FELICIA F NORWOOD 11/08/17
Authorized By Date

HFS /BUREAU OF FISCAL OPERATIONS
Filing Agency/Division

C-23.1(R-6-07)

STATE OF ILLINOIS

CONTRACT-OBLIGATION DOCUMENT FY18

Agency No. 478

PLEASE TYPE

Fiscal Year	Transaction Code	Contract/Obligation No.	Transaction Date	Nine Digit Taxpayer ID. Number	Legal Status
2018	28 20	16M0000023	11/13/17	[redacted]	08

Contract Action	Class Code	Governors Release No.	Vendors Name and Address
1. ___ New 2. X Change	POSTED 3		NEXTLEVEL HEALTH PARTNERS INC 303 W MADISON STREET STE 1150 CHICAGO IL 60606

Appropriation Account Code	Obligation Amount
001-47865-4900-70-00	48,851.00
346-47865-4400-00-00	0.00
793-47865-4900-00-00	0.00

Multiple Year Contract: From 12/31/15 (MO/DAY/YR) To 12/30/20 (MO/DAY/YR)

Maximum Contract Amount: 309,501,089.00

Current Fiscal Year of Contract: From 07/01/17 (MO/DAY/YR) To 12/31/17 (MO/DAY/YR)

Annual Contract Amount: 55,046,851.00 Reimbursement Expenses Included

Multiple Year Contract Amounts Year 2-7(and over)

2	3	4
101,781,695.00	101,781,695.00	50,890,848.00
5	**6**	**7**

Description 4460 Medical Serv Pa Recip-Vendor

RECEIVED
NOV 17 2017
State Comptroller
Obligations Section

ICP/CONTRACTOR WILL ADMINISTER THE DEPARTMENT'S INTEGRATED CARE PROGRAM SERVICES TO SENIORS, BLIND & DISABLED NON-MEDICARE ELIGIBLE MEDICARE BENEFICIARIES THRU THE FULL SPECTRUM OF MEDICAID COVERED SERVICES.
MULTI-YEAR CONTRACT - YEAR 3 OF 6
TO FILE AMENDMENT #6

Obligations to the state will cease immediately without penalty of further payment being require if, in any fiscal year, the Illinois GeneralAssembly or federal funding source fails to appropriate or otherwise make available sufficientfunds for this agreement.

Method of Compensation	Procurement Information	Travel Expense
(If Multiple Rates, Specify) 0.00 Rate Per MR Time	Award Code P Publication Date / / Reference Subcontractor Utilization (y/n) N Subcontractor Disclosure (y/n) N	YES ___ NO X Amount Advance Payment YES X NO ___

LATOYA CRAWFORD 217-524-7330 11/16/17
Prepared By / Phone Number Date

HFS /Bureau of Managed Care
Contracting Agency/Division

FELICIA F NORWOOD 11/16/17
Authorized By Date

HFS /BUREAU OF FISCAL OPERATIONS
Filing Agency/Division

C-23.1(R-6-07)

Illinois Department of Healthcare and Family Services

CONTRACT APPROVAL DOCUMENT

Procurement Tracking # 2016-24-004-PBC7 KA6

The attached (select one) amendment with (Enter Contractor's Name below)

NextLevel Health Partners - ICP

in the amount of $ 126,089.00 for FY'2018-2021 is approved.

Michelle Maher 10/25/17 — 10-24-17

Bureau Chief (or equivalent) signature — Date

Michelle Maher

Bureau Chief (or equivalent) printed name

Teresa T. Hursey — 10-26-17

Division Administrator signature — Date

Teresa T. Hursey

Division Administrator printed name

Deputy / Assistant Director signature — Date

Deputy / Assistant Director printed name

Michael P Casey Dum — 31 Oct 17

Division of Finance signature — Date

Michael Casey

Division of Finance printed name

RECEIVED
NOV 15 2017
EXPENDITURE ACCOUNTING

The amendment is subject to the CMS Procurement Business Case process. Yes ○ No ◉

All applicable approvals have been obtained by the Department. Yes ◉ No ○

If the amendment equals or exceeds $250,000 in a fiscal year, or the amendment or renewal results in a contract that equals or exceeds $250,000 in a fiscal year, the following signatures are needed:

Chief Legal Counsel signature — Date

N/A

Chief Legal Counsel printed name

Chief Fiscal Officer signature — Date

N/A

Chief Fiscal Officer printed name

STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

and

NEXTLEVEL HEALTH PARTNERS, INC., AN ILLINOIS CORPORATION

AMENDMENT NO. 6 TO THE CONTRACT FOR FURNISHING HEALTH SERVICES IN AN INTEGRATED CARE PROGRAM BY A MANAGED CARE ORGANIZATION 2016-24-004-KA6 (NLHP)

WHEREAS, the Parties to the Contract for Furnishing Health Services in an Integrated Care Program by a Managed Care Organization ("Contract"), the **Illinois Department of Healthcare and Family Services**, 201 South Grand Avenue East, Springfield, Illinois 62763-0001 ("Department"), acting by and through its Director, and **NextLevel Health Partners, Inc.** ("Contractor"), desire to amend the Contract; and

WHEREAS, pursuant to Section 9.1.18, the Contract may be modified or amended by the mutual consent of the Parties; and

WHEREAS, the Contract has been previously amended;

NOW THEREFORE, the Parties agree to amend the Contract further as follows:

1. Section 5.1 is amended by adding new Section 5.1.8, to read as follows:

   5.1.8 Institution for Mental Diseases in lieu of Covered Services. Contractor may provide psychiatric and substance use disorder inpatient services in an Institution for Mental Diseases (IMD) that are medically appropriate and cost effective in lieu of the Covered Services under the State Plan to Enrollees between the ages of twenty-one (21) and sixty-four (64) who have inpatient stays in an IMD of no more than fifteen (15) days in a calendar month. Contractor shall not require an Enrollee to use such in lieu of services. The Department represents that Capitation rates paid hereunder for IMD in lieu of services are actuarially sound and based on covered services under the State Plan. Eligibility and length of stay will be determined by IMD admissions status on the first day of every calendar month. This section 5.1.8 is applicable only to those periods beginning on or after January 1, 2017.

2. Section 7.1 is amended by adding new Section 7.1.2 and new Section 7.1.3, to read as follows:

   7.1.2 The Department shall pay Contractor a monthly Capitation payment for an Enrollee receiving inpatient treatment in an Institution for Mental Diseases provided all requirements of 42 CFR §438.6(e) are met. This section 7.1.2 is applicable only to those periods beginning on or after January 1, 2017.

7.1.3 The Department shall pay Contractor a separate, State-funded-only monthly Capitation payment for an Enrollee who is residing in an Institution for Mental Diseases on the first day of the month. The monthly Capitation is shown as "State Only IMD" rate cell in Attachment IV. This section 7.1.3 is applicable only to those periods beginning on or after January 1, 2017.

3. Attachment IV-C is deleted in its entirety and replaced with Attachment IV-D, which is attached hereto and hereby incorporated into this Amendment. As of the effective date of this Amendment, all references in the Contract to Attachment IV shall be interpreted as references to Attachment IV-D.

All other terms and conditions of the Contract shall remain in full force and effect.

IN WITNESS WHEREOF, the Parties have hereunto caused this agreement to amend the Contract to be executed by their duly authorized representatives, effective as of the date of last signature.

NEXTLEVEL HEALTH PARTNERS INC.

By: _____

Printed Name: CHERYL R. WHITAKER

Title: CEO

Date: 10/3/17

FEIN: [redacted]

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

By: _____

Printed Name: Felicia F. Norwood

Title: Director

Date: _____

7.1.3 The Department shall pay Contractor a separate, State-funded-only monthly Capitation payment for an Enrollee who is residing in an Institution for Mental Diseases on the first day of the month. The monthly Capitation is shown as 'State Only IMD' rate cell in Attachment IV. This section 7.1.3 is applicable only to those periods beginning on or after January 1, 2017.

3. Attachment IV-C is deleted in its entirety and replaced with Attachment IV-D, which is attached hereto and hereby incorporated into this Amendment. As of the effective date of this Amendment, all references in the Contract to Attachment IV shall be interpreted as references to Attachment IV-D.

All other terms and conditions of the Contract shall remain in full force and effect.

IN WITNESS WHEREOF, the Parties have hereunto caused this agreement to amend the Contract to be executed by their duly authorized representatives, effective as of the date of last signature.

NEXTLEVEL HEALTH PARTNERS INC.

By: _____

Printed Name: CHERYL R. WINAKER

Title: CEO

Date: 10/3/17

FEIN: [redacted]

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

By: _____

Printed Name: Felicia F. Norwood

Title: Director

Date: 11-9-17

RECEIVED
NOV 15 2017
EXPENDITURE ACCOUNTING

Attachment IV-D
Rate Sheet

NEXTLEVEL HEALTH PARTNERS, INC.

Contracting Areas	Effective January 1, 2016: Region IV (Suburban Cook) Region VI (City of Chicago)
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 unless they voluntarily enroll in an MCO; • 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	See below

All capitation rates listed are 100% of actuarially certified rates, but only a percentage may be paid in accordance with Section 7.10.1.

Service Package 1 Rates effective January 1, 2016 through June 30, 2016:						
Rate Cell	Region I (N.W. Illinois) PMPM	Region II (Central Illinois) PMPM	Region III (Southern Illinois) PMPM	Region IV (Suburban Cook Co) PMPM	Region V (Collar Counties) PMPM	Region VI (City of Chicago) PMPM
Community Residents	$882.44	$879.05	$784.84	$1,035.00	$907.03	$1,035.00
HCBS DD Waiver	$652.22	$708.96	$615.88	$693.92	$658.00	$693.92
ICF/MR Other	$769.92	$786.39	$760.52	$919.75	$909.45	$919.75
Nursing Facility	$1,879.79	$1,936.00	$2,080.38	$1,901.59	$1,798.52	$1,901.59
HCBS Other Waivers	$1,727.53	$1,984.78	$1,677.27	$1,737.58	$1,647.05	$1,737.58
ICF/MR State Op Facility	$357.97	$357.97	$357.97	$367.97	$367.97	$367.97

Initial Statewide Service Package 2 Rates effective January 1, 2016 through June 30, 2016:						
Rate Cell	Region I (N.W. Illinois) PMPM	Region II (Central Illinois) PMPM	Region III (Southern Illinois) PMPM	Region IV (Suburban Cook Co) PMPM	Region V (Collar Counties) PMPM	Region VI (City of Chicago)
Nursing Facility	NA	NA	NA	$2,587.28	NA	$2,587.28
HCBS Other Waivers	NA	NA	NA	$2,587.28	NA	$2,587.28

***Nursing Facility and HCBS Other Waiver LTSS rates are blended into one rate and will vary by health plan.**

Service Package 1 Rates effective July 1, 2016 – December 31, 2016:						
Rate Cell	Region I (N.W. Illinois) PMPM	Region II (Central Illinois) PMPM	Region III (Southern Illinois) PMPM	Region IV (Suburban Cook Co) PMPM	Region V (Collar Counties) PMPM	Region VI (City of Chicago) PMPM
Community Residents	$918.88	$916.45	$819.07	$1,071.64	$937.46	$1,071.64
HCBS DD Waiver	$653.45	$710.30	$617.03	$696.29	$662.64	$696.29
ICF/MR Other	$770.86	$787.35	$761.45	$922.81	$912.49	$922.81
Nursing Facility	$1,881.75	$1,938.01	$2,082.55	$1,898.98	$1,780.13	$1,898.98
HCBS Other Waivers	$1,732.18	$1,994.19	$1,685.19	$1,747.29	$1,658.60	$1,747.29
ICF/MR State Op Facility	$357.97	$357.97	$357.97	$367.97	$367.97	$367.97

