

**STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**

and

MERIDIAN HEALTH PLAN OF ILLINOIS, INC.

**AMENDMENT NO. 1 TO THE
CONTRACT FOR FURNISHING HEALTH SERVICES
BY A MANAGED CARE ORGANIZATION THROUGH
THE DCFS YOUTH MANAGED CARE SPECIALTY PLAN
2020-24-401-KA1**

WHEREAS, the Parties to the Contract for Furnishing Health Services 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 **Meridian Health Plan of Illinois, 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;

NOW THEREFORE, the Parties agree to amend the Contract as follows:

1. Section 1.1.16 is amended by deleting and replacing with the following:
1.1.16 [This section intentionally left blank]
2. Section 1.1.179 is amended by deleting and replacing with the following:
1.1.179 [This section intentionally left blank]
3. Section 1.1.208 is amended by deleting and replacing with the following:
1.1.208 **Baseline Period** means the period of time beginning September 1, 2020, to December 31, 2021.
4. Section 1.1.209 is amended by deleting and replacing with the following:
1.1.209 **Beyond Medical Necessity** means a psychiatric hospitalization that continues after a DCFS Youth in Care has been medically cleared for discharge. The hospital is reimbursed for the Beyond Medical Necessity stay by DCFS through August 31, 2020. Effective September 1, 2020, Contractor shall reimburse the hospital.

5. Article I is amended by adding a new definition at 1.1.211a:
 - 1.1.211a **Covered Enrollee** has the meaning set forth in the Introduction.

6. Section 2.1 is amended by deleting and replacing subsection 2.1.11 as follows:

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

7. Section 2.1 is amended by deleting and replacing subsection 2.1.14 as follows:

2.1.14 This Contract shall be enforceable solely to the extent applicable to Covered Enrollees. Additionally, references herein to requirements that contradict provisions specific to Covered Enrollees shall be deemed unenforceable and superseded by those contractual provisions specifically applicable to the Covered Enrollees. If any provision of this Contract is deemed unenforceable pursuant to the preceding sentences of this Section 2.1.14, the remainder of this Contract shall remain enforceable and shall not be affected thereby. For the avoidance of doubt, references herein to populations other than the Covered Enrollees, including services for populations other than the Covered Enrollees, shall not be binding with respect to the Covered Enrollees or such populations (or otherwise). In furtherance of the foregoing, Contractor shall not have any obligation hereunder to perform any services other than in respect of Covered Enrollees and the Department shall not have any obligation hereunder to make any capitation or other payment in respect of any services performed other than in respect of Covered Enrollees. All terms and provisions of Amendment No. 6 shall be incorporated herein by reference except to the extent modified hereby.

8. Section 2.2 is amended by adding new subsections 2.2.1, 2.2.1.1, 2.2.1.2 and 2.2.1.3 as follows:

2.2.1 Contract Provisions Related to the COVID-19 Public Health Emergency
Effective March 1, 2020 and through the duration of the Novel Coronavirus Disease (COVID-19) public health emergency, and any extensions thereof, Contractor shall perform services and duties in such manner that incorporates all applicable provisions of flexibility provided in the Department's Section 1135 and Section 1115 Waivers as approved by federal CMS, the CMS-approved HCBS 1915(c) Waivers' Appendix K, Disaster State Plan Amendments, written concurrence from federal CMS, and applicable provisions provided by the "Federal CMS COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers." The Department will provide Contractor with written notice of all applicable provisions. Furthermore, throughout the duration of the COVID-19 public health emergency, the following revised Contract provisions are effective:

2.2.1.1 Contractor's prior authorization requirements can be no more restrictive than those implemented by the Department for the FFS Medicaid Program.

2.2.1.2 Contractor's duties that require in-person contact with an Enrollee may be replaced with HIPAA-compliant audio-only real-time telephonic interaction, or a virtual real-time visit, either of which must be sufficient in both substance and duration to meet the key components of an in-person contact.

2.2.1.3 Contractor shall cover Medically Necessary Covered Services provided by a non-Network Provider for the diagnosis and treatment of COVID-19. Contractor may not require prior authorization for such services.

9. Subsection 2.3.1 is amended by deleting subsections 2.3.1.1 through 2.3.1.19, and replacing with subsections 2.3.1.1 through 2.3.1.6, as follows:

2.3.1.1 Chief Executive Officer (CEO). The CEO shall be a full-time position, with clear authority over general administration and implementation of requirements set forth in the Contract.

2.3.1.2 Chief Medical Officer (CMO). The CMO shall be a full-time position, a board-certified Illinois-licensed Physician and have a minimum of eight (8) years of experience practicing medicine. This position will lead and oversee Contractor's clinical strategy and clinical programs (both physical and behavioral health). This position will be responsible for Contractor's Utilization Management Program, Care Coordination, Long-Term Services and Support, quality improvement, accreditation, credentialing, pharmacy, Appeals and Grievances, health services, Behavioral Health services, and medical policy. This position shall manage Contractor's Quality Assessment and Performance Improvement Program. This position shall attend all quarterly quality meetings.

