

**STATE OF ILLINOIS**  
**Solicitation for Care Coordination Entities and**  
**Managed Care Community Networks**  
For  
**Seniors and Adults with Disabilities**

**Innovations Project/2013-24-002**

The Office of the Governor, the Department of Human Services, Divisions of Mental Health, Rehabilitation Services and Developmental Disabilities, the Department on Aging, the Department of Public Health and the Department of Healthcare and Family Services are soliciting Proposals from responsible Bidders to meet the State's needs for care coordination services to Seniors and Adults with Disabilities enrolled in the Medicaid Program. This Solicitation 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)). This Solicitation, therefore, need not strictly comply with the Code and Rules (44 Ill. Admin. Code 1.2005(q)).

Public Act 96-1501 requires the Department of Healthcare and Family Services (Department) to move at least 50% of recipients eligible for comprehensive medical benefits in all programs administered by the Department to a risk-based care coordination program by January 1, 2015. For the complete details of this requirement see 305 ILCS 5/5-30. This Solicitation fulfills a goal to allow Providers to design and offer care coordination models other than traditional Health Maintenance Organizations (HMOs). The Department invites innovative Proposals to demonstrate that Providers can provide equal or better care coordination services, produce equal or better health outcomes and render equal or better savings than traditional HMOs. In the absence of such successful models, the Department will fulfill the statutory mandate through traditional HMOs.

Although this Solicitation specifies minimum requirements for the composition of a collaboration, Bidders should understand that the State is looking for the most comprehensive models that take a holistic approach to individuals served and attempts to coordinate services for all of their needs. The State encourages models that attempt to coordinate social services beyond those covered by the Medicaid program.

Please read the entire Solicitation package and submit your Letter of Intent and Proposal in accordance with all instructions. In this document the State of Illinois will be referred to as "State", "Agency", "Department", "we" or "us". The person submitting a Proposal will be referred to as "Bidder", or "You". "We" is used appropriate to the context.

**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, AND OTHER GENERAL INFORMATION

**1.0 PROJECT CONTACT:** If you have a question or suspect an error, please submit your question or comment to the following e-mail address with the subject line "SPD Solicitation": [HFS.carecoord@illinois.gov](mailto:HFS.carecoord@illinois.gov)

**1.1 Further Information:** Answers to all questions will be posted to the Care Coordination Innovations Project page of the Department website. To ensure timely answers, questions regarding this Solicitation must be submitted no later than February 10, 2012, but should be submitted as soon as possible. Prior to submitting questions, please check the Department website for answers to previously submitted questions. Written responses will be posted on the Procurement Bulletin and the Department website. The State may hold a webinar to answer questions that emerge. The date and time of the webinar will be posted on the Department website. In addition, the State may periodically post additional information about this Solicitation, particularly with regard to data and shared savings calculations. You should check the website regularly: <http://www2.illinois.gov/hfs/Pages/default.aspx>

The State may hold technical assistance sessions for persons interested in submitting a Care Coordination Entity (CCE) or Managed Care Community Network (MCCN) Proposal. Please monitor the Department website for information regarding future technical assistance sessions.

**1.2 PROPOSAL DUE DATE, TIME AND SUBMISSION LOCATION:** Due Date: May 25, 2012  
Time: 2:00 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:**  
Innovations SPD Care Coordination Program  
[Bidder Name & Address]

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 may not consider Proposals, modifications or withdrawals submitted after the due date and time. All times are State of Illinois local times (Central Time).

**1.3 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 two (2) copies of the Proposal on CD in the following format: Microsoft Word and/or Excel. If you are requesting confidential treatment, you must make that request in the form and manner specified elsewhere in this Solicitation.

**1.4 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.

**1.5 AWARD:** We will post a notice to the Procurement Bulletin and the Department website to notify potential awardees of an award. We may accept or reject your Proposal as submitted, or may require Contract negotiations. If negotiations do not result in an acceptable agreement, we may reject your Proposal and begin negotiations with another Bidder. There is no predetermined number of awardees. All State contracts have certain certifications and requirements that potential awardees must agree to comply with in order to receive a contract. In addition, Contracts may have terms specified by federal regulations. All Contracts are subject for approval of Federal CMS for available federal matching funds. The final number of awards will be based on the number of quality Proposals, geographic coverage of Proposals and the State's ability to administer the programs. See Section 2 for an overview of how we will evaluate Proposals.

**1.6 PUBLIC RECORDS AND REQUESTS FOR CONFIDENTIAL TREATMENT:** Proposals become the property of the State and these and late submissions will not be returned. Your Proposal 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 Proposal that we treat certain information as exempt. We will not honor requests to exempt entire Proposals. You must show the specific grounds in FOIA or other law or rule that support exempt treatment. Regardless, we will disclose the successful Bidder's name, and the substance of the Proposal. If you request exempt treatment, you must submit an additional copy of the Proposal with exempt information deleted. This copy must tell the general nature of the material removed and shall retain as much of the Proposal 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 Proposal 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.

**1.7 DEFINITIONS.** Whenever used in this Solicitation including schedules, appendices, exhibits, and attachments to this Solicitation, the following terms will have the meanings defined below. Any objections or questions regarding the definitions shall be raised with the Department during the Solicitation process.

**1.7.1 Adults with Disabilities:** An individual who is over 18 and under 65 years of age, who meets the definition of blind or disabled under Section 1614(a) of the Social Security Act (42 U.S.C.1382), and whose Medicaid eligibility is based on meeting that definition.

**1.7.2 Affordable Care Act:** The health insurance reform legislation President Obama signed into law on March 23, 2010, Public Law 111-148, as amended through May 1, 2010 by Public Law 111-152. <http://docs.house.gov/energycommerce/ppacacon.pdf>

- 1.7.3 Behavioral Health:** This term refers to mental health and substance abuse Covered Services.
- 1.7.4 Bidder:** The CCE or MCCN submitting a Proposal under this Solicitation.
- 1.7.5 Care Coordination Entity (CCE):** A CCE is a collaboration of providers and community agencies, governed by a lead entity, that receives a care coordination payment in order to provide care coordination services for its Enrollees.
- 1.7.6 Centers for Medicare & Medicaid Services (Federal CMS):** The agency within DHHS that is responsible for the administration of the Medicare program and, in partnership with the states, administers Medicaid, the State Children's Health Insurance Program (CHIP), and the Health Insurance Portability and Accountability Act (HIPAA).
- 1.7.7 Client:** Any individual receiving benefits under the Medicaid or Children's Health Insurance Programs (CHIP).
- 1.7.8 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/>.
- 1.7.9 Contractor:** A CCE or MCCN that has executed a Contract with the State to provide the services requested by this Solicitation.
- 1.7.10 Covered Services:** Benefits and services provided to medical assistance Clients as defined under the Illinois State Plan and HCBS Waivers.
- 1.7.11 Dual Eligible:** A Client who receives services through both the Medicare and the Medicaid Programs.
- 1.7.12 Enrollee:** A Client who is enrolled in a CCE or MCCN.
- 1.7.13 Enrollment Period:** The twelve (12) month period beginning the effective date of enrollment.
- 1.7.14 Execution:** The point at which all the parties have signed the Contract between the Contractor and the State.
- 1.7.15 Federally Qualified Health Center (FQHC):** A health center that meets the requirements of 89 IL Admin Code 140.461(d).
- 1.7.16 Fee-For-Service:** The method of billing under which a Provider charges for each encounter or service rendered.
- 1.7.17 Health Insurance Portability and Accountability Act (HIPAA):** Also known as the Kennedy-Kassebaum Bill, the Kassebaum-Kennedy Bill, K2, or Public Law 104-191 and all amendments thereto, the federal law that makes a number of changes that have the goal of allowing persons to qualify immediately for comparable health insurance coverage when they change their employment relationships. Title II, Subtitle F, of HIPAA provides DHHS with the authority to mandate the use of standards for electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information.
- 1.7.18 Health Maintenance Organization (HMO):** A health maintenance organization as defined in the Health Maintenance Organization Act (215 ILCS 125/1-1 et seq.).
- 1.7.19 Health Plan Employer Data and Information Set (HEDIS®):** The Healthcare Effectiveness Data and Information Set established by the National Committee for Quality Assurance (NCQA).
- 1.7.20 HFS:** The Illinois Department of Healthcare and Family Services and any successor agency. In this Solicitation, HFS is also referred to as "Department".
- 1.7.21 Home and Community-Based Services (HCBS) Waivers:** Waivers under Section 1915(c) of the Social Security Act that allow Illinois to cover home and community services and provide programs that are designed to meet the unique needs of individuals with disabilities who qualify for the level of care provided in an institution but who, with special services, may remain in their homes and communities.
- 1.7.22 ILCS:** Illinois Compiled Statutes. An unofficial version of the ILCS can be viewed at <http://www.ilga.gov/legislation/ilcs/ilcs.asp>.
- 1.7.23 Illinois Client Enrollment Broker (ICEB):** The entity contracted by the Department to conduct enrollment activities for Potential Enrollees, including providing impartial education on health care delivery choices, CCEs, and MCCNs, providing enrollment materials, assisting with the selection of a PCP and CCE or MCCN, and processing requests to change CCEs or MCCNs. The following link is to the ICEB website: <http://illinoisceb.com/>
- 1.7.24 Integrated Care Program (ICP):** The program under which the Department contracted with HMOs to provide the full spectrum of Medicaid Covered Services through a risk-based integrated care delivery system to Seniors and Adults with Disabilities who are eligible for Medicaid but are not eligible for Medicare.
- 1.7.25 Illinois Health Connect (IHC):** The State's Primary Care Case Management Program, Illinois Health Connect, is a statewide mandatory program where Clients must choose or are assigned to a PCP as their medical home. This program operates through a State Plan Amendment pursuant to 42 CFR Section 438.
- 1.7.26 Managed Care Community Network (MCCN):** A MCCN (305 ILCS 5/5-11(b)) is an entity, other than a Health Maintenance Organization, that is owned, operated, or governed by providers of health care services within Illinois and that provides or arranges primary, secondary and tertiary managed health care services under contract with the Department exclusively to persons

participating in programs administered by the Department.

- 1.7.27 **Managed Care Organization (MCO):** A HMO or MCCN as defined herein that is under contract with the Department.
- 1.7.28 **Marketing:** Any written or oral communication from a CCE or MCCN or its representative that can reasonably be interpreted as intended to influence a Client to enroll, not enroll, or to disenroll from a CCE or MCCN.
- 1.7.29 **Marketing Materials:** Materials produced in any medium, by or on behalf of the Contractor that can reasonably be interpreted as intended to market to Potential Enrollees. Marketing Materials includes written materials and oral presentations.
- 1.7.30 **Medicaid:** The program under Title XIX of the Social Security Act that provide medical benefits to groups of low-income people.
- 1.7.31 **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.
- 1.7.32 **Open Enrollment:** The specific period of time each year in which Enrollees shall have the opportunity to change from one CCE or MCCN to another CCE or MCCN or to disenroll from their CCE or MCCN.
- 1.7.33 **Other IHC Adults:** Illinois Health Connect (IHC) Adults whose eligibility for Medicaid is not based on a disability and is over 18 and under 65 years of age.
- 1.7.34 **Person:** Any individual, corporation, proprietorship, firm, partnership, trust, association, governmental authority, vendor, or other legal entity whatsoever, whether acting in an individual, fiduciary, or other capacity.
- 1.7.35 **Physician:** A Person licensed to practice medicine in all its branches under the Medical Practice Act of 1987.
- 1.7.36 **Potential Enrollee:** A Client who may be eligible for enrollment in a CCE or a MCCN, but is not yet an Enrollee of a CCE or MCCN.
- 1.7.37 **Primary Care Provider (PCP):** A Provider, including a WHCP, who within the Provider's scope of practice and in accordance with State certification requirements or State licensure requirements, is responsible for providing all preventive and primary care services to his or her assigned Enrollees in the CCE or MCCN.
- 1.7.38 **Priority Populations:** Seniors and Adults with Disabilities (including long-term care populations, those with Serious Mental illness, HCBS Waiver populations, and Dual Eligibles).
- 1.7.39 **Proposal:** A Bidder's response to the Solicitation, consisting of the technical Proposal and all required forms and certifications. All required forms and certifications must be completed, signed, and returned by the Bidder.
- 1.7.40 **Provider:** A Person enrolled with the Department to provide Covered Services to a Client.
- 1.7.41 **Quality Measure:** A quantifiable measure to assess how well an organization carries out a specific function or process.
- 1.7.42 **Senior:** A Client who is 65 years of age or older and who is eligible for Medicaid.
- 1.7.43 **Serious Mental Illness (SMI):** A Client who is at least 18 years of age whose emotional or behavioral functioning is so impaired as to interfere with their capacity to remain in the community without supportive treatment. The mental impairment is severe and persistent and may result in a limitation of their capacities for primary activities of daily living, interpersonal relationships, homemaking, self-care, employment or recreation. The mental impairment may limit their 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 enrolling Target Populations, the following diagnoses will be 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).
- 1.7.44 **Solicitation:** This document plus any additional documents and clarifying questions and answers the State may publish.
- 1.7.45 **Spend-down:** The policy that allows an individual to qualify for Medicaid 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 as the spend-down amount represents medical expenses the individual is responsible to pay.
- 1.7.46 **State:** The State of Illinois, as represented through any agency, department, board, or commission.
- 1.7.47 **State Plan:** The Illinois State Plan filed with the Centers for Medicare & Medicaid Services, in compliance with Title XIX and Title XXI of the Social Security Act.
- 1.7.48 **Target Population:** The sub-population within the Priority Populations that a CCE or MCCN chooses to target in its care coordination model.
- 1.7.49 **Third Party Administrator:** An organization providing health insurance or care coordination administrative functions without bearing risk, properly licensed by the State of Illinois.

**1.7.50 Women's Health Care Provider (WHCP):** A Physician specializing by certification or training in obstetrics, gynecology or family practice.

**1.8 ACRONYMS.** Whenever used in this Solicitation including schedules, appendices, exhibits, and attachments to this Solicitation, the following acronyms will have the meanings identified below.