Initial Statewide Service Package 2 Rates effective July 1, 2016 – December 31, 2016:						
Rate Cell	Region I (N.W. Illinois) PMPM	Region II (Central Illinois) PMPM	Region III (Southern Illinois) PMPM	Region IV (Suburban Cook Co) PMPM	Region V (Collar Counties) PMPM	Region VI (City of Chicago)
Nursing Facility	NA	NA	NA	$2,278.27	NA	$2,278.27
HCBS Other Waivers	NA	NA	NA	$2,278.27	NA	$2,278.27

***Nursing Facility and HCBS Other Waiver LTSS rates are blended into one rate and will vary by health plan.**

NextLevel Final Service Package 2 Rates effective January 1, 2016 – December 31, 2016:						
Rate Cell	Region I (N.W. Illinois) PMPM	Region II (Central Illinois) PMPM	Region III (Southern Illinois) PMPM	Region IV (Suburban Cook Co) PMPM	Region V (Collar Counties) PMPM	Region VI (City of Chicago)
Nursing Facility	NA	NA	NA	$2,587.28	NA	$2,587.28
HCBS Other Waivers	NA	NA	NA	$2,587.28	NA	$2,587.28

Service Package 1 Rates effective January 1, 2017:						
Rate Cell	Region I (N.W. Illinois) PMPM	Region II (Central Illinois) PMPM	Region III (Southern Illinois) PMPM	Region IV (Suburban Cook Co) PMPM	Region V (Collar Counties) PMPM	Region VI (City of Chicago) PMPM
Community Residents	$982.77	$868.62	$799.22	$1,068.52	$994.36	$1,068.52
HCBS DD Waiver	$693.37	$751.15	$638.68	$742.71	$716.68	$742.71
ICF/MR Other	$775.35	$751.40	$707.12	$1,108.23	$999.34	$1,108.23
Nursing Facility	$1,882.42	$2,282.46	$1,990.94	$2,358.08	$1,989.28	$2,358.08
HCBS Other Waivers	$1,901.28	$2,049.35	$1,602.34	$2,130.74	$2,070.32	$2,130.74
ICF/MR State Op Facility	$255.89	$255.10	$254.03	$290.05	$271.17	$290.05

Initial Statewide Service Package 2 Rates effective January 1, 2017:						
Rate Cell	Region I (N.W. Illinois) PMPM	Region II (Central Illinois) PMPM	Region III (Southern Illinois) PMPM	Region IV (Suburban Cook Co) PMPM	Region V (Collar Counties) PMPM	Region VI (City of Chicago)
Nursing Facility	$1,792.01	$1,817.47	$1,666.28	$2,341.05	$2,099.13	$2,341.05
HCBS Other Waivers	$1,792.01	$1,817.47	$1,666.28	$2,341.05	$2,099.13	$2,341.05

***Nursing Facility and HCBS Other Waiver LTSS rates are blended into one rate and will vary by health plan.**

Supplemental Capitation Payment for Hospital Services effective January 1, 2016 through September 30, 2016:						
Rate Cell	**Region I (N.W. Illinois) PMPM**	**Region II (Central Illinois) PMPM**	**Region III (Southern Illinois) PMPM**	**Region IV (Suburban Cook Co) PMPM**	**Region V (Collar Counties) PMPM**	**Region VI (City of Chicago)**
All rate cells except ICF/MR State Op Facility	$450.79	$483.02	$365.49	309.46	$309.46	309.46

Supplemental Capitation Payment for Hospital Services effective October 1, 2016:						
Rate Cell	**Region I (N.W. Illinois) PMPM**	**Region II (Central Illinois) PMPM**	**Region III (Southern Illinois) PMPM**	**Region IV (Suburban Cook Co) PMPM**	**Region V (Collar Counties) PMPM**	**Region VI (City of Chicago)**
All rate cells except ICF/MR State Op Facility	$308.78	$377.26	$303.58	$230.91	$331.85	$230.91

State Only IMD Rates January 1, 2017 through December 31, 2017						
Rate Cell	**Region I (N.W. Illinois) PMPM**	**Region II (Central Illinois) PMPM**	**Region III (Southern Illinois) PMPM**	**Region IV (Suburban Cook Co) PMPM**	**Region V (Collar Counties) PMPM**	**Region VI (City of Chicago)**
State IMD only	$3,832.21	$4,348.90	$3,968.65	$4,714.39	$5,509.16	$4,714.39

STATE OF ILLINOIS

CONTRACT - OBLIGATION DOCUMENT

Agency No. 478

PLEASE TYPE

Fiscal Year	Transaction Code	Contract/ Obligation No	Transaction Date	Nine Digit Taxpayer ID Number	Legal Status
2018	28 20	16M0000023	12/20/2017	[redacted]	06

Contract Action	Class Code	Governor's Release No.	Vendor's Name and Address
1 ____ New 2 X Change	POSTED 2		NEXTLEVEL HEALTH PARTNERS INC 303 W MADISON STREET STE 1150 CHICAGO IL 60606

Appropriation Account Code	Obligation Amount
001-47865-4900-70-00	$0.00

Multiple Year Contract	Maximum Contract Amt
From 12/31/2015 MO/DAY/YR To 12/31/2019 MO/DAY/YR	$309,501,089.00
Current Fiscal Year of Contract	**Annual Contract Amt**
From 7/1/2017 MO/DAY/YR To 6/30/2018 MO/DAY/YR	$55,046,851.00 Reimbursement Exp Included

Multiple Year Contract Amts				Year 2 - 7 (and over)	
2	$101,781,695.00	3	$152,672,543.00	4	
5		6		7	

Description

4460 MEDICAL SERV PA RECIP - VENDOR
ICP/CONTRACTOR WILL ADMINISTER THE DEPARTMENT'S INTEGRATED CARE PROGRAM SERVICES TO SENIORS, BLIND & DISABLED NON-MEDICARE ELIGIBLE MEDICARE BENEFICIARIES THRU THE FULL SPECTRUM OF MEDICAID COVERED SERVICES.
MULTI-YEAR CONTRACT, YR 3 OF 5 TO FILE $0.00 AMENDMENT #8 - CONTRACT TERM EFFECTIVE 12/31/2019.

Method of Compensation	Procurement Information	Travel Expenses
(If Multiple Rates, Specify)	Award Code P	Yes ____ No X
	Publication Date	
$0.00 Per MR	Reference #	Amount
Rate Time	Subcontractor Utilization (Y/N) N	
	Subcontractor Disclosure (Y/N) N	Advance Payment Yes X No ____

LATOYA CRAWFORD	217-524-7330	12/20/2017	HFS / BUREAU OF MANAGED CARE
Prepared by	Phone	Date	Contracting Agency/Division
FELICIA F. NORWOOD		12/20/2017	HFS/ BUREAU OF FISCAL OPERATIONS
Authorized by		Date	Filing Agency/Division

C-23 6/07

RECEIVED
DEC 29 2017
State Comptroller
Obligations Section

IHFS Illinois Department of Healthcare and Family Services

CONTRACT APPROVAL DOCUMENT

Procurement Tracking # 2016-24-004-KA8

The attached (select one) amendment with (Enter Contractor's Name below)

NEXTLEVEL - ICP

in the amount of $ 0 for FY'2018 is approved.

Michelle Maher RM 12.12.17 — 12-12-17
Bureau Chief (or equivalent) signature — Date

Michelle Maher
Bureau Chief (or equivalent) printed name

Teresa T. Hursey — 12-12-17
Division Administrator signature — Date

Teresa T. Hursey
Division Administrator printed name

Deputy / Assistant Director signature — Date

Deputy / Assistant Director printed name

Michael P. Casey RM — 14 Dec 17
Division of Finance signature — Date

MICHAEL P. CASEY
Division of Finance printed name

The amendment is subject to the CMS Procurement Business Case process. Yes ○ No ◉

All applicable approvals have been obtained by the Department. Yes ◉ No ○

If the amendment equals or exceeds $250,000 in a fiscal year, or the amendment or renewal results in a contract that equals or exceeds $250,000 in a fiscal year, the following signatures are needed:

Chief Legal Counsel signature — Date

N/A
Chief Legal Counsel printed name

Chief Fiscal Officer signature — Date

N/A
Chief Fiscal Officer printed name

STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

and

NEXTLEVEL HEALTH PARTNERS, INC., AN ILLINOIS CORPORATION

AMENDMENT NO. 8 TO THE CONTRACT FOR FURNISHING HEALTH SERVICES IN AN INTEGRATED CARE PROGRAM BY A MANAGED CARE ORGANIZATION 2016-24-004-KA8 (NLHP)

WHEREAS, the Parties to the Contract for Furnishing Health Services in an Integrated Care Program by a Managed Care Organization ("Contract"), the **Illinois Department of Healthcare and Family Services**, 201 South Grand Avenue East, Springfield, Illinois 62763-0001 ("Department"), acting by and through its Director, and **NextLevel Health Partners, Inc.** ("Contractor"), desire to amend the Contract; and

WHEREAS, pursuant to Section 9.1.18, the Contract may be modified or amended by the mutual consent of the Parties; and

WHEREAS, the Contract has been previously amended; and

WHEREAS, pursuant to Section 8.8, Termination for Convenience, a written notice of partial termination of this Contract was given to Contractor on September 28, 2017, which partial termination shall be effective at 11:59 P.M. Central Time ("CT") on December 31, 2017; and

WHEREAS, the Parties desire to amend the Contract to successfully complete duties, obligations and transactions that must occur throughout the close-out/run-out period; and

WHEREAS, the Parties desire to terminate the Contract, as amended, effective at 11:59 P.M. CT on December 31, 2019;

NOW THEREFORE, the Contract, as previously amended, is further amended as follows, effective January 1, 2018:

1. Section 8.3, Continuing Duties in the Event of Termination, is amended by adding a new section 8.3.1, to read as follows:

   8.3.1 In the event of termination of this Contract, in whole or in part, certain terms and conditions of the Contract shall remain in full force and effect until such time that the Department, in its sole discretion, determines that all remaining duties and obligations have been completed. Such terms and conditions shall include, but not be limited to, the following:

8.3.1.1 Section(s) governing data submission and payment related to Medical Loss Ratio (MLR);

8.3.1.2 Section(s) governing payment to network and out-of-network providers;

8.3.1.3 Section(s) governing completion of enrollee satisfaction surveys;

8.3.1.4 Section(s) governing cooperation with medical records review;

8.3.1.5 Section(s) governing submission of all reports for periods of operation, including encounter data;

8.3.1.6 Section(s) governing retention of records; and

8.3.1.7 Section(s) governing sanctions, as applicable to the duties and obligations in this Section 8.3.1.

2. This Contract is partially terminated by the written notice dated September 28, 2017, which notice is hereby incorporated as a part of the Contract.

3. This Contract, as amended, is terminated effective 11:59 P.M. CT on December 31, 2019.

IN WITNESS WHEREOF, the Parties have hereunto caused this Amendment No. 8 to the Contract to be executed by their duly authorized representatives. effective as of the date of last signature.

NEXTLEVEL HEALTH PARTNERS INC.

By: _____

Printed Name: Cheryl Rucker-Whitaker

Title: CEO

Date: Dec 4, 2017

FEIN: [redacted]

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

By: _____

Printed Name: Felicia F. Norwood

Title: Director

Date: 12-15-17

STATE OF ILLINOIS

CONTRACT-OBLIGATION DOCUMENT

Agency No. 478

PLEASE TYPE

Fiscal Year	Transaction Code	Contract/Obligation No.	Transaction Date	Nine Digit Taxpayer ID. Number	Legal Status
2018	28 20	16M0000023	01/04/18	[redacted]	08

Contract Action	Class Code	Governors Release No.
1. ___ New 2. X Change	___ ___	POSTED 3

Vendors Name and Address

NEXTLEVEL HEALTH PARTNERS INC
303 W MADISON STREET STE 1150
CHICAGO IL 60808

Appropriation Account Code	Obligation Amount
001-47865-4900-70-00	0.00
346-47865-4400-00-00	0.00
793-47865-4900-00-00	0.00

Multiple Year Contract: From 12/31/15 (MO/DAY/YR) To 12/31/19 (MO/DAY/YR)

Maximum Contract Amount: 309,501,089.00

Current Fiscal Year of Contract: From 07/01/17 (MO/DAY/YR) To 08/30/18 (MO/DAY/YR)

Annual Contract Amount: 55,046,851.00 Reimbursement Expenses Included

Multiple Year Contract Amounts Year 2-7(and over)

2	3	4
101,781,695.00	152,672,543.00	
5	**6**	**7**

RECEIVED
JAN 10 2018
State Comptroller
Obligations Section

Description 4460 Medical Serv Pa Recip-Vendor

ICP/CONTRACTOR WILL ADMINISTER THE DEPARTMENT'S INTEGRATED CARE PROGRAM SERVICES TO SENIORS, BLIND & DISABLED NON-MEDICARE ELIGIBLE MEDICARE BENEFICIARIES THRU THE FULL SPECTRUM OF MEDICAID COVERED SERVICES.
MULTI-YEAR CONTRACT - YEAR 3 OF 6
TO FILE AMENDMENT #5

Obligations to the state will cease immediately without penalty of further payment being require if, in any fiscal year, the Illinois GeneralAssembly or federal funding source fails to appropriate or otherwise make available sufficientfunds for this agreement.

Method of Compensation	Procurement Information	Travel Expense
0.00 Rate Per MR Time (If Multiple Rates, Specify)	Award Code P Publication Date / / Reference Subcontractor Utilization (y/n) N Subcontractor Disclosure (y/n) N	YES ___ NO X Amount Advance Payment YES X NO ___

LATOYA CRAWFORD 217-524-7330 01/05/18
Prepared By / Phone Number Date

HFS /Bureau of Managed Care
Contracting Agency/Division

FELICIA F NORWOOD 01/05/18
Authorized By Date

HFS /BUREAU OF FISCAL OPERATIONS
Filing Agency/Division

C-23.1(R-6-07)

HFS Illinois Department of Healthcare and Family Services

CONTRACT APPROVAL DOCUMENT

Procurement Tracking # 2016-24-004-PSC8

The attached (select one) amendment with (Enter Contractor's Name below)

NEXTLEVEL - ICP

in the amount of $ 5 [illegible] 12-19-17 for FY 17-18 is approved.

Michelle Maher for PM 12.19.17 — 12/28/17
Bureau Chief (or equivalent) signature — Date

Michelle Maher
Bureau Chief (or equivalent) printed name

[signature] — 12/26/17
Division Administrator signature — Date

Teresa T. Hursey
Division Administrator printed name

Deputy / Assistant Director signature — Date

Deputy / Assistant Director printed name

[signature] — 12-23-17
Division of Finance signature — Date

Michael Casey
Division of Finance printed name

The amendment is subject to the CMS Procurement Business Case process. Yes ◉ No ○

All applicable approvals have been obtained by the Department. Yes ◉ No ○

If the amendment equals or exceeds $250,000 in a fiscal year, or the amendment or renewal results in a contract that equals or exceeds $250,000 in a fiscal year, the following signatures are needed:

[signature] — 12/28/17
Chief Legal Counsel signature — Date

Chief Legal Counsel printed name

[signature] — 12-28-17
Chief Fiscal Officer signature — Date

Jack Dodds
Chief Fiscal Officer printed name

STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

and

NEXTLEVEL HEALTH PARTNERS, INC., AN ILLINOIS CORPORATION

AMENDMENT NO. 5 TO THE CONTRACT FOR FURNISHING HEALTH SERVICES IN AN INTEGRATED CARE PROGRAM BY A MANAGED CARE ORGANIZATION 2016-24-004-KA5 (NLHP)

WHEREAS, the Parties to the Contract for Furnishing Health Services in an Integrated Care Program by a Managed Care Organization ("Contract"), the **Illinois Department of Healthcare and Family Services,** 201 South Grand Avenue East, Springfield, Illinois 62763-0001 ("Department"), acting by and through its Director, and **NextLevel Health Partners, Inc.** ("Contractor"), desire to amend the Contract; and

WHEREAS, pursuant to Section 9.1.18, the Contract may be modified or amended by the mutual consent of the Parties; and

WHEREAS, the Contract has been previously amended;

NOW THEREFORE, the Parties agree to amend the Contract further as follows:

1. Section 5.4 is amended by deleting in its entirety and replacing with the following, and adding new Section 5.4.2 to read as follows:

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 such refusal is documented in its ethical guidelines, mission statement, constitution, bylaws, articles of incorporation, regulations, or other governing documents. If Contractor chooses to exercise this right, Contractor must promptly notify the Department in writing of its intent to exercise its right of conscience and submit proof that such refusal is incorporated in Contractor's governing documents in accordance with 745 ILCS 70/11.2. Such notification shall contain the 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, but in all events, Enrollees shall be informed no fewer than thirty (30) days before implementation of such a policy.

5.4.2 Such notice shall include information on how an Enrollee can obtain information from the Department regarding those Covered Services subject to this section 5.4.

2. Section 5.20.8 is deleted in its entirety and replaced with the following:

5.20.8 Reports regarding Enrollees in Supportive Living Facilities (SLF) must be made to the Department of Healthcare and Family Services' SLP Complaint Hotline at 1-844-528-8444.

3. Section 5.25 is amended by adding new Section 5.25.6A to read as follows:

5.25.6A Contractor shall establish and follow a uniform process for post-authorization of, and payment for, non-Emergency transportation that is consistent with the procedures and requirement established by the Department and set forth in the Medicaid Managed Care Provider Manual.

4. Section 7.4 (Title only), is hereby deleted and replaced with the following:

7.4 Risk Adjustment for Years 2016 and 2017.

7.4.1 Capitation rates calculated under this Contract will be risk adjusted semi-annually using a standard industry risk adjustment tool, such as the Chronic Illness and Disability Payment System (CDPS), Medicaid Rx (MRx), or a combination of the two (CDPS+Rx). Capitation rates for a Contractor operated by a governmental body will not be risk adjusted in 2017. The version of the risk adjustment tool will reflect the most recent version publicly available. The Department will either use standard weights as published by the University of California at San Diego or develop custom weights using Illinois-specific data, where 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 across all rate cells. The risk scores may be established using a credibility formula for each MCO and rate cell if enrollment is not sufficiently large enough to assume full credibility. The credibility formula to be used will be determined by an independent actuary. To the extent CDPS or CDPS+Rx is used to perform risk adjustment, all diagnosis codes submitted by Contractor shall be included in calculations of risk scoring irrespective of placement of such diagnosis codes in the encounter records. The Department reserves the right to request additional data from Contractor related to non-accepted encounter records. Encounter records will not be supplemented by medical record data. Diagnosis must be recorded in the patient's record

prior to claim submission and may not be retroactively adjusted through appropriate encounter submission except to correct errors. Diagnosis codes from claims that included a lab or radiology procedure or revenue code on any line, with the exception of those associated with an inpatient hospital claim, will not be included for the purpose of risk adjustment analysis. Such codes could be for testing purposes only and may not indicate the presence of a disease condition. A significant increase in risk scores by Contractor may warrant an audit of the diagnosis collection and submission methods.

7.4.2 Each six (6) months, Enrollee risk scores shall be re-calculated using Department Fee-For-Service claims data, MCO encounter data, or both, for claims with dates of service during a twelve-month experience period preceding the payment adjustment period (each six month period being an "adjustment period"). Data will be collected with a minimum of four months of paid claims run-out. Contractor's risk adjustment factor will be calculated using enrollment figures from the first month of the payment adjustment period or the most recently available enrollment within two months of the beginning of the adjustment period. The Department shall provide written notification to Contractor of Contractor's risk adjustment factor, along with sufficient detail supporting the calculations. Contractor shall have thirty (30) days after the date the Department sent such 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 timeframe 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. The application of risk scores shall be budget neutral to the Department across the program, or normalized to a 1.0000 value among the contracting MCOs.

7.4.3 The blended LTSS Service Package II capitation rate will be risk adjusted for 2017. The nursing home portion of the Nursing Facility rate will be risk adjusted based on the composite Resource Utilization Group (RUG) score for each MCO's nursing facility's population.

5. Attachment IV-B is deleted in its entirety and replaced with Attachment IV-C, which is attached hereto and hereby incorporated into this Amendment. As of the effective date of this Amendment, all references in the Contract to Attachment IV shall be interpreted as references to Attachment IV-C.

6. Attachment XXIII, Illinois Medicaid Health Plan Encounter Utilization Monitoring (EUM) Requirements, is deleted in its entirety and replaced with Attachment XXIII-A, which is attached hereto and hereby incorporated into this Amendment. As of the effective date of this Amendment, all references in the Contract to Attachment XXIII, Illinois Medicaid Health Plan Encounter Utilization Monitoring (EUM) Requirements shall be interpreted as references to Attachment XXIII-A.

All other terms and conditions of the Contract shall remain in full force and effect.

IN WITNESS WHEREOF, the Parties have hereunto caused this agreement to amend the Contract to be executed by their duly authorized representatives, effective as of the date of last signature.

NEXTLEVEL HEALTH PARTNERS INC.

By: _____

Printed Name: Cheryl Rucker-Whitaker

Title: CEO

Date: 12.15.2017

FEIN: [redacted]

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

By: _____

Printed Name: Felicia F. Norwood

Title: Director

Date: 1-3-18

Attachment IV-C

Rate Sheet

NEXTLEVEL HEALTH PARTNERS, INC.

Contracting Areas	Effective January 1, 2016: Region IV (Suburban Cook) Region VI (City of Chicago)
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 unless they voluntarily enroll in an MCO; • 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	See below

All capitation rates listed are 100% of actuarially certified rates, but only a percentage may be paid in accordance with Section 7.10.1.

Service Package 1 Rates effective January 1, 2016 through June 30, 2016:						
Rate Cell	Region I (N.W. Illinois) PMPM	Region II (Central Illinois) PMPM	Region III (Southern Illinois) PMPM	Region IV (Suburban Cook Co) PMPM	Region V (Collar Counties) PMPM	Region VI (City of Chicago) PMPM
Community Residents	$882.44	$879.05	$784.84	$1,035.00	$907.03	$1,035.00
HCBS DD Waiver	$652.22	$708.96	$615.88	$693.92	$658.00	$693.92
ICF/MR Other	$769.92	$786.39	$760.52	$919.75	$909.45	$919.75
Nursing Facility	$1,879.79	$1,936.00	$2,080.38	$1,901.59	$1,798.52	$1,901.59
HCBS Other Waivers	$1,727.53	$1,984.78	$1,677.27	$1,737.58	$1,647.05	$1,737.58
ICF/MR State Op Facility	$357.97	$357.97	$357.97	$367.97	$367.97	$367.97

Initial Statewide Service Package 2 Rates effective January 1, 2016 through June 30, 2016:						
Rate Cell	Region I (N.W. Illinois) PMPM	Region II (Central Illinois) PMPM	Region III (Southern Illinois) PMPM	Region IV (Suburban Cook Co) PMPM	Region V (Collar Counties) PMPM	Region VI (City of Chicago)
Nursing Facility	NA	NA	NA	$2,587.28	NA	$2,587.28
HCBS Other Waivers	NA	NA	NA	$2,587.28	NA	$2,587.28

***Nursing Facility and HCBS Other Waiver LTSS rates are blended into one rate and will vary by health plan.**

Service Package 1 Rates effective July 1, 2016 – December 31, 2016:						
Rate Cell	Region I (N.W. Illinois) PMPM	Region II (Central Illinois) PMPM	Region III (Southern Illinois) PMPM	Region IV (Suburban Cook Co) PMPM	Region V (Collar Counties) PMPM	Region VI (City of Chicago) PMPM
Community Residents	$918.88	$916.45	$819.07	$1,071.64	$937.46	$1,071.64
HCBS DD Waiver	$653.45	$710.30	$617.03	$696.29	$662.64	$696.29
ICF/MR Other	$770.86	$787.35	$761.45	$922.81	$912.49	$922.81
Nursing Facility	$1,881.75	$1,938.01	$2,082.55	$1,898.98	$1,780.13	$1,898.98
HCBS Other Waivers	$1,732.18	$1,994.19	$1,685.19	$1,747.29	$1,658.60	$1,747.29
ICF/MR State Op Facility	$357.97	$357.97	$357.97	$367.97	$367.97	$367.97

Initial Statewide Service Package 2 Rates effective July 1, 2016 – December 31, 2016:						
Rate Cell	Region I (N.W. Illinois) PMPM	Region II (Central Illinois) PMPM	Region III (Southern Illinois) PMPM	Region IV (Suburban Cook Co) PMPM	Region V (Collar Counties) PMPM	Region VI (City of Chicago)
Nursing Facility	NA	NA	NA	$2,278.27	NA	$2,278.27
HCBS Other Waivers	NA	NA	NA	$2,278.27	NA	$2,278.27

***Nursing Facility and HCBS Other Waiver LTSS rates are blended into one rate and will vary by health plan.**

NextLevel Final Service Package 2 Rates effective January 1, 2016 – December 31, 2016:						
Rate Cell	Region I (N.W. Illinois) PMPM	Region II (Central Illinois) PMPM	Region III (Southern Illinois) PMPM	Region IV (Suburban Cook Co) PMPM	Region V (Collar Counties) PMPM	Region VI (City of Chicago)
Nursing Facility	NA	NA	NA	$2,587.28	NA	$2,587.28
HCBS Other Waivers	NA	NA	NA	$2,587.28	NA	$2,587.28

Service Package 1 Rates effective January 1, 2017:						
Rate Cell	Region I (N.W. Illinois) PMPM	Region II (Central Illinois) PMPM	Region III (Southern Illinois) PMPM	Region IV (Suburban Cook Co) PMPM	Region V (Collar Counties) PMPM	Region VI (City of Chicago) PMPM
Community Residents	$982.77	$868.62	$799.22	$1,068.52	$994.36	$1,068.52
HCBS DD Waiver	$693.37	$751.15	$638.68	$742.71	$716.68	$742.71
ICF/MR Other	$775.35	$751.40	$707.12	$1,108.23	$999.34	$1,108.23
Nursing Facility	$1,882.42	$2,282.46	$1,990.94	$2,358.08	$1,989.28	$2,358.08
HCBS Other Waivers	$1,901.28	$2,049.35	$1,602.34	$2,130.74	$2,070.32	$2,130.74
ICF/MR State Op Facility	$255.89	$255.10	$254.03	$290.05	$271.17	$290.05

Initial Statewide Service Package 2 Rates effective January 1, 2017:						
Rate Cell	Region I (N.W. Illinois) PMPM	Region II (Central Illinois) PMPM	Region III (Southern Illinois) PMPM	Region IV (Suburban Cook Co) PMPM	Region V (Collar Counties) PMPM	Region VI (City of Chicago)
Nursing Facility	$1,792.01	$1,817.47	$1,666.28	$2,341.05	$2,099.13	$2,341.05
HCBS Other Waivers	$1,792.01	$1,817.47	$1,666.28	$2,341.05	$2,099.13	$2,341.05

***Nursing Facility and HCBS Other Waiver LTSS rates are blended into one rate and will vary by health plan.**

Supplemental Capitation Payment for Hospital Services effective January 1, 2016 through September 30, 2016:						
Rate Cell	Region I (N.W. Illinois) PMPM	Region II (Central Illinois) PMPM	Region III (Southern Illinois) PMPM	Region IV (Suburban Cook Co) PMPM	Region V (Collar Counties) PMPM	Region VI (City of Chicago)
All rate cells except ICF/MR State Op Facility	$450.79	$483.02	$365.49	309.46	$309.46	309.46

Supplemental Capitation Payment for Hospital Services effective October 1, 2016:						
Rate Cell	Region I (N.W. Illinois) PMPM	Region II (Central Illinois) PMPM	Region III (Southern Illinois) PMPM	Region IV (Suburban Cook Co) PMPM	Region V (Collar Counties) PMPM	Region VI (City of Chicago)
All rate cells except ICF/MR State Op Facility	$308.78	$377.26	$303.58	$230.91	$331.85	$230.91

Attachment XXIII-A

2016

Illinois Medicaid Health Plan Encounter Utilization Monitoring (EUM) Requirements: General Process (Page 1 of 2)						
Evaluation Period	Final date for MCO to submit encounter claims to be included in the evaluation	Final date for MCO to e-mail EUM spend data to HFS (See #2 below)	Evaluation Date	Service Dates Measured (Calendar Year)	Cumulative Percentage Difference between Plan Reported and Encounter Reported Service Cost PMPM (Encounter/Plan-1)	
					$50,000 Financial Penalty if at or above:	Auto-Assignment Shut-Off if at or above:
1	1/15/2016	1/15/2016	2/29/2016	Q3 2014	20%	Test Period – measured at 30%
2	4/15/2016	4/15/2016	5/20/2016	Q3 2014 – Q2 2015	20%	30%
3	7/15/2016	7/15/2016	8/19/2016	Q3 2014 – Q4 2015	15%	25%
4	10/14/2016	10/14/2016	11/18/2016	Q3 2014 – Q1 2016	10%	20%

General Implementation Procedures:

1. The Department will inform Contractor in writing what spend data is to be included and provided. Failure to send accurate spend data by the deadline will result in both the Financial Penalty and Auto-Assignment Shut-Off to occur.

When Medicaid spend data is sent, it must be accompanied by an attestation letter signed by Contractor's Executive Director/CEO.

2. If Contractor has more than one contract as a MCO with the Department, each contract will be measured separately and sanctions will be imposed by contract.
3. Auto-Assignment will not be shut-off for the first Evaluation Period as this will be treated as a test period. Contractor will be measured at 30% for this test period.
4. Note that the Financial Penalty will apply for the first Evaluation Period. Please see the *Auto-Assignment Specific Process* for additional information about Auto-Assignment shut-off.
5. For contracts that have an initial Effective Date on or after December 1, 2015, the Department will implement the EUM Requirements on the first Evaluation Date that occurs twelve (12) months after enrollment begins.
6. Contractor shall email all related data to the Department's designated Contract Monitor and Paul Stieber (paul.stieber@illinois.gov), with Bhavin Shah (bhavin.shah@illinois.gov) and Robert Mendonsa (robert.mendonsa@illinois.gov) copied.

Illinois Medicaid Health Plan Encounter Utilization Monitoring (EUM) Requirements:
Auto-Assignment Specific Process (Page 2 of 2)

Evaluation Period	HFS to communicate any Auto-Assignment Shut-Off to Client Enrollment Broker by this date:	Date Auto-Assignment Shut-Off occurs	30 Day Re-Evaluation date	Final date for MCO to submit data for 30 Day Re-Evaluation	If Auto-Assignment Re-Evaluation is positive, Auto-Assignment re-start date	If Auto-Assignment remains off, 60 Day Re-Evaluation date	Final date for MCO to submit data for 60 Day Re-Evaluation	If Auto-Assignment Re-Evaluation is positive, Auto-Assignment re-start date
1	3/18/2016	4/1/2016	4/19/2016	4/5/2016	5/1/2016	5/19/2016	5/5/2016	6/1/2016
2	6/17/2016	7/1/2016	7/19/2016	7/5/2016	8/1/2016	8/19/2016	8/5/2016	9/1/2016
3	9/16/2016	10/1/2016	10/19/2016	10/5/2016	11/1/2016	11/18/2016	11/4/2016	12/1/2016
4	12/16/2016	1/1/2017	1/19/2017	1/5/2017	2/1/2017	2/20/2017	2/6/2017	3/1/2017

Auto-Assignment Shut-Off Implementation Procedures:

1. If Auto-Assignment is shut-off, it will be re-evaluated at 30 days. If Contractor meets or exceeds the objective, Auto-Assignment will be re-started on the first of the following month. If Contractor does not reach the objective at the 30 day re-evaluation, it will be re-assessed at 60 days.

2. Contractor shall email all related data to the Department's designated Contract Monitor and Paul Stieber (paul.stieber@illinois.gov), with Bhavin Shah (bhavin.shah@illinois.gov) and Robert Mendonsa (robert.mendonsa@illinois.gov) copied.

2017

Illinois Medicaid Health Plan Encounter Utilization Monitoring (EUM) Requirements for 2017: General Process (Page 1 of 2)

Evaluation Period	Final date for MCO to submit encounter claims to be included in the evaluation	Final date for MCO to email EUM spend data to HFS (See #2 below)	Evaluation Date (EUM Summary Reports due date)	Service Dates Measured (Calendar year)	Cumulative Percentage Difference between Plan Reported and Encounter Reported Service Cost PMPM (Plan/Encounter)	
					$50,000 Financial Penalty if at or below:	Auto-Assignment Shut-Off if at or below:
1	1/20/2017	1/20/2017	2/24/2017	Q1 2015 – Q2 2016	90%	85%
2	4/14/2017	4/14/2017	5/19/2017	Q2 2015 – Q3 2016	90%	85%
3	7/14/2017	7/14/2017	8/18/2017	Q3 2015 – Q4 2016	95%	90%
4	10/13/2017	11/17/2017	11/15/2017	Q4 2015 – Q1 2017	95%	90%

General Implementation Procedures:

7. The Department will inform Contractor in writing what spend data is to be included and provided. Failure to send accurate spend data by the deadline will result in both the Financial Penalty and Auto-Assignment Shut-Off to occur.

   When Medicaid spend data is sent, it must be accompanied by an attestation letter signed by Contractor's Executive Director/CEO.

8. If Contractor has more than one contract as a MCO with the Department, each contract will be measured separately and sanctions will be imposed by contract.
9. For contracts that have an initial Effective Date on or after December 1, 2015, the Department will implement the EUM Requirements on the first Evaluation Date that occurs twelve (12) months after enrollment begins.
10. Contractor shall email all related data to the Department's designated Contract Monitor, Bhavin Shah (bhavin.shah@illinois.gov) and Paul Stieber (paul.stieber@illinois.gov).

11/30/2016

Illinois Medicaid Health Plan Encounter Utilization Monitoring (EUM) Requirements for 2017: Auto-Assignment Specific Process (Page 2 of 2)

Evaluation Period	HFS to communicate any Auto-Assignment Shut-Off to Client Enrollment Broker by this date:	Date Auto-Assignment Shut-Off occurs	30 Day Re-Evaluation date	Final date for MCO to submit data for 30 Day Re-Evaluation	If Auto-Assignment Re-Evaluation is positive, Auto-Assignment re-start date	If Auto-Assignment remains off, 60 Day Re-Evaluation date	Final date for MCO to submit data for 60 Day Re-Evaluation	If Auto-Assignment Re-Evaluation is positive, Auto-Assignment re-start date
1	3/17/2017	4/1/2017	4/21/2017	4/7/2017	5/1/2017	5/19/2017	5/5/2017	6/1/2017
2	6/16/2017	7/1/2017	7/21/2017	7/7/2017	8/1/2017	8/18/2017	8/4/2017	9/1/2017
3	9/15/2017	10/1/2017	10/20/2017	10/6/2017	11/1/2017	11/17/2017	11/3/2017	12/1/2017
4	12/15/2017	1/1/2018	1/19/2018	1/5/2018	2/1/2018	2/16/2018	2/2/2018	3/1/2018

Auto-Assignment Shut-Off Implementation Procedures:

3. If Auto-Assignment is shut-off, it will be re-evaluated at 30 days. If Contractor meets or exceeds the objective, Auto-Assignment will be re-started on the first of the following month. If Contractor does not reach the objective at the 30 day re-evaluation, it will be re-assessed at 60 days.
4. Contractor shall email all related data to the Department's designated Contract Monitor, Bhavin Shah (bhavin.shah@illinois.gov) and Paul Stieber (paul.stieber@illinois.gov)

11/30/2016

STATE OF ILLINOIS

CONTRACT-OBLIGATION DOCUMENT

Agency No. 478

PLEASE TYPE

Fiscal Year	Transaction Code	Contract/Obligation No.	Transaction Date	Nine Digit Taxpayer ID. Number	Legal Status
2018	28 25	16M0000023	02/20/18	[redacted]	08

Contract Action	Class Code	Governors Release No.	Vendors Name and Address
1. ___ New 2. X Change	POSTED 3		NEXTLEVEL HEALTH PARTNERS INC 303 W MADISON STREET STE 1150 CHICAGO IL 60606

Appropriation Account Code	Obligation Amount
346-47865-4400-00-00	4,238,459.54

Multiple Year Contract	Maximum Contract Amount
From 12/31/15 MO/DAY/YR To 12/31/19 MO/DAY/YR	305,262,629.48
Current Fiscal Year of Contract	**Annual Contract Amount**
From 07/01/17 MO/DAY/YR To 06/30/18 MO/DAY/YR	50,808,391.48 Reimbursement Expenses Included

Multiple Year Contract Amounts Year 2-7(and over)

2	3	4
101,781,695.00	152,672,543.00	
5	**6**	**7**

Description 4460 Medical Serv Pa Recip-Vendor

RECEIVED
FEB 22 2018
State Comptroller
Obligations Section

ICP/CONTRACTOR WILL ADMINISTER THE DEPARTMENT'S INTEGRATED CARE PROGRAM SERVICES TO SENIORS, BLIND & DISABLED NON-MEDICARE ELIGIBLE MEDICARE BENEFICIARIES THRU THE FULL SPECTRUM OF MEDICAID COVERED SERVICES.
MULTI-YEAR CONTRACT - YEAR 3 OF 6
TO DECREASE LINE 3 PER FINANCE/BUDGET

Obligations to the state will cease immediately without penalty of further payment being require if, in any fiscal year, the Illinois GeneralAssembly or federal funding source fails to appropriate or otherwise make available sufficientfunds for this agreement.

Method of Compensation	Procurement Information	Travel Expense
(If Multiple Rates, Specify) 0.00 Rate Per MR Time	Award Code P Publication Date / / Reference Subcontractor Utilization (y/n) N Subcontractor Disclosure (y/n) N	YES ___ NO X Amount Advance Payment YES X NO ___

LATOYA CRAWFORD 217-524-7330 02/21/18
Prepared By / Phone Number Date

HFS /Bureau of Managed Care
Contracting Agency/Division

FELICIA F NORWOOD 02/21/18
Authorized By Date

HFS /BUREAU OF FISCAL OPERATIONS
Filing Agency/Division

C-23.1(R-6-07)

2 Transactions

STATE OF ILLINOIS

CONTRACT-OBLIGATION DOCUMENT

1 of 2

Agency No. 478

PLEASE TYPE

Fiscal Year	Transaction Code	Contract/Obligation No.	Transaction Date	Nine Digit Taxpayer ID. Number	Legal Status
2018	28 20	16M0000023	02/28/18	[redacted]	08

Contract Action	Class Code	Governors Release No.	Vendors Name and Address
1. ___ New 2. X Change	___ ___	POSTED 3	NEXTLEVEL HEALTH PARTNERS INC 303 W MADISON STREET STE 1150 CHICAGO IL 60606

Appropriation Account Code	Obligation Amount
348-47865-4400-00-00	0.00
793-47865-4900-00-00	5,000,000.00

Multiple Year Contract	Maximum Contract Amount
From 12/31/15 MO/DAY/YR To 12/31/19 MO/DAY/YR	305,262,629.46
Current Fiscal Year of Contract	**Annual Contract Amount**
From 07/01/17 MO/DAY/YR To 06/30/18 MO/DAY/YR	50,808,391.46 Reimbursement Expenses Included

Multiple Year Contract Amounts	Year 2-7(and over)				
2	101,781,695.00	3	152,672,543.00	4	
5		6		7	

Description 4460 Medical Serv Pa Recip-Vendor

RECEIVED
MAR 01 2018
State Comptroller
Obligations Section

ICP/CONTRACTOR WILL ADMINISTER THE DEPARTMENT'S INTEGRATED CARE PROGRAM SERVICES TO SENIORS, BLIND & DISABLED NON-MEDICARE ELIGIBLE MEDICARE BENEFICIARIES THRU THE FULL SPECTRUM OF MEDICAID COVERED SERVICES.
MULTI-YEAR CONTRACT - YEAR 3 OF 6
TO DECREASE LINE 1 AND INCREASE LINE 2 PER FINANCE/BUDGET

Obligations to the state will cease immediately without penalty of further payment being require if, in any fiscal year, the Illinois GeneralAssembly or federal funding source fails to appropriate or otherwise make available sufficientfunds for this agreement.

Method of Compensation	Procurement Information	Travel Expense
0.00 Rate Per MR Time (If Multiple Rates, Specify)	Award Code P Publication Date / / Reference Subcontractor Utilization (y/n) N Subcontractor Disclosure (y/n) N	YES ___ NO X Amount Advance Payment YES X NO ___

LATOYA CRAWFORD 217-524-7330 02/28/18
Prepared By / Phone Number Date

HFS /Bureau of Managed Care
Contracting Agency/Division

FELICIA F NORWOOD 02/28/18
Authorized By Date

HFS /BUREAU OF FISCAL OPERATIONS
Filing Agency/Division

C-23.1(R-6-07)

2 Transactions

STATE OF ILLINOIS

CONTRACT-OBLIGATION DOCUMENT

2 of 2

Agency No. 478

PLEASE TYPE

Fiscal Year	Transaction Code	Contract/Obligation No.	Transaction Date	Nine Digit Taxpayer ID. Number	Legal Status
2018	28 25	16M0000023	02/28/18	[redacted]	06

Contract Action	Class Code	Governors Release No.
1. ___ New 2. X Change	POSTED 3	

Vendors Name and Address

NEXTLEVEL HEALTH PARTNERS INC
303 W MADISON STREET STE 1150
CHICAGO IL 60606

Appropriation Account Code	Obligation Amount
001-47865-4900-70-00	5,000,000.00

Multiple Year Contract: From 12/31/15 MO/DAY/YR To 12/31/19 MO/DAY/YR

Maximum Contract Amount: 305,262,629.46

Current Fiscal Year of Contract: From 07/01/17 MO/DAY/YR To 06/30/18 MO/DAY/YR

Annual Contract Amount: 50,808,391.46 Reimbursement Expenses Included

Multiple Year Contract Amounts Year 2-7(and over)

2	3	4
101,781,695.00	152,672,543.00	
5	**6**	**7**

Description 4460 Medical Serv Pa Recip-Vendor

RECEIVED
MAR 01 2018
State Comptroller
Obligations Section

ICP/CONTRACTOR WILL ADMINISTER THE DEPARTMENT'S INTEGRATED CARE PROGRAM SERVICES TO SENIORS, BLIND & DISABLED NON-MEDICARE ELIGIBLE MEDICARE BENEFICIARIES THRU THE FULL SPECTRUM OF MEDICAID COVERED SERVICES.
MULTI-YEAR CONTRACT - YEAR 3 OF 6
TO DECREASE LINE 1 AND INCREASE LINE 2 PER FINANCE/BUDGET

Obligations to the state will cease immediately without penalty of further payment being require if, in any fiscal year, the Illinois GeneralAssembly or federal funding source fails to appropriate or otherwise make available sufficientfunds for this agreement.

Method of Compensation

(If Multiple Rates, Specify)

0.00 Rate Per MR Time

Procurement Information

Award Code P
Publication Date / /
Reference
Subcontractor Utilization (y/n) N
Subcontractor Disclosure (y/n) N

Travel Expense

YES ___ NO X
Amount
Advance Payment
YES X NO ___

LATOYA CRAWFORD 217-524-7330 02/28/18
Prepared By / Phone Number Date

HFS /Bureau of Managed Care
Contracting Agency/Division

FELICIA F NORWOOD 02/28/18
Authorized By Date

HFS /BUREAU OF FISCAL OPERATIONS
Filing Agency/Division

C-23.1(R-6-07)

STATE OF ILLINOIS

2 Transactions 1 of 2

CONTRACT-OBLIGATION DOCUMENT

FY18

Agency No. 478

PLEASE TYPE

Fiscal Year	Transaction Code	Contract/Obligation No.	Transaction Date	Nine Digit Taxpayer ID. Number	Legal Status
2018	28 20	18M0000023	5-31-18	[redacted]	06

Contract Action	Class Code	Governors Release No.
1. ___ New 2. X Change	___ ___ POSTED 3	

Vendors Name and Address

NEXTLEVEL HEALTH PARTNERS INC
303 W MADISON STREET STE 1150
CHICAGO IL 60606

Appropriation Account Code	Obligation Amount
793-47865-4900-00-00	881,429.82

Multiple Year Contract — From 12/31/15 MO/DAY/YR To 12/31/19 MO/DAY/YR

Maximum Contract Amount: 305,262,629.46

Current Fiscal Year of Contract — From 07/01/17 MO/DAY/YR To 06/30/18 MO/DAY/YR

Annual Contract Amount: 50,808,391.46 Reimbursement Expenses Included

Multiple Year Contract Amounts Year 2-7(and over)

2	3	4
101,781,685.00	152,672,543.00	
5	**6**	**7**

Description 4460 Medical Serv Pa Recip-Vendor

RECEIVED
JUN 01 2018
State Comptroller
Obligations Section

ICP/CONTRACTOR WILL ADMINISTER THE DEPARTMENT'S INTEGRATED CARE PROGRAM SERVICES TO SENIORS, BLIND & DISABLED NON-MEDICARE ELIGIBLE MEDICARE BENEFICIARIES THRU THE FULL SPECTRUM OF MEDICAID COVERED SERVICES.
MULTI-YEAR CONTRACT - YEAR 3 OF 6
TO DECREASE LINE 1 AND INCREASE LINE 2 PER FINANCE/BUDGET

Obligations to the state will cease immediately without penalty of further payment being require if, in any fiscal year, the Illinois GeneralAssembly or federal funding source fails to appropriate or otherwise make available sufficientfunds for this agreement.

Method of Compensation	Procurement Information	Travel Expense
(If Multiple Rates, Specify) 0.00 Rate Per MR Time	Award Code P Publication Date / / Reference Subcontractor Utilization (y/n) N Subcontractor Disclosure (y/n) N	YES ___ NO X Amount Advance Payment YES X NO ___

LATOYA CRAWFORD 217-524-7330 06/01/18
Prepared By / Phone Number Date

HFS /Bureau of Managed Care
Contracting Agency/Division

FELICIA F NORWOOD 06/01/18
Authorized By Date

HFS /BUREAU OF FISCAL OPERATIONS
Filing Agency/Division

C-23.1(R-6-07)

STATE OF ILLINOIS

2 Transactions 2052

CONTRACT-OBLIGATION DOCUMENT

FY18

Agency No. 478

PLEASE TYPE

Fiscal Year	Transaction Code	Contract/Obligation No.	Transaction Date	Nine Digit Taxpayer ID. Number	Legal Status
2018	28 25	15M0000023	05/31/18	[redacted]	08

Contract Action	Class Code	Governors Release No.
1. ___ New 2. X Change	___ ___	

Vendors Name and Address

NEXTLEVEL HEALTH PARTNERS INC
303 W MADISON STREET STE 1150
CHICAGO IL 60606

Appropriation Account Code	Obligation Amount
001-47865-4900-70-00	881,429.82

Multiple Year Contract

From 12/31/15 MO/DAY/YR To 12/31/19 MO/DAY/YR

Maximum Contract Amount: 305,262,629.46

Current Fiscal Year of Contract

From 07/01/17 MO/DAY/YR To 06/30/18 MO/DAY/YR

Annual Contract Amount: 50,808,391.46 Reimbursement Expenses Included

Multiple Year Contract Amounts Year 2-7(and over)

2	3	4
101,781,695.00	152,672,543.00	
5	**6**	**7**

Description 4460 Medical Serv Pa Recip-Vendor

RECEIVED
JUN 01 2018
State Comptroller
Obligations Section

ICP/CONTRACTOR WILL ADMINISTER THE DEPARTMENT'S INTEGRATED CARE PROGRAM SERVICES TO SENIORS, BLIND & DISABLED NON-MEDICARE ELIGIBLE MEDICARE BENEFICIARIES THRU THE FULL SPECTRUM OF MEDICAID COVERED SERVICES.
MULTI-YEAR CONTRACT - YEAR 3 OF 6
TO DECREASE LINE 1 AND INCREASE LINE 2 PER FINANCE/BUDGET

Obligations to the state will cease immediately without penalty of further payment being require if, in any fiscal year, the Illinois GeneralAssembly or federal funding source fails to appropriate or otherwise make available sufficientfunds for this agreement.

Method of Compensation

(If Multiple Rates, Specify)

0.00 Rate Per MR Time

Procurement Information

Award Code: P
Publication Date: / /
Reference:
Subcontractor Utilization (y/n): N
Subcontractor Disclosure (y/n): N

Travel Expense

YES ___ NO X
Amount:
Advance Payment YES X NO ___

LATOYA CRAWFORD 217-524-7330 06/01/18
Prepared By / Phone Number Date

HFS /Bureau of Managed Care
Contracting Agency/Division

FELICIA F NORWOOD 06/01/18
Authorized By Date

HFS /BUREAU OF FISCAL OPERATIONS
Filing Agency/Division

C-23.1(R-6-07)

STATE OF ILLINOIS

CONTRACT-OBLIGATION DOCUMENT

FY19

Agency No. 478

PLEASE TYPE

Fiscal Year	Transaction Code	Contract/Obligation No.	Transaction Date	Nine Digit Taxpayer ID. Number	Legal Status
2019	28 10	16M0000023	05/28/18	[redacted]	08

Contract Action	Class Code	Governors Release No.	Vendors Name and Address
1. X New 2. ___ Change	25 K	POSTED 3	NEXTLEVEL HEALTH PARTNERS INC 303 W MADISON STREET STE 1150 CHICAGO IL 60606

Appropriation Account Code	Obligation Amount
001-47865-4900-70-00	1,000,000.00

Multiple Year Contract	Maximum Contract Amount
From 12/31/15 MO/DAY/YR To 12/31/19 MO/DAY/YR	2,750,000.00
Current Fiscal Year of Contract	**Annual Contract Amount**
From 07/01/18 MO/DAY/YR To 06/30/19 MO/DAY/YR	1,000,000.00 Reimbursement Expenses Included

CORRECTED COPY

Multiple Year Contract Amounts Year 2-7(and over)

2	3	4
1,750,000.00		
5	**6**	**7**

Description 4660 HFS MCO Payments

RECEIVED
JUL 20 2018
State Comptroller
Obligations Section

CONTRACTOR WILL PROVIDE INTEGRATED CARE SERVICES TO ADULT AGED, BLIND AND DISABLED NON-MEDICARE ELIGIBLE MEDICARE BENEFICIARIES THE FULL SPECTRUM OF MEDICAID COVERED SERVICES.
MULTI-YEAR CONTRACT, YR 5 OF 5
FILING FY19 PORTION

Obligations to the state will cease immediately without penalty of further payment being require if, in any fiscal year, the Illinois GeneralAssembly or federal funding source fails to appropriate or otherwise make available sufficientfunds for this agreement.

Method of Compensation	Procurement Information	Travel Expense
(If Multiple Rates, Specify) 0.00 Rate Per MR Time	Award Code P Publication Date / / Reference Subcontractor Utilization (y/n) N Subcontractor Disclosure (y/n) N	YES ___ NO X Amount Advance Payment YES X NO ___

CHRIS GRAHAM 217-524-7214 07/13/18
Prepared By / Phone Number Date

HFS /Bureau of Managed Care
Contracting Agency/Division

PATRICIA R. BELLOCK 07/13/18
Authorized By Date

HFS /BUREAU OF FISCAL OPERATIONS
Filing Agency/Division

C-23.1(R-0-07)

STATE OF ILLINOIS

CONTRACT-OBLIGATION DOCUMENT

FY19

Agency No. 478

PLEASE TYPE

Fiscal Year	Transaction Code	Contract/Obligation No.	Transaction Date	Nine Digit Taxpayer ID. Number	Legal Status
2019	28 10	16M0000023	06/28/18	[redacted]	06

Contract Action	Class Code	Governors Release No.
1. X New 2. ___ Change	25 K	

Vendors Name and Address

NEXTLEVEL HEALTH PARTNERS INC
303 W MADISON STREET STE 1150
CHICAGO IL 60606

Appropriation Account Code	Obligation Amount
001-47865-4900-70-00	1,000,000.00

Multiple Year Contract

From 12/31/15 MO/DAY/YR To 12/30/20 MO/DAY/YR

Maximum Contract Amount: ~~3,625~~,000.00

Current Fiscal Year of Contract

From 07/01/18 MO/DAY/YR To 08/30/19 MO/DAY/YR

Annual Contract Amount: 1,000,000.00
Reimbursement Expenses Included

Multiple Year Contract Amounts Year 2-7(and over)

2	3	4
1,750,000.00	875,000.00	
5	**6**	**7**

Description 4660 HFS MCO Payments

RECEIVED
JUL 18 2018
State Comptroller
Obligations Section

CONTRACTOR WILL PROVIDE INTEGRATED CARE SERVICES TO ADULT AGED, BLIND AND DISABLED NON-MEDICARE ELIGIBLE MEDICARE BENEFICIARIES THE FULL SPECTRUM OF MEDICAID COVERED SERVICES.
MULTI-YEAR CONTRACT, YR 5 OF 5
FILING FY19 PORTION

Obligations to the state will cease immediately without penalty of further payment being require if, in any fiscal year, the Illinois GeneralAssembly or federal funding source fails to appropriate or otherwise make available sufficientfunds for this agreement.

Method of Compensation	Procurement Information	Travel Expense
(If Multiple Rates, Specify)	Award Code P	YES ___ NO X
0.00 Rate Per MR Time	Publication Date / /	Amount
	Reference	Advance Payment
	Subcontractor Utilization (y/n) N	YES X NO ___
	Subcontractor Disclosure (y/n) N	

CHRIS GRAHAM 217-524-7214 07/13/18
Prepared By / Phone Number Date

HFS /Bureau of Managed Care
Contracting Agency/Division

PATRICIA R. BELLOCK 07/13/18
Authorized By Date

HFS /BUREAU OF FISCAL OPERATIONS
Filing Agency/Division

C-23.1(R-6-07)

Illinois Department of Healthcare and Family Services

CONTRACT APPROVAL DOCUMENT

Procurement Tracking # 2016-24-004-PBC5

The attached (select one) amendment with (Enter Contractor's Name below)

NEXTLEVEL HEALTH PARTNERS - ICP

in the amount of $ 1.5mil FY17; $1.75mil FY18; $1.75mil FY19; $1.75mil FY20 and $875,000.00 FY21. is approved.

[signature]	4-5-17
Bureau Chief (or equivalent) signature	Date
Michelle Mishler	
Bureau Chief (or equivalent) printed name	
[signature]	4-12-17
Division Administrator signature	Date
Teresa T. Hussey	
Division Administrator printed name	
Deputy / Assistant Director signature	Date
Deputy / Assistant Director printed name	
[signature]	04-21-17
Division of Finance signature	Date
Robert J Casey	
Division of Finance printed name	

RECEIVED
JUN 28 2016
EXPENDITURE ACCOUNTING

The amendment is subject to the CMS Procurement Business Case process. Yes ◉ No ○

All applicable approvals have been obtained by the Department. Yes ◉ No ○

If the amendment equals or exceeds $250,000 in a fiscal year, or the amendment or renewal results in a contract that equals or exceeds $250,000 in a fiscal year, the following signatures are needed:

[signature]	4/25/17
Chief Legal Counsel signature	Date
Chief Legal Counsel printed name	
[signature]	4-27-17
Chief Fiscal Officer signature	Date
JACK DODDS	
Chief Fiscal Officer printed name	

STATE OF ILLINOIS

FY18

CONTRACT-OBLIGATION DOCUMENT

Agency No. 478

PLEASE TYPE

Fiscal Year	Transaction Code	Contract/Obligation No.	Transaction Date	Nine Digit Taxpayer ID. Number	Legal Status
2018	28 25	16M0000023	07/23/18	[redacted]	06

Contract Action	Class Code	Governors Release No.	Vendors Name and Address
1. ___ New 2. X Change	___ ___	POSTED 3	NEXTLEVEL HEALTH PARTNERS INC 303 W MADISON STREET STE 1150 CHICAGO IL 60606

Appropriation Account Code	Obligation Amount
793-47865-4900-00-00	9,440,359.41

Multiple Year Contract	Maximum Contract Amount
From 12/31/15 MO/DAY/YR To 12/31/19 MO/DAY/YR	295,822,270.05
Current Fiscal Year of Contract	**Annual Contract Amount**
From 07/01/17 MO/DAY/YR To 06/30/18 MO/DAY/YR	41,368,032.05 Reimbursement Expenses Included

Multiple Year Contract Amounts Year 2-7(and over)

2	3	4
101,781,695.00	152,672,543.00	
5	**6**	**7**

Description 4460 Medical Serv Pa Recip-Vendor

RECEIVED
JUL 26 2018
State Comptroller
Obligations Section

ICP/CONTRACTOR WILL ADMINISTER THE DEPARTMENT'S INTEGRATED CARE PROGRAM SERVICES TO SENIORS, BLIND & DISABLED NON-MEDICARE ELIGIBLE MEDICARE BENEFICIARIES THRU THE FULL SPECTRUM OF MEDICAID COVERED SERVICES.
MULTI-YEAR CONTRACT - YEAR 3 OF 6
TO DECREASE LINE 1 AND INCREASE LINE 2 PER FINANCE/BUDGET

Obligations to the state will cease immediately without penalty of further payment being require if, in any fiscal year, the Illinois GeneralAssembly or federal funding source fails to appropriate or otherwise make available sufficientfunds for this agreement.

Method of Compensation	Procurement Information	Travel Expense
(If Multiple Rates, Specify) 0.00 Rate Per MR Time	Award Code P Publication Date / / Reference Subcontractor Utilization (y/n) N Subcontractor Disclosure (y/n) N	YES ___ NO X Amount Advance Payment YES X NO ___

KIMBERLY FITZGERALD 217-558-5416 07/24/18
Prepared By / Phone Number Date

HFS /Bureau of Managed Care
Contracting Agency/Division

PATRICIA R. BELLOCK 07/24/18
Authorized By Date

HFS /BUREAU OF FISCAL OPERATIONS
Filing Agency/Division

C-23.1(R-6-07)

FY19

STATE OF ILLINOIS

CONTRACT-OBLIGATION DOCUMENT

Agency No. 478

PLEASE TYPE

Fiscal Year	Transaction Code	Contract/Obligation No.	Transaction Date	Nine Digit Taxpayer ID. Number	Legal Status
2019	28 20	16M0000023	08/15/18	[redacted]	08

Contract Action	Class Code	Governors Release No.
1. ___ New 2. X Change	POSTED 3	

Vendors Name and Address

NEXTLEVEL HEALTH PARTNERS INC
303 W MADISON STREET STE 1150
CHICAGO IL 60606

Appropriation Account Code	Obligation Amount
001-47865-4900-70-00	1,000,000.00

Multiple Year Contract — From 12/31/15 MO/DAY/YR To 12/31/19 MO/DAY/YR

Maximum Contract Amount: 3,750,000.00

Current Fiscal Year of Contract — From 07/01/18 MO/DAY/YR To 08/30/19 MO/DAY/YR

Annual Contract Amount: 2,000,000.00 Reimbursement Expenses Included

Multiple Year Contract Amounts Year 2-7(and over)

2	3	4
1,750,000.00		
5	**6**	**7**

Description 4660 HFS MCO Payments

RECEIVED
AUG 20 2018
State Comptroller
Obligations Section

CONTRACTOR WILL PROVIDE INTEGRATED CARE SERVICES TO ADULT AGED, BLIND AND DISABLED NON-MEDICARE ELIGIBLE MEDICARE BENEFICIARIES THE FULL SPECTRUM OF MEDICAID COVERED SERVICES.
MULTI-YEAR CONTRACT, YR 5 OF 5
to increase line 1 per finance/budget

Obligations to the state will cease immediately without penalty of further payment being require if, in any fiscal year, the Illinois GeneralAssembly or federal funding source fails to appropriate or otherwise make available sufficientfunds for this agreement.

Method of Compensation	Procurement Information	Travel Expense
0.00 Rate Per MR Time (If Multiple Rates, Specify)	Award Code P Publication Date / / Reference Subcontractor Utilization (y/n) N Subcontractor Disclosure (y/n) N	YES ___ NO X Amount Advance Payment YES X NO ___

CHRIS GRAHAM 217-524-7214 08/16/18
Prepared By / Phone Number Date

HFS /Bureau of Managed Care
Contracting Agency/Division

PATRICIA R. BELLOCK 08/16/18
Authorized By Date

HFS /BUREAU OF FISCAL OPERATIONS
Filing Agency/Division

C-23.1(R-6-07)

STATE OF ILLINOIS

CONTRACT-OBLIGATION DOCUMENT

FY19

Agency No. 478

PLEASE TYPE

Fiscal Year	Transaction Code	Contract/Obligation No.	Transaction Date	Nine Digit Taxpayer ID. Number	Legal Status
2019	28 20	16M0000023	10/11/18	[redacted]	08

Contract Action	Class Code	Governors Release No.	Vendors Name and Address
1. ___ New 2. X Change	___ ___ POSTED 3		NEXTLEVEL HEALTH PARTNERS INC 303 W MADISON STREET STE 1150 CHICAGO IL 60606

Appropriation Account Code	Obligation Amount
001-47865-4900-70-00	3,000,000.00

Multiple Year Contract	Maximum Contract Amount
From 12/31/15 MO/DAY/YR To 12/31/19 MO/DAY/YR	6,750,000.00
Current Fiscal Year of Contract	**Annual Contract Amount**
From 07/01/18 MO/DAY/YR To 06/30/19 MO/DAY/YR	5,000,000.00 Reimbursement Expenses Included

Multiple Year Contract Amounts Year 2-7(end over)

2	3	4
1,750,000.00		
5	**6**	**7**

Description 4660 HFS MCO Payments

RECEIVED
OCT 23 2018
State Comptroller
Obligations Section

CONTRACTOR WILL PROVIDE INTEGRATED CARE SERVICES
TO ADULT AGED, BLIND AND DISABLED NON-MEDICARE
ELIGIBLE MEDICARE BENEFICIARIES THE FULL
SPECTRUM OF MEDICAID COVERED SERVICES.
MULTI-YEAR CONTRACT, YR 5 OF 5
TO INCREASE LINE 01 PER FINANCE/BUDGET

Obligations to the state will cease immediately without penalty of further payment being require if, in any fiscal year, the Illinois GeneralAssembly or federal funding source fails to appropriate or otherwise make available sufficientfunds for this agreement.

Method of Compensation	Procurement Information	Travel Expense
(If Multiple Rates, Specify) 0.00 Rate Per MR Time	Award Code P Publication Date / / Reference Subcontractor Utilization (y/n) N Subcontractor Disclosure (y/n) N	YES ___ NO X Amount Advance Payment YES X NO ___

AMY ROBERTS 2175577270 10/22/18
Prepared By / Phone Number Date

HFS /Bureau of Managed Care
Contracting Agency/Division

PATRICIA R. BELLOCK 10/22/18
Authorized By Date

HFS /BUREAU OF FISCAL OPERATIONS
Filing Agency/Division

C-23.1(R-8-07)

RECEIVED

OCT 19 2018

EXPENDITURE ACCOUNTING

Illinois Department of Healthcare and Family Services

CONTRACT APPROVAL DOCUMENT

Procurement Tracking # 2016-24-004-K (NLH)

The attached (select one) COD increase with (Enter Contractor's Name below)

NextLevel Health Partners Inc

in the amount of $ 3,000,000.00 for FY'19 is approved.

Laura Ray — 10/18/18

Bureau Chief (or equivalent) signature — Date

Laura Ray

Bureau Chief (or equivalent) printed name

Teresa T. Hursey — 10-12-18

Division Administrator signature — Date

Teresa T. Hursey

Division Administrator printed name

Deputy / Assistant Director signature — Date

Deputy / Assistant Director printed name

Michael P. Casey — 10-17-18

Division of Finance signature — Date

Michael P. Casey

Division of Finance printed name

The COD increase is subject to the CMS Procurement Business Case process. Yes ○ No ◉

All applicable approvals have been obtained by the Department. Yes ◉ No ○

If the COD increase equals or exceeds $250,000 in a fiscal year, or the amendment or renewal results in a contract that equals or exceeds $250,000 in a fiscal year, the following signatures are needed:

[signature] — 10/19/18

Chief Legal Counsel signature — Date

Christopher S Ganza

Chief Legal Counsel printed name

[signature] — 17 Oct 18

Chief Fiscal Officer signature — Date

David V. Moody

Chief Fiscal Officer printed name

IHFS Illinois Department of Healthcare and Family Services

CHANGE ORDER JUSTIFICATION

Procurement Tracking # 2016-24-004-K (NLH)

Purchase Order or Contract # 16M0000023

The following statements and determinations are made by the submitting agency, are true and accurate to the best knowledge of the submitting agency and are provide to assure compliance with statue 720 ILCS 5/33E-9. this form must be completed for any contract change that will result in an increase or decrease in costs of $10,000 or more, or which shortens or extends the time for completion of the contract by 30 days or more. This will become part of the permanent contract file.

Submitting Agency Illinois Department of Healthcare and Family Services

Submitted by Laura Ray (Signature) 10/4/18 (Date)

Printed Name and Title Laura Ray, Acting Bureau Chief

1. Vendor Name NextLevel Health Partners Inc

2. Brief description of contract.

Contract to provide integrated care services to adult aged, blind and disabled Non-Medicare eligible Medicaid beneficiaries. This obligation request is to increase the contract by $3,000,000.00 to cover retro rate adjustments that are due under the contract.

3. Type and amount of change

____ a. The completion date will be by 30 days or more.

Original completion date: _____

Revised completion date: _____

X b. The dollar amount will be increased by $10,000 or more.

Original dollar amount: 2,000,000

Revised dollar amount: 5,000,000

4. Why is the change needed?

____ a. The circumstances were not reasonably foreseeable at the time the contract was signed.

X b. The change is germane to the original contract signed.

____ c. The change order is in the best interest of the Agency and authorized by law.

CMS Reviews (initial accept or reject) (if applicable)

Procurement Accept _____ Reject _____ Date _____

Legal Accept _____ Reject _____ Date _____

2 Transactions
1 of 2

STATE OF ILLINOIS

CONTRACT-OBLIGATION DOCUMENT

FY19

Agency No. 478

PLEASE TYPE

Fiscal Year	Transaction Code	Contract/Obligation No.	Transaction Date	Nine Digit Taxpayer ID. Number	Legal Status
2019	28 20	16M0000023	06/17/19	[redacted]	06

Contract Action	Class Code	Governors Release No.	Vendors Name and Address
1. ___ New 2. X Change	K 25 POSTED 3		NEXTLEVEL HEALTH PARTNERS INC 303 W MADISON STREET STE 1150 CHICAGO IL 60606

Appropriation Account Code	Obligation Amount
793-47865-4900-00-00	1,110,000.39

Multiple Year Contract	Maximum Contract Amount
From 12/31/15 MO/DAY/YR To 12/31/19 MO/DAY/YR	6,750,000.00
Current Fiscal Year of Contract	**Annual Contract Amount**
From 07/01/18 MO/DAY/YR To 06/30/19 MO/DAY/YR	5,000,000.00 Reimbursement Expenses Included

Multiple Year Contract Amounts Year 2-7(and over)

2	3	4
1,750,000.00		
5	**6**	**7**

Description 4660 HFS MCO Payments

CONTRACTOR WILL PROVIDE INTEGRATED CARE SERVICES
TO ADULT AGED, BLIND AND DISABLED NON-MEDICARE
ELIGIBLE MEDICARE BENEFICIARIES THE FULL
SPECTRUM OF MEDICAID COVERED SERVICES.
MULTI-YEAR CONTRACT, YR 5 OF 5
TO DECREASE LINE 01 AND INCREASE LINE 02 PER FINANCE/BUDGET.

RECEIVED
JUN 19 2019
State Comptroller
Obligations Section

Obligations to the state will cease immediately without penalty of further payment being require if, in any fiscal year, the Illinois GeneralAssembly or federal funding source fails to appropriate or otherwise make available sufficientfunds for this agreement.

Method of Compensation	Procurement Information	Travel Expense
(If Multiple Rates, Specify) 0.00 Rate Per MR Time	Award Code P Publication Date / / Reference Subcontractor Utilization (y/n) N Subcontractor Disclosure (y/n) N	YES ___ NO X Amount Advance Payment YES X NO ___

AMY ROBERTS 2175577270 06/19/19
Prepared By / Phone Number Date

HFS /Bureau of Managed Care
Contracting Agency/Division

THERESA EAGLESON 06/19/19
Authorized By Date

HFS /BUREAU OF FISCAL OPERATIONS
Filing Agency/Division

C-23.1(R-6-07)

2 Transactions
2 of 2

STATE OF ILLINOIS

CONTRACT-OBLIGATION DOCUMENT

FY19

Agency No. 478

PLEASE TYPE

Fiscal Year	Transaction Code	Contract/Obligation No.	Transaction Date	Nine Digit Taxpayer ID. Number	Legal Status
2019	28 25	16M0000023	06/17/19	[redacted]	06

Contract Action	Class Code	Governors Release No.	Vendors Name and Address
1. ___ New 2. X Change	25 K	POSTED 3	NEXTLEVEL HEALTH PARTNERS INC 303 W MADISON STREET STE 1150 CHICAGO IL 60606

Appropriation Account Code	Obligation Amount
001-47865-4900-70-00	1,110,000.39

Multiple Year Contract	Maximum Contract Amount
From 12/31/15 MO/DAY/YR To 12/31/19 MO/DAY/YR	6,750,000.00
Current Fiscal Year of Contract	**Annual Contract Amount**
From 07/01/18 MO/DAY/YR To 06/30/19 MO/DAY/YR	5,000,000.00 Reimbursement Expenses Included

Multiple Year Contract Amounts Year 2-7(and over)

2	3	4
1,750,000.00		
5	**6**	**7**

Description 4660 HFS MCO Payments

RECEIVED
JUN 19 2019
State Comptroller
Obligations Section

CONTRACTOR WILL PROVIDE INTEGRATED CARE SERVICES
TO ADULT AGED, BLIND AND DISABLED NON-MEDICARE
ELIGIBLE MEDICARE BENEFICIARIES THE FULL
SPECTRUM OF MEDICAID COVERED SERVICES.
MULTI-YEAR CONTRACT, YR 5 OF 5
TO DECREASE LINE 01 AND INCREASE LINE 02 PER FINANCE/BUDGET.

Obligations to the state will cease immediately without penalty of further payment being require if, in any fiscal year, the Illinois GeneralAssembly or federal funding source fails to appropriate or otherwise make available sufficientfunds for this agreement.

Method of Compensation	Procurement Information	Travel Expense
(If Multiple Rates, Specify) 0.00 Rate Per MR Time	Award Code P Publication Date / / Reference Subcontractor Utilization (y/n) N Subcontractor Disclosure (y/n) N	YES ___ NO X Amount Advance Payment YES X NO ___

AMY ROBERTS 2175577270 06/19/19
Prepared By / Phone Number Date

HFS /Bureau of Managed Care
Contracting Agency/Division

THERESA EAGLESON 06/19/19
Authorized By Date

HFS /BUREAU OF FISCAL OPERATIONS
Filing Agency/Division

C-23.1(R-6-07)

STATE OF ILLINOIS

CONTRACT - OBLIGATION DOCUMENT

Agency No. 478

FY20

PLEASE TYPE

Fiscal Year	Transaction Code	Contract/ Obligation No	Transaction Date	Nine Digit Taxpayer ID Number	Legal Status
2020	28 10	16M0000023	07/17/20	[redacted]	06

Contract Action	Order Type	Governor's Release No.	Vendor's Name and Address
1 X New 2 Change	K Class Code 25	POSTED 3	NEXTLEVEL HEALTH PARTNERS INC 303 W MADISON STREET STE 1150 CHICAGO IL 60606

Appropriation Account Code	Obligation Amount
001-47865-4900-70-00	$104,000.00

Multiple Year Contract	Maximum Contract Amt
From 12/31/15 (MO/DAY/YR) 12/31/19 (MO/DAY/YR)	$104,000.00

Current Fiscal Year of Contract	Annual Contract Amt
From 07/01/19 (MO/DAY/YR) 12/31/19 (MO/DAY/YR)	$104,000.00 Reimbursement ##

Multiple Year Contract Amts						Year 2 - 7 (and over)
2		3		4		
5		6		7		

Description

4660 HFS MCO PAYMENT
CONTRACTOR WILL PROVIDE INTEGRATED CARE SERVICES TO ADULT AGED, BLIND AND DISABLED NON-MEDICARE ELIGIBLE MEDICARE BENEFICIARIES THE FULL SPECTRUM OF MEDICAID COVERED SERVICES.
AWARD CODE: P - PURCHASE OF CARE
MULTI-YEAR CONTRACT: YEAR 5 OF 5
FILING FY20 OBLIGATION

RECEIVED
JUL 17 2020
State Comptroller
Obligations Section

Method of Compensation		Procurement Information		Travel Expenses	
	(If Multiple Rates, Specify)	Award Code	P	Yes	No X
		Publication Date			
		Reference #			Amount
$0.00 Per MR		Subcontractor Utilization (Y/N)	N		
Rate Time		Subcontractor Disclosure (Y/N)	N	Yes X	No

Prepared by	Phone	Date	Contracting Agency/Division
DENNISE PARKER	217-524-7301	07/17/20	HFS / BUREAU OF MANAGED CARE

Authorized by	Date	Filing Agency/Division
THERESA A. EAGLESON	07/17/20	HFS / BUREAU OF FISCAL OPERATIONS

C-23 6/07

FY20

Illinois Department of Healthcare and Family Services

CONTRACT APPROVAL DOCUMENT

Procurement Tracking # 2016-24-004

The attached (select one) COD increase with (Enter Contractor's Name below)

NextLevel Health Partners Inc (ICP)

in the amount of $ 104,000.00 for FY' 20 is approved.

email approval — 6-19-2020
Bureau Chief (or equivalent) signature — Date

Laura Ray
Bureau Chief (or equivalent) printed name

Kelly Cunningham — 6-19-2020
Division Administrator signature — Date

Kelly Cunningham
Division Administrator printed name

Deputy / Assistant Director signature — Date

Deputy / Assistant Director printed name

Michael P Casey DVM — 24 June 2020
Division of Finance signature — Date

Michael P. Casey
Division of Finance printed name

The COD increase is subject to the CMS Procurement Business Case process. Yes ○ No ◉

All applicable approvals have been obtained by the Department. Yes ◉ No ○

If the COD increase equals or exceeds $250,000 in a fiscal year, or the amendment or renewal results in a contract that equals or exceeds $250,000 in a fiscal year, the following signatures are needed:

Chief Legal Counsel signature — Date

Steffanie Garrett
Chief Legal Counsel printed name

Chief Fiscal Officer signature — Date

Gary Casper
Chief Fiscal Officer printed name

Brennan, Mary

From:	Brennan, Mary
Sent:	Friday, June 26, 2020 12:02 PM
To:	Parker, Dennise
Cc:	Cabbell, Sandra
Subject:	FW: COD Increases for 2015-24-004,2016-24-004,2010-24-005,
Attachments:	2015-24-004 COD HEALTH CARE SERVICE_06232020094216.pdf; 2015-24-004 COD HUMANA_06232020094340.pdf; 2015-24-004 COD ILLINI CARE_06232020094901.pdf; 2015-24-004 COD MOLINA_06232020095002.pdf; 2015-24-004 COD MERIDIAN_06232020095213.pdf; 2016-24-004 COD NEXT LEVEL ICP_06232020094551.pdf; 2010-24-005 COD AETNA_06232020094738.pdf; 2015-24-004 ICP COD INCREASES_06242020145230.pdf

Please be sure to attach the approval to each CAD for the Comptroller and possible audits.

From: Brennan, Mary
Sent: Friday, June 26, 2020 11:58 AM
To: Parker, Dennise <Dennise.Parker@illinois.gov>
Cc: Sinclair, Sandra <Sandra.Sinclair@Illinois.gov>
Subject: FW: COD Increases for 2015-24-004,2016-24-004,2010-24-005,

Please see below Mike's authorization for the attached CADS

From: Casey, Mike P.
Sent: Friday, June 26, 2020 2:04 AM
To: Brennan, Mary <Mary.Brennan@Illinois.gov>
Cc: Casey, Mike P. <Michael.P.Casey@Illinois.gov>
Subject: FW: COD Increases for 2015-24-004,2016-24-004,2010-24-005,

I authorize the attached documents for processing.

From: Brennan, Mary <Mary.Brennan@Illinois.gov>
Sent: Wednesday, June 24, 2020 2:45 PM
To: Casey, Mike P. <Michael.P.Casey@Illinois.gov>
Subject: FW: COD Increases for 2015-24-004,2016-24-004,2010-24-005,

For your review and signatures.

From: Tripp, Jamie
Sent: Wednesday, June 24, 2020 11:12 AM
To: Brennan, Mary <Mary.Brennan@Illinois.gov>
Subject: FW: COD Increases for 2015-24-004,2016-24-004,2010-24-005,

Ok to forward on. Thanks!

From: Vaughn, Peter H. <Peter.H.Vaughn@illinois.gov>
Sent: Wednesday, June 24, 2020 11:11 AM

Parker, Dennise

From: Ray, Laura
Sent: Friday, June 19, 2020 12:25 PM
To: Parker, Dennise
Cc: Sawicki, Jennifer
Subject: FW: NextLevel Health 16M23 - FY20 special eligibility drop adjustment
Attachments: CAD increase.pdf; COJ increase.pdf; CODD - 16M0000023 - NextLevel Health Partners.xls

Importance: High

I authorize the processing of the attached CAD & COJ for NextLevel Health Partners Inc - 16M0000023

From: Sawicki, Jennifer <Jennifer.Sawicki@illinois.gov>
Sent: Friday, June 19, 2020 9:44 AM
To: Parker, Dennise <Dennise.Parker@illinois.gov>; Ray, Laura <Laura.Ray@Illinois.gov>
Cc: Sawicki, Jennifer <Jennifer.Sawicki@illinois.gov>; Roberts, Amy <Amy.Roberts@illinois.gov>
Subject: FW: NextLevel Health 16M23 - FY20 special eligibility drop adjustment
Importance: High

Dennise – Looks good.

Laura,
This is ready for your approval/authorization. If email approval please state "I authorize the processing of the attached CAD & COJ for NextLevel Health Partners Inc - 16M0000023"

Thanks,
Jennifer

From: Parker, Dennise <Dennise.Parker@illinois.gov>
Sent: Friday, June 19, 2020 9:16 AM
To: Roberts, Amy <Amy.Roberts@illinois.gov>; Sawicki, Jennifer <Jennifer.Sawicki@illinois.gov>
Cc: Parker, Dennise <Dennise.Parker@illinois.gov>
Subject: NextLevel Health 16M23 - FY20 special eligibility drop adjustment
Importance: High

Ladies,

Can you please review and let me know of any changes needed to the attached NextLevel Health- CAD/COJ/CODD ?
If you are good with these forms then I please forward to Bureau Chief for approval.

Laura Ray only needs to approve the CAD & COJ.
The CODD is included to keep the packet together in case I work from home and need to forward the packet to the next signature person. ☺

Email Approval verbiage "I authorize the processing of the attached CAD & COJ for NextLevel Health Partners Inc - 16M0000023"

Thanks