2.3.1.3 Care Management Manager. The Care Management Manager shall be a full-time position. This position shall be a licensed Physician, licensed registered nurse, or other professional as approved by the Department based on Contractor's ability to demonstrate that the professional possesses the training and education necessary to meet the requirements for Case Management and Disease Management Program activities required in the Contract. This position will direct all activities pertaining to Case Management and Care Coordination activities and monitor utilization of Enrollees' physical health and behavioral health.

2.3.1.4 Integrated Health Homes (IHH) Program Manager. The IHH Program Manager shall be a full-time position that oversees the IHH program and ensures IHH program alignment with Department requirements, Provider education and oversight, and general management of the IHH program.

2.3.1.5 Transition Officer. The Transition Officer shall be a full-time position and shall assist Contractor in the transition from Contractor's implementation team to regular ongoing operations. This position shall be filled no later than the start date of the Contract and shall continue through one hundred twenty (120) days after the start date of operations, or until all administrative roles are fully staffed, whichever is later.

2.3.1.6 Other key personnel identified by Contractor.

10. Subsection 2.3.2, and all of its subsections, are amended by deleting and replacing as follows:

2.3.2 Designated liaisons.

2.3.2.1 Contractor shall designate no less than one (1) full-time liaison who will serve as an account manager to the Department and to DCFS to facilitate communications between the Department and Contractor's executive leadership and staff.

2.3.2.2 Contractor shall designate a liaison who will be a consumer advocate for High-Needs Children. This individual shall be responsible for internal advocacy for these Enrollees' interests, including ensuring input in policy development, planning, decision-making, and oversight.

2.3.2.3 Contractor shall designate a liaison who will be a consumer advocate for Enrollees who need Behavioral Health services. This position shall be responsible for internal advocacy for these Enrollees' interests, including ensuring input in policy development, planning, decision-making, and oversight, as well as coordination of recovery and resilience activities.

2.3.2.4 Eight (8) full-time liaisons will be stationed on-site and hosted by DCFS Regional Offices throughout the State, as designated by the Department in consultation with DCFS, to provide administrative coordination with DCFS staff and stakeholders. Liaisons will be available during regular work hours to communicate with and to provide education and training to DCFS staff and stakeholders regarding managed care, and to engage in immediate problem resolution with Contractor's administrative staff. Issues or barriers reported to a liaison must be addressed and the resolution communicated to the appropriate DCFS staff or stakeholder within three (3) Business Days. Beginning no sooner than six (6) months after the Comprehensive Implementation Date Contractor may, as needed, adjust the number of full-time liaisons, subject to consultation with DCFS and the Department's Prior Approval.

11. Section 2.9 is amended by deleting and replacing subsections 2.9.2 and 2.9.3, as follows:

2.9.2 Contractor shall report monthly to DCMS on BEP vendor payments and goal attainment during each State Fiscal Year, in a format specified by DCMS, 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 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 representation by Contractor.

2.9.3 Contractor shall submit to the Department's BEP liaison its initial BEP utilization plan and related signed letters of intent no later than the Comprehensive Implementation Date for Department approval; provided that such BEP utilization plan will be based on aggregate amounts spent from the Effective Date (in respect of Former Youth in Care) or the Comprehensive Implementation Date (in respect of Youth in Care), as applicable. After submission, Contractor shall 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.

12. Section 4.1 is amended by deleting subsections 4.1.1.1 through 4.1.1.4, and replacing with subsections 4.1.1.1 through 4.1.1.3, as follows:

4.1.1.1 For enrollments of DCFS Youth in Care effective on the Comprehensive Implementation Date and after, the Department shall assign the DCFS Youth in Care into Contractor’s DCFS Youth Managed Care Specialty Plan. The DCFS Guardianship Administrator will have a ninety (90)-day change period after the Effective Enrollment Date to select another Health Plan as provided in Section 4.10.1.

4.1.1.2 For enrollments of Former Youth in Care effective on the Effective Date, the Department will mail the Prospective Enrollee notice of the opportunity to choose a Health Plan at least thirty (30) days prior to the Effective Enrollment Date. When a selection is not made within that period, the Prospective Enrollee will be assigned to Contractor. The notice will include the provision of all education regarding Health Plan choices, and the ninety (90)-day change period after the Effective Enrollment Date to select another Health Plan as provided in Section 4.10.1.

4.1.1.3 At the time a DCFS Youth in Care Enrollee becomes a Former Youth in Care, the Enrollee will remain enrolled with Contractor. The ICES will mail an enrollment notice to the Enrollee within five (5) Business Days of the Enrollee becoming a Former Youth in Care. The mailed enrollment notice will include the notice of continued Health Plan assignment and the provision of all education regarding Health Plan choices, and the ninety (90)-day change period after the Effective Enrollment Date to select another Health Plan as provided in Section 4.10.1.

13. Section 4.4 and its subsection 4.4.1 are deleted and replaced with the following:

4.4 [This section intentionally left blank]

14. Section 4.5, to correct a numbering error, is amended by deleting and replacing as follows:

4.5 ENROLLMENT BY AUTOMATIC ASSIGNMENT

Contractor, to be a qualified MCO, cannot be subject to the intermediate sanction described in 42 CFR 438.702(a)(4), and must have the capacity to enroll Prospective Enrollees. In no event will assignments or enrollments exceed the capacity of an MCO.

15. Section 4.6 is amended by deleting and replacing as follows:

4.6 ENROLLMENT OF NEWBORNS, INFANTS, AND CHILDREN

16. Section 4.10 is amended by adding a new subsection 4.10.2, and renumbering subsequent subsections, as follows:

4.10.2 Open Enrollment Period. Following an Enrollee’s Effective Enrollment Date, every twelve (12) months thereafter, each Enrollee shall have a sixty (60)-day period in which to change MCOs in which the Enrollee is enrolled. 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 may not change MCOs at any time other than the Open Enrollment Period, except as provided in section 4.10.3.

4.10.3 **Disenrollment by Enrollee.** All disenrollment must be pursuant to 42 CFR §438.56.

4.10.3.1 When an Enrollee is subject to mandatory managed care enrollment under the Medicaid Managed Care Program, an Enrollee may request to disenroll for cause from Contractor for any of the following reasons at any time by notifying Contractor, orally or in writing, of the Enrollee's request to disenroll. Subject to the requirements in section 4.14.4, such a request shall be granted by the Department when the reason matches any of the following as determined by the Department:

4.10.3.1.1 the Enrollee moves out of the Contracting Area;

4.10.3.1.2 Contractor, due to its exercise of right of conscience pursuant to section 5.6, does not provide the Covered Service that the Enrollee seeks;

4.10.3.1.3 the Enrollee needs related Covered Services to be performed at the same time, not all the related services are available through Contractor, and the Enrollee's Provider determines that receiving the services separately would subject the Enrollee to unnecessary risk;

4.10.3.1.4 when a change in Enrollee's LTSS Provider (residential, institutional, or employment support) from a Network Provider to a non-Network Provider results in a disruption to residence or employment; or,

4.10.3.1.5 other reasons, including: poor quality of care; a sanction imposed by the Department pursuant to 42 CFR 438.702(a)(4); lack of access to Covered Services; lack of access to Providers experienced in dealing with the Enrollee's healthcare needs; or if the Enrollee is automatically re-enrolled pursuant to section 4.11 and such loss of coverage causes the Enrollee to miss the open Enrollment Period; or an Enrollee's Primary Care Provider's contract with Contractor is terminated resulting in disruption to the Enrollee.

17. Section 4.11 is amended by deleting and replacing, as follows:

4.11 RE-ENROLLMENT AFTER RESUMPTION OF ELIGIBILITY

If an Enrollee with Contractor is disenrolled due to the loss of HFS Medical Program coverage, but the Enrollee's HFS Medical Program coverage is reinstated within two (2) calendar months, the Department will attempt to re-enroll the Enrollee with Contractor, provided that the Enrollee's eligibility status is still valid for participation and, subject to section 4.14.1.3, the Enrollee resides in the Contracting Area.

18. Section 4.14 is amended by deleting and replacing subsections 4.14.1.3 and 4.14.4, as follows:

4.14.1.3 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 4.14.1.3 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.

4.14.4 Disenrollment from Contractor as provided in sections 4.10.3 and 4.14.5 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, takes effect. The approved disenrollment date shall be effective no later than 11:59 p.m. on the last day of the month following the month the Department received the request from Contractor. If the Department fails to make a disenrollment determination within this timeframe, the disenrollment is considered approved for such effective date.

19. Section 5.2 is amended by deleting and replacing subsections 5.2.1, 5.2.2, 5.2.3, and 5.2.6.10, as follows:

5.2.1 Covered Services for all Enrollees are as follows:

5.2.2 [This Section Intentionally Left Blank]

5.2.3 [This Section Intentionally Left Blank]

5.2.6.10 If the Department determines that timely access to Covered Services cannot be ensured due to few or no in-State IHCPs, Contractor will be considered to have met the requirement in section 5.2.6.3 if:

20. Section 5.7 is amended by deleting and replacing subsections 5.7.1.3, 5.7.1.4, 5.7.1.7, 5.7.3, and 5.7.8, as follows:

5.7.1.3 For NFs, 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 Network Provider meets all applicable State and federal requirements for participation in the HFS Medical Program. Contractor may require as a condition for participation in its network that a NF agree to provide access to Contractor's or Subcontractor's Care Management team to permit qualified members of the team to write medication and lab orders, to access Enrollees to conduct physical examinations, and to serve as PCP for an Enrollee.

5.7.1.4 For Providers of each of the Covered Services identified in this section 5.7.1.4 under an 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 Network Providers served at least eighty percent (80%) of the number of Participants in each county who received 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) such Providers, so long as such Providers accept Contractor's rates, even if one (1) Provider served more than eighty percent (80%) of the Participants, unless the Department grants Contractor an exception, in writing. These Covered Services include:

5.7.1.7 [This Section Intentionally Left Blank]

5.7.3 Network Provider enrollment and termination. Contractor shall ensure that all Network Providers, including out-of-state Network 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. Once a Contractor is aware that a Network Provider will be terminated, Contractor must inform the Department of this termination in writing (e-mail or letter) within three (3) Business Days.

5.7.8 Provider agreements. Contractor's Provider Agreements shall require that Network Providers submit benefit expense claim data, as defined in section 7.11.5.2, for all Covered Services provided to Enrollees.

21. Section 5.7 is further amended by adding new subsection 5.7.16, as follows:

5.7.16 Ongoing Follow-up Services. Contractor is responsible for the provision of ongoing follow-up services. Contractor shall contract with all current qualified HealthWorks DHS agencies to provide ongoing follow-up services to DCFS Youth in Care. Ongoing follow-up services must commence following provision of Interim Medical Case Management services and continue through the age of five (5) years. Ongoing follow-up services shall include, at a minimum, ensuring that DCFS Youth in Care are assigned a primary care physician, receive preventive health care services and maintain records of such services, have a plan of care. To be considered a qualified Provider, the Provider must be in good standing with the Department's FFS Medical Program. Contractor may establish quality standards for Providers, subject to the Department's Prior Approval. Contractor may terminate contracts with Providers who do not meet those quality standards if the Provider is informed at the time the standards come into effect and the standards have been in effect for at minimum one (1) year. Contractor shall notify the Department no less than sixty (60) days prior to the termination date of a contract with any HealthWorks lead agency.

22. Section 5.7 is further amended to correct the numbering of 5.8-5.7.16, and replaced with the following:

5.7.17 Directed and Pass-through Payments. Contractor shall comply with the Department's instructions in disbursing payments pursuant to CMS-approved directed payment programs and pass-through payments pursuant to 42 CFR 438.6. Directed payments must be made directly to an account of the Provider and cannot be made to an intermediary. The Department will transmit to Contractor detailed instructions on the distribution of funds at the time such funds are paid to Contractor. The instructions will indicate the amounts to be paid to each eligible provider and the timeframe for making the payments.

23. The numbering and title of Section 5.8 is amended to correct as follows:

5.8 ACCESS-TO-CARE STANDARDS

24. Subsection 5.8.1 is amended by deleting and replacing, as follows:

5.8.1 Network adequacy standards. Contractor's Provider Network must include all necessary Provider types, including primary care Providers, Behavioral Health Providers, OB/GYNs, dental

care Providers, hospitals, other specialists, and pharmacies, with sufficient capacity to provide timely Covered Services to Enrollees in accordance with the standards outlined herein. For each Provider type, Contractor must provide access to at least ninety percent (90%) of Enrollees within each county of the Contracting Area within the prescribed time and distance standard required by this section 5.8.1, with the exception of pharmacy services, which must provide one-hundred percent (100%) coverage to Enrollees as required in section 5.8.1.1.7. Exceptions to the time and distance standards may be considered and approved at the discretion of the Department. Exception requests must be submitted to the Department in writing.

25. Subsection 5.8.1 is further amended by deleting (and not replacing) subsections 5.8.1.2, 5.8.1.3, and 5.8.1.4.

26. Subsection 5.8.8 is amended by deleting and replacing subsection 5.8.8.1, and is further amended by deleting (and not replacing) subsection 5.8.8.2, as follows:

5.8.8.1 For Enrollees, Contractor's maximum primary care Provider panel size shall be one-thousand eight-hundred (1,800) Enrollees. An additional maximum of nine hundred (900) of such Enrollees is allowed for each resident Physician, nurse practitioner, Physician assistant, and APN who is one-hundred percent (100%) full-time equivalent employee or contractor.

27. Section 5.11 is amended by deleting and replacing subsection 5.11.2, and is further amended by deleting (and not replacing) subsection 5.11.2.1, as follows:

5.11.2 **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 IPoCs and identification of Enrollees' needs. Contractor shall have fully operational portals, which provide Enrollees, Providers, DCFS Guardianship Administrator, DCFS Authorized Agents, and DCFS Caseworkers access to relevant information from the Care Management system. Contractor shall also have the capability of utilizing secure email to provide the DCFS Guardianship Administrator, DCFS Authorized Agents, and DCFS Caseworkers with relevant information from the Care Management system.

28. Subsection 5.12.3 is amended by deleting and replacing subsections 5.12.3.1 and 5.12.3.2, as follows:

5.12.3.1 *Qualifications.* Care Coordinators who serve High-Needs Children, 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.

5.12.3.2 *Training requirements.* Care Coordinators who serve High-Needs Children, 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 training requirements set forth in Attachment XVI.

29. Subsection 5.13.1 is amended by deleting and replacing subsection 5.13.1.2, as follows:

5.13.1.2 *Predictive modeling*. Contractor shall utilize claims and CCD to risk stratify the population and to identify complex and high-risk conditions requiring immediate Care Management.

30. Subsections 5.13.1.4.3 and 5.13.2 are amended, by deleting and replacing, as follows:

5.13.1.4.3 If DCFS is not in agreement with the risk level determination made by Contractor for a DCFS Youth in Care, Contractor will work collaboratively with the Department and DCFS to resolve the disagreement and ensure that the best interest and needs of DCFS Youth in Care are met.

5.13.2 **Outreach**. Contractor shall use its best efforts to locate all Enrollees who are identified through risk stratification as being complex risk, high- risk or moderate- risk. For the purpose of this section, the Department will define best efforts on an annual basis. Where appropriate, Contractor shall use community-based organizations to locate and engage such Enrollees.

31. Section 5.14 is amended by deleting and replacing subsection 5.14.3.6, as follows:

5.14.3.6 maintaining frequent contact with the Enrollee through various methods including in-person visits, e-mail, and telephone, as appropriate to the Enrollee's needs and risk level or upon the Enrollee's request.

32. Section 5.15 is amended, by deleting and replacing subsections 5.15.1.5, 5.15.1.5.4, 5.15.3, and 5.15.4, as follows:

5.15.1.5 for DCFS Youth in Care Enrollees, include information from DCFS as available and an IPoC that is coordinated and consistent with the DCFS Service Plan as follows, given that DCFS provides this information to Contractor:

5.15.1.5.4 Contractor shall notify the DCFS Caseworker within two (2) Business Days when the IPoC is updated. The updated IPoC shall be available for the DCFS Caseworker through the Enrollee portal or through secure email.

5.15.3 For Enrollees transferring MCOs for whom an IPoC has been developed, Contractor will use the Enrollee's existing service plan, and that 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 and only after completion of an in-person health-risk assessment.

5.15.4 The Enrollee or the Enrollee's Authorized Representative must review and sign the IPoC and all subsequent revisions. Acceptable forms of signature include electronic forms such as e-signatures and voice recordings. In the event the Enrollee refuses to sign the IPoC, Contractor shall:

33. Section 5.16 is amended by deleting and replacing, as follows:

5.16 ONGOING ASSESSMENT AND STRATIFICATION

Contractor will analyze predictive-modeling reports and other surveillance data of all Enrollees monthly to identify risk-level changes. As risk levels change, assessments and reassessments will be completed as necessary and IPoCs created or updated. Contractor shall review IPoCs of high risk and complex risk DCFS Youth Enrollees at least every thirty (30) days, and of moderate risk DCFS Youth Enrollees at least every ninety (90) days, and conduct reassessments as necessary based upon such reviews. At a minimum, Contractor shall conduct a health risk reassessment annually for each DCFS Youth Enrollee who has an IPoC. In addition, Contractor shall conduct an in-person health-risk 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. Contractor will provide updated IPoCs to Providers that are involved in providing Covered Services to Enrollee within no more than five (5) Business Days. Contractor shall make available an updated IPoC through the Enrollee and Provider portals and secure email.

34. Section 5.21 is amended by deleting and replacing subsections 5.21.1.5 and 5.21.7.4, as follows:

5.21.1.5 the procedures for obtaining Post-Stabilization Services in accordance with the terms set forth in section 5.20.1.2;

5.21.7.4 *Written contacts.* Contractor shall produce communications for 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 condition. The communications shall include Contractor's toll-free phone number and invite Enrollees to contact the ICT or the nurse advice line with any questions. Contractor communications shall include reminders about needed preventive services or screenings, reminders about the risks associated with progression of the Enrollee's disease, and information about any available incentives for receiving a needed service.

35. Section 5.23 is amended by deleting and replacing subsections 5.23.1.2, 5.23.1.8, 5.23.1.9, and 5.23.1.10, as follows:

5.23.1.2 Contractor shall comply with Critical Incident reporting requirements of the DHS-DRS, IDoA, and HFS HCBS Waivers for incidents and events that do not rise to the level of Abuse, Neglect, or exploitation. Such reportable incidents include those identified in Attachments XVII, and XVIII for the appropriate HCBS Waivers.

5.23.1.8 Reports regarding Enrollees aged eighteen (18) and older receiving mental health or Developmental Disability services in programs that are operated, licensed, certified, or funded by DHS are to be made to Illinois Department of Human Services Office of the Inspector General hotline.