- 1.8.1** ACA: Affordable Care Act
- 1.8.2** CCE: Care Coordination Entity
- 1.8.3** CFR: Code of Federal Regulation
- 1.8.4** DHHS: The United States Department of Health and Human Services
- 1.8.5** DHR: Department of Human Rights
- 1.8.6** EHR: Electronic Health Record
- 1.8.7** Federal CMS: Centers for Medicare & Medicaid Services
- 1.8.8** FFS: Fee-for-Service
- 1.8.9** FOIA: Freedom of Information Act
- 1.8.10** FQHC: Federally Qualified Health Center
- 1.8.11** HCBS Waivers: Home and Community-Based Services Waivers
- 1.8.12** HEDIS: Health Plan Employer Data and Information Set
- 1.8.13** HFS: The Illinois Department of Healthcare and Family Services
- 1.8.14** HIPAA: Health Insurance Portability and Accountability Act
- 1.8.15** HIT: Health Information Technology
- 1.8.16** HMO: Health Maintenance Organization
- 1.8.17** ICEB: Illinois Client Enrollment Broker
- 1.8.18** ILCS: Illinois Compiled Statutes
- 1.8.19** LOI: Letter of Intent
- 1.8.20** LTC: Long-term Care
- 1.8.21** MCCN: Managed Care Community Network
- 1.8.22** MCO: Managed Care Organization
- 1.8.23** NCQA: National Committee for Quality Assurance
- 1.8.24** PCP: Primary Care Provider
- 1.8.25** PMPM: Per Member Per Month
- 1.8.26** SMI: Serious Mental Illness
- 1.8.27** SPD: Seniors and Persons with Disabilities
- 1.8.28** WHCP: Women's Health Care Provider

## SECTION 2 – HOW WE WILL EVALUATE OFFERS

2.1 **EVALUATION CATEGORIES:** We will evaluate Proposals using the point system described below.

CCE and MCCN Evaluation Categories	Maximum Points
Governance Structure, Scope of Collaboration, and Leadership	250
Populations/Geography	100
Care Coordination Model	450
Health Information Technology	200
Total	1,000

2.2 **MCCNs:** In addition to evaluation of the care coordination Proposal as described above, a MCCN will be reviewed for financial solvency and network adequacy based on its separate MCCN application, as required by Section 3.1.2.2.

2.3 **Proposal Checklist:** The State will evaluate complete Proposals using the evaluation point system described in Section 2.1. To be complete, a Proposal must include all of the following:

2.3.1 Submission of a Letter of Intent by February 29, 2012;

2.3.2 Complete answers, including applicable Attachments, to all of the questions about the care coordination model contained in Section 3.2 of this Solicitation;

2.3.3 Selection of financial model(s) and complete answers to the questions with respect to the model(s) in Section 3.3;

2.3.4 Completed and signed Taxpayer Identification Form and Disclosure of Conflicts of Interest Form included in Section 3.6;

2.3.5 Signed Proposal; and

2.3.6 Submission of the original Proposal and the required copies, as specified in Sections 1.2 and 1.3.

## 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 one or more qualified, experienced and financially sound Care Coordination Entity(ies) (CCE) or Managed Care Community Network(s) (MCCN) to enter into a Contract for the Innovations Project. There is no predetermined number of awards; the decision to award a Contract(s) will depend upon the models proposed, including populations and geographical distribution. The initial term of the Contract will be three years, with options to renew the Contract for a potential total term of 10 years. The State will review programs during the third year of the initial term to evaluate which programs are the highest performing and most cost-effective, in order to determine how to further invest resources. This Solicitation is Phase I of the Innovations Project. The Innovations Project consists of several phases through which the State seeks a redesigned health care delivery system that is more patient-centered with a focus on improved health outcomes, enhanced patient access, and patient safety. To achieve these goals, the State seeks entities to coordinate care across the spectrum of the healthcare system with a particular emphasis on managing transitions between levels of care and coordination between physical and mental health and substance abuse. In this Phase 1 of the Innovations Project, the State is seeking Proposals from CCEs and MCCNs that engage community partners in promoting coordinated quality care across Provider and community settings, offer new risk-based funding incentives and flexibilities, and measure delivery system effectiveness and efficiency. Illinois Public Act 096-1501 broadly defines care coordination to include not just traditional managed care companies, but also new alternative models of care organized and managed by hospitals, Physician groups, Federally Qualified Health Centers (FQHC) or social service organizations. Under this definition, care coordination must include providing or arranging for a majority of care around the patient's needs, including a medical home with a Primary Care Provider (PCP), specialist services, diagnostic and treatment services, mental health and substance abuse services, inpatient and outpatient hospital services, and rehabilitation and long-term care services. A separate Solicitation for children with complex and/or multiple chronic medical needs is anticipated for release in Spring 2012.

**3.1.1.1** The intent of Phase I is to test community interest and capacity to provide alternative models of coordinating care (i.e. not through traditional Health Maintenance Organizations), organized by CCEs and MCCNs, while complying with Illinois Public Act 096-1501, aligning with Affordable Care Act (ACA) initiatives, and building on interagency collaborations.

**3.1.1.1.1** Illinois Public Act 096-1501 (215 ILCS 106/23) requires 50 percent of medical assistance clients to be in risk-based care coordination programs by January 1, 2015 (Please follow the following link for the full legislative text: [http://www2.illinois.gov/hfs/PublicInvolvement/cc/Documents/096\\_1501cc.pdf](http://www2.illinois.gov/hfs/PublicInvolvement/cc/Documents/096_1501cc.pdf)).

**3.1.1.1.2** Section 2703 of the ACA creates a new State Plan option to provide coordinated care through a health home for Clients with two or more chronic conditions and provides a temporary 90 percent Medicaid matching rate for applicable services. (Please follow the following link for the Federal CMS State Medicaid Director's letter: <http://www.cms.gov/smdl/downloads/SMD10024.pdf>).

**3.1.1.1.3** Federal CMS announced two financial models to allow States to test the coordination and integration of care for Medicare and Medicaid services for dually eligible Clients. Phase I of the Innovations project will accept Proposals that test care coordination models for dually eligible Clients under the Managed Fee-for-Service option outlined by Federal CMS. Please note: Proposals may serve dually eligible Clients without meeting the Managed FFS requirements. (Please follow the link for the Federal CMS State Medicaid Director's letter: [http://www.cms.gov/smdl/downloads/Financial\\_Models\\_Supporting\\_Integrated\\_Care\\_SMD.pdf](http://www.cms.gov/smdl/downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf)).

**3.1.2 Organizational Structure – Collaborators.** The CCE or MCCN must develop and implement a care coordination model that meets the guidelines outlined in this Solicitation.

**3.1.2.1 CCE.** A CCE is a collaboration of providers and community agencies (organizations), governed by a lead entity, that receives a care coordination payment in order to provide care coordination services for its Enrollees. The collaboration must include, at a minimum, participation from PCPs, hospitals, mental health Providers, and substance abuse Providers. Under this arrangement, medical services are still reimbursed via Fee-For-Service (with the exception of a CCE who proposes an alternative reimbursement methodology under Section 3.1.6.1.1.3). The State is looking for the most comprehensive models that take a holistic approach to individuals served and attempts to coordinate services for all of their needs. To become a CCE, a group of Providers may create a new corporate entity as a lead entity or designate one of the participating organizations as a lead entity in order to Contract with the State. A CCE may subcontract with a Managed Care Organization (MCO) or a Third Party Administrator (TPA) for back office functions, such as IT systems support. MCOs may not bear any financial risk for the CCEs.

**3.1.2.1.1 Lead Entity.** A lead entity agrees to serve as the legal entity responsible for executing the CCE Contract with the State. A lead entity may be a Medicaid enrolled Provider, a non-Medicaid enrolled provider, or a local governmental non-Medicaid authority, but it cannot be a MCO. A lead entity is not restricted to not-for-profit entities.



**3.1.2.2 MCCN.** A MCCN (305 ILCS 5/5-11(b)) is an entity other than a Health Maintenance Organization, that is owned, operated, or governed by providers of health care services within Illinois and that provides or arranges primary, secondary and tertiary managed health care services under contract with the Department exclusively to persons participating in programs administered by the Department. A MCCN receives a monthly capitation rate for all services covered by the MCCN. An existing MCCN must submit a Proposal that details its plan for coordinating care among the services for which it assumes risk under a new Contract with the State. An organization applying to become a new MCCN must complete a MCCN application and submit a Proposal that details its care coordination plan for the services for which it will assume risk. The MCCN application will be posted to the Department website by February 29, 2012.

**3.1.2.2.1 MCCN Services.** Both existing and new MCCNs must, at a minimum, assume risk for services included in Service Package I in the Integrated Care Program (ICP). However, a MCCN has the option to exclude dental and pharmacy services from the services for which it will assume risk. A MCCN has the option to include Service Package II in the Integrated Care Program in the services for which it will assume risk. Please refer to the ICP contracts for more information.  
<http://www2.illinois.gov/hfs/PublicInvolvement/IntegratedCareProgram/Pages/default.aspx>.

**3.1.2.3 Matchmaking.** The State has made available a database to assist potential collaborators in identifying other entities who may be interested in participating in a CCE or MCCN:  
<http://www2.illinois.gov/hfs/PublicInvolvement/cc/mm/Pages/SubmitMatchmaking.aspx>

**3.1.2.4 Letter of Intent (LOI).** The Department is requiring Letters of Intent (LOIs) from those entities that are anticipating – or seriously considering – submitting a Proposal for providing services under the Phase I of the Innovations Project. While submitting a LOI does not commit an entity to actually submit a Proposal, the Department will not accept Proposals from nor provide data to entities that have not submitted a LOI. In order to be considered for an award and to receive data, please complete and submit a LOI using the template in Attachment D and a signed Data Use Agreement (Attachment D-Section C) by February 29, 2012. In the LOI, a Bidder must request data for its population of interest by specifying population parameters (geography, disability, specific chronic disease, etc.). The Department will provide data that will include a broad array of utilization measures, which will be common across all populations.

**3.1.3 Populations.** Clients eligible for care coordination services under this Solicitation include: Seniors, Adults with Disabilities (including long-term care populations, those with Serious Mental illness, HCBS Waiver populations, and Dual Eligibles), Other IHC Adults, and children in the families of adults enrolled in a CCE or MCCN.

**3.1.3.1 Restrictions.** Enrollees in a CCE must also be enrolled in IHC, and may not be in a MCO. Enrollees in a MCO may not be enrolled in IHC or a CCE. Enrollees may only be enrolled in one CCE or MCCN at a time.

**3.1.3.2 Limits.** A CCE or MCCN must serve a minimum of 500 Clients from the Priority Populations described in 3.1.3.3.

**3.1.3.2.1** In Cook, DuPage, Lake, St. Clair, Will and Kane counties, a CCE or MCCN may serve up to an equal number of Other IHC Adults as those served from the Priority Populations.

**3.1.3.2.2** In all other counties, a CCE or MCCN will not be held to a one-to-one ratio of Priority Populations to Other IHC Adults if it agrees to accept all non-excluded Clients in its geographic service area. The State intends to control enrollment to ensure that the CCE or MCCN is not serving a disproportionate share of non-Priority Populations.

**3.1.3.2.3** A CCE or MCCN may propose to phase-in enrollment, but must reach the requirement of serving a minimum of 500 Enrollees from the Priority Populations within a reasonable period of time as determined by the State.

**3.1.3.3 Priority Populations.** Priority Populations include: Seniors and Adults with Disabilities (including long-term care populations, those with Serious Mental illness, HCBS Waiver populations, and Dual Eligibles). The State is particularly interested in Proposals that include Clients with SMI and/or substance abuse.

**3.1.3.4 Target Population.** A CCE or MCCN may target a particular Priority Population or specified subpopulation (Target Population) for outreach; however, within the Priority Population or specified sub-population (Target Population), it may not discriminate on the basis of health status. Enrollment cannot be limited to the Target Population but may be limited to the Priority Populations.

**3.1.3.5 Excluded Populations.** Clients excluded from participation in the Innovations Project include: 1) Clients eligible for the Integrated Care Program (ICP) in Suburban Cook (non-606 zip codes), DuPage, Kane, Kankakee, Lake, and Will counties; 2) Spend-down populations; 3) children under age 19 who are not in the family of an adult enrolled in a CCE or



MCCN; 4) Clients in the Illinois Breast and Cervical Cancer Program; 5) Clients in Health Benefits for Workers with Disabilities; and 6) Clients enrolled in partial benefit plans.

**3.1.3.6 Enrollment.** Initial participation in a CCE or MCCN is voluntary. However, an Enrollee will be locked-in to his or her selected CCE or MCCN for 12-months after the effective date of enrollment. Enrollees will have the opportunity to drop out of a CCE or MCCN with cause at any time consistent with 42 C.F.R. 438.56, without cause during the 90 days following enrollment, and during an Open Enrollment period held at least every 12 months. An Enrollee must select a PCP, but will not be locked-in to a PCP. Enrollees may switch PCPs within the CCE once per month. It is the intent of the Department to move toward mandatory enrollment in a CCE, MCCN or MCO in at least some areas of the State once sufficient plans are in place to give all Enrollees a choice of plans.

**3.1.3.6.1 CCE-Only PCP Selection.** An Enrollee must select a PCP in IHC within his or her CCE through the Illinois Client Enrollment Broker (ICEB), but will not be locked-in to a PCP. This includes individuals choosing to enroll in a CCE, who today are not mandated to choose IHC.

**3.1.3.6.2 Illinois Client Enrollment Broker (ICEB).** The ICEB will handle enrollment. CCEs or MCCNs must refer a Potential Enrollee to the ICEB for eligibility determination and enrollment.

**3.1.3.6.3 Disenrollment.** The Department determines the cause for disenrollment consistent with 42 C.F.R. 438.56. The ICEB will handle disenrollment.

**3.1.4 Care Coordination Model.** The role of care coordination is to facilitate the delivery of appropriate health care and other services, and care transitions between Providers and community agencies. Care coordination services must include facilitating care between hospitals and PCPs, and among hospitals, mental health Providers, substance abuse Providers, and PCPs. Care coordination may also facilitate care among existing HCBS Waiver case managers and other community agencies and services and among PCPs, specialists, and dental Providers. Proposals must include a description of how the Bidder's model is sensitive to the culture and specific needs of the population the Bidder proposes to serve.

**3.1.4.1 Medical Home/PCP Requirements.** A Proposal submitted by a CCE or MCCN must demonstrate an adequate medical home network. PCPs may be enrolled in more than one CCE or MCCN. Any CCE must have a network of medical homes that are also enrolled as PCPs in IHC and must not exceed the PCP to Client ratio requirement that exists in IHC. PCPs participating in a CCE will continue to receive IHC care management fees for CCE Enrollees.

**3.1.4.2 Health Homes.** If a CCE or MCCN plans to implement the Health Homes Option in Section 2703 of the ACA, the Proposal must include the services and meet the requirements defined in Section 2703. The State is not putting restrictions on which chronic conditions to manage; however, priority will be given to those CCEs or MCCNs that propose to serve the most vulnerable and expensive populations. CCEs and MCCNs will be required to track and report health home populations. The State is in the process of developing a methodology for CCEs and MCCNs to report health home populations and will provide this information as soon as it is available.

**3.1.4.3 Quality Measures.** The State will track and monitor performance using prescribed HEDIS and HEDIS-like, and other Quality Measures (Attachment A), most of which are used to monitor performance in the ICP. (To the extent measures used in ICP are not claims based, the State may decide not to use them to measure CCEs.) In order to compare models, the State will use common measures for Priority Populations and for all models serving similar populations. The State may consider other measures to be used for particular models. The State is investigating adding additional measures with respect to mental health that it feels will more accurately track true quality outcomes for those with SMI. To the extent possible, the State will measure patient and caregiver satisfaction.

**3.1.4.3.1 Pay-for-Performance.** The State will institute a pay-for-performance structure as outlined in Section 3.4 Payment Terms and Conditions. The Quality Measures targeted to be used as pay-for-performance measures are listed in Attachment A and further described in Attachments B and C.

**3.1.4.4 Marketing and Outreach.** CCEs and MCCNs may conduct Marketing activities consistent with Federal regulations found at 42 C.F.R. Section 438.104. Subject to the Department's prior approval, CCEs and MCCNs may market by mail, mass media, advertising, and community-oriented Marketing directed at Potential Enrollees.

**3.1.4.4.1** Providers participating in a CCE or MCCN may inform their patients of the CCE or MCCN opportunities available to them, including the services provided by the CCE or MCCN of which the Provider is a member.

**3.1.5 Health Information Technology.** Proposals must include a description of electronic capabilities and planned use of health information technology in coordinating care. The State is not specifying any particular EHR system or electronic functionality, but every Proposal must include some electronic functionality.

- 3.1.5.1 To support care coordination activities, a CCE or MCCN must have or develop electronic capabilities no later than 12 months after Contract Execution.
- 3.1.5.2 The State acknowledges that collaborators will need time and resources to build the CCE infrastructure, thus, CCEs-only may use fees advanced for start-up costs to fund initial investments in these activities. See Section 3.1.6.1.5 for more details.

### 3.1.6 Financial Models.

#### 3.1.6.1 CCE Reimbursement.

3.1.6.1.1 Illinois Public Act 096-1501 requires that 50 percent of medical assistance clients be enrolled in risk-based care coordination programs by January 1, 2015. A CCE may propose reimbursement from one or more of three risk-based options, where full payment is based on meeting specified Quality Measures:

3.1.6.1.1.1 **Care Coordination Fee:** A CCE choosing this reimbursement option will be reimbursed an administrative Per Member Per Month (PMPM) fee for each population type in its care coordination model. See Section 3.1.4.3.1 Pay-for-Performance and Section 3.4 Payment Terms and Conditions for more details.

3.1.6.1.1.2 **Shared Savings:** A CCE choosing this reimbursement option will be eligible to receive shared savings payments. Shared savings calculations will compare the projected cost of care with care coordination to baselines developed by the State and Federal CMS. The CCE will be eligible for up to 50 percent of savings annually (the remaining savings will go to federal and State governments) and will propose how its shared savings will be distributed among its collaborators. See Section 3.1.4.3.1 Pay-for-Performance and Section 3.4 Payment Terms and Conditions for more details.

3.1.6.1.1.2.1 The State is working with Federal CMS to develop baseline PMPMs and trends for the populations defined in this Solicitation and will provide this information when it is available. The Department is working with the hospital industry to reform the hospital reimbursement system. Initial baselines will be based on the current hospital reimbursement system. If a new reimbursement system is implemented before or during the term of a Contract awarded as a result of this Solicitation, the State will make appropriate adjustments to either the baselines or final costs based on the new system in order to reconcile costs between the two systems. In addition, baselines will be risk-adjusted for the profile of the population in a specific care coordination model. Federal CMS may impose other requirements on shared savings models and the Department will share this information as soon as it is available.

3.1.6.1.1.3 **Interagency Payment Flexibility Proposal:** A CCE may choose and is encouraged to develop new, innovative payment methodologies as long as the model facilitates care coordination among a diverse set of Providers and incentivizes more efficient practice. These models may include combining payment streams from multiple State agencies and new methods for paying for currently reimbursed services such as bundled payments and payments for episodes of care. A CCE may also propose regulatory flexibility to enable better coordination of care.

3.1.6.1.2 Regardless of the reimbursement method proposed for care coordination services, medical services will remain under a FFS payment structure or an alternative reimbursement methodology proposed and PCPs will continue to receive the IHC care management fee.

3.1.6.1.3 The Proposal must be at least cost neutral over three years. The State will monitor cost neutrality throughout the Contract period and reserves the right to terminate the Contract before the end of the initial term if the Contract is not cost neutral. The baselines set by the State and Federal CMS will be the basis for the cost neutrality analysis.

3.1.6.1.4 The Proposal may detail how the CCE may advance to become a MCCN and assume increased risk for all benefits and services over time.

- 3.1.6.1.5 At its sole discretion, the State may consider advancing, a portion of the care coordination fees to fund start-up costs, such as investments in health information technology or start up costs for Assertive Community Treatment and Community Support Team services. Any advance payments made will be recouped from future care coordination payments on a negotiated schedule.
- 3.1.6.1.6 A CCE may use revenue from its reimbursement to directly pay for a non-Covered Service.
- 3.1.6.1.7 All financial models are subject to federal approval before finalization of a Contract.
- 3.1.6.1.8 The 90 percent federal match available under Section 2703 of the ACA for qualified Enrollees and services will not affect reimbursement for a CCE operating as a health home. The eight quarters of 90 percent federal match applies to State reimbursement only. CCE fees proposed must be sustainable and cost neutral regardless of the federal match rate the State may receive.

**3.1.6.2 MCCN Reimbursement:** For MCCNs, the State, in conjunction with its independent actuary, will set actuarially sound capitation rates for services that are at-risk. There will not be a bidding process to set rates. A MCCN may pay for non-Covered Services within the capitation rate set by the Department. Payment of the full capitation rate is subject to the MCCN meeting specified Quality Measures. See Section 3.1.4.3.1 Pay-for-Performance and Section 3.4 Payment Terms and Conditions.

- 3.1.6.2.1 All financial models are subject to federal approval before finalization of a Contract.
- 3.1.6.2.2 The 90 percent federal match available under Section 2703 of the ACA for qualified Enrollees and services will not affect reimbursement for a MCCN operating as a health home. The eight quarters of 90 percent federal match applies to State reimbursement only.

**3.2 Proposal Contents.** This Section will serve as the opportunity for the Bidder, by responding to the questions below, to convey its vision and structure for serving as a CCE or MCCN under the Innovations Project. The State has designed this Solicitation to allow a potential Bidder to demonstrate its understanding of operating a CCE or MCCN and its ability to design, implement and operate such a program. The State understands that there can be varied approaches to such programs. Therefore, the State has outlined minimal care coordination requirements for CCEs and MCCNs, but has not fully prescribed in this Solicitation how such a system should be designed or operated. Instead, this Section of the Solicitation asks numerous questions of each Bidder in order to elicit innovative strategies and to better enable the State to evaluate the true understanding and abilities of a Bidder. The following section requires complete responses that address each question and provide any experience the Bidder has had in said area.

**3.2.1 Governance Structure, Scope of Collaboration, and Leadership**

- 3.2.1.1 Please provide the name of the Care Coordination Entity (CCE) or Managed Care Community Network (MCCN).
- 3.2.1.2 **CCE-Only.** Who are the collaborators including but not limited to PCPs, hospitals, mental health Providers, and substance abuse Providers? Please submit articles of incorporation and by-laws. Using the format found in Attachment E (Table 1), list each collaborator and its relationship with the CCE. The Department has the right to request agreements, contracts, letters of intent, etc.
  - 3.2.1.2.1 Who is the lead entity contracting with the State?
  - 3.2.1.2.2 Please explain your plans, if any, for advancing to full-risk capitation over time and applying to be a MCCN.
- 3.2.1.3 **MCCN-Only.** Who are the MCCN founders or owners? Please submit articles of incorporation and by-laws. Attach a list of the entire network of contracted Providers in addition to the providers who are the founders or owners of the MCCN. Use the format found in Attachment E (Table 2). The Department has the right to request agreements, contracts, letters of intent, etc.
- 3.2.1.4 Explain how your analysis of claims data leads you to believe the scope of your CCE collaboration/MCCN network (collaboration) is sufficient to effectively coordinate the care of and ensure access to care for the population you propose to serve. In discussing the scope of CCE collaborators/MCCN network of Providers (collaborators), indicate how the number of collaborators is sufficient and how the collaborators match the utilization patterns of the population you propose to serve.
- 3.2.1.5 Describe the governance structure of the CCE or MCCN, such as policies and mechanisms in place to share information and ensure compliance with the care coordination model described in your Proposal. Please attach the relevant articles of incorporation or by-laws that outline the governance structure as Attachment G.

- 3.2.1.6 Describe additional resources available to the CCE or MCCN to assist in implementation or operation of your care coordination model (funds committed by collaborators, Federal Innovations grants, private grants, etc.).
- 3.2.1.7 What financial management mechanisms do you expect to have in place at the time of implementation to manage the CCE or MCCN including any subcontracting arrangement?
- 3.2.1.8 Describe your plan for consumer input into the operations and management of the program.
- 3.2.1.9 Describe the experience of your collaborators in serving the needs and coordinating the care of the population you propose to serve.
- 3.2.1.10 Give the background of the key leaders of your collaboration, the role they will play, and the vision they bring to your Proposal.

### 3.2.2 Populations / Geography

- 3.2.2.1 Which Priority Populations do you propose to serve?
  - 3.2.2.1.1 How many of each Priority Population do you propose to serve?
  - 3.2.2.1.2 Within the Priority Populations listed in this Solicitation are there particular subsets you intend to target? Please clearly define your Target Population.
- 3.2.2.2 Do you propose to serve non-Priority Populations in your area? If so, which ones and how many do you propose to serve?
- 3.2.2.3 Which geographical area(s) do you propose to serve?
- 3.2.2.4 Do you plan to phase-in enrollment? Provide an estimated timetable (as part of Attachment H, below) for phasing in enrollment including when you expect to meet the minimum requirement for Priority Populations.
- 3.2.2.5 Provide a detailed draft implementation work plan as Attachment H, with an estimated timetable to begin enrollment no later than January 1, 2013, and include at least the following elements:
  - 3.2.2.5.1 Projected dates for hiring staff, by position;
  - 3.2.2.5.2 Projected dates for finalizing legal documents;
  - 3.2.2.5.3 Projected dates of finalizing collaborator and network participation;
  - 3.2.2.5.4 Projected dates (including important milestones) for implementation of electronic communication;
  - 3.2.2.5.5 Projected dates of staff training;
  - 3.2.2.5.6 Projected dates of development, Department approval, and public release of Marketing Materials;
  - 3.2.2.5.7 Projected dates for opening enrollment to Priority Populations; and
  - 3.2.2.5.8 Projected dates for opening enrollment to non-Priority Populations.

### 3.2.3 Care Coordination Model

- 3.2.3.1 Provide your definition and approach to care coordination, including your identification of any deficiencies in the health care market specific to your proposed population and geographical area and how your model will help overcome these deficiencies.
  - 3.2.3.1.1 If you are targeting Clients with SMI, please expressly indicate how your model design will meet the needs of that population and how it will interface with State-operated facilities.
- 3.2.3.2 Provide a detailed description of your care coordination model and how it meets the needs of the population you propose to serve including:

- 3.2.3.2.1** Services; and
- 3.2.3.2.2** How you will address and monitor transitions of care, including appropriate follow-up, from:
  - 3.2.3.2.2.1** Inpatient to Outpatient (PCP, Mental Health Providers, and Substance Abuse Providers);
  - 3.2.3.2.2.2** PCP to Mental Health Providers and Substance Abuse Providers, and vice versa; and
  - 3.2.3.2.2.3** Outpatient (PCP and Mental Health Providers and Substance Abuse Providers) to Inpatient.
- 3.2.3.3** Provide a comprehensive statement of your proposed three-year staffing plan to demonstrate adequate support of your care coordination model. Include organizational charts and detailed job descriptions for key staff.
- 3.2.3.4** Describe your expanded medical home functionality within your PCP network, including minimum hours of operation after hours availability, minimum appointment standards, and access standards.
- 3.2.3.5** Describe your proposed Provider to Enrollee ratios, including your plan to monitor and maintain ratios, for:
  - 3.2.3.5.1** PCP to Enrollees;
  - 3.2.3.5.2** Mental Health Provider to Enrollees;
  - 3.2.3.5.3** Substance Abuse Provider to Enrollees; and
  - 3.2.3.5.4** Specialist to Enrollees, if applicable.
- 3.2.3.6** Provide a detailed three-year budget as Attachment I that includes:
  - 3.2.3.6.1** Revenue sources (projected care coordination or capitation reimbursement revenue and other revenue sources); and
  - 3.2.3.6.2** Costs (operations, staffing, health information technology, performance incentive payments, estimates of reimbursement distribution among collaborators, and other costs).
- 3.2.3.7** To the extent that your model includes Dual Eligibles, describe your plan to address the specific needs of dually eligible populations.
  - 3.2.3.7.1** If your model to serve Dual Eligibles meets the requirements outlined in Federal CMS' Managed FFS model, describe:
    - 3.2.3.7.1.1** How you will promote seamless integration and access to all services in the Medicare and Medicaid programs, based on the Enrollee's needs, through coordination across both programs; and
    - 3.2.3.7.1.2** How you will assure access to all necessary care:
      - 3.2.3.7.1.2.1** Is provided in a culturally and linguistically appropriate manner;
      - 3.2.3.7.1.2.2** Includes caregivers, when appropriate;
      - 3.2.3.7.1.2.3** Is provided in the appropriate care setting including the home and community;
      - 3.2.3.7.1.2.4** Is person-centered; and
      - 3.2.3.7.1.2.5** Encourages consumer-direction.
- 3.2.3.8** Describe how you will maintain a profile for each Enrollee that includes:
  - 3.2.3.8.1** Demographics;
  - 3.2.3.8.2** PCP;

- 3.2.3.8.3** Results of risk assessment, if applicable; and
- 3.2.3.8.4** Care management assignment, if applicable.
- 3.2.3.9** Submit a sample Enrollee profile as Attachment J.
- 3.2.3.10** If you are proposing to operate as a health home and serve Clients eligible under Section 2703 of the ACA, describe:
  - 3.2.3.10.1** How you meet the definition of a health home;
  - 3.2.3.10.2** The process for identifying Clients with chronic conditions as defined in Section 2703 of the ACA and further clarified by the State;
  - 3.2.3.10.3** How many Clients you expect to serve; and
  - 3.2.3.10.4** How you will provide the following required services in addition to those outlined in Section 3.2.3.2:
    - 3.2.3.10.4.1** Comprehensive Care Management;
    - 3.2.3.10.4.2** Comprehensive Transitional Care, including appropriate follow-up, from inpatient to other settings;
    - 3.2.3.10.4.3** Care Coordination and health promotion;
    - 3.2.3.10.4.4** Individual family support, which includes authorized representatives;
    - 3.2.3.10.4.5** Referral to community and social support services (e.g. homelessness assistance and housing counseling), if relevant; and
    - 3.2.3.10.4.6** The use of HIT to link services, as feasible and appropriate.
- 3.2.3.11** What is your approach to discharge planning and ensuring Enrollees receive appropriate follow-up services?
- 3.2.3.12** How will your model of care decrease hospital readmission rates?
- 3.2.3.13** Describe the process for identifying mental health and substance abuse issues among primary care patients and ensuring the delivery of appropriate mental health and substance abuse care.
  - 3.2.3.13.1** Describe how you will educate PCPs in your CCE or MCCN about the importance of screening for mental health and substance abuse issues and the use of evidence-based practices in the treatment of Enrollees with SMI and substance abuse disorders.
- 3.2.3.14** Please describe your plans, if any, to co-locate physical health and mental health or substance abuse services.
- 3.2.3.15** Describe the process for emergency department data utilization review and identification of Enrollees with high utilization.
- 3.2.3.16** Explain the strategies to address high emergency department utilization that you will implement.
- 3.2.3.17** Describe strategies you will employ to promote wellness and encourage access to and utilization of preventive care.
- 3.2.3.18** Describe how you will educate PCPs on their responsibilities for compliance with the American Disabilities Act.
- 3.2.3.19** Describe the strategies that you will utilize to address Potential Enrollees who are very mobile, difficult to locate, homeless, or difficult to engage.
- 3.2.3.20** Describe methods you will employ to ensure your care coordination model takes into account the culture of and the specific needs of the population you propose to serve.
  - 3.2.3.20.1** Describe how you will supply interpretive services for all key oral contacts and ensure that written materials can be easily understood by the various populations.

- 3.2.3.20.2** Describe alternative methods of communication and how Enrollees will access these methods.
- 3.2.3.21** Describe any incentives you will allow PCPs and other Providers to use to encourage healthy behaviors and patient engagement in preventive care.
- 3.2.3.22** To the extent your model includes care coordinators, provide proposed care coordinator to Enrollee ratios and describe:
- 3.2.3.22.1** How caseloads will differ depending on the needs of the Enrollees they are assigned;
  - 3.2.3.22.2** The qualifications of care coordinators and whether they vary depending on the Enrollee assigned;
  - 3.2.3.22.3** The duties of your care coordinators; and
  - 3.2.3.22.4** The training programs care coordinators may receive regarding cultural competency.
- 3.2.3.23** To the extent your care coordination model includes any of the following services, describe how you will facilitate the delivery of appropriate health care and coordinate care between medical homes and:
- 3.2.3.23.1** Specialist services;
  - 3.2.3.23.2** Dental services;
  - 3.2.3.23.3** Existing HCBS Waiver case management services; and
  - 3.2.3.23.4** Other community agencies and services.
- 3.2.3.24** To the extent your care coordination model includes medication management, describe your approach to monitoring prescription drug usage including selected standards, models, and algorithms.
- 3.2.3.25** To the extent your plan includes Enrollee health education plans, explain your plans and submit sample materials.
- 3.2.3.26** Describe your plan for monitoring quality of care provided to your Enrollees and providing ongoing feedback to affiliated Providers on their performance.
- 3.2.3.27** Propose at least one Quality Measure to be used as a pay-for-performance measure. CCEs must propose at least one Quality Measure for each financial reimbursement method requested (See Section 3.1.6.1.1). The proposed measure should be related to your proposed care coordination model, not already included in Attachment A, and best demonstrate successful care coordination. See Section 3.4 Payment Terms and Conditions for more details.
- 3.2.3.28** Describe the experience of the collaborators using data to track utilization and to monitor Quality Measures.
- 3.2.3.29** Describe how you will improve access to care.
- 3.2.3.30 Enrollee Care Plan.** Enrollee care plans are required for Priority Populations. To the extent your care coordination model includes Enrollee care plans for non-Priority Populations, please answer the following questions for those populations also.
- 3.2.3.30.1** Describe your approach to Enrollee care plan development, including:
    - 3.2.3.30.1.1** The populations for which you will develop a care plan;
    - 3.2.3.30.1.2** How each Enrollee's needs, goals, and preferences are identified and addressed;
    - 3.2.3.30.1.3** Who develops and completes the Enrollee care plan and the process for collaboration; and
    - 3.2.3.30.1.4** Your approach, if any, to risk stratification and how it relates to Enrollee care plan development.
  - 3.2.3.30.2** Provide a sample Enrollee care plan as Attachment K.
  - 3.2.3.30.3** Describe how the Enrollee care plan will be made available to Providers and Enrollees.



- 3.2.3.30.4 Describe your strategies to enhance Enrollee compliance with Enrollee care plans.
- 3.2.3.30.5 Describe how you will coordinate Enrollee care plan development and implementation with Enrollee care plans and case coordinators serving Enrollees in HCBS Waivers.
- 3.2.3.30.6 Many of the Enrollees may already be enrolled in IHC and may have an Enrollee care plan with the Enrollee's PCP. Describe how you will incorporate these existing Enrollee care plans into the development of new Enrollee care plans.

### 3.2.3.31 Outreach

- 3.2.3.31.1 Describe your plan for outreach to engage the population you propose to serve.
- 3.2.3.31.2 Describe your staffing plan for outreach.
- 3.2.3.31.3 Describe the outreach process in your PCP offices.
- 3.2.3.31.4 Describe how you will ensure that written materials can be easily understood by various populations, including ensuring the accuracy of translated materials.
- 3.2.3.31.5 Describe alternative methods of communication you will offer and how Enrollees will access these methods.

## 3.2.4 Health Information Technology (HIT)

- 3.2.4.1 Describe the technology capacity among the collaborators (CCE collaborators/MCCN network) at the time of submission, including:
  - 3.2.4.1.1 PCP communication capabilities to support their role in care coordination;
  - 3.2.4.1.2 Mental Health and Substance Abuse Provider communication capabilities to support their role in care coordination;
  - 3.2.4.1.3 Hospital communication capabilities to support their role in care coordination; and
  - 3.2.4.1.4 Indicate which collaborating or network Providers have registered for Electronic Health Records Payment Incentive Program payments with either the State or federal government.
- 3.2.4.2 What is the expected HIT functionality of the collaborators 12 months after Contract Execution and how will this capacity support your care coordination model?
  - 3.2.4.2.1 Describe your connection to and support of: 1) PCPs, 2) Hospitals, and 3) Mental Health and Substance Abuse Providers; and
  - 3.2.4.2.2 Describe how you will address issues of privacy and confidentiality.
- 3.2.4.3 Describe any resources you plan to provide to collaborators in the area of HIT.

## 3.3 Financial Model

### 3.3.1 CCE Reimbursement<sup>1</sup>

- 3.3.1.1 Which of the three reimbursement options is the CCE selecting? *Note:* CCEs may select more than one option (See Section 3.1.6.1.1).

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<sup>1</sup>The State is working to develop baselines by population type that will be used to develop cost neutrality projections and shared savings calculations. The State will provide this information as soon as it is available. Actual costs, including any care coordination fee incurred, will be compared to these prescribed baselines.

- 3.3.1.2 If proposing a Care Coordination Fee, propose an administrative PMPM by population type for each of the first three years of the Contract, following the template provided in Attachment F.
  - 3.3.1.3 If proposing another interagency payment flexibility methodology, describe the proposed payment structure including amounts and how often the CCE would be paid.
  - 3.3.1.4 With respect to Department data, please indicate the population definition number(s) and version number that you relied upon for preparing this Proposal.
  - 3.3.1.5 Please describe any data (other than data received from the Department) that you relied upon.
  - 3.3.1.6 Please describe in detail how you expect your care coordination model to result in cost neutrality – to reduce costs by at least as much as the care coordination fees you expect to receive over three years.
  - 3.3.1.7 How do you plan to distribute the payment(s) among collaborators?
  - 3.3.1.8 What percentage of payment(s), if any, do you plan to put into a reserve pool?
  - 3.3.1.9 Please list all case management fees collaborators receive other than IHC fees, such as case management fees paid in HCBS Waivers. The State will not pay twice for the same care coordination services.
  - 3.3.1.10 Do you plan to request an advance on the care coordination fee to assist in the development of the CCE infrastructure prior to implementation?
    - 3.3.1.10.1 What percentage or amount are you requesting?
    - 3.3.1.10.2 Describe the intended use of the fee advance.
    - 3.3.1.10.3 Propose a repayment schedule.
- 3.3.2 **MCCN Reimbursement.** If applying to become a MCCN, describe in detail the package of services for which you will assume risk as well as any risk corridors or stop loss requirements.

### 3.4 Payment Terms and Conditions

#### 3.4.1 CCE Payment Terms and Conditions

- 3.4.1.1 **Care Coordination Fees:** Reimbursement to the CCE will be an administrative Per Member Per Month (PMPM) fee, paid monthly subject to the withhold described herein.
  - 3.4.1.1.1 **Pay-for-Performance:** Following the first two full calendar quarters of operation, the State will withhold a percentage of CCE fees from each month's payment. The CCE can earn the withheld amounts as an incentive payment by meeting Quality Measure targets. There will be five Quality Measures, each with an equal portion of the incentive payment tied to it. The State has determined four of the measures based on their applicability to the Priority Populations and these are set forth in Attachment B (Table 1) and Attachment C. The fifth measure will be proposed by the CCE and negotiated with the State and should be specific to the care coordination model or a particular population the CCE proposes to serve. This proposed measure should be utilization based so that it can be measured on a quarterly basis. Measurement and incentive payments on these Quality Measures will be done on a quarterly basis following a one-year claims run out. Therefore, the first payment will follow the seventh full calendar quarter of operation under the Contract.
  - 3.4.1.1.2 The incentive payment structure is described below.
    - 3.4.1.1.2.1 In Year One, beginning in the third full calendar quarter of operation, the State will withhold .5 percent of CCE fees per month for each measure for a total of 2.5 percent of fees per month. By meeting Quality Measure targets, CCEs will have the opportunity to earn incentive payments equal to .5 percent of total fees per measure for the third and fourth full calendar quarter of operation in Year One.
    - 3.4.1.1.2.2 In Year Two, the State will withhold .75 percent of CCE fees per month for each measure for a total of 3.75 percent of fees per month. By meeting Quality Measure targets, CCEs will have

the opportunity to earn incentive payments equal to .75 percent of total fees per quarter per measure in Year Two.

**3.4.1.1.2.3** In Year Three, the State will withhold one percent of CCE fees per month for each Quality Measure for a total of 5.0 percent of fees per month. By meeting Quality Measure targets, CCEs will have the opportunity to earn incentive payments equal to 1.0 percent of total fees per quarter per measure in Year Three.

**3.4.1.2 Shared Savings Reimbursement:** Shared savings will be calculated and paid on an annual basis with a reconciliation process for necessary adjustments. In order to accurately calculate actual costs and, therefore, savings, the Department must wait until all claims for the measurement year are submitted. Because Providers have one year from the date of service to bill the Department, the lag time between the end of the measurement year and the calculation of savings and payment of shared savings is more than one year.

**3.4.1.2.1 Pay-for-Performance:** If the State determines there are savings in a given year, CCEs will have the opportunity to share in those savings. CCEs will receive a base amount of 10 percent of calculated savings annually and may earn up to another 40 percent of calculated savings. In order to receive the remaining 40 percent of calculated shared savings, CCEs will be required to meet Quality Measure targets. There will be four Quality Measure targets. The State has determined three measures based on their applicability to the Priority Populations as outlined in Attachment B (Table 2) and Attachment C. One measure will be negotiated and specific to the care coordination model and population proposed. By meeting the specified targets, CCEs will have the ability to earn 10 percent of calculated savings per measure. The maximum amount of shared savings payments a CCE may receive per year is 50 percent.

**3.4.1.3 Inter-agency Payment Flexibility Proposal:** The State will determine the payment terms and Quality Measures based on the specific model proposed.

**3.4.1.4 CCE Quality Measure Targets.**

**3.4.1.4.1** For each Quality Measure used as pay-for-performance measure used pursuant to Sections 3.4.1.1.1 and 3.4.1.1.2, the quarterly target goal will be set at a percentage above the baseline equal to 2.5 percent of the difference between the baseline score and 100 percent. For example, if the baseline is 50 percent, 2.5 percent of the difference between 50 percent and 100 percent is 1.25 percent, and the goal will be set at 51.25 percent. In subsequent measurement years, the previous year's performance will be the baseline for that measurement year unless the previous year's performance was below that year's baseline, in which case the previous highest baseline is used as the baseline for the next year.

**3.4.1.4.2** For each Quality Measure used as pay-for-performance pursuant to Section 3.4.1.2.1, the annual target goal will be set at a percentage above the baseline equal to 10 percent of the difference between the baseline score and 100 percent. For example, if the baseline is 50 percent, 10 percent of the difference between 50 percent and 100 percent is 5 percent, and the goal will be set at 55 percent. In subsequent measurement years, the previous year's performance will be the baseline for that measurement year unless the previous year's performance was below that year's baseline, in which case the previous highest baseline is used as the baseline for the next year.

**3.4.2 MCCN Payment Terms and Conditions**

**3.4.2.1 MCCN Payment Terms:** MCCNs will be paid a capitation rate developed by the State's actuary.

**3.4.2.1.1** MCCNs may propose negotiating risk corridors or stop loss requirements.

**3.4.2.2 Pay-for-Performance:** Following the first two full calendar quarters of operation, portions of the capitation rate will be withheld and paid based on meeting specific Quality Measures set forth in Attachment B (Table 3) and Attachment C. The MCCN can earn the withheld amounts as an incentive payment by meeting Quality Measure targets. There will be four Quality Measures, each with an equal portion of the incentive payment tied to it. The State has determined three of the measures based on their applicability to the Priority Populations and these are set forth in Attachment B (Table 3) and Attachment C. The fourth measure will be proposed by the MCCN and negotiated with the State and should be specific to the care coordination model or a particular population the MCCN proposes to serve.

**3.4.2.2.1** The incentive payment structure is described below.

**3.4.2.2.1.1** In Year One, beginning in the third full calendar quarter of operation, the State will withhold 1.0 percent of the capitation rate per month. By meeting Quality Measure targets, MCCNs will have the opportunity to earn incentive payments equal to the amount withheld during the third and fourth full calendar quarters of operation in Year One.

**3.4.2.2.1.2** In Year Two, the State will withhold 1.5 percent of the capitation rate per month. By meeting Quality Measure targets, MCCNs will have the opportunity to earn incentive payments equal to the amount withheld in Year Two.

**3.4.2.2.1.3** In Year Three, the State will withhold 2.0 percent of the capitation rate per month. By meeting Quality Measure targets, MCCNs will have the opportunity to earn incentive payments equal to the amount withheld in Year Three.

**3.4.2.3 MCCN Quality Measure Targets:** For each Quality Measure used as pay-for-performance pursuant to Sections 3.4.2.2 and 3.4.2.2.1, the annual target goal will be set at a percentage above the baseline equal to 10 percent of the difference between the baseline score and 100 percent. For example, if the baseline is 50 percent, 10 percent of the difference between 50 percent and 100 percent is 5 percent, and the goal will be set at 55 percent. In subsequent measurement years, the previous year's performance will be the baseline for that measurement year unless the previous year's performance was below that year's baseline, in which case the previous highest baseline is used as the baseline for the next year.

**3.5 Compliance with Federal law, regulation, and policy.** All CCE and MCCN Contracts must be compliant with federal regulations found at 42 C.F.R. Part 438. See [http://www.access.gpo.gov/nara/cfr/waisidx\\_02/42cfr438\\_02.html](http://www.access.gpo.gov/nara/cfr/waisidx_02/42cfr438_02.html) for the federal regulations.

**3.6 Required Forms.** Consistent with Section 2, all Proposals must include completing and submitting the following:

**3.6.1** Taxpayer Identification Number

**3.6.2** Disclosures and Conflicts of Interest

**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:** \_\_\_\_\_

## DISCLOSURES AND CONFLICTS OF INTEREST

**Instructions:** The CCE/MCCN 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. Failure to fully disclose shall render the contract, bid, proposal, subcontract, or relationship voidable if the Department deems it in the best interest of the State of Illinois.

- 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. For multi-year contracts CCEs/MCCNs 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 CCE/MCCN submits a 10K, it must still complete Sections 2, 3, 4, 5 and 6 and submit the disclosure form.

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

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

Name of CCE/MCCN: \_\_\_\_\_

D/B/A (if used): \_\_\_\_\_

Name of any Parent Organization: \_\_\_\_\_

### Section 1: Disclosure of Financial Interest in the CCE/MCCN. (All CCEs/MCCNs must complete this section)

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

- a. If CCE/MCCN is a Publicly traded corporation subject to SEC reporting requirements
- The CCE/MCCN shall submit its 10K disclosure (include proxy if referenced in 10k) in satisfaction of the financial and conflict of interest disclosure requirements. 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 the CCE/MCCN is a privately held corporation with more than 400 shareholders
- These CCEs/MCCNs 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.

OR

- c. If CCE/MCCN is an individual, sole proprietorship, partnership, tax-exempt or any other not qualified to use subsections (A) or (B), complete (i) and (ii) below as appropriate.

- For each individual having any of the following financial interests in the CCE/MCCN (or its parent), please mark each that apply and show the applicable name and address. Use a separate form for each individual.
  - Do you have an ownership share of greater than 5% of the offering entity or parent entity?  
 Yes  No
  - Do you have an ownership share of less than 5%, but which has a value greater than \$106,447.20?  
 Yes  No
  - 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 \_\_\_\_\_.

1. 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 CCE/MCCN 's contract. Yes  No
2. State employment of spouse, father, mother, son, or daughter, including contractual employment for services in the previous 2 years. Yes  No
3. Elective status; the holding of elective office of the State of Illinois, the government of the United States, any unit of local government authorized by the Constitution of the State of Illinois or the statutes of the State of Illinois currently or in the previous 3 years. Yes  No
4. Relationship to anyone holding elective office currently or in the previous 2 years; spouse, father, mother, son, or daughter. Yes  No
5. Appointive office; the holding of any appointive government office of the State of Illinois, the United States of America, or any unit of local government authorized by the Constitution of the State of Illinois or the statutes of the State of Illinois, which office entitles the holder to compensation in excess of expenses incurred in the discharge of that office currently or in the previous 3 years. Yes  No
6. Relationship to anyone holding appointive office currently or in the previous 2 years; spouse, father, mother, son, or daughter. Yes  No
7. Employment, currently or in the previous 3 years, as or by any registered lobbyist of the State government. Yes  No
8. Relationship to anyone who is or was a registered lobbyist in the previous 2 years; spouse, father, mother, son, or daughter. Yes  No
9. Compensated employment, currently or in the previous 3 years, by any registered election or re-election committee registered with the Secretary of State or any county clerk in the State of Illinois, or any political action committee registered with either the Secretary of State or the Federal Board of Elections. Yes  No
10. Relationship to anyone; spouse, father, mother, son, or daughter; who is or was a compensated employee in the last 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: Conflicts of Interest (All CCEs/MCCNs 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 CCEs/MCCNs 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.

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

Each Proposal submitted by a CCE or MCCN 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:

- a. 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
- b. 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 Proposal that does not include this disclosure shall not be considered responsive. We may consider this disclosure when evaluating the 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:

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

Does the CCE/MCCN 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.

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

Is the CCE/MCCN 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.

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

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

**This Disclosure is signed and made under penalty of perjury.**

This information is submitted on behalf of: \_\_\_\_\_  
(CCE/MCCN/Subcontractor Name)

Name of Authorized Representative: \_\_\_\_\_

Title of Authorized Representative: \_\_\_\_\_

Signature of Authorized Representative: \_\_\_\_\_

Date: \_\_\_\_\_

**3.7 HIPAA Compliance Obligations.** CCEs/MCCNs that are awarded Contracts will be required to comply with HIPAA Compliance Obligations.

**A. Definitions.**

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

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

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

**C. Limitations on Contractor's Uses and Disclosures. Contractor shall:**

1. Not use or further disclose PHI other than as permitted or required by the Contract or as required by law;
2. Use appropriate safeguards to prevent use or disclosure of PHI other than as provided for by this Contract;
3. Mitigate, to the extent practicable, any harmful effect that is known to Contractor of a use or disclosure of PHI by Contractor in violation of the requirements of this Contract;
4. Report to the Agency/Buyer any use or disclosure of PHI not provided for by this Contract of which Contractor becomes aware;
5. Ensure that any agents, including a subContractor, to whom Contractor provides PHI received from the Agency/Buyer or created or received by Contractor on behalf of the Agency/Buyer, agree to the same restrictions and conditions that apply through this Contract to Contractor with respect to such information;
6. Provide access to PHI in a Designated Record Set to the Agency/Buyer or to another individual whom the Agency/Buyer names, in order to meet the requirements of 45 CFR section 164.524, at the Agency/Buyer's request, and in the time and manner specified by the Agency/Buyer;
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/Buyer directs or that Contractor agrees to pursuant to 45 CFR section 164.526 at the request of the Agency/Buyer or an individual, and in a time and manner specified by the Agency/Buyer;

8. Make Contractor's internal practices, books, and records, including policies and procedures and PHI, relating to the use and disclosure of PHI received from the Agency/Buyer or created or received by Contractor on behalf of the Agency/Buyer available to the Agency/Buyer and to the Secretary of Health and Human Services for purposes of determining the Agency/Buyer'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/Buyer to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR section 164.528;
10. Provide to the Agency/Buyer or to an individual, in a time and manner specified by the Agency/Buyer, information collected in accordance with the terms of this Contract to permit the Agency/Buyer to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR section 164.528;
11. Return or destroy all PHI received from the Agency/Buyer or created or received by Contractor on behalf of the Agency/Buyer that Contractor still maintains in any form, and to retain no copies of such PHI, upon termination of this Contract for any reason. If such return or destruction is not feasible, Contractor shall provide the Agency/Buyer with notice of such purposes that make return or destruction infeasible, and upon the parties' written agreement that return or destruction is infeasible, Contractor shall extend the protections of the Contract to the PHI and limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible. This provision shall apply equally to PHI that is in the possession of Contractor and to PHI that is in the possession of subContractors or agents of Contractor.

**D. Agency/Buyer Obligations.** The Agency/Buyer shall:

1. Provide Contractor with the Agency/Buyer's Notice of Privacy Practices and notify Contractor of any changes to said Notice;
2. Notify Contractor of any changes in or revocation of permission by an individual to use or disclose PHI, to the extent that such changes may affect Contractor's permitted or required uses and disclosures of PHI;
3. Notify Contractor of any restriction to the use or disclosure of PHI that the Agency/Buyer had agreed to in accordance with 45 CFR section 164.522, to the extent that such restriction may affect Contractor's use or disclosure of PHI;
4. Not request that Contractor use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by the Agency/Buyer.

**E. Breach Requirements.**

1. Sections 164.308, 164.310, 164.312 and 164.316 of title 45, Code of Federal Regulations, apply to the Contractor in the same manner that such sections apply to the Agency. The Contractor'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 Contractor creates, receives, maintains, or transmits on behalf of the covered entity as required by HIPAA;
  - b. Ensuring that any agent, including a subContractor, to whom the Contractor 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, Contractor 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 Contractors becomes aware;
  - d. Ensure that any agents, including a subContractor, to whom the Contractor provides Protected Health Information received from the Agency or created or received by the Contractor on behalf of the Agency agrees to the same restrictions and conditions that apply to the Contractor 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 Contractor 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 Contractor 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 Contractor discovers a Breach of Unsecured Protected Health Information, the Contractor agrees to take the following measures within 10 calendar days after the Contractor 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. part E. Such notice by the Contractor shall be provided without unreasonable delay, 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, Contractor must notify the Agency of any such incident within the above timeframe even if Contractor has not conclusively determined within that time that the incident constitutes a Breach as defined by HIPAA. The Contractor 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 Contractor, including any person other than the individual committing the Breach, that is an employee, officer or other agent of the Contractor or an associate of the Contractor;
  - 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 a sample copy of the notice for the Agency.
4. Notification Duty. It is Contractors duty to provide the Breach notification to the affected individuals unless Agency agrees to provide the Breach notification.
5. Costs. Contractor assumes all costs for providing Breach notification unless Agency agrees to assume any costs.
6. Indemnification for Breach Notification. Contractor 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. part E.
- F. Interpretation. Any ambiguity in this Contract shall be resolved in favor of a meaning that permits the Agency/Buyer 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 the Department 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 Department 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:** \_\_\_\_\_

**Attachment A\***  
**Quality Measures**

The following Attachments A, B, and C relate to Quality Measures. The Department will use the Quality Measures listed in Attachment A to monitor performance. Seven of the Quality Measures in Attachment A are targeted to be used as pay-for-performance measures, where full payment is based on meeting targets associated with these measures, and are indicated in the P4P Year column. Attachments B and C provide further information on the Quality Measures targeted to be used as pay-for-performance.

#	Category	Quality Measure	P4P Year
1	<b>Behavioral Health Risk Assessment and Follow-up</b>	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		
	2) Behavior Health follow-up within 30 days of screening		
2	<b>Alcohol and other Drug Dependence Treatment</b>	Enrollees with new episode of alcohol or other drug (AOD) dependence who received initiation and engagement of AOD treatment.	
3	<b>Behavioral Health Support</b>	Follow-up with a Provider within 30 days after initial Behavioral Health diagnosis	1, 2, 3
4	<b>Behavioral Health Support</b>	Follow-up after hospitalization for Mental Illness	
	1) Follow-up in 7 days		
	2) Follow-up in 30 days		
5	<b>Care Coordination Influenza Immunization Rate</b>	Enrollees who received at least one influenza immunization annually.	
6	<b>Dental Utilization</b>	Enrollees who receive an annual dental visit	
	1) Annual Dental Visit –All		

\*The State has made available to the Department website the specifications for all Quality Measures listed in Attachment A. <http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/default.aspx>



#	Category	Quality Measure	P4P Year
	2) Annual Dental Visit – DD only		
7	<b>Dental ER Utilization</b>	Emergency room visits for Enrollees with dental primary diagnoses.	
8	<b>Diabetes Care</b>	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		
	2) Microalbuminuria testing 1 X per year		
	3) Cholesterol testing 1X per year		
	4) Statin Therapy 80% of the time		
	5) ACE/ARB 80% of the time		
	6) DD Waiver Program Support	Services for Enrollees in DD Waiver and Enrollees with DD Diagnostic History - HbA1c testing 1x per year	
9	<b>Congestive Heart Failure</b>	Increased utilization of disease specific therapies (meet 2 of 3).	
	1) ACE/ARB 80% of the time		
	2) Beta Blocker 80% of the time		
	3) Diuretic 80% of the time		
10	<b>Coronary Artery Disease</b>	Increased utilization of disease specific therapies (meet 2 of 4).	
	1) Cholesterol testing 1X per year		
	2) Statin Therapy 80% of the time		

Attachment A-2

\*The State has made available to the Department website the specifications for all Quality Measures listed in Attachment A.  
<http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/default.aspx>

#	Category	Quality Measure	P4P Year
	3) ACE/ARB 80% of the time		
	4) Beta Blocker Post MI for 6 months following MI		
11	<b>Chronic Obstructive Pulmonary Disease</b>	Increased utilization of disease specific therapies (meet 2 of 3).	
	1) Acute COPD Exacerbation w/corticosteroid		
	2) History of hospitalizations for COPD with bronchodilator medications		
	3) Spirometry testing (1 time in last three years)		
12	<b>Ambulatory Care</b>	Emergency Department visits per 1,000 Enrollees	1, 2, 3
	1) Waiver Program Support	Services for Population in DD Waiver and Clients with Diagnostic History - Emergency Department Utilization Rate per 1,000	
13	<b>Ambulatory Care follow-up after Emergency Department Visit</b>	Follow-up with any Provider within 14 days following Emergency Department visit	
14	<b>Inpatient Utilization- General Hospital/ Acute Care</b>	General Hospital Inpatient Utilization Admits per 1,000 Enrollees	1, 2, 3
15	<b>Mental Health Utilization</b>	Mental Health services utilization per 1,0000 Enrollees	
16	<b>Ambulatory Care Follow-up after Inpatient Discharge</b>	Ambulatory care follow-up visit with assigned PCP within 14 days of inpatient discharge	1, 2, 3

Attachment A-3

\*The State has made available to the Department website the specifications for all Quality Measures listed in Attachment A.  
<http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/default.aspx>

#	Category	Quality Measure	P4P Year
17	Inpatient Hospital Re-Admission	Inpatient Hospital 30 day readmissions. In addition, Mental Health readmissions reported separately	1, 2, 3
18	Long Term Care Residents – Urinary Tract Infection Hospital Admission	Hospital Admissions due to urinary tract infections for LTC Residents	
19	Long Term Care Residents – Bacterial Pneumonia Hospital Readmission	Hospital Admission due to bacterial pneumonia for LTC Residents	
20	Long Term Care Residents – Prevalence of Pressure Ulcers	LTC Residents that have category/ stage II or greater pressure ulcers.	
21	Medication Reviews	Annual monitoring for Enrollees on persistent medications	
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)	
23	Medication Reviews	Antidepressant Medication Management - At least 180 days continuous treatment with antidepressant medication during 231 day period following IESD	
24	Medication Reviews	Percentage of Enrollees diagnosed with schizophrenia who maintain medication adherence at 6 months and 12 months	
25	Preventive Services	Colorectal Cancer Screening	
26	Preventive Services	Breast Cancer Screening	
27	Preventive Services	Cervical Cancer Screening	
28	Preventive Services	Adult BMI Assessment	

#	Category	Quality Measure	P4P Year
29	<b>Access to Enrollee's Assigned PCP</b>	Enrollees who had an annual ambulatory or preventive care visit with Enrollee's assigned PCP	1, 2, 3
30	<b>Retention Rate for LTC and HCBS Waiver Enrollees Service in the Community</b>	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.	
31	<b>Medication Therapy Management</b>	Complete a Medication Review of All Enrollees taking 5 or More Prescription Medications with Documented Plan for Reducing Medications when Appropriate	1, 2, 3

**Attachment B\***  
**Quality Measures: Pay-for-Performance (P4P) Measures**

**Table 1 (CCE-Only)\***

# Per Attach. A	Year	CCE Incentive Payment P4P Measure	CY'10 Baseline Measurement <sup>1/</sup>	Year 1 <sup>2/</sup> (Q3&4) % of Fees withheld for P4P <sup>3/</sup>	Year 2 % of Fees withheld for P4P <sup>3/</sup>	Year 3 % of Fees withheld for P4P <sup>3/</sup>
16	1, 2, 3	Ambulatory care follow-up visit with assigned PCP within 14 days of inpatient discharge	TBD	.5%	.75%	1%
14	1, 2, 3	General Hospital Inpatient Utilization Admits per 1,000 Enrollees	TBD	.5%	.75%	1%
12	1, 2, 3	Emergency Department visits per 1,000 Enrollees	TBD	.5%	.75%	1%
17	1, 2, 3	Inpatient Hospital 30-day readmissions	TBD	.5%	.75%	1%
TBD	1, 2, 3	Proposed Measure	TBD	.5%	.75%	1%

1/The State will use statewide Calendar Year (CY) 2010 baseline measurements for Seniors and Adults with Disabilities, but may consider other baselines for specific care coordination models and populations proposed. CY 2010 baseline measurements will be provided at a later date.

2/Beginning with the fees paid during the third quarter of Year One, CCEs are eligible for incentive payments.

3/ Percent of Fees withheld for P4P represents the amount of total CCE fees in a quarter per measure that CCEs are eligible to earn as an incentive payment for meeting each quality measurement target.

**Table 2 (CCE-Only)\***

# Per Attach. A	Year	CCE Shared Savings P4P Measures	CY'10 Baseline Measurement <sup>1/</sup>	Year 1 % of Total P4P <sup>2/</sup>	Year 2 % of Total P4P <sup>2/</sup>	Year 3 % of Total P4P <sup>2/</sup>
29	1, 2, 3	Enrollees who had an annual ambulatory or preventive care visit with Enrollee's assigned PCP	TBD	10%	10%	10%
3	1, 2, 3	Follow-up with a Provider within 30 Days After an Initial Behavioral Health Diagnosis	TBD	10%	10%	10%
31	1, 2, 3	Medication Review of all Enrollees Taking More than Five Prescription Medications	TBD	10%	10%	10%
TBD	1, 2, 3	Proposed Measure	TBD	10%	10%	10%

1/The State will use statewide CY 2010 baseline measurements for Seniors and Adults with Disabilities, but may consider other baselines for specific care coordination models and populations proposed. CY 2010 baseline measurements will be provided at a later date.

2/Percent of Total P4P represents the amount of shared savings per measure per year that CCEs are eligible to earn for meeting each quality measurement target.

**Table 3 (MCCN-Only)\***

# Per Attach. A	Year	MCCN Incentive Payment P4P Measures	CY'10 Baseline Measurement <sup>1/</sup>	Year 1 <sup>2/</sup> (Q3&4) % Withheld for P4P <sup>3/</sup>	Year 2 % Withheld for P4P <sup>3/</sup>	Year 3 % Withheld for P4P <sup>3/</sup>
16	1, 2, 3	Ambulatory care follow-up visit with assigned PCP within 14 days of inpatient discharge	TBD	.25%	.375%	.50%
17	1, 2, 3	Inpatient Hospital 30-day readmissions	TBD	.25%	.375%	.50%
3	1, 2, 3	Follow-up with a Provider within 30 Days After an Initial Behavioral Health Diagnosis	TBD	.25%	.375%	.50%
TBD	1, 2, 3	Proposed Measure	TBD	.25%	.375%	.50%

1/The State will use statewide Calendar Year (CY) 2010 baseline measurements for Seniors and Adults with Disabilities, but may consider other baselines for specific care coordination models and populations proposed. CY 2010 baseline measurements will be provided at a later date.

2/Beginning with the capitation payments made during the third quarter of Year One, MCCNs are eligible for incentive payments.

3/ Percent Withheld for P4P represents the amount of the capitation rate withheld that MCCNs are eligible to earn as an incentive payment for meeting each quality measurement target.

\*The State and stakeholders continue to discuss the most appropriate pay-for-performance measures and the State reserves the right to change the measures listed above during the Solicitation process or during Contract negotiations.

**RFP Attachment C**  
**Quality Measures: Pay-for-Performance Measures Specifications**

**Measure 3 (FUP) – Follow-up with a Provider within 30 Days After an Initial Behavioral Health Diagnosis (State-Defined)**

**Description**

This measure determines if a member had timely follow-up with a practitioner following their initial Behavioral Health diagnosis.

**Eligible Population**

- Ages** All
- Continuous enrollment** 30 days following the date of the initial Behavioral Health diagnosis.
- Allowable gap** No gaps in enrollment.
- Event/ diagnosis** Diagnosed with a mental illness between December 2 of the prior year and December 1 of the measurement year (Table FUH-A). Use the earliest diagnosis during the measurement year.  
  
To be considered the initial diagnosis, the member should have negative claims / encounter history with a mental health diagnosis (principal or secondary diagnosis) for the six months prior to the current episode.

**Table FUH-A: Codes to Identify Mental Health Diagnosis**

ICD-9-CM Diagnosis
295–299, 300.3, 300.4, 301, 308, 309, 311–314

**Administrative Specification**

- Denominator** The eligible population.
- Numerator** An outpatient visit, intensive outpatient encounter or partial hospitalization (Table FUH-C) with any practitioner within 30 days after the initial diagnosis.

**Table FUH-C: Codes to Identify Visits**

CPT	HCPCS	
90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99383-99387, 99393-99397, 99401-99404, 99411, 99412, 99510	G0155, G0176, G0177, G0409-G0411, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485	
CPT	WITH	POS
90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876	<i>WITH</i>	03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72
99221-99223, 99231-99233, 99238, 99239, 99251-99255	<i>WITH</i>	52, 53
UB Revenue		
0510, 0513, 0515-0517, 0519-0523, 0526-0529, 0900-0905, 0907, 0911-0917, 0919, 0982, 0983		



**Measure 3 (FUP) - Follow-up with a Provider within 30 Days After an Initial Behavioral Health Diagnosis (State-Defined)**

**Exclusions (required)**

**Mental health readmission or direct transfer** Exclude members admitted to or directly transferred to a *non-acute facility* for a mental health principal diagnosis (Tables MPT-A, MPT-B) within the 30-day follow-up period. These members are excluded from the measure because admission or transfer may prevent an outpatient follow-up visit from taking place. Refer to Table FUH-B for codes to identify non-acute care.

**Non-mental health readmission or direct transfer** Exclude members transferred directly or admitted within 30 days after the initial diagnosis to an acute or non-acute facility for a non-mental health principal diagnosis. This includes an ICD-9-CM Diagnosis code or DRG code other than those in Tables MPT-A and MPT-B. These members are excluded from the measure because a hospitalization or transfer may prevent an outpatient follow-up visit from taking place.

**Table FUH-B: Codes to Identify Non-acute Care**

Description	HCPCS	UB Revenue	UB Type of Bill	POS
Hospice		0115, 0125, 0135, 0145, 0155, 0650, 0656, 0658, 0659	81x, 82x	34
SNF		019x	21x, 22x, 28x	31, 32
Hospital transitional care, swing bed or rehabilitation			18x	
Rehabilitation		0118, 0128, 0138, 0148, 0158		
Respite		0655		
Intermediate care facility				54
Residential substance abuse treatment facility		1002		55
Psychiatric residential treatment center	T2048, H0017-H0019	1001		56
Comprehensive inpatient rehabilitation facility				61
Other non-acute care facilities that do not use the UB revenue or type of bill codes for billing (e.g., ICF, SNF)				

**Measure 12 (AMB) - Emergency Department Visits Per 1,000 Enrollees**

**Description**

This measure summarizes utilization of ambulatory care in the following categories.

- Outpatient Visits
- ED Visits (**Required**)

**Note: The CCE or MCCN will only be responsible for measuring the ED Visits section of this HEDIS measure.**

**Calculations**

- Product** Medicaid.
- Member months** For each product line and table, report all member months for the measurement year. IDSS automatically produces member year's data for the commercial and Medicare product lines. Refer to *Specific Instructions for Use of Services Tables* for more information.
- Counting multiple services** *For combinations of multiple ambulatory services falling in different categories on the same day, report each service that meets the criteria in the appropriate category.*
- Outpatient visits** Use Table AMB-A to identify outpatient visits. Count each occurrence of the CPT codes listed in Table AMB-A if rendered by different practitioners (a CPT code may count more than once on the same date of service if rendered by different practitioners).  
  
Report services without regard to practitioner type, training or licensing.

**Table AMB-A: Codes to Identify Outpatient Visits**

Description	CPT	UB Revenue
Office or other outpatient visits	99201-99205, 99211-99215, 99241-99245	051x, 0520-0523, 0526-0529, 0982, 0983
Home visits	99341-99345, 99347-99350	
Nursing facility care	99304-99310, 99315, 99316, 99318	0524, 0525
Domiciliary or rest home care	99324-99328, 99334-99337	
Preventive medicine	99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429	
Ophthalmology and optometry	92002, 92004, 92012, 92014	
Newborn Care*	99461	

*\*Note: Newborn care is in the table to reflect the HEDIS specifications, but it does not apply to the IL ABD population.*

**Measure 12 (AMB) - Emergency Department Visits Per 1,000 Enrollees**

**ED visits** Use Table AMB-B to identify ED visits. Count once each visit to an ED that does not result in an inpatient stay, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit.

**Table AMB-B: Codes to Identify ED Visits**

<b>CPT</b>	<b>UB Revenue</b>
99281-99285	045x, 0981

**OR**

<b>CPT</b>	<b>WITH</b>	<b>POS</b>
10040-69979	<b>WITH</b>	23

*Note: The rates will be reported as rates per 1000 member months.*

**Exclusions (required)**

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- The measure does not include mental health or chemical dependency services. Exclude (from all categories) claims and encounters that contain any code in Table AMB-C.

**Table AMB-C: Codes to Identify Exclusions**

<b>CPT</b>	<b>Principal ICD-9-CM Diagnosis</b>	<b>ICD-9-CM Procedure</b>
90801-90899	290-316	94.26, 94.27, 94.6
<b>Principal ICD-9-CM Diagnosis</b>	<b>WITH</b>	<b>Secondary ICD-9-CM Diagnosis</b>
960-979	<b>WITH</b>	291-292, 303-305

**Note**

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- *This measure provides a reasonable proxy for professional ambulatory encounters. It is neither a strict accounting of all ambulatory resources nor an effort to be all-inclusive.*

**Measure 14 (IPU) - General Hospital Inpatient Admits Per 1,000 Enrollees**

**Description**

This measure summarizes utilization of acute inpatient care and services in the following categories:

- Total inpatient
- Medicine
- Surgery
- Maternity

**Calculations**

**Member months** For each product line and table, report all member months for the measurement year. IDSS automatically produces member year's data for the commercial and Medicare product lines. Refer to *Specific Instructions for Use of Services Tables* for more information.

Maternity rates are reported per 1,000 male and per 1,000 female total member months in order to capture deliveries as a percentage of the total inpatient discharges.

**Discharges** Refer to the codes in Table IPU-A to identify total inpatient discharges, then use Table IPU-B to separate discharges into *Maternity*, *Surgery* and *Medicine*. Count each discharge in the Total category and only one other category based on the hierarchy below.

**Table IPU-A: Codes to Identify Total Inpatient Discharges**

Principal ICD-9-CM Diagnosis	OR	MS—DRG
001-289, 317-999, V01-V29, V40-V90	<b>OR</b>	001-013, 020-042, 052-103, 113-117, 121-125, 129-139, 146-159, 163-168, 175-208, 215-264, 280-316, 326-358, 368-395, 405-425, 432-446, 453-517, 533-566, 573-585, 592-607, 614-630, 637-645, 652-675, 682-700, 707-718, 722-730, 734-750, 754-761, 765-770, 774-782, 789-795, 799-804, 808-816, 820-830, 834-849, 853-858, 862-872, 901-909, 913-923, 927-929, 933-935, 939-941, 947-951, 955-959, 963-965, 969-970, 974-977, 981-989, 998, 999

**WITH**

UB Type of Bill	OR	Any acute inpatient facility code
11x, 12x, 41x, 84x	<b>OR</b>	

**Days** Count all days associated with the identified discharges. Report days for total inpatient, maternity, surgery and medicine.

**ALOS** Refer to the *Specific Instructions for Use of Services Tables* for the formula. Calculate average length of stay for total inpatient, maternity, surgery and medicine.

**Total inpatient** Use Table IPU-A to identify all acute inpatient discharges.

The Total Inpatient should be the sum of the three categories (*Medicine*, *Surgery*, and *Maternity*) and any MS-DRGs defined as "principal diagnosis invalid as discharge diagnosis or ungroupable."

Categorize each inpatient discharge using the hierarchy below.

**Measure 14 (IPU) - General Hospital Inpatient Admits Per 1,000 Enrollees**

**Maternity** Include birthing center deliveries in this measure and count them as one day of stay. Refer to Table IPU-B for ICD-9-CM Principal Diagnosis codes, UB Revenue, UB Type of Bill and DRG codes. A delivery is not required to be included in the Maternity category; any maternity-related stay is included in the Maternity category.

**Surgery** DRGs are the preferred method to identify surgical discharges. An organization that uses ICD-9-CM Diagnosis codes must identify total inpatient, remove maternity-related discharges and include the remaining discharges accompanied by UB revenue code 036X.

**Medicine** DRGs are the preferred method to identify medical discharges. An organization that uses ICD-9-CM Diagnosis codes must identify total acute inpatient discharges, remove maternity related discharges and remove all discharges accompanied by UB revenue code 036X.

Newborn care rendered from birth to discharge home from delivery is not included in this measure. Only report MS-DRGs 789–795 under *Medicine* if newborn care is rendered after the baby has been discharged home from delivery and is subsequently rehospitalized.

**Note:** The use of DRGs is preferred to report discharges in all categories. Organizations that use DRGs should categorize them by the hierarchy described above (i.e., Maternity, then Surgery, then Medicine). If DRGs are unavailable, use the other specified codes (e.g., ICD-9-CM codes) and categorize these codes by hierarchy.

**Table IPU-B: Codes to Identify Medicine, Surgery and Maternity Inpatient Discharges**

Description	Principal ICD-9-CM Diagnosis	UB Revenue	UB Type of Bill	MS—DRG
Maternity	630-676, 678-679, V24.0	0112, 0122, 0132, 0142, 0152, 0720-0722, 0724	84x	765-770, 774-782
Surgery	Total—Maternity*	036x		001-013, 020-042, 113-117, 129-139, 163-168, 215-264, 326-358, 405-425, 453-517, 573-585, 614-630, 652-675, 707-718, 734-750, 799-804, 820-830, 853-858, 901-909, 927-929, 939-941, 955-959, 969-970, 981-989
Medicine	Total—Maternity—Surgery			052-103, 121-125, 146-159, 175-208, 280-316, 368-395, 432-446, 533-566, 592-607, 637-645, 682-700, 722-730, 754-761, 789-795, 808-816, 834-849, 862-872, 913-923, 933-935, 947-951, 963-965, 974-977

\* If the organization uses ICD-9-CM Diagnosis codes to report this measure, all discharges reported in the *Surgery* group must be in conjunction with UB revenue code 036x.

**Exclusions (required)**

- The measure does not include services for discharges with a principal diagnosis of mental health or chemical dependency. Exclude claims and encounters that contain any of the following codes.

**Table IPU-C: Codes to Identify Exclusions**

Principal ICD-9-CM Diagnosis	WITH	Secondary ICD-9-CM Diagnosis
960-979		291-292, 303-305

**Measure 16 (API) - Ambulatory Care Follow-up Visit with Assigned PCP within 14 Days of Inpatient Discharge (State-Defined)**

**Description**

This measure determines if a member had an ambulatory care follow-up with their assigned PCP after having an inpatient hospital stay.

**Eligible Population**

- Product lines** Medicaid.
- Ages** All
- Continuous enrollment** Date of discharge through 14 days after discharge.
- Allowable gap** No gaps in enrollment.
- Event/ diagnosis** Discharged alive from an inpatient setting (Table IPU-A) on or between December 18 of the prior year and December 17 of the measurement year.  
  
This measure excludes inpatient discharges with a principal diagnosis for mental illness, or chemical dependency.  
  
The denominator for this measure is based on inpatient discharges, not members. Include all events for those members who have more than one discharge on or between December 18 of the prior year and December 17 of the measurement year.

**Table IPU-A: Codes to Identify Total Inpatient Discharges**

Principal ICD-9-CM Diagnosis	MS—DRG
<b>OR</b>	001-013, 020-042, 052-103, 113-117, 121-125, 129-139, 146-159, 163-168, 175-208, 215-264, 280-316, 326-358, 368-395, 405-425, 432-446, 453-517, 533-566, 573-585, 592-607, 614-630, 637-645, 652-675, 682-700, 707-718, 722-730, 734-750, 754-761, 765-770, 774-782, 789-795, 799-804, 808-816, 820-830, 834-849, 853-858, 862-872, 901-909, 913-923, 927-929, 933-935, 939-941, 947-951, 955-959, 963-965, 969-970, 974-977, 981-989, 998, 999

**WITH**

<b>UB Type of Bill</b>	<b>OR</b>	Any acute inpatient facility code
11x, 12x, 41x, 84x		

**Measure 16 (API) - Ambulatory Care Follow-up Visit with Assigned PCP within 14 Days of Inpatient Discharge (State-Defined)**

**Administrative Specification**

- Denominator**      The eligible population
- Numerator**      An ambulatory care follow-up visit with an assigned PCP or a provider affiliated with the assigned PCP within 14 days of the inpatient discharge. Use Table AAP-A to determine follow-up visits.

**Table AAP-A: Codes to Identify Preventive/Ambulatory Health Services**

Description	CPT	HCPCS	ICD-9-CM Diagnosis	UB Revenue
Office or other outpatient services	99201-99205, 99211-99215, 99241-99245			051x, 0520-0523, 0526-0529, 0982,0983
Home services	99341-99345, 99347-99350			
Nursing facility care	99304-99310, 99315, 99316, 99318			0524, 0525
Domiciliary, rest home or custodial care services	99324-99328, 99334-99337			
Preventive medicine	99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99420, 99429	G0344, G0402, G0438, G0439		
Ophthalmology and optometry	92002, 92004, 92012, 92014			
General medical examination			V70.0, V70.3, V70.5, V70.6, V70.8, V70.9	

**Exclusions (required)**

- Exclude inpatient hospitalizations for deliveries (births).

**Table IPU-B: Codes to Identify Maternity Inpatient Discharges**

Description	Principal ICD-9-CM Diagnosis	UB Revenue	UB Type of Bill	MS—DRG
Maternity	640-676, 678, 679, V24.0, V27.x, V30-V37, V39	0112, 0122, 0132, 0142, 0152, 0720-0722, 0724	84x	765-770, 774-782

- Exclude discharges in which the patient was transferred directly or readmitted within 14 days after discharge to an acute or non-acute facility. These discharges are excluded from the measure because re-hospitalization or transfer may prevent an outpatient follow-up visit from taking place.
- The measure does not include services for inpatient discharges with a principal diagnosis of mental health or chemical dependency. Exclude claims and encounters that contain any of the following codes.

**Table IPU-C: Codes to Identify Exclusions**

Principal ICD-9-CM Diagnosis	WITH	Secondary ICD-9-CM Diagnosis
960-979		291-292, 303-305

**Measure 17A (IHR) - Inpatient Hospital 30-Day Readmission Rate (State-Defined)**

**Description**

This measure determines if a member had an inpatient hospital readmission *for the same discharge diagnosis* after having an initial inpatient hospital stay.

**Eligible Population**

<b>Product</b>	Medicaid
<b>Ages</b>	All
<b>Continuous enrollment</b>	Date of discharge through 30 days after discharge.
<b>Allowable gap</b>	No gaps in enrollment.
<b>Event/ diagnosis</b>	Discharged alive from an inpatient setting (Table IPU-A) on or between December 18 of the prior year and December 1 of the measurement year.

This measure excludes inpatient discharges with a principal diagnosis for mental illness defined in Table MPT-A below.

**Table MPT-A: Codes to Identify Mental Health Diagnosis (Exclusions)**

ICD-9-CM Diagnosis
290, 293-302, 306-316

The denominator for this measure is based on discharges, not members. Include all events for those members who have more than one discharge on or between December 18 of the prior year and December 1 of the measurement year.

Exclude admissions for pregnancies / deliveries: DRG codes 370-375, ICD-9 codes 630 – 679.

**Table IPU-A: Codes to Identify Total Inpatient Discharges**

Principal ICD-9-CM Diagnosis		MS—DRG
001-289, 317-999, V01-V29, V40-V90	<b>OR</b>	001-013, 020-042, 052-103, 113-117, 121-125, 129-139, 146-159, 163-168, 175-208, 215-264, 280-316, 326-358, 368-395, 405-425, 432-446, 453-517, 533-566, 573-585, 592-607, 614-630, 637-645, 652-675, 682-700, 707-718, 722-730, 734-750, 754-761, 765-770, 774-782, 789-795, 799-804, 808-816, 820-830, 834-849, 853-858, 862-872, 901-909, 913-923, 927-929, 933-935, 939-941, 947-951, 955-959, 963-965, 969-970, 974-977, 981-989, 998, 999

**WITH**

UB Type of Bill		
11x, 12x, 41x, 84x	<b>OR</b>	Any acute inpatient facility code



**Measure 17A (IHR) - Inpatient Hospital 30-Day Readmission Rate (State-Defined)**

**Administrative Specification**

**Denominator**            The eligible population

**Numerator**            An inpatient hospital readmission within 30 days from the initial discharge. **The inpatient diagnosis for the readmission must be the same as the discharge diagnosis from the initial hospitalization.**

**For measure 17A, exclude inpatient hospitalizations for mental illness, since these will be examined with measure 17B.**

Exclude transfers to an *acute facility* following the inpatient hospitalization. If the member was transferred, count the discharge from the facility to which the member was transferred.

Exclude both the initial discharge and the direct transfer discharge if the direct transfer discharge occurs after December 1 of the measurement year.

Exclude direct transfer to a *non-acute facility* within the 30-day follow-up period. Refer to Table FUH-B for codes to identify non-acute care.

**Table FUH-B: Codes to Identify Non-acute Care**

Description	HCPCS	UB Revenue	UB Type of Bill	POS
Hospice		0115, 0125, 0135, 0145, 0155, 0650, 0656, 0658, 0659	81x, 82x	34
SNF		019x	21x, 22x, 28x	31, 32
Hospital transitional care, swing bed or rehabilitation			18x	
Rehabilitation		0118, 0128, 0138, 0148, 0158		
Respite		0655		
Intermediate care facility				54
Residential substance abuse treatment facility		1002		55
Psychiatric residential treatment center	T2048, H0017-H0019	1001		56
Comprehensive inpatient rehabilitation facility				61
Other non-acute care facilities that do not use the UB revenue or type of bill codes for billing (e.g., ICF, SNF)				

**Measure 17B (IMR) –Inpatient Mental Hospital 30-Day  
Readmission Rate (State-Defined)**

**Description**

This measure determines if a member had an inpatient mental hospital readmission **for the same discharge diagnosis** after having an initial inpatient mental hospital stay.

**Eligible Population**

<b>Product</b>	Medicaid
<b>Ages</b>	All
<b>Continuous enrollment</b>	Date of discharge through 30 days after discharge.
<b>Allowable gap</b>	No gaps in enrollment.
<b>Event/ diagnosis</b>	Discharged alive from a mental hospital inpatient setting (Table IPU-A) on or between December 18 of the prior year and December 1 of the measurement year.  The denominator for this measure is based on discharges, <u>not members</u> . Include all events for those members who have more than one discharge on or between January 1 and December 1 of the measurement year.
<b>Inpatient</b>	Include inpatient care at either a hospital or a treatment facility with mental health as the principal diagnosis.  Use one of the following criteria to identify inpatient services: <ul style="list-style-type: none"> <li>• An inpatient facility code in conjunction with a principal mental health diagnosis (Table MPT-A), <b>or</b></li> <li>• MS-DRGs (Table MPT-B)</li> </ul>

**Table MPT-A: Codes to Identify Mental Health Diagnosis**

ICD-9-CM Diagnosis
290, 293-302, 306-316

**Table MPT-B: Codes to Identify Inpatient Services**

MS—DRG
876, 880-887; exclude discharges with ICD-9-CM Principal Diagnosis code 317-319

**Note:** DSM-IV codes mirror ICD-9-CM codes. A CCE or MCCN that has access only to DSM-IV codes should use and document them. Follow the specifications outlined above for ICD-9-CM codes.

**Measure 17B (IMR) –Inpatient Mental Hospital 30-Day  
Readmission Rate (State-Defined)**

**Administrative Specification**

**Denominator**            The eligible population

**Numerator**             An inpatient hospital readmission within 30 days from the initial discharge.

Exclude transfers to an *acute facility* following the inpatient hospitalization. If the member was transferred, count the discharge from the facility to which the member was transferred.

**For measure 17B, exclude inpatient hospitalizations that were not related to mental illness, since these will be examined with measure 17A.**

Exclude both the initial discharge and the direct transfer discharge if the direct transfer discharge occurs after December 1 of the measurement year.

Exclude direct transfer to a *non-acute facility* within the 30-day follow-up period. Refer to Table FUH-B for codes to identify nonacute care.

**Table FUH-B: Codes to Identify Non-acute Care**

Description	HCPCS	UB Revenue	UB Type of Bill	POS
Hospice		0115, 0125, 0135, 0145, 0155, 0650, 0656, 0658, 0659	81x, 82x	34
SNF		019x	21x, 22x, 28x	31, 32
Hospital transitional care, swing bed or rehabilitation			18x	
Rehabilitation		0118, 0128, 0138, 0148, 0158		
Respite		0655		
Intermediate care facility				54
Residential substance abuse treatment facility		1002		55
Psychiatric residential treatment center	T2048, H0017-H0019	1001		56
Comprehensive inpatient rehabilitation facility				61
Other non-acute care facilities that do not use the UB revenue or type of bill codes for billing (e.g., ICF, SNF)				

**Measure 29 (AMP) - Enrollees Who Had an Annual Ambulatory or Preventive Care Visit with Enrollee's Assigned PCP (State-Defined)**

**Description**

The percentage of members who had an ambulatory or preventive care visit with the member's assigned PCP during the measurement year.

**Eligible Population**

<b>Product lines</b>	Medicaid
<b>Ages</b>	All Ages.
<b>Continuous enrollment</b>	The measurement year.
<b>Allowable gap</b>	No more than one gap in enrollment of up to 45 days during the year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
<b>Anchor date</b>	December 31 of the measurement year.

**Administrative Specification**

<b>Denominator</b>	The eligible population.
<b>Numerator</b>	One or more ambulatory or preventive care visits (Table AAP-A) during the measurement year with the member's assigned PCP. For group practices, the provider may be any provider assigned to that group. Count members who changed providers during the year, if they had an ambulatory care visit with any of their assigned providers during the year.

**Table AAP-A: Codes to Identify Preventive/Ambulatory Health Services**

Description	CPT	HCPCS	ICD-9-CM Diagnosis	UB Revenue
Office or other outpatient services	99201-99205, 99211-99215, 99241-99245			051x, 0520-0523, 0526-0529, 0982, 0983
Home services	99341-99345, 99347-99350			
Nursing facility care	99304-99310, 99315, 99316, 99318			
Domiciliary, rest home or custodial care services	99324-99328, 99334-99337			
Preventive medicine	99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99420, 99429	G0344, G0402 G0438, G0439		
General medical examination			V70.0, V70.3, V70.5, V70.6, V70.8, V70.9	

**Measure 31 – Medication review of all Enrollees Taking More than Five Prescription Medications (State-Defined)**

**Description**

Complete a medication review of all Enrollees taking 5 or more prescription medications with documented plan for reducing medications when appropriate.

**Eligible Population**

<b>Product lines</b>	Medicaid
<b>Ages</b>	All Ages.
<b>Continuous enrollment</b>	The measurement year.
<b>Allowable gap</b>	No more than one gap in enrollment of up to 45 days during the year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
<b>Anchor date</b>	December 31 of the measurement year.

**Administrative Specification**

<b>Denominator</b>	The eligible population.
<b>Numerator</b>	A medication review and a documented plan for reducing a member's medications, when appropriate, for members who are taking five or more prescription medications.

\*The Department is developing specifications for what a medication review must include, and the manner in which reviews must be reported to the Department. The State will publish these specifications as soon as they are completed.

## **Attachment D Letter of Intent (LOI)**

In order to allow for appropriate planning around the Innovations Project, the Department is requiring Letters of Intent (LOIs) from those entities that are anticipating—or seriously considering—submitting a Proposal for providing services under the Innovations Project. While submitting an LOI does not commit an entity to actually submit a Proposal, HFS will not accept Proposals from nor provide data to entities that have not submitted an LOI.

**The Department wants one LOI per entity, irrespective of the number of collaborators within the entity.** The organization and person submitting the LOI will be the Department's primary contact unless the contact is subsequently changed. If an entity determines it is no longer interested in making a Proposal, it should withdraw its LOI.

The LOI must include the following items:

- Required: Section A (Contact information)
- Required: Section B (Proposal Summary/Self-Assessment Form)

The LOI may include the following items:

- If data are being requested, Section C (HIPAA Data Use Agreement\*)
- Optional: Section D (Request for Technical Assistance)

*\* The Department will provide what HIPAA defines as a 'limited data set'. The data will not contain directly identifiable information, but will have sufficient granularity that HIPAA protections still apply.*

The expected high-level timeline for Phase I of the Innovations Project is as follows:

- Solicitation published – January 20, 2012
- Last date to submit LOI- February 29, 2012
- Data sharing – As the Solicitation is published and LOI are received
- Proposals due – May 25, 2012
- Proposal evaluation – Complete by September, 2012
- Contract negotiation – On going September to November, 2012
- Contract Start – January 2013

Please send the completed LOI to Michelle Maher at [Michelle.Maher@illinois.gov](mailto:Michelle.Maher@illinois.gov). If you have questions about the LOI submission, please contact Michelle Maher.

**Section A: Contact Information**

Name of Care Coordination Entity (CCE) or Managed Care Community Network (working name is acceptable)

\_\_\_\_\_

Primary Contact Information:

Name \_\_\_\_\_

Title \_\_\_\_\_

Organization \_\_\_\_\_

Address \_\_\_\_\_

Email \_\_\_\_\_

Phone \_\_\_\_\_

Other information (e.g., assistant) \_\_\_\_\_

Primary Contact Person for Data (if different):

Name \_\_\_\_\_

Title \_\_\_\_\_

Organization \_\_\_\_\_

Address \_\_\_\_\_

Email \_\_\_\_\_

Phone \_\_\_\_\_

Other information (e.g., assistant) \_\_\_\_\_



**Section B: Proposal Outline/Self-Assessment**

The Department is not seeking exhaustive detail on any of the following—that will be the purpose of the Proposal. However, high-level answers will:

- help the State understand who is likely to submit Proposals; and
- help interested entities understand the range of issues that must be addressed in the Proposal, thus giving them a chance to prepare for the eventual submission.

This Section B is simply a list of topic areas that we assume you will address in a separate document. Sections A, C, and D must be completed and returned along with the document in which you answer the questions below.)

1. **Intended Population.** Please describe the population you expect to target in your Proposal. Please be as specific as is appropriate with respect to age, geography, health status, disability status, and any other parameters that define the population you expect to target in your Proposal. Describe, at a high level, the plan for recruiting Potential Enrollees and how many Enrollees you think you will be able to accommodate.
2. **Primary Collaborators.** Please list any specifically identified collaborators who have agreed to join the potential CCE or MCCN. While it may be premature to have a complete list, it should be possible to indicate thoughts on the type of provider collaborators that will be needed and give a sense of the state of development with any collaborators that have been identified. Please provide sufficient information to illustrate who will be the primary collaborators and what will be their responsibilities.
3. **Care Coordination Model.** Give an outline of your care coordination model briefly touching on the various care coordination functions you expect to perform. What are the financial management mechanisms that you anticipate will be necessary to manage the CCE or MCCN? At this point, we are not expecting a full description of your care coordination model just a high-level summary of the major components of your expected proposal.
4. **Operating Agreements and Target Dates.** What are the main operating agreements that will have to be developed with the participating collaborators? To what extent has work started on developing these arrangements? When will the remaining work be completed?
5. **Health Information Technology.** What are the current thoughts on how clinical data will be exchanged? It will be very hard to actually coordinate care without some degree of automation in the exchange of clinical information. Few entities will have a full-blown, interoperable Electronic Health Record (EHR) system in place. In the absence of such an EHR, however, explain how the CCE or MCCN will manage clinical information, both to make clinical decisions and to provide feedback to Providers.

6. **Working Capital.** Even for non-MCCN CCEs, some upfront funds may be necessary to develop care coordination functions. For CCE Proposals only, the Department, in its sole discretion, may consider providing some upfront funds through an advanced care coordination fee that would be recouped on a negotiated schedule, but the CCE will also need some additional funds. What are the current thoughts on the sources of funding for upfront care coordination expenses? If you are considering applying to become a MCCN, what is the source of your capital reserve requirements? How much reserve do you anticipate needing to hold?
7. **Other Information.** Please provide any other information that you think will better enable the Department to understand and meet your needs or the general needs of potential CCEs and MCCNs.



**Section C: Data Use Agreement**

Illinois Department of Healthcare and Family Services  
And

DATA USE AGREEMENT

This Data Use Agreement (the "Agreement") is effective as of \_\_\_\_\_ (the "Agreement Effective Date") by and between Illinois Department of Healthcare and Family Services ("Covered Entity") and \_\_\_\_\_ ("Data User").

RECITALS

WHEREAS, Covered Entity possesses Individually Identifiable Health Information that is protected under HIPAA (as hereinafter defined) and the HIPAA Regulations (as hereinafter defined), and is permitted to use or disclose such information only in accordance with HIPAA and the HIPAA Regulations;

WHEREAS, Data User wishes to perform certain Activities (as hereinafter defined);

WHEREAS, Covered Entity wishes to disclose a Limited Data Set (as hereinafter defined) to Data User for use by Data User for performance of the Activities (as hereinafter defined);

WHEREAS, Covered Entity wishes to ensure that Data User will appropriately safeguard the Limited Data Set in accordance with HIPAA and the HIPAA Regulations; and

WHEREAS, Data User agrees to protect the privacy of the Limited Data Set in accordance with the terms and conditions of this Agreement, HIPAA and the HIPAA Regulations;

NOW THEREFORE, Covered Entity and Data User agree as follows:

1. Definitions. The parties agree that the following terms, when used in this Agreement, shall have the following meanings, provided that the terms set forth below shall be deemed to be modified to reflect any changes made to such terms from time to time as defined in HIPAA and the HIPAA Regulations.
  - a. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.
  - b. "HIPAA Regulations" means the regulations promulgated under HIPAA by the United States Department of Health and Human Services, including, but not limited to, 45 C.F.R. Part 160 and 45 C.F.R. Part 164.
  - c. "Covered Entity" means a health plan (as defined by HIPAA and the HIPAA Regulations), a health care clearinghouse (as defined by HIPAA and the HIPAA Regulations), or a health care provider (as defined by HIPAA and the HIPAA Regulations) who transmits any health information in electronic form in connection with a transaction covered by the HIPAA Regulations.
  - d. "Individually Identifiable Health Information" means information that is a subset of health information, including demographic information collected from an individual, and;
    - (1) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and



- (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and
  - a) that identifies the individual; or
  - b) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.
- e. "Protected Health Information" or "PHI" means Individually Identifiable Health Information that is transmitted by electronic media; maintained in any medium described in the definition of the term electronic media in the HIPAA Regulations; or transmitted or maintained in any other form or medium. Protected Health Information excludes Individually Identifiable Health Information in education records covered by the Family Educational Right and Privacy Act, as amended, 20 U.S.C. § 1232g, and records described at 20 U.S.C. § 1232g(a)(4)(B)(iv).

2. Obligations of Covered Entity.

- a. Limited Data Set. Covered Entity agrees to disclose the following Protected Health Information to Data User: data tables describing Medicaid recipients and the services provided to said recipients (the "Limited Data Set"). Such Limited Data Set shall not contain any of the following identifiers of the individual who is the subject of the Protected Health Information, or of relatives, employers or household members of the individual: names; postal address information, other than town or city, State, and zip code; telephone numbers; fax numbers; electronic mail addresses; social security numbers; medical record numbers; health plan beneficiary numbers; account numbers; certificate/license numbers; vehicle identifiers and serial numbers, including license plate numbers; device identifiers and serial numbers; Web Universal Resource Locators (URLs); Internet Protocol (IP) address numbers; biometric identifiers, including finger and voice prints; and full face photographic images and any comparable images.

3. Obligations of Data User.

- a. Performance of Activities. Data User may use and disclose the Limited Data Set received from Covered Entity only in connection with the preparation of a Care Coordination Innovations Proposal on behalf of the Covered Entity (the "Activities"). Data User shall limit the use or receipt of the Limited Data Set to the following individuals or classes of individuals who need the Limited Data Set for the performance of the Activities:

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- b. Nondisclosure Except As Provided In Agreement. Data User shall not use or further disclose the Limited Data Set except as permitted or required by this Agreement.
- c. Use Or Disclosure As If Covered Entity. Data User may not use or disclose the Limited Data Set in any manner that would violate the requirements of HIPAA or the HIPAA Regulations if Data User were a Covered Entity.
- d. Identification Of Individual. Data User may not use the Limited Data Set to identify or contact any individual who is the subject of the PHI from which the Limited Data Set was created.
- e. Disclosures Required By Law. Data User shall not, without the prior written consent of Covered Entity, disclose the Limited Data Set on the basis that such disclosure is required by law without notifying Covered Entity so that Covered Entity shall have an opportunity to object to the disclosure and to seek appropriate relief. If Covered Entity objects to such disclosure, Data User shall refrain from disclosing the Limited Data Set until Covered Entity has exhausted all alternatives for relief.
- f. Safeguards. Data User shall use any and all appropriate safeguards to prevent use or disclosure of the Limited Data Set other than as provided by this Agreement.
- g. Data User's Agents. Data User shall not disclose the Limited Data Set to any agent or subcontractor of Data User except with the prior written consent of Covered Entity. Data User shall ensure that any agents, including subcontractors, to whom it provides the Limited Data Set agree in writing to be bound by the same restrictions and conditions that apply to Data User with respect to such Limited Data Set.
- h. No identification. Data User will not join the Limited Data Set to other data sets in any way that will reveal the identity of Medicaid recipients.

- i. Reporting. Data User shall report to Covered Entity within 4 hours of Data User becoming aware of any use or disclosure of the Limited Data Set in violation of this Agreement or applicable law.

4. Material Breach, Enforcement and Termination.

- a. Term. This Agreement shall be effective as of the Agreement Effective Date, and shall continue until the Agreement is terminated in accordance with the provisions of Section 4.c..
- b. Covered Entity's Rights of Access and Inspection. From time to time upon reasonable notice, or upon a reasonable determination by Covered Entity that Data User has breached this Agreement, Covered Entity may inspect the facilities, systems, books and records of Data User to monitor compliance with this Agreement. The fact that Covered Entity inspects, or fails to inspect, or has the right to inspect, Data User's facilities, systems and procedures does not relieve Data User of its responsibility to comply with this Agreement, nor does Covered Entity's (1) failure to detect or (2) detection of, but failure to notify Data User or require Data User's remediation of, any unsatisfactory practices constitute acceptance of such practice or a waiver of Covered Entity's enforcement or termination rights under this Agreement. The parties' respective rights and obligations under this Section 4.b. shall survive termination of the Agreement.
- c. Termination. Covered Entity may terminate this Agreