Contract

Between

United States Department of Health and Human Services Centers for Medicare & Medicaid Services

In Partnership with

State of Illinois Department of Healthcare and Family Services

and

[PLAN NAME] Effective: September 1, 2019

This Contract, effective on November 5, 2013, and amended by addendum effective March 31, 2015, and amended and restated effective September 14, 2016, and January 1, 2018, is hereby amended and restated effective September 1, 2019, between the Department of Health and Human Services, acting by and through the Centers for Medicare & Medicaid Services (CMS), the State of Illinois, acting by and through the Department of Healthcare and Family Services (Department) and [PLAN NAME] (the Contractor). The Contractor's principal place of business is [PLAN ADDRESS].

WHEREAS, CMS is an agency of the United States, Department of Health and Human Services, responsible for the administration of the Medicare, Medicaid, and State Children's Health Insurance Programs under Title XVIII, Title IX, Title XIX, and Title XXI of the Social Security Act;

WHEREAS, the Department is the Illinois agency responsible for operating a program of medical assistance under 42 U.S.C. § 1396 et seq., 305 ILCS 5/5-1 et seq. and 215 ILCS 106/1 et seq., designed to pay for medical services for eligible individuals;

WHEREAS, the Contractor is in the business of providing medical services, and CMS and the Department desire to purchase such services from the Contractor;

WHEREAS, the Contractor agrees to furnish these services in accordance with the terms and conditions of this Contract and in compliance with all federal and State laws and regulations;

WHEREAS, this Contract replaces in its entirety, the Contract entered into by CMS, the Department, and [PLAN NAME] (Contractor) executed November 5, 2013 and re-executed September 14, 2016, and January 1, 2018, provided, however, that any duties, obligations, responsibilities, or requirements that are imposed upon the Contractor in this revised Contract but that were not imposed upon the Contractor previously under this Contract or under applicable laws or regulations, shall be effective September 1, 2019.

NOW, THEREFORE, in consideration of the mutual promises set forth in this Contract, the Parties agree as follows:

1. This Addendum amends **Subsection 2.12.5.2.5** to read as follows:

   2.12.5.2.5 If the IRE's decision is not wholly in favor of the Enrollee, the Contractor must send a notice to the Enrollee informing him or her of his or her rights to file an Appeal with either the State Fair Hearing system or Administrative Law Judge, or both, at the choice of the Enrollee. The Contractor must send the notice within 3 business days after the date it receives the IRE's decision in all cases.

2. This Addendum amends **Subsection 4.1.2** to read as follows:

   4.1.2 Demonstration Year Dates

   Capitation Rate updates will take place on January 1st of each calendar year, however savings percentages and quality withhold percentages (see Sections 4.2.3.1 and 4.4.4**)** will be applied based on Demonstration Years, as follows:

Demonstration Year	Calendar Dates
1	February 1, 2014 - December 31, 2015
2	January 1, 2016 - December 31, 2016
3	January 1, 2017 - December 31, 2017
4	January 1, 2018 - December 31, 2018
5	January 1, 2019 - December 31, 2019
6	January 1, 2020 - December 31, 2020
7	January 1, 2021 - December 31, 2021
8	January 1, 2022 - December 31, 2022

3. This Addendum amends **Subsection 4.2.3** as follows:

   4.2.3 Aggregate Savings Percentages

   4.2.3.1 Aggregate savings percentages will be applied equally, as follows, to the baseline spending amounts for the Medicare Parts A/B Component and Medicaid components of the capitated rate herein.

   4.2.3.1.1 Demonstration Year 1: 1%

4.2.3.1.2 Demonstration Year 2: 3%

4.2.3.1.3 Demonstration Year 3: 5%

4.2.3.1.4 Demonstration Year 4: 5%

4.2.3.1.5 Demonstration Year 5: 5%

4.2.3.1.6 Demonstration Year 6: 6%

4.2.3.1.7 Demonstration Year 7: 6%

4.2.3.1.8 Demonstration Year 8: 6%

4. This Addendum amends subsection 4.3 Medical Loss Ratios (MLR) as follows:

4.3 Medical Loss Ratio (MLR)

4.3.1 Medical Loss Ratio Guarantee: The Contractor has a Target Medical Loss Ratio of eighty-five percent (85%) for Demonstration Years 1 through 5, eighty-six percent (86%) for Demonstration Year 6, eighty-seven percent (87%) for Demonstration Year 7, and eighty-eight percent (88%) for Demonstration Year 8. As described below, any collected remittances would be distributed proportionally back to the Medicaid and Medicare programs on a percent of premium basis. If the Medical Loss Ratio calculated as set forth below is less than the Target Medical Loss Ratio, the Contractor shall refund to the Department and CMS 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 and CMS shall calculate a Medical Loss Ratio for Enrollees under this Contract for each Coverage Year, and shall provide to the Contractor the amount to be refunded, if any, to the Department and CMS respectively. Any refunded amounts will be distributed back to the Medicaid and Medicare programs, with the amount to each payor based on the proportion between the Medicare and Medicaid Components. At the option of CMS and the Department, separately, any amount to be refunded may be recovered either by requiring the Contractor to make a payment or by an offset to future Capitation payment. The Medical Loss Ratio Calculation shall be determined as set forth below; however, the Department and CMS may adopt NAIC reporting standards and protocols after giving written notice to the Contractor.

4.3.1.1 For Demonstration Years 1 through 5, if a Contractor has an MLR below eighty-five percent (85%) of the joint Medicare and Medicaid payment to the Contractor, the Contractor must remit the amount by which the eighty-five percent (85%) threshold exceeds the Contractor's actual MLR multiplied by the total Capitation Rate revenue of the contract.

4.3.1.2 For Demonstration Years 6 through 8, in addition to remitting the amount by which the eighty-five percent (85%) threshold exceeds the Contractor's MLR multiplied by the total Capitation Rate revenue, the Contractor will also remit according to the following schedule:

4.3.1.2.1 In Demonstration Year 6, if the Contractor's MLR is below eighty-six percent (86%) and above eighty-five percent (85%), the Contractor would remit fifty percent (50%) of the difference between its MLR and eighty-five percent (85%) multiplied by the total Capitation Rate revenue;

4.3.1.2.2 In Demonstration Year 7, if the Contractor's MLR is below eighty-seven percent (87%) and above eighty-five percent (85%), the Contractor would also remit fifty percent (50%) of the difference between its MLR and eighty-five percent (85%) multiplied by the total Capitation Rate revenue; and

4.3.1.2.3 In Demonstration Year 8, if the Contractor's MLR is below eighty-eight percent (88%) and above eighty-five percent (85%), the Contractor would also remit fifty percent (50%) of the difference between its MLR and eighty-five percent (85%) multiplied by the total Capitation Rate revenue.

4.3.1.3 The Contractor is required to report their MLR experience based on 42 C.F.R. §§ 422.2400 et seq. and §§ 423.2400 et seq., except that the numerator in the MLR calculation will include:

4.3.1.3.1 All Covered Services required in the Demonstration under Section 2.4 and Appendix A of this contract;

4.3.1.3.2 Any services purchased in lieu of more costly Covered Services and consistent with the objectives of the MMAI;

4.3.1.3.3 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;

4.3.1.3.4 Other Benefit Expense. Any service provided directly to an Enrollee not capable of being sent as Encounter Data to the Department 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; and

4.3.1.3.5 To the extent not already so adjusted by 42 C.F.R. §§ 422.2400 et seq. and §§ 423.2400 et seq., when the Contractor has a subcapitated payment to an Affiliate, only the actual payments to Providers, rather than the full subcapitated payment.

4.3.1.4 The revenue used in the Medical Loss Ratio calculation will consist of the total Capitation rate revenue, due from the Department and CMS for services during the Coverage Year, as defined in the annual MLR reporting instructions provided to the Contractor.

4.3.1.5 Data Submission. The Contractor shall submit to the Department and CMS, in the form and manner prescribed by the Department and CMS, the necessary data to calculate and verify the Medical Loss Ratio within nineteen (19) months after the end of the Coverage Year. Such data shall include data submission as defined in the annual MLR reporting instructions provided to the Contractor.

4.3.1.6 Medical Loss Ratio Calculation. Within ninety (90) days following data submission as defined in the annual MLR reporting instructions provided to the Contractor, the Department and CMS shall calculate the Medical Loss Ratio in a timely manner by dividing the Benefit Expense by the Revenue. The Medical Loss Ratio shall be expressed as a percentage rounded to the second decimal point. The

Contractor shall have sixty (60) days to review the Medical Loss Ratio Calculation. Each Party shall have the right to review all data and methodologies used to calculate the Medical Loss Ratio.

4.3.1.7 Coverage Year. The Coverage Year shall be the demonstration year. The Medical Loss Ratio Calculation shall be prepared using all data available from the Coverage Year, including IBNP and eighteen (18) months of run-out for Benefit Expense.

4.3.2 Medicaid Medical Loss Ratio (MLR). If at any point for Medicaid rating periods beginning on or after July 1, 2017, the joint MLR covering both Medicare and Medicaid, as described above in 4.3.1, ceases, the Contractor is required to calculate and report their MLR experience for Medicaid, consistent with the requirements at 42 CFR 42 C.F.R. §438.4, §438.5, §438.8 and §438.74.

5 This Addendum amends **subsection 4.4.4.7 and Figure 4.2** to read as follows:

4.4.4.7 Withhold Measures in Demonstration Years 2-8

4.4.4.7.1.1 The quality withhold will increase to 2% in Demonstration Year 2 and 3% in Demonstration Years 3 through 8.

4.4.4.7.1.2 Payment will be based on performance on the quality withhold measures listed in Figure 4.2, below. The Contractor must report these measures according to the prevailing technical specifications for the applicable measurement year.

4.4.4.7.1.3 If the Contractor is unable to report at least three of the quality withhold measures listed in Figure 4.2 for a given year due to low Enrollment or inability to meet other reporting criteria, alternative measures will be used in the quality withhold analysis. Additional information about this policy is available in separate technical guidance.

Figure 4.2: Quality Withhold Measures for Demonstration Years 2-8

Measure	Source	CMS Core Withhold Measure	Illinois Withhold Measure
Encounter Data	CMS-defined measure	X	
Plan All-Cause Readmissions	NCQA/HEDIS	X	
Annual Flu Vaccine	AHRQ/CAHPS	X	
Follow-up After Hospitalization for Mental Illness	NCQA/HEDIS	X	
Reducing the Risk of Falling	NCQA/HEDIS/HOS	X	
Controlling Blood Pressure	NCQA/HEDIS	X	
Part D Medication Adherence for Diabetes Medications	CMS/PDE Data	X	
Care for Older Adults (COA) **For Demonstration Years 2-5 only**	NCQA/HEDIS		X
Adults' Access to Preventive/Ambulatory Health Services (AAP) **For Demonstration Years 6-8 only**	NCQA/HEDIS		X
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	NCQA/HEDIS		X
Movement of Members Within Service Populations	State-defined measure		X

5. This Addendum amends **subsection 5.7.1** to read as follows:

5.7.1 This Contract shall be in effective through December 31, 2022, so long as the contractor meets all federal submission requirements and has not provided CMS and the Department with a notice of intention not to renew, pursuant to 42 C.F.R. 422.506 or Section 5.5, above, provided, however, that any duties, obligations, responsibilities, or requirements that are imposed upon the Contractor in this revised Contract but that were not imposed upon the Contractor previously under this Contract or under applicable laws or regulations, shall be effective September 1, 2019.

6. A new Appendix, Appendix O, is added to the contract, and will read:

Appendix O. Additional Medicare Waivers

In addition to the waivers granted for the MMAI demonstration in the MOU, CMS hereby waives:

- Section 1860-D1 of the Social Security Act, as implemented in 42 C.F.R. § 423.38(c)((4)(i), and extend Sections 1851(a), (c), (e), and (g) of the Social Security Act, as implemented in 42 C.F.R. Part 422, Subpart B only insofar as such provisions are inconsistent with allowing dually eligible beneficiaries to change Enrollment on a monthly basis.
- Section 1852(j) of Title XVIII of the Act, as implemented in 42 C.F.R. § 422.504(i)(4)(iv) only insofar as such provisions are inconsistent with allowing MMPs to use provider credentialing in the IMPACT system as full credentialing for participation as an MMAI network provider without further audit of the IMPACT system required by the MMPs. MMPs remain required to adhere to the requirements of 42 C.F.R. § 422.504(i)(4)(iv) for any MMAI providers not enrolled in the IMPACT system. Neither this action, nor being credentialed via IMPACT, waives or changes the requirement that MMAI providers not enrolled in the IMPACT system be enrolled in Medicare.

Written Notices

Notices to the Parties as to any matter hereunder will be sufficient if given in writing and sent by certified mail, postage prepaid, or delivered in hand to:

To: Centers for Medicare and Medicaid Services Medicare-Medicaid Coordination Office 7500 Security Boulevard, S3-13-23 Baltimore, MD 21244

To: Illinois Department of Healthcare and Family Services Bureau of Managed Care 201 South Grand Avenue East Springfield, IL 62763

Electronic copies to:

_____

_____

_____

_____

Signatures

In Witness Whereof, CMS, the Department, and the Contractor have caused this Contract to be executed by their respective authorized officers:

[PLAN NAME]

_____
NAME AND TITLE

_____ _____
SIGNATURE DATE

Electronic copies to:

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In Witness Whereof, CMS, the State of Illinois, and the Contractor have caused this Contract to be executed by their respective authorized officers:

State of Illinois, Department of Healthcare and Family Services:

_____ _____

Theresa Eagleson Date
Director
Illinois Department of Healthcare and Family Services

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In Witness Whereof, CMS, the State of Illinois, and the Contractor have caused this Contract to be executed by their respective authorized officers:

United States Department of Health and Human Services, Centers for Medicare & Medicaid Services:

_____ _____

Ruth A. Hughes Date
Deputy Director
Division of Medicaid Field Operations North
Centers for Medicare & Medicaid Services
United States Department of Health and Human Services

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In Witness Whereof, CMS, the State of Illinois, and the Contractor have caused this Contract to be executed by their respective authorized officers:

United States Department of Health and Human Services, Centers for Medicare & Medicaid Services:

_____ _____

Kathryn Coleman Date
Director
Medicare Drug & Health Plan Contract Administration Group
Centers for Medicare & Medicaid Services
United States Department of Health and Human Services