5.23.1.9 [This Section Intentionally Left Blank]

5.23.1.10 Contractor shall provide the Department, upon request, with its protocols for reporting suspected Abuse, Neglect, and exploitation and other Critical Incidents that are reportable, including those in Attachment XVII and Attachment XVIII.

36. Section 5.28 is amended by deleting and replacing subsection 5.28.1.2, as follows:
- 5.28.1.2 *Data reporting*. 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 the Department or having received Prior Approval. A schedule of all reports and information submissions and the frequency required for each under this Contract are provided in Attachment XIII. For purposes of this section 5.28, the following terms shall have the following meanings: “initially” means the later of (i) thirty (30) days following (A) the Effective Date (in respect of Former Youth in Care) or (B) the Comprehensive Implementation Date (in respect of Youth in Care), as applicable, and (ii) the date on which Department provides all information reasonably necessary for Contractor to submit such reports and information; “annual” means the State Fiscal Year; and “quarter” means three (3) consecutive calendar months of the State Fiscal Year beginning with the first (1st) 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.
37. Section 5.29 is amended by deleting (and not replacing) subsections 5.29.5.1 and 5.29.5.2.
38. Section 5.29 is further amended by deleting and replacing subsections 5.29.11, 5.29.11.1, and 5.29.11.2, as follows:
- 5.29.11 The Department will notify Contractor of any applicable patient credit amounts for Enrollees who are in a NF by the monthly patient credit file.
- 5.29.11.1 Contractor shall delegate collection of patient credit to the NF and shall pay such facility the difference between the patient credit amount and the rate agreed to by such facility.
- 5.29.11.2 Contractor shall electronically process patient credit information received by Contractor from the Department
39. Section 5.31 is amended by deleting (and not replacing) subsection 5.31.2.
40. Section 5.40 is amended by deleting and replacing subsection 5.40.8, as follows:
- 5.40.8 **Family Leadership Council (FLC)**. Contractor shall establish the FLC within ninety (90) days of the Effective Date of this Contract to create opportunities to engage families directly regarding issues in Children's Behavioral Health. Contractor shall establish, through its FLC, a Care Coordination model that is person- and family-centric, and a mechanism for providing Contractor with a direct HFS Medical Program beneficiary feedback loop. The FLC shall not be used to review the needs of individual Enrollees.

41. Article V is amended by adding a new section 5.41 and its subsections, as follows:

5.41 HANDLING OF SENSITIVE DATA

5.41.1 Pursuant to Executive Order 2019-08, the Department will provide Contractor on at least a monthly basis with highly sensitive data from the Illinois Department of Public Health (DPH) related to certain of Contractor's Enrollees who have data in the DPH's HIV/AIDS Registry. Contractor shall handle such data in the strictest confidence in compliance with the privacy provisions of all applicable laws, rules, and regulations, including HIPAA, the AIDS Confidentiality Act (410 ILCS 305), the HIV/Aids Registry Act (410 ILCS 310), and the Illinois Sexually Transmissible Disease Control Act (410 ILCS 325), and with the provisions of this section 5.41. The purpose of the data exchange is to advance the goals of zero community transmissions of HIV and ensuring that persons living with HIV will get the care they need to thrive.

5.41.2 The details of the HIV-related data received from the DPH via the Department shall be closely held and accessible only to Contractor's Chief Medical Officer (CMO) and their designees, all of whom will be subject to the same standards and liability as the CMO. The data shall only be integrated into a repository for the sole purpose of Care Coordination and treatment of Enrollees living with HIV. Contractor's repository for the data shall have data security protocols, consistent with those outlined in Attachment XIV, in place which shall be submitted to the Department for review and approval.

5.41.3 Contractor's CMO shall use the data received from the HIV/AIDS Registry, along with Contractor's pharmacy, medical, and other claims data, to provide alerts to Care Coordinators to prompt them to ensure all best practices regarding the management and treatment of HIV are being followed with respect to Enrollees, including periodic viral load testing, drug regimen prescribing and adherence, and annual physician visits. These alerts may be developed based on the data permitted to be shared under this Contract and may include viral suppression status ("suppressed" or "not suppressed"), the date of the last lab test, and name of the Provider that ordered the last lab test (if available). Contractor shall work with appropriate HIV consumer and legal advocacy groups for the target population to develop and implement best practices for outreach and engagement.

5.41.4 Contractor shall track, and report quality metrics related to HIV, including the CQMC HIV Consensus Core Set, as directed by the Department.

42. Section 7.1 is amended by deleting and replacing subsection 7.1.1, as follows:

7.1.1 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 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 (15th) day of the service month. Rates reflected in Attachment IV are for the period as set forth in Attachment IV, except as adjusted pursuant to

this Article VII. Rates may be updated periodically to reflect future time periods, additional service packages, additional populations, or changes that affect the cost of providing covered services that the Department determines to be actuarially significant. The Department will provide Contractor with an opportunity to review, comment on, and accept in writing any such update, including supporting data, before such update is implemented. The parties will work together to resolve any discrepancies.

43. Article VII is amended by deleting and replacing section 7.4 and adding subsections 7.4.1, 7.4.2, and 7.4.2.1, as follows:

7.4 RISK ADJUSTMENT

7.4.1 Capitation rates under this Contract, excluding the portion attributable to supplemental payments and other fees not retained by the MCOs, will be risk-adjusted by each population category against the other full-risk MCOs providing Covered Services to the same population category within the same rate-setting region. The population categories that will be risk-adjusted are DCFS Youth in Care and DCFS Former Youth in Care. Capitation rates calculated under this Contract will be adjusted in accordance with publicly available risk-adjustment software. Risk adjustment will be performed at least once a year. 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 HFS Medical 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 HFS Medical Program for at least six (6) full months, then such Enrollee shall receive the composite average risk score across all MCOs for a given rate cell. The risk scores shall be established for each MCO across all rate cells. As necessary, the risk scores will be established using a credibility formula for each MCO. The credibility formula to be used will be determined by an independent actuary. All diagnosis codes submitted by Contractor shall be included in calculations of risk scoring irrespective of placement of such diagnosis codes in the Encounter Data records. Diagnosis codes from claims or Encounters that included a lab and radiology procedure or revenue code on any line, with the exception of those associated with an inpatient hospital claim, will not be collected for the risk-adjustment analysis. It is assumed that these diagnosis codes could be for testing purposes and may not definitively indicate a beneficiary's disease condition. Encounter records may not be supplemented by medical record data. Diagnosis codes may only be recorded by the Provider at the time of the creation of the medical record and may not be retroactively adjusted except to correct errors. A significant change in risk scores by an MCO may warrant an audit of the diagnosis collection and submission methods. To the extent that the Department's contracted actuarial firm believes Encounter Data limitations are resulting in risk score variances between MCOs, the Department reserves the right to request diagnosis codes and other information to perform risk adjustment.

7.4.2 Initial Risk Adjustment Period. The initial risk adjustment period shall be the following time periods for the DCFS populations during CY 2020: for DCFS Former Youth in Care, February 2020 through June 2020; and for DCFS Youth in Care, September 2020 through December 2020. The risk scores for the initial risk adjustment period will be calculated using Contractor's monthly enrollment through the duration of the initial risk adjustment period with the specific

MCO. Risk adjustment for the second half of CY 2020 for the Former Youth in Care population will be weighted based on July 2020 enrollment. The claims data to be used for such calculations shall be the Department's FFS claims data for claims with dates of service from the most recent twelve (12)-month period that the Department determines is reasonably complete. To the extent an Enrollee was enrolled with another Contractor during the most recent twelve (12)-month period that the Department determines is reasonably complete, the Encounters accepted by the Department during the period shall be used in addition to the aforementioned FFS claims data.

7.4.2.1 The Department shall provide written notification to Contractor of Contractor's initial 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 time frame to achieve a good-faith resolution of the disputed matter. Modifications to Contractor's Capitation payment resulting from the application of the risk adjustment factor, if any, shall be effective retroactively to the first month of initial enrollment and prospectively to the end of the initial risk adjustment period. All risk scores shall be budget-neutral to the Department or normalized to a 1.0000 value between the MCOs.

44. Section 7.10 is amended by deleting and replacing subsection 7.10.9.5, as follows:

7.10.9.5 premium revenue, which, for purposes of the MLR 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;

45. Section 7.16 is amended by deleting and replacing subsections 7.16.3 and 7.16.4.5, as follows:

7.16.3 Failure to submit ad hoc reports. If Contractor fails to submit any ad hoc report in an accurate, complete, and timely manner, as provided in section 5.28.1.3, then the Department may, at its sole discretion and without notice, impose a monetary sanction of up to US \$50,000. The Department may also, without further notice, impose an additional monetary sanction until an accurate and complete response is submitted.

7.16.4.5 There will be no limit on sanctions associated with cost report submissions for each calendar year period. For sections 7.16.4.3 and 7.16.4.4, a written warning will be provided upon the first instance in each separate calendar year.

46. Section 7.23 is amended by deleting and replacing subsections 7.23.2 and 7.23.3, as follows:

7.23.2 The risk corridor ratio is established as a percentage of actual expenses divided by Contractor's target amount. The target amount is calculated by multiplying the sum of benefit expenses and quality improvement expenses by Enrollee months for the rating periods scheduled for September 1, 2020 through December 31, 2021.

7.23.3 The sixteen-month risk corridor will be calculated using values reported consistent with the medical loss ratio (MLR) reporting. The payment or recoupment amount will be an adjustment to the denominator of the MLR for the calculation of the calendar year 2021 MLR.

47. Article VII is amended by deleting and replacing section 7.24, as follows:

7.24 INTERIM ADMINISTRATIVE PAYMENT

Department shall pay Contractor an administrative fee of \$4,056,000 for the period from November of 2019 through January of 2020 to support preliminary Care Coordination and other administrative activities, as described in Section 4.3.1, to prepare for the Comprehensive Implementation Date of the DCFS Youth Managed Care Specialty Plan. For the avoidance of doubt, the obligation set forth in the preceding sentence supersedes the obligation of Department to make such payment to Contractor pursuant to Section 7.24 of Amendment No. 6 to the Contract for Furnishing Health Services by a Managed Care Organization 2018-24-401-402-KA6. For the period from February of 2020 through May of 2020, the Department shall pay Contractor an administrative fee of \$5,135,730.

48. Article VII is amended by adding section 7.25, as follows:

7.25 Reimbursement for Emergency Ground Ambulance Service

For dates of service on or after January 1, 2020, and continuing through March 31, 2021, Contractor shall reimburse for emergency ground ambulance services (current procedural terminology (CPT) codes A0427 and A0429), including affiliated mileage and oxygen, at the FFS Medicaid Program fee schedule rates as provided by the Department, inclusive of Government Emergency Medical Transportation (GEMT) rates. These services are outside of Contractor's risk-based Capitation payments and shall be paid on behalf of the Department by Contractor as an Administrative Services Organization. The Department shall reimburse Contractor on a quarterly basis the actual paid amounts expended by Contractor based on encounter claims accepted by the Department during the quarter, or, other quarterly documentation mutually agreed to by the Parties, plus a \$35,000 per quarter administrative fee. Accrued payments are due to Contractor thirty (30) days after execution of this contract amendment; subsequent payments are due within thirty (30) days of the end of a quarter. State Prompt Payment Act (30 ILCS 540) requirements apply to these payments.

49. Section 9.1 is amended by deleting and replacing subsection 9.1.22.6, as follows:

9.1.22.6 Nothing in sections 9.1.22.3, 9.1.22.4, or 9.1.22.5 may be construed to require Contractor to contract with Providers beyond the number necessary to meet the needs of its Enrollees; preclude Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or preclude Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to Enrollees.

50. Section 9.1 is further amended by adding subsection 9.1.41, as follows:

9.1.41 Loss of legal authority. Should any part of the scope of work under this Contract relate to a State program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which federal CMS has withdrawn federal authority, or which is the subject of legislative repeal) Contractor must do no work on that part after the effective date of the loss of program authority. The Department must adjust payment of Capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. If Contractor works on a program or activity no longer authorized after the date the legal authority for the work ends, Contractor will not be paid for that work. If the Department paid Contractor in advance to work on a no-longer-authorized program or activity and under the terms of this Contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to the Department. However, if Contractor worked on a program or activity prior to the date the legal authority ended for that program or activity, and the Department included the cost of performing that work in its payments to Contractor, Contractor may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

51. Section 9.2 is amended by deleting and replacing subsection 9.2.34.5, as follows:

9.2.34.5 whether any Person identified in sections 9.2.34.1, 9.2.34.2, 9.2.34.3, and 9.2.34.4 is currently terminated, suspended, barred, or otherwise excluded from participation in, or has voluntarily withdrawn from as the result of a settlement agreement, any program under federal law including any program under Titles XVIII, XIX, XX, or XXI of the Social Security Act, or has within the past 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 in, or has voluntarily withdrawn from, as the result to a settlement agreement, such programs; and

52. Attachments are amended as follows:

- The *List of Attachments* is deleted and replaced;
- *Attachment I: Service Package II Covered Services*, is deleted and replaced;
- *Attachment IV – Rate Sheet* is deleted and replaced;
- *Attachment XI – Quality Assurance (including Table 1)* is deleted and replaced;
- *Attachment XII – Utilization Review and Peer Review* is deleted and replaced, to correct contract numbering;
- *Attachment XIV – Data Security and Connectivity Specifications* is deleted and replaced, to correct contract numbering;
- *Attachment XVI – Qualifications and Training*, is deleted and replaced;
- *Attachment XIX – HFS Incident Reporting for SLFs*, is deleted and replaced with [This Section Intentionally Left Blank];
- *Attachment XXI – Required Minimum Standards of Care* is deleted and replaced, to correct contract numbering; and
- *Attachment XXII – Children’s Behavioral Health Service Requirements*, is deleted and replaced, to correct contract numbering.

IN WITNESS WHEREOF, the Parties have hereunto caused this Amendment No. 1 to the Contract to be executed by their duly authorized representatives, effective as of the date of last signature.

MERIDIAN HEALTH PLAN OF ILLINOIS, INC.

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

By: _____

By: _____

Printed Name: _____

Printed Name: Theresa Eagleson

Title: _____

Title: Director

Date: _____

Date: _____

FEIN: _____