

STATE OF ILLINOIS

SOLICITATION DOCUMENT

MEDICARE-MEDICAID ALIGNMENT INITIATIVE / 2013-24-004

The Illinois Department of Healthcare and Family Services (Department) is requesting Proposals (Offers) from responsible Offerors to meet the needs of the United States and State. Below is a brief description of our needs with detailed requirements in subsequent sections of this solicitation. If you are interested and able to meet these requirements, please submit a Proposal. **This procurement is a Purchase of Care, which is exempt from the Procurement Code (30 ILCS 500/1-10(b)(3)) and Standard Procurement Rules (44 Ill. Admin. Code 1.10(d)(3)).** The State, however, has chosen to solicit contractors by means of the Request for Proposal process provided for in the Code (30 ILCS 500/20-15) and Rules (44 Ill. Admin. Code 1.2015). This procurement, therefore, need not strictly comply with the Code and Rules (44 Ill. Admin. Code 1.2005(q)). We will make awards to the most responsible Offerors in accordance with Section 2, How We Will Evaluate Offers.

We are issuing this solicitation in the following form and you must take that into account when reading and responding:

- Invitation for Bids
- Request for Proposals
- Request for Proposals (Professional and Artistic Services)

Brief Description: The Department is seeking the services of qualified, experienced and financially sound Plans to enter into risk-based contracts to provide the full spectrum of Medicare and Medicaid Covered Services through an integrated care delivery system to a significant portion of Seniors and Adults (aged 21 and over) with Disabilities who are eligible for Medicare and Medicaid, in the counties of Cook, Lake, Kane, DuPage, Will, and Kankakee. This delivery system is called the Medicare-Medicaid Alignment Initiative. The State is proposing to operate this initiative in partnership with CMS through Section 1115A of the Social Security Act as well as through Medicaid State Plan authority to implement voluntary managed care for those who are Dual Eligibles.

The solicitation package consists of two parts:

Part A INSTRUCTIONS FOR SUBMITTING AND EVALUATING PROPOSALS: Part A consists of the following sections:

- SECTION 1 INSTRUCTIONS, DATES, RESERVATIONS AND OTHER GENERAL INFORMATION
- SECTION 2 HOW WE WILL EVALUATE PROPOSALS
- SECTION 3 SPECIFICATIONS / QUALIFICATIONS / STATEMENT OF WORK

These sections provide information necessary for submitting a Proposal, set forth the basic legal and policy requirements associated with this solicitation and tell how we will evaluate Proposals.

Part B PROPOSAL RESPONSE FORMS: Part B consists of the following sections:

- SECTION 4 PROPOSAL TO THE STATE OF ILLINOIS
- SECTION 5 RESPONSIBILITY FORMS
- SECTION 6 RESPONSIVENESS
- SECTION 7 PAYMENT TERMS AND CONDITION
- SECTION 8 MODEL CONTRACT

Your response to Part B will constitute your Proposal to the State and will provide us with information about you, what you will provide, and your ability to perform. We will evaluate this information as well as compliance with the Instructions.

In this document the United States of America and the Centers for Medicare & Medicaid Services will be referred to as "United States" or "CMS". The State of Illinois and the Illinois Department of Healthcare and Family Services will be referred to as "State", "Department", "HFS", "we", or "us". "Agencies" refers collectively to both CMS and HFS, except that if such term is used in connection with the Medicaid SPD Program, such term refers to HFS only. The person submitting a Proposal will be referred to as "Offeror", "Plan", "Contractor" or "you".

On April 6, 2012, HFS submitted a demonstration proposal to CMS that will align and integrate Medicare and Medicaid benefits and financing to the greatest extent possible for individuals who are eligible for both programs (Medicare-Medicaid Alignment Initiative). The proposal details how the State will structure, implement, and evaluate an integrated delivery system and payment model aimed at improving the quality, coordination, and cost-effectiveness of care for individuals who are eligible for both Medicare and Medicaid. A copy of the Medicare-Medicaid Alignment Initiative proposal is available for review at: http://www2.illinois.gov/hfs/PublicInvolvement/cc/Documents/cc_proposal.pdf.

While this proposal is pending approval by CMS, Offerors may apply for this Medicare-Medicaid Alignment Initiative by submitting a response to this RFP with the information required to meet HFS criteria. Successful Offerors will receive a Contract with CMS and the State in order to simplify and

unify funding and rules that Plans face when serving individuals who are dually eligible. All subsequent references in this RFP to the Medicare-Medicaid Alignment Initiative and Contract include the condition that they are pending federal approval. Any Medicaid SPD Program contract awarded in addition to the Contract is also subject to federal approval.

Please read the entire solicitation package and submit your Proposal for evaluation in accordance with all instructions.

Public Act 95-971 contains new registration requirements regarding bids and proposals submitted by Offerors. You must read and comply with the requirements. See www.purchase.state.il.us for additional information.

NON-DISCRIMINATION POLICY In compliance with the State and Federal Constitutions, the Illinois Human Rights Act, the U.S. Civil Rights Act, and Section 504 of the Federal Rehabilitation Act, the State of Illinois does not discriminate in employment, contracts, or any other activity.

SECTION 1 – INSTRUCTIONS, DATES, RESERVATIONS AND OTHER GENERAL INFORMATION

- 1.1 **PROJECT CONTACT:** If you have a question or suspect an error, you must immediately notify the Project Contact identified in this section. Do not discuss the solicitation or your Proposal, directly or indirectly, with any officer or employee of the Agencies other than the Project Contact. Only written answers to questions shall be binding on the State.

Michelle Maher
HealthCare and Family Services
201 South Grand Avenue East
Springfield, IL 62763

Phone: 217-524-7478
Fax: 217-524-7535
TDD: 800-526-5812

- 1.2 **OFFEROR CONFERENCE / SITE VISIT:** Yes No
Date and Time: N/A
Mandatory Attendance: Yes No
Location: N/A

Questions regarding the RFP may be submitted by e-mail with a subject line "MMAI RFP Question" to HFS.carecoord@illinois.gov by 5:00 p.m. (Local Time) on May 21, 2012. Questions submitted after 5:00 p.m. (Local Time) on May 21, 2012, may be answered at the discretion of the State. We will provide written responses to these questions and only those written responses shall be binding. Written responses will be posted on the Procurement Bulletin as an addendum to the RFP. The Department may post the responses to questions received in one addendum document or incrementally in multiple addenda documents. Offerors are advised to monitor the Procurement Bulletin during the duration of the RFP posting period to view addenda issued by the Department in response to this RFP.

- 1.3 **PROPOSAL DUE DATE, TIME AND SUBMISSION LOCATION:** Due Date: June 18, 2012 Time: 1:00 p.m.

DELIVER PROPOSALS TO:
Illinois Department of Healthcare and Family Services
Attn: Michelle Maher
201 South Grand Avenue East
Springfield, IL 62763

LABEL OUTSIDE OF ENVELOPE / CONTAINER:
Medicare-Medicaid Alignment Initiative/ 2013-24-004
June 18, 2012, 1:00 p.m.
[Offeror Name & Address]

We will open Proposals at the Due Date, Time and Delivery Location. Prior to the due date, you may mail or hand-deliver Proposals, modifications, and withdrawals. We do not allow e-mail, fax, or other electronic submissions. We must physically receive submissions as specified; it is not sufficient to show you mailed or commenced delivery before the due date and time. We will not consider Proposals, modifications or withdrawals submitted after the due date and time. All times are State of Illinois local times.

- 1.4 **NUMBER OF COPIES:** You must submit one (1) signed original and fourteen (14) copies of the Proposal in a sealed container. In addition, you must submit one (1) copy of the Proposal on CD in the following format: Microsoft Word and/or Excel and two (2) copies of the file on CD requested in Section 3.2.2.13. If you are requesting confidential treatment, you must make that request in the form and manner specified elsewhere in this solicitation. You must also submit one (1) original, one (1) copy, and one (1) CD of your Business Enterprise Program Utilization Plan (see Section 1.9) in a separate sealed envelope within your Proposal container. Proposals must be no longer than 500 pages, one-sided, on 8.5" by 11" size paper (spreadsheets may be on larger size paper), with one (1) inch margins, and no smaller than eleven (11) point font. The 500 page limit for Proposals includes all attachments.

In accordance with Public Act 95-971, if you do not submit the State Board of Elections Registration Certificate as required, your Proposal will be disqualified.

- 1.5 **OFFER FIRM TIME:** Your Offer must remain firm for 180 days from opening.

1.6 SECURITY: Bid Bond \$ NA Performance Bond \$ NA .

1.7 PROTEST REVIEW OFFICE:

Illinois Department of Healthcare and Family Services
Office of Procurement Management
Attn: HFS Agency Procurement Officer
2200 Churchill Road, A-1
Springfield, IL 62702

Ph: 217-557-5777
Fax: 217-557-6745
TDD: 800-526-5812

You may submit a written protest of our actions to the PROTEST REVIEW OFFICE following the requirements of the Standard Procurement Rules (44 Ill. Adm. Code 1.5550). We must physically receive the protest by noon of the seventh calendar day after you knew or should have known of the facts giving rise to the protest.

1.8 SMALL BUSINESS SET-ASIDE: Yes No. If "Yes" is marked, you must be certified by the Small Business Set-Aside Program at the time Proposals are due in order for us to evaluate your Proposal. For complete requirements and to certify your business in the Small Business Set-Aside Program, visit <http://www2.illinois.gov/cms/business/sell2/sbsp/Pages/default.aspx>.

1.9 MINORITY, FEMALE AND PERSONS WITH DISABILITY SUBCONTRACTING: Yes No. If "Yes" is marked, this solicitation contains a goal to include businesses owned and controlled by minorities, females and persons with disabilities in the State's procurement and contracting processes. This solicitation includes a specific Business Enterprise Program (BEP) utilization goal of 20% of the Administrative Allowance of the Capitation payments based on the availability of certified vendors to perform the anticipated direct subcontracting opportunities of this contract. In addition to the number of copies requested above, **you must submit an original and 1 copy of the Utilization Plan and Letter of Intent, sealed separately within the Proposal container.** Failure to submit a Utilization Plan as instructed later in this solicitation will render the offer non-responsive. All questions regarding the subcontracting goal must be directed to Susan Hartman at Susan.Hartman@illinois.gov or (312) 814-2200. Subcontracting vendors must be certified by DCMS as BEP vendors before the time of contract award. Go to <http://www2.illinois.gov/cms/business/sell2/bep/Pages/default.aspx> for complete requirements for BEP certification.

1.10 PUBLIC CONTRACTS NUMBER: (775 ILCS 5/2-105) If you do not have a Department of Human Rights' (DHR) Public Contracts Number or have not submitted a completed application to DHR for one before opening we may not be able to consider your Proposal. Please contact DHR at 312-814-2431 or visit <http://www.state.il.us/dhr/index.htm> for forms and details.

1.11 OUT OF STATE COMPANIES: Non-Illinois Offerors must contact the Illinois Secretary of State (217-782-1834) regarding a Certificate of Authority to Transact Business in Illinois (805 ILCS 5/13). Application Form BCA 13.15 may be downloaded from http://www.cyberdriveillinois.com/publications/business_services/dfc.html.

1.12 ILLINOIS PROCUREMENT BULLETIN (Bulletin): We publish procurement information (including updates) in the electronic Bulletin (<http://www.purchase.state.il.us>) and to the Department's care coordination website <http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/default.aspx>. Procurement information may not be available in any other form or location. You are responsible for monitoring the Bulletin; we cannot be held responsible if you fail to receive the optional e-mail notices.

1.13 AWARD: We will post a notice to the Bulletin identifying the apparent awardees. The notice extends the Offer Firm Time until we sign a contract or determine not to sign a contract. We may accept or reject your Offer as submitted, or may require contract negotiations. If negotiations do not result in an acceptable agreement, we may reject your Offer and begin negotiations with another Offeror. Protested awards are not final and are subject to resolution of the protest.

1.14 PUBLIC RECORDS AND REQUESTS FOR CONFIDENTIAL TREATMENT: Offers become the property of the State and these and late submissions will not be returned. Your Offer will be open to the public under the Illinois Freedom of Information Act (FOIA) (5 ILCS 140) and other applicable laws and rules, unless you request in your Offer that we treat certain information as exempt. We will not honor requests to exempt entire Offers. You must show the specific grounds in FOIA or other law or rule that support exempt treatment. Regardless, we will disclose the successful Offeror's name, and the substance of the Offer. If you request exempt treatment, you must submit an additional copy of the Offer with exempt information deleted. This copy must tell the general nature of the material removed and shall retain as much of the Offer as possible. You will be responsible for any costs or damages associated with our defending your request for exempt treatment. You agree the State may copy the Offer to facilitate evaluation, or to respond to requests for public records. You warrant that such copying will not violate the rights of any third party.

1.15 RESERVATIONS: You must read and understand the solicitation and tailor your Offer and activities to ensure compliance. We reserve the right to amend the solicitation; reject any or all Offers; to award by item, group of items, or grand total; and to waive minor defects. We may request a clarification; inspect your premises; interview staff; request a presentation; or otherwise verify the contents of the Offer, including information about subcontractors and suppliers. We may request Best & Final Offers when appropriate. We will make all decisions on compliance, evaluation, terms and conditions, and shall make decisions solely in the best interests of the State. This competitive process requires that you provide additional information and otherwise cooperate with us. If you do not comply with requests for information and

cooperate, we may reject your Offer. You have no right to an award by submitting an Offer, nor do you have the right to a Contract based on our posting your name in a Bulletin notice. We are not responsible for and will not pay any costs associated with the preparation and submission of your Offer. If you are the awardee, you shall not commence, and will not be paid for, any billable work prior to the date all Parties execute the Contract.

- 1.16 GOVERNING LAW AND FORUM:** Illinois law and rule govern this solicitation and any resulting contract. You must bring any action relating to this solicitation or any resulting contract in the appropriate court in Illinois. We do not allow binding arbitration. This document contains statutory references designated with "ILCS". You may view the full text at <http://www.ilga.gov/legislation/ilcs/ilcs.asp>. The Illinois Procurement Code (30 ILCS 500) and the Standard Procurement Rules (44 Ill. Adm. Code 1) may be viewed by users registered for the Illinois Procurement Bulletin at <http://www.purchase.state.il.us>.
- 1.17 EMPLOYMENT TAX CREDIT:** Offerors who hire qualified veterans and certain ex-offenders may be eligible for tax credits. Please contact the Illinois Dept. of Revenue (312-814-3215) for information about tax credits. If you receive this tax credit you must report to the Dept. of Central Management Services the number of individuals hired for whom you received tax credits. You must submit this information by August 31 of each year covering the previous 12 months (July–June) (PA 94-1067; 30 ILCS 500/45-67 and 45-70).
- 1.18 DEFINITIONS.** Whenever used in this RFP, or amendment, including schedules, appendices, exhibits, and attachments to this RFP, the following terms will have the meanings defined below. Any objections or questions regarding the definitions shall be raised with the State during the RFP process.
- 1.18.1 834 Audit File:** The electronic HIPAA transaction that the Contractor retrieves monthly from the Department that reflects the Enrollees for the following calendar month.
- 1.18.2 834 Daily File:** The electronic HIPAA transaction that the Contractor retrieves from the Department each day that reflects changes in enrollment subsequent to the previous 834 Audit File.
- 1.18.3 Abuse:** (i) A manner of operation that results in excessive or unreasonable costs to the Federal or State health care programs, generally used in conjunction with Fraud; or (ii) the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish (42 CFR Section 488.301), generally used in conjunction with Neglect.
- 1.18.4 Action:** (i) The denial or limitation of authorization of a requested service; (ii) the reduction, suspension, or termination of a previously authorized service; (iii) the denial of payment for a service; (iv) the failure to provide services in a timely manner; (v) the failure to respond to an Appeal in a timely manner, or (vi) solely with respect to a Plan that is the only contractor serving a rural area, the denial of an Enrollee's request to obtain services outside of the Contracting Area.
- 1.18.5 Administrative Allowance:** That portion of the Capitation allocated by the Agencies for the administrative cost of the Contract.
- 1.18.6 Administrative Rules:** The sections of the Illinois Administrative Code that govern the HFS Medical Program, a part of which is the Medicaid Program.
- 1.18.7 Adults with Disabilities:** For purposes of this RFP only, individuals who are twenty-one (21) years of age or older, who meet the definition of blind or disabled under Section 1614(a) of the Social Security Act (42 U.S.C.1382), and who are eligible for Medicaid.
- 1.18.8 Advanced Practice Nurse:** A Provider of medical and preventive services, including Certified Nurse Midwives, Certified Family Nurse Practitioners and Certified Pediatric Nurse Practitioners, who is licensed as an Advance Practice Nurse, holds a valid license in Illinois, is legally authorized under statute or rule to provide services, and is enrolled with the Department and contracted with the Plan.
- 1.18.9 Affiliate:** Any individual, firm, corporation (including, without limitation, service corporation and professional corporation), partnership (including, without limitation, general partnership, limited partnership and limited liability partnership), limited liability company, joint venture, business trust, association or other contractor that now or in the future directly or indirectly controls, is controlled by, or is under common control with Offeror or Contractor.
- 1.18.10 Affiliated:** Associated with Offeror or Contractor for the purpose of providing health care services under Offeror's or Contractor's Plan for the Medicare-Medicaid Alignment Initiative pursuant to a written contract or agreement, including, but not limited to, a contracted Provider and network Provider. Affiliated Providers, however, shall not include a Provider who has an agreement or contract with a Plan for the provision of limited services (e.g., a single case agreement).
- 1.18.11 Appeal:** A request for review of a decision made by the Contractor with respect to an Action.
- 1.18.12 Authorized Person(s):** The Illinois Department of Healthcare and Family Services Office of Inspector General, the Medicaid Fraud Control Unit of the Illinois State Police, the United States Department of Health and Human Services, the Illinois Auditor General and other State and federal agencies with monitoring authority related to Medicare or Medicaid.
- 1.18.13 Business Day:** Monday through Friday, 8:00 a.m. to 5:00 p.m. Central Time and including State holidays except for New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day and Christmas Day.

- 1.18.14 **Capitation:** The reimbursement arrangement in which a fixed rate of payment per Enrollee per month is made, regardless of whether the Enrollee receives Covered Services in that month, to Contractor for the performance of all of Contractor's duties and responsibilities pursuant to the Contract.
- 1.18.15 **Care Coordinator:** An agent of Contractor who, together with an Enrollee, Providers, and other members of the interdisciplinary care team, establishes an Individualized Care Plan for the Enrollee and, through interaction with network Providers, ensures the Enrollee receives necessary services.
- 1.18.16 **Care Management:** Services that assist Enrollees in gaining access to needed services, including medical, social, educational and other services, regardless of the funding source for the services.
- 1.18.17 **Centers for Medicare & Medicaid Services (CMS):** The agency within DHHS that is responsible for the administration of the Medicare Program and, in partnership with the states, administers the Medicaid Program, the State Children's Health Insurance Program (CHIP), and the Health Insurance Portability and Accountability Act (HIPAA).
- 1.18.18 **Certified Local Health Department:** An agency of local government authorized under 77 Ill. Adm. Code Part 600 to develop and administer programs and services that are aimed at maintaining a healthy community.
- 1.18.19 **Chronic Health Condition:** A health condition with an anticipated duration of at least twelve (12) months.
- 1.18.20 **Code:** The Illinois Procurement Code, 30 ILCS 500/1-5 et seq. Unofficial versions of the Code and Standard Procurement Rules (44 Ill. Adm. Code 1) may be viewed at <http://www.purchase.state.il.us/>.
- 1.18.21 **Complaint:** A phone call, letter or personal contact from a Participant, Enrollee, family member, Enrollee representative or any other interested person expressing a concern related to the health, safety or well-being of an Enrollee.
- 1.18.22 **Confidential Information:** Any material, data, or information disclosed by any Party to another Party that, pursuant to agreement of the Parties or the State's grant of a proper request for confidentiality, is not generally known by or disclosed to the public or to Third Parties including, without limitation: (i) all materials, know-how, processes, trade secrets, manuals, confidential reports, services rendered by the State, financial, technical and operational information, and other matters relating to the operation of a Party's business; (ii) all information and materials relating to Third Party contractors of the State that have provided any part of their information or communications infrastructure to them; (iii) software; and (iv) any other information that the Parties agree should be kept confidential. See also Section 1.14 of this RFP, "Public Records and Requests for Confidential Treatment."
- 1.18.23 **Contract:** The three-party document, inclusive of all attachments, exhibits, schedules, addenda, and any subsequent amendments hereto, entered between CMS and the Department, and a Contractor, for the provision of health care services under the Medicare-Medicaid Alignment Initiative requested by this RFP.
- 1.18.24 **Contracting Area:** The area for which the Medicare-Medicaid Alignment Initiative will be operational, consisting of the following counties in Illinois: Cook, Lake, Kane, DuPage, Will, and Kankakee. For purposes of a MCCN proposing to cover fewer counties than listed above, Contracting Area means the area it is proposing to serve.
- 1.18.25 **Contractor:** A Plan selected, pursuant to this RFP, to provide Covered Services under the Medicare-Medicaid Alignment Initiative.
- 1.18.26 **Covered Services:** Those Medicare benefits pursuant to 42 C.F.R. 422.101 and Medicaid State Plan benefits and services described in *Attachment B: Medicaid Covered Services* of this RFP and any additional services proposed by Offeror and accepted by the Agencies.
- 1.18.27 **Determination of Need (DON):** The tool used by the Department or the Department's authorized representative to determine eligibility (level of care) for nursing facility and home and community-based services (HCBS) waivers for persons with disabilities, HIV/AIDS, brain injury, supportive living and the elderly. This assessment includes scoring for a mini-mental state examination (MMSE), functional impairment and unmet need for care in fifteen (15) areas including activities of daily living such as eating, bathing, grooming, dressing, transferring and continence; and instrumental activities of daily living including managing money, meal preparation, telephoning, laundry, housework, being outside the home, routine health, special health and being alone. The final score is calculated by adding the results of the MMSE, the level of impairment and the unmet need for care scores. In order to be eligible for nursing facility or waiver services, an individual must receive at least fifteen (15) points on functional impairment section and a minimum total score of twenty-nine (29) points.
- 1.18.28 **Developmental Disability(ies) (DD):** A disability that (i) is attributable to a diagnosis of mental retardation or related condition such as cerebral palsy or epilepsy, (ii) manifests before the age of twenty-two (22) and is likely to continue indefinitely, (iii) results in impairment of general intellectual functioning or adaptive behavior, and (iv) results in substantial functional limitations in three (3) or more areas of major life activities, such as self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living.
- 1.18.29 **DHHS:** The United States Department of Health and Human Services.
- 1.18.30 **DHS:** The Illinois Department of Human Services, and any successor agency.
- 1.18.31 **DHS-DASA:** The Division of Alcohol and Substance Abuse within DHS that operates treatment services for alcoholism & addiction through an extensive treatment provider network throughout the State of Illinois. <http://www.dhs.state.il.us/page.aspx?item=29725>

- 1.18.32 **DHS-DDD:** The Division of Developmental Disabilities within DHS that operates programs for persons with Developmental Disabilities.
- 1.18.33 **DHS-DMH:** The Division of Mental Health within DHS that is the State mental health authority.
- 1.18.34 **DHS-DRS:** The Division of Rehabilitation Services, and any successor agency, within DHS that operates the home services programs for persons with physical disabilities, brain injury and HIV/AIDS.
- 1.18.35 **DHS-OIG:** The Department of Human Services Office of Inspector General is the entity responsible for investigating allegations of Abuse and Neglect of people who receive mental health or Developmental Disability services in Illinois and for seeking ways to prevent such Abuse and Neglect. Annual reporting is conducted in response to the Department of Human Services Act (20 ILCS 1305/1-17) and the Adults with Disabilities Domestic Abuse Intervention Act (20 ILCS 2435). <http://www.dhs.state.il.us/page.aspx?item=29972>
- 1.18.36 **Disaster:** An outage or failure of the Agencies' or Contractor's data, electrical, telephone, technical support, or back-up system, whether such outage or failure is caused by an act of nature, equipment malfunction, human error, or other source.
- 1.18.37 **Disease Management Program:** A program that employs a set of interventions designed to improve the health of individuals, especially those with Chronic Health Conditions. Disease Management Program services include: (i) a population identification process; (ii) use and promotion of evidence-based guidelines; (iii) use of collaborative practice models to include Physician and support service Providers; (iv) Enrollee self-management education (includes primary prevention, behavioral modification, and compliance surveillance); (v) Care Management; (vi) process and outcome measurement, evaluation and management; and (vii) routine reporting/feedback loop (includes communication with the Enrollee, Physician, ancillary Providers and practice profiling). A Disease Management Program may be part of a Care Management program.
- 1.18.38 **DoA:** The Illinois Department on Aging, and any successor agency.
- 1.18.39 **DPH:** The Illinois Department of Public Health, and any successor agency, the State Survey Agency responsible for promoting the health of the people of Illinois through the prevention and control of disease, injury, licensure, and certification of LTC (or Nursing) Facilities and ICF/DD facilities.
- 1.18.40 **Dual Eligible:** A Participant who is enrolled in both Medicare (Parts A and B) and the Medicaid Program (full-benefit).
- 1.18.41 **Emergency Medical Condition:** A medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to, severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.
- 1.18.42 **Emergency Services:** Those inpatient and outpatient health care services that are Covered Services, including transportation, needed to evaluate or Stabilize an Emergency Medical Condition, and which are furnished by a Provider qualified to furnish Emergency Services.
- 1.18.43 **Encounter:** An individual service or procedure provided to an Enrollee that would result in a claim if the service or procedure were to be reimbursed Fee-For-Service under the Medicaid Program.
- 1.18.44 **Encounter Data:** The compilation of data elements, as specified by the Agencies in written notice to the Contractor, identifying an Encounter that includes information similar to that required in a claim for Fee-For-Service payment under the Medicare or HFS Medical Program.
- 1.18.45 **Enrollee:** A Participant who is enrolled with a Contractor. "Enrollee" shall include the guardian where the Enrollee is an adult for whom a guardian has been named; provided, however, that the Contractor is not obligated to cover services for any individual who is not enrolled as an Enrollee with the Contractor.
- 1.18.46 **Execution:** The point at which all of the Parties have signed the Contract.
- 1.18.47 **External Quality Review Organization (EQRO):** An organization contracted with the Department that meets the competence and independence requirements set forth in 42 CFR Section 438.354, and performs external quality review (EQR) and EQR-related activities as set forth in 42 CFR Section 438.358.
- 1.18.48 **Federally Qualified Health Center (FQHC):** A health center that meets the requirements of 89 Ill. Admin. Code 140.461(d).
- 1.18.49 **Fee-For-Service:** The method of charging which bills for each Encounter or service rendered.
- 1.18.50 **Fraud:** Knowing and willful deception, or a reckless disregard of the facts, with the intent to receive an unauthorized benefit.
- 1.18.51 **Grievance:** An expression of dissatisfaction by an Enrollee, including Complaints, about any matter other than a matter that is properly the subject of an Appeal.
- 1.18.52 **Habilitation:** An effort directed toward the alleviation of a disability or toward increasing a person's level of physical, mental, social or economic functioning. Habilitation may include, but is not limited to, diagnosis, evaluation, medical services, residential care, day care, special living arrangements, training, education, sheltered employment, protective services, counseling and other services.

- 1.18.53 Health Insurance Portability and Accountability Act (HIPAA):** The federal law that includes provisions that allow individuals to qualify immediately for comparable health insurance coverage when they change their employment relationships, and that authorizes DHHS to: (i) mandate standards for electronic exchange of health care data; (ii) specify what medical and administrative code sets should be used within those standards; (iii) require the use of national identification systems for health care patients, Providers, payers (or plans), and employers (or sponsors); and (iv) specify the types of measures required to protect the security and privacy of personally identifiable health care information.
- 1.18.54 Health Maintenance Organization (HMO):** A health maintenance organization as defined in the Health Maintenance Organization Act (215 ILCS 125/1-1 et seq.).
- 1.18.55 Health Plan Employer Data and Information Set (HEDIS®):** The Healthcare Effectiveness Data and Information Set established by the National Committee for Quality Assurance (NCQA).
- 1.18.56 HFS:** The Illinois Department of Healthcare and Family Services and any successor agency. In this RFP, HFS is also referred to as "Department".
- 1.18.57 Home and Community-Based Services (HCBS) Waivers:** Waivers under Section 1915(c) of the Social Security Act that allow the State to cover, as part of the Medicaid program, home and community services and provide programs that are designed to meet the unique needs of individuals with disabilities who qualify for the level of care provided in an institution but who, with special services, may remain in their homes and communities.
- 1.18.58 Homemaker Service:** General non-medical support by supervised and trained homemakers to assist Participants with their activities of daily living and instrumental activities of daily living.
- 1.18.59 Hospitalist:** A Physician who is part of a coordinated group working together, whose entire professional focus is the general medical care of hospitalized Enrollees in an acute care facility and whose activities include Enrollee care, communication with families, significant others, PCPs, and leadership related to hospital medicine.
- 1.18.60 ILCS:** Illinois Compiled Statutes. An unofficial version of which can be viewed at <http://www.ilga.gov/legislation/ilcs/ilcs.asp>.
- 1.18.61 Individualized Care Plan:** An Enrollee-centered, goal-oriented, culturally relevant, and logical, written plan of care that assures that the Enrollee receives medical and medically-related necessary services in a supportive, effective, efficient, timely and cost-effective manner that emphasizes prevention and continuity of care.
- 1.18.62 Ineligible Person:** A Person, including an Offeror or Contractor, that:(i) under either Section 1128 or Section 1128A 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 participating in, any program under federal law including any program under Titles XVIII, XIX, XX or XXI of the Social Security Act; and (ii) has not been reinstated in the Medicaid Program or federal health care programs after a period of exclusion, suspension, debarment, or ineligibility; or (iii) has been convicted of a criminal offense related to the provision of health care items or services in the last ten (10) years; or, (iv) has within the past three-year period had one or more public transactions (federal, state, or local) terminated for cause or default.
- 1.18.63 Institutionalization:** Residency in a nursing facility, ICF/DD or State Operated Facility, but not including admission in an acute care or Rehabilitation hospital setting.
- 1.18.64 Integrated Care Program:** The program under which the Department contracts with HMOs in the suburban Cook (non-606 zip codes), DuPage, Kane, Kankakee, Lake and Will counties to provide the full spectrum of Medicaid Covered Services through an integrated care delivery system to Seniors and Adults with Disabilities who are eligible for Medicaid but are not eligible for Medicare.
- 1.18.65 Intermediate Care Facility (ICF):** A facility for Residents who have long-term illnesses or disabilities and who may have reached a relatively stable plateau that provides basic nursing care and other restorative services under periodic medical direction, including services that may require skill in administration.
- 1.18.66 Intermediate Care Facility for the Developmentally Disabled (ICF/DD):** A facility for Residents who have physical, intellectual, social and emotional needs, that provides services primarily for ambulatory adults with Developmental Disabilities and addresses itself to the needs of persons with mental disabilities or those with related conditions. Also known as Intermediate Care Facility for the Mentally Retarded (ICF/MR).
- 1.18.67 Long-Term Care (LTC) Facility or Nursing Facility:** (i) A facility that provides skilled nursing or intermediate long-term care services, whether public or private and whether organized for profit or not-for-profit, that is subject to licensure by the DPH under the Nursing Home Care Act, including a county nursing home directed and maintained under Section 5-1005 of the Counties Code; or, (ii) a part of a hospital in which skilled or intermediate long-term care services within the meaning of Title XVIII or XIX of the Social Security Act are provided.
- 1.18.68 Managed Care Community Network (MCCN):** An entity, other than a HMO, that is owned, operated, or governed by Providers of health services in Illinois and that provides or arranges primary, secondary and tertiary managed health care services under contract with the Department exclusively to persons participating in programs administered by the Department.

- 1.18.69 **Mandated Reporting:** Immediate reporting required from a mandated reporter of suspected maltreatment when the mandated reporter has reasonable cause to believe that an individual known to the mandated reporter in a professional or official capacity may be Abused or Neglected. RFP Attachment A outlines the Abuse, Neglect and exploitation reporting requirements for Illinois citizens.
- 1.18.70 **Marketing:** Any written or oral communication from a healthcare delivery system, Plan, or a Plan's representative that can reasonably be interpreted as intended to influence a Participant to enroll, not enroll, or to disenroll from a health care delivery system.
- 1.18.71 **Marketing Materials:** Materials produced in any medium, by or on behalf of Contractor or its representative that can reasonably be interpreted as intended to market to Potential Enrollees. Marketing Materials includes written materials and oral presentations.
- 1.18.72 **Medicaid Program:** The program under Title XIX of the Social Security Act that provides medical benefits to groups of low-income people. "Medicaid (full-benefit)" means a Participant who has been found eligible for all benefits under Medicaid.
- 1.18.73 **Medically Necessary:** A service, supply or medicine that is appropriate and meets the standards of good medical practice in the medical community, as determined by the Provider in accordance with the Contractor's guidelines, policies or procedures, for the diagnosis or treatment of a covered illness or injury, for the prevention of future disease, to assist in the Enrollee's ability to attain, maintain, or regain functional capacity, or to achieve age-appropriate growth.
- 1.18.74 **Medicare Program:** The program under Title XVIII of the Social Security Act that provides health insurance for the aged and disabled.
- 1.18.75 **National Committee for Quality Assurance (NCQA):** A private 501(c) (3) not for profit organization dedicated to improving health care quality and has a process for providing accreditation, certification and recognition, e.g., health plan accreditation.
- 1.18.76 **National Provider Identification Number (NPI):** The national standard identifier for healthcare providers for use in the healthcare industry.
- 1.18.77 **Neglect:** A failure (i) to notify the appropriate health care professional, (ii) to provide or arrange necessary services to avoid physical or psychological harm to a Resident, or (iii) to terminate the residency of a Participant whose needs can no longer be met, causing an avoidable decline in function. Neglect may be either passive (non-malicious) or willful.
- 1.18.78 **Negotiated Risk:** The process by which an Enrollee, or his or her representative, may negotiate and document with Providers what risks each is willing to assume in the provision of Medically Necessary Covered Services and the Enrollee's living environment, and by which the Enrollee is informed of the risks of these decisions and of the potential consequences of assuming these risks.
- 1.18.79 **Nursing Facility (NF):** See Long-Term Care Facility.
- 1.18.80 **Occupational Therapy:** A medically prescribed service identified in the Individualized Care Plan that is designed to increase independent functioning through adaptation of the tasks and environment, that is provided by a licensed occupational therapist who meets Illinois licensure standards. <http://www.idfpr.com/dpr/WHO/ot.asp>.
- 1.18.81 **Offer:** See "Proposal".
- 1.18.82 **Offer Firm Time:** The one hundred eighty (180) day period following the opening of Proposals during which the Proposal shall remain firm and unaltered. A Proposal may be accepted, subject to successful contract negotiations, at any time during the Offer Firm Time. See RFP Section 1.5.
- 1.18.83 **Offeror:** The Plan submitting a Proposal under this RFP.
- 1.18.84 **Office of Inspector General (OIG):** The Office of Inspector General for the Department as set forth in 305 ILCS 5/12-13.1 or the corresponding federal Office.
- 1.18.85 **Participant:** Any individual who is eligible for Medicare and Medicaid.
- 1.18.86 **Party/Parties:** The United States, through CMS, and State, through HFS, and a Plan awarded a Contract pursuant to this procurement process, or the State, through HFS, and a Plan awarded a subsequent contract under the Medicaid SPD Program.
- 1.18.87 **Person:** Any individual, corporation, proprietorship, firm, partnership, trust, association, governmental authority, contractor, or other legal entity whatsoever, whether acting in an individual, fiduciary, or other capacity.
- 1.18.88 **Performance Measure:** A quantifiable measure to assess how well an organization carries out a specific function or process.
- 1.18.89 **Person:** Any individual, corporation, proprietorship, firm, partnership, trust, association, governmental authority, contractor, or other legal entity whatsoever, whether acting in an individual, fiduciary, or other capacity.
- 1.18.90 **Person With an Ownership or Controlling Interest:** A Person that: (i) has a direct or indirect, singly or in combination, ownership interest equal to five percent (5%) or more in Contractor; (ii) owns an interest of five percent (5%) or more in any mortgage, deed of trust, note or other obligations secured by Contractor if that interest equals at least five percent (5%) of the value of the property or assets of Contractor; (iii) is an officer or director of Contractor if Contractor is organized as a corporation; (iv) is a

member of Contractor if Contractor is organized as a limited liability company; or, (v) is a partner in Contractor if Contractor is organized as a partnership.

- 1.18.91 **Personal Assistant:** An individual who provides Personal Care to an Enrollee when it has been determined by the Care Coordinator that the Enrollee has the ability to supervise the Personal Assistant.
- 1.18.92 **Personal Care:** Assistance with meals, dressing, movement, bathing or other personal needs or maintenance, or general supervision and oversight of the physical and mental well-being of an Enrollee.
- 1.18.93 **Personal Emergency Response System (PERS):** An electronic device that enables an Enrollee at high risk of Institutionalization to secure help in an emergency.
- 1.18.94 **Physical Therapy:** A medically-prescribed service that is provided by a licensed physical therapist and identified in the Individualized Care Plan that utilizes a variety of methods to enhance an Enrollee's physical strength, agility and physical capacity for activities of daily living.
- 1.18.95 **Physician:** An individual licensed to practice medicine in all its branches under the Medical Practice Act of 1987 or any such similar statute of the state in which the individual practices medicine.
- 1.18.96 **Plan:** A HMO or MCCN.
- 1.18.97 **Post-Stabilization Services:** Medically Necessary Non-Emergency Services furnished to an Enrollee after the Enrollee is Stabilized following an Emergency Medical Condition, in order to maintain such Stabilization.
- 1.18.98 **Potential Enrollee:** A Participant who may enroll in the Medicare-Medicaid Alignment Initiative, but is not yet an Enrollee of a Plan.
- 1.18.99 **Pre-Admission Screening (PAS):** Universal preadmission screening of all individuals, regardless of payment source, who enter a nursing facility (Nursing Home Care Act [210 ILCS 45/2-201.5](#) and 89 Ill. [Adm. Code 140.642](#)) to determine if they meet a nursing facility level of care as defined by state assessment tools. Although the screening rule covers only nursing facility placements, preadmission screenings are also completed on individuals who wish to participate in the home and community-based waiver programs, rather than reside in Nursing Facilities, as defined in the waivers.
- 1.18.100 **Primary Care Provider (PCP):** A Provider, including a WHCP or other specialist, who within the Provider's scope of practice and in accordance with State certification requirements or State licensure requirements, is responsible for providing all preventive and primary care services to his or her assigned Enrollees in the Plan.
- 1.18.101 **Prior Approval:** Review and written approval by the Agencies of any Contractor materials or actions, as set forth in the Contract, including but not limited to, subcontracts, intended courses of conduct, or procedures or protocols, that Contractor must obtain before such materials are used, executed, implemented or followed.
- 1.18.102 **Proposal:** An Offeror's response to the RFP, consisting of the technical Proposal and all required forms and certifications, all of which are completed, signed, and returned by the Offeror. The Proposal may also be referred to as the Offer.
- 1.18.103 **Prospective Enrollee:** A Potential Enrollee who has begun the process of enrollment with the Contractor but whose coverage under the Contractor has not yet begun.
- 1.18.104 **Protected Health Information (PHI):** Except as otherwise provided in HIPAA, which shall govern the definition of PHI, information created or received from or on behalf of a Covered Contractor as defined in 45 CFR Section 160.103, that relates to (i) the provision of health care to an individual; (ii) the past, present or future physical or mental health or condition of an individual; or (iii) past, present or future payment for the provision of health care to an individual. PHI includes demographic information that identifies the individual or about which there is a reasonable basis to believe, can be used to identify the individual. PHI is the information transmitted or held in any form or medium.
- 1.18.105 **Provider:** A Person enrolled with CMS or the Department to provide Covered Services to an Enrollee. Contractor is not a Provider.
- 1.18.106 **Quality Assessment and Performance Improvement (QAPI):** The program required by 42 CFR Section 438.240, in which Plans are required to have an ongoing quality assessment and performance improvement program for the services furnished to Enrollees, that: (i) assess the quality of care and identify potential areas for improvement, ideally based on solid data and focused on high volume/high risk procedures or other services that promise to substantially improve quality of care, using current practice guidelines and professional practice standards when comparing to the care provided; and (ii) correct or improve processes of care and clinic operations in a way that is expected to improve overall quality.
- 1.18.107 **Quality Assurance (QA):** A formal set of activities to review, monitor and improve the quality of services by a Provider or Plan, including quality assessment, ongoing quality improvement and corrective actions to remedy any deficiencies identified in the quality of direct Enrollee, administrative and support services.
- 1.18.108 **Quality Assurance Plan (QAP):** A written document developed by the Plan in consultation with its QAP committee and Medical Director that details the annual program goals and measurable objectives, utilization review activities, access and other Performance Measures that are to be monitored with ongoing Physician profiling and focus on quality improvement.

