STATE COMPLIANCE ADDENDUM (MEDICAID PRODUCTS)

(ILLINOIS DEPARTMENT OF INSURANCE)

PROVISIONS APPLICABLE TO PROVIDERS

Aetna Better Health of Illinois Inc. f/k/a IlliniCare Health Plan, Inc. ("Company") serves as a managed-care organization with a Medicaid Contract in Illinois. The Company does not participate in any other lines of business. As a licensed HMO, the Company is subject to regulation by the Illinois Department of Insurance ("DOI"). The DOI requires that specific terms and conditions be incorporated into agreements with providers. As such, this State Compliance Addendum is incorporated by reference into the Agreement between Company (or its Affiliate, as the case may be) and the Provider executing this Agreement (as identified on the first page thereof), and such Provider must comply with the requirements set forth herein.

3.0 Network Participation

The following shall be added to the end of Section 3.0 Network Participation:

"Company may enter into an agreement with third parties allowing such third parties to obtain Company's rights and responsibilities as if the third party were the contracting entity."

8.5 Assignment

The following shall be added to the end of Section 8.4 Assignment:

"As required by 50 IL Adm Code 2051.290(h), in the event that such assignment and assumption is needed as a result of the acquisition by another insurer that is a non-affiliate of Company, this Agreement cannot be assigned without Provider's prior written consent."

8.0 Miscellaneous

The following shall be added to the end of Section 8.0 Miscellaneous:

8.9 Insolvency Risk-Bearance. As required by Ill. Admin. Code T. 50, 4521.50, to the extent Provider participates in capitated HMO Plans, Company acknowledges that in the event of Provider's insolvency, Company or Payer is secondarily liable as the ultimate risk bearer for unpaid health care services rendered to Members.

8.10 Holding Members Harmless. As required by Ill. Admin. Code T. 50, 4521.50, if Provider participates in capitated HMO Plans agrees that in no event, including but not limited to nonpayment by HMO of amounts due Provider under this contract, insolvency of the HMO or any breach of this contract by the HMO, shall the Provider or its assignees or subcontractors have a right to or seek any type of payment from, bill, charge, collect a deposit from, or have any recourse against, the enrollee, persons acting on the Member's behalf (other than the HMO), the employer or group contract holder for services provided pursuant to this contract; except for the payment of applicable co-payments or deductibles for services covered by the organization or fees for services not covered by the HMO. The requirements of this clause shall survive any termination of this contract for services rendered prior to such termination, regardless of the cause of such termination. The HMO's Members, the persons acting on the Member's behalf (other than the HMO), and the employer or group contract holder shall be third party beneficiaries of this clause. This clause supersedes any oral or written agreement now existing or hereafter entered into between the Provider and the Member, persons acting on the Member's behalf (other than the HMO) and the employer or group contract holder.

8.11 Access to Records. As required by Ill. Admin. Code T. 50, 2051.290(c), Provider must maintain and make medical records available:

a) To Company for the purpose of determining, on a concurrent or retrospective basis, the medical necessity and appropriateness of care provided to Members;
b) To appropriate State and federal authorities and their agents involved in assessing the accessibility and availability of care or investigating Member grievances or complaints; and

c) To show compliance with the applicable State and federal laws related to privacy and confidentiality of medical records.

8.12 Admitting Privileges. As required by Ill. Admin. Code T. 50, 2051.290 e), Provider who is a physician licensed to practice medicine in all its branches must have admitting privileges in at least one hospital with which Company has a written provider contract. Company shall be notified immediately of any changes in privileges at any hospital or admitting facility. Reasonable exceptions shall be made for physicians who, because of the type of clinical specialty, or location or type of practice, do not customarily have admitting privileges.

8.13 Provider Insurance. As required by Ill. Admin. Code T. 50, 4521.50(a)(7), Provider has adequate professional liability and malpractice coverage effective as of the effective date of the Agreement and will maintain such coverage through insurance, self-funding, or other means satisfactory to Company. Company must be notified no less than 15 days in advance of any reduction or cancellation of the required coverage.

8.14 Non-Discrimination. As required by Ill. Admin. Code T. 50, 2051.290 j), Provider will provide health care services without discrimination against any Member on the basis of participation in the preferred provider program, source of payment, age, sex, ethnicity, religion, sexual preference, health status or disability.

8.15 Collection of Copayment/Coinsurance/Deductible. As required by Ill. Admin. Code T. 50, 2051.290 k), Provider shall collect applicable copayments, coinsurance and/or deductibles from Members as provided by the Member's Plan, and to provide notice to Members of their personal financial obligations for non-covered services. This also includes any amount of applicable discounts or, alternatively, a fee schedule that reflects any discounted rates.

8.16 Availability of Services. As required by Ill. Admin. Code T. 50, 2051.290 l), Provider will make Provider Services available to Members on a twenty-four (24) hour per day, seven (7) day per week basis, according to generally accepted standards of medical practice.

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EXHIBIT C-2

STATE COMPLIANCE ADDENDUM (MEDICAID PRODUCTS)

(ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES)

PROVISIONS APPLICABLE TO PROVIDERS AND SUBCONTRACTORS

This State Compliance Addendum Governing Illinois Medicaid Services shall govern the provision of Covered Services to Members who are eligible and covered under, as well as the provision of any administrative or health-benefit management services/functions that relate to, as applicable:

> the *State of Illinois Contract Between the Department of Healthcare and Family Services and Aetna Better Health of Illinois Inc. f/k/a IlliniCare Health Plan, Inc. Medicaid Contract 2018-24-401("Medicaid Contract").*

Aetna Better Health of Illinois Inc. f/k/a IlliniCare Health Plan, Inc. ("Company") serves as a managed-care organization under the Medicaid Contract (the "State Contract") on behalf of the State of Illinois and its Department for Healthcare and Family Services ("HFS" and collectively, the "State").

The State requires that specific terms and conditions be incorporated into the Agreement. As such, this State Compliance Addendum is incorporated by reference into the Agreement between Company (or its Affiliate, as the case may be) and the Provider or Subcontractor executing this Agreement (as identified on the first page thereof), and such Provider or Subcontractor must comply with the requirements set forth herein. Note that this State Compliance Addendum contains some, but not all, of the terms and requirements with which you must comply. Other terms and requirements with which you must comply are set forth in the Agreement and in the policies, procedures, and provider manual of Company (or its Affiliate, as the case may be). This State Compliance Addendum and the Agreement may be revised as directed by the State.

For purposes of this State Compliance Addendum, the individuals who are enrolled with Company under the State Contract will be referred to as the "Enrollees." All capitalized terms not defined in this State Compliance Addendum shall have the respective meanings that are ascribed to them in the Agreement.

If there is any conflict between the terms of this State Compliance Addendum and any of the other terms of this Agreement, including any attachments, schedules, exhibits, and/or addenda made part of this Agreement, the terms of this State Compliance Addendum will govern and control with respect to the provision of Covered Services to Members who are eligible and covered under the State Contract and with respect to the provision of any administrative or health-benefit management services/functions that relate to those Covered Services or to the State Contract. Except as provided herein, all other provisions of the Agreement not inconsistent with this State Compliance Addendum shall remain in full force and effect, and to the extent possible under applicable law, the terms of this State Compliance Addendum shall be construed to be supplementary to, and not in conflict with, the terms and conditions of the Agreement.

The Provider or Subcontractor identified on the first page of the Agreement acknowledges and agrees that all provisions of this State Compliance Addendum shall apply equally to its/their employees, independent contractors, subcontractors, downstream entities, or related entities that provide Covered Services to Members who are eligible and covered under the State Contract, or that provide administrative or health-benefit management services/functions relating to those Covered Services or to the State Contract, and it/they represent and warrant that it/they shall take all steps necessary to cause such employees, independent contractors, subcontractors, downstream entities, or related entities to comply with this State Compliance Addendum and all applicable laws and regulations.

CONTRACTUAL AND STATUTORY/REGULATORY REQUIREMENTS

A. Definitions

The following additional definitions shall apply with respect to the requirements set forth in this State Compliance Addendum:

a. "Authorized Persons" – Collectively means HFS, HFS's Office of Inspector General ("HFS OIG"), the Medicaid Fraud Control Unit of the Illinois State Police, the Illinois Auditor General, the United States Department of Health and Human Services and the Centers for Medicare and Medicaid Services ("CMS"), the Illinois Attorney

General and any other State or federal agencies with monitoring authority related to Medicaid and State Children's Health Insurance Program ("SCHIP"). [Medicaid Contract § 1.1.19]

b. "Provider" – Means any individual or entity that is enrolled with the State to provide Covered Services to Enrollees and that is associated with Company pursuant to a written contract or agreement for the purpose of providing health care services under the State Contract. [Medicaid Contract § 1.1.160 and § 1.1.136]

c. "Subcontractor" – Means any individual or entity, other than a Provider, with which Company has entered into a written agreement for the purpose of delegating responsibilities applicable to Company under the State Contract. [Medicaid Contract § 1.1.193]

B. Requirements Applicable to State Contract and Covered Services

1. Practice Coverage and Hours; Enrollee Appointments. Provider agrees to provide Covered Services to Enrollees as set forth in the Agreement, including without limitation the following when such Covered Services are specified in the Agreement:

a. Primary care providers (PCPs) and specialty Providers 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 (after-hours voicemail alone is not acceptable). [Medicaid Contract § 5.8.4]

b. Provider shall offer to Enrollees hours of operation that are no less than the hours of operation offered to persons who are not Enrollees. [Medicaid Contract § 5.8.3]

c. Provider shall ensure that time-specific appointments for routine, preventive care to an Enrollee are available within five (5) weeks from the date of request for such care, and within two (2) weeks from the date of request for infants under age six (6) months. If an Enrollee has more serious problems that are not deemed emergency medical conditions, Provider shall triage that Enrollee and, if necessary or appropriate, immediately refer that Enrollee for urgent medically necessary care or provide that Enrollee with an appointment within one (1) business day of the request. If an Enrollee has a problem or complaint that is not deemed serious, Provider shall see that Enrollee within three (3) weeks from the date of request for such care. If Enrollee seeks an initial prenatal visit without expressed problems, the Provider shall see that Enrollee within two (2) weeks after a request if the Enrollee is in her first trimester, within one (1) week if the Enrollee is in her second trimester, and within three (3) days if the Enrollee is in her third trimester. [Medicaid Contract § 5.8.3]

2. Payments; Hold Harmless of Enrollees/State.

a. Provider/Subcontractor acknowledges and agrees that Company shall not pay a Provider/Subcontractor for any provider-preventable condition. Provider/Subcontractor shall report all provider-preventable conditions associated with claims for payment or Enrollee treatments for which payment would otherwise be made. [Medicaid Contract § 5.29.9]

b. Provider/Subcontractor acknowledges and agrees that Company is prohibited by applicable federal law from making payments to financial institutions located outside of the United States for items or services provided under a Medicaid state plan or waiver. [42 U.S.C. § 1396a(a)(80); 42 C.F.R. § 438.602(i)]

c. Provider/Subcontractor acknowledges and agrees that Company is prohibited by applicable federal law from making payments to any provider with respect to which the State has determined there is a credible allegation of fraud in accordance with 42 C.F.R. § 455.23. [42 U.S.C. § 455.23]

d. Except as permitted or required by HFS in 89 Ill. Adm. Code 125, in HFS's fee-for-service copayment policy in effect at the time Covered Services are provided, and/or in the State Contract, neither Company nor Provider/Subcontractor may seek or obtain funding through fees or charges to any Enrollee receiving Covered Services under the State Contract. Provider/Subcontractor furthermore acknowledges and agrees that imposing

charges in excess of those permitted under the State Contract is a violation of Section 1128B(d) of the Social Security Act and subjects the party imposing such charges to criminal penalties. [Medicaid Contract § 5.34]

e. Provider/Subcontractor agrees that in no event, including but not limited to the nonpayment by Company of amounts due to Provider/Subcontractor under the Agreement, the insolvency of Company, or any breach of the Agreement by Company, shall Provider/Subcontractor or its assignees or subcontractors have a right to seek any type of payment from, bill, charge, collect a deposit from, or have any recourse against the Enrollee or persons acting on the Enrollee's behalf (other than Company) for services provided pursuant to the Agreement except for the payment of applicable copayments or deductibles for services covered by Company or fees for services not covered by Company. The requirements of this provision shall survive any termination of the Agreement for services rendered prior to such termination, regardless of the cause of such termination. Company's Enrollees and all persons acting on the Enrollees' behalf (other than Company) shall be third-party beneficiaries of this provision. This provision supersedes any oral or written agreement now existing or hereafter entered into between Provider/Subcontractor and the Enrollee or persons acting on the Enrollee's behalf (other than Company). [215 ILCS 125/2-8(a)]

f. Any dispute between Company and Provider/Subcontractor shall be solely between those parties, and Company and Provider/Subcontractor shall each hold harmless the State and its agencies, officers, employees, agents, and volunteers from and against such dispute and 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, regardless of the reason. [Medicaid Contract 7.13, 9.1.8; and 9.1.28]

3. Standards of Care. In addition to complying with other applicable standards of care, Provider/Subcontractor shall:

a. Timely identify any Enrollees with high-risk pregnancies and, if clinically indicated, arrange for a maternal fetal medicine specialist or a transfer to Level III perinatal facilities in accordance with ACOG guidelines and the Illinois Perinatal Act requirements. Risk –appropriate care shall be ongoing during the perinatal period [Medicaid Contract 3.1.3.13.4]

b. Cooperate and communicate with other service providers who serve Enrollees, including without limitation Special Supplemental Nutrition Programs for Women, Infants, and Children (commonly referred to as "WIC" programs); Head Start programs; Early Intervention programs; day care programs, school systems and others. Such cooperation may include performing annual physical examinations for schools and the sharing of information (with the consent of the Enrollee, parent or legal guardian if the Enrollee is under age). [Medicaid Contract § 3.1.4]

4. Cultural Competence; Prohibition on Discrimination. In addition to complying with other applicable standards:

Provider/Subcontractor shall cooperate in the implementation of, and comply with all requirements set forth in, Company's Cultural Competence Plan, which shall include implementation of the NCQA Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards). Provider/Subcontractor acknowledges and agrees that all Covered Services shall be provided in a culturally competent manner by ensuring the cultural competence of all Provider/Subcontractor staff, from clerical to executive management. Furthermore, Subcontractors shall complete Company's initial and annual cultural-competence training. [Medicaid Contract §2.7]

b. Provider/Subcontractor 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,. Executive Orders 11246 and 11375 and 42 CFR 438.3(d)(4). Provider/Subcontractor furthermore 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 Agreement. Provider/Subcontractor will furthermore not discriminate against Enrollees or prospective or potential Enrollees on the basis of health status, need for health services, or payment source. All Provider/Subcontractor locations where Enrollees receive Covered Services shall comply with the Americans with Disabilities Act of 1990. [77 Ill. Admin. Code § 240.50(d)(4); Medicaid Contract § 9.1.22.]

5. Anti-Gag Clause; Prohibition on Retaliation. Provider/Subcontractor shall not be prohibited or otherwise restricted or discouraged from, and shall not prohibit or otherwise restrict or discourage its downstream providers or subcontractors from, taking any of the following actions so long as those actions are within the lawful scope of the acting party's practice: (a) advocating for medically appropriate health care services for Enrollees, which may include without limitation appealing denials and protesting decisions, policies, and practices; (b) advising an Enrollee about the health status of that Enrollee or medical care or treatment for that Enrollee's condition or disease regardless of whether benefits for such care or treatment are provided under the Agreement and/or the State Contract; and/or (c) discussing with Enrollees, prospective Enrollees, or the public any health care services, health care providers, utilization review policies, quality assurance policies, or terms and conditions of plans and plan policy. Furthermore, Company shall not retaliate against Provider/Subcontractor, and Provider/Subcontractor shall not retaliate against its downstream providers or subcontractors, for any of the foregoing actions. Notwithstanding the foregoing, nothing in this provision shall be construed to prohibit: (a) Company or Provider/Subcontractor from making a determination not to pay for a particular health care service, from enforcing reasonable peer review or utilization review protocols, or from determining whether a physician or other health care provider has complied with those protocols; and/or (b) a Provider that is a hospital from taking disciplinary actions against a physician as authorized by law. [215 ILCS 134/30(a); 215 ILCS 134/35(a)–(d).] [Medicaid Contract § 5.36]

6. Grievances and Appeals. Provider/Subcontractor shall comply with Company's grievance and appeal processes referenced in the Agreement, and Company shall notify Provider/Subcontractor within fifteen (15) days following any substantive change to such procedures. [Medicaid Contract § 5.32.7]

7. Data and Reporting.

a. Provider/Subcontractor shall submit all data, reports, and clinical information required by Company under the State Contract in such manner and format, and pursuant to such timeframes, as requested by Company and/or HFS. Provider/Subcontractor shall ensure that all data and reports that it submits to Company are accurate and complete, and Provider/Subcontractor furthermore acknowledges and agrees that all such data and reports shall be available to HFS and, upon request, to federal CMS. [Medicaid Contract § 5.28]

b. If Provider/Subcontractor provides Covered Services to Enrollees under a Illinois Department of Human Services ("DHS") Home and Community-Based Services ("HCBS") Waiver, under the Medicaid Clinic Option, or under the Medicaid Rehabilitation Option, or provides subacute alcoholism and substance-abuse treatment services pursuant to 89 Ill. Admin. Code §§ 148.340–148.390 and 77 Ill. Admin. Code Part 2090, such Provider/Subcontractor shall enter any data regarding Enrollees that is required under State rules, or under a contract between the Provider/Subcontractor and DHS, into any subsystem maintained by DHS, including, but not limited to, DHS's Automated Reporting and Tracking System (DARTS). [Medicaid Contract § 5.32.2.3]

8. Delegation. If Company delegates to Provider/Subcontractor any activities or obligations under the State Contract:

a. Company shall remain ultimately responsible for the performance of those responsibilities and nothing in the Agreement shall be construed to terminate Company's legal responsibility to DHS to assure that all activities under the State Contract are carried out. [Medicaid Contract § 5.32.3-.5.32.24]

b. Provider/Subcontractor acknowledges and agrees that Company's oversight committee will oversee Provider/Subcontractor's activities and performance under the Agreement to ensure compliance with all applicable contractual and statutory requirements, including without limitation the Illinois Human Rights Act, the U.S. Civil Rights Act, and Section 504 of the federal Rehabilitation Act. Company's oversight of Provider/Subcontractor will include, without limitation: pre-delegation audits; quarterly delegation oversight reviews of delegate performance; monthly joint-operation meetings; annual audits of Provider/Subcontractor; regular monitoring of Enrollee complaints with respect to Provider/Subcontractor; and documentation of issues and development of a corrective action plan, as warranted, to improve performance. [Medicaid Contract § 2.7.5]

9. Quality Assurance. With respect to Company's quality-assurance obligations under the State Contract:

a. Provider/Subcontractor shall participate in and cooperate with Company's quality-assurance program (QAP), shall cooperate with Company with respect to Company's QAP obligations under the State Contract,

and shall cooperate with Company's quality improvement committee. Provider/Subcontractor shall furthermore allow Company to access Provider/Subcontractor's Enrollee medical records to permit effective quality review and monitoring of Provider/Subcontractor's compliance with policies and procedures, specifications, and appropriateness of care, and such access shall include the right of Company to make and/or obtain a copy (in either electronic or hardcopy form) of such records. [Medicaid Contract § Attachment XI]

b. Provider/Subcontractor shall provide, arrange for, or participate in the quality-assurance programs mandated by the Illinois Health Maintenance Organization Act, unless the Illinois Department of Public Health has certified that such programs will be fully implemented without any participation or action from Provider/Subcontractor. [215 ILCS 125/2-8(b); 50 Ill. Admin. Code § 4521.50(a)(4)]

c. Provider/Subcontractor acknowledges and agrees that Company shall perform quality-assurance evaluations of Provider/Subcontractor's practices, which shall include monitoring of Enrollee accessibility to ensure linguistic and physical accessibility. [Medicaid Contract § 2.7.6]

d. Provider/Subcontractor shall cooperate and comply with all remedial or corrective actions that Company implements with respect to Provider/Subcontractor and/or its services under the Agreement, upon Company's determination that Provider/Subcontractor has furnished inappropriate or substandard services or has failed to furnish services that should have been furnished. [Medicaid Contract § Attachment XI]

e. If Company delegates to Provider/Subcontractor any quality-assurance activities or obligations that Company has under the State Contract:

(i) Company and Provider/Subcontractor shall agree in writing upon the delegated activities, the accountability of Provider/Subcontractor for those activities, and the frequency of Provider/Subcontractor's reporting to Company related to those activities. [Medicaid Contract Attachment XI and 5.32.2]

(ii) Company and Provider/Subcontractor shall agree in writing upon the standards and procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the actual quality of care being provided. [Medicaid Contract § Attachment XI]

(iii) All such delegated activities shall conform to the requirements set forth in the State Contract. [Medicaid Contract Attachment XI]

(iv) Provider/Subcontractor acknowledges and agrees that Company shall engage in continuous and ongoing evaluation and oversight of such delegated activities, including approval of quality-improvement plans and regular specified reports, as well as a formal review of such activities. Company's oversight of Provider/Subcontractor's performance of these 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 Company's annual audit shall be submitted to HFS as part of Company's QA/UR/PR Annual Report. [Medicaid Contract Attachment XI

(v) If Company or Provider/Subcontractor identifies areas requiring improvement, Company or Provider/Subcontractor, as appropriate, shall take corrective action and implement a quality improvement initiative. If one or more deficiencies are identified, Provider/Subcontractor must develop and implement a corrective action plan, with protections put in place by Company to prevent such deficiencies from recurring. Evidence of ongoing monitoring of the delegated activities sufficient to assure corrective action shall be provided to HFS through quarterly or annual reporting. [Medicaid Contract Attachment XI]

10. Pharmacy Benefits. In addition to the other requirements set forth herein that are applicable to Covered Services, with respect to pharmacy-related Covered Services under the State Contract:

a. Provider/Subcontractor shall administer all pharmacy benefits in accordance with the provisions and requirements of the State Contract and all applicable State and federal laws and regulations. [Medicaid Contract § 5.3.12]

b. Provider/Subcontractor shall cooperate with Company with respect to Company's obligations under the State Contract to submit required pharmacy-related reports and data to applicable federal and State authorities. [Medicaid Contract Attachment XIII]

c. If Company delegates to Provider/Subcontractor any pharmacy-related activities or obligations that Company has under the State Contract, Provider/Subcontractor shall comply with all pharmacy-related provisions and requirements set forth in the State Contract, including required coverage of all drugs on the HFS's Preferred Drug List. [Medicaid Contract 5.3]

(i) Company and Provider/Subcontractor shall not permit or allow, whether by contract, written policy, or procedure, any individual or entity to dispense a different drug in place of the drug or brand of drug ordered or prescribed without the express permission of the person ordering or prescribing the drug, except as provided under Section 3.14 of the Illinois Food, Drug and Cosmetic Act (codified at 410 ILCS 620/3.14). [215 ILCS 134/30(b)]

11. Children's Behavioral Health Service Requirements. In addition to the other requirements set forth herein that are applicable to Covered Services, with respect to any behavioral-health Covered Services that Provider/Subcontractor provides to Enrollees that are children (a child is an individual up to but not including age 21 and any Medicaid eligible individual that is admitted before the age of twenty-one (21) to an inpatient psychiatric institution qualifying as inpatient psychiatric services for individuals under age twenty-one (21) pursuant to Federal Medicaid regulations codified at 42 CFR 440.160, until the individual is either discharged from the institution or until the individual's twenty-second (22nd) birthday, whichever comes first):

a. Provider/Subcontractor shall administer all such behavioral-health benefits in accordance with the provisions and requirements of Attachment XXII of the State Contract and in accordance with all applicable State and federal laws and regulations. [Medicaid Contract Attachment XXII]

b. Contractor shall require, as a provision of its Provider agreement with Providers of Mobile Crisis Response Services, that staff responsible for providing the services hold the following credentials: (i) Mental Health Professional (MHP) with direct access to a Qualified Mental Health professional (QMHP); (ii) Qualified Mental Health Professional; or (iii) Licensed Practitioner of the Healing Arts. [Medicaid Contract Attachment XXII, Section 1.4.6]

c. Contractor shall include within its network of Providers the necessary levels of care, with sufficient intensity, required to meet the needs of Enrollees in order to provide true alternatives to institutions (e.g., PRTFs and hospitals) when clinically appropriate. [Medicaid Contract Attachment XXII, Section 1.5.1.4]

d. Contractor shall have provisions in the Provider agreements of its Providers responsible for providing Mobile Crisis Response Services for CARES to authorize and dispatch Mobile Crisis Response Services, which shall be reimbursed by Contractor. In the event that CARES is unable to dispatch the Contractor's Mobile Crisis Response Service, CARES shall engage the fee-for-service SASS Program to ensure Crisis response to the Enrollee. In the event that an Enrollee is screened, due to necessity, by a Non- Network Provider of SASS services, Contractor shall pay for the screening at the Medicaid rate. [Medicaid Contract Attachment XXII, Section 1.6.5]

12. Third-Party Payment Sources. The Medicaid program is the payer of last resort for all Covered Services in accordance with federal regulations. If verified existence of Third Party Liability (TPL) has been established by Company at the time the claim is filed with Company, Company shall cost avoid (reject) the claim and return it to the Provider for a determination of the amount of any TPL, unless the claim is for prenatal services, labor, delivery and post-partum services, preventative pediatrics and EPSDT services per 42 U.S.C. § 1396(a)(25)(E) and 42 C.F.R. § 433.139. For these services, a cost avoidance approach is prohibited. Verification of TPL includes determination that the policy is active, enforceable and for Covered Services. [Medicaid Contract 9.1.38]

13. Cooperation with Company. Provider/Subcontractor shall cooperate with Company with respect to Company's obligations under the State Contract, including without limitation:

a. Company's obligation to submit financial and expense-related reports/data to the State relating to the risk adjustment and Medical Loss Ratio (MLR) adjustment set forth in the State Contract. [Medicaid Contract 7.4]

b. Company's obligation to investigate, pursue, and report on coordination-of-benefit and third-party-liability resources and recoveries. [Medicaid Contract 7.4]

c. Company's obligation to develop the Enrollee's care plan and to encourage Provider/Subcontractor to support Enrollees in directing their own care and in development of the Enrollee's care plan. [Medicaid Contract 5.13.5]

d. Company's obligation to avoid unnecessary utilization of emergency services by Enrollees and to promote care management through the Enrollees' primary care providers (PCPs) [Medicaid Contract 5.20.1.1.6]

e. Company's obligation to establish and maintain an HFS-approved peer-review program to review the quality of care that Provider/Subcontractor provides to Enrollees. [Medicaid Contract 5.22.5]

f. Company's obligation to provide orientation, education, and training for Provider/Subcontractor as set forth in the State Contract, including without limitation (i) training on how to identify, recognize potential concerns related to, and report on suspected or alleged abuse, neglect, and exploitation being suffered by Enrollees, and (ii) education on the application of required clinical guidelines. [Medicaid Contract 5.10, Attachment XI]

g. Company's obligation to participate in any State-required performance-improvement projects. [Medicaid Contract 7.16.8]

h. Company's obligation to remit to Provider/Subcontractor, if applicable, any "hospital access payments" authorized under 305 ILCS 5/5A-12.2(s)–(t) and 305 ILCS 5/5A-12.5 (Public Act 98-651, enacted June 14, 2014).

i. Company's obligation to respond to any letter of concern, written deficiency notice, or request for a corrective action plan that Company receives from the State relating to Provider/Subcontractor or the services that are within the scope of the Agreement. [Medicaid Contract 7.16.9]

j. Company's obligations and responsibilities relating to the "HMO self-evaluation structure" and associated activities set forth in 77 Ill. Admin. Code § 240.60. [77 Ill. Admin. Code § 240.50(d)(1)(C)]

14. Notice of Legal Action. If Provider/Subcontractor, its parent, or one of its affiliates becomes a party to any litigation, investigation, or transaction that may reasonably be considered to have a material impact on Provider/Subcontractor's ability to perform under the Agreement, Provider/Subcontractor shall immediately notify Company in writing. [Medicaid Contract 9.1.24]

15. State Review of Agreement. Provider/Subcontractor acknowledges and agrees that Company may be required to submit a copy of the Agreement to HFS for review, and that HFS reserves the right to require Company to amend the Agreement as reasonably necessary to conform to Company's duties and obligations under the State Contract. [Medicaid Contract § 5.32.11]

16. Termination of Agreement and Effect Thereof.

a. In the event the Agreement is terminated, such termination shall not constitute termination of any other agreement that Provider/Subcontractor has entered into with Company or an Affiliate of Company unless otherwise agreed to in writing by the parties. Furthermore, in the event this State Compliance Addendum is terminated, such termination shall not constitute termination of any other Product Addendum or Product Participation that Provider/Subcontractor has entered into with Company pursuant to the Agreement unless otherwise agreed to in writing by the Parties.

b. Notwithstanding anything in the Agreement to the contrary, if either Company or Provider/Subcontractor seeks (i) to terminate the Agreement "with cause" (as that term is used and defined in the Agreement), the terminating party shall provide at least sixty (60) days' written notice to the other party; or (ii) to terminate the Agreement "without cause" (as that term is used and defined in the Agreement), the terminating party shall provide at least ninety (90) days' written notice to the other party. Furthermore, Provider/Subcontractor shall cooperate with Company with respect to Company's obligation to provide timely notice to Enrollees of any termination that would curtail or eliminate services to such Enrollees, with such notice to be sent (i) at least sixty (60) days prior to that termination, or (ii) immediately, if Company receives less than sixty (60) days' notice of that termination from Provider/Subcontractor. The notice to be sent to Enrollees shall include instructions regarding referrals that have previously been issued and appointments that may be pending. [50 Ill. Admin. Code § 4521.50(a)(5)–(6)]

c. Notwithstanding anything in the Agreement to the contrary, Company shall retain the right to terminate the Agreement, or impose other sanctions, if the performance of Provider/Subcontractor is inadequate. Company shall monitor the performance of Provider/Subcontractor on an ongoing basis, shall subject Provider/Subcontractor to formal review on no less than a triennial basis, and to the extent deficiencies or areas for improvement are identified during an informal or formal review, shall require Provider/Subcontractor to take appropriate corrective action. Furthermore, Company shall promptly terminate the Agreement if Provider/Subcontractor is or becomes terminated, barred, or suspended, or has 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. [Medicaid Contract 5.32.8]

17. Maintenance, Access to, and Confidentiality of Records.

a. Provider/Subcontractor shall maintain books and records relating to the performance of the State Contract and/or the Agreement and necessary to support amounts charged under the State Contract and the Agreement. Books and records, including information stored in databases or other computer systems, shall be maintained by Provider/Subcontractor for a period of ten (10) years from the later of the date of final payment under the Agreement or completion of the Agreement, the date of completion of any audit, or such longer time as may be required by federal law or regulation. Books and records required to be maintained under this provision shall, along with any equipment, facilities, or premises, be accessible for review or audit by representatives of Company or any Authorized Persons (along with the Executive Inspector General and the Chief Procurement Officer) upon reasonable notice and during normal business hours, at any time during the ten (10) year period noted above or such longer time as may be required by federal law or regulation. Such access shall include the right to make and/or obtain a copy (in either electronic or hardcopy form) of such books and records. Provider/Subcontractor 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 provision shall establish a presumption in favor of the State for the recovery of any funds paid by the State under the State Contract for which adequate books and records are not available to support the purported disbursement. Provider/Subcontractor shall not impose a charge for audit or examination of Provider/Subcontractor's books and records. [Medicaid Contract § 9.1.2]

b. Provider/Subcontractor may have or gain access to confidential data or information owned or maintained by the State or Company in the course of carrying out Provider/Subcontractor's responsibilities under the Agreement and/or the State Contract. Provider/Subcontractor shall presume all information received from the State or Company, or to which it gains access pursuant to the Agreement and/or the State Contract, is confidential. No confidential data collected, maintained, or used in the course of performance of the Agreement and/or the State Contract shall be disseminated except as authorized by law and with the written consent of the State and/or Company, as applicable, either during the term of the State Contract or thereafter, unless otherwise expressly provided in the State Contract. Provider/Subcontractor must return any and all data collected, maintained, created, or used in the course of the performance of the Agreement and/or the State Contract, in whatever form it is maintained, promptly at the earlier of the termination of the Agreement or the termination of the State Contract, or earlier at the request of the State, or notify the State and/or Company, as applicable, in writing of its destruction. The foregoing obligations shall not apply to confidential data or information that is: (i) lawfully in Provider/Subcontractor's possession prior to its acquisition from the State and/or Company; (ii) received in good faith from a third-party not subject to any confidentiality obligation to the State and/or Company; (iii) now is or later becomes publicly known through no breach

of confidentiality obligation by Provider/Subcontractor; or (iv) is independently developed by Provider/Subcontractor without the use or benefit of the confidential information of the State and/or Company. [Medicaid Contract 9.1.6]

c. Provider/Subcontractor 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 Provider/Subcontractor and Provider/Subcontractor's employees, by Provider/Subcontractor's corporate affiliates and their employees, and by Provider/Subcontractor's subcontractors and their employees, pursuant to 305 ILCS 5/11-9, 11-10, and 11-12; 42 U.S.C. § 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 Provider/Subcontractor, in the course of performing under the terms of the Agreement, serves as a business associate of Company and/or HFS, as "business associate" is defined in the HIPAA Privacy Rule (45 C.F.R. § 160.103), Provider/Subcontractor shall assist Company and/or HFS in responding to the client as provided in the HIPAA Privacy Rule, and shall maintain for a period of ten (10) years any records relevant to an individual's eligibility for services under the HFS Medical Program. [Medicaid Contract 9.1.21]

d. Provider/Subcontractor, to which Company provides Enrollee PHI that Company has received from HFS or created or received by Company on behalf of HFS, agrees to the same restrictions, conditions, and requirements that apply under the terms of the State Contract to Company with respect to such information. [Medicaid Contract Attachment VI]

e. Company may designate in writing certain agreements between Company and any Provider/Subcontractor as confidential or proprietary. If Company makes such an election, HFS 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 HFS receives a request for said information under the State Freedom of Information Act, however, it may require Company to submit justification for asserting the exemption. Company, Provider and Subcontractor acknowledge and agree HFS may honor a properly executed criminal or civil subpoena. [Medicaid Contract 5.32.12]

18. Medical Records. With respect to Enrollee medical records:

a. In addition to the requirements set forth in the Agreement, Provider/Subcontractor shall maintain Enrollee medical records in a timely, legible, accurate, current, complete, and organized manner, with appropriate dates and identification and initialing/signature of the Provider/Subcontractor, to facilitate retrieval and compilation of records, to ensure Enrollee continuity of care, and to permit effective and confidential patient care and quality review. For each encounter or episode of care that Provider/Subcontractor has with an Enrollee, Provider/Subcontractor shall place the following information into the Enrollee's medical records: (1) the reason for the encounter; (2) evidence of the Provider/Subcontractor's assessment of the Enrollee's health problems; (3) current diagnosis of the Enrollee, including the results of any diagnostic tests; (4) the plan of treatment, including any therapies and health education; (5) any medical history relevant to the current episode of care; and (6) confirmation that all outcomes of ancillary reports, such as laboratory tests and x-rays, have been reviewed by the individual or entity who ordered the reports and that follow-up actions have been taken regarding report results that are deemed significant by the individual or entity who ordered those reports. [77 Ill. Admin. Code §§ 240.50(c)(1), 240.90(a)–(b); Medicaid Contract 5.26.3]

b. Provider/Subcontractor shall ensure that Enrollee medical records contain documented efforts to obtain Enrollee consent when required by law. Provider/Subcontractor shall furthermore only release Enrollee medical records to Authorized Persons, or to any primary care provider (PCP), women's health care provider (WHCP), or other Provider of Enrollee (subject to Enrollee's consent when required by law), and shall only release original Enrollee medical records in accordance with federal or State law, court orders, subpoenas, or a valid records-release form executed by the Enrollee. Provider/Subcontractor shall protect the confidentiality and privacy of minors, and shall abide by all federal and State laws regarding the confidentiality and disclosure of medical records, mental health records, and any other information about Enrollees. Provider/Subcontractor shall produce Enrollee medical records to HFS upon request. [Medicaid Contract 5.26.3]

c. If Provider/Subcontractor is an Enrollee's primary care provider (PCP), Provider/Subcontractor shall furthermore maintain a permanent medical record for that Enrollee to ensure continuity of care. The medical record for each Enrollee who has had a routine, scheduled appointment with his/her primary care provider (PCP) shall

include the following information: (1) identification; (2) patient history; (3) known past surgical procedures; (4) known past and current diagnoses and problems; and (5) known allergies and untoward reactions to drugs. [77 Ill. Admin. Code § 240.90(c); Medicaid Contract §5.26.3]

d. If Enrollee changes PCPs or "medical homes," Provider/Subcontractor shall forward Enrollee's medical records or copies thereof to the new PCP or "medical home" promptly upon Enrollee's transfer. [Medicaid Contract §5.26.3

e. Provider/Subcontractor shall only record diagnosis codes in Enrollee's medical records at the time of creation of that medical record, and shall not retroactively adjust any such diagnosis codes except to correct errors. [Medicaid Contract § 5.26.3]

19. Use of Hospitalists. Neither Company nor Provider/Subcontractor shall require or otherwise mandate, whether by contract, written policy, or procedure, any Enrollee to substitute his or her participating primary care provider (PCP) during inpatient hospitalization, such as with a hospitalist physician, without the agreement of that Enrollee's participating primary care provider (PCP). Company and Provider/Subcontractor (if applicable) shall inform Enrollees of any policies, recommendations, or guidelines concerning the substitution of the Enrollee's primary care provider (PCP) when hospitalization is necessary in the manner set forth in 215 ILCS 5/15(d)–(e). [215 ILCS 134/30(c)]

20. Provider Enrollment, Credentialing, Licensure, and Privileges.

a. Provider/Subcontractor shall be enrolled as a provider in the HFS Medical Program (as defined below), if such enrollment is required by HFS's rules or policy in order to submit claims for reimbursement or otherwise participate in the HFS Medical Program. Provider/Subcontractor shall not, in turn, contract or subcontract with an individual or entity that has voluntarily withdrawn from the HFS Medical Program as the result of a settlement agreement. For purposes of this provision, the term "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 Titles XIX (42 U.S.C. § 1396 *et seq.*) and XXI (42 U.S.C. § 1397aa *et seq.*) of the Social Security Act, and Section 12-4.35 of the Illinois Public Aid Code (305 ILCS 5/12-4.35); and (ii) the State Children's Health Insurance Program administered under 215 ILCS 106 and Title XXI of the Social Security Act (42 U.S.C. § 1397aa *et seq.*). [Medicaid Contract § 5.28.4; 1.1.94; Attachment XI]

b. Provider shall comply with all credentialing and recredentialing policies and procedures that Company implements to verify Provider's credentials, including without limitation by completing a credentialing application in accordance with applicable policies and procedures. Furthermore, Provider shall comply with all applicable credentialing/recredentialing standards and requirements set forth in the State Contract and in applicable federal and State laws, regulations, and written policies.] [Medicaid Contract § 1.1.94; Attachment XI]

c. If Provider/Subcontractor operates a laboratory testing site that provides services to Enrollees, (i) that site shall possess a valid Clinical Laboratory Improvement Amendment (CLIA) certificate and comply with the CLIA regulations found at 42 C.F.R. Part 493, and (ii) Provider/Subcontractor shall report lab values to Company directly. [Medicaid Contract § 5.28.9.4]

d. If Provider is a physician, such physician Provider shall have and maintain admitting privileges and, as appropriate, delivery privileges at a hospital that is also a participating Provider with Company; or, in lieu of these admitting and/or delivery privileges, such physician Provider shall have a written referral agreement with a separate physician who is a participating Provider with Company and who has such privileges at a hospital that is also a participating Provider with Company. Such physician Provider shall coordinate care with the referring physician and shall ensure that Enrollee medical records are appropriately transferred; the physicians' written referral agreement shall contain appropriate provisions that document and require such coordination of care and transfer of medical records. [Medicaid Contract § 5.32.2.2]

e. If Provider/Subcontractor provides long-term care and HCBS services under the Agreement, Provider/Subcontractor shall be approved and authorized by the State to provide such Covered Services, and shall only provide to Enrollees those particular Covered Services for which they are approved and authorized. [Medicaid Contract § 5.9.3]

21. Disclosure of Ownership and Control; Prohibited Relationships; Background Checks.

a. Consistent with federal disclosure requirements described in 42 C.F.R. § 455.100 through 42 C.F.R. § 455.106 and 42 C.F.R. § 438.610, and to ensure that Company does not make a payment to an individual or entity that has been criminally convicted of a felony, is debarred, suspended, or otherwise excluded from participating in federal health care programs, or is excluded from participating in procurement activities under the Federal Acquisition Regulation, or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, Provider/Subcontractor shall disclose to Company: any required ownership and control, relationship, and financial interest information; any changes to ownership and control, relationship, and financial interest information; and information on any criminal convictions regarding Provider/Subcontractor and any owner(s) and managing employee(s) at the time the Agreement is executed and annually thereafter, and any time there are changes to such information. [Medicaid Contract § 9.2.34]

b. No Provider/Subcontractor, no individual who has a direct or indirect ownership or controlling interest of 5% or more of that Provider/Subcontractor, and no officer, director, agent, or managing employee (*i.e.*, general manager, business manager, administrator, director, or like individual who exercises operational or managerial control over that Provider/Subcontractor or who directly or indirectly conducts the day-to-day operation of that Provider/Subcontractor) shall be an entity or individual: (1) who has been convicted of any offense under Section 1128(a) of the Social Security Act (42 U.S.C. § 1320a-7(a)) or of any offense related to fraud or obstruction of an investigation or a controlled substance described in Section 1128(b)(1)–(3) of the Social Security Act (42 U.S.C. § 1320a-7(b)(1)–(3)); (2) against whom a civil monetary penalty has been assessed under Section 1128A or 1129 of the Social Security Act (42 U.S.C. §1320a-7a; 42 U.S.C. §1320a-8); or (3) who has been excluded from participation in a program under Title XVII, 1902(a)(39) and (41) of the Social Security Act, Section 4724 of the Balanced Budget Act or under a State health care program. [Medicaid Contract § 9.2.34]

c. Provider/Subcontractor shall not be an Excluded Person (as that term is defined below), and shall not employ, subcontract with, or affiliate with an Excluded Person. The term "Excluded Person" means any individual or entity that (i) 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; (ii) has not been reinstated in the program after a period of exclusion, suspension, debarment, or ineligibility; or (iii) 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. Provider/Subcontractor acknowledges and agrees that under the State Contract, Company must terminate its relationship with Provider/Subcontractor immediately upon learning that such Provider/Subcontractor meets the definition of an Excluded Person, and must notify the HFS OIG of the termination. [Medicaid Contract § 5.25; 9.1.33]

d. Provider/Subcontractor acknowledges and agrees that prior to entering into the Agreement, Company may be required to submit a disclosure statement to HFS identifying any agreements, Providers, and/or Subcontractors in which any of the following have a financial interest of five percent (5%) or more: (a) any individual or entity also having a financial interest of five percent (5%) or more in Company or Company's affiliates as defined by 42 C.F.R. § 455.101; (b) any director, officer, trustee, partner, or employee of Company or Company's Affiliates; and (c) any member of the immediate family of any individual or entity designated above. [Medicaid Contract § 5.32.13]

e. Provider/Subcontractor acknowledges and agrees that the State may conduct, at the State's expense and whenever the State deems it reasonably necessary for security reasons, criminal and driver history background checks of Provider/Subcontractor and its officers, employees, or agents, and furthermore acknowledges and agrees that Provider/Subcontractor shall immediately reassign any such individual who, in the opinion of the State, does not pass the background checks. [Medicaid Contract § 9.1.13]

22. Program Integrity.

a. As a condition of receiving payment, Provider agrees to comply with the State Contract, Section 5.35. [Medicaid Contract (3rd Amend.), Section 5.35.1]

b. Any Subcontractors delegated responsibility for coverage of services or payment of claims under the Agreement, shall implement and maintain a compliance program, as described within 42 CFR 438.608, that includes, at a minimum, the following: (1) Written policies, procedures, and standards of conduct that demonstrate compliance with all applicable requirements and standards under the Contract and all federal and state requirements related to program integrity; (2) A designated Compliance Officer who is responsible for developing and implementing policies and procedures designed to ensure compliance with program integrity requirements. The Compliance Officer shall report directly to Contractor's CEO and Board of Directors. (3) A Regulatory Compliance Committee, consisting of members of the Board of Directors and senior management, which is responsible for oversight of the Contractor's compliance program. (4) A system of training and education for the Compliance Officer, Board of Directors, senior managers, and employees regarding Contractor's obligation to comply with federal and state requirements. (5) Effective lines of communication between the Compliance Officer and Contractor's employees, Subcontractors, and Network Providers. (6) Effective lines of communication between Contractor's Compliance Officer, Contractor's employees and the Office of Inspector General (OIG). (7) Enforcement of regulatory standards and program integrity-related requirements through well-publicized disciplinary guidelines. (8) A system of established and implemented procedures that includes surveillance and utilization controls conducted by a designated Special Investigations Unit (SIU) of dedicated staff adequate in number for routine internal monitoring, auditing of program integrity compliance risks, prompt response to compliance issues, investigation of potential compliance problems identified in the course of self-evaluation and audits, correction of identified compliance problems through corrective action plans, and ongoing compliance with program integrity-related requirements. (9) Under the purview of the Compliance Officer, Contractor shall employ Fraud, Waste and Abuse Investigators at a minimum ratio of one (1) investigator to every 100,000 Enrollees. [Medicaid Contract, (3rd Amend.), Section 5.35.2]

c. Recoveries of overpayments. Subcontractors shall have internal policies and procedures to identify and recover overpayments within timeframes as determined by the OIG, specifically for the recovery of overpayments due to Fraud, Waste, Abuse, mismanagement, and misconduct. [Medicaid Contract (3rd Amend.), Section 5.35.11]

d. Self-Disclosure. Contractor shall include in its Network Provider agreements the requirement that the Provider/Subcontractor shall report to Contractor when it has received an overpayment from Contractor. The Provider shall return the identified overpayment to Contractor within sixty (60) days of identifying the overpayment and notify Contractor in writing the specific reason for the overpayment and how the overpayment was identified by the Provider. [Medicaid Contract (3rd Amend.), Section 5.35.12]

e. In accordance with State Contract, Section 5.35, Subcontractor shall report in writing to the OIG any suspected Fraud, Waste, Abuse, or financial misconduct associated with any service or function provided for under this Contract by any parties directly or indirectly affiliated with the State Contract, including Contractor's staff, Subcontractors, the Department's employees, and the Department's Contractors. Subcontractor shall make this report within three (3) days after first suspecting Fraud, Waste, Abuse, or financial misconduct. Nothing in this section precludes 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. [Medicaid Contract, Section 9.1.29]

23. Business Enterprise Program (BEP) Registration. In the event that Provider/Subcontractor is a minority-owned business, a female-owned business, or a business owned by persons with disabilities, then Provider/Subcontractor shall seek and obtain State certification as a Business Enterprise Program (BEP) vendor under the Business Enterprise Program Act for Minorities, Females and Persons with Disabilities. Provider/Subcontractor shall furthermore cooperate with Company with respect to Company's obligations under the State Contract related to the Business Enterprise Program (BEP) and shall, among other things, maintain a record of all relevant data with respect to the utilization of BEP-certified individuals and entities, 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 Agreement. [Medicaid Contract § 2.9.2 & 7.16.5]

24. Marketing Activities. Provider/Subcontractor shall not engage in any inappropriate or unallowable marketing activities and practices as set forth in the State Contract and 42 C.F.R. § 438.104, and shall submit to Company for its review any marketing or information materials of Provider/Subcontractor that relate to the State Contract, prior to disseminating same. Provider/Subcontractor furthermore shall not induce any employees of the State to improperly reveal any confidential information regarding Enrollees or otherwise use such confidential information in a fraudulent manner. [Medicaid Contract § 4.17]

25. Compliance with Laws, the State Contract, and Company Policies and Procedures.

a. Provider/Subcontractor shall perform all services and other duties under the Agreement in accordance and compliance with, and subject to, all applicable federal, State, and local laws, rules, ordinances, regulations, orders, federal circulars, and license and permit requirements in the performance of the Agreement, including without limitation, 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, and/or federal CMS. Company shall be in compliance with applicable tax requirements and shall be current in payment of such taxes. Company shall obtain at its own expense all licenses and permissions necessary for the performance of the Agreement. [Medicaid Contract 2.5]

b. Provider/Subcontractor shall be bound by the terms and conditions of the State Contract that are appropriate to the services provided by, or activities delegated to, Provider/Subcontractor in connection with the State Contract. These terms and conditions include, without limitation, the record-keeping and audit provisions of the State Contract, such that the Authorized Persons shall have the same rights to audit and inspect Provider/Subcontractor (and any downstream providers or subcontractors thereof) as they have to audit and inspect Company. [Medicaid Contract § 5.32.2.1]

c. Provider/Subcontractor shall comply with the prior-authorization requirements and processes set forth in Company's policies and procedures. [Medicaid Contract § 5.19.7]

d. Provider/Subcontractor shall comply with all utilization-management and peer-review programs, processes, and timeframes established by Company. [Medicaid Contract Attachment XII]

26. State Employee Handbook. If Provider/Subcontractor or any of its employees and subcontractors provide services under the Agreement at a location controlled by HFS or any other State agency, Provider/Subcontractor shall abide by all applicable provisions of the controlling State agency's Employee Handbook. [Medicaid Contract § 9.1.27]

27. Prohibition on Gifts. Provider/Subcontractor and its principals, employees, and subcontractors are prohibited from giving gifts to HFS employees, and from giving gifts to, or accepting gifts from, any individual or entity that has a contemporaneous contract with HFS involving duties or obligations related to the Agreement and/or the State Contract. [Medicaid Contract § 9.1.30]

28. No Transfer of Liability to Providers. Neither Company nor Subcontractor shall transfer or attempt to transfer to any health care provider, by indemnification, hold harmless, or contribution requirements that are set forth in any contract, written policy, or procedure, any liability relating to activities, actions, or omissions of Company and/or Subcontractor or their respective officers, employees, or agents; provided, however that nothing in this provision shall relieve any health care provider from liability for his, her, or its own negligence in the performance of his, her, or its duties arising from treatment of an Enrollee. [215 ILCS 134/95]

29. Capitated Contracts. If Company compensates Provider/Subcontractor under the Agreement on a capitated basis for furnishing, arranging, or providing health care services:

a. Provider/Subcontractor agrees that in no event, including but not limited to nonpayment by Company of amounts due to Provider/Subcontractor under the Agreement, insolvency of Company, or any breach of the Agreement by Company, shall Provider/Subcontractor or its assignees or subcontractors have a right to or seek any type of payment from, bill, charge, collect a deposit from, or have any recourse against, the Enrollee or persons acting on the Enrollee's behalf (other than Company) for services provided pursuant to the Agreement, except for the payment of applicable copayments or deductibles for services covered by Company or fees for services not covered by Company. The requirements of this provision shall survive any termination of the Agreement for services rendered prior to such termination, regardless of the cause of such termination. Company's Enrollees and persons acting on the Enrollees' behalf (other than Company) shall be third-party beneficiaries of this provision. This provision supersedes any oral or written agreement now existing or hereafter entered into between Provider/Subcontractor and the Enrollee or persons acting on the Enrollee's behalf (other than Company). [50 Ill. Admin. Code § 4521.50(e)]

b. Provider/Subcontractor shall submit timely encounter data/records for all Covered Services that it has provided to Enrollees, in the format specified by the State, so that Company can meet the encounter-reporting specifications and requirements set forth in the State Contract. Provider/Subcontractor shall be responsible for transmitting all data to Company as required by 42 C.F.R. § 438. [Medicaid Contract § 7.10.10]

c. If Provider/Subcontractor is a "Managed Care Organization" as that term is defined in 50 Ill. Admin. Code § 5241.20, Provider/Subcontractor shall submit to Company copies of Provider/Subcontractor's quarterly financial statements, which shall include Provider/Subcontractor's balance sheet and statements of income and cash flow within forty-five (45) days after the end of each fiscal period. In addition, Provider/Subcontractor shall submit, within ninety (90) days after the end of Provider/Subcontractor's fiscal year, copies of Provider/Subcontractor's audited annual financial statements prepared in accordance with generally accepted accounting principles, if available. Provider/Subcontractor acknowledges and agrees that HFS, at its discretion, may require Company to submit for HFS's inspection the financial statements that Company has received from Provider/Subcontractor (which such financial statements shall be deemed confidential by HFS). Provider/Subcontractor agrees to fully cooperate with, and disclose all relevant information requested by, Company's actuaries for the preparation of such actuaries' opinion in accordance with the Actuarial Standards Board Actuarial Standards of Practice No. 16. Company acknowledges that in the event of Provider/Subcontractor's insolvency, Company is secondarily liable as the ultimate risk bearer for unpaid health care services rendered to Company's Enrollees. [50 Ill. Admin Code §5241.50(d)] For purposes of this provision, "Managed Care Organization" or "MCO" means a partnership, association, corporation, or other legal entity, including but not limited to individual practice associations (IPAs) and physician hospital organizations (PHOs), that delivers or arranges for the delivery of health care services through providers it has contracted with or otherwise made arrangements with to furnish those health care services. [50 Ill. Admin. Code § 5241.20]

30. Compensation. Provider-compensation models shall reimburse for Covered Services provided and may reimburse for performance. Company shall not permit any payment to Provider for Covered Services other than the payment made by Contractor, except when specifically required by the State Contract or applicable law as provided in 42 CFR §438.60.

31. Binding. All provider agreements and subcontracts are binding and Company will promptly terminate all contracts with providers and subcontractors or impose other sanctions if the performance is inadequate, as determined by either DFS or the Company. Company will promptly terminate contracts with providers that are terminated, barred, or 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. [Medicaid Contract 5.32.10]

32. Lab Testing Sites All laboratory testing sites providing services under this Agreement must possess a valid Clinical Laboratory Improvement Amendments (CLIA) certificate and comply with the CLIA regulations found at 42 CFR §493. [Medicaid Contract 5.32.10]

33. Foreign Entities Access to PHI. No subcontractor that is not subject to the jurisdiction of the United States of America shall have access to any HFS information technology system that contains PHI. [Medicaid Contract 5.32.15]

34. Required Certifications of Provider/Subcontractor. Provider/Subcontractor acknowledges and agrees that its compliance with Section 9.2 of each of the State Contract and each subsection of Section 9.2 (collectively, the "Standard Certifications") is a material requirement and condition of this Agreement during the entire term thereof, including during any renewal periods. By executing the Agreement, Provider/Subcontractor certifies compliance with the Standard Certifications in their entirety, and Provider/Subcontractor is under a continuing obligation to remain in compliance with, and to report any non-compliance with respect to, the Standard Certifications. Furthermore, Provider/Subcontractor shall include the Standard Certifications in any subcontracts or other contracts with its downstream entities or related entities that Provider/Subcontractor enters into in connection with the State Contract. During the term of the State Contract, Provider/Subcontractor shall confirm compliance with the Standard Certifications 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 the State Contract remains in effect. As part of each Standard Certification, Provider/Subcontractor acknowledges and agrees that if Provider/Subcontractor or its subcontractors, downstream entities, or related entities provide false information, or fail to be or remain in compliance with the Standard Certifications, one or more of the following sanctions will apply: (a) the Agreement

may be void by operation of law; (b) the State may void the Agreement; and (c) Provider/Subcontractor and its subcontractors, downstream entities, or related entities may be subject to one or more of the following: suspension, debarment, denial of payment, civil fine, or criminal penalty. [Medicaid Contract § 9.2.1]

The Standard Certifications are set forth below:

a. Provider/Subcontractor certifies it and its employees will comply with applicable provisions of the United States 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 the performance of this Agreement. [Medicaid Contract § 9.2.2]

b. Provider/Subcontractor certifies, if applicable, 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. [Medicaid Contract § 9.2.3]

c. Provider/Subcontractor (if an individual, sole proprietor, partner, or an individual as member of an LLC) certifies, if applicable, that it has not received (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). [Medicaid Contract § 9.2.4]

d. Provider/Subcontractor certifies, if applicable, 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. [Medicaid Contract § 9.2.5]

e. Provider/Subcontractor certifies that it has neither been convicted of bribing or attempting to bribe an officer or employee of the State or any other state, nor made an admission of guilt of such conduct that is a matter of record (30 ILCS 500/50-5). [Medicaid Contract § 9.2.7]

f. If Provider/Subcontractor has been convicted of a felony, Provider/Subcontractor 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). [Medicaid Contract § 9.2.8]

g. If Provider/Subcontractor, or any officer, director, partner, or other managerial agent of Provider/Subcontractor, 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, Provider/Subcontractor certifies that at least five (5) years have passed since the date of the conviction. Provider/Subcontractor further certifies that it is not barred from being awarded a contract and acknowledges that the State shall declare the Agreement void if this certification is false (30 ILCS 500/50-10.5). [Medicaid Contract §9.2.9]

h. Provider/Subcontractor 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). [Medicaid Contract § 9.2.10]

i. Provider/Subcontractor 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 Provider/Subcontractor and its affiliates acknowledge that the State may declare the Agreement void if this certification is false (30 ILCS 500/50-11) or if Provider/Subcontractor 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). [Medicaid Contract § 9.2.11]

j. Provider/Subcontractor certifies that it and its 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 Agreement being declared void. [Medicaid Contract § 9.2.12]

k. Provider/Subcontractor 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). [Medicaid Contract § 9.2.13]

l. Provider/Subcontractor 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 Provider/Subcontractor 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). [Medicaid Contract § 9.2.14]

m. Provider/Subcontractor certifies that it is not in violation of the "Revolving Door" section of the Illinois Procurement Code (30 ILCS 500/50-30). [Medicaid Contract § 9.2.15]

n. Provider/Subcontractor 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). [Medicaid Contract § 9.2.16]

o. Provider/Subcontractor 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). [Medicaid Contract § 9.2.17]

p. In accordance with the Steel Products Procurement Act, Provider/Subcontractor 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). [Medicaid Contract § 9.2.18]

q. If Provider/Subcontractor employs twenty-five (25) or more employees, Provider/Subcontractor certifies that it will provide a drug free workplace pursuant to the Drug Free Workplace Act (30 ILCS 580). [Medicaid Contract § 9.2.19]

r. Provider/Subcontractor certifies that neither Provider/Subcontractor nor any substantially owned affiliate of Provider/Subcontractor 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 (30 ILCS 582). [Medicaid Contract §9.2.20]

s. Provider/Subcontractor 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). [Medicaid Contract § 9.2.21]

t. Provider/Subcontractor 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). [Medicaid Contract § 9.2.22]

u. Provider/Subcontractor 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). [Medicaid Contract § 9.2.23]

v. Provider/Subcontractor 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 Agreement have been or will be produced in whole or in part by forced labor, or indentured labor under penal sanction (30 ILCS 583). [Medicaid Contract § 9.2.24]

w. Provider/Subcontractor certifies that no foreign-made equipment, materials, or supplies furnished to the State under the Agreement have been produced in whole or in part by the labor or any child under the age of twelve (30 ILCS 584). [Medicaid Contract § 9.2.25]

x. Provider/Subcontractor certifies that it is not in violation of Section 50-14.5 of the Illinois Procurement Code (30 ILCS 500/50-14.5), which 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." [Medicaid Contract § 9.2.26]

y. Provider/Subcontractor warrants and certifies that it and, to the best of its knowledge, its subcontractors, downstream entities, or related entities, have and will comply with Executive Order No. 1 (2007). That Order generally prohibits contractors and subcontractors from hiring the then-serving Illinois Governor's family members to lobby procurement activities of the State, or any other unit of government in the State 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. [Medicaid Contract § 9.2.27]

z. Provider/Subcontractor certifies that information technology, including electronic information, software, systems, and equipment developed or provided under the Agreement 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). [Medicaid Contract § 9.2.28]

aa. Provider/Subcontractor 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.* If at any time during the term of the Agreement, Provider/Subcontractor becomes barred, suspended, or excluded from participation in this transaction, Provider/Subcontractor shall, within thirty (30) days after becoming barred, suspended, or excluded, provide to HFS a written description of each offense causing the exclusion, the date(s) of the offense(s), the action(s) causing the offense(s), any penalty assessed or sentence imposed, and the date any penalty was paid or sentence completed. [Medicaid Contract § 9.2.29]

bb. Provider/Subcontractor certifies that neither Provider/Subcontractor, nor any party directly or indirectly affiliated with Provider/Subcontractor, including but not limited to Provider/Subcontractor's officers, directors, employees, and subcontractors, and the officers, directors, and employees of Provider/Subcontractor's subcontractors, shall have or acquire any Conflict of Interest (as defined below) in performance of the Agreement. Provider/Subcontractor shall disclose in writing any Conflicts of Interest to HFS no later than seven (7) days after learning of the Conflict of Interest. HFS may initiate any inquiry as to the existence of a Conflict of Interest, and Provider/Subcontractor shall cooperate with all such inquiries. HFS shall determine, in its sole discretion, whether a Conflict of Interest exists or whether Provider/Subcontractor failed to make any required disclosure. If HFS concludes that a Conflict of Interest exists, or that Provider/Subcontractor failed to disclose any Conflict of Interest, HFS may impose one or more remedies in its sole discretion, including without limitation the elimination of the Conflict of Interest or the non-renewal or termination of the Agreement. [Medicaid Contract § 9.2.30]

i. For purposes of this provision, "Conflict of Interest" shall mean an interest of Provider/Subcontractor, or any entity described above, which may be direct or indirect, professional, personal, financial, or beneficial in nature that, in the sole discretion of HFS, compromises, appears to compromise, or gives the appearance of impropriety with regard to Provider/Subcontractor's duties and responsibilities under the Agreement. 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 Provider/Subcontractor becomes a party to any litigation, investigation, or transaction that materially impacts Provider/Subcontractor's ability to perform under the Agreement. Any situation where Provider/Subcontractor's role under the Agreement competes with Provider/Subcontractor'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. [Medicaid Contract § 9.2.30.1]

cc. Provider/Subcontractor 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. [Medicaid Contract § 9.2.31]

dd. Provider/Subcontractor 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 Provider/Subcontractor, 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. 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, Provider/Subcontractor shall complete and submit Standard Form LLL, "Disclosure Forms to Report Lobbying," in accordance with its instructions. Such form is to be obtained at Provider/Subcontractor's request from the HFS Bureau of Fiscal Operations. Provider/Subcontractor shall require that the language of this certification be included in the award document for sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly. This certification is a material representation of fact upon which reliance was placed when the Agreement 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. [Medicaid Contract 9.2.32]

ee. Provider/Subcontractor 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). Provider/Subcontractor will not make a political contribution that will violate these requirements, which are effective for the duration of the term of office of the incumbent State governor or for a period of two (2) years after the end of the Agreement's term, whichever is longer. Provider/Subcontractor will certify, as applicable, either that it is not required to register as a business entity with the State Board of Elections, or has registered with the State Board of Elections and will appropriately and timely update that registration. [Medicaid Contract Attachment X]

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