- 1.18.109 Quality Assurance Plan (QAP) Committee:** A committee established by the Plan with the approval of the Agencies, that consists of a cross representation of all types of Providers, including PCPs, specialists, dentists and long term care representatives from the Plan's network and throughout the entire Contracting Area and that, at the request of the Agencies, shall include the Agencies' staff in an advisory capacity.
- 1.18.110 Quality Assurance Program:** The Plan's overarching mission, vision and values, which through its goals, objectives and processes committed in writing in the QAP, are demonstrated through continuous improvement and monitoring of medical care, Enrollee safety, behavioral health services, and the delivery of services to Enrollees, including ongoing assessment of program standards to determine the quality and appropriateness of care, Care Management and coordination. It is implemented through the integration, coordination of services, and resource allocation throughout the organization, its partners, Providers, other entities delegated to provide services to Enrollees, and extended community involved with Enrollees.
- 1.18.111 Referral:** An authorization provided by a PCP to enable an Enrollee to seek medical care from another Provider.
- 1.18.112 Rehabilitation:** The process of restoration of skills to an individual who has had an illness or injury so as to regain maximum self-sufficiency and function in a normal or as near normal manner as possible in therapeutic, social, physical, behavioral and vocational areas.
- 1.18.113 Resident:** An Enrollee living in a facility who is eligible for Medicaid payment for facility services.
- 1.18.114 Resident Review:** a clinical reassessment of the Resident's functional capabilities to determine if the existing level of Skilled Nursing care is the most appropriate to meet his or her needs or if the individual could maximize personal recovery in the least restrictive, community-based integrated living environment such as permanent supportive housing models with a full array of wrap around support services, such as assertive community treatment, crisis services, case management, psycho-social Rehabilitation, supportive employment or in therapeutic transitional supervised/supported residential settings with support services and skills development as an interim step toward permanent supportive housing.
- 1.18.115 Respite:** Services that provide the needed level of care and supportive services to enable the Enrollee to remain in the community, or home-like environment, while periodically relieving the non-paid family member or other caretaker of care-giving responsibilities.
- 1.18.116 Risk Mitigation:** Based on an assessment or inventory of risks in the areas of Caregiver (vulnerability of participant or vulnerability due to caregiver); Environment (safety and accessibility); Behavioral (danger to self, others or illegal behavior); Medical Complications (medication and treatment, activities of daily living, specific conditions); and Compliance, a care plan is developed including strategies to prevent or ameliorate the addressed risks. The plan is closely monitored to determine changes in approaches.
- 1.18.117 Rural Health Clinic (RHC):** A Provider that has been designated by the Public Health Service, DHHS, or the Governor of the State of Illinois, and approved by the Public Health Service, in accordance with the Rural Health Clinics Act (see Public Law 95-210) as a RHC.
- 1.18.118 Serious Mental Illness (SMI):** A diagnosis of a Participant who is at least 18 years of age whose emotional or behavioral functioning is so impaired as to interfere with the capacity to remain in the community without supportive treatment. The mental impairment is severe and persistent and may result in a limitation of capacities for primary activities of daily living, interpersonal relationships, homemaking, self-care, employment or recreation. The mental impairment may limit the ability to seek or receive local, state or federal assistance such as housing, medical and dental care, rehabilitation services, income assistance and food stamps, or protective services. For purposes of this RFP, the following diagnoses are used: schizophrenia (295.xx), schizophreniform disorder (295.4), schizo-affective disorder (295.7), delusional disorder (297.1), shared psychotic disorder (297.3), brief psychotic disorder (298.8), psychotic disorder (298.9), bipolar disorders (296.0x, 296.4x, 296.5x, 296.6x, 296.7, 296.80, 296.89, 296.90, cyclothymic disorder (301.13), major depression (296.2x, 296.3x), obsessive compulsive disorder (300.30), anorexia nervosa (307.1), and bulimia nervosa (307.51).
- 1.18.119 Service Authorization Request:** A request by an Enrollee or by a Provider on behalf of an Enrollee for the provision of a Covered Service.
- 1.18.120 Significant Change:** A decline or improvement in a Participant's status that will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, where the decline or improvement impacts more than one area of the Participant's health status and requires revision of the Individualized Care Plan.
- 1.18.121 Skilled Nursing:** Nursing services provided within the scope of the State's Nurse Practice Act by registered nurses, licensed practical nurses, or vocational nurses licensed to practice in the State.
- 1.18.122 Skilled Nursing Facility (SNF):** A group care facility that provides Skilled Nursing care, continuous Skilled Nursing observations, restorative nursing and other services under professional direction with frequent medical supervision, during the post acute phase of illness or during reoccurrences of symptoms in long-term illness.
- 1.18.123 SNFist:** A Physician or Advanced Practice Nurse licensed under the State's Nurse Practice Act who is part of an organized system of care, meaning a coordinated group working together, whose entire professional focus is the general medical care of individuals residing in a Nursing Facility and whose activities include Enrollee care oversight, communication with families, significant others, PCPs, and Nursing Facility administration.

- 1.18.124 **Speech Therapy:** A medically-prescribed speech or language based service that is provided by a licensed speech therapist and identified in the Individualized Care Plan, and that is used to evaluate or improve an Enrollee's ability to communicate.
- 1.18.125 **Spend-down:** The policy that allows an individual to qualify for the Medicaid Program by incurring medical expenses at least equal to the amount by which his or her income or assets exceed eligibility limits. It operates similarly to deductibles in private insurance in that the Spend-down amount represents medical expenses the individual is responsible to pay.
- 1.18.126 **Stabilization or Stabilized:** A determination with respect to an Emergency Medical Condition made by an attending emergency room Physician or other treating Provider that, within reasonable medical probability, no material deterioration of the condition is likely to result upon discharge or transfer to another facility.
- 1.18.127 **State:** The State of Illinois, as represented through any State agency, department, board, or commission.
- 1.18.128 **State Fiscal Year:** The State's fiscal year, which begins on the first day of July of each calendar year and ends on the last day of June of the following calendar year. For example, FY 2013 begins July 1, 2012 and ends June 30, 2013.
- 1.18.129 **State Operated Facility:** Any facility, site or location owned, managed, controlled or operated by the State.
- 1.18.130 **State Plan:** The Illinois State Plan filed with CMS, in compliance with Title XIX of the Social Security Act.
- 1.18.131 **Supportive Living Facility (SLF):** A residential apartment-style (assisted living) setting in Illinois that is (i) certified by the Department that provides or coordinates flexible Personal Care services, twenty-four (24) hour supervision and assistance (scheduled and unscheduled), activities, and health related services with a service program and physical environment designed to minimize the need for Residents to move within or from the setting to accommodate changing needs and preferences; (ii) has an organizational mission, service programs and physical environment designed to maximize Residents' dignity, autonomy, privacy and independence; and (iii) encourages family and community involvement.
- 1.18.132 **Third Party:** Any Person other than CMS, the Department, Contractor, or any of Contractor's Affiliates.
- 1.18.133 **Utilization Management (UM) Program:** A comprehensive approach and planned activities for evaluating the appropriateness, need and efficiency of services, procedures and facilities according to established criteria or guidelines under the provisions of the Medicare-Medicaid Alignment Initiative. Utilization Management typically includes new activities or decisions based upon the analysis of a care, and describes proactive procedures, including discharge planning, concurrent planning, pre-certification and clinical case appeals. It also covers proactive processes, such as concurrent clinical reviews and peer reviews, as well as Appeals introduced by the Provider, payer or Enrollee.
- 1.18.134 **Women's Health Care Provider (WHCP):** A Physician specializing by certification or training in obstetrics, gynecology or family practice.
- 1.19 **ACRONYMS.** Whenever used in this RFP, or amendment, including schedules, appendices, exhibits, and attachments to this RFP, the following acronyms will have the meanings identified below.
- 1.19.1 AABD: Aid to the Aged, Blind and Disabled
- 1.19.2 BEP: Business Enterprise Program Act for Minorities, Females and Persons with Disabilities
- 1.19.3 BI: Brain Injury
- 1.19.4 CCP: Community Care Program
- 1.19.5 CCU: Case Coordination Units
- 1.19.6 CFR: Code of Federal Regulation
- 1.19.7 CMS: Centers for Medicare & Medicaid Services
- 1.19.8 CMU: Case Management Units
- 1.19.9 DCMS: The Illinois Department of Central Management Services
- 1.19.10 DD: Developmental Disability
- 1.19.11 DD: Developmental Disability
- 1.19.12 DHHS: The United States Department of Health and Human Services
- 1.19.13 DHR: The Illinois Department of Human Rights
- 1.19.14 DHS: The Illinois Department of Human Services
- 1.19.15 DHS-DASA: The Division of Alcohol and Substance Abuse within DHS
- 1.19.16 DHS-DDD: The Division of Developmental Disabilities within DHS
- 1.19.17 DHS-DMH: The Division of Mental Health within DHS

- 1.19.18 DHS-DRS: The Division of Rehabilitation Services, and any successor agency, within DHS
- 1.19.19 DHS-OIG: The Department of Human Service Office of Inspector General
- 1.19.20 DoA: The Illinois Department on Aging
- 1.19.21 DOC: The Illinois Department of Corrections
- 1.19.22 DON: Determination of Need
- 1.19.23 DPH: The Illinois Department of Public Health
- 1.19.24 DSM-IV: Diagnostic and Statistical Manual of Mental Disorders, 4th Edition
- 1.19.25 EMR: Electronic Medical Record
- 1.19.26 EQRO: External Quality Review Organization
- 1.19.27 FOIA: Freedom of Information Act
- 1.19.28 FQHC: Federally Qualified Health Center
- 1.19.29 HBWD: Health Benefits for the Working Disabled
- 1.19.30 HCBS Waivers: Homes and Community-Based Services Waivers
- 1.19.31 HCPCS: Healthcare Common Procedure Coding System
- 1.19.32 HEDIS: Health Plan Employer Data and Information Set
- 1.19.33 HFS: The Illinois Department of Healthcare and Family Services
- 1.19.34 HIPAA: Health Insurance Portability and Accountability Act
- 1.19.35 HIT: Health Information Technology
- 1.19.36 HMO: Health Maintenance Organization
- 1.19.37 HSP: Home Services Program
- 1.19.38 ICF: Intermediate Care Facility
- 1.19.39 ICF/DD: Intermediate Care Facility for the Developmentally Disabled
- 1.19.40 ICF/MR: Intermediate Care Facility for the Mentally Retarded
- 1.19.41 ILCS: Illinois Compiled Statutes
- 1.19.42 IPSEC: Internet Protocol Security
- 1.19.43 LTC: Long-term Care
- 1.19.44 NCOA: National Committee for Quality Assurance
- 1.19.45 NPI: National Provider Identification
- 1.19.46 OIG: Office of Inspector General
- 1.19.47 PAS: Pre-Admission Screening
- 1.19.48 PCP: Primary Care Provider
- 1.19.49 PERS: Personal Emergency Response System
- 1.19.50 PHI: Protected Health Information
- 1.19.51 PIP: Performance Improvement Project
- 1.19.52 QA: Quality Assurance
- 1.19.53 QAP: Quality Assurance Plan
- 1.19.54 QAPI: Quality Assessment and Performance Improvement
- 1.19.55 RHC: Rural Health Clinic
- 1.19.56 SLF: Supportive Living Facility
- 1.19.57 SMI: Serious Mental Illness
- 1.19.58 SPD: Seniors and Persons with Disabilities

- 1.19.59 SNF: Skilled Nursing Facility
- 1.19.60 TDD: Teletypewriter
- 1.19.61 TTY: Telecommunications Device for the Deaf
- 1.19.62 UM: Utilization Management
- 1.19.63 UR: Utilization Review
- 1.19.64 VPN: Virtual Private Network
- 1.19.65 WHCP: Women's Health Care Provider

SECTION 2 – HOW WE WILL EVALUATE OFFERS

2.1 OFFER RESPONSE FORMS: We will evaluate the information you provide in the Offer Response Forms. You will find these forms in later sections of this solicitation.

2.2 EVALUATION CATEGORIES: We evaluate three categories of information: Administrative Compliance, Responsibility and Responsiveness. We will consider the information you supply or don't supply, and the quality of that information when evaluating your Offer. If we find a failure or deficiency, we may have to reject the Offer or reflect that in the evaluation.

2.2.1 ADMINISTRATIVE COMPLIANCE: We will determine whether your Offer complied with the Instructions for submitting Offers. Except for late submissions, we may require that an Offeror correct deficiencies as a condition of further evaluation.

2.2.2 RESPONSIBILITY: We will determine whether you are a "Responsible" Offeror; an Offeror with whom we can or should do business. Factors that we may evaluate to determine Responsibility include, but are not limited to: certifications, conflict of interest, financial disclosures, taxpayer identification number, past performance, references (including those found outside the Offer), compliance with applicable laws, financial stability and the perceived ability to perform completely as specified. You must at all times have financial resources sufficient, in the opinion of the State, to ensure performance of the Contract and must provide proof upon request. We may require that an Offeror correct any deficiencies as a condition of further evaluation.

2.2.3 RESPONSIVENESS: We will determine whether the Offer meets the stated requirements. Minor differences or deviations that have negligible impact on the suitability of the supply or service to meet the State's needs may be accepted or corrections allowed. If no administratively compliant and responsible Offeror meets a particular requirement, we may waive that requirement.

2.3 AWARD: We will award to five (5), or fewer, but at least two (2), responsible Offerors whose Proposals pass Administrative review, are Responsive, and who show the greatest ability to implement the Medicare-Medicaid Alignment Initiative through the entire Contracting Area. We may make an additional award to an MCCN that offers to implement the Medicare-Medicaid Alignment Initiative in one or more counties, as specified in the Offer, in the Contracting Area. We will determine how well Proposals meet the Responsiveness requirements. We will rank Proposals from best to least qualified using a point ranking system (unless otherwise specified) as an aid in conducting the evaluation. The point evaluation system is described below.

2.3.1 The chart below shows the elements of Responsiveness that we will evaluate, their relative weights in point format and any minimum point requirements. The total number of points for Responsiveness is 1,000.

Responsiveness Elements	Maximum Points
Organization/ Operation	140
Provider Network and Services	200
Care Coordination and Care Management	400
Outcomes/ Evaluation	60
Health Information Technology	100
References/ Other Contracts/ Past Performance	100
Total	1,000

2.3.2 In addition to submitting a Proposal to the State through this RFP process, each Offeror must submit the information outlined in *Attachment E: Medicare Requirements* through the Health Plan Management System (HPMS). Award of a Contract will be contingent upon successfully meeting the following criteria outlined in *Attachment E: Medicare Requirements*. Plans should also be aware that there is some information that will be collected through HPMS, but will be evaluated as part of this RFP, including, but not limited to, the medical and pharmacy networks. The State's review of HPMS information for this RFP will be distinct from, but informed by, CMS' review and determination. There will also be questions that Offerors need to answer as part of the Model of Care section of the application submitted through HPMS that appear in this RFP. Plans should provide consistent or the same answers where applicable. In its review of an Offer, the State will consider a Plan's past performance in the Medicare Program and in any state's Medicaid program, using CMS' past performance analysis and star rating system as well as HEDIS scores. In the State's determination to make an Award, the State will consider whether a Plan has a history of consistently poor performance.

SECTION 3 – SPECIFICATIONS / QUALIFICATIONS / STATEMENT OF WORK

3.1 DEPARTMENT'S NEED FOR SUPPLIES / SERVICES

3.1.1 Overview. The State is seeking the services of up to five (5), and at least two (2), qualified, experienced and financially sound Plans to enter into risk-based contracts for the Medicare-Medicaid Alignment Initiative, to provide the full spectrum of Medicare and Medicaid Covered Services through an integrated care delivery system to Seniors and Adults with Disabilities who are enrolled in Medicare Parts A and B, and Medicaid (full-benefit). The Agencies will enter into one (1) year Contracts, with options for two (2) additional one (1) year renewals – in select regions of the State – with Plans that will be accountable for the care delivered to Dual Eligible beneficiaries and for robust care coordination efforts where performance will be measured and payment will be tied to quality measurement goals. Contractors may be offered the opportunity to provide the full spectrum of Medicaid services to Seniors and Adults with Disabilities who are not eligible for Medicare (Medicaid SPD Program). Offering Contractors the opportunity to provide services to those eligible for the Medicaid SPD Program will assist in ensuring continuity of care as many Medicaid-eligible beneficiaries become Medicare-eligible as well. If the State finds two (2) or more Contractors to be performing well, the State may expand the geographic areas under the Medicare-Medicaid Alignment Initiative and the Medicaid SPD Program and offer such Contractors the opportunity to serve the expanded geographic areas, subject to each such Contractor establishing the capability to so serve through a readiness review and CMS approval.

3.1.1.1 Implementation Date. The Medicare-Medicaid Alignment Initiative will begin enrollment effective January 1, 2013.

3.1.1.2 Goals. An integrated care delivery system is built on a foundation of well-resourced medical homes with an emphasis on wellness, preventive care, effective evidence-based management of Chronic Health Conditions, disability competence, care coordination, and improved utilization of community-based services aimed at improving independence in the community. The Proposal submitted by the Offeror must be a system that relies on a network of Primary Care Providers (PCPs), clinics, hospitals, Nursing Facilities, pharmacies, specialty care Providers, dentists, oral surgeons, mental health professionals, providers of LTSS, and many other service providers, including ancillary Providers, social workers, health educators, home health nurses, aides, self-directed Personal Assistants, speech, occupational and physical therapists, nutritionists, and others. This RFP is one in a series of initiatives undertaken by the State through its Innovations Project.

3.1.1.2.1 The Innovations Project initiatives are an effort to redesign the health care delivery system to one that is more person-centered with a focus on improved health outcomes, enhanced beneficiary access, and beneficiary safety and to implement the Affordable Care Act and Illinois Public Act 96-1501. IL Public Act 96-1501 requires that at least 50 percent of recipients eligible for comprehensive medical benefits in all programs administered by the Department to be enrolled in a risk-based care coordination program by January 1, 2015.

3.1.1.2.2 Due to the fragmented care Dual Eligible beneficiaries often receive – Medicare and Medicaid often work at cross purposes and impede care coordination – and the high cost of providing care to this population, the Agencies are focusing efforts on improving care for Dual Eligible beneficiaries while reducing cost growth. The goals of the Medicare-Medicaid Alignment Initiative – through integrated Medicare and Medicaid benefits and services, and integrated financing streams – are to:

3.1.1.2.2.1 Create a unified delivery system that is easier for beneficiaries to navigate;

3.1.1.2.2.2 Improve care delivery, coordination, and utilization of community-based services;

3.1.1.2.2.3 Eliminate conflicting incentives between Medicare and Medicaid that encourage cost shifting, reduce beneficiary access to high-quality care and community-based services, and result in a lack of Care Management for chronic conditions;

3.1.1.2.2.4 Improve beneficiary satisfaction with the health care received; and

3.1.1.2.2.5 Achieve cost savings.

3.1.1.3 Medicare-Medicaid Alignment Initiative. Below provides an overview of many of the initiative's proposed requirements including geographic area, Covered Services, network requirements, consumer protections, care model, and enrollment. For all of the proposed Medicare-Medicaid Alignment Initiative requirements, see the State's proposal to CMS, which can be found at http://www2.illinois.gov/hfs/PublicInvolvement/cc/Documents/cc_proposal.pdf.

3.1.1.3.1 Geographic Area: The Medicare-Medicaid Alignment Initiative will operate in two distinct areas of the State:

3.1.1.3.1.1 Greater Chicago Area: Cook, DuPage, Kane, Kankakee, Lake, and Will counties;

3.1.1.3.1.2 Central Illinois Area: Knox, Peoria, Tazewell, McLean, Logan, DeWitt, Sangamon, Macon, Christian, Piatt, Champaign, Vermillion, Ford, Menard, and Stark counties

3.1.1.3.1.3 This RFP is to solicit Plans for the Greater Chicago Area only. The HMOs are required to cover this entire Contracting Area, and MCCNs may cover this entire Contracting Area or a portion of the Contracting Area on a county-wide basis. If the State finds two (2) or more Contractors to be performing well, the State may expand the geographic areas under the

Medicare-Medicaid Alignment Initiative and offer such Contractors the opportunity to serve the expanded geographic areas, subject to each such Contractor establishing the capability to so serve through a readiness review and CMS approval.

3.1.1.3.2 Care Delivery.

3.1.1.3.2.1 **Covered Services.** For individuals defined in Section 3.1.1.3.7, Plans must provide or arrange to provide the full array of benefits and supportive services afforded individuals under Medicare in accordance with 42 C.F.R. 422.101 (including inpatient, outpatient, hospice, durable medical equipment, skilled nursing facilities, home health, and pharmacy) and Medicaid including behavioral health, long-term institutional and community-based long-term supports and services (LTSS). (See *Attachment B: Medicaid Covered Services* for a list of Medicaid State Plan services and *Attachment C: Home and Community Based Services* for the HCBS waiver services). Medicare Part D requirements will apply to Plans including, but not limited to, benefits, cost sharing, network adequacy, and formularies.

3.1.1.3.2.2 **Supplemental Benefits.** Plans may propose to offer supplemental benefits that exceed those currently provided in either Medicare or Medicaid as long as they are provided within the Medicare and Medicaid Capitation rate (with no additional compensation beyond the Capitation rate). If the Capitation rates referenced in Section 7 are provided seven (7) or fewer days before the due date for Proposals, or after the due date for Proposals, under this RFP, Offerors will have seven (7) days after the date such rates are provided to amend any list of supplemental benefits being proposed.

3.1.1.3.2.3 **Networks.** Plans will be required to establish and maintain a network of providers – either directly or through sub-contractual arrangements – that assures access to all Medicaid and Medicare benefits and services. The networks must include a broad array of providers including PCPs, specialists, behavioral health providers, ancillary providers, hospitals, pharmacists, home health agencies, Providers of durable medical equipment, Advanced Practice Nurses (APNs), and providers of LTSS and other community supports. Plans will be required to establish and maintain provider networks that at least meet State Medicaid access standards for long-term care services and Medicare access standards for medical services and prescription drugs. The State and CMS will negotiate network adequacy requirements for areas of overlap between the two programs, such as home health care services. Network adequacy will be measured, in part, based on the information provided through HPMS. The State will evaluate networks on the basis that, for services where Medicare is the primary payor, network Providers must at least be enrolled in the Medicare program and, for services where Medicaid is the primary payor, network Providers must at least be enrolled in the Medicaid Program.

3.1.1.3.3 **Care Model.** The initiative will ensure access to all Medicare and Medicaid benefits and comprehensive services that address the Enrollees' full range of needs. Care will be delivered in a team-based setting with integrated care coordination and Care Management services based on the needs and goals of Enrollees. Beneficiaries enrolled in the Medicare-Medicaid Alignment Initiative will choose a medical home that will deliver evidence-based primary care as part of a multi-disciplinary care team.

3.1.1.3.3.1 **Care Coordination.** Plans will be required to provide care coordination services that ensure effective linkages and coordination between the medical home and other providers and services, monitor transitions between levels of care, facilitate discharge planning, and provide Care Management for those identified to have complex needs. Plans will be responsible for coordinating referrals for other non-Covered Services, such as supportive housing and other social services, to maximize opportunities for independence in the community.

3.1.1.3.3.2 **Care Management.** Contractors will provide an initial health risk and behavioral health risk assessment for all new Enrollees within ninety (90) days after enrollment and use predictive modeling and surveillance data in order to stratify Enrollees to the appropriate level of intervention. Enrollees are generally stratified into three levels: low, moderate and high risk. Those Enrollees stratified to moderate or high-risk levels will receive a further comprehensive health risk and, if needed, behavioral health risk assessment within 120 days after completion of the initial assessment. Contractors must assign all Enrollees to an interdisciplinary care team, develop an Individualized Care Plan with the help of the Enrollee and provide Care Management.. Contractors will analyze predictive modeling reports and other surveillance data of all Enrollees monthly to identify risk level changes. As risk levels change, assessments will be completed as necessary and Individualized Care Plans and interventions updated. Contractors will reassess Enrollees at high-risk at least every thirty (30) days and

those with moderate-risk at a minimum of every ninety (90) days, and update the Individualized Care Plans as needed.

- 3.1.1.3.3.3 **Interdisciplinary Care Teams.** Interdisciplinary care teams will support medical homes, assist in the development of Individualized Care Plans, and provide Care Management for all Enrollees. Each interdisciplinary care team will be led by a primary Care Coordinator who is responsible for coordination of all benefits and services the Enrollee may need. Care Coordinators will have prescribed caseload limits that vary based on risk-level. Interdisciplinary care teams will be structured based on the needs of the Enrollee and may include a behavioral health professional, the PCP, a community liaison, home health aide, pharmacist, and specialist. Members of the interdisciplinary care team will assist the Care Coordinator in providing access to all services and resources an Enrollee may need, including community-based services.
- 3.1.1.3.3.4 **Health Information Technology (HIT).** The State will seek Plans that have technology in place to assist with care coordination that includes a clinical information system to be used to track care delivered outside the medical home and to share information between Providers and the interdisciplinary care team. The State recognizes that such technology may not be available system-wide at implementation. Offerors shall propose a timeline and strategy for rolling out the capabilities described.
- 3.1.1.3.3.5 **Integration of Physical and Behavioral Health.** Contractors shall integrate primary and behavioral health services with an emphasis on co-location of physical and behavioral health. Co-location of physical and behavioral health is accomplished through Providers working together in the same practice setting to provide a team-based approach to care delivery and immediate referral when necessary. It may be accomplished through co-location of practices, the placement of a behavioral health clinician in a primary care setting, the placement of a primary care clinician in a behavioral health practice, or an alternative arrangement.
- 3.1.1.3.4 **Consumer Protections.** Each Plan must ensure sufficient consumer protections including choice of Providers within the Plan's network and opportunities to maintain relationships with existing Providers. In addition to maintaining an existing course of treatment with an out-of-network Provider for 180 days after enrollment, Enrollees will be able to maintain existing PCP arrangements for 180 days and all current Providers will be offered Single Case Agreements to continue to care for that Enrollee beyond 180 days if they remain outside the network. Plans may choose to transition Enrollees to a network Provider sooner than 180 days as long as the Enrollee is not in an existing course of treatment and certain requirements are met including that an Enrollee is assigned to a medical home that is capable of meeting the Enrollee's needs.
 - 3.1.1.3.4.1 **Ongoing Consumer Involvement.** Contractors must implement meaningful consumer input processes in their ongoing operations, including operation of a consumer advisory committee and measurement of quality of service and care. The State will hold stakeholder meetings throughout the terms of the Contracts to ensure beneficiary satisfaction and quality of care.
 - 3.1.1.3.4.2 **Consumer-direction.** Enrollees must be allowed to participate in their own Individualized Care Plan development, including the selection of Providers and services to receive or not receive. The right of Enrollees to select their own Personal Assistants will be preserved and protected. Enrollees will be the co-employer of Personal Assistants with support from Plans and a fiscal vendor for timekeeping and related issues. The State is exploring – and believes there is merit in – contracting with a single vendor that all Contractors would pay based on the workload of their Personal Assistants.
 - 3.1.1.3.4.3 **Cultural Competency.** To ensure all Covered Services are provided in a culturally competent manner, Contractors shall implement a cultural competence plan that meets NCOA standards for Culturally and Linguistically Appropriate Services in Health Care. Plans will ensure the cultural competence of Providers and all Contractor staff and provide training as appropriate engaging local organizations to develop and provide the relevant training.
- 3.1.1.3.5 **Performance Measurement.** At a minimum, the State will use applicable Performance Measures from the Integrated Care Program to assess Contractor performance. See *Attachment D: Quality and Pay-for-Performance Measures* for an initial list of proposed measures. The State will work with CMS and stakeholders to identify additional measures specific to the population to be served under the Medicare-Medicaid Alignment Initiative and for additional measures related to improved LTSS and consumer satisfaction. The State's proposed pay-for-Performance Measures are under consideration by CMS and the final measures to be used as pay-for-performance may change based on negotiations with CMS. See *Section 7: Payment Terms and Conditions* for more detail on the State's proposed incentive payment plan and pay-for-performance.

3.1.1.3.6 Enrollment. Participation in the demonstration is voluntary. The State will implement a unified, passive enrollment process that provides beneficiaries the opportunity to enroll or disenroll from a Plan at any time. Potential Enrollees will have the opportunity to choose from at least two Plans serving the entire geographic area in addition to any selected MCCN serving a limited geographic area, or to choose to remain in Medicaid fee-for-service (FFS). Enrollees will not be locked-in to Plans and will be able to disenroll or transfer Plans on a month-to-month basis at any time during the year. Additionally, Enrollees will not be locked-in to PCPs. Requests to change PCPs must be honored within 30 days. The State is working with CMS to develop a single unified enrollment process.

3.1.1.3.6.1 Enrollment Phase-in. The State is proposing to phase-in enrollment to ensure Plans have adequate time to process enrollment, complete health risk assessments, and to ensure a smooth transition for Enrollees. Consistent with CMS guidance, the State will first phase-in individuals who affirmatively chose to enroll in the demonstration and individuals eligible for the low-income subsidy who would otherwise be subject to the annual Prescription Drug Plan (PDP) reassignment. Those individuals who are phased-in first will have enrollment effective dates of January 1, 2013. The State proposes to phase-in a maximum of 5,000 Enrollees per Plan per month thereafter. The State will not auto-assign a number of beneficiaries to a MCCN that exceeds its capacity. Potential Enrollees will receive enrollment notices with ample time to make an informed choice to enroll or not enroll in a Plan.

3.1.1.3.6.2 Client Enrollment Broker (CEB). A CEB – under contract with the State – will facilitate enrollment and develop and run an algorithm to run assignments for the auto-enrollment process. The assignments will be carried out by the State and CMS. The CEB will also help to increase awareness about the demonstration and to inform enrollment choices through avenues such as mailings or print and virtual media and through outreach and education sessions for Potential Enrollees.

3.1.1.3.7 Population. The populations included as Potential Enrollees in the Medicare-Medicaid Alignment Initiative are individuals who are enrolled in Medicare Parts A and B, and Medicaid (full-benefit). The charts below show the number of eligibles to be included in the Medicare-Medicaid Alignment Initiative for the Greater Chicago Area. The first shows the population by county according to their category of assistance, i.e. the characteristic that makes them eligible. The second chart breaks down the same population by the setting or delivery system in which they receive care. Within the selected geographic area, the population that is eligible for the Medicare-Medicaid Alignment Initiative is full-benefit Dual Eligible beneficiaries – those that are enrolled in Medicare Parts A and B and Medicaid (full-benefit) – up to 100 percent of the federal poverty level and ages 21 and over. The Medicare-Medicaid Alignment Initiative population includes individuals in the AABD category of assistance only. The Medicare-Medicaid Alignment Initiative population excludes individuals listed in Section 3.1.1.3.7.4, below.

3.1.1.3.7.1 As of December 31, 2010, there were approximately 136,000 beneficiaries in the initiative population targeted for enrollment, of which approximately 118,000 are in the Greater Chicago Contracting Area (79% of the Greater Chicago region individuals reside in Cook county). Of the initiative population in the Greater Chicago area, 58.9 percent is age 65 or older. For the initiative population in the Greater Chicago area, the average Medicaid per member per month calendar year (CY) 2010 net costs were \$811 compared to \$323 for all other full benefit Medicaid beneficiaries in Illinois. Of the initiative population in the Greater Chicago area, 18.6 percent received care in an institutional setting and 17.1 percent received care in a HCBS setting and contributed approximately 28.3 percent and 19 percent of total institutional care costs and HCBS costs among all full benefit Medicaid beneficiaries Statewide. Individuals with Serious Mental Illness (SMI) constitute 21.3 percent of the initiative population in the Greater Chicago area and approximately 42.7 percent of this subpopulation received care in an institutional setting. The charts below provide more detail on the Greater Chicago area initiative population as of December 31, 2010.

3.1.1.3.7.2 Number of Potential Enrollees for the Medicare-Medicaid Alignment Initiative, **by county and HFS category of assistance** (unduplicated)

HFS county code	County	Category of Assistance			
		TOTAL	Aged	Disabled	HBWD
TOTAL		118,050	69,574	48,288	188
030	DuPage	7,107	4,523	2,569	15
053	Kane	5,134	3,002	2,116	16
054	Kankakee	1,889	899	983	7
057	Lake	5,565	3,187	2,357	21
107	Will	4,781	2,688	2,085	8
200	Cook	93,574	55,275	38,178	121

3.1.1.3.7.3 Number of Potential Enrollees for the Medicare-Medicaid Alignment Initiative, by county and institutional or waiver program status (unduplicated)

HFS county code	County	TOTAL	Community residents	Institutional Residents	HCBS waiver program participants					MFP
				Nursing facility	Aging (Seniors & Disabled)	Brain injury	HIV/AIDS	Supportive (assisted) living	Physical disability	
TOTAL		118,050	75,973	27,927	13,081	1,001	378	2,749	2,939	2
030	DuPage	7,107	4,169	2,166	469	39	6	112	146	0
053	Kane	5,134	3,254	1,044	250	29	20	413	124	0
054	Kankakee	1,889	1,087	454	136	17	0	124	71	0
057	Lake	5,565	3,446	1,601	300	28	4	92	94	0
107	Will	4,781	3,020	1,160	224	46	7	122	202	0
200	Cook	93,574	60,997	15,502	11,702	842	341	1,886	2,302	2

3.1.1.3.7.4 **Excluded Populations.** The populations included as Potential Enrollees in the Medicare-Medicaid Alignment Initiative are the aged, blind and disabled populations (Categories 01/91, 02/92, and 03/93 respectively). The following aged, blind and disabled populations are excluded from participation in the Medicare-Medicaid Alignment Initiative:

3.1.1.3.7.4.1 Participants under 21 years of age;

3.1.1.3.7.4.2 Participants who have a Developmental Disability and who receive services in an institutional setting or through a HCBS waiver;

3.1.1.3.7.4.3 Participants with Spend-down;

3.1.1.3.7.4.4 Participants in the Illinois Breast and Cervical Cancer program and other partial benefit programs; and,

3.1.1.3.7.4.5 Participants with Comprehensive Third Party Insurance.

3.1.2 **Current Delivery System and Services.** In this Section we describe how services are currently delivered to Potential Enrollees. While services described herein are required to be provided by Contractors, Contractors are not required to use the entities or processes described herein in their delivery of services.

3.1.2.1 **Current Medicaid Program Structure for Target Population.** The Potential Enrollees currently receive certain Covered Services through the Medicaid Fee-For-Service system. The Potential Enrollees receive Medicare services through a Medicare Advantage plan or Medicare Fee-For-Service system.

3.1.2.2 **Dental Services.** The Department contracts with DentaQuest, formerly known as Doral Dental of Illinois, as the fiscal intermediary and administrator of the dental program. The services provided by DentaQuest include Participant and Provider services such as providing Participants access and referrals to dental care, Participant education, recruiting and retaining a dental network, developing and maintaining dental policies and procedures in the Dental Office Reference Manual, performing provider education, disseminating information and performing provider profiling and feedback. DentaQuest also provides the general administration of the dental program, including Participant eligibility checks, claims administration and payment processing for dental claims, operation of a referral system to assist Providers in locating needed dental resources, data management and reporting, website operations, prior authorization for certain dental services and operating a dental quality assurance program. A list of dental Covered Services can be found in RFP

Attachment B. Additional information on the Department's dental program can be found at: http://www.hfs.illinois.gov/mch/dental_prov.html.

3.1.2.3 Alcohol and Substance Abuse Services. DHS-DASA is the lead agency for all substance abuse issues for the State of Illinois, DHS-DASA is responsible for coordinating the efforts of all State programs dealing with problems related to substance abuse. Treatment services to Participants are delivered under contract by community-based agencies. This system enables clients to be assessed and treated as close to their home communities as possible, allows communities to take ownership of their programs and facilitates public information and other adjunct services. Treatment services are delivered through a continuum approach, with individual clients moving from one level of care to another based upon their assessed needs. Level I and Level II services are face-to-face clinical services in a non-residential setting while Level III services are in a 24-hour structured and supervised treatment environment. More information on services and resources provided in Illinois may be found at the DHS Alcoholism and Addiction website: <http://www.dhs.state.il.us/page.aspx?item=29725>.

3.1.2.4 Community Mental Health Services. The primary mission of the DHS-DMH is to assure that recovery-oriented, evidence-based, culturally sensitive community-focused treatment and supports are accessible to adults most in need of mental health services, in order that they may be empowered to recover, succeed in accomplishing their goals and live full and productive lives. Recovery is a person-centered, individualized process. Therefore, service planning and service delivery must be consumer-directed, and the evaluation of outcomes must include consumer-level indicators of recovery and resilience. A range of treatments and services, evidence-based practices and exemplary practices, are employed and advanced across Illinois to promote recovery. DHS-DMH also strongly supports that all of these services are individually strength-based, thereby designed to foster recovery and resiliency for all consumers. It is the vision of DHS-DMH that all persons who experience mental illness will recover and that effective treatment and supports essential for full participation in one's community will be accessible and available at all stages of a person's life.

3.1.2.4.1 The Medicaid Community Mental Health Services Program is for individuals who require mental health services as indicated by a diagnosis contained in the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) or the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV) (1994) or DSM-IV-TR (2000) (American Psychiatric Association). Services are designed to benefit Participants:

3.1.2.4.1.1 Who require an evaluation to determine the need for mental health treatment;

3.1.2.4.1.2 Who are assessed to require Medically Necessary mental health treatment to reduce the mental disability and to restore an individual to the maximum possible functioning level;

3.1.2.4.1.3 Who are experiencing a substantial change/deterioration in age appropriate or independent role functioning, acute symptomatology, and who require crisis intervention services to achieve Stabilization; or

3.1.2.4.1.4 Who, because of substantial impairment in role functioning, require multiple coordinated mental health services delivered in a variety of systems.

3.1.2.4.2 A comprehensive list of mental health services from the Rule 132 Service Definition and Reimbursement Guide can be found at: http://www.hfs.illinois.gov/assets/070107_cmph_guide.pdf. This link provides information on community mental health services and reimbursement details, such as HCPCS codes and units of service. It also lists general requirements for eligibility and community mental health Providers, as well as minimum staff requirements for the individual services. More information on mental health services and resources in Illinois may be found at the DHS Mental Health website: <http://www.dhs.state.il.us/page.aspx?item=29728>.

3.1.2.4.3 Community hospitals are considered Mental Health facilities under 405 ILCS 5/1-114 and 59 Ill. Admin. Code Section 111.20. A link to the Administrative Code section may be found at: <http://www.ilga.gov/commission/jcar/admincode/059/059001110000200R.html>.

3.1.2.5 State Operated Hospitals

3.1.2.5.1 State-operated hospitals (SOHs) with acute civil units provide inpatient treatment to individuals who are eighteen years of age or older. Individuals served include those persons with Serious Mental Illness who cannot be served in a less restrictive setting. In addition, many of the individuals served also have other complicating problems such as substance abuse and Developmental Disabilities. Individuals are screened and subsequently referred by the community mental health center serving the county or geographical region where the person resides. The community mental health center is involved with all referrals to each regional SOH to ensure continuity of care. Individuals are generally admitted to the unit that serves their geographical region. Lengths of stay average less than two weeks but can be much longer or shorter depending upon individual need. A full range of programs and services are offered in the areas of medical/psychiatric

services, nursing, psychology, social work, educational/vocational rehabilitation services, activity therapy, and spiritual services. Assessment and treatment planning are multi-disciplinary activities involving the individual, family/significant others, the community mental health center, other support services and the hospital treatment team. The individual served and treatment team collaboratively develops a treatment plan which outlines recovery goals based on an assessment of the individual's needs. The following strategies may be incorporated into an individual's treatment plan:

3.1.2.5.1.1 Supportive counseling and psychotherapy;

3.1.2.5.1.2 Group and family therapy supplemented by skills training;

3.1.2.5.1.3 Vocational evaluation and counseling;

3.1.2.5.1.4 Psycho-social skills training groups;

3.1.2.5.1.5 Substance abuse counseling;

3.1.2.5.1.6 Illness and medication education;

3.1.2.5.1.7 Referral to specialized service programs;

3.1.2.5.1.8 Community groups;

3.1.2.5.1.9 Wellness Recovery Action Planning (WRAP); and

3.1.2.5.1.10 Aftercare Planning in concert with the Participants, family and the community mental health center.

3.1.2.5.2 Although the Contractor will not be required to provide these services, several SOHs have additional services provided by the forensic program that operate:

3.1.2.5.2.1 Within the framework of the criminal statutes, involves persons adjudicated as Unfit to Stand Trial in restoration of fitness to stand trial efforts.

3.1.2.5.2.2 Within the framework of the criminal statutes, for all persons adjudicated Not Guilty by Reason of Insanity evaluates, recommends, and provides appropriate treatment to begin the rehabilitation process which will allow the individual to progress towards greater freedom and eventual release and reintegration into the community.

3.1.2.5.2.3 Provides expert evaluations of the patient's condition and progress, makes recommendations for fitness, continued care, or release to the community criminal courts.

3.1.2.5.3 Services provided in SOHs are regulated under the Mental Health and Developmental Disabilities Code 405 ILCS 5/CH. I) and the Illinois Administrative Code (59 Ill. Admin Code). A link to the statute may be found at: <http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1496&ChapAct=405%26nbsp%3BILCS%26nbsp%3B5%2F&ChapterID=34&ChapterName=MENTAL+HEALTH&ActName=Mental+Health+and+Developmental+Disabilities+Code%2E>. For more information, see also <http://intranet.dhs.onenet/page.aspx?item=13122>.

3.1.2.6 **Participant Direction.** Participant direction of services means that the Participant has the authority to exercise decision making authority over some or all of her/his services and accepts the responsibility for taking a direct role in managing them. Participant direction is an alternative to Provider management of services wherein a service Provider has the responsibility for managing all aspects of service delivery in accordance with the participant-centered Individualized Care Plan. Participant direction promotes personal choice and control over the delivery of services, including who provides services and how they are delivered. For example, the Participant may be afforded the opportunity and be supported to recruit, hire, and supervise individuals who furnish daily supports. When a service is Provider-managed, a Provider selected by the Participant carries out these responsibilities.

3.1.2.7 **Pre-Admission Screening (PAS) for Nursing Facility Level of Care.** Pre-Admission Screening is conducted for all individuals, regardless of payment source, who enter a nursing facility to determine whether they meet a nursing facility level of care as defined by State assessment tools. Although the screening rule covers only nursing facility placements, preadmission screenings are also completed on individuals who wish to participate in the home and community-based waiver programs, rather than nursing facilities, as defined in the waivers. **This PAS process will continue as currently in place to determine whether Enrollees are entitled to these services through the Contractor.** Beginning July 1, 1996, federal requirements for universal screening were put in place that any individual seeking admission to a Long-Term Care Facility be screened to determine the need for that level of service regardless of payment source. Illinois' preadmission screening rule, 89 Ill Admin Code 140.642, may be found at: <http://www.hfs.illinois.gov/assets/140.pdf>. In Illinois, there are designated entities that conduct level of care evaluations for the institutional and the waiver populations. The Department, as the Medicaid agency, oversees the performance of these entities, ensuring that applicable level of care criteria has been properly applied. When a person seeks admission to a Long-Term Care Facility, the local screening agency is contacted to conduct an assessment. The contracted screening vendor will conduct a full

assessment to determine whether the person meets eligibility criteria requiring 24 hour skilled nursing care. Screening agencies are contracted through either the Department on Aging for those 60 years of age or older or Department of Human Services for those with mental illness, Developmental Disabilities or physical disabilities under the age of 60 years. The Long-Term Care Facility should not admit a Resident without a screen except under very limited circumstances. The screen determines whether the potential Resident is appropriate for the admitting facility. Medicaid payment begins on the date of admission, date of screen or date of eligibility, whichever is later, unless the Resident is admitted due to loss of a caregiver, from a hospital emergency room or from out-of-state. If a screen indicates a suspicion of mental illness or Developmental Disability, DHS-DMH or DHS-DDD is contacted to perform the screen to determine whether the Resident has a diagnosis that would make a nursing facility inappropriate, and in another setting would be more appropriate to the Resident's needs. Persons identified for Resident Review are determined by the Medicaid authority, DHS-DMH, State policy and Federal policy. Resident Reviews will be conducted under two circumstances: an "Initial Review" following admission of a person to a licensed nursing facility and reviews based on a Significant Change in the Resident's condition. (89 Ill Admin Code 140.642 f (link provided above)). The goal of Resident Review assessments are to determine whether the mental health needs identified in the PAS assessment are integrated into the individual's facility care plan, to offer the consumer choice in his living arrangement and to determine whether the Participant could begin the transition to a less institutional setting. If assessment of the Resident Review determines that the Participant is a good candidate for transition, then transition planning should occur with the responsible community service vendor.

3.1.2.8 Pre-Admission Screening of Waiver Participants. Federal law, 42 CFR Section 441.301(b)(1), requires that Home and Community-Based Services provided through Title XIX Medicaid waivers be provided only to individuals who would otherwise require services at a level of care in a Medicaid certified institution, specifically a hospital, nursing facility, or Intermediate Care Facility for the Developmentally Disabled (ICF/DD). This Federal regulation may be viewed at: [42 CFR 441.301\(b\)\(1\)](#). In order to comply with the regulation, an assessment must be conducted and a determination must be made indicating that an individual would need services at an institutional level of care, whether it is a hospital, nursing facility, or ICF/DD; if the waiver was not otherwise available. This level of care assessment must be done prior to the initiation of services and at least annually to verify that the individual continues to require the specified institutional level of care. In some programs, the assessments are conducted more often.

3.1.2.8.1 The current Pre-Admission Screening agencies for HCBS waivers are located statewide and are listed below by agency and program:

State Agency	Waiver Programs	Level of Care	Screening Agents	Tool
Division of Rehabilitation Services (DHS- DRS)	-Persons with Disabilities -Persons with HIV or AIDS -Persons with Brain Injury	Nursing Facility	Care Coordination Units DRS local offices	Determination of Need (DON)
Department on Aging (DoA)	-Seniors	Nursing Facility	Care Coordination Units	DON
Healthcare and Family Services	-Supportive Living	Nursing Facility	Care Coordination Units DRS Local Offices	DON
Note: The DHS-DRS and DoA screening agents also conduct Nursing Facility Pre-Admission Screening. Also, as stated in Section 3.1.1.3.7.4, individuals who are under the age of 21 or who have a Developmental Disability are excluded from participation in the Medicare-Medicaid Alignment Initiative. To the extent that such individuals are referenced in Section 3.1.2.8 or related text, this information is for providing Medicaid system-wide context only and is not intended to imply that such individuals are eligible to participate in the Medicare-Medicaid Alignment Initiative.				

3.1.2.9 Nursing Facility General Services – Medicaid Requirements. Long term care services covered by the Department for Medicaid-eligible Residents, as found in 89 Ill. Adm. Code 140.511, include Skilled Nursing Facilities and Intermediate Care Facilities (SNF and ICF). The facility must provide an ongoing program of activities to meet the interests and preferences and the physical, mental and psychosocial well-being of each Resident (77 Ill. Adm. Code 300.1410, Activity Program). Facilities must provide the following services at no additional charge:

- 3.1.2.9.1** All staff, routine equipment and supplies including oxygen (if less than one tank has been furnished to the Resident for the month in question);
- 3.1.2.9.2** Room and board, supervision and oversight, and all laundry services;
- 3.1.2.9.3** Food substitutes and nutritional supplements;

- 3.1.2.9.4 Medications that are regularly available without prescription at a commercial pharmacy and that may be stocked by the facility under Department of Public Health regulations;
 - 3.1.2.9.5 Over-the-counter drugs or items ordered by a Physician; and
 - 3.1.2.9.6 All other services necessary for compliance with the requirements of the Department of Public Health as set forth in the Skilled Nursing and Intermediate Care Facilities Code (77 Ill. Adm. Code 300).
- 3.1.2.10 Home and Community-Based Services (HCBS).** The provision of Home and Community-Based Services (HCBS) waivers allow Participants to receive non-traditional services in the community or in their own homes, rather than being placed in an institutional setting. Each HCBS waiver is designed for individuals with similar needs and offers a different set of services. Illinois currently operates nine HCBS waivers. Those HCBS waivers that serve only individuals who are under the age of 21 or who have a Developmental Disability are not described below. To the extent that such individuals are referenced in Section 3.1.2.10 or related text, this information is for providing Medicaid system-wide context only and is not intended to imply that such individuals are eligible to participate in the Medicare-Medicaid Alignment Initiative. For a complete list of waiver services, service definitions, and service limits included in the Medicare-Medicaid Alignment Initiative, see *Attachment C: Home and Community Based Waiver Services*. More information on the Illinois HCBS waivers may be found at the following link: <http://www2.illinois.gov/hfs/MedicalPrograms/HCBS/Pages/default.aspx>.
- 3.1.2.10.1 HCBS Waiver for Persons who are Elderly.** The Department on Aging (DoA) is the operating agency for the HCBS waiver for persons who are elderly, which is part of the Community Care Program (CCP). The CCP offers services to persons age 60 and over who meet functional and financial eligibility criteria. Those who meet Medicaid eligibility criteria are HCBS waiver participants. There are three services in this program: Homemaker Services, Adult Day Care and Personal Emergency Response Systems. The need for services is determined by local community agencies, Case Coordination Units (CCU)/Case Management Units (CMU), which are under contract with DoA.
 - 3.1.2.10.2 HCBS Waiver for Assisted Living, Supportive Living Program.** The HFS Division of Medical Programs is the operating agency for the Supportive Living Program. The Supportive Living Program serves persons age 65 and older or persons age 22 to 64 who have physical disabilities. A Supportive Living Facility (SLF) is a Department approved residential setting in Illinois that: provides or coordinates flexible Personal Care services, 24 hour supervision and assistance (scheduled and unscheduled), activities, and health-related services with a service program and physical environment designed to minimize the need for Residents to move within or from the setting to accommodate changing needs and preferences; has an organizational mission, service programs and a physical environment designed to maximize Residents' dignity, autonomy, privacy and independence; and encourages family and community involvement. More information relating to services and requirements under this program, as well as a list of operational programs, can be found at the HFS website: www.slfillinois.com.
 - 3.1.2.10.3 HCBS Waivers for Persons with Disabilities; Persons with HIV or AIDS, and Persons with Brain Injury.** The DHS Division of Rehabilitation Services (DHS-DRS) is the operating agency for three of the Illinois HCBS waivers: persons with disabilities, persons with HIV/AIDS, and persons with brain injury. These waivers are part of a larger program called the Home Services Program (HSP). HSP is a consumer-directed program where most Participants hire, supervise, and terminate their own Personal Assistants. The program was designed using an independent living model, under the philosophy that regardless of disabilities or abilities, all persons have the right and responsibility to determine the direction of their lives and to fully and meaningfully participate as members of society. Although there are many services offered in these programs, the service used most often is Personal Assistant. The State of Illinois serves as a co-employer for payment, unemployment, workers compensation and tax purposes and pays the Personal Assistants through a payroll system that processes paychecks every two weeks. Hourly pay of Personal Assistants is currently determined by a labor contract with Service Employees International Union. Below is a brief description of the population served in each program.
 - 3.1.2.10.3.1 Persons with Disabilities Waiver:** The waiver for persons with disabilities serves individuals between the ages of birth through 59 years, unless the individual was receiving services prior to the 60th birthday and chose to remain in the waiver. The person must have a medical determination of a diagnosed, severe disability, which is expected to last for at least 12 months or for the duration of life.
 - 3.1.2.10.3.2 Persons with HIV/AIDS Waiver:** The waiver for persons with HIV/AIDS serves individuals of any age who have a medical determination of HIV or AIDS with severe functional limitations, which are expected to last at least 12 months or for the duration of life.
 - 3.1.2.10.3.3 Persons with Brain Injury Waiver:** The waiver for persons with brain injury serves individuals of any age who have an acquired brain injury. In this circumstance, brain injury is defined as: traumatic brain injury, infection (encephalitis, meningitis), anoxia, stroke, aneurysm, electrical injury, malignant or benign neoplasm of the brain, or toxic

encephalopathy. The definition does not include degenerative, congenital or neurological disorders related to aging.

3.2 SUPPLIES OR SERVICES REQUIRED. This section will serve as the opportunity for the Offeror to convey its vision and structure for the Medicare-Medicaid Alignment Initiative by responding to the subsections below. In addition, Offerors will be asked for information or data concerning their existing health plan. If you currently operate one or more health care plans and are using one of those health care plans as an example in a response, provide the name of the health care plans for which you are providing the information or data in each instance. The State has designed this RFP to allow potential Offerors to demonstrate their understanding of the Medicare-Medicaid Alignment Initiative and ability to design, implement and operate such a system. The State understands that there can be varied approaches to such a system. Therefore, the State generally has not prescribed in this RFP how such a system should be designed or operated. This Section of the RFP seeks a significant amount of information from Offerors in order to elicit innovative strategies and to better enable the State to evaluate the true understanding and abilities of Offerors. The following section requires complete responses from the Offeror that address each subsection and provide any experience the Offeror has in said area.

3.2.1 Organization/Operation

3.2.1.1 Discuss the history and ownership of your organization.

3.2.1.1.1 Include your experience in providing managed care in general, and specifically your experience providing the services that are proposed for this or similar populations.

3.2.1.1.2 Explain your qualifications to respond to this RFP. Include accreditations, certifications and recognitions achieved, e.g., NCCA Health Plan Accreditation.

3.2.1.1 Describe your experience with implementing and using evidence-based practices, including which evidence-based practices you employ, an outline of specific goals and benchmarks, outreach strategies and sample materials, and your successes and challenges with improving outcomes for operating the following:

3.2.1.1.1 Disease Management Programs;

3.2.1.1.2 Care Coordination and Care Management programs for Chronic Health Conditions (including end-stage renal disease (ESRD)), Behavioral Health conditions, and those with SMI, substance abuse, and Developmental Disabilities;

3.2.1.1.3 Programs aimed at reducing inappropriate ER utilization and avoidable hospital readmissions particularly among Nursing Facility Residents.

3.2.1.2 Describe your plan for consumer input into the operations and management of this program including:

3.2.1.2.1 Structure and responsibilities of a consumer advisory board:

3.2.1.2.1.1 Number of required consumer or consumer representatives on the board;

3.2.1.2.1.2 Description of consumer representatives allowed to participate;

3.2.1.2.1.3 Roles and responsibilities of the consumer advisory board;

3.2.1.2.1.4 How feedback of the consumer advisory board will be integrated into the ongoing management of the program; and

3.2.1.2.2 Describe experience in other programs with consumer input and any examples of program changes that resulted from this input.

3.2.1.3 Describe your philosophy and approach to consumer direction including:

3.2.1.3.1 How you plan to engage and support Enrollees in directing their own care including selecting Providers and services to receive, and as a co-employer over Personal Assistants;

3.2.1.3.2 Oversight and management of services that are consumer selected; and

3.2.1.3.3 How you manage situations that are not achieving desired outcomes.

3.2.1.4 Describe your Quality Program, including your philosophy and resources invested toward your QAPI Program, including but not limited to:

3.2.1.4.1 Governing Body;

3.2.1.4.2 Committee for development, implementation, and overseeing the QAPI Program;

3.2.1.4.3 Resources, staffing and qualifications including data and analytical resources;

3.2.1.4.4 Provider participation through planning, design, implementation and review;

3.2.1.4.5 QAPI Program education to Providers and Enrollees; and

- 3.2.1.4.6 Draft Quality Assurance and Performance Improvement Plan.
- 3.2.1.5 Describe your ongoing monitoring and evaluation of your QAPI including:
 - 3.2.1.5.1 Overall effectiveness and demonstrated improvement;
 - 3.2.1.5.2 Ongoing analysis of key Performance Measures and how you will use the results of that analysis to improve the model of care;
 - 3.2.1.5.3 Frequency of monitoring, evaluation and analysis; and
 - 3.2.1.5.4 Communication of improvements in your QAPI program to stakeholders.
- 3.2.1.6 Describe your experience performing performance improvement projects (PIPs). Give examples of actual PIPs, detailing the:
 - 3.2.1.6.1 PIP's focus and reason for selection;
 - 3.2.1.6.2 Barriers;
 - 3.2.1.6.3 Interventions used; and
 - 3.2.1.6.4 Improvement achieved, including sustained improvement.
- 3.2.1.7 Provide a narrative describing your Utilization Management (UM) Program Plan as well as its functions and responsibilities including how:
 - 3.2.1.7.1 You exercise these responsibilities, including criteria used and any special issues in applying Utilization Management guidelines for inpatient care (including urgent and emergency), behavioral health, waiver services and long term care services;
 - 3.2.1.7.2 Describe how your UM Program detects, monitors, and evaluates under-utilization, over-utilization, and inappropriate utilization of services as well as processes to address opportunities for improvement;
 - 3.2.1.7.3 Specify the type of personnel responsible for each level of UM, including prior authorization and decision-making; and
 - 3.2.1.7.4 Provide a narrative description of your prior authorization processes.
- 3.2.1.8 Provide a plan to accommodate the proposed enrollment phase-in of 5,000 Potential Enrollees per month to ensure that you are able to administer the initial health risk and behavioral health risk assessments to all new Enrollees and comprehensive health risk and, if needed, behavioral health risk assessments, provide appropriate medical homes to all new Enrollees, assign an Interdisciplinary Care Team, and develop Individualized Care Plans in a timely manner. The detailed draft implementation work plan, with an estimated timetable to begin enrollment no later than January 1, 2013, must include, but not be limited to:
 - 3.2.1.8.1 Initial planning meetings;
 - 3.2.1.8.2 Coordination with State staff;
 - 3.2.1.8.3 Periodic update meetings;
 - 3.2.1.8.4 Customer service training;
 - 3.2.1.8.5 Communication development;
 - 3.2.1.8.6 Approval and production;
 - 3.2.1.8.7 Contract development and Execution;
 - 3.2.1.8.8 Network development/Provider relations;
 - 3.2.1.8.9 Development of system capabilities; and
 - 3.2.1.8.10 Timeframes for completing initial and comprehensive health risk and behavioral health risk assessments and Individualized Care Plans.
- 3.2.1.9 The Agencies will require reporting of complete Encounter Data. As such, describe:
 - 3.2.1.9.1 How you will ensure that your Providers submit all Encounter Data to you, particularly if you sub-capitate any providers;
 - 3.2.1.9.2 Any problems you experienced in past implementation of Encounter Data from testing to production and the steps and timeline for resolving those problems;
 - 3.2.1.9.3 Your experience submitting Encounter Data provided to a Medicaid agency, Medicare agency or private payer including:

3.2.1.9.3.1 How successful were you in getting the data accepted by the payers' system; and

3.2.1.9.3.2 What percentage of Encounter Data were you able to get successfully accepted.

3.2.1.10 Provide a comprehensive statement of your proposed staffing plan demonstrating how you will provide adequate staffing to address all requirements found in the RFP or proposed by you. Include:

3.2.1.10.1 Comprehensive organizational charts;

3.2.1.10.2 Job descriptions for all key staff described in Section 3.3.1 (information provided to CMS through HPMS relating to this question may be provided in response to this question; however, to the extent such titles or job descriptions differ from those described in Section 3.3.1, provide an explanation reconciling those differences);

3.2.1.10.3 Résumés of known key staff; and

3.2.1.10.4 Detail of the implementation team and how it will differ from the on-going staff. Include:

3.2.1.10.4.1 A timeline for transitioning from the implementation team to permanent staff; and

3.2.1.10.4.2 A description of your plan for transition from the implementation team to the permanent staff including for how long they will overlap and how you will ensure the permanent staff is equipped to operate the program.

3.2.1.11 Describe your plan for keeping management level staff turnover to a minimum.

3.2.1.12 Describe how you will approach Abuse and Neglect and unusual incidents in the community setting.

3.2.1.13 Describe how you will seek to hire people with disabilities to act as peer supports.

3.2.1.14 Describe how you will ensure cultural competency throughout your network of Providers and all Contractor staff including:

3.2.1.14.1 How you will develop a cultural competency plan that meets NCQA standards for Culturally and Linguistically Appropriate Services in Health Care;

3.2.1.14.2 What training programs and support you will offer Contractor staff and Providers regarding cultural competency;

3.2.1.14.3 How you will engage local organizations to develop and provide the relevant training;

3.2.1.15 Describe how you will develop and ensure key oral contacts and written materials are compliant with federal requirements and;

3.2.1.15.1 How you will supply interpretive services for all key oral contacts;

3.2.1.15.2 How you will ensure written materials can be easily understood by the various populations included in this initiative;

3.2.1.15.3 Alternative methods of communication you will offer and how Enrollees will access these methods; and

3.2.1.15.4 How you will ensure the accuracy of translated materials and provide examples of materials currently provided to members in your other contracts, including actual client handbooks.

3.2.2 Provider Network and Services

3.2.2.1 Describe your medical home network including:

3.2.2.1.1 Types of providers that will serve in a PCP capacity;

3.2.2.1.2 How it is equipped to promote evidence-based wellness and preventive care and management of Chronic Health Conditions and to fully coordinate care as part of an interdisciplinary care team, including your plan for supporting Providers that are not capable of operating as true medical homes and for helping them advance toward NCQA certification;

3.2.2.1.3 How you will ensure that frail Seniors or persons with Chronic Health Conditions (including ESRD and HIV/AIDS), Developmental Disabilities, physical disabilities, or SMI, have medical homes equipped to handle the special needs of these subpopulations;

3.2.2.1.4 Your ratios of PCPs to Enrollees not exceeding a ratio of 1:600 and any limits you may have on panel sizes and how you determine those limits; and

3.2.2.1.5 Details of your criteria for medical home selection for Enrollees, including standards for maximum distance or travel times.

- 3.2.2.2 Describe Hospitalist programs you propose to operate including how many, where, and how such programs will:
 - 3.2.2.2.1 Minimize admissions and lengths of stay;
 - 3.2.2.2.2 Ensure adequate discharge planning;
 - 3.2.2.2.3 Include communication among Enrollees, families and significant others, and hospital leadership.
- 3.2.2.3 Describe the components and operation of the SNFist program you are required to operate, including:
 - 3.2.2.3.1 Types of providers;
 - 3.2.2.3.2 Targeted caseloads of these Providers;
 - 3.2.2.3.3 Hours of availability in the Nursing Facility;
 - 3.2.2.3.4 Employment relationship with these providers;
 - 3.2.2.3.5 How the SNFist program will communicate with the interdisciplinary care team to provide continual updates to the Individualized Care Plan; and
 - 3.2.2.3.6 In which facilities in your network you will operate a SNFist program.
- 3.2.2.4 Describe any home visit and telehealth programs you propose to operate.
- 3.2.2.5 Describe any palliative care program you propose to operate.
- 3.2.2.6 Describe the ability of your network laboratories to report electronic lab values for use in Performance Measures and Case Management.
- 3.2.2.7 Describe how you will assure access to dental services for all Enrollees, including those with disabilities.
- 3.2.2.8 Describe the mental health continuum of services you will use for those with SMI and the continuum of services for those with mental health and behavioral health needs that may not meet SMI and your rationale for this continuum.
- 3.2.2.9 Describe the process and criteria you will use, both initially and ongoing, to identify substance abuse and mental health Providers who will be Providers within your network.
 - 3.2.2.9.1 Describe how you propose to evaluate the existing substance abuse and mental health Provider pool to provide Covered Services.
- 3.2.2.10 Describe your approach to ensuring quality nursing care to Residents of Nursing Facilities and home and community-based services. Include experience and innovations in providing this service under other contracts.
- 3.2.2.11 Describe any services you will offer to Enrollees beyond those required, including how any such proposed additional services may offer Enrollees opportunities for independence in the community. If the Capitation rates referenced in Section 7 are provided seven (7) or fewer days before the due date for Proposals, or after the due date for Proposals, under this RFP, Offerors will have seven (7) days after the date such rates are provided to amend any list of supplemental benefits being proposed.
- 3.2.2.12 The State will base its evaluation of the Offeror's network of Affiliated hospital, PCPs, medical homes, pharmacies, and ancillary providers through the information provided in HPMS as of July 2, 2012. As part of your Proposal, provide a CD listing of your network of Providers that are not included in HPMS, including health centers, behavioral health providers, dentists, including oral surgeons, Nursing Facilities, and Providers of LTSS. Include in this listing an analysis that demonstrates network adequacy of those Providers. If you subcontract for Case Management services, list other provider types you are contracting with. Indicate your level of commitment by describing your agreements, i.e. letter of intent, pending contract, contract. The data must be submitted in a Microsoft Excel file format including the following fields:
 - 3.2.2.12.1 Provider Last Name;
 - 3.2.2.12.2 Provider First Name;
 - 3.2.2.12.3 Provider Specialty;
 - 3.2.2.12.4 Provider Address;
 - 3.2.2.12.5 Provider County;
 - 3.2.2.12.6 NPI;
 - 3.2.2.12.7 Provider Tax ID; and
 - 3.2.2.12.8 Agreement Description.

- 3.2.2.13 Provide distinct maps indicating the distribution of all Medicare and Medicaid Providers, including PCPs, medical homes, specialist, hospitals, behavioral health Providers, dentists, oral surgeons, Nursing Facilities, Providers of LTSS, and other Providers available in the Contracting Area.
- 3.2.2.14 Describe how your network will assure adequate access to medical, mental health, substance abuse, and social services throughout the Contracting Area and at least meets:
 - 3.2.2.14.1 Medicaid access standards found at 42 CFR 438.206; and
 - 3.2.2.14.2 Medicare network requirements found at 42 CFR 417.416
- 3.2.2.15 Describe the specialized expertise in your Provider network, including the facilities and Providers that correspond to the population served under this Medicare-Medicaid Alignment Initiative and how you will ensure Enrollees have access to Providers with specialized expertise that understand and are capable of providing services to meet the Enrollee's needs. You may provide the information included in your application to CMS for Model of Care component 5a and supplement as you consider necessary.
- 3.2.2.16 Describe how you will use safety net providers that have traditionally served Enrollees, such as FOHCs, Certified Local Health Departments and Community Mental Health Centers.
- 3.2.2.17 Describe how you will implement the State's requirement to offer Single Case Agreements with an out-of-network Provider so an Enrollee will be able to maintain the Enrollee's existing Provider beyond the 180 days if the Provider remains outside the network.
- 3.2.2.18 Describe how you will implement the process for transitioning Enrollees to a network Provider in fewer than 180 days if all State requirements are met.
- 3.2.2.19 Detail your Provider credentialing process and process for recredentialing every three years in accordance with NCOA standards, when applicable, and Illinois standards otherwise.
- 3.2.2.20 Describe how you will evaluate Provider sites to ensure that individuals with disabilities have access to those sites and that sufficient sites are equipped to serve Enrollees with developmental or other disabilities and are compliant with the American Disabilities Act (ADA);
 - 3.2.2.20.1 Describe how you will work with Providers to comply with the ADA and ensure that Enrollees will have access to services equivalent to those offered at inaccessible facilities.
- 3.2.2.21 Detail your plan for ensuring 24-hour telephone access to medical professionals for consultation and to obtain medical care.

3.2.3 Care Coordination and Care Management

3.2.3.1 Interdisciplinary Care Team

- 3.2.3.1.1 For this question, you may provide the information included in your application to CMS for Model of Care component 4a and 4b and supplement as necessary. Describe who will participate in a interdisciplinary care team and:
 - 3.2.3.1.1.1 How the structure will vary based on risk-level and Enrollee needs and preferences;
 - 3.2.3.1.1.2 Who will lead the care teams;
 - 3.2.3.1.1.3 How the Enrollee and the Enrollee's caregiver will be involved in the development of the care team; and
 - 3.2.3.1.1.4 Describe the process for ensuring the Enrollee has adequate access to the care team.
- 3.2.3.1.2 Describe the role and responsibilities of the Care Coordinator including:
 - 3.2.3.1.2.1 Caseload size and how that will vary based on risk level; and
 - 3.2.3.1.2.2 Qualifications of Care Coordinators and whether those qualifications vary depending on the Enrollees assigned to them.
- 3.2.3.1.3 For this question, you may provide the information included in your application to CMS for Model of Care component 5d and supplement as necessary. Describe how your Provider network coordinates with the interdisciplinary care team and the Enrollee to deliver specialized services, including:
 - 3.2.3.1.3.1 How care needs are communicated to care team members;
 - 3.2.3.1.3.2 Which personnel ensure that follow-up is scheduled and performed; and
 - 3.2.3.1.3.3 Your plan for training Providers about care coordination, the roles and responsibilities of the interdisciplinary care team, including communication pathways between Providers and the

interdisciplinary care team, Individualized Care Plan development, consumer direction, and any HIT to support care coordination.

3.2.3.2 Risk Stratification/Assessment/Individualized Care Plan Development

- 3.2.3.2.1 A well-designed process for developing and implementing Individualized Care Plans is a critical component for assuring that Enrollees' needs are being addressed. Describe your process for developing and completing an Individualized Care Plan including:
- 3.2.3.2.1.1 Who completes the Individualized Care Plan. For this question, you may provide the information included in your application to CMS for Model of Care component 8a and 8c and supplement as necessary;
 - 3.2.3.2.1.2 How the interdisciplinary care team is involved in developing and maintaining the Individualized Care Plan. For this question, you may provide the information included in your application to CMS for Model of Care component 8c and supplement as necessary;
 - 3.2.3.2.1.3 How each Enrollee's needs, goals and preferences are identified and strategies are developed to address those needs, goals and preferences;
 - 3.2.3.2.1.4 Your process to address back up plan arrangements for services that enable Enrollees in HCBS waivers to remain in the community;
 - 3.2.3.2.1.5 The supports and information that are made available to the Enrollee (and/or family or legal representative, as appropriate) to direct and be actively engaged in the Enrollee's Care Plan development process and the Enrollee's input into who is included in the process;
 - 3.2.3.2.1.6 How the Individualized Care Plan is made available to Providers and Enrollees;
 - 3.2.3.2.1.7 How any changes to the Individualized Care Plan are communicated to the interdisciplinary care team, Providers and Enrollees. For this question, you may provide the information included in your application to CMS for Model of Care component 8e and supplement as necessary; and
 - 3.2.3.2.1.8 Strategies and programs to enhance Enrollee compliance with Individualized Care Plans.
- 3.2.3.2.2 Provide three examples of case studies of individuals stratified to low, moderate, and high-risk including:
- 3.2.3.2.2.1 Who completes the Individualized Care Plan;
 - 3.2.3.2.2.2 The structure of the individual's interdisciplinary care team;
 - 3.2.3.2.2.3 An example of an Individualized Care Plan, including interventions to be completed;
 - 3.2.3.2.2.4 A description of how often Individualized Care Plans are updated; and
 - 3.2.3.2.2.5 Care Management activities to be provided.
- 3.2.3.2.3 Describe the strategies that you will utilize to locate and engage Enrollees in their own care.
- 3.2.3.2.4 Describe the process for management of substance abuse issues including:
- 3.2.3.2.4.1 Referral and follow up process, both with the Enrollee and the substance abuse Provider;
 - 3.2.3.2.4.2 Coordination with the interdisciplinary care team; and
 - 3.2.3.2.4.3 How you will assure that Enrollees are given appropriate and individualized treatment based on their assessed mental health or substance abuse challenges.
- 3.2.3.2.5 Describe your process for identifying the need and arranging services for Enrollees with Habilitation and Rehabilitation needs and cognitive deficits, and how you will integrate care delivery for Enrollees with co-occurring mental illnesses and substance abuse.
- 3.2.3.2.6 Describe your process for emergency department utilization review and identification of Enrollees with high utilization including:
- 3.2.3.2.6.1 Your process for analyzing the data and determining whether Enrollees need enhanced Case Management services; and
 - 3.2.3.2.6.2 How you will provide such Case Management and any other strategies for addressing high emergency department utilization particularly among Nursing Facility Residents.
- 3.2.3.2.7 Describe your approach to Risk Mitigation and Negotiated Risk for Enrollees who are living in the community, but are at risk of institutional care, including caregiver, environment, medical, and behavioral compliance.

3.2.3.3 Care Transition

- 3.2.3.3.1 Describe your plans and policies for transition of care for Enrollees who are currently under treatment for acute and Chronic Health Conditions.
- 3.2.3.3.2 Describe your process for notifying Enrollees and Providers of your transition of care policy including the process for notification near the end of the transition period.
- 3.2.3.3.3 Describe how you will coordinate Individualized Care Plan development and implementation with care plans and case coordinators currently serving Enrollees who are receiving services through HCBS waivers.
- 3.2.3.3.4 Describe how you will assess the needs of Enrollees who are currently in mental health or substance abuse treatment and effectively manage their current treatment plans and possible transfer to a different Provider.
- 3.2.3.3.5 Describe strategies you will use to encourage continuity of care including incentives you may offer to providers currently used by Potential Enrollees to join your network.

3.2.3.4 Care Integration

- 3.2.3.4.1 Describe how you will design the compensation structure of medical homes and other Providers in your network to promote the goals of medical homes and accountable, integrated care including:
 - 3.2.3.4.1.1 Initial reimbursement; and
 - 3.2.3.4.1.2 Incentives or pay-for-performance programs.
- 3.2.3.4.2 Describe how you will ensure integration of care between medical homes and other levels of care, including
 - 3.2.3.4.2.1 Hospital admission and discharge;
 - 3.2.3.4.2.2 Emergency room follow-up;
 - 3.2.3.4.2.3 Specialty care;
 - 3.2.3.4.2.4 Medically complex care;
 - 3.2.3.4.2.5 Medication Management;
 - 3.2.3.4.2.6 Nutrition;
 - 3.2.3.4.2.7 Mental Health;
 - 3.2.3.4.2.8 Substance and alcohol abuse;
 - 3.2.3.4.2.9 Institutional care;
 - 3.2.3.4.2.10 Transition from institution to community living arrangements;
 - 3.2.3.4.2.11 HCBS waiver services;
 - 3.2.3.4.2.12 Community care and in home support services;
 - 3.2.3.4.2.13 Wellness;
 - 3.2.3.4.2.14 Dental services; and
 - 3.2.3.4.2.15 The role of the interdisciplinary care team in ensuring the integration of care.
- 3.2.3.4.3 Describe your Enrollee health education programs and materials and submit samples.
 - 3.2.3.4.3.1 Include descriptions of any incentive programs you may operate specifically and list any rewards for specific actions.
- 3.2.3.4.4 Describe your philosophy and approach to facilitate Enrollees needing nursing home level of care to live in the community including:
 - 3.2.3.4.4.1 How the interdisciplinary care team will identify HCBS waiver services, and opportunities and resources that encourage independence in the community.
- 3.2.3.4.5 Explain your plans for coordinating with HCBS waivers listed in *Attachment C* including:
 - 3.2.3.4.5.1 The role, if any, current HCBS case managers will have on the interdisciplinary care team;
 - 3.2.3.4.5.2 The expected relationship with current providers of HCBS waiver services; and
 - 3.2.3.4.5.3 Your strategy for increasing access to and utilization of HCBS waiver services.

- 3.2.3.4.6 Describe how you will assist Enrollees in accessing services (beyond those included as Covered Services, such as housing, social service agencies, and senior centers, and your process for coordinating with entities that provide such services.
- 3.2.3.4.7 Describe your process for coordinating care with out-of-network Providers and the process for determining approval for accessing out of network Providers.

3.2.4 Outcomes/ Evaluation

- 3.2.4.1 Describe how you will monitor the quality measures in Attachment D including:
 - 3.2.4.1.1 How you will provide ongoing feedback to Providers regarding their performance on these quality measures; and
 - 3.2.4.1.2 How you will involve your Provider network in outcome measurement monitoring and quality improvement activities.
- 3.2.4.2 List your measurable goals and related outcome measures with respect to the population you will be serving.
 - 3.2.4.2.1 Describe how you will know when those goals are met; and
 - 3.2.4.2.2 Describe actions you will take if goals are not met in the expected timeframes.
- 3.2.4.3 Describe your process for determining satisfaction among your Enrollees, including assessing non-medical outcomes important to the Enrollees and activities to promote Enrollee empowerment and control, and community integration. Submit examples of your Enrollee Satisfaction Surveys and the quality improvement plans for similar populations in other markets.

3.2.5 Health Information Technology

- 3.2.5.1 Give an overview of how you will use health information technology (HIT) to provide care coordination and Care Management including how it will:
 - 3.2.5.1.1 Maintain a profile for each Enrollee that includes demographics, PCP, Care Management assignment, and the results of the risk assessment;
 - 3.2.5.1.2 Notify providers, Enrollees and the care team of risk assessment results and care gap alerts;
 - 3.2.5.1.3 Track care delivered outside the medical home;
 - 3.2.5.1.4 Support Care Management activities; and
 - 3.2.5.1.5 Track inbound and outbound Enrollee communication including among the Enrollee, their Providers, and the interdisciplinary care team.
- 3.2.5.2 Describe the technology resources of your major network Providers:
 - 3.2.5.2.1 At the time of your Proposal submission;
 - 3.2.5.2.2 Any projected improvements by the time of Contract implementation, and list expected milestones during the term of the Contract;
 - 3.2.5.2.3 List:
 - 3.2.5.2.3.1 How many have fully functioning Electronic Medical Records (EMRs);
 - 3.2.5.2.3.2 How many are currently in the process of converting to EMRs;
 - 3.2.5.2.3.3 Which groups of Providers share the same EMRs;
 - 3.2.5.2.3.4 What percentage of prescriptions are dispensed using e-prescribing; and
 - 3.2.5.2.3.5 Any other available HIT uses that are pertinent to the management of care for Enrollees.
- 3.2.5.3 Describe your ability to exchange health information with:
 - 3.2.5.3.1 Providers that have functioning EMRs;
 - 3.2.5.3.2 Providers that do not have functioning EMRs.
 - 3.2.5.3.2.1 For those Providers without functioning EMRs, describe your process for exchanging clinical information.
- 3.2.5.4 Describe how you will promote meaningful use of HIT by Providers within your network.
- 3.2.5.5 Describe the functionalities of your HIT resources at the Plan level at:

- 3.2.5.5.1 The time of your Proposal;
 - 3.2.5.5.2 Any projected improvements by the time of Contract implementation; and
 - 3.2.5.5.3 List expected milestones during the term of the Contract.
- 3.2.5.6 Describe any resources you plan to provide to your network Providers in the area of HIT. In particular, describe any plans for HIT in the area of behavioral health.

3.3 CONTRACTOR AND STAFF REQUIREMENTS

- 3.3.1 **List of Individuals in an Administrative Capacity.** The Contractor shall provide the following minimum key positions (either through direct employment or subcontract):
- 3.3.1.1 **Chief Executive Officer (CEO)** – The CEO shall be a full-time position, located in Illinois, with clear authority over general administration and implementation of requirements set forth in the Contract, including responsibility to oversee the budget and accounting system implemented by the Contractor. This position shall be responsible for the daily conduct and operations of the Contractor’s plan.
 - 3.3.1.2 **Medical Director** – The Medical Director shall be an Illinois licensed Physician and shall be actively involved in all major clinical program components of the Contractor’s plan including review of medical care provided, medical professional aspects of Provider contracts, and other areas of responsibility as may be designated by the Contractor. The Medical Director shall devote sufficient time to the Contractor’s plan to ensure timely medical decisions, including after hours consultation as needed. The Medical Director shall be responsible for managing the Contractor’s Quality Assessment and Performance Improvement Program. The Medical Director shall attend all quarterly quality meetings.
 - 3.3.1.3 **Quality Management Coordinator** – The Quality Management Coordinator shall be a full-time position located in Illinois. The Quality Management Coordinator shall be an Illinois licensed Physician, Illinois licensed registered nurse, or another licensed clinician as approved by the State based on the Contractor’s ability to demonstrate that the clinician possesses the training and education necessary to meet the requirements for quality improvement activities required in the Contract. The Quality Management Coordinator must, at a minimum, be responsible for directing the activities of the quality improvement staff in monitoring and auditing the Contractor’s healthcare delivery system to meet the State’s goal of providing health care services that improve the health status and health outcomes of its Enrollees.
 - 3.3.1.4 **Utilization Management Coordinator** – The Utilization Management Coordinator shall be a full time position. The Utilization Management Coordinator shall be a Physician licensed in Illinois, or registered nurse licensed in Illinois, or other professional as approved by the State based on the Contractor’s ability to demonstrate that the professional possesses the training and education necessary to meet the requirements for utilization review activities required in the Contract. This position will manage the inpatient certification review staff for inpatient initial, concurrent and retrospective reviews. The review staff shall consist of registered nurses, Physicians, Physician’s assistants or licensed practical nurses experienced in inpatient reviews and under the direct supervision of a registered nurse, Physician, or Physician’ assistant.
 - 3.3.1.5 **Care Coordination/Disease Management Program Manager** – The Care Coordination/Disease Management Program Manager shall be a full time position. The Care Coordination/Disease Management Program Manager shall be a licensed Physician, licensed registered nurse, or other professional as approved by the Department based on the Contractor’s ability to demonstrate that the professional possesses the training and education necessary to meet the requirements for Case Management and Disease Management Program activities required in the Contract. This manager will direct all activities pertaining to Case Management and care coordination and monitor utilization of Enrollees physical health and behavioral health treatment.
 - 3.3.1.6 **Community Liaison** – The Community Liaison shall be a full time position responsible for coordinating the provision of services with the waiver programs, community resources, other State agencies, and any other community entity that traditionally provides services for Potential Enrollees.
 - 3.3.1.7 **Chief Financial Officer (CFO)** – The Chief Financial Officer shall be a full-time position responsible for overseeing the budget and accounting systems of the Contractor. The CFO shall, at a minimum, be responsible for ensuring that the Contractor meets the State’s requirements for financial performance and its reporting.
 - 3.3.1.8 **Member Services Director** – The Member Services Director shall be a full-time position responsible for coordinating communications with Enrollees and other Enrollee services such as acting as an Enrollee advocate. This position shall devote sufficient time to the Illinois account. There shall be sufficient member service staff to enable Enrollees to receive prompt resolution of their problems or inquiries.
 - 3.3.1.9 **Provider Service Director** – The Provider Service Director shall be a full time position responsible for coordinating communications between the Contractor and its subcontractors and other Providers.

- 3.3.1.10 **Management Information System (MIS) Director** – The MIS Director shall be a full-time position that oversees and maintains the data management system that is capable of valid data collection and processing, timely and accurate reporting, and correct claims payment.
- 3.3.1.11 **Compliance Officer** – The Compliance Officer shall oversee the Contractor's compliance plan, oversee the Complaint, Grievance and fair hearing process and ensure and verify that Fraud and Abuse is reported in accordance with the Medicare and Medicaid guidelines.
- 3.3.1.12 **Designated Liaisons** – The Contractor shall designate a Management Information System (MIS) Liaison and a general management primary liaison to facilitate communications between the Agencies and the Contractor's executive leadership and staff. A liaison may also serve in a key position.
- 3.3.1.13 Other key personnel identified by the Contractor.

3.4 SUBCONTRACTING REQUIREMENTS

- 3.4.1 Subcontractor Disclosure. Will you be using any subcontractors? Yes No
- 3.4.2 Provider Agreements and Subcontracts. Contractor may provide or arrange to provide any Covered Services with Affiliated Providers or fulfill any other obligations under this Contract by means of subcontractual relationships. No Provider agreement or subcontract can terminate the legal responsibilities of Contractor to the Agencies to perform under the Contract. All Provider agreements or subcontracts entered into by Contractor must be in writing and must provide the following:
 - 3.4.2.1 That Affiliated Providers and subcontractors shall be bound by the terms and conditions of this Contract that are appropriate to the service or activity delegated under the subcontract, including, but not limited to, the record keeping and audit provisions of this Contract, such that the Agencies or Authorized Persons shall have the same rights to audit and inspect subcontractors as they have to audit and inspect Contractor.
 - 3.4.2.2 That Contractor shall remain responsible for the performance of any of its responsibilities delegated to Affiliated Providers or subcontractors.
 - 3.4.2.3 That an Affiliated Provider is not an Ineligible Person.
 - 3.4.2.4 That Contractor will report to the Agencies all entities that are sub-capitated or assume risk.
 - 3.4.2.5 That all Provider agreements and subcontracts must comply with the Lobbying Certification contained in Section 5 of this RFP.
 - 3.4.2.6 That all subcontracts with Affiliated Providers must include information about the Contractor's Grievance and Appeal processes. Contractor shall amend the subcontract as soon as practicable after notification from the Agencies of any substantive change to such procedures.
 - 3.4.2.7 That Contractor will monitor the performance of all Affiliated Providers and subcontractors on an ongoing basis, subject each Affiliated Provider and subcontractor to formal review on a triennial basis, and, to the extent deficiencies or areas for improvement are identified during an informal or formal review, require that the Affiliated Provider or subcontractor take appropriate corrective action.
 - 3.4.2.8 That Contractor retains the right to terminate any Provider agreement or subcontract, or impose other sanctions, if the performance of the Affiliated Provider or subcontractor is inadequate.
 - 3.4.2.9 That, except as permitted or required by the Department in 89 Ill. Adm. Code 125 or the Department's Medical Program co-payment policy in effect at the time services are provided, neither Contractor nor its subcontractors, Affiliated Providers, or non-Affiliated Providers may seek or obtain funding through fees or charges to any Enrollee receiving Covered Services pursuant to this Contract.
- 3.4.3 Any contract or subcontract between Contractor and a FQHC or a RHC shall be executed in accordance with 1902(a)(13)(C) and 1903(m)(2)(A)(ix) of the Social Security Act, as amended by the Balanced Budget Act of 1997 and shall provide payment that is not less than the level and amount of payment which Contractor would make for the Covered Services if the services were furnished by a Provider which is not an FQHC or a RHC.
- 3.4.4 Prior to entering into a Provider agreement or subcontract, Contractor shall submit a disclosure statement to the Department specifying any Provider agreement or subcontract and Providers or subcontractors in which any of the following have a five percent (5%) or more financial interest:
 - 3.4.4.1 Any Person also having a five percent (5%) or more financial interest in Contractor or its Affiliates as defined by 42 CFR Section 455.101;
 - 3.4.4.2 Any director, officer, trustee, partner or employee of Contractor or its Affiliates; or
 - 3.4.4.3 Any member of the immediate family of any Person designated in (a) or (b) above.
 - 3.4.4.4 Upon request by the Agencies, Contractor shall immediately submit copies of executed contracts and subcontracts.

3.5 REFERENCES/ OTHER CONTRACTS/ PAST PERFORMANCE

- 3.5.1 **References:** You must provide references from established private firms or government agencies, (four preferred; two of each type preferred) other than the procuring agency, that can attest to your experience and ability to perform the contract subject of this solicitation. You must provide the name, contact information and a description of the supplies or services provided. You must attach your references with the responsibility forms.
- 3.5.2 **Other Contracts:** Please list all contracts you have had in the last three years to provide risk based managed care services to any payer indicating the entity with which you have a contract. List all Medicare and Medicaid contracts separately. You must provide the name, contact information and a description of the supplies or services provided. You must attach this information with the responsibility forms.
- 3.5.3 **Past Performance:** The State will consider a Plan's past performance in public and commercial programs based on all information available to the State. In considering past performance in the Medicare Program and the Medicaid program of any state, the State will use CMS' past performance analysis and star rating system as well as HEDIS scores. Please list: (i) your most recent three years of HEDIS results; (ii) all sanctions, penalties and corrective action plans relating to all Medicaid plans you operate in any state and all Medicare Advantage plans you operate in any state taken in the last five years, including information about the reason for the corrective action plan and the resolution; and, (iii) CMS' past performance analysis for the most recent calendar year. If you have no Medicare Program and no Medicaid program experience, include in your response any of the requested information relating to your commercial experience in the State. For all of the requested information in this Section 3.5.3, include plans operated by your parent organization, subsidiaries, and related organizations, if any.

3.6 WHERE SERVICES ARE TO BE PERFORMED

- 3.6.1 Contractor shall maintain an administrative office in Illinois from which the majority of Illinois specific administrative functions are performed.
- 3.6.2 **Work Location Disclosure:** Offeror shall disclose the location where the services required shall be performed. If at multiple locations, the known or anticipated value of the services performed at each location shall be identified. This information and economic impact on Illinois and its residents may be considered in the evaluation. If any work identified for performance in the United States is moved to another country, such action may be deemed a breach of the Contract.

3.7 OTHER SPECIFICATIONS

- 3.7.1 **Certificate of Authority.** In order to enter into a Contract with the Department, a Contractor that is or intends to be a HMO must have and maintain for the term of the Contract, including any Contract extension or renewal, a valid Certificate of Authority as a Health Maintenance Organization under 215 ILCS 125/1-1, et seq. If Offeror does not currently have a valid Certificate of Authority as an HMO, the Offeror must have made application for such in order to submit a Proposal. Proof of Contractor's current Certificate of Authority or application for a Certificate of Authority must be included in its Proposal. In order to enter into a Contract with the Department, a Contractor that is or intends to be a MCCN must meet and maintain for the term of the Contract, including any Contract extension or renewal, the requirements of 89 Ill. Admin. Code 143.100-143.500.
- 3.7.2 **Financial Statements.** The Proposal must provide the information described below for the Offeror itself. If the information described below does not exist for the Offeror, provide for the parent company.
- 3.7.2.1 Audited financial statements for the two most recent fiscal years for which the statements are available, as submitted to the Department of Insurance. The statements must include a balance sheet, income statement and a statement of cash flows. Statements must be complete with opinions, notes and management letters. If no audited statements are available, explain why and submit unaudited financial statements.
- 3.7.2.2 Balance sheet as of the end of the month immediately preceding the month in which application is made.
- 3.7.2.3 Documentation of lines of credit that are available, including maximum credit amount and available amount.
- 3.7.2.4 Short-term and long-term debt ratings by at least one nationally recognized rating service, if applicable.
- 3.7.2.5 Medical loss ratios for the most current two years defined as total medical and hospital cost divided by total premium income.

End of Instructions

SECTION 4 – OFFER TO UNITED STATES OF AMERICA AND STATE OF ILLINOIS

Project Title / Reference # Medicare-Medicaid Alignment Initiative/ 2013-024-004

The undersigned authorized representative of the identified Offeror does hereby submit this Offer to perform in full compliance with the subject solicitation. By completing and signing this Form, we are making an Offer to the United States of America and State of Illinois that they may accept. Offeror is also certifying to compliance with the various requirements of the solicitation and the documents contained in the solicitation.

Offeror has marked each blank below as appropriate and has used N/A when a section is not applicable to this solicitation. Offeror understands that failure to meet all requirements is cause for disqualification.

Offeror has:

- Reviewed the Offer Form, including all referenced documents as well as the solicitation Instructions, filled in all relevant blanks, provided any requested information, and
- Signed on the space(s) provided.

Acknowledgment of Amendments

- Offeror acknowledges receipt of any and all amendments to the solicitation and have taken those into account in making this Offer.

Offer Response Forms. Accompanying and as part of this Offer, the State will find:

For all Offers

- Designated number of copies
- Electronic copies
- Completed Responsibility Forms packet
- Business and Directory Information
- Conflict of Interest Disclosures
- Completed and Signed Taxpayer Identification Number form
- Completed Minority, Female and Person with Disability Status and Subcontracting form
- Convictions and Judgments
- Attestations for Participation in the Medicare-Medicaid Alignment Initiative
- References
- Other Contracts
- Past Performance
- Political Contributions - **Offeror has made the certification required by Public Act 95-971, and attached the State Board of Elections certificate of registration as required.**
- Certificate of Authority or proof of application for a Certificate of Authority (See Section 3.7.1)
- Financial Statements (See Section 3.7.2)

For RFPs

- Response to Statement of Work/Specifications/Qualifications sections completed and submitted in the Offer package.

Exceptions. In preparing the Offer, Offeror has taken (check one)

- No Exceptions
- Exceptions to the State's language or requirements in the following sections of the Offer:
 - Contract
 - Responsibility forms

Details of the exceptions are shown (check one)

- in the text of each section of the Offer
- on a separate labeled attachment

Domestic Products (check one)

Offeror is not making a claim for preference under the Procurement of Domestic Products Act (30 ILCS 517).

Offeror is making a claim for preference under the Procurement of Domestic Products Act (30 ILCS 517). After reading the Act, Offeror certifies it is eligible and that the following product or products bid or proposed in response to this solicitation meet the requirements of the Act. Check and complete as applicable:

All products

The following individual products (show line item if applicable)

Request for Confidential Treatment (check one)

Offeror is not requesting confidential treatment for this Offer.

Offeror is seeking confidential treatment for portions of this Offer. Offeror has supplied, as an attachment to this Offer, a listing of the provisions identified by section number for which it seeks confidential treatment along with the statutory basis under Federal and Illinois law for exempting that information from public disclosure. **Offeror has supplied an additional copy of the Offer with confidential information deleted.** In the event the designation of confidentiality of this information is challenged, the undersigned hereby agrees to provide legal counsel or other necessary assistance to defend the designation of confidentiality and agrees to hold the United States of America and State harmless for any costs or damages arising out of the United States of America and State agreeing to withhold the materials based on Offeror's request. Offeror is including a detailed justification to support the statutory basis under Federal and Illinois law for exempting that information from public disclosure.

Protests and Negotiations

If Offeror is selected for award, Offeror understands that does not entitle Offeror to a Contract. Offeror further understands the award is conditioned on favorable resolution of any protests and to successful negotiation of terms and conditions including, but not limited to, price and any exceptions requested.

Offeror Contact Person: The contact person for purposes of responding to any questions the United States of America and State may have is:

Printed Name _____ Title _____

Address _____

Phone _____ Fax _____

Email _____

(Offeror name and DBA)

(Signature of party authorized to bind the named Offeror)

Printed Name _____ Title _____

Address _____

Phone _____ Fax _____

E-mail _____

SECTION 5 – RESPONSIBILITY FORMS

We have identified various information we need in order to determine if you are eligible to contract with the State and can be considered a "Responsible" Offeror.

You will need to:

Review each of the Responsibility forms, fill in all relevant blanks and provide any requested information.

Business and Directory Information

Conflict of Interest Disclosures

Minority, Female, Person with Disability Status and Subcontracting

Political Contributions

Convictions and Judgments

Attestations for Participation in the Medicare-Medicaid Alignment Initiative

Complete and sign the:

Taxpayer Identification Form

Attach Certificate of Authority or proof of application for Certificate of Authority (see Section 3.7.1)

Attach your Financial Statements (see Section 3.7.2)

Attach References, Other Contracts, and Past Performance (see Section 3.5).

You must include all of this as part of your Offer or risk disqualification.

Business and Directory Information

- (a) Name of Business (Official Name and D/B/A)
- (b) Business Headquarters (include Address, Telephone and Facsimile)
- (c) If a Division or Subsidiary of another organization provide the name and address of the parent
- (d) Billing Address
- (e) Name of Chief Executive Officer
- (f) Customer Contact (include Name, Title, Address, Telephone, Toll-Free Number, Facsimile and E-mail)
- (g) Company Website
- (h) Type of Organization (i.e., Sole Proprietor, Corporation, Partnership, etc. -- should be the same as on the Taxpayer ID form below)
- (i) Length of Time in Business
- (j) Annual Sales (for most recently completed Fiscal Year)
- (k) Number of Full-Time Employees (average from most recent Fiscal Year)
- (l) Type of and description of business
- (m) State of incorporation, state of formation or state of organization
- (n) Identify and specify the location(s) and telephone numbers of the major offices and other facilities that relate to the Offeror's performance under the terms of this solicitation.
- (o) Department of Human Rights (DHR) Public Contract Number
If Offeror has employed fifteen (15) or more full-time employees at any time during the 365-day period immediately preceding the publication of this solicitation in the Illinois Procurement Bulletin (or issuance date if not published), then Offeror must have a current Public Contract Number or have proof of having submitted a completed application for one prior to the Solicitation opening date. (44 Ill. Adm. Code 750.210(a)) For application information call the DHR Public Contracts unit at (312) 814-2431.

Show # _____ or attach proof of application.

(p) Information Regarding Debarment, Litigation and Terminations

1. During the last five (5) years has any order, judgment or decree of any Federal or State authority been issued barring, suspending or otherwise limiting your right to contract with any governmental entity, including school districts, or to engage in any business practice or activity?
Yes___ No___
2. Is there any current, pending or threatened litigation, administrative or regulatory proceedings, or similar matters that could affect your ability to perform the required services.
Yes___ No___
3. During the last five (5) years has any customer terminated a contract for cause or accepted damages in lieu of for cause termination?
Yes___ No___

(q) Disclosure of Business Operations with Iran (30 ILCS 500/50-36)

Each bid, offer, or proposal submitted for a State contract, other than a small purchase defined in Section 20-20 [of the Illinois Procurement Code], shall include a disclosure of whether or not the bidder, offeror, or proposing entity, or any of its corporate parents or subsidiaries, within the 24 months before submission of the bid, offer, or proposal had business operations that involved contracts with or provision of supplies or services to the Government of Iran, companies in which the Government of Iran has any direct or indirect equity share, consortiums or projects commissioned by the Government of Iran and:

- (1) more than 10% of the company's revenues produced in or assets located in Iran involve oil-related activities or mineral-extraction activities; less than 75% of the company's revenues produced in or assets located in Iran involve contracts with or provision of oil-related or mineral – extraction products or services to the Government of Iran or a project or consortium created exclusively by that Government; and the company has failed to take substantial action; or
- (2) the company has, on or after August 5, 1996, made an investment of \$20 million or more, or any combination of investments of at least \$10 million each that in the aggregate equals or exceeds \$20 million in any 12- month period that directly or significantly contributes to the enhancement of Iran's ability to develop petroleum resources of Iran.

A bid, offer, or proposal that does not include this disclosure shall not be considered responsive. We may consider this disclosure when evaluating the bid, offer, or proposal or awarding the contract.

You must check one of the following items and if item 2 is checked you must also make the necessary disclosure:

___ There are no business operations that must be disclosed to comply with the above cited law.

___ The following business operations are disclosed to comply with the above cited law:

DISCLOSURES AND CONFLICTS OF INTEREST

Instructions: Offeror shall disclose financial interests, potential conflicts of interest and contract information identified in Sections 1, 2 and 3 below as a condition of receiving an award or contract (30 ILCS 500/50-13 and 50-35). Failure to fully disclose shall render the contract, bid, proposal, subcontract, or relationship voidable by the chief procurement officer if s/he deems it in the best interest of the State of Illinois and may be cause for barring from future contracts, bids, proposals, subcontracts, or relationships with the State.

- There are six sections to this form and each must be completed to meet full disclosure requirements.
- Note: The requested disclosures are a continuing obligation and must be promptly supplemented for accuracy throughout the process and throughout the term of the resultant contract if the bid/offer is awarded. As required by 30 ILCS 500/50-2, for multi-year contracts Offerors must submit these disclosures on an annual basis.

A publicly traded entity may submit its 10K disclosure in satisfaction of the disclosure requirements set forth in Section 1 below. HOWEVER, if a Offerors submits a 10K, they still must complete Sections 2, 3, 4, 5 and 6 and submit the disclosure form.

If the Offeror is a wholly owned subsidiary of a parent organization, separate disclosures must be made by the Offeror and the parent. For purposes of this form, a parent organization is any entity that owns 100% of the Offeror.

This disclosure information is submitted on behalf of (show official name of Offeror, and if applicable, D/B/A and parent):

Name of Offeror: _____

D/B/A (if used): _____

Name of any Parent Organization: _____

Section 1: Section 50-35 Disclosure of Financial Interest in the Offeror. *(All Offerors must complete this section)*

Offerors must complete subsection (a), (b) or (c) below. Please read the following subsections and complete the information requested.

- a. If Offeror is a Publicly traded corporation subject to SEC reporting requirements
- i. Offeror shall submit their 10K disclosure (include proxy if referenced in 10k) in satisfaction of the financial and conflict of interest disclosure requirements set forth in subsections 50-35 (a) and (b) of the Procurement Code. The SEC 20f or 40f, supplemented with the names of those owning in excess of 5% and up to the ownership percentages disclosed in those submissions, may be accepted as being substantially equivalent to 10K.

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

OR

- b. If Offeror is a privately held corporation with more than 400 shareholders
- i. These Offerors may submit the information identified in 17 CFR 229.401 and list the names of any person or entity holding any ownership share in excess of 5% in satisfaction of the financial and conflict of interest disclosure requirements set forth in subsections 50-35 a and b of the Illinois Procurement Code.

OR

- c. If Offeror is an individual, sole proprietorship, partnership or any other not qualified to use subsections (A) or (B), complete (i) and (ii) below as appropriate.
- i. For **each individual** having any of the following financial interests in the Offeror (or its parent), please mark each that apply and show the applicable name and address. Use a separate form for each individual.

1. Do you have an ownership share of greater than 5% of the offering entity or parent entity?

Yes No

2. Do you have an ownership share of less than 5%, but which has a value greater than \$106,447.20?

Yes No

3. Do you receive more than \$106,447.20 of the offering entity's or parent entity's distributive income? (Note: Distributive income is, for these purposes, any type of distribution of profits. An annual salary is not distributive income.)
 Yes No
4. Do you receive greater than 5% of the offering entity's or parent entity's total distributive income, but which is less than \$106,447.20?
 Yes No
5. If you responded yes to any of questions 1 – 4 above, please provide either the percentage or dollar amount of your ownership or distributive share of income: _____. For partnerships with more than 50 partners, the percentage share of ownership of each individual identified above may be shown in the following ranges (dollar value fields must also be completed when applicable):
 0.5% or less _____ >0.5 to 1.0% _____ >1.0 to 2.0% _____ >2.0 to 3.0 % _____ > 3.0 to 4.0% _____ %
 >4.0 to 5.0% _____ and in additional 1% increments as appropriate _____ %
6. If you responded yes to any of the questions 1-4 above, please check the appropriate type of ownership/distributable income share:
 Sole Proprietorship Stock Partnership Other (explain) _____
 Name: _____
 Address: _____

ii. In relation to individuals identified above, indicate whether any of the following potential conflict of interest relationships apply. If "Yes," please describe each situation (label with appropriate letter) using the space at the end of this Section (attach additional pages as necessary). If no individual has been identified above, mark not applicable (N/A) here _____.

- (a) State employment, currently or in the previous 3 years, including contractual employment of services directly with the individuals identified in Section 1 in their individual capacity unrelated to the Offeror's contract. Yes No
- (b) State employment of spouse, father, mother, son, or daughter, including contractual employment for services in the previous 2 years. Yes No
- (c) Elective status; the holding of elective office of the State of Illinois, the government of the United States, any unit of local government authorized by the Constitution of the State of Illinois or the statutes of the State of Illinois currently or in the previous 3 years. Yes No
- (d) Relationship to anyone holding elective office currently or in the previous 2 years; spouse, father, mother, son, or daughter. Yes No
- (e) Appointive office; the holding of any appointive government office of the State of Illinois, the United States of America, or any unit of local government authorized by the Constitution of the State of Illinois or the statutes of the State of Illinois, which office entitles the holder to compensation in excess of expenses incurred in the discharge of that office currently or in the previous 3 years. Yes No
- (f) Relationship to anyone holding appointive office currently or in the previous 2 years; spouse, father, mother, son, or daughter. Yes No
- (g) Employment, currently or in the previous 3 years, as or by any registered lobbyist of the State government. Yes No
- (h) Relationship to anyone who is or was a registered lobbyist in the previous 2 years; spouse, father, mother, son, or daughter. Yes No
- (i) Compensated employment, currently or in the previous 3 years, by any registered election or reelection committee registered with the Secretary of State or any county clerk in the State of Illinois, or any political action committee registered with either the Secretary of State or the Federal Board of Elections. Yes No
- (j) Relationship to anyone; spouse, father, mother, son, or daughter; who is or was a compensated employee in the last 2 years of any registered election or reelection committee registered with the Secretary of State or any county clerk in the State of Illinois, or any political action committee registered with either the Secretary of State or the Federal Board of Elections. Yes No

Section 2: Section 50-13 Conflicts of Interest *(All Offerors must complete this section)*

(a) Prohibition. It is unlawful for any person holding an elective office in this State, holding a seat in the General Assembly, or appointed to or employed in any of the offices or agencies of State government and who receives compensation for such employment in excess of 60% of the salary of the Governor of the State of Illinois [\$106,447.20], or who is an officer or employee of the Capital Development Board or the Illinois Toll Highway Authority, or who is the spouse or minor child of any such person to have or acquire any contract, or any direct pecuniary interest in any contract therein, whether for stationery, printing, paper, or any services, materials, or supplies, that will be wholly or partially satisfied by the payment of funds appropriated by the General Assembly of the State of Illinois or in any contract of the Capital Development Board or the Illinois Toll Highway Authority.

(b) Interests. It is unlawful for any firm, partnership, association, or corporation, in which any person listed in subsection (a) is entitled to receive (i) more than 7 1/2% of the total distributable income or (ii) an amount in excess of the salary of the Governor (\$177,412.00), to have or acquire any such contract or direct pecuniary interest therein.

(c) Combined interests. It is unlawful for any firm, partnership, association, or corporation, in which any person listed in subsection (a) together with his or her spouse or minor children is entitled to receive (i) more than 15%, in the aggregate, of the total distributable income or (ii) an amount in excess of 2 times the salary of the Governor [\$354,824.00], to have or acquire any such contract or direct pecuniary interest therein.

Check One: No Conflicts Of Interest
 Potential Conflict of Interest (If checked, name each conflicted individual, the nature of the conflict, and the name of the State agency that is associated directly or indirectly with the conflicted individual.)

Section 3: Debarment/Legal Proceeding Disclosure *(All Offerors must complete this section).*

Each of the persons identified in Sections 1, 2 and 3 must each identify any of the following that occurred within the previous 10 years:

Debarment from contracting with any governmental entity	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Professional licensure discipline	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Bankruptcies	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Adverse civil judgments and administrative findings	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Criminal felony convictions	Yes <input type="checkbox"/>	No <input type="checkbox"/>

If any of the above is checked yes, please identify with descriptive information the nature of the debarment and legal proceeding. The State reserves the right to request more information, should the information need further clarification.

Section 4: Disclosure of Business Operations with Iran *(All Offerors must complete this section).*

In accordance with 30 ILCS 500/50-36, each bid, offer, or proposal submitted for a State contract, other than a small purchase defined in Section 20-20 [of the Illinois Procurement Code], shall include a disclosure of whether or not the bidder, offeror, or proposing entity, or any of its corporate parents or subsidiaries, within the 24 months before submission of the bid, offer, or proposal had business operations that involved contracts with or provision of supplies or services to the Government of Iran, companies in which the Government of Iran has any direct or indirect equity share, consortiums or projects commissioned by the Government of Iran and:

- (1) more than 10% of the company's revenues produced in or assets located in Iran involve oil-related activities or mineral-extraction activities; less than 75% of the company's revenues produced in or assets located in Iran involve contracts with or provision of oil-related or mineral – extraction products or services to the Government of Iran or a project or consortium created exclusively by that Government; and the company has failed to take substantial action;
or
- (2) the company has, on or after August 5, 1996, made an investment of \$20 million or more, or any combination of investments of at least \$10 million each that in the aggregate equals or exceeds \$20 million in any 12- month period that directly or significantly contributes to the enhancement of Iran's ability to develop petroleum resources of Iran.

A bid, offer, or proposal that does not include this disclosure shall not be considered responsive. We may consider this disclosure when evaluating the bid, offer, or proposal or awarding the contract.

You must check one of the following items and if item 2 is checked you must also make the necessary disclosure:

There are no business operations that must be disclosed to comply with the above cited law.

The following business operations are disclosed to comply with the above cited law:

Section 5: Current and Pending Contracts *(All Offerors must complete this section).*

Does the Offeror have any contracts pending contracts, bids, proposals or other ongoing procurement relationships with units of State of Illinois government? Yes No

If yes, please identify each contract, pending contract, bid, proposal and other ongoing procurement relationship it has with units of State of Illinois government by showing agency name and other descriptive information such as bid number, project title, purchase order number or contract reference number.

Section 6: Representative Lobbyist/Other Agent *(All Offerors must complete this section).*

Is the Offeror represented by or employing a lobbyist required to register under the Lobbyist Registration Act or other agent who is not identified under Sections 1 and 2 and who has communicated, is communicating, or may communicate with any State officer or employee concerning the bid, offer or contract? Yes No

If yes, please identify each agent / lobbyist, including name and address.

Costs/Fees/Compensation/Reimbursements related to assistance to obtain contract (describe):

Offeror certifies that none of these costs will be billed to the State in the event of contract award. Offeror must file this information with the Secretary of State.

This Disclosure is signed and made under penalty of perjury pursuant to Sections 500/50-13 and 500/50-35(a) of the Illinois Procurement Code.

This Disclosure information is submitted on behalf of: _____
(Offeror/Subcontractor Name)

Name of Authorized Representative: _____
Title of Authorized Representative: _____
Signature of Authorized Representative: _____
Date: _____

Minority, Female, Persons with Disability Status and Subcontracting

The Business Enterprise Program Act for Minorities, Females and Persons with Disabilities (BEP) (30 ILCS 575) establishes a goal for contracting with businesses that have been certified as owned and controlled by persons who are minority, female or who have disabilities.

Contract Goal to be achieved by the Offeror: This contract includes a specific Business Enterprise Program (BEP) utilization goal of 20% of the Administrative portion of the Capitation payments based on the availability of certified vendors to perform the anticipated direct subcontracting opportunities of this contract. In addition to the other award criteria established for this contract, the Agency will award this contract to a Contractor that meets the goal or makes good faith efforts to meet the goal. This goal is also applicable to change orders and allowances within the scope of work provided by the certified vendor.

Following are guidelines for the Offeror's response in the Utilization Plan. A format for the utilization plan is included in this section. Offeror should include any additional information that will add clarity to the Offeror's proposed utilization of certified vendors to meet the targeted goal. The Utilization Plan must demonstrate that the Offeror has either met the contract goal or that it has made good faith efforts to do so.

At the time of proposal submission, the certified vendor may not yet be certified with DCMS Business Enterprise Program; **however, the certified vendor must meet the eligibility requirements and be fully certified in the BEP Program before contract award.** Visit <http://www2.illinois.gov/cms/business/sell2/bep/Pages/default.aspx> for complete requirements and to apply for certification in the Business Enterprise Program.

If applicable, the Plan should include an executed Joint Venture agreement specifying the terms and conditions of the relationship between the partners and their relationship and responsibilities to the contract. The joint venture agreement must clearly evidence that the certified vendor will be responsible for a clearly defined portion of the work and that its responsibilities, risks, profits and contributions of capital and personnel are proportionate to its ownership percentage. It must include specific details related to the parties' contributions of capital, personnel and equipment and share of the costs of insurance and other items; the scopes to be performed by the certified vendor's own forces and under its supervision; and the commitment of management, supervisory personnel and operative personnel employed by the certified vendor to be dedicated to the performance of the contract. Each joint venture partner must execute the proposal to the Agency.

An agreement between a Contractor and a certified vendor in which the certified vendor promises not to provide subcontracting quotations to other vendors is prohibited. The Agency may request additional information to demonstrate compliance. The Offeror agrees to cooperate promptly with the Agency in submitting to interviews, allowing entry to places of business, providing further documentation, or soliciting the cooperation of a proposed certified vendor. Failure to cooperate may render the proposal non-responsive. **The contract will not be finally awarded until the Offeror's Utilization Plan is approved.**

Certified Vendor Locator References: Offerors may consult DCMS' BEP Certified Vendor Directory at <https://www2.illinois.gov/cms/business/sell2/Pages/VendorSearch.aspx>, as well as the directories of other certifying agencies but subcontracting vendors must be certified by DCMS as BEP vendors before the time of contract award.

Contractor Assurance: The Contractor shall not discriminate on the basis of race, color, national origin, sexual orientation or sex in the performance of this contract. Failure by the Vendor to carry out these requirements is a material breach of this contract, which may result in the termination of this contract or such other remedy, as the Agency deems appropriate. This assurance must be included in each subcontract that the Vendor signs with a subcontractor or supplier.

Calculating Certified Vendor Participation: The Utilization Plan documents work anticipated to be performed by all certified vendors and paid for upon satisfactory completion. Only the value of payments made for the work actually performed by certified BEP vendors is counted toward the contract goal. Counting guidelines are summarized below:

- 1) The value of the work actually performed by the certified vendor's forces shall be counted towards the goal. The entire amount of that portion of the contract that is performed by the certified vendor's forces, including supplies purchased or equipment leased by the BEP vendor shall be counted, except supplies purchased and equipment rented from the Contractor.
- 2) A joint venture shall count the portion of the total dollar value of the contract equal to the distinct, clearly defined portion of the work of the contract that the certified vendor performs with its forces toward the goal. A joint venture shall also count the dollar value of work subcontracted to other certified vendors. Work performed by the forces of a non-certified joint venture partner shall not be counted toward the goal.
- 3) When a certified vendor subcontracts part of the work of its contract to another firm, the value of the subcontracted work shall be counted toward the contract goal only if the certified vendor's subcontractor is a certified vendor. Work that a certified vendor subcontracts to a non-certified vendor will not count towards the goal.
- 4) A Contractor shall count towards the goal 100% of its expenditures for materials and supplies required under the contract and obtained from a certified vendor manufacturer, regular dealer or supplier.

- 5) A Contractor shall count towards the goal the following expenditures to certified vendors that are not manufacturers, regular dealers or suppliers:
 - (a) The fees or commissions charged for providing a bona fide service, such as professional, technical, consultant or managerial services and assistance in the procurement of essential personnel, facilities, equipment, materials or supplies required for performance of the contract, provided that the fee or commission is determined by the Agency to be reasonable and not excessive as compared with fees customarily allowed for similar services.
 - (b) The fees charged for delivery of materials and supplies required by the contract (but not the cost of the materials and supplies themselves) when the hauler, trucker, or delivery service is not also the manufacturer of or a regular dealer in the materials and supplies, provided that the fee is determined by the Agency to be reasonable and not excessive as compared with fees customarily allowed for similar services. The certified vendor trucking firm must be responsible for the management and supervision of the entire trucking operation for which it is responsible on the contract, and must itself own and operate at least one fully licensed, insured and operational truck used on the contract.
 - (c) The fees or commissions charged for providing any bonds or insurance specifically required for the performance of the contract, provided that the fee or commission is determined by the Agency to be reasonable and not excessive as compared with fees customarily allowed for similar services.
- 6) A Contractor shall count towards the goal only expenditures to firms that perform a commercially useful function in the work of the contract.
 - (a) A firm is considered to perform a commercially useful function when it is responsible for execution of a distinct element of the work of a contract and carries out its responsibilities by actually performing, managing, and supervising the work involved. The certified vendor must also be responsible, with respect to materials or supplies used on the contract, for negotiating price, determining quality and quantity, ordering the materials or supplies, and installing the materials (where applicable) and paying for the material or supplies. To determine whether a firm is performing a commercially useful function, the Agency shall evaluate the amount of work subcontracted, whether the amount the firm is to be paid under the contract is commensurate with the work it is actually performing and the credit claimed for its performance of the work, industry practices, and other relevant factors.
 - (b) A certified vendor does not perform a commercially useful function if its role is limited to that of an extra participant in a transaction or contract through which funds are passed in order to obtain certified vendor participation. In determining whether a certified vendor is such an extra participant, the Agency shall examine similar transactions, particularly those in which certified vendors do not participate, and industry practices.
- 7) A Contractor shall not count towards the goal expenditures that are not direct, necessary and proximately related to the work of the contract. Only the amount of services or goods that are directly attributable to the performance of the contract shall be counted. Ineligible expenditures include general office overhead or other Contractor support activities.

Good Faith Effort Procedures: If the Contractor cannot meet the goal, the Contractor must document in the Utilization Plan its good faith efforts that could reasonably have been expected to meet the goal. The State Agency will consider the quality, quantity, and intensity of the Contractor's efforts.

- 1) The following is a list of types of action that the State Agency will consider as evidence of the Contractor's good faith efforts to meet the goal. Other factors or efforts brought to the attention of the State Agency may be relevant in appropriate cases.
 - (a) Soliciting through all reasonable and available means (e.g., attendance at pre-offer meetings, advertising and/or written notices) the interest of all certified vendors that have the capability to perform the work of the contract. The Contractor must solicit this interest within sufficient time to allow the certified vendors to respond to the solicitation. The Contractor must determine with certainty if the certified vendors are interested by taking appropriate steps to follow up initial solicitations and encourage them to bid. The Contractor must provide interested certified vendors with adequate information about the plans, specifications, and requirements of the contract in a timely manner to assist them in responding promptly to the solicitation.
 - (b) Selecting portions of the work to be performed by certified vendors in order to increase the likelihood that the goal will be achieved. This includes, where appropriate, breaking out contract work items into economically feasible units to facilitate certified vendor participation, even when the Contractor might otherwise prefer to perform these work items with its own forces.
 - (c) Making a portion of the work available to certified vendors and selecting those portions of the work or material needs consistent with their availability, so as to facilitate certified vendor participation.
 - (d) Negotiating in good faith with interested certified vendors. Evidence of such negotiation includes the names, addresses, and telephone numbers of certified vendors that were considered; a description of the information provided regarding the plans and specifications for the work selected for subcontracting and evidence as to why additional agreements could not be reached for certified vendors to perform the work. A Contractor using good business judgment will consider a number of factors in negotiating with certified vendors and will take a

firm's price and capabilities into consideration. The fact that there may be some additional costs involved in finding and using certified vendors is not in itself sufficient reason for a Contractor's failure to meet the goal, as long as such costs are reasonable. Contractors are not required to accept higher quotes from certified vendors if the price difference is excessive or unreasonable.

- (e) Thoroughly investigating the capabilities of certified vendors and not rejecting them as unqualified without sound reasons. The certified vendor's memberships in specific groups, organizations, or associations and political or social affiliations are not legitimate causes for the rejection or non-solicitation of bids in the Contractor's efforts to meet the goal.
 - (f) Making efforts to assist interested certified vendors in obtaining lines of credit or insurance as required by the State Agency, the Contractor or to perform the scope of work.
 - (g) Making efforts to assist interested certified vendors in obtaining necessary equipment, supplies, materials, or related assistance or services.
 - (h) Effectively using the services of available minority/women community organizations; minority/women vendors' groups; local, state, and federal minority/women business assistance offices; and other organizations that provide assistance in the recruitment and placement of certified vendors.
- 2) In evaluating the Contractor's good faith efforts, the good faith efforts of other vendors to meet the goal on this solicitation or similar contracts may be considered.
 - 3) If the State Agency determines that the Contractor has made good faith efforts to meet the goal, the State Agency will award the contract provided that the Contractor is otherwise eligible for award. If the Agency determines that the Contractor has not made good faith efforts, the State Agency will notify the Contractor of that preliminary determination. The preliminary determination shall include a statement of reasons why good faith efforts have not been found, and may include additional good faith efforts that the Contractor could take. The Contractor shall have 5 Business Days to make the suggested good faith efforts and any other additional good faith efforts to meet the goal. The Contractor shall submit an amended Utilization Plan if additional certified vendor commitments to meet the goal are secured. If additional certified vendor commitments sufficient to meet the goal are not secured, the Contractor shall report the final good faith efforts made in the time allotted. All additional efforts taken by the Contractor will be considered. If the State Agency determines that good faith efforts have not been made, it will notify the Contractor in writing of the reasons for its determination within 5 Business Days after receipt of the final Utilization Plan.

Contract Compliance: Compliance with this section is an essential part of the Contract. The following administrative procedures and remedies govern the Contractor's compliance with the contractual obligations established by the Utilization Plan. After approval of the Plan and award of the contract, the Utilization Plan becomes part of the contract. If the Contractor did not succeed in obtaining enough certified vendor participation to achieve the goal, and the Utilization Plan was approved and contract awarded based upon a determination of good faith, the total dollar value of certified vendor work calculated in the approved Utilization Plan as a percentage of the awarded contract value shall become the contract goal.

- 1) The Utilization Plan may not be amended without the Agency's prior written approval.
- 2) The Contractor may not make changes to its contractual BEP certified vendor commitments or substitute BEP certified vendors without the prior written approval of the State Agency. Unauthorized changes or substitutions, including performing the work designated for a certified vendor with the Contractor's own forces, shall be a violation of the utilization plan and a breach of the contract, and shall be cause to terminate the contract, and/or seek other contract remedies or sanctions. The facts supporting the request for changes must not have been known nor reasonably should have been known by the parties prior to entering into the subcontract. The Contractor must negotiate with the certified vendor to resolve the problem. Where there has been a mistake or disagreement about the scope of work, the certified vendor can be substituted only where agreement cannot be reached for a reasonable price or schedule for the correct scope of work.
- 3) Substitutions of a certified vendor shall be permitted under the following circumstances:
 - (a) Unavailability after receipt of reasonable notice to proceed;
 - (b) Failure of performance;
 - (c) Financial incapacity;
 - (d) Refusal by the certified vendor to honor the bid or proposal price or scope;
 - (e) Material mistake of fact or law about the elements of the scope of work of a solicitation where a reasonable price cannot be agreed;
 - (f) Failure of the certified vendor to meet insurance, licensing or bonding requirements;
 - (g) The certified vendor's withdrawal of its bid or proposal; or
 - (h) Decertification of the certified vendor.
- 4) If it becomes necessary to substitute a certified vendor or otherwise change the Utilization Plan, the Contractor must notify the State Agency in writing of the request to substitute a certified vendor or otherwise change the Utilization Plan. The request must state specific reasons for the substitution or change. The State Agency will approve or deny a request for substitution or other change in the Utilization Plan within 5 Business Days after receipt of the request.

- 5) Where the Contractor has established the basis for the substitution to the State Agency's satisfaction, it must make good faith efforts to meet the contract goal by substituting a certified vendor. Documentation of a replacement vendor, or of good faith efforts to replace the certified vendor, must meet the requirements of the initial Utilization Plan. If the goal cannot be reached and good faith efforts have been made, the Contractor may substitute with a non-certified vendor.
- 6) If a Contractor plans to hire a subcontractor for any scope of work that was not previously disclosed in the Utilization Plan, the Contractor must obtain the approval of the State Agency to modify the Utilization Plan and must make good faith efforts to ensure that certified vendors have a fair opportunity to bid on the new scope of work.
- 7) A new subcontract must be executed and submitted to the State Agency within 5 Business Days after the Contractor's receipt of the State Agency's approval for the substitution or other change.
- 8) The Contractor shall maintain a record of all relevant data with respect to the utilization of certified vendors, including but without limitation, payroll records, invoices, canceled checks and books of account for a period of at least 5 years after the completion of the contract. Full access to these records shall be granted by the Contractor upon 48 hours written demand by the State Agency to any duly authorized representative thereof, or to any municipal, state or federal authorities. The State Agency shall have the right to obtain from the Contractor any additional data reasonably related or necessary to verify any representations by the Contractor. After the performance of the final item of work or delivery of material by a certified vendor and final payment to the certified vendor by the Contractor, but not later than 30 calendar days after such payment, the Contractor shall submit a statement confirming the final payment and the total payments made to the BEP vendor under the contract.
- 9) The State Agency will periodically review the Contractor's compliance with these provisions and the terms of its contract. Without limitation, the Contractor's failure to comply with these provisions or its contractual commitments as contained in the Utilization Plan, failure to cooperate in providing information regarding its compliance with these provisions or its Utilization Plan, or provision of false or misleading information or statements concerning compliance, certification status or eligibility of certified vendors, good faith efforts or any other material fact or representation shall constitute a material breach of this contract and entitle the State Agency to declare a default, terminate the contract, or exercise those remedies provided for in the contract or at law or in equity.
- 10) The State Agency reserves the right to withhold payment to the Contractor to enforce these provisions and the Contractor's contractual commitments. Final payment shall not be made on the contract until the Contractor submits sufficient documentation demonstrating compliance with its Utilization Plan.

UTILIZATION PLAN

_____ (the Offeror) submits the following Utilization Plan as part of our proposal in accordance with the requirements of the Minority, Female, Persons with Disability Status and Subcontracting section of the solicitation for _____. The Offeror understands that compliance with this section is an essential part of this contract and that the Utilization Plan will become a part of the contract, if awarded.

_____ (the Offeror) makes the following assurance and agrees to include the assurance in each subcontract with a subcontractor or supplier utilized on this contract: The Offeror shall not discriminate on the basis of race, color, national origin, sexual orientation or sex in the performance of this contract. Failure to carry out these requirements is a material breach of this contract, which may result in the termination of this contract or such other remedy, as the State Agency deems appropriate.

Offeror's person responsible for compliance:

Name: _____

Title: _____

Telephone: (____) _____ extension _____

Email: _____

Offeror submits one (1) of the following statements:

- Offeror is certified (or are eligible and have applied to be certified) with BEP and plans to fully meet the BEP utilization goal through self-performance.
- Offeror attaches Section I to demonstrate its Plan fully meets the BEP utilization goal of 20% through subcontracting.
- Offeror attaches Section I to detail that it does not fully meet the BEP utilization goal. Offeror also attaches Section II, Demonstration of Good Faith Efforts.

**Section I
Utilization of Certified Vendors**

Please submit a separate Section I for each proposed certified vendor.

To achieve the BEP utilization goal through subcontracting, the following is proposed:

- 1) The proposed certified vendor's company name, address and phone number:

At the time of submission, the above certified vendor is:

- Certified with the DCMS Business Enterprise Program (BEP)
- Meets the criteria and has submitted an application for certification with BEP
(BEP certification must be completed before contract award)
- Certified as a disadvantaged, minority, or woman business enterprise with the following governmental agency or private organization:
(BEP certification must be completed before contract award)

- 2) A detailed description of the commercially useful work to be done by this certified vendor is as follows:

- 3) The total estimated cost to the state for this contract is \$_____. The portion of the contract which will be subcontracted to this certified vendor is \$_____, or _____% of the total cost of the contract.

- 4) A notarized signed letter of intent between _____ (the Offeror) and _____ (the certified vendor) detailing the work to be performed by the certified vendor and the agreed upon rates or prices, conforming to the Utilization Plan is included.

- 5) A joint venture agreement is not required, as the arrangement between _____ and _____ is that of contractor/sub-contractor and not a joint venture.
or,
A joint venture agreement between _____ and _____ is included in lieu of the letter of intent.

- 6) The Offeror has not prohibited or otherwise limited _____ (certified vendor) from providing subcontractor quotes to other potential offerors/vendors.

Offeror understands that the State Agency may require additional information to verify its compliance and it agrees to cooperate immediately in submitting to interviews, allowing entry to any of its office locations, providing further documentation, or soliciting the cooperation of its proposed certified vendor. Offeror will maintain appropriate records relating to its utilization of the certified vendor including: invoices, cancelled checks, books of account, and time records.

Section II

Demonstration of Good Faith Efforts to Achieve BEP Subcontracting Goal

If the BEP subcontracting goal was not achieved, the Good Faith Efforts checklist (Section II A) and contacts log (Section II B) must be submitted with the solicitation response (or as otherwise specified by DCMS). **Failure to do so may render the Offeror's solicitation response non-responsive and cause it to be rejected, or render the Offeror ineligible for contract award, at DCMS' sole discretion.** The Offeror will promptly provide evidence in support of its Good Faith Efforts to DCMS upon request.

Section II A

Good Faith Efforts Checklist

Insert on each line below the initials of the authorized Offeror representative who is certifying on behalf of the Offeror that the Offeror has completed the activities described below. **If any of the items below were not completed, attach a detailed written explanation why each such item was not completed.** If any other efforts were made to obtain BEP participation in addition to the items listed below, attach a detailed written explanation.

- _____ Identified portions of the project work capable of performance by available BEP vendors, including, where appropriate, breaking out contract work items into economically feasible units to facilitate BEP participation even when the Offeror could perform those scopes with its own forces.
- _____ Solicited through reasonable and available means (e.g., written notices, advertisements) BEP vendors to perform the types of work that could be subcontracted on this project, within sufficient time to allow them to respond.
- _____ Provided timely and adequate information about the plans, specifications and requirements of the contract. Followed up initial solicitations to answer questions and encourage BEP vendors to submit proposals or bids.
- _____ Negotiated in good faith with interested BEP vendors that submitted proposals or bids and thoroughly investigated their capabilities.
- _____ Made efforts to assist interested BEP vendors in obtaining bonding, lines of credit, or insurance as may be required for performance of the contract (if applicable).
- _____ Utilized resources available to identify available certified vendors, including but not limited to BEP assistance staff; local, state and federal minority or women business assistance offices; and other organizations that provide assistance in the recruitment and placement of diverse businesses.

Section II B

Good Faith Efforts Contacts Log for Soliciting

BEP Sub-consultant, Subcontractor or Supplier Participation

Use this form to document all contacts and responses (telephone, e-mail, fax, etc.) regarding the solicitation of BEP sub-consultants, subcontractors and suppliers. Duplicate as needed. (It is not necessary to show contacts with certified vendors with which the Offeror reached an agreement to participate on this project, as shown on Section I of this Plan.)

Name of certified vendor firm	Date and method of contact	Scope of work solicited	Reason agreement was not reached

**Letter of Intent (LOI)
Between Prime Offeror and Certified Vendor**

Instructions: The responsive Offeror is required to submit this signed and notarized Letter of Intent from each certified vendor identified on the Utilization Plan. LOIs must be submitted with the proposal and must be notarized by both parties. Submit a separate LOI for each proposed certified vendor. The amount and scope of work indicated on each LOI shall be the actual amount indicated on the Utilization Plan submitted with the proposal and approved by the State Agency.

Changes to the Utilization Plan including substitution of certified vendors are permitted only after award of the contract and only with prior written approval of the State Agency. A request for changes to the Utilization Plan must be submitted on the *Request for Change of Utilization Plan Form* for all levels of subcontracting. LOIs must be submitted for all additions of certified vendors to the Utilization Plan prior to the start of work.

Project Name _____ Project/Solicitation Number: _____

Name of Prime Offeror: _____

Address: _____
Street City State Zip Code

Telephone: () _____ Fax: () _____ Email: _____

Name of Certified Vendor: _____

Address: _____
Street City State Zip Code

Telephone: () _____ Fax: () _____ Email: _____

Type of agreement: Services Supplies Both Services/Supplies

Type of payment: Lump Sum _____ Hourly Rate _____ Unit Price _____

Period of Performance: _____ Proposed Subcontract Amount \$ _____ or Proposed % of Contract _____

Description of work to be performed by certified vendor:

List the governmental agency or private organization with whom the certified vendor is currently certified as a disadvantaged, minority, or woman business enterprise.

The prime vendor and the certified vendor above hereby agree that upon the execution of a contract for the above-named project between the prime vendor and the State of Illinois, the certified vendor will perform the scope of work for the price as indicated above.

Prime Offeror (Company Name and D/B/A):

Certified Vendor (Company Name and D/B/A):

Signature

Signature

Printed Name

Printed Name

Title: _____ Date: _____

Title: _____ Date: _____

Subscribed and sworn before me this
_____ day of _____, 200_____.

Subscribed and sworn before me this
_____ day of _____, 200_____.

Notary Public

Notary Public

My Commission expires: _____

My Commission expires: _____

Political Contributions

Public Act 95-971 addresses political contributions by Offerors, including affiliated persons and entities. The Act contains registration requirements and provides that all offers submitted to the State after January 1, 2009 contain a certificate of registration from the Illinois State Board of Elections or a certification that the offering entity is not required to register. Further information about the registration requirements can be found on the Board of Elections website, www.elections.il.gov. Failure to submit this information will result in disqualification.

By submission of an Offer, you acknowledge and certify that you have read, understand and will comply with Public Act 95-971, including but not limited to, all provisions relating to reporting and making contributions to state officeholders, declared candidates for State offices and covered political organizations that promote the candidacy of an officeholder or declared candidate for office. Offeror acknowledges that the State may declare any resultant contract void if this certification is false or if the Act is violated.

In compliance with Public Act 95-971, check the following certification that applies to you:

Offeror is not required to register as a business entity with the State Board of Elections.

or

Offeror has registered as a business entity with the State Board of Elections and acknowledges a continuing duty to update the registration as required by the Act. **Note: a copy of the official certificate of registration as issued by the State Board of Elections must be submitted as part of your Offer.**

TAXPAYER IDENTIFICATION NUMBER

I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. person (including a U.S. resident alien).
 - *If you are an individual, enter your name and SSN as it appears on your Social Security Card.*
 - *If you are a sole proprietor, enter the owner's name on the name line followed by the name of the business and the owner's SSN or EIN.*
 - *If you are a single-member LLC that is disregarded as an entity separate from its owner, enter the owner's name on the name line and the d/b/a on the business name line and enter the owner's SSN or EIN.*
 - *If the LLC is a corporation or partnership, enter the entity's business name and EIN and for corporations, attach IRS acceptance letter (CP261 or CP277).*
 - *For all other entities, enter the name of the entity as used to apply for the entity's EIN and the EIN.*

Name: _____

Business Name: _____

Taxpayer Identification Number:

Social Security Number _____

or

Employer Identification Number _____

Legal Status (check one):

- | | |
|--|---|
| <input type="checkbox"/> Individual | <input type="checkbox"/> Governmental |
| <input type="checkbox"/> Sole Proprietor | <input type="checkbox"/> Nonresident alien |
| <input type="checkbox"/> Partnership | <input type="checkbox"/> Estate or trust |
| <input type="checkbox"/> Legal Services Corporation | <input type="checkbox"/> Pharmacy (Non-Corp.) |
| <input type="checkbox"/> Tax-exempt | <input type="checkbox"/> Pharmacy/Funeral Home/Cemetery (Corp.) |
| <input type="checkbox"/> Corporation providing or billing
medical and/or health care services | <input type="checkbox"/> Limited Liability Company (select applicable tax classification) |
| <input type="checkbox"/> Corporation NOT providing or billing
medical and/or health care services | <input type="checkbox"/> D = disregarded entity |
| | <input type="checkbox"/> C = corporation |
| | <input type="checkbox"/> P = partnership |

Signature: _____

Date: _____

CONVICTIONS AND JUDGMENTS

If the Offeror, its parent, a subsidiary or an affiliated company has been convicted, pleaded guilty, or been found liable in the last 10 years or currently is facing criminal or civil actions for False Claims Act violations, Medicaid Fraud, Medicare Fraud, consumer Fraud, healthcare Fraud, or similar actions in any jurisdiction, the Offeror shall list the jurisdiction in which the action was heard or is pending, the case name and docket number, and the exact charges, findings or allegations. Convictions or findings of liability must be listed regardless of whether they are currently under appeal. You may provide any explanatory material you feel would be helpful in evaluating your company's fitness to be awarded a Contract in light of the information disclosed. If there is nothing to disclose in response to this question, please so indicate.

Attestations for Participation in the Medicare-Medicaid Alignment Initiative

_____ (Offeror) hereby attests that it will:

1. Demonstrate the capacity to serve additional Enrollees under the proposed Medicare-Medicaid Alignment Initiative and to expand to the proposed Contracting Area (as applicable);
2. Establish meaningful beneficiary input processes that may include beneficiary participation on Plan governing boards and/or establishment of beneficiary advisory boards;
3. Collect, analyze, report, and act on quality and performance data through a systematic and continuous quality improvement program to be specified by CMS and the State;
4. Provide complete and accurate Encounter Data in accordance with the format and timing to be outlined by CMS and the State;
5. Comply with unified Marketing requirements/review process as outlined by CMS and the State. Offeror will further ensure that all Marketing Materials/beneficiary information is integrated to the extent possible and is accessible and understandable to beneficiaries, including those with disabilities and limited English proficiency, consistent with the unified Marketing requirements;
6. Comply with uniform appeals process as developed by CMS and the State;
7. Employ customer service representatives who shall answer Enrollee inquiries and respond to Enrollee complaints and concerns;
8. Ensure the privacy of Enrollee health records, and provide for access by Enrollees to such records as specified in the Contract; and,
9. Contract with Providers that are credentialed in accordance with the State's credentialing and re-credentialing policies.

Signature

Title

On behalf of: _____ (Offeror)

Date

SECTION 6 – RESPONSIVENESS

Proposals shall be organized in the following order. To be considered responsive to this RFP, the Offeror must:

1. Have filed a timely notice of intent to apply for the 2013 Capitated Financial Alignment Demonstration Application with CMS, filed timely said Application, and said Application has been found by CMS to meet all of its requirements.
2. Respond to each question in Section 3.2 of the RFP by stating in detail what experience the Offeror has, if applicable, and what processes and procedures the Offeror proposes for the Medicare-Medicaid Alignment Initiative. A simple restatement of RFP language will not be considered an acceptable response and may cause the Proposal to be disqualified. For each stated requirement or question, or for each request for information or data, you must provide the number of the section or subsection of the RFP to which you are responding. Your numbered responses must be in sequential order, corresponding to the RFP.
3. Answer the Subcontracting Requirements questions and confirm agreement with Section 3.4.
4. Disclose the Work Location for each administrative function as required in Section 3.6.
5. Complete Section 4, OFFER TO THE UNITED STATES OF AMERICA AND STATE OF ILLINOIS.
6. Complete Section 5, RESPONSIBILITY FORMS.
7. Confirm agreement with Section 7, PAYMENT TERMS AND CONDITIONS, or note any exceptions taken with a full explanation.
8. Confirm agreement with Section 8, MODEL CONTRACT, or note any exceptions taken with a full explanation.
9. Meet the requirements of Section 1.4.

SECTION 7 – PAYMENT TERMS AND CONDITIONS

- 7.1 MEDICARE-MEDICAID ALIGNMENT INITIATIVE RATES:** The payment terms and conditions set forth in Section 7.1 are proposed and may change based on negotiation with CMS. Reimbursement to the Contractors will be by Per Member/Per Month (PMPM) Capitation rates. The Agencies' actuaries will develop actuarially sound rates that will be used in the Contracts and based on baseline spending in both programs and anticipated savings that will result from integration and improved Care Management. The State will make monthly payments to Contractors for the Medicaid portion of the Capitation rate. CMS will make monthly payments to Contractors for the Medicare portion of the Capitation rate including Part D. These rates will be posted on the Procurement Bulletin as soon as they are developed.
- 7.1.1 RISK ADJUSTMENT:** The Agencies' actuaries will develop a methodology to risk adjust the actuarially sound base Capitation rates for the population for each Contractor. More details will be provided when the Agencies determine the risk adjustment methodology.
- 7.1.2 INCENTIVE POOL PAYMENTS:** The State proposed the following incentive pool payment methodology, which is still under review by CMS and may change based on negotiations with CMS.
- 7.1.2.1** The Agencies will withhold a portion of the contractual Capitation rate each month. The withheld amount will be 1% in the first measurement year, 2.0% in the second measurement year, and 3.0% in the third measurement year. Contractors may earn payments from the incentive pool by achieving certain pay-for performance (P4P) quality metrics set forth in Attachment D. A portion of the Incentive Pool will be allocated to each P4P metric. If the Contractor reaches the target goal on that metric, the Contractor will earn the percentage of the Incentive Pool assigned to that P4P metric. The date of the first month of the withhold and P4P measurement will be negotiated between the Agencies and the Contractors. After the initial year, Contractor will not be eligible for any Incentive Pool payments if it fails to meet a minimum performance standard. The minimum performance standard will require the Contractor to score at or above the baseline on all P4P measures.
- 7.1.2.2** P4P metric baselines and targets and the weight of each P4P metric for incentive pool payment will be set in consultation with CMS.

SECTION 8 – MODEL CONTRACT

The following are provisions the State proposes to include as terms of the Contract, and with which Contractor will be required to comply. Offerors are not expected to respond to any of these provisions in their Proposals, but shall confirm agreement to comply or note any exceptions taken (See Section 6 Responsiveness). If you are unable to accept one or more of these provisions, you must identify any exception that you want the State to consider. You may show these changes in your Proposal by striking over language you find problematic and underlining alternate language, or by listing the sections and showing the alternate language on a separate page. You must provide these exceptions requests and alternate language with your Proposal. Please note that most of these provisions are required by law or important policy and that CMS or the Department has very limited ability to consider and accept changes. Any proposed changes may be considered in the evaluation of the Offeror's Proposal. The State may, at its discretion, withdraw an award if an Offeror subsequently seeks to change language that the Offeror did not identify as an exception in its Proposal.

Note that, as stated in the introductory portion of this RFP, the proposal for this Medicare-Medicaid Alignment Initiative submitted by the Department to CMS and this Model Contract are pending federal approval. The Model Contract may change based on CMS modifications or requirements as a result of the negotiation of the memorandum of understanding between the Department and CMS.

Any contract for the Medicaid SPD Program will be a separate contract with similar terms. It will be subject to CMS review and approval. If not approved, the Department may negotiate with a contractor to seek terms to gain CMS' approval or, at the sole option of the Department, withdraw any award and terminate any contract without penalty. Any such contract may be offered only upon the Plan's passing a readiness review for the Medicaid SPD Program.

MODEL CONTRACT

Article I	Definitions and Acronyms
Article II	Terms and Conditions
Article III	Eligibility
Article IV	Enrollment, Coverage and Termination of Coverage
Article V	Duties of Contractor
Article VI	Duties of the Agencies
Article VII	Payment and Funding
Article VIII	Term, Renewal and Termination
Article IX	General Terms

UNITED STATES OF AMERICA
& STATE OF ILLINOIS

CONTRACT

Between the

CENTERS FOR MEDICARE & MEDICAID SERVICES
& ILLINOIS DEPARTMENT OF HEALTHCARE
AND FAMILY SERVICES

and

_____, AN ILLINOIS _____

for

Furnishing Health Services to
Medicare-Medicaid Beneficiaries
Under the Medicare-Medicaid Alignment Initiative

2013-24-004-K

ARTICLE I

DEFINITIONS AND ACRONYMS

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

[To Be Completed]

ARTICLE II
TERMS AND CONDITIONS

- 2.1 **Rules of Construction.** Unless otherwise specified or the context otherwise requires:
- 2.1.1 Provisions apply to successive events and transactions;
 - 2.1.2 "Or" is not exclusive;
 - 2.1.3 References to statutes, regulations, and rules include subsequent amendments and successors thereto;
 - 2.1.4 The various headings of this Contract are provided for convenience only and shall not affect the meaning or interpretation of this Contract or any provision hereof;
 - 2.1.5 If any payment or delivery hereunder between Contractor and the Agencies shall be due on any day that is not a Business Day, such payment or delivery shall be made on the next succeeding Business Day;
 - 2.1.6 Words in the plural that should be singular by context shall be so read, and words in the singular shall be read as plural where the context dictates;
 - 2.1.7 Days shall mean calendar days;
 - 2.1.8 References to masculine or feminine pronouns shall be interchangeable where the context requires;
 - 2.1.9 References in the Contract to Potential Enrollee, Prospective Enrollee and Enrollee shall include the parent, caretaker relative or guardian where such Potential Enrollee, Prospective Enrollee or Enrollee is an adult for whom a guardian has been named; provided, however, that this rule of construction does not require Contractor to provide Covered Services for a parent, caretaker relative or guardian who is not separately enrolled as an Enrollee with Contractor;
 - 2.1.10 Contractor agrees that its representations regarding any service, standard or methodology that is in Contractor's response to the Request for Proposal No. 2013-24-003 (RFP), together with any best and final offers agreed to by the Parties in writing (collectively, "Proposal") and that is not otherwise excluded from, prohibited by, contrary to or materially altered by this Contract is a binding duty, responsibility or obligation on Contractor and performance of such, or similar as may be agreed to by the Parties, may be required by the Department and CMS without amending this Contract. The Parties acknowledge that Contractor may have specifically provided names of various programs, methodologies, strategies and coordination tools that Contractor uses in the conduct of its business separate and apart from this Contract and that these names and their descriptions may be referenced from time to time throughout this Contract. The Agencies acknowledge that Contractor may change the names of the various programs, methodologies, strategies and coordination tools, may change its vendors providing such, and may enhance such from time to time without amending this Contract; provided, however, that at no time may Contractor diminish their functionality in the aggregate;
 - 2.1.11 The terms of this Contract shall be interpreted if possible to be consistent with the terms of the RFP under which the Contract was awarded and with the Proposal submitted by Contractor in response to the RFP. In the event of a conflict, the order of precedence for the interpretation of this Contract is: this Contract (including amendments, schedules, attachments, addenda and exhibits), the RFP (including the State's responses to questions submitted by potential offerors), and the Proposal submitted by Contractor in response to the RFP;
 - 2.1.12 Whenever this Contract requires that an action be taken within a specified time period after receipt of a notice, document, report or other communication, the date the notice, document, report or other communication shall be deemed to have been received shall be in accordance with the following:
 - 2.1.12.1 if sent by first class mail, on the date of postmark by the United States Postal Service (USPS);
 - 2.1.12.2 if sent by registered or certified mail, on the date of signature on the USPS return receipt;
 - 2.1.12.3 if sent by courier or hand-delivery, on the date of signature on the courier's receipt form;
 - 2.1.12.4 if sent by e-mail, fax, or other electronic means, on the date of transmission.
 - 2.1.13 Whenever this Contract requires that a notice, document, report or other communication be sent within a specified time period after another action, the date the notice, document, report or other communication shall be deemed to have been sent shall be in accordance with the following:
 - 2.1.13.1 if sent by first class, registered or certified mail, on the date of postmark by the USPS;
 - 2.1.13.2 if sent by courier, on the date of delivery to the courier;

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

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

2.3 **Certificate of Authority.** Contractor must obtain and maintain during the term of this Contract a valid _____ as a _____ under _____. Contractor shall provide proof of _____ upon the Department's or CMS' request.

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

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

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

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

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

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

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

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

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

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

2.6.1.6 The written policies and procedures for cultural competence;

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

2.6.1.8 The availability of interpretive services;

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

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

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

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

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

- 2.6.2 **Staff.** Contractor shall proactively hire staff who reflects the diversity of Enrollee demographics. Contractor shall require all staff to complete linguistic and cultural competency training upon hire, and no less frequently than annually thereafter. Contractor shall provide training targeted to individual staff members as necessary.
- 2.6.3 **Providers.** Contractor shall contract with a culturally-diverse network of Providers of both genders, and prioritize recruitment of bilingual or multi-lingual Providers. Provider contracts will require compliance with Contractor's Cultural Competence Plan. During the credentialing and recredentialing process, Contractor will confirm the languages used by Providers, including American Sign Language, and physical access to Provider office locations.
- 2.6.4 **Subcontractors.** Contractor will require that its Subcontractors (i) comply with Contractor's Cultural Competence Plan, and (ii) complete Contractor's initial and annual cultural competence training. Contractor's Delegated Oversight Committee will provide oversight of Subcontractors to ensure compliance with contractual and statutory requirements, including, but not limited to, the Illinois Human Rights Act, the U. S. Civil Rights Act, and Section 504 of the federal Rehabilitation Act. This oversight will occur through quarterly delegation oversight audits, monthly joint operation meetings and regular monitoring of Enrollee Complaints.
- 2.6.5 **Provider Monitoring.** Contractor shall perform Quality Assurance evaluations of Provider practices, which shall include monitoring of Enrollee accessibility to ensure linguistic and physical accessibility. Contractor shall support Providers in achieving accessibility.
- 2.6.6 **Readiness Review.** Contractor shall submit its completed Cultural Competence Plan to the Department at least one (1) week prior to the Agencies' Readiness Review.
- 2.7 **Provider Site Access.** All Provider locations where Enrollees receive services shall comply with the requirements of the Americans with Disabilities Act (ADA). Contractor's network shall have Provider locations that are able to accommodate the unique needs of Enrollees.
- 2.8 **BEP Goals.**
- 2.8.1 Contractor shall meet the BEP subcontracting goals set by the Department. The Department shall notify Contractor of the goal at least ninety (90) days prior to the start of each State Fiscal Year. The goal will be set as percentages of the Administrative Allowance included in Capitation payments made to Contractor as set forth in Attachment ___, multiplied by the anticipated Enrollee months during the State Fiscal Year. The calculation for State Fiscal Year 2013 is Addendum A to Attachment ___ and, for subsequent State Fiscal Years, additional addenda may be appended to Attachment ___ upon written notice to Contractor without amendment of this Contract.
- 2.9.2 Prior to the start of each State Fiscal Year, Contractor shall submit a BEP Utilization Plan for such State Fiscal Year, in a format specified by the Department, sufficient to demonstrate compliance with the goals set by the Department for such State Fiscal Year. Contractor shall maintain a record of all relevant data with respect to the utilization of BEP certified subcontractors, including, but not limited to, payroll records, invoices, canceled checks and books of account, for a period of at least five (5) years after the completion of this Contract. Upon three (3) Business Days' written notice, Contractor shall grant full access to these records to any Authorized Person. The Department shall have the right to obtain from Contractor any additional data reasonably related or necessary to verify any representations by Contractor.

ARTICLE III

ELIGIBILITY

- 3.1 **Determination of Eligibility.** The Department has the exclusive right to determine an individual's eligibility for Medicaid under the HFS Medical Program. CMS has the exclusive right to determine an individual's eligibility for Medicare. Together, the Department and CMS have the exclusive right to determine an individual's eligibility to become an Enrollee. Such determinations shall be final and are not subject to review or appeal by Contractor. Nothing in this Article III prevents Contractor from providing the Department or CMS with information Contractor believes indicates that an Enrollee's eligibility was incorrectly determined or has changed so that enrollment with Contractor is no longer appropriate or that the Capitation rate for that Enrollee should be adjusted.
- 3.2 **Nondiscrimination.** Contractor shall not discriminate against a Potential Enrollee, Prospective Enrollee or Enrollee on any basis prohibited by Section 9.1.23.

ARTICLE IV

ENROLLMENT, COVERAGE
AND TERMINATION OF COVERAGE

[To Be Completed]

ARTICLE V
DUTIES OF CONTRACTOR
[To Be Completed]

ARTICLE VI

DUTIES OF CMS AND THE DEPARTMENT

[To Be Completed]

ARTICLE VII
PAYMENT AND FUNDING
[To Be Completed]

ARTICLE VIII

TERM, RENEWAL AND TERMINATION

- 8.1 Term of this Contract.** This Contract shall take effect on the Effective Date and shall continue for a period of one (1) year.
- 8.2 Renewal.** If the Contract is renewed, the renewal shall be subject to the same terms and conditions as the original Contract unless otherwise stated. The Contract may not renew automatically, nor may the Contract renew solely at Contractor's option. The Department reserves the right to renew for two (2) additional one (1) year terms for a total of three (3) years.
- 8.3 Continuing Duties in the Event of Termination.** Upon termination of this Contract, the Parties are obligated to perform those duties that survive under this Contract. Such duties include, but are not limited to, payment to Affiliated or non-Affiliated Providers, completion of Enrollee satisfaction surveys, cooperation with medical records review, all reports for periods of operation, including Encounter Data, and retention of records. Termination of this Contract does not eliminate Contractor's responsibility to the Agencies for overpayments which the Agencies determine in a subsequent audit may have been made to Contractor, nor does it eliminate any responsibility the Agencies may have for underpayments to Contractor. Contractor warrants that if this Contract is terminated, Contractor shall promptly supply all information in its possession or that may be reasonably obtained, which is necessary for the orderly transition of Enrollees and completion of all Contract responsibilities.
- 8.4 Immediate Termination for Cause.** In addition to any other termination rights under this Contract, the Agencies may terminate this Contract, in whole or in part, immediately upon notice to Contractor if it is determined that the actions, or failure to act, of Contractor, its agents, employees or subcontractors have caused, or reasonably could cause, jeopardy to health, safety, or property. This Contract may be terminated immediately if the Agencies determine that Contractor fails to meet the financial requirements established by the Illinois Department of Insurance pursuant to the Health Maintenance Organization Act or by the Department relating to a MCCN.
- 8.5 Termination for Cause.** In addition to any other termination rights under this Contract, if Contractor fails to perform to the Agencies' satisfaction any material requirement of this Contract or is in violation of a material provision of this Contract, the Agencies will provide written notice to Contractor requesting that the breach or noncompliance be remedied within the period of time specified in the Agencies' written notice, which shall be no fewer than sixty (60) days. If the breach or noncompliance is not remedied by that date, the Agencies may: (i) immediately terminate the Contract without additional written notice, or (ii) enforce the terms and conditions of the Contract. In either event, the Agencies may also seek any available legal or equitable remedies and damages.
- 8.6 Social Security Act.** This Contract may be terminated by the Agencies with cause upon at least fifteen (15) days' written notice to Contractor for any reason set forth in Section 1932(e)(4)(A) of the Social Security Act. In the event such notice is given, Contractor may request in writing a hearing, in accordance with Section 1932 of the Social Security Act by the date specified in the notice. If such a request is made by the date specified, then a hearing under procedures determined by the Agencies will be provided prior to termination. The Agencies reserve the right to notify Enrollees of the hearing and its purpose and inform them that they may disenroll from Contractor, and to suspend further enrollment with Contractor during the pendency of the hearing and any related proceedings.
- 8.7 Temporary Management.** While one (1) or more agencies of the State have the authority and retain the power under 42 C.F.R. 438.702 to impose temporary management upon Contractor for repeated violations of the Contract, the Agencies may exercise the option to terminate the Contract prior to imposition of temporary management. This does not preclude other State agencies from exercising such power at their discretion.
- 8.8 Termination for Convenience.** Following ninety (90) days' written notice, the Agencies may terminate this Contract in whole or in part without paying penalty or incurring any further obligation to Contractor.
- 8.9 Other Termination Rights.** This Contract may be terminated immediately or upon notice by the Agencies, in their sole discretion, in the event of the following:
- 8.9.1** Material failure of Contractor to maintain the representations, warranties and applicable certifications set forth in Section 9.2.
 - 8.9.2** Failure of Contractor to maintain general liability insurance coverage as required in this Contract.
 - 8.9.3** Any case or proceeding is commenced by or against Contractor seeking a decree or order with respect to the other party under the United States Bankruptcy Code or any other applicable bankruptcy or other similar law, including, without limitation, laws governing liquidation and receivership, and such proceeding is not dismissed within ninety (90) days after its commencement.
 - 8.9.4** Material misrepresentation or falsification of any information provided by Contractor in the course of dealings between the Parties.

- 8.9.5 Contractor takes any action to sell, transfer, dissolve, merge, or liquidate its business.
- 8.9.6 Failure of the Parties to negotiate an amendment necessary for statutory or regulatory compliance as provided in this Contract.
- 8.9.7 Funds for this Contract become unavailable as set forth in Section 7.____ or Section 9.1.1.
- 8.10 **Automatic Termination.** This Contract shall automatically terminate on a date set by the Agencies upon the conviction of a felony of Contractor, or a Person with an Ownership or Controlling Interest in Contractor.
- 8.11 **Reimbursement in the Event of Termination.** In the event of termination of this Contract, Contractor shall be responsible and liable for payment to Providers for any and all claims for Covered Services rendered to Enrollees prior to the effective termination date.

ARTICLE IX

GENERAL TERMS

9.1 Standard Business Terms and Conditions

- 9.1.1 Availability of Appropriation (30 ILCS 500/20-60):** This Contract is contingent upon and subject to the availability of funds. The Agencies, at their sole option, may terminate or suspend this Contract, in whole or in part, without penalty or further payment being required, if: (i) the Illinois General Assembly or the federal funding source fails to make an appropriation sufficient to pay such obligation, or if funds needed are insufficient for any reason; (ii) the Governor decreases the Department's funding by reserving some or all of the Department's appropriation(s) pursuant to power delegated to the Governor by the Illinois General Assembly; or (iii) the Department determines, in its sole discretion or as directed by the Office of the Governor, that a reduction is necessary or advisable based upon actual or projected budgetary considerations. Contractor will be notified in writing of the failure of appropriation or of a reduction or decrease.
- 9.1.2 Audit/Retention Of Records (30 ILCS 500/20-65):** Unless otherwise required by this Contract, Contractor and its subcontractors shall maintain books and records relating to the performance of the Contract or any subcontract and necessary to support amounts charged to the United States or the State under the Contract or subcontract. Books and records, including information stored in databases or other computer systems, shall be maintained by Contractor for a period of three (3) years from the later of the date of final payment under the Contract or completion of the Contract, and by a subcontractor for a period of three (3) years from the later of the date of final payment under the subcontract or completion of the subcontract. If federal funds are used to pay Contract costs, Contractor and its subcontractors must retain the books and records for five (5) years. Books and records required to be maintained under this Section 9.1.2 shall be available for review or audit by representatives of the Department, the Auditor General, the Executive Inspector General, the Chief Procurement Officer, State of Illinois internal auditors or other federal or State governmental entities with monitoring authority, upon reasonable notice and during normal business hours. Contractor and its subcontractors shall cooperate fully with any such audit and with any investigation conducted by any of these entities. Failure to maintain the books and records required by this Section 9.1.2 shall establish a presumption in favor of the United States and the State for the recovery of any funds paid by the United States or the State under the Contract for which adequate books and records are not available to support the purported disbursement. Contractor or its subcontractors shall not impose a charge for audit or examination of Contractor's books and records.
- 9.1.3 Time Is Of The Essence:** Time is of the essence with respect to Contractor's performance of this Contract. Unless otherwise directed by the Agencies, Contractor shall continue to perform its obligations while any dispute concerning the Contract is being resolved.
- 9.1.4 No Waiver Of Rights:** Except as specifically waived in writing, failure by a Party to exercise or enforce a right does not waive that Party's right to exercise or enforce that or other rights in the future.
- 9.1.5 Force Majeure:** Failure by either Party to perform its duties and obligations will be excused by unforeseeable circumstances beyond its reasonable control and not due to its negligence, including but not limited to acts of nature, acts of terrorism, riots, labor disputes, fire, flood, explosion, and governmental prohibition. The non-declaring Party may cancel the Contract without penalty if performance does not resume within thirty (30) days after the declaration.
- 9.1.6 Confidential Information:** It is understood that each Party to this Contract, including its agents and subcontractors, may have or gain access to confidential data or information owned or maintained by the other Party in the course of carrying out its responsibilities under this Contract. Contractor shall presume all information received from CMS and the State, or to which it gains access pursuant to this Contract, is confidential. Contractor's information (excluding information regarding rates paid by Contractor to its Providers and subcontractors), unless clearly marked as confidential and exempt from disclosure under the federal and Illinois Freedom of Information Acts, shall be considered public. No confidential data collected, maintained, or used in the course of performance of the Contract shall be disseminated except as authorized by law and with the written consent of the disclosing Party, either during the term of the Contract or thereafter, or as otherwise set forth in this Contract. The receiving Party must return any and all data collected, maintained, created or used in the course of the performance of the duties of this Contract, in whatever form it is maintained, promptly at the end of the term of this Contract, or earlier at the request of the disclosing Party, or notify the disclosing Party in writing of its destruction. The foregoing obligations shall not apply to confidential data or information that is: (i) lawfully in the receiving Party's possession prior to its acquisition from the disclosing Party; (ii) received in good faith from a third-party not subject to any confidentiality obligation to the disclosing Party; (iii) now is or later becomes publicly known through no breach of confidentiality obligation by the receiving Party; or (iv) is independently developed by the receiving Party without the use or benefit of the disclosing Party's Confidential Information.
- 9.1.7 Use And Ownership:** Excluding all materials, information, processes, and programs that are owned by or proprietary to Contractor or that are licensed to Contractor by a Third Party, including any modifications or enhancements thereto, all work

performed or supplies created by Contractor under this Contract, whether written documents or data, goods or deliverables of any kind, shall be deemed work-for-hire under copyright law and all intellectual property and other laws, and the United States and the State are granted sole and exclusive ownership to all such work, unless otherwise agreed in writing. Contractor hereby assigns to the United States and the State all right, title, and interest in and to such work including any related intellectual property rights, and waives any and all claims that Contractor may have to such work, including any so-called "moral rights", in connection with the work. Contractor acknowledges the United States and the State may use the work product for any purpose. Confidential data or information contained in such work shall be subject to confidentiality provisions of this Contract.

- 9.1.8 **License:** The federal and State governments reserve a royalty-free, non-exclusive, and irrevocable license to reproduce, publish, or otherwise use, and to authorize others to use, for federal and State government purposes, the copyright in any work developed under a grant, sub-grant, or contract under a grant or sub-grant or any rights of copyright to which a contractor purchases ownership.
- 9.1.9 **Indemnification And Liability:** Contractor shall indemnify and hold harmless the United States and the State, their agencies, officers, employees, agents and volunteers from any and all costs, demands, expenses, losses, claims, damages, liabilities, settlements and judgments, including in-house and contracted attorneys' fees and expenses, arising out of: (i) any breach or violation by Contractor of any of its certifications, representations, warranties, covenants or agreements; (ii) any actual or alleged death or injury to any individual, damage to any property or any other damage or loss claimed to result in whole or in part from Contractor's negligent performance; or (iii) any act, activity or omission of Contractor or any of its employees, representatives, subcontractors or agents. No Party shall be liable for incidental, special, consequential or punitive damages.
- 9.1.10 **Insurance:** Contractor shall, at all times during the term of this Contract and any renewals thereof, maintain and provide a Certificate of Insurance naming the United States and the State as additional insureds for all required bonds and insurance. Certificates may not be modified or canceled until at least thirty (30) days' notice has been provided to the Agencies. Contractor shall provide: (i) General Commercial Liability-occurrence form in amount of \$1,000,000 per occurrence (Combined Single Limit Bodily Injury and Property Damage) and \$2,000,000 Annual Aggregate; (ii) Auto Liability, including Hired Auto and Non-owned Auto, (Combined Single Limit Bodily Injury and Property Damage) in amount of \$1,000,000 per occurrence; and (iii) Worker's Compensation Insurance in amount required by law. Insurance shall not limit Contractor's obligation to indemnify, defend, or settle any claims.
- 9.1.11 **Independent Contractor:** Contractor shall act as an independent contractor and not an agent or employee of, or joint venturer with, the Agencies. All payments by the Agencies shall be made on that basis.
- 9.1.12 **Solicitation and Employment:** Contractor shall give notice immediately to the Department's Ethics Officer if Contractor solicits or intends to solicit State employees to perform any work under this Contract.
- 9.1.13 **Compliance with the Law:** Contractor, its employees, agents, and subcontractors shall comply with all applicable federal, State, and local laws, rules, ordinances, regulations, orders, federal circulars and license and permit requirements in the performance of this Contract. Contractor shall be in compliance with applicable tax requirements and shall be current in payment of such taxes. Contractor shall obtain at its own expense, all licenses and permissions necessary for the performance of this Contract.
- 9.1.14 **Background Check:** Whenever the State deems it reasonably necessary for security reasons, the State may conduct, at its expense, criminal and driver history background checks of Contractor's and its subcontractors' officers, employees or agents. Contractor or the subcontractor shall reassign immediately any such individual who, in the opinion of the State, does not pass the background checks.
- 9.1.15 **Applicable Law:** This Contract shall be construed in accordance with and is subject to the laws and rules of the State. The applicable provisions of the Department of Human Rights' Equal Opportunity requirements (44 Ill. Adm. Code 750) are incorporated by reference. Any claim against the State arising out of this Contract must be filed exclusively with the Illinois Court of Claims (705 ILCS 505/1). The State shall not enter into binding arbitration to resolve any contract dispute. The State does not waive sovereign immunity by entering into this Contract. The applicable provisions of the official text of cited statutes are incorporated by reference. In compliance with the Illinois and federal Constitutions, the Illinois Human Rights Act, the U. S. Civil Rights Act, and Section 504 of the federal Rehabilitation Act and other applicable laws and rules, the State does not unlawfully discriminate in employment, contracts, or any other activity.
- 9.1.16 **Anti-Trust Assignment:** If Contractor does not pursue any claim or cause of action it has arising under federal or State antitrust laws relating to the subject matter of the Contract, then upon request of the United States Attorney General or the Illinois Attorney General, Contractor shall assign to the United States or the State rights, title and interest in and to the claim or cause of action.
- 9.1.17 **Contractual Authority:** The agency that signs for the State shall be the only State entity responsible for performance and payment under the Contract.

- 9.1.18 Notices:** Notices and other communications provided for herein shall be given in writing by first class, registered or certified mail, return receipt requested, by receipted hand delivery, by courier (UPS, Federal Express or other similar and reliable carrier), or by e-mail, fax or other electronic means, showing the date and time of successful receipt as provided in Sections 2.1.12 and 2.1.13. Except as otherwise provided herein, notices shall be sent to the Contract Monitors set forth on Attachment XV using the contact information in that Attachment. By giving notice, either Party may change the Contract Monitor or his or her contact information.
- 9.1.19 Modifications And Survival:** Amendments, modifications and waivers must be in writing and signed by authorized representatives of the Parties. Any provision of this Contract officially declared void, unenforceable, or against public policy, shall be ignored and the remaining provisions shall be interpreted, as far as possible, to give effect to the Parties' intent. All provisions that by their nature would be expected to survive, shall survive termination.
- 9.1.20 Performance Record / Suspension:** Upon request of the Agencies, Contractor shall meet to discuss performance or provide contract performance updates to help ensure proper performance of this Contract. The Agencies may consider Contractor's performance under this Contract and compliance with law and rule to determine whether to continue this Contract, suspend Contractor from doing future business with the United States or the State for a specified period of time, or to determine whether Contractor can be considered responsible on specific future contract opportunities.
- 9.1.21 Freedom Of Information Act (FOIA):** This Contract and all related public records maintained by, provided to or required to be provided to the Agencies are subject to their respective Freedom of Information Acts notwithstanding any provision to the contrary that may be found in this Contract. If CMS or the Department receives a request for a record relating to Contractor under this Contract, or Contractor's provision of services, or the arranging of the provision of services, under this Contract, notice will be provided to Contractor as soon as practicable and, within the period available under FOIA, Contractor may identify those records, or portions thereof, that it in good faith believes to be exempt from production and the justification for such exemption. The Agencies shall make good faith efforts to notify Contractor regarding a request for a record that has been the subject of a previous request under FOIA.
- 9.1.22 Confidentiality Of Program Recipient Identification:** Contractor shall ensure that all information, records, data, and data elements pertaining to applicants for and recipients of public assistance, or to Providers, facilities, and associations, shall be protected from unauthorized disclosure by Contractor and Contractor's employees, by Contractor's corporate Affiliates and their employees, and by Contractor's subcontractors and their employees, pursuant to 305 ILCS 5/11-9, 11-10, and 11-12; 42 USC 654(26); 42 C.F.R. Part 431, Subpart F; and 45 C.F.R. Part 160 and 45 C.F.R. Part 164, Subparts A and E. To the extent that Contractor, in the course of performing the Contract, serves as a business associate of either of the Agencies, as "business associate" is defined in the HIPAA Privacy Rule (45 C.F.R. 160.103), Contractor shall assist the Agencies in responding to the client as provided in the HIPAA Privacy Rule, and shall maintain for a period of six (6) years any records relevant to an individual's eligibility for services under the Medicare and HFS Medical Programs.
- 9.1.23 Nondiscrimination:** (i) Contractor shall abide by all Federal and State laws, regulations, and orders that prohibit discrimination because of race, color, religion, sex, national origin, ancestry, age, physical or mental disability, including, but not limited to, the Federal Civil Rights Act of 1964, the Americans with Disabilities Act of 1990, the Federal Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, the Illinois Human Rights Act, and Executive Orders 11246 and 11375. (ii) Contractor further agrees to take affirmative action to ensure that no unlawful discrimination is committed in any manner including, but not limited to, the delivery of services under this Contract. (iii) Contractor will not discriminate against Potential Enrollees, Prospective Enrollees, or Enrollees on the basis of health status or need for health services. (iv) Contractor may not discriminate against any Provider who is acting within the scope of his/her licensure solely on the basis of that licensure or certification. (v) Contractor will provide each Provider or group of Providers whom it declines to include in its network written notice of the reason for its decision. (vi) Nothing in subsection (iv) or (v), above, may be construed to require Contractor to contract with Providers beyond the number necessary to meet the needs of its Enrollees; precludes Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or precludes Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to Enrollees.
- 9.1.24 Child Support:** Contractor shall ensure that it is in compliance with paying, or any other obligations it may have in enforcing, child support payments pursuant to a court or administrative order of this or any other State. Contractor will not be considered out of compliance with the requirements of this Section 9.1.24 if, upon request by the Department, Contractor provides:
- 9.1.24.1** Proof of payment of past-due amounts in full;
- 9.1.24.2** Proof that the alleged obligation of past-due amounts is being contested through appropriate court or administrative proceedings and Contractor provides proof of the pendency of such proceedings; or
- 9.1.24.3** Proof of entry into payment arrangements acceptable to the appropriate State agency.

- 9.1.25 **Notice Of Change In Circumstances:** In the event Contractor, Contractor's parent, or an Affiliate, becomes a party to any litigation, investigation or transaction that may reasonably be considered to have a material impact on Contractor's ability to perform under this Contract, Contractor will immediately notify the Agencies in writing.
- 9.1.26 **Performance Of Services And Duties:** Contractor shall perform all services and other duties as set forth in this Contract in accordance with, and subject to, applicable federal and State regulations and Administrative Rules and policies, including rules, regulations and policies that may be issued or promulgated from time to time during the term of this Contract. Contractor shall be provided copies of such upon Contractor's written request.
- 9.1.27 **Consultation:** Upon request, Contractor shall promptly furnish the Agencies with copies of all relevant correspondence and all documents prepared in connection with the services rendered under this Contract.
- 9.1.28 **Employee Handbook:** Contractor shall require that its employees and subcontractors who provide services under this Contract at a location controlled by the Department, or any other State agency, abide by applicable provisions of the controlling agency's Employee Handbook.
- 9.1.29 **Disputes Between Contractor And Other Parties:** Any dispute between Contractor and any Third Party, including any subcontractor, shall be solely between such Third Party and Contractor, and the Agencies shall be held harmless by Contractor. Contractor agrees to assume all risk of loss and to indemnify and hold the Agencies and their officers, agents, and employees harmless from and against any and all liabilities, demands, claims, suits, losses, damages, causes of action, fines or judgments, including costs, attorneys' and witnesses' fees, and expenses incident thereto, for Contractor's failure to pay any subcontractor, either timely or at all, regardless of the reason.
- 9.1.30 **Fraud And Abuse:** Contractor shall report in writing to the Agencies' respective Office of Inspector General (OIG) any suspected Fraud, Abuse or misconduct associated with any service or function provided for under this Contract by any parties directly or indirectly affiliated with this Contract, including but not limited to, Contractor's staff, Contractor's subcontractors, the Agencies' employees or the Agencies contractors. Contractor shall make this report within three (3) days after first suspecting Fraud, Abuse or misconduct. Contractor shall not conduct any investigation of the suspected Fraud, Abuse or misconduct without the express concurrence of the OIG; the foregoing notwithstanding, Contractor may conduct and continue investigations necessary to determine whether reporting is required under this Section 9.1.30. Contractor must report the results of such an investigation to OIG as described in the first sentence of this Section 9.1.30. Contractor shall cooperate with all investigations of suspected Fraud, Abuse or misconduct reported pursuant to this paragraph. Contractor shall require adherence with these requirements in any contracts it enters into with subcontractors. Nothing in this Section precludes Contractor or subcontractors from establishing measures to maintain quality of services and control costs that are consistent with their usual business practices, conducting themselves in accordance with their respective legal or contractual obligations or taking internal personnel-related actions.
- 9.1.31 **Gifts:** Contractor and Contractor's principals, employees and subcontractors are prohibited from giving gifts to Agencies' employees, and from giving gifts to, or accepting gifts from, any Person who has a contemporaneous contract with either of the Agencies involving duties or obligations related to this Contract.
- 9.1.32 **Media Relations And Public Information:** Subject to any disclosure obligations of Contractor under applicable law, rule, or regulation, news releases pertaining to this Contract or the services or project to which it relates shall only be made with Prior Approval by, and in coordination with, the Agencies. Contractor shall not disseminate any publication, presentation, technical paper, or other information related to Contractor's duties and obligations under this Contract unless such dissemination has received Prior Approval from the Agencies.
- 9.1.33 **Excluded Individuals/Entities:** Contractor shall screen all current and prospective employees, contractors and subcontractors prior to engaging their services under this Contract and at least annually thereafter, by:
- 9.1.33.1 Requiring that current or prospective employees, contractors or sub-contractors to disclose whether they are Excluded Individuals/Entities; and
- 9.1.33.2 Reviewing the list of sanctioned Persons maintained by the OIG (available at <http://www.state.il.us/agency/oig>), and the Excluded Parties List System maintained by the U.S. General Services Administration (available at <http://epls.arnet.gov/>).
- 9.1.33.3 For purposes under this Section, "Excluded Individual/Entity" shall mean a Person which:
- 9.1.33.3.1 Under Section 1128 of the Social Security Act, is or has been terminated, barred, suspended or otherwise excluded from participation in, or as the result of a settlement agreement has voluntarily withdrawn from participation in, any program under federal law, including any program under Titles IV, XVIII, XIX, XX or XXI of the Social Security Act;

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

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

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

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

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

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

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

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

9.1.36 **Sale or Transfer:** Contractor shall provide the Agencies with the earliest possible advance notice of any sale or transfer of Contractor's business. The Agencies have the right to terminate this Contract upon notification of such sale or transfer.

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

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

9.1.39 **Disclosure of Ownership and Control.** Contractor shall file with the Agencies a disclosure statement that complies with the requirements of 42 CFR 455.104(a) and conforms to the definitions set forth in 42 CFR 455.101. The disclosure statement shall be filed before Contractor executes this Contract, and shall be updated at intervals between Contract renewals within thirty-five (35) days after the Agencies' written request. At the time this Contract is executed, Contractor shall disclose to the Agencies information on any transaction between Contractor and a party in interest described in Section 1318(b) of the Public Health Services Act. The information shall be updated as necessary, and shall include: (i) any sale, exchange or leasing of any property between Contractor and such a party; (ii) any furnishing for consideration of goods, services (including management services) or facilities between Contractor and such a party, but not including salaries paid to employees for services provided in the normal course of their employment; and (iii) any lending of money or other extension of credit between Contractor and such a party.

9.1.40 **Disclosure of Business Transactions.** At the written request of the Agencies, Contractor shall file a disclosure statement with the Agencies that complies with the requirements of 42 CFR 455.105(b) and conforms to the definitions set forth in 42 CFR 455.101.

9.2 Certifications

9.2.1 **General.** Contractor acknowledges and agrees that compliance with this Section 9.2 and each subsection thereof is a material requirement and condition of this Contract, including renewals. By executing this Contract, Contractor certifies compliance, as applicable, with this Section and is under a continuing obligation to remain in compliance and report any non-compliance. This Section applies to subcontractors used on this Contract. Contractor shall include these Standard Certifications in any subcontract used in the performance of the Contract using the Standard Subcontractor Certification form provided by the Agencies. If this Contract extends over multiple fiscal years, including the initial term and all renewals, Contractor and its subcontractors shall confirm compliance with this Section in the manner and format determined by the Agencies by the date specified by the Agencies

and in no event later than July 1 of each year that this Contract remains in effect. If the Parties determine that any certification in this Section is not applicable to this Contract, it may be stricken without affecting the remaining subsections.

- 9.2.1.1** As part of each certification, Contractor acknowledges and agrees that if Contractor or its subcontractors provide false information, or fail to be or remain in compliance with the Standard Certification requirements, one (1) or more of the sanctions listed below will apply. Identifying a sanction or failing to identify a sanction in relation to any of the specific certifications does not waive imposition of other sanctions or preclude application of sanctions not specifically identified.
- 9.2.1.1.1** the Contract may be void by operation of law,
 - 9.2.1.1.2** either of the Agencies may void the Contract, and
 - 9.2.1.1.3** Contractor and its subcontractors may be subject to one or more of the following: suspension, debarment, denial of payment, civil fine, or criminal penalty.
- 9.2.2** Contractor certifies that it and its employees will comply with applicable provisions of the U.S. Civil Rights Act, Section 504 of the Federal Rehabilitation Act, the Americans with Disabilities Act (42 U.S.C. § 12101 et seq.) and applicable rules in performance under this Contract.
- 9.2.3** Contractor certifies that it is not in default on an educational loan (5 ILCS 385/3). This applies to individuals, sole proprietorships, partnerships and individuals as members of LLCs.
- 9.2.4** Contractor (if an individual, sole proprietor, partner or an individual as member of a LLC) certifies that it has not received an (i) an early retirement incentive prior to 1993 under Section 14-108.3 or 16-133.3 of the Illinois Pension Code, 40 ILCS 5/14-108.3 and 40 ILCS 5/16-133.3, or (ii) an early retirement incentive on or after 2002 under Section 14-108.3 or 16-133.3 of the Illinois Pension Code, 40 ILCS 5/14-108.3 and 40 ILCS 5/16-133, (30 ILCS 105/15a).
- 9.2.5** Contractor certifies that it is a properly formed and existing legal entity (30 ILCS 500/1.15.80, 20-43); and as applicable has obtained an assumed name certificate from the appropriate authority, or has registered to conduct business in Illinois and is in good standing with the Illinois Secretary of State.
- 9.2.6** To the extent there was an incumbent contractor providing the services covered by this Contract and the employees of that contractor that provide those services are covered by a collective bargaining agreement, Contractor certifies (i) that it will offer to assume the collective bargaining obligations of the prior employer, including any existing collective bargaining agreement with the bargaining representative of any existing collective bargaining unit or units performing substantially similar work to the services covered by the Contract subject to its bid or offer; and (ii) that it shall offer employment to all employees currently employed in any existing bargaining unit performing substantially similar work that will be performed under this Contract (30 ILCS 500/25-80). This does not apply to heating, air conditioning, plumbing and electrical service contracts.
- 9.2.7** Contractor certifies that it has not been convicted of bribing or attempting to bribe an officer or employee of the State or any other state, nor has Contractor made an admission of guilt of such conduct that is a matter of record (30 ILCS 500/50-5).
- 9.2.8** If Contractor has been convicted of a felony, Contractor certifies at least five (5) years have passed after the date of completion of the sentence for such felony, unless no Person held responsible by a prosecutor's office for the facts upon which the conviction was based continues to have any involvement with the business (30 ILCS 500/50-10).
- 9.2.9** If Contractor, or any officer, director, partner, or other managerial agent of Contractor, has been convicted of a felony under the Sarbanes-Oxley Act of 2002, or a Class 3 or Class 2 felony under the Illinois Securities Law of 1953, Contractor certifies that at least five (5) years have passed since the date of the conviction. Contractor further certifies that it is not barred from being awarded a contract and acknowledges that the State shall declare the Contract void if this certification is false (30 ILCS 500/50-10.5).
- 9.2.10** Contractor certifies that it is not barred from having a contract with the State based on violating the prohibition on providing assistance to the State in identifying a need for a contract (except as part of a public request for information process) or by reviewing, drafting or preparing a solicitation or similar documents for the State (30 ILCS 500/50-10.5e).
- 9.2.11** Contractor certifies that it and its Affiliates are not delinquent in the payment of any debt to the State (or if delinquent has entered into a deferred payment plan to pay the debt), and Contractor and its affiliates acknowledge the State may declare the Contract void if this certification is false (30 ILCS 500/50-11) or if Contractor or an Affiliate later becomes delinquent and has not entered into a deferred payment plan to pay off the debt (30 ILCS 500/50-60).
- 9.2.12** Contractor certifies that it and all Affiliates shall collect and remit Illinois Use Tax on all sales of tangible personal property into the State in accordance with provisions of the Illinois Use Tax Act (30 ILCS 500/50-12) and acknowledges that failure to comply can result in the Contract being declared void.

- 9.2.13 Contractor certifies that it has not been found by a court or the Pollution Control Board to have committed a willful or knowing violation of the Environmental Protection Act within the last five (5) years, and is therefore not barred from being awarded a contract (30 ILCS 500/50-14).
- 9.2.14 Contractor certifies that it has not paid any money or valuable thing to induce any Person to refrain from bidding on a State contract, nor has Contractor accepted any money or other valuable thing, or acted upon the promise of same, for not bidding on a State contract (30 ILCS 500/50-25).
- 9.2.15 Contractor certifies that it is not in violation of the "Revolving Door" section of the Illinois Procurement Code (30 ILCS 500/50-30).
- 9.2.16 Contractor certifies that it has not retained a Person to attempt to influence the outcome of a procurement decision for compensation contingent in whole or in part upon the decision or procurement (30 ILCS 500/50-38).
- 9.2.17 Contractor certifies that it will report to the Illinois Attorney General and the Chief Procurement Officer any suspected collusion or other anti-competitive practice among any bidders, offerors, contractors, proposers or employees of the State (30 ILCS 500/50-40, 50-45, 50-50).
- 9.2.18 In accordance with the Steel Products Procurement Act, Contractor certifies that steel products used or supplied in the performance of a contract for public works shall be manufactured or produced in the United States, unless the executive head of the procuring agency grants an exception (30 ILCS 565).
- 9.2.19 If Contractor employs twenty-five (25) or more employees and this Contract is worth more than \$5000, Contractor certifies that it will provide a drug free workplace pursuant to the Drug Free Workplace Act (30 ILCS 580).
- 9.2.20 Contractor certifies that neither Contractor nor any substantially owned Affiliate is participating or shall participate in an international boycott in violation of the U.S. Export Administration Act of 1979 or the applicable regulations of the U.S. Department of Commerce. This applies to contracts that exceed \$10,000 (30 ILCS 582).
- 9.2.21 Contractor certifies that it has not been convicted of the offense of bid rigging or bid rotating or any similar offense of any state or of the United States (720 ILCS 5/33E-3, E-4).
- 9.2.22 Contractor certifies that it complies with the Illinois Department of Human Rights Act and rules applicable to public contracts, including equal employment opportunity, refraining from unlawful discrimination, and having written sexual harassment policies (775 ILCS 5/2-105).
- 9.2.23 Contractor certifies that it does not pay dues to or reimburse or subsidize payments by its employees for any dues or fees to any "discriminatory club" (775 ILCS 25/2).
- 9.2.24 Contractor certifies that it complies with the State Prohibition of Goods from Forced Labor Act, and certifies that no foreign-made equipment, materials, or supplies furnished to the State under the Contract have been or will be produced in whole or in part by forced labor, or indentured labor under penal sanction (30 ILCS 583).
- 9.2.25 Contractor certifies that no foreign-made equipment, materials, or supplies furnished to the State under this Contract have been produced in whole or in part by the labor or any child under the age of twelve (12) (30 ILCS 584).
- 9.2.26 Contractor certifies that it is not in violation of Section 50-14.5 of the Illinois Procurement Code (30 ILCS 500/50-14.5) that states: "Owners of residential buildings who have committed a willful or knowing violation of the Lead Poisoning Prevention Act (410 ILCS 45) are prohibited from doing business with the State until the violation is mitigated".
- 9.2.27 Contractor warrants and certifies that it and, to the best of its knowledge, its subcontractors have and will comply with Executive Order No. 1 (2007). The Order generally prohibits contractors and subcontractors from hiring the then-serving Governor's family members to lobby procurement activities of the State, or any other unit of government in Illinois including local governments if that procurement may result in a contract valued at over \$25,000. This prohibition also applies to hiring for that same purpose any former State employee who had procurement authority at any time during the one-year period preceding the procurement lobbying activity.
- 9.2.28 Contractor certifies that information technology, including electronic information, software, systems and equipment, developed or provided under this Contract, will comply with the applicable requirements of the Illinois Information Technology Accessibility Act Standards as published at <http://www.dhs.state.il.us/IITAA/IITAAWebImplementationGuidelines.html> (30 ILCS 587).
- 9.2.29 **Non-Exclusion:**

- 9.2.29.1 Contractor certifies that it is not currently barred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal or State department or agency, and is not currently barred or suspended from contracting with the State under Section 50-35(f), 50-35(g) or 50-65 of the Illinois Procurement Code, 30 ILCS 500/1-1 et seq.
- 9.2.29.2 If at any time during the term of this Contract, Contractor becomes barred, suspended, or excluded from participation in this transaction, Contractor shall, within thirty (30) days after becoming barred, suspended or excluded, provide to the Department a written description of each offense causing the exclusion, the date(s) of the offense, the action(s) causing the offense(s), any penalty assessed or sentence imposed, and the date any penalty was paid or sentence complete.
- 9.2.30 **Conflict Of Interest:** In addition to any other provision in this Contract governing conflicts of interest, Contractor certifies that neither Contractor, nor any party directly or indirectly affiliated with Contractor, including, but not limited to, Contractor's officers, directors, employees and subcontractors, and the officers, directors and employees of Contractor's subcontractors, shall have or acquire any Conflict of Interest in performance of this Contract.
- 9.2.30.1 For purposes of this Section 9.2.30, "Conflict of Interest" shall mean an interest of Contractor, or any entity described above, which may be direct or indirect, professional, personal, financial, or beneficial in nature that, in the sole discretion of the Department, compromises, appears to compromise, or gives the appearance of impropriety with regard to Contractor's duties and responsibilities under this Contract. This term shall include potential Conflicts of Interest. A Conflict of Interest may exist even if no unethical or improper act results from it or may arise where Contractor becomes a party to any litigation, investigation, or transaction that materially impacts Contractor's ability to perform under this Contract. Any situation where Contractor's role under the Contract competes with Contractor's professional or personal role may give rise to an appearance of impropriety. Any conduct that would lead a reasonable individual, knowing all the circumstances, to a conclusion that bias may exist or that improper conduct may occur, or that gives the appearance of the existence of bias or improper conduct, is a Conflict of Interest.
- 9.2.30.2 Contractor shall disclose in writing any Conflicts of Interest to the Department no later than seven (7) days after learning of the Conflict of Interest. The Department may initiate any inquiry as to the existence of a Conflict of Interest. Contractor shall cooperate with all inquiries initiated pursuant to this Section 9.2.30. Contractor shall have an opportunity to discuss the Conflict of Interest with the Department and suggest a remedy under this Section.
- 9.2.30.3 Notwithstanding any other provisions in this Contract, the Department shall, in its sole discretion, determine whether a Conflict of Interest exists or whether Contractor failed to make any required disclosure. This determination shall not be subject to appeal by Contractor. If the Department concludes that a Conflict of Interest exists, or that Contractor failed to disclose any Conflict of Interest, the Department may impose one or more remedies, as set forth below.
- 9.2.30.4 The appropriate remedy for a Conflict of Interest shall be determined in the sole discretion of the Department and shall not be subject to appeal by Contractor. Available remedies shall include, but not be limited to, the elimination of the Conflict of Interest or the non-renewal or termination of the Contract.
- 9.2.31 **Clean Air Act And Clean Water Act:** Contractor certifies that it is in compliance with all applicable standards, orders or regulations issued pursuant to the federal Clean Air Act (42 U.S.C. 7401 et seq.) and the federal Water Pollution Control Act (33 U.S.C. 1251 et seq.). Violations shall be reported to the United States Department of Health and Human Services and the appropriate Regional Office of the United States Environmental Protection Agency.
- 9.2.32 **Lobbying:**
- 9.2.32.1 Contractor certifies that, to the best of its knowledge and belief, no federally appropriated funds have been paid or will be paid by or on behalf of Contractor, to any Person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal loan or grant, or the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan or cooperative agreement.
- 9.2.32.2 If any funds other than federally appropriated funds have been paid or will be paid to any Person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this federal contract, grant, loan or cooperative agreement, Contractor shall complete and submit Standard Form LLL, "Disclosure Forms to Report Lobbying," in accordance with its instructions. Such Form is to be obtained at Contractor's request from the Department's Bureau of Fiscal Operations.

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

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

9.2.33 Contractor certifies that it has accurately completed the certification relating to Public Act 95-971 (political contributions).

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

**UNITED STATES OF AMERICA
CENTERS FOR MEDICARE & MEDICAID**

STATE OF ILLINOIS
Department of Healthcare and Family Services

By: _____
Official Signature

By: _____
Julie Hamos, Director

Printed Name

Title

Date: _____

Date: _____

Address: _____

Address: _____
201 South Grand Avenue East

Springfield, IL 62763-0002

Phone: _____

Phone: 217-782-1200

Fax: _____

Fax: 217-524-7979

E-mail: _____

E-mail: HFS.Director@illinois.gov

OFFEROR/CONTRACTOR

By: _____
Official Signature

Printed Name

Title

Date: _____

Address: _____

Phone: _____

Fax: _____

E-mail: _____

Attachment __

STATE OF ILLINOIS DRUG-FREE WORKPLACE CERTIFICATION

Contractor certifies that it will not engage in the unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance in the performance of the Agreement.

This business or corporation has twenty-five (25) or more employees, and Contractor certifies and agrees that it will provide a drug free workplace by:

- A) Publishing a statement:
 - 1) Notifying employees that the unlawful manufacture, distribution, dispensation, possession or use of a controlled substance, including cannabis, is prohibited in the grantee's or contractor's workplace.
 - 2) Specifying the actions that will be taken against employees for violations of such prohibition.
 - 3) Notifying the employees that, as a condition of employment on such contract, the employee will:
 - a) abide by the terms of the statement; and
 - b) notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five (5) days after such conviction.
- B) Establishing a drug free awareness program to inform employees about:
 - 1) the dangers of drug abuse in the workplace;
 - 2) Contractor's policy of maintaining a drug free workplace;
 - 3) any available drug counseling, rehabilitation, and employee assistance programs; and
 - 4) the penalties that may be imposed upon an employee for drug violations.
- C) Providing a copy of the statement required by subparagraph (a) to each employee engaged in the performance of the contract or grant and to post the statement in a prominent place in the workplace.
- D) Notifying the contracting or granting agency within ten (10) days after receiving notice under part (B) or paragraph (3) of subsection (a) above from an employee or otherwise receiving actual notice of such conviction.
- E) Imposing a sanction on, or requiring the satisfactory participation in a drug abuse assistance or rehabilitation program by, any employee who is so convicted, as required by section 5 of the Drug Free Workplace Act, 1992 Illinois Compiled Statute, 30 ILCS 580/5.
- F) Assisting employees in selecting a course of action in the event drug counseling, treatment, and rehabilitation is required and indicating that a trained referral team is in place.
- G) Making a good faith effort to continue to maintain a drug free workplace through implementation of the Drug Free Workplace Act, 1992 Illinois Compiled Statute, 30 ILCS 580/1 *et seq.*

THE UNDERSIGNED AFFIRMS, UNDER PENALTIES OF PERJURY, THAT HE OR SHE IS AUTHORIZED TO EXECUTE THIS CERTIFICATION ON BEHALF OF

Signature of Authorized Representative

Contract ID Number

Printed Name and Title

Date

Attachment ____
BEP Utilization Plan

[To Be Completed]

Attachment __

Public Act 95-971

Contractor certifies that it has read, understands, and is in compliance with the registration requirements of the Elections Code (10 ILCS 5/9-35) and the restrictions on making political contributions and related requirements of the Illinois Procurement Code (30 ILCS 500/20-160 and 50-37). Contractor will not make a political contribution that will violate these requirements. These requirements are effective for the duration of the term of office of the incumbent Governor or for a period of two (2) years after the end of the Contract term, whichever is longer.

In accordance with Section 20-160 of the Illinois Procurement Code, Contractor certifies as applicable:

- Contractor is not required to register as a business entity with the State Board of Elections,
or
- Contractor has registered **and has attached a copy** of the official certificate of registration as issued by the State Board of Elections. As a registered business entity, Contractor acknowledges a continuing duty to update the registration as required by the Act.

Attachment __

Quality Assurance (QA)

(This Quality Assurance attachment is subject to change as a result of the negotiation of the memorandum of understanding between the Department and CMS.)

1. Contractor shall establish procedures such that Contractor shall be able to demonstrate that it meets the requirements of the HMO Federal qualification regulations (42 C.F.R. 417.106), the Medicare HMO/CMP regulations (42 C.F.R. 417.418(c)), and the regulations promulgated pursuant to the Balanced Budget Act of 1997 (42 C.F.R. 438.200 et seq.). These regulations require that Contractor have an ongoing fully implemented Quality Assurance Program for health services that:
 - a. incorporates widely accepted practice guidelines that meet the criteria referenced above, and are distributed to Affiliated Providers, as appropriate, and to Enrollees and Potential Enrollees, upon request, and:
 - i. are based on valid and reliable clinical evidence;
 - ii. consider the needs of Enrollees;
 - iii. are adopted in consultation with Affiliated Providers; and
 - iv. are reviewed and updated periodically as appropriate.
 - b. monitors the health care services Contractor provides, including assessing the appropriateness and quality of care;
 - c. stresses health outcomes and monitors Enrollee risks status and improvement in health outcomes;
 - d. provides a comprehensive program of care coordination, Care Management, and Disease Management, with needed outreach to assure appropriate care utilization and community referrals;
 - e. provides review by Physicians and other health professionals of the process followed in the provision of health services;
 - f. includes fraud control provisions;
 - g. establishes and monitors access standards;
 - h. uses systematic data collection of performance and Enrollee results, provides interpretation of these data to its Affiliated Providers- (including, without limitation, Enrollee-specific and aggregate data provided by the Department, such as HEDIS® and State defined measures), and institutes needed changes;
 - i. includes written procedures for taking appropriate remedial action and developing corrective action and quality improvement whenever, as determined under the Quality Assurance Program, inappropriate or substandard services have been furnished or Covered Services that should have been furnished have not been provided;
 - j. describes its implementation process for reducing unnecessary emergency room utilization and inpatient services, including (thirty)30-day readmissions;
 - k. describes its process for obtaining clinical results, findings, including emergency room and inpatient care, pharmacy information, lab results, feedback from other care providers, etc., to provide such data and information to the PCP or specialist, or others, as determined appropriate, on a real-time basis;
 - l. describes its process to assure follow up services within (seven) 7 days from inpatient care for behavioral health, with a behavioral health provider, or within (fourteen)14 day follow up for inpatient medical care, with a PCP or specialist, or follow up within (fourteen)14 days following an emergency room visit;
 - m. details its processes for establishing Medical Homes and the coordination between the PCP and behavioral health provider, specialists and PCP, or specialists and behavioral health providers;
 - n. details its processes for determining and facilitating Enrollees needing nursing home, supportive living facility (SLF) or ICF/DD level of care, or to live in the community with HCBS supports;
 - o. describes its processes for addressing Abuse and Neglect and unusual incidents in the community setting;

- p. details its compensation structure, incentives, pay-for-performance programs, value purchasing strategies, and other mechanisms utilized to promote the goals of Medical Homes and accountable, integrated care;
 - q. describes its health education procedures and materials for Enrollees; processes for training, monitoring, and holding providers accountable for health education; and oversight of Provider requirements to coordinate care and provide health education topics (e.g., obesity, heart smart activities, mental health and substance abuse resources) and outreach documents (e.g., about chronic conditions) using evidence based guidelines and best practice strategies; and
 - r. provides for systematic activities to monitor and evaluate the dental services rendered.
2. Contractor shall provide to the Department a written description of its Quality Assurance Plan (QAP) for the provision of clinical services (e.g., medical, medically related services, care coordination, Care Management, Disease Management, and behavioral health services). This written description must meet federal and State requirements:
- a. Goals and objectives — The written description shall contain a detailed set of QA objectives that are developed annually and include a workplan and timetable for implementation and accomplishment.
 - b. Scope — The scope of the QAP shall be comprehensive, addressing both the quality of clinical care and the quality of non-clinical aspects of service, such as and including: availability, accessibility, coordination, and continuity of care.
 - c. Methodology — The QAP methodology shall provide for review of the entire range of care provided, by assuring that all demographic groups, care settings, (e.g., inpatient, ambulatory, and home care), and types of services (e.g., preventive, primary, specialty care, behavioral health, dental and ancillary services) are included in the scope of the review. Documentation of the monitoring and evaluation plan shall be provided to the Department.
 - d. Activities — The written description shall specify quality of care studies and other activities to be undertaken over a prescribed period of time, and methodologies and organizational arrangements to be used to accomplish them. Individuals responsible for the studies and other activities shall be clearly identified in the written workplan and shall be appropriately skilled or trained to undertake such tasks. The written description shall provide for continuous performance of the activities, including tracking of issues over time.
 - e. Provider review — The written description shall document how Physicians and other health professionals will be involved in reviewing quality of care and the provision of health services and how feedback to health professionals and Contractor staff regarding performance and Enrollee results will be provided.
 - f. Focus on health outcomes — The QAP methodology shall address health outcomes; a complete description of the methodology shall be fully documented and provided to Department.
 - g. Systematic process of quality assessment and improvement — The QAP shall objectively and systematically monitor and evaluate the quality, appropriateness of, and timely access to, care and service to Enrollees, and pursue opportunities for improvement on an ongoing basis. Documentation of the monitoring activities and evaluation plan shall be provided to the Department.
 - h. Enrollee and advocate input --- The QAP shall detail its operational and management plan for including Enrollee and advocate input into its QAP processes.
3. Contractor shall provide the Department with the QAP written guidelines which delineate the QA process, specifying:
- a. Clinical areas to be monitored:
 - i. The monitoring and evaluation of clinical care shall reflect the population served by Contractor in terms of age groups, disease categories, and special risk status, and shall include quality improvement initiatives, as determined appropriate by Contractor or as required by the Department.
 - ii. The QAP shall, at a minimum, monitor and evaluate care and services in certain priority clinical areas of interest specified by the Department, based on the needs of Enrollees.
 - iii. At its discretion or as required by the Department, Contractor's QAP must monitor and evaluate other important aspects of care and service, including coordination with community resources.

- iv. At a minimum, the following areas shall be monitored:
 - a) For all populations:
 - 1. Emergency room utilization.
 - 2. Inpatient hospitalization.
 - 3. Thirty (30)-day readmission rate.
 - 4. Assistance to Enrollees accessing services outside the Covered Services, such as housing, social service agencies, senior center.
 - 5. Health education provided.
 - 6. Coordination of primary and specialty care.
 - 7. Coordination of care, Care Management, Disease Management, and other activities.
 - 8. Individualized Care Plan.
 - 9. Utilization of dental benefits.
 - 10. Preventive health care for adults (e.g., annual health history and physical exam; mammography; papanicolaou test, immunizations).
 - 11. PCP or behavioral health follow-up after emergency room or inpatient hospitalization.
 - c) For Chronic Health Conditions (such conditions specifically including, without limitation, diabetes, asthma, CHF, CAD, COPD, Behavioral Health, including those with one or more co-morbidities). Appropriate treatment, follow-up care, and coordination of care, Care Management and Disease Management for all Enrollees.
 - 1. Identification of Enrollees with special health care needs and processes in place to assure adequate, ongoing risk assessments, treatment plans developed with the Enrollee's participation in consultation with any specialists caring for the Enrollee, to the extent possible, the appropriateness and quality of care, and if approval is required, such approval occurs in a timely manner.
 - 2. Care coordination, Care Management, Disease Management, and Chronic Health Conditions action plan, as appropriate.
 - d) For behavioral health:
 - 1. Behavioral health network adequate to serve the behavioral health care needs of Enrollees, including mental health and substance abuse services sufficient to provide care within the community in which the Enrollee resides.

2. Assistance sufficient to access behavioral health services, including transportation and escort services.
3. Enrollee access to timely behavioral health services.
4. An Individualized Care Plan or treatment and provision of appropriate level of care;
5. Coordination of care between Providers of medical and behavioral health services to assure follow-up and continuity of care
6. Involvement of the PCP in aftercare.
7. Enrollee satisfaction with access to and quality of behavioral health services
8. Mental health outpatient and inpatient utilization, and follow up.
9. Chemical dependency outpatient and inpatient utilization, and follow up.

e) For pregnant women:

1. Timeliness and frequency of prenatal visits.
2. Provision of ACOG recommended prenatal screening tests.
3. Birth outcomes.
4. Referral to the Perinatal Centers, as appropriate.
5. Length of hospitalization for the mother.
6. Length of newborn hospital stay for the infant.
7. Assist the Enrollee in finding an appropriate PCP for the infant.

f) For Enrollees in Nursing Facilities and Enrollees receiving HCBS Waiver services:

1. Maintenance in, or movement to, community living.
2. Number of hospitalizations and length of hospital stay.
3. Falls resulting in hospitalizations.
4. Behavior resulting in injury to self or others.
5. Enrollee non-compliance of services.
6. Medical errors resulting in hospitalizations.
7. Occurrences of pressure ulcers, weight loss, and infections.

b. Use of Quality Indicators — Quality indicators are measurable variables relating to a specified clinical area, which are reviewed over a period of time to monitor the process of outcomes of care delivered in that clinical area:

- i. Contractor shall identify and use quality indicators that are objective, measurable, and based on current knowledge and clinical experience.

- ii. Contractor shall document that methods and frequency of data collected are appropriate and sufficient to detect the need for a program change.
 - iii. For the priority clinical areas specified by the Department, Contractor shall monitor and evaluate quality of care through studies which address, but are not limited to, the quality indicators also specified by the Department.
- c. Analysis of clinical care and related services, including behavioral health, Long-Term Care and HCBS Waiver services: Appropriate clinicians shall monitor and evaluate quality through review of individual cases where there are questions about care, and through studies analyzing patterns of clinical care and related service.
 - ii. Multi-disciplinary teams shall be used, where indicated, to analyze and address systems issues.
 - iii. Clinical and related service areas requiring improvement shall be identified and documented, and a corrective action plan shall be developed and monitored.
- d. Conduct Performance Improvement Projects (PIPs)/Quality Improvement Projects (QIPs) ---- PIPs/QIPs (42 C.F.R. 438.240 (1) (d)), shall be designed to achieve, through ongoing measurements and intervention, significant improvement of the quality of care rendered, sustained over time, and resulting in a favorable effect on health outcome and Enrollee satisfaction. Performance measurements and interventions shall be submitted to the Department annually as part of the QA/UR/PR Annual Report and at other times throughout the year upon request by the Department. If Contractor implements a PIP/QIP that spans more than one (1) year, Contractor shall report annually the status of such project and the results thus far. The PIPs/QIPs topics and methodology shall be submitted to the Department for Prior Approval.
- e. Implementation of Remedial or Corrective Actions — The QAP shall include written procedures for taking appropriate remedial action whenever, as determined under the QAP, inappropriate or substandard services are furnished, including in the area of behavioral health, or services that should have been furnished were not. Quality Assurance actions that result in remedial or corrective actions shall be forwarded by Contractor to the Department on a timely basis. Written remedial or corrective action procedures shall include:
 - i. specification of the types of problems requiring remedial or corrective action;
 - ii. specification of the person(s) or entity responsible for making the final determinations regarding quality problems;
 - iii. specific actions to be taken;
 - iv. a provision for feedback to appropriate health professionals, providers and staff;
 - v. the schedule and accountability for implementing corrective actions;
 - vi. the approach to modifying the corrective action if improvements do not occur; and
 - vii. procedures for notifying a PCP group that a particular Physician is no longer eligible to provide services to Enrollees.
- f. Assessment of Effectiveness of Corrective Actions — Contractor shall monitor and evaluate corrective actions taken to assure that appropriate changes have been made. Contractor shall assure follow-up on identified issues to ensure that actions for improvement have been effective and provide documentation of the same.
- g. Evaluation of Continuity and Effectiveness of the QAP:
 - i. At least annually, Contractor shall conduct a regular examination of the scope and content of the QAP (42 C.F.R. 438.240 (1)(i)(ii)) to ensure that it covers all types of services, including behavioral health services, in all settings, through an Executive Summary and Overview of the Quality Improvement Program, including Quality Assurance (QA), Utilization Review (UR) and Peer Review (PR).
 - ii. At the end of each year (as specified in Attachment XIII), a written report on the QAP shall be prepared by Contractor and submitted to the Department as a component part of the QA/UR/PR Annual Report. The report shall include an Executive Summary that provides a high-level discussion/analysis of each area of the Annual Report of findings, accomplishments, barriers and continued need for quality improvement. The report shall, at a minimum, provide detailed analysis of each of the following:
 - a)

- b) QA/UR/PR Plan with overview of goal areas;
- c) Major Initiatives to comply with the State Quality Strategy,
- d) Quality Improvement and work plan monitoring;
- e) Provider Network Access and Availability and Service Improvements, including access and utilization of dental services;
- f) Cultural Competency;
- g) Fraud and Abuse Monitoring;
- h) Population Profile;
- i) Improvements in Care Management and Clinical Services/Programs;
- j) Findings on Initiatives and Quality Reviews;
- k) Effectiveness of Quality Program Structure;
- l) Comprehensive Quality Improvement Work Plans;
- m) Chronic Conditions;
- n) Behavioral Health (includes mental health and substance abuse services);
- o) Discussion of Health Education Program;
- p) Member Satisfaction;
- q) Enrollee Safety;
- r) Fraud, Waste and Abuse and Privacy and Security; and
- s) Delegation.

4. Contractor shall have a QAP Committee. Contractor shall have a governing body to which the QA Committee shall be held accountable ("Governing Body"). The Governing Body of Contractor shall be the Board of Directors or, where the Board's participation with quality improvement issues is not direct, a designated committee of the senior management of Contractor. This Board of Directors or Governing Body shall be ultimately responsible for the execution of the QAP. However, changes to the medical Quality Assurance Program shall be made by the chair of the QA Committee. Responsibilities of the Governing Body include:
 - a. Oversight of QAP — Contractor shall document that the Governing Body has approved the overall Quality Assurance Program and an annual QAP.
 - b. Oversight Entity — The Governing Body shall document that it has formally designated an accountable entity or entities within the organization to provide oversight of QA, or has formally decided to provide such oversight as a committee of the whole.
 - c. QAP Progress Reports — The Governing Body shall routinely receive written reports from the QAP Committee describing actions taken, progress in meeting QA objectives, and improvements made.
 - d. Annual QAP Review — The Governing Body shall formally review on a periodic basis (but no less frequently than annually) a written report on the QAP which includes: studies undertaken, results, subsequent actions, and aggregate data on utilization and quantity of services rendered, to assess the QAP's continuity, effectiveness and current acceptability. Behavioral health shall be included in the Annual QAP Review.
 - e. Program Modification — Upon receipt of regular written reports from the QAP Committee delineating actions taken and improvements made, the Governing Body shall take action when appropriate and direct that the operational QAP be modified on an ongoing basis to accommodate review findings and issues of concern within Contractor. This activity shall be documented in the minutes of the meetings of the Governing Board in sufficient detail to demonstrate that it has directed and followed up on necessary actions pertaining to Quality Assurance.

5. The QAP shall delineate an identifiable structure responsible for performing QA functions within Contractor. Contractor shall describe its committees' structure in its QAP and shall be submitted to the Department for approval. This committee or committees and other structure(s) shall have:
 - a. Regular Meetings — The QAP Committee shall meet on a regular basis with specified frequency to oversee QAP activities. This frequency shall be sufficient to demonstrate that the structure/committee is following-up on all findings and required actions, but in no case shall such meetings be held less frequently than quarterly. A copy of the meeting summaries/minutes shall be submitted to the Department no later than thirty (30) days after the close of the quarterly reporting period.
 - b. Established Parameters for Operating — The role, structure and function of the QAP Committee shall be specified.
 - c. Documentation — There shall be records kept documenting the QAP Committee's activities, findings, recommendations and actions.

- d. Accountability — The QAP Committee shall be accountable to the Governing Body and report to it on a scheduled basis on activities, findings, recommendations and actions.
 - e. Membership – there shall be active participation in the QAP Committee as set forth in Section 1.18.109 of the RFP.
 - f. Enrollee Advisory Committee and Community Stakeholder Committee – There shall be an Enrollee Advisory Committee and Community Stakeholder Committee that will provide feedback to the QAP Committee on the Plan's performance from Enrollee and community perspectives. These committees shall recommend program enhancements based on Enrollee and community needs; review Provider and Enrollee satisfaction survey results; evaluate performance levels and telephone response timelines; evaluate access and provider feedback on issues requested by the QAP Committee; identify key program issues; such as disparities, that may impact community groups; and offer guidance on reviewing Enrollee materials and effective approaches for reaching enrollees. The Enrollee Advisory Committee will be comprised of randomly selected Enrollees, family members and other caregivers. The Community Stakeholder Committee will be comprised of local representation from key community stakeholders such as churches, advocacy groups, and other community-based organizations. Contractor will educate Enrollees and community stakeholders about these committees through materials such as handbooks, newsletters, websites and communication events.
6. There shall be a designated Quality Management Coordinator, as set forth in Section 3.3.1.3 of the RFP. Contractor's Medical Director shall have substantial involvement in QA activities and shall be responsible for the required reports.
- a. Adequate Resources — The QAP shall have sufficient material resources, and staff with the necessary education, experience, or training, to effectively carry out its specified activities.
 - b. Provider Participation in the QAP
 - i. Affiliated Physicians and other Affiliated Providers shall be kept informed about the written QAP.
 - ii. Contractor shall include in all agreements with Affiliated Provider and Subcontractors a requirement securing cooperation with the QAP.
 - iii. Contracts shall specify that Affiliated Providers and Subcontractors will allow access to the medical records of its Enrollees to Contractor.
7. Contractor shall remain accountable for all QAP functions, even if certain functions are delegated to other entities. If Contractor delegates any QA activities to subcontractors:
- a. There shall be a written description of the following: the delegated activities; the subcontractor's accountability for these activities; and the frequency of reporting to Contractor.
 - b. Contractor shall have written procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the actual quality of care being provided.
 - c. Contractor shall be held accountable for subcontractor's performance and must assure that all activities conform to this Contract's requirements.
 - d. There shall be evidence of continuous and ongoing evaluation and oversight of delegated activities, including approval of quality improvement plans and regular specified reports, as well as a formal review of such activities. Oversight of delegated activities must include no less than an annual audit, analyses of required reports and Encounter Data, a review of Enrollee complaints, Grievances, Provider complaints and appeals, and quality of care concerns raised through Encounter Data, monitoring activities, or other venues. Outcomes of the annual audit shall be submitted to the Department as part of the QA/UR/PR Annual Report.
 - e. Contractor shall be responsible for, directly or through monitoring of delegated activities, credentialing and re-credentialing, and shall review such credentialing files performed by the delegated entity no less than annually, as part of the annual audit.
 - f. If Contractor or subcontractor identifies areas requiring improvement, Contractor and subcontractor, as appropriate, shall take corrective action and implement a quality improvement initiative. If one or more deficiencies are identified, the subcontractor must develop and implement a corrective action plan, with protections put in place by Contractor to prevent such deficiencies from reoccurring. Evidence of ongoing monitoring of the delegated activities sufficient to assure corrective action shall be provided to the Department through quarterly or annual reporting.
8. The QAP shall contain provisions to assure that Affiliated Physicians and other Affiliated Providers, are qualified to perform their services and are credentialed by Contractor. Recredentialing shall occur at least once every three (3) years. Contractor's written policies shall include procedures for selection and retention of Physicians and other Providers.

9. All services provided by or arranged to be provided by Contractor shall be in accordance with prevailing professional community standards. All clinical practice guidelines shall be based on established evidence-based best practice standards of care, promulgated by leading academic and national clinical organizations, and shall be adopted by Contractor's QAP Committee with sources referenced and guidelines documented in Contractor's QAP. Contractor's QAP shall be updated no less than annually and when new significant findings or major advancements in evidence-based best practices and standards of care are established. Contractor shall provide ongoing education to Affiliated Providers on required clinical guideline application and provide ongoing monitoring to assure that its Affiliated Providers are utilizing them. At a minimum, clinical practice guidelines and best practice standards of care shall be adopted by Contractor for the following conditions and services:
 - a. Asthma;
 - b. Congestive Heart Failure (CHF);
 - c. Coronary Artery Disease (CAD);
 - d. Chronic Obstructive Pulmonary Disease (COPD);
 - e. Diabetes;
 - f. Adult Preventive Care;
 - g. Smoking Cessation;
 - h. Behavioral Health (mental health and substance abuse) screening, assessment, and treatment, including medication management and PCP follow-up;
 - i. Psychotropic medication management;
 - j. Clinical Pharmacy Medication Review;
 - k. Coordination of community support and services for Enrollees in HCBS Waivers;
 - l. Dental services;
 - m. Community reintegration and support; and
 - n. Long-term Care (LTC) residential coordination of services.
10. Contractor shall put a basic system in place which promotes continuity of Care Management. Contractor shall provide documentation on:
 - a. Monitoring the quality of care across all services and all treatment modalities.
 - b. Studies, reports, protocols, standards, worksheets, minutes, or such other documentation as may be appropriate, concerning its QA activities and corrective actions and make such documentation available to the Department upon request.
11. The findings, conclusions, recommendations, actions taken, and results of the actions taken as a result of QA activity, shall be documented and reported to appropriate individuals within the organization and through the established QA channels. Contractor shall document coordination of QA activities and other management activities.
 - a. QA information shall be used in recertification, recontracting and annual performance evaluations.
 - b. QA activities shall be coordinated with other performance monitoring activities, including utilization management, risk management, and resolution and monitoring of Enrollee Complaints and Grievances.
 - c. There shall be a linkage between QA and the other management functions of Contractor such as:
 - i. network changes.
 - ii. benefits redesign.
 - iii. medical management systems (e.g., pre-certification).
 - v. practice feedback to Physicians.
 - vi. other services, such as dental, vision, etc.
 - vii. member services.
 - viii. Care Management, disease management.

ix. Enrollee education.

- d. In the aggregate, without reference to individual Physicians or Enrollee identifying information, all Quality Assurance findings, conclusions, recommendations, actions taken, results or other documentation relative to QA shall be reported to Department on a quarterly basis or as requested by the Department. The Department shall be notified of any Provider or Subcontractor who ceases to be an Affiliated Provider or Subcontractor for a quality of care issue.
12. Contractor shall, at the direction of the Department, cooperate with the external, independent quality review process conducted by the EQRO. Contractor shall address the findings of the external review through its Quality Assurance Program by developing and implementing performance improvement goals, objectives and activities, which shall be documented in the next quarterly report submitted by Contractor following the EQRO's findings.
 13. Contractor's Quality Assurance Program shall systematically and routinely collect data to be reviewed for quality oversight, monitoring of performance, and Enrollee care outcomes. The Quality Assurance Program shall include provision for the interpretation and dissemination of such data to Contractor's Affiliated Providers. The Quality Assurance Program shall be designed to perform quantitative and qualitative analytical activities to assess opportunities to improve efficiency, effectiveness, appropriate health care utilization, and Enrollee health status, per 42 C.F.R. 438.242 (2). Contractor shall ensure that data received from Providers and included in reports are accurate and complete by (1) verifying the accuracy and timeliness of reported data; (2) screening the data for completeness, logic, and consistency; and (3) collecting service information in standardized formats to the extent feasible and appropriate. Contractor shall have in effect a program consistent with the utilization control requirements of 42 C.F.R. Part 456. This program will include, when required by the regulations, written plans of care and certifications of need of care.
 14. Contractor shall perform and report the quality and utilization measures identified in Table 1 – Performance Measures using the HEDIS® and HEDIS®-like Performance Measure Specifications methodology, as provided by the Department. Contractor shall not modify the reporting specifications methodology prescribed by the Department without first obtaining the Department's written approval. Contractor must obtain an independent validation of its HEDIS® and HEDIS®-like findings by a recognized entity, e.g., NCQA-certified auditor, as approved by the Department. The Department's External Quality Review Organization will perform an independent validation of at least a sample of Contractor's findings. **(Note: the above reference to Table 1 can be found at Attachment D of this RFP.)**
 15. Contractor shall monitor other Performance Measures not specifically stated in Attachment XI that are required by Federal CMS. The Department will use its best efforts to notify Contractor of new Federal CMS requirements.

Attachment

Utilization Review/Peer Review

(Utilization Review/Peer Review attachment is subject to change as a result of the negotiation of the memorandum of understanding between the Department and CMS.)

1. Contractor shall have a utilization review and peer review committee(s) whose purpose will be to review data gathered and the appropriateness and quality of care. The committee(s) shall review and make recommendations for changes when problem areas are identified and report suspected Fraud and Abuse in the HFS Medical Program to the Department's Office of Inspector General. The committees shall keep minutes of all meetings, the results of each review and any appropriate action taken. A copy of the minutes shall be submitted to the Department no later than thirty (30) days after the close of the quarterly reporting period. At a minimum, these programs must meet all applicable federal and State requirements for utilization review. Contractor and the Department may further define these programs.
2. Contractor shall implement a Utilization Review Plan, including medical and dental peer review as required. Contractor shall provide the Department with documentation of its utilization review process. The process shall include:
 - a. Written program description — Contractor shall have a written Utilization Management Program description which includes, at a minimum, procedures to evaluate medical necessity criteria used and the process used to review and approve the provision of medical services.
 - b. Scope — The program shall have mechanisms to detect under-utilization as well as over-utilization.
 - c. Preauthorization and concurrent review requirements — For organizations with preauthorization and concurrent review programs:
 - i. Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions;
 - ii. Utilize practice guidelines that have been adopted, pursuant to Exhibit.
 - iii. Review decisions shall be supervised by qualified medical professionals and any decision to deny a Service Authorization Request or to authorize a service in an amount, duration or scope that is less than requested must be made by a health care professional who has appropriate clinical expertise in treating the Enrollee's condition or disease;
 - iv. Efforts shall be made to obtain all necessary information, including pertinent clinical information, and consultation with the treating Physician, as appropriate;
 - v. The reasons for decisions shall be clearly documented and available to the Enrollee and the requesting Provider, provided, however, that any decision to deny a service request or to authorize a service in an amount, duration or scope that is less than requested shall be furnished in writing to the Enrollee;
 - vi. There shall be written well-publicized and readily available Appeal mechanisms for both Providers and Enrollees;
 - vii. Decisions and appeals shall be made in a timely manner as required by the circumstances and shall be made in accordance with the timeframes specified in this Contract for standard and expedited authorizations;
 - viii. There shall be mechanisms to evaluate the effects of the program using data on Enrollee satisfaction, Provider satisfaction or other appropriate measures;
 - ix. If Contractor delegates responsibility for utilization management, it shall have mechanisms to ensure that these standards are met by the subcontractor.
3. Contractor further agrees to review the utilization review procedures, at regular intervals, but no less frequently than annually, for the purpose of amending same, as necessary in order to improve said procedures. All amendments must receive Prior Approval. Contractor further agrees to supply the Department and its designee with the utilization information and data, and reports prescribed in its approved utilization review system or the status of such system. This information shall be furnished in accordance to Attachment XIII of this Contract or upon request by the Department.

4. Contractor shall establish and maintain a peer review program, subject to Prior Approval, to review the quality of care being offered by Contractor, employees and subcontractors. This program shall provide, at a minimum, the following:
 - a. A peer review committee comprised of Physicians and dentists, formed to organize and proceed with the required reviews for both the health professionals of Contractor's staff and any Affiliated Providers which include:
 - i. A regular schedule for review;
 - ii. A system to evaluate the process and methods by which care is given; and
 - iii. A medical record review process.
 - b. Contractor shall maintain records of the actions taken by the peer review committee with respect to Providers and those records shall be available to the Department upon request.
 - c. A system of internal medical review, including behavioral health services, waiver and long term care services, medical evaluation studies, peer review, a system for evaluating the processes and outcomes of care, health education, systems for correcting deficiencies, and utilization review.
 - d. At least two (2) medical evaluation studies must be completed annually that analyze pressing problems identified by Contractor, the results of such studies and appropriate action taken. One of the studies may address an administrative problem noted by Contractor and one may address a clinical problem or diagnostic category. One brief follow-up study shall take place for each medical evaluation study in order to assess the actual effect of any action taken. Contractor's medical evaluation studies' topic and design must receive Prior Approval.
 - e. Contractor shall participate in the annual collaborative PIPS/QIPs, as mutually agreed upon and directed by the Department.
5. Contractor further agrees to review the peer review procedures, at regular intervals, but no less frequently than annually, for the purpose of amending same in order to improve said procedures. All amendments must be approved by the Department. Contractor shall supply the Department and its designee with the information and reports related to its peer review program upon request.
6. The Department may request that peer review be initiated on specific Providers.
7. The Department may conduct its own peer reviews at its discretion.

Attachment ____

Required Deliverables, Submissions and Reporting

To be Completed

Attachment ____
Data Security Connectivity Specifications

As used in this Attachment, "CMS" means the Illinois Department of Central Management Services, and "Vendor" means Contractor.

Third Party Network (TPN) or Internet Connection

The line connection to the CMS data center must either be through the private State telecommunications network to the CMS Third Party Network (TPN) or through a secure connection via the Internet. A secure connection over the Internet will require a Site-to-Site Virtual Private Network (VPN) or the use of SSL sessions depending upon the communication requirements.

Private State Telecommunications Network Requirements

If the Vendor chooses to connect through the private State telecommunications network, Contractor site terminating dedicated network connection must be located within the State of Illinois. HFS must submit the orders to CMS for processing, design, installation and configuration of the connection for the Vendor. The Vendor must supply information concerning the circuit termination point, onsite contact, and other information required for the order to be submitted to CMS for processing and installation by the appropriate CMS contractor. The Vendor must provide authorized HFS' personnel access to the location and the phone demark for the location where the circuit is to be installed. The vendor must provide space and power for a State of Illinois managed router to be installed at the site.

Internet Site-to-Site VPN Requirements

If the Vendor chooses to connect through secure connections via the Internet, the connection may be made using a Site-to-Site VPN. In this type of connection, the Vendor will be responsible for the cost of the connection between the Vendor and its Internet Service Provider (ISP), troubleshooting and any redundancy requirements associated with the Vendor's connection to the Internet or for Disaster recovery. The vendor will also be responsible to procure, install, and support, any VPN equipment required at the Vendor's location to support secure Site-to-Site VPN communications via the Internet with CMS.

HFS will coordinate with the Vendor to ensure that any authorization/certificate paperwork required for the establishment of the VPN connection is completed. CMS currently utilizes a Cisco 7600 series router with IPSEC accelerators to provide VPN connections to the CMS data center. For VPN authentication, CMS uses "pre-shared keys". Only STATIC IP addresses, no subnet pool addresses, from the Vendor's network are allowed by CMS.

CMS Supported Encryption Configurations

Phase 1 IKE Properties (ISAKMP Protection Suites)

- Encryption Algorithm.
- Triple-DES (3DES).
- Advanced Encryption Standard (AES) preferred
- Data Integrity.
- Hashing Algorithm: SHA or MD5 supported (MD5 is preferred).
- Diffie-Hellman Group: Group 5 supported only.
- Security Association Lifetime: 86400 seconds.

Phase 2 IPSEC Properties:

- Encryption Algorithm.
- Triple-DES (3DES).
- Advanced Encryption Standard (AES) preferred
- Data Integrity.
- Hashing Algorithm: SHA or MD5 supported (MD5 is preferred).
- Perfect Forward Secrecy: Disabled.

Internet SSL/TLS Requirements for File Transfer Protocol

If the Vendor's only communication requirement is to send or receive data files, the connection may be made using secure FTP (FTPS) via the Internet. The Vendor will be responsible for the cost of the connection between the Vendor and its Internet Service Provider (ISP), troubleshooting and any redundancy requirements associated with the Vendor's connection to the Internet or for Disaster recovery. The Vendor is responsible for any costs associated with obtaining a secure FTP client that supports SSL/TLS. The Vendor will be responsible for initiating the secure FTP sessions to the CMS Data Center and perform any necessary firewall changes to reach the provided IP address and ftp control and data ports.

Exchanging Configuration Information

HFS will work with the Vendor to determine the configuration and define any connection parameters between the Vendor and the CMS data center. This will include any security requirements CMS requires for the specific connection type the Vendor is using. The Vendor is required to work with both HFS and CMS in exchanging configuration information required to make the connection secure and functional for all parties.

Transmission Control Protocol/Internet Protocol (TCP/IP)

The Vendor shall cooperate in the coordination of the interface with CMS and HFS. TCP/IP (Transmission Control Protocol/Internet Protocol) must be used for all connections from the Vendor to the CMS data center.

Firewall Devices

The Vendor shall be responsible for the installation, configuration, and troubleshooting of any firewall devices required on the Vendor's side of the data communication link.

Attachment __
Contract Monitors

For CMS:

Telephone:
Fax:
Email:

For the Department:

Michelle Maher
Bureau of Managed Care
Illinois Department of Healthcare and Family Services
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Springfield, IL 62763

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For Contractor:

Telephone:
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Email:

RFP Attachment A - Mandated Reporting

Mandated reporters are required to report suspected maltreatment immediately when they have reasonable cause to believe that an individual known to them in their professional or official capacity may be Abused or Neglected. Although anyone may make a report, mandated reporters are professionals who may work with children, elderly, or persons with disabilities. The following outlines the Abuse, Neglect and exploitation reporting requirements for Illinois citizens.

Children (Under the age of 18)

As mandated by the Abused and Neglected Child Reporting Act (325 ILCS 5/4), persons required to report Abuse and Neglect of children and youth under the age of 18 includes:

1. Medical Personnel: Physicians, physician assistants, psychiatrists, surgeons, residents, interns, dentists, dentist hygienists, pathologists, osteopaths, coroners, medical examiners, Christian Science practitioners, respiratory care practitioners, chiropractors, podiatrists, acupuncturists, registered and licensed practical nurses, advanced practice nurses, emergency medical technicians, hospital administrators and other personnel involved in the examination, care or treatment of patients.
2. School and Child Care Personnel: Teachers, school personnel, educational advocates assigned to a child pursuant to the School Code, truant officers, directors and staff assistants of day care centers and nursery schools, and child care workers.
3. Law Enforcement: Truant officers, probation officers, law enforcement officers, and field personnel of the Department of Corrections.
4. State Agencies: Field personnel from the Departments of Children and Family Services, Healthcare and Family Services, Juvenile Justice, Public Health, Human Services (acting as successor to the Department of Mental Health and Developmental Disabilities, Rehabilitation Services, or Public Aid), Corrections, Human Rights, or Children and Family Services, supervisor and administrator of general assistance under the Illinois Public Aid Code, probation officers, animal control officers or Illinois Department of Agriculture Bureau of Animal Health and Welfare field investigators.
5. Others: Social workers, social service administrators, substance abuse treatment personnel, domestic violence program personnel, crisis line or hotline personnel, foster parents, homemakers, home health aides, funeral home director or employee, licensed professional counselors, licensed clinical professional counselors, genetic counselors, recreational program or facility personnel, registered psychologists and assistants working under the direct supervision of a psychologist, members of the clergy.

A full version of the Abused and Neglected Child Reporting Act can be found on the Illinois General Assembly website at the following hyperlink: [325 ILCS 5/](#)

Reporting Procedures

The types of critical incidents that must be reported include any specific incident of Abuse or Neglect or a specific set of circumstances involving suspected Abuse or Neglect, where there is demonstrated harm to the child or a substantial risk of physical or sexual injury to the child. Critical incidents must be reported if the alleged perpetrator is a parent, guardian, foster parent, relative caregiver, paramour, any individual residing in the same home, any person responsible for the child's welfare at the time of the alleged Abuse or Neglect, or any person who came to know the child through an official capacity or position of trust (for example: health care professionals, educational personnel, recreational supervisors, members of the clergy, volunteers or support personnel) in settings where children may be subject to Abuse and Neglect.

Mandated reporters are required to report suspected child maltreatment immediately when they have reasonable cause to believe that a child known to them in their professional or official capacity may be an Abused or Neglected child. This is done by calling the Department of Children and Family Services 24-hour Child Abuse Hotline 1-800-25-ABUSE or 1-800-358-5117 (TTY). Reports must be confirmed in writing to the local investigation unit within 48 hours after the hotline call.

Persons Age 18 through 59

For individuals aged 18 and older, mandated reporters under 59 Illinois Administrative Code 50 includes all Medicaid Agency and Operating Agency staff and all community agency employees (including payroll employees, contractual employees, volunteers, and subcontractors). More details on the Administrative Code may be found at the following hyperlink: [59 IL Adm. Code 50](#)

Reporting Procedures

At the time when the DRS central office is made aware of an incident, an HSP Counselor is assigned to the case. HSP counselors assist with reporting and remain involved in the case to ensure the customer is safe from harm and that an adequate plan of care is in place. DRS also works with each case until there is satisfactory resolution.

The DHS Office of the Inspector General, which is a semi-independent entity that reports to both the Governor and the Secretary of DHS, investigates alleged Abuse, Neglect and exploitation of adults with mental, developmental, or physical disabilities in private homes and of adults with mental or Developmental Disabilities in DHS-funded community agencies. To make a report of Abuse, Neglect, or exploitation, please call the DHS OIG Hotline at 1-800-368-1463 (voice and TTY)

The DHS Office of Inspector General Adults with Disabilities Abuse Project has statutory authority to respond to allegations related to Adults with Disabilities between the ages of 18 and 59 who reside in domestic situations. DHS OIG has authority to investigate, take emergency

action, work with local law enforcement authorities, obtain financial and medical records, and pursue guardianship. With the individual's consent, substantiated cases are referred to DHS for development of a service plan to meet identified needs.

Elderly (Age 60 and over)

Under the Elder Abuse and Neglect Act (*320 ILCS 202/f-5*), persons required as mandated reporters while carrying out their professional duties in working with the elderly population includes:

1. A professional or professional's delegate while engaged in:
 - 1.1. Social services
 - 1.2. Law enforcement
 - 1.3. Education
 - 1.4. The care of an eligible adult or eligible adults
 - 1.5. Any of the occupations required to be licensed under the Clinical Psychologist Licensing Act, the Clinical Social Work and Social Work Practice Act, the Illinois Dental Practice Act, the Dietetic and Nutrition Services Practice Act, the Marriage and Family Therapy Licensing Act, the Medical Practice Act of 1987, the Naprapathic Practice Act, the Nurse Practice Act, the Nursing Home Administrators Licensing and Disciplinary Act, the Illinois Occupational Therapy Practice Act, the Illinois Optometric Practice Act of 1987, the Pharmacy Practice Act, the Illinois Physical Therapy Act, the Physician Assistant Practice Act of 1987, the Podiatric Medical Practice Act of 1987, the Respiratory Care Practice Act, the Professional Counselor and Clinical Professional Counselor Licensing Act, the Illinois Speech-Language Pathology and Audiology Practice Act, the Veterinary Medicine and Surgery Practice Act of 2004, and the Illinois Public Accounting Act;
2. An employee of a vocational rehabilitation facility prescribed or supervised by the Department of Human Services;
3. An administrator, employee, or person providing services in or through an unlicensed community based facility;
4. Any religious practitioner who provides treatment by prayer or spiritual means alone in accordance with the tenets and practices of a recognized church or religious denomination, except as to information received in any confession or sacred communication enjoined by the discipline of the religious denomination to be held confidential;
5. Field personnel of the Department of Healthcare and Family Services, Department of Public Health, and Department of Human Services, and any county or municipal health department;
6. Personnel of the Department of Human Services, the Guardianship and Advocacy Commission, the State Fire Marshal, local fire departments, the Department on Aging and its subsidiary Area Agencies on Aging and provider agencies, and the Office of State Long Term Care Ombudsman;
7. Any employee of the State of Illinois not otherwise specified herein who is involved in providing services to eligible adults, including professionals providing medical or rehabilitation services and all other persons having direct contact with eligible adults;
8. A person who performs the duties of a coroner or medical examiner; or
9. A person who performs the duties of a paramedic or an emergency medical technician.

A full version of the Elder Abuse and Neglect Act can be found on the Illinois General Assembly website at the following hyperlink: [320 ILCS 20/](#)

Reporting Procedures

Persons can report suspected Abuse, Neglect or exploitation to DoA by utilizing the Elder Abuse Hotline number at 1-866-800-1409, available 24 hours a day, seven days a week. Reports may also be made directly to the local Elder Abuse Provider Agency in the service area.

DoA policy specifically states that if direct service workers witness or identify a case of possible Abuse or Neglect, they are mandated to personally report the allegations to the designated Elder Abuse Provider Agency or to DoA's Hotline numbers. DoA's Office of Elder Rights maintains a tracking system of ANE investigations and statistical reports are generated annually.

Persons with Developmental Disabilities in Residential Facilities

For individuals under the age of 18

For individuals under the age of 18, mandated reporters are those professionals identified in the Abused and Neglected Child Reporting Act (*325 ILCS 5/4*). Please see the section on Children (Under the age of 18) for requirements.

A full version of the Abused and Neglected Child Reporting Act can be found on the Illinois General Assembly website at the following hyperlink: [325 ILCS 5/](#)

For individuals aged 18 and older

For individuals aged 18 and older, mandated reporters under *59 Illinois Administrative Code 50* include all Medicaid Agency and Operating Agency staff and all community agency employees (including payroll employees, contractual employees, volunteers, and subcontractors).

More details on the Administrative Code may be found at the following hyperlink: [59 IL Adm. Code 50](#)

Reporting Procedures

The types of critical incidents that must be reported include any allegation of physical or mental Abuse, Neglect or financial exploitation committed by anyone against the Waiver participant. Unauthorized use of restraint, seclusion or restrictive interventions is considered Abuse and must be reported. Serious injuries that require treatment by a Physician or a nurse where Abuse or Neglect is suspected and medication errors that have an adverse outcome must be reported. Serious injuries that require treatment by a Physician or a nurse must be included in a quarterly quality assurance report to the Operating Agency.

Deaths must be reported if the death occurred while the individual was present in an agency program or if the death occurs within 14 days after discharge, transfer or deflection from the agency program. Deaths must be reported within 24 hours from the time the death was first discovered or the reporter was informed of the death (only four hours if Abuse or Neglect is suspected).

Anyone may make a report under either rule by calling the DHS Office of the Inspector General 24-hour hotline at 1-800-368-1463 (voice and TTY)

Mandated reporters must report the allegation within four hours after the time it was first discovered by the staff. Mandated reporters must report allegations if they are told about Abuse or Neglect, if they witness it, or if they suspect it.

Long Term Care Facility Residents

Persons required to make reports or cause reports to be made as defined by the Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30) include:

- Any long term care facility administrator, agent or employee
- Any Physician, hospital, surgeon, registered nurse, dentist, osteopath, chiropractor, podiatrist, coroner, social worker, social services administrator, or law enforcement officer
- Any accredited religious practitioner who provides treatment by spiritual means alone through prayer in accordance with the tenets and practices of the accrediting church
- Field personnel of the Department of Healthcare and Family Services and the Illinois Department of Public Health and County or Municipal Health Departments
- Personnel of the Department of Human Services (acting as the successor to the Department of Mental Health and Developmental Disabilities or the Department of Healthcare and Family Services), the Guardianship and Advocacy Commission, the State Fire Marshal, local fire department inspectors or other personnel, the Illinois Department on Aging or its subsidiary Agencies on Aging, or employee of a facility licensed under the Assisted Living and Shared Housing Act
- All employees of the State of Illinois who are involved in providing services to residents, including professionals providing medical or rehabilitation services and all other persons having direct contact with residents
- All employees of community service agencies who provide services to a resident of a public or private long term care facility outside of that facility.

Any long term care surveyor of the Illinois Department of Public Health who has reasonable cause to believe in the course of a survey that a resident has been Abused or Neglected and initiates an investigation while on site at the facility shall be exempt from making a report under this Section but the results of any such investigation shall be forwarded to the central register in a manner and form described by the Department.

In addition to the above persons required to report suspected resident Abuse and Neglect, any other person may make a report to the Department, or to any law enforcement officer, if such person has reasonable cause to suspect a resident has been Abused or Neglected.

A full version of the Abused and Neglected Long Term Care Facility Residents Reporting Act can be found on the Illinois General Assembly website at the following hyperlink: [210 ILCS 30/](#)

Reporting Procedures

The types of critical incidents that must be reported include any allegation of physical or mental Abuse, Neglect or financial exploitation committed by anyone against the Waiver participant. Unauthorized use of restraint, seclusion or restrictive interventions is considered Abuse and must be reported. Serious injuries that require treatment by a Physician or a nurse where Abuse or Neglect is suspected and medication errors that have an adverse outcome must be reported. Serious injuries that require treatment by a Physician or a nurse must be included in a quarterly quality assurance report to the Operating Agency.

Mandated reporters must report the allegation within four hours after the time it was first discovered by the staff. Mandated reporters must also report allegations if they are told about Abuse or Neglect, if they witness it, or if they suspect it. Reports are to be made to the Department of Public Health (DPH) Long Term Care/Nursing Home Hotline at 1-800-252-4343.

Deaths must be reported if the death occurred while the individual was present in an agency program or if the death occurs within 14 days after discharge, transfer or deflection from the agency program. Deaths must be reported within 24 hours from the time the death was first discovered or the reporter was informed of the death (only four hours if Abuse or Neglect is suspected).

RFP ATTACHMENT B
Medicaid Covered Services for Adults¹

- Advanced Practice Nurse services;
- Ambulatory Surgical Treatment Center services;
- Audiology services;
- Chiropractic services;
- Limited diagnostic, restorative, and treatment dental services per the Medicaid State Plan (See additional detail below);
- Family planning services and supplies;
- FQHCs, RHCs and other Encounter rate clinic visits;
- Home health agency visits;
- Hospital emergency room visits;
- Hospital inpatient services;
- Hospital ambulatory services;
- Laboratory and x-ray services;
- Medical supplies, equipment, prostheses and orthoses, and respiratory equipment and supplies;
- Mental health services provided under the Medicaid Clinic Option or Medicaid Rehabilitation Option;
- Nursing Facility services;
- Optical services and supplies;
- Optometrist services;
- Palliative and Hospice services;
- Pharmacy Services;
- Physical, Occupational and Speech Therapy services;
- Physician services;
- Podiatric services;
- Post-Stabilization Services;
- Renal Dialysis services;
- Respiratory Equipment and Supplies;
- Subacute alcoholism and substance abuse services pursuant to 89 Ill. Admin. Code Sections 148.340 through 148.390 and 77 Ill. Admin. Code Part 2090; and
- Transportation to secure Covered Services.

¹ Attachment B lists all Medicaid State Plan services. For Dual Eligible beneficiaries, Medicare is the primary payer for many of the services.

Addendum to Attachment B

Covered Dental Services for Adults	Adults (> age 20)	Requires Prior Approval
DIAGNOSTIC SERVICES		
Oral Exams (For adults, limited to 1 st visit per dentist.)	X	
X-rays	X	
Restorative Services		
Amalgams	X	
Resins	X	
Crowns (For adults, limited to facial front teeth only.)	X	Y
Sedative Fillings	X	
Endodontic Services		
Root Canals (For adults, limited to facial front teeth only.)	X	
Removable Prosthodontic Services		
Complete Denture (upper and lower)	X	Y
Denture Relines	X	Y
Maxillofacial Prosthetics	X	Y
Oral and Maxillofacial Services		
Extractions	X	
Surgical Extractions	X	Y
Adjunctive General Services		
General Anesthesia	X	Y
IV Sedation	X	Y
Nitrous Oxide	X	
Conscious Sedation	X	Y
Therapeutic Drug Injection	X	Y

RFP ATTACHMENT C
HOME AND COMMUNITY BASED SERVICES

Service	DoA	DHS-DRS			Definition	Standards	Service Limits
	Persons who are Elderly	Persons with Disabilities (PD)	Persons with HIV/AIDS	Persons with Brain Injury (BI)			
Adult Day Service	x	x	x	x	Adult day service is the direct care and supervision of adults in a community-based setting for the purpose of providing personal attention; and promoting social, physical and emotional well-being in a structured setting.	DOA: 89 Il. Adm. Code 240.1505-1590 Contract with Department on Aging, Contract requirements, DRS: 89 Il. Adm. Code 686.100	DOA, DRS The amount, duration, and scope of services is based on the service plan and is included in the service cost maximum/monthly cost limit. This service will not be duplicative of other services in the Waiver.
Adult Day Service Transportation	x	x	x	x	Agency provision or arrangement of transportation, with at least one vehicle physically accessible, to enable clients to receive adult day care service at the adult day care service provider's site and participate in sponsored outings.	DOA: 89 Il. Adm. Code 240.1505-1590 DRS: 89 Il. Adm. Code 686.100	DOA: Services are provided according to the plan of care within the service cost maximum. DRS: Will provide a maximum of two one-way trips per day.
Case Management (Administrative Claim)	x	x	x	x	Case management includes services that assist participants in gaining access to needed MFP, waiver and State Plan services, as well as medical, social, educational and other services, regardless of the funding source for the services. Responsibilities include assessment, care plan development and ongoing monitoring and review.	DOA: 89 Il. Adm. Code 240.1430 DRS PD: 89 Il. Adm. Code 220.605 DRS BI and HIV: http://www.ilga.gov/commission/jcar/admincode/089/08900686sections.html	

Service	DoA	DHS-DRS			Definition	Standards	Service Limits
	Persons who are Elderly	Persons with Disabilities (PD)	Persons with HIV/AIDS	Persons with Brain Injury (BI)			
Community Transition Services	X (MFP only)	X (MFP only)			<p>Community transition services are non-recurring set-up expenses for MFP participants who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses.</p> <p>Allowable expenses are those necessary to establish a basic household but that do not constitute room and board.</p>	<p>Enrolled vendor approved by the Service Facilitator and the participant/guardian</p>	<p>One-time transition services are viewed mainly to be one-time costs. In the event that the MFP participant should need the services after the twelve (12) month period of Money Follows the Person eligibility, Flexible Senior Spending (FSS) funds are available for the MFP participant's needs.</p> <p>No more than \$4,000 maximum may be spent per participant on Community Transition Services without the prior approval of the Community Reintegration Program (CRP) Manager or designee.</p>

Service	DoA	DHS-DRS			Definition	Standards	Service Limits
	Persons who are Elderly	Persons with Disabilities (PD)	Persons with HIV/AIDS	Persons with Brain Injury (BI)			
Environmental Accessibility Adaptations-Home	X (MFP only)	x	x	x	<p>Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require Institutionalization.</p> <p>Excluded are those adaptations or improvements to the home that are of general utility and are not of direct remedial benefit to the participant.</p>	<p>DOA and DRS: 89 Il. Adm. Code 686.705(d)</p>	<p>DOA – MFP Only Requests for Home Modifications in excess of the \$3,000 limit will be considered on a case-by-case basis by IDOA. Requests for Assistive technology in excess of the \$1,000 limit will be considered on a case-by-case basis by IDOA.</p> <p>DRS Environmental Accessibility Adaptations may be provided to a customer if the total cost for purchase of all environmental modifications and assistive equipment purchases, rentals, and repairs does not exceed \$25,000 over 5 years.</p>

Service	DoA	DHS-DRS			Definition	Standards	Service Limits
	Persons who are Elderly	Persons with Disabilities (PD)	Persons with HIV/AIDS	Persons with Brain Injury (BI)			
Supported Employment				x	Supported employment services consist of intensive, ongoing supports that enable participants, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need supports, to perform in a regular work setting. It may include assisting the participant to locate a job or develop a job on behalf of the participant, and is conducted in a variety of settings; including work sites where persons without disabilities are employed.	DHS: 89 Il. Adm. Code 530	BI When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by participants receiving waiver services as a result of their disabilities and will not include payment for the supervisory activities rendered as a normal part of the business setting. The amount, duration, and scope of services is based on the DON assessment conducted by the case manager and the service cost maximum determined by the DON score.
Home Health Aide (Extended State Plan service)		x	x	x	Service provided by an individual that meets Illinois licensure standards for a Certified Nursing Assistant (CNA) and provides services as defined in 42CFR 440.70, with the exception that limitations on the amount, duration, and scope of such services imposed by the State's approved Medicaid State Plan shall not be applicable.	DRS: Individual: 210 ILCS 45/3-206 Agency: 210 ILCS 55	Services provided are in addition to any services provided through the State Plan. The amount, duration, and scope of services is based on the DON assessment conducted by the case manager and the service cost maximum determined by the DON.

Service	DoA	DHS-DRS			Definition	Standards	Service Limits
	Persons who are Elderly	Persons with Disabilities (PD)	Persons with HIV/AIDS	Persons with Brain Injury (BI)			
Nursing, Intermittent (Extended State Plan service)		x	x	x	Nursing services that are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or a licensed practical nurse, licensed to practice in the state. Nursing through the waiver focuses on long term habilitative needs rather than short-term acute restorative needs. Intermittent nursing waiver services are in addition to any Medicaid State Plan nursing services for which the participant may qualify.	DRS: Home Health Agency: 210 ILCS 55 Licensed Practical Nurse: 225 ILCS 65 Registered Nurse: 225 ILCS 65	The amount, duration, and scope of services is based on the DON assessment conducted by the case manager and the service cost maximum determined by the DON score. All waiver clinical services require a prescription from a Physician. The duration and/or frequency of these services are dependent on continued authorization of the Physician, and relevance to the customer's service plan.
Nursing, Skilled (RN and LPN) (Extended State Plan service)		x	x	x	Service provided by an individual that meets Illinois licensure standards for nursing services and provides shift nursing services.	DRS: Home Health Agency: 210 ILCS 55 Licensed Practical Nurse: 225 ILCS 65 Registered Nurse: 225 ILCS 65	DRS The amount, duration, and scope of services is based on the DON score and service cost maximum level.
Occupational Therapy (Extended State Plan service)		x	x	x	Service provided by a licensed occupational therapist that meets Illinois standards. Services are in addition to any Medicaid State Plan services for which the participant may qualify. Occupational therapy through the waiver focuses on long term habilitative needs rather than short-term acute restorative needs	DRS: Occupational Therapist: 225 ILCS 75 Home Health Agency: 210 ILCS 55	DRS All waiver clinical services require a prescription from a Physician. The duration and/or frequency of these services are dependent on continued authorization of the Physician, and relevance to the customer's service plan. The amount, duration, and scope of services is based on the DON score and service cost maximum level.

Service	DoA	DHS-DRS			Definition	Standards	Service Limits
	Persons who are Elderly	Persons with Disabilities (PD)	Persons with HIV/AIDS	Persons with Brain Injury (BI)			
Physical Therapy (Extended State Plan service)		x	x	x	Service provided by a licensed physical therapist that meets Illinois standards. Services are in addition to any Medicaid State Plan services for which the participant may qualify. Physical Therapy through the waiver focuses on long term habilitative needs rather than short-term acute restorative needs.	DRS: Physical Therapist 225 ILCS 90 Home Health Agency: 210 ILCS 55	DRS All waiver clinical services require a prescription from a Physician. The duration and/or frequency of these services are dependent on continued authorization of the Physician, and relevance to the customer's service plan. The amount, duration, and scope of services is based on the DON score and service cost maximum level.
Speech Therapy (Extended State Plan service)		x	x	x	Service provided by a licensed speech therapist that meets Illinois standards. Services are in addition to any Medicaid State Plan services for which the participant may qualify. Speech Therapy through the waiver focuses on long term Habilitation needs rather than short-term acute restorative needs.	DRS: Speech Therapist 225 ILCS 110 Home Health Agency: 210 ILCS 55	DRS All waiver clinical services require a prescription from a Physician. The duration and/or frequency of these services are dependent on continued authorization of the Physician, and relevance to the customer's service plan. The amount, duration, and scope of services is based on the DON score and service cost maximum level.

Service	DoA	DHS-DRS			Definition	Standards	Service Limits
	Persons who are Elderly	Persons with Disabilities (PD)	Persons with HIV/AIDS	Persons with Brain Injury (BI)			
Prevocational Services				x	Prevocational services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. This can include teaching concepts such as compliance, attendance, task completion, problem solving and safety. Prevocational Services are provided to persons expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs).	89 Il. Adm. Code 530	<p>The amount, duration, and scope of services is based on the DON assessment conducted by the case manager and the service cost maximum determined by the DON score.</p> <p>All prevocational services will be reflected in the individual's plan of care as directed to habilitative, rather than explicit employment objectives.</p>
Habilitation-Day				x	<p>BI</p> <p>Day Habilitation assists with the acquisition, retention, or improvement in self-help, socialization, and adaptive skills which takes place in a non-residential setting, separate from the home or facility which the individual resides. The focus is to enable the individual to attain or maintain his or her maximum functional level.</p> <p>Day Habilitation shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care. In addition, day Habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.</p>	BI 59 Il. Adm. Code 119	<p>BI</p> <p>The amount, duration, and scope of services is based on the DON assessment conducted by the case manager and the service cost maximum determined by the DON score.</p> <p>This service shall be furnished 4 or more hours per day on a regularly scheduled basis, for 1 or more days per week unless provided as an adjunct to other day activities included in the individual's plan of care.</p>

Service	DoA	DHS-DRS			Definition	Standards	Service Limits
	Persons who are Elderly	Persons with Disabilities (PD)	Persons with HIV/AIDS	Persons with Brain Injury (BI)			
Homemaker	x	x	x	x	Homemaker Service is defined as general non-medical support by supervised and trained homemakers. Homemakers are trained to assist individuals with their activities of daily living, including Personal Care, as well as other tasks such as laundry, shopping, and cleaning. The purpose of providing Homemaker Service is to maintain, strengthen and safeguard the functioning of MFP participants in their own homes in accordance with the authorized plan of care.	DOA: 89 Il. Adm. Code 240 DRS: 89 Il. Adm. Code 686.200	DOA: Service is limited by the service cost maximum, except for transport. There is a maximum of 100 hours a month. DRS: This service will only be provided if Personal Care services are not available or are insufficient to meet the care plan or the consumer cannot manage a Personal Assistant. The amount, duration, and scope of services is based on the DON score and service cost maximum level.
Home Delivered Meals		x	x	x	Prepared food brought to the client's residence that may consist of a heated luncheon meal and/or a dinner meal which can be refrigerated and eaten later. This service is designed primarily for the client who cannot prepare his/her own meals but is able to feed him/herself.	89 Il. Adm. Code 686.500	The amount, duration, and scope of services is based on the DON assessment conducted by the HSP counselor or case manager and the service cost maximum determined by the DON score.

Service	DoA	DHS-DRS			Definition	Standards	Service Limits
	Persons who are Elderly	Persons with Disabilities (PD)	Persons with HIV/AIDS	Persons with Brain Injury (BI)			
Personal Assistant		x	x	x	Personal Assistants provide assistance with eating, bathing, personal hygiene, and other activities of daily living in the home and at work (if applicable). When specified in the plan of care, this service may also include such housekeeping chores as bed making, dusting, vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the consumer, rather than the consumer's family. Personal Care providers must meet state standards for this service. The Personal Assistant is the employee of the consumer. The State acts as fiscal agent for the consumer.	89 Il. Adm. Code 686.10	<p>The amount, duration, and scope of services is based on the DON score and service cost maximum level.</p> <p>These services may include assistance with preparation of meals, but does not include the cost of the meals themselves.</p> <p>Personal Care will only be provided when it has been determined by the case manager that the consumer has the ability to supervise the Personal Care provider and the service is not otherwise covered.</p>
Personal Emergency Response System (PERS)	x	x	x	x	PERS is an electronic device that enables certain individuals at high risk of Institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. Trained professionals staff the response center.	<p>DOA: Standards for Emergency Home Response 89 Il. Adm. Code 240</p> <p>DRS: 89 Il. Adm. Code 686.300</p>	PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

Service	DoA	DHS-DRS			Definition	Standards	Service Limits
	Persons who are Elderly	Persons with Disabilities (PD)	Persons with HIV/AIDS	Persons with Brain Injury (BI)			
Respite		x	x	x	DRS Respite services provide relief for unpaid family or primary care givers, who are currently meeting all service needs of the customer. Services are limited to Personal Assistant, homemaker, nurse, adult day care, and provided to a consumer to provide his or her activities of daily living during the periods of time it is necessary for the family or primary care giver to be absent.	Adult Day Care 89 Il. Adm. Code 686.100 Home Health Aide 210 ILCS 45/3-206 RN/LPN 225 ILCS 65 Home Health Agency: 210 ILCS 55 Homemaker 89 Il. Adm. Code 686.200 PA 89 Il. Adm. Code 686.10	DRS The amount, duration, and scope of services is based on the DON score and service cost maximum level. Services are limited to Personal Assistant, homemaker, nurse, adult day care, and provided to a consumer to provide his or her activities of daily living during the periods of time it is necessary for the family or primary care giver to be absent.
Specialized Medical Equipment and Supplies		X	x	x	Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. All items shall meet applicable standards of manufacture, design and installation.	DRS: 68 Il. Adm. Code 1253 Pharmacies 225.ILCS.85 Medical Supplies 225.ILCS.51	DRS: Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State Plan and shall exclude those items, which are not of direct medical or remedial benefit to the individual. The amount, duration, and scope of services is based on the DON score and service cost maximum level.

Service	DoA	DHS-DRS			Definition	Standards	Service Limits
	Persons who are Elderly	Persons with Disabilities (PD)	Persons with HIV/AIDS	Persons with Brain Injury (BI)			
Supportive Living Facilities (In another waiver)					An affordable assisted living model administered by the Department of Healthcare and Family Services that offers frail elderly (65 and older) or persons with disabilities (22 and older) housing with services.	89 II Admin Code 146.215	Frail elderly between the ages of 60 and 64 would not be eligible for SLF residency due to the program's minimum age requirement of 65.
Behavioral Services (M.A. and PH.D)				x	Behavioral services provide remedial therapies to decrease maladaptive behaviors and/or to enhance the cognitive functioning of the recipient. These services are designed to assist customers in managing their behavior and cognitive functioning and to enhance their capacity for independent living.	Speech Therapist 225 ILCS 110/ Social Worker 225 ILCS 20/ Clinical Psychologist 225 ILCS 15/ Licensed Counselor 225 ILCS 107/	The amount, duration, and scope of services is based on the DON score and service cost maximum level. The services are based on a clinical recommendation and are not covered under the State Plan.

RFP Attachment D
Performance and Pay-for-Performance Measures²

#	Category	Performance Measure	Specification Source	Proposed P4P Measures
1	Behavioral Health Risk Assessment and Follow-up	New Enrollees who completed a behavioral health assessment (BHRA) within 60 days of enrollment. Also measures percent of Enrollees with a positive finding on BHRA who receive follow-up with MH provider within 30 days of assessment		
	1) Behavioral Screening/ Assessment within 60 days of enrollment		State	
	2) Behavior Health follow-up within 30 days of screening		State	
2	Alcohol and other Drug Dependence Treatment	Enrollees with new episode of alcohol or other drug (AOD) dependence who received initiation and engagement of AOD treatment.	HEDIS®	
3	Behavioral Health Support	Appropriate follow-up with any Provider within 30 days after initial BH diagnosis.	State	Years 2, 3
4	Behavioral Health Support	Follow-up after hospitalization for Mental Illness		
	1) Follow-up in 7 days		HEDIS®	
	2) Follow-up in 30 days		HEDIS®	Years 2, 3
5	Care Coordination Influenza Immunization Rate	Enrollees who received at least one influenza immunization annually.	State	
6	Dental Utilization	Enrollees who receive an annual dental visit		
	1) Annual Dental Visit –All		State	
7	Dental ER Utilization	Emergency room visits for Enrollees with dental primary diagnoses.	State	
8	Diabetes Care	Increased utilization of disease specific therapies. Meet two of numbers 1, 2, and 3 and one of numbers 4 and 5.		
	1) HbA1c testing 1x per year		HEDIS®	Years 2, 3
	2) Microalbuminuria testing 1 X per year		HEDIS®	Years 2, 3

² The State, CMS, and stakeholders continue to discuss performance measures and pay-for-performance measures appropriate to the Medicare-Medicaid Alignment Initiative population. The final set of measures will be negotiated between the State and CMS. Therefore, the State and CMS reserve the right to change the measures listed above during the RFP process or during Contract negotiations.

#	Category	Performance Measure	Specification Source	Proposed P4P Measures
	3) Cholesterol testing 1X per year		HEDIS®	Years 2, 3
	4) Statin Therapy 80% of the time		State	Years 2, 3
	5) ACE/ARB 80% of the time		State	Years 2, 3
9	Congestive Heart Failure	Increased utilization of disease specific therapies (meet 2 of 3).		
	1) ACE/ARB 80% of the time		State	Years 2, 3
	2) Beta Blocker 80% of the time		State	Years 2, 3
	3) Diuretic 80% of the time		State	Years 2, 3
10	Coronary Artery Disease	Increased utilization of disease specific therapies (meet 2 of 4).		
	1) Cholesterol testing 1X per year		HEDIS®	Years 2, 3
	2) Statin Therapy 80% of the time		State	Years 2, 3
	3) ACE/ARB 80% of the time		State	Years 2, 3
	4) Beta Blocker Post MI for 6 months following MI		HEDIS®	Years 2, 3
11	Chronic Obstructive Pulmonary Disease	Increased utilization of disease specific therapies (meet 2 of 3).		
	1) Acute COPD Exacerbation w/corticosteroid		HEDIS®	Years 2, 3
	2) History of hospitalizations for COPD with a bronchodilator medications		HEDIS®	Years 2, 3
	3) Spirometry testing (1 time in last three years)		HEDIS®	Years 2, 3
12	Ambulatory Care	Emergency Department visits per 1,000 Enrollees	HEDIS®	Years 2, 3
13	Ambulatory Care follow-up after Emergency Department Visit	Follow-up with any Provider within 14 days following Emergency Department visit	State	Years 2, 3

#	Category	Performance Measure	Specification Source	Proposed P4P Measures
14	Inpatient Utilization- General Hospital/ Acute Care	General Hospital Inpatient Utilization Admits per 1,000 Enrollees	HEDIS®	
15	Mental Health Utilization	Mental Health services utilization per 1,0000 Enrollees	HEDIS®	
16	Ambulatory Care Follow-up after Inpatient Discharge	Ambulatory care follow-up visit within 14 days of every inpatient discharge	State	Years 2, 3
17	Inpatient Hospital Re-Admission	Inpatient Hospital 30-day readmissions. In addition, Mental Health readmissions reported separately	State	Years 2, 3
18	Long Term Care Residents – Urinary Tract Infection Hospital Admission	Hospital Admissions due to urinary tract infections for LTC Residents	AHRQ	
19	Long Term Care Residents – Bacterial Pneumonia Hospital Readmission	Hospital Admission due to bacterial pneumonia for LTC Residents	HSAG	
20	Long Term Care Residents – Prevalence of Pressure Ulcers	LTC Residents that have category/ stage II or greater pressure ulcers.	State	Year 3
21	Medication Reviews	Annual monitoring for Enrollees on persistent medications	HEDIS®	
22	Medication Reviews	Antidepressant Medication Management - At least 84 days continuous treatment with antidepressant medication during 114 day period following Index Episode Start Date (IESD)	HEDIS®	Years 2, 3
23	Medication Reviews	Antidepressant Medication Management - At least 180 days continuous treatment with antidepressant medication during 231 day period following IESD	HEDIS®	Years 2, 3
24	Medication Reviews	Percentage of Enrollees diagnosed with schizophrenia who maintain medication adherence at 6 months and 12 months	State	
25	Preventive Services	Colorectal Cancer Screening	HEDIS®	
26	Preventive Services	Breast Cancer Screening	HEDIS®	
27	Preventive Services	Cervical Cancer Screening	HEDIS®	
28	Preventive Services	Adult BMI Assessment	HEDIS®	
29	Access to Enrollee's Assigned PCP	Enrollees who had an annual ambulatory or preventive care visit with Enrollee's assigned PCP.	State	Years 2, 3

#	Category	Performance Measure	Specification Source	Proposed P4P Measures
30	Retention Rate for LTC and HCBS Waiver Enrollees Service in the Community	LTC and HCBS Waiver Enrollees served in the community at the beginning of the year and continued to be served in the community during the year.	State	Years 2, 3

**Attachment E
Medicare Requirements**

Issue	Timeline for Submission/Review for CY 2013
Notice of Intent to Apply (NOIA)	NOIAs were due no later than April 2 nd
Part D Formulary	<p>Formulary due date: April 30 (for new formulary); May 14 (for crosswalk to existing non-demonstration plan formulary)</p> <p>Due date for Part D-required supplemental formulary files: June 8</p> <p>Due date for any special supplemental file for State covered supplemental drugs: June 15 (target)</p> <p>Review Period: April 30-Early July</p>
Part D Medication Therapy Management Program (MTMP)	<p>Due Date: May 25</p> <p>Review Period: May 7-Late July</p>
Demonstration Application	<p>Due Date: May 24</p> <p>Review Period: May 24-July 30</p> <p>CMS expects that applicants will be given at least one opportunity during the specified review period to correct deficiencies.</p>
Part D Application	<p>Due Date: May 24</p> <p>Review Period: May 24-July 30</p> <p>CMS expects that applicants will be given at least one opportunity during the specified review period to correct deficiencies.</p>
Solvency/ Licensure	<p>Due Date: May 24</p> <p>Review Period: May 24-July 30</p> <p>CMS expects that applicants will be given at least one opportunity during the specified review period to correct deficiencies.</p>
Fiscal Soundness	<p>Due Date: May 24</p> <p>Review Period: May 24-July 30</p> <p>CMS expects that applicants will be given at least one opportunity during the specified review period to correct deficiencies.</p> <p>Ongoing reporting requirements: April (Annual); Quarterly submissions</p>
Administrative and Management Arrangements	<p>Due Date: May 24</p> <p>Review Period: May 24-July 30</p> <p>CMS expects that applicants will be given at least one opportunity during the specified review period to correct deficiencies.</p>
Network Adequacy: Medical Services and	Due Date: May 24

Issue	Timeline for Submission/Review for CY 2013
Prescription Drugs	<p data-bbox="735 191 1024 218">Review Period: May 4-July 30</p> <p data-bbox="735 254 1273 338">CMS expects that applicants will be given at least one opportunity during the specified review period to correct deficiencies.</p>
Model of Care	<p data-bbox="735 348 911 375">Due Date: May 24</p> <p data-bbox="735 411 1037 438">Review Period: May 24-July 30</p> <p data-bbox="735 474 1273 558">CMS expects that applicants will be given at least one opportunity during the specified review period to correct deficiencies.</p>
Benefits	<p data-bbox="735 562 906 590">Due Date: June 4</p> <p data-bbox="735 625 1029 653">Review Period: June 4-July 30</p>

RFP Attachment F
HIPAA Compliance Obligations

A. Definitions.

1. "Designated Record Set" shall have the same meaning as the term "designated record set" in 45 C.F.R. section 164.501.
2. "Individual" shall have the same meaning as the term "individual" in 45 C.F.R. section 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. section 164.502(g).
3. "PHI" means Protected Health Information, which shall have the same meaning as the term "protected health information" in 45 C.F.R. section 164.501, limited to the information created or received by Vendor from or on behalf of the Agency.
4. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Part 160 and 45 C.F.R. Part 164 subparts A and E.
5. "Required by law" shall have the same meaning as the term "required by law" in 45 C.F.R. section 164.501.
6. "Vendor" means Contractor.

B. Vendor's Permitted Uses and Disclosures.

1. Except as otherwise limited by this Contract, Vendor may use or disclose PHI to perform functions, activities, or services for, or on behalf of, the Agency as specified in this Contract, provided that such use or disclosure would not violate the Privacy Rule if done by the Agency.
2. Except as otherwise limited by this Contract, Vendor may use PHI for the proper management and administration of Vendor or to carry out the legal responsibilities of Vendor.
3. Except as otherwise limited by this Contract, Vendor may disclose PHI for the proper management and administration of Vendor, provided that the disclosures are required by law, or Vendor obtains reasonable assurances from the person to whom the PHI is disclosed that the PHI will remain confidential and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person. Vendor shall require the person to whom the PHI was disclosed to notify Vendor of any instances of which the person is aware in which the confidentiality of the PHI has been breached.
4. Except as otherwise limited by this Contract, Vendor may use PHI to provide data aggregation services to the Agency as permitted by 45 C.F.R. section 164.504(e)(2)(i)(B).
5. Vendor may use PHI to report violations of law to appropriate federal and state authorities, consistent with 45 C.F.R. section 164.502(j)(1).

C. Limitations on Vendor's Uses and Disclosures. Vendor shall:

1. Not use or further disclose PHI other than as permitted or required by the Contract or as required by law;
2. Use appropriate safeguards to prevent use or disclosure of PHI other than as provided for by this Contract;
3. Mitigate, to the extent practicable, any harmful effect that is known to Vendor of a use or disclosure of PHI by Vendor in violation of the requirements of this Contract;
4. Report to the Agency any use or disclosure of PHI not provided for by this Contract of which Vendor becomes aware;
5. Ensure that any agents, including a subcontractor, to whom Vendor provides PHI received from the Agency or created or received by Vendor on behalf of the Agency, agree to the same restrictions and conditions that apply through this Contract to Vendor with respect to such information;
6. Provide access to PHI in a Designated Record Set to the Agency or to another individual whom the Agency names, in order to meet the requirements of 45 C.F.R. section 164.524, at the Agency's request, and in the time and manner specified by the Agency;
7. Make available PHI in a Designated Record Set for amendment and to incorporate any amendments to PHI in a Designated Record Set that the Agency directs or that Vendor agrees to pursuant to 45 C.F.R. section 164.526 at the request of the Agency or an individual, and in a time and manner specified by the Agency;
8. Make Vendor's internal practices, books, and records, including policies and procedures and PHI, relating to the use and disclosure of PHI received from the Agency or created or received by Vendor on behalf of the Agency available to the Agency and to the Secretary of Health and Human Services for purposes of determining the Agency's compliance with the Privacy Rule;
9. Document disclosures of PHI and information related to disclosures of PHI as would be required for the Agency to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. section 164.528;
10. Provide to the Agency or to an individual, in a time and manner specified by the Agency, information collected in accordance with the terms of this Contract to permit the Agency to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. section 164.528;
11. Return or destroy all PHI received from the Agency or created or received by Vendor on behalf of the Agency that Vendor still maintains in any form, and to retain no copies of such PHI, upon termination of this Contract for any reason. If such return or destruction is not feasible, Vendor shall provide the Agency with notice of such purposes that make return or destruction infeasible, and upon the parties' written agreement that return or destruction is infeasible, Vendor shall extend the protections of the Contract to the PHI and limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible. This provision shall apply equally to PHI that is in the possession of Vendor and to PHI that is in the possession of subcontractor or agents of Vendor.

- D. Agency Obligations.** The Agency shall:
1. Provide Vendor with the Agency's Notice of Privacy Practices and notify Vendor of any changes to said Notice;
 2. Notify Vendor of any changes in or revocation of permission by an individual to use or disclose PHI, to the extent that such changes may affect Vendor's permitted or required uses and disclosures of PHI;
 3. Notify Vendor of any restriction to the use or disclosure of PHI that the Agency had agreed to in accordance with 45 C.F.R. section 164.522, to the extent that such restriction may affect Vendor's use or disclosure of PHI;
 4. Not request that Vendor use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by the Agency.
- E. Breach Requirements.**
1. Sections 164.308, 164.310, 164.312 and 164.316 of title 45, Code of Federal Regulations, apply to the Vendor in the same manner that such sections apply to the Agency. The Vendor's obligations include but are not limited to the following:
 - a. Implementing administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic Protected Health Information that the Vendor creates, receives, maintains, or transmits on behalf of the covered entity as required by HIPAA;
 - b. Ensuring that any agent, including a sub Vendor, to whom the Vendor provides such information ,agrees to implement reasonable and appropriate safeguards to protect the data; and
 - c. Reporting to the Agency any security incident of which it becomes aware.
 2. Privacy Obligations. To comply with the privacy obligations imposed by HIPAA, Vendor agrees to:
 - a. Abide by any Individual's request to restrict the disclosure of Protected Health Information consistent with the requirements of Section 13405(a) of the HITECH Act;
 - b. Use appropriate safeguards to prevent use or disclosure of the information other than as provided for by the Underlying Agreement and this Addendum;
 - c. Report to the Agency any use or disclosure of the information not provided for by the Underlying Agreement of which the Vendors becomes aware;
 - d. Ensure that any agents, including a sub Vendor, to whom the Vendor provides Protected Health Information received from the Agency or created or received by the Vendor on behalf of the Agency, agrees to the same restrictions and conditions that apply to the Vendor with respect to such information;
 - e. Make available to the Agency within ten (10) calendar days Protected Health Information to comply with an Individual's right of access to their Protected Health Information in compliance with 45 C.F.R. § 164.524 and Section 13405(f) of the HITECH Act;
 - f. Make available to the Agency within fifteen (15) calendar days Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with 45 C.F.R. § 164.526;
 - g. Make available to the Agency within fifteen (15) calendar days the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528 and Section 13405(c) of the HITECH Act;
 - h. To the extent practicable, mitigate any harmful effects that are known to the Vendor of a use or disclosure of Protected Health Information or a Breach of Unsecured Protected Health Information in violation of this Addendum;
 - i. Use and disclose an Individual's Protected Health Information only if such use or disclosure is in compliance with each and every applicable requirement of 45 C.F.R. § 164.504(e);
 - j. Refrain from exchanging any Protected Health Information with any entity of which the Vendor knows of a pattern of activity or practice that constitutes a material breach or violation of HIPAA;
 - k. To comply with Section 13405(b) of the HITECH Act when using, disclosing, or requesting Protected Health Information in relation to this Addendum by limiting disclosures as required by HIPAA.
 3. Breach Notification. In the event that the Vendor discovers a Breach of Unsecured Protected Health Information, the Vendor agrees to take the following measures within 10 calendar days after the Vendor first becomes aware of the incident:
 - a. To notify the Agency of any incident involving the acquisition, access, use or disclosure of Unsecured Protected Health Information in a manner not permitted under 45 C.F.R. parts D and E. Such notice by the Vendor shall be provided after the Vendor first becomes aware of the incident, except where a law enforcement official determines that a notification would impede a criminal investigation or cause damage to national security. For purposes of clarity for this provision, Vendor must notify the Agency of any such incident within the above timeframe even if Vendor has not conclusively determined within that time that the incident constitutes a Breach as defined by HIPAA. The Vendor is deemed to have become aware of the Breach as of the first day on which such Breach is known or reasonably should have been known to such entity or associate of the Vendor, including any person other than the individual committing the Breach, that is an employee, officer or other agent of the Vendor or an associate of the Vendor;
 - b. To include the names of the Individuals whose Unsecured Protected Health Information has been, or is reasonably believed to have been, the subject of a Breach;

- c. To complete and submit the Breach Notice form to the Agency (see Exhibit A); and
 - d. To include for the Agency a sample copy of the notice that was used to inform individuals about the breach.
4. Notification Duty. It is Vendors duty to provide the Breach notification to the affected individuals unless Agency agrees to provide the Breach notification.
 5. Costs. Vendor assumes all costs for providing Breach notification unless Agency agrees to assume any costs.
 6. Indemnification for Breach Notification. Vendor shall indemnify the Agency for costs associated with any incident involving the acquisition, access, use or disclosure of Unsecured Protected Health Information in a manner not permitted under 45 C.F.R. parts D and E.
 7. Security Rule Compliance. Vendor shall comply with the Security Rule's administrative, physical and technical safeguard requirements. As part of compliance with the Security Rule, Vendor shall develop and implement written security policies and procedures with respect to the electronic PHI they handle. By signing this Amendment, the Vendor assures and acknowledges compliance with the requirements of HITECH including meeting the administrative, physical and technical safeguard requirements of the HIPAA Security Rule. (45 C.F.R. Part 160, 162, 164.) Vendor also assures and acknowledges that the electronic PHI they transmit is encrypted and that it will adopt internal procedures for reporting breaches and mitigating potential damages.

F. **Interpretation.** Any ambiguity in this Contract shall be resolved in favor of a meaning that permits the Agency to comply with the Privacy Rule.

EXHIBIT A
NOTIFICATION TO THE AGENCY OF BREACH OF
UNSECURED PROTECTED HEALTH INFORMATION

NOTE: The Contractor must use this form to notify HFS of any Breach of Unsecured Protected Health Information. Contractor must immediately or within 10 calendar days of the breach being discovered provide a copy of this completed form to:

(1) the Contract Administrator (insert name) _____, in compliance with the Notice Requirements of the Underlying Agreement, and (2) the HFS Privacy Officer at:

Illinois Department of Healthcare and Family Services
Attn: Privacy Officer
201 South Grand Avenue East
Springfield, Illinois 62763

Information to be Supplied:

Contract Information

Contract Number

Contract Title

Contact Person for this Incident:

Contact Person's Title:

Contact's Address:

Contact's E-mail:

Contact's Telephone No.:

NOTICE:

Contractor hereby notifies the Agency that there has been a Breach of Unsecured (unencrypted) Protected Health Information that Contractor has used or has had access to under the terms of the Contractor Agreement, as described in detail below:

Date of Breach Date of Discovery of Breach:

Detailed Description of the Breach:

Types of Unsecured Protected Health Information involved in the Breach (such as full name, SSN, Date of Birth, Address, Account Number, Disability Code, etc – List All).

What steps are being taken to investigate the breach, mitigate losses, and protect against any further breaches?

Number of Individuals Impacted If over 500, do individuals live in multiple states?

Submitted by:

Signature: _____ **Date:** _____

Printed Name and Title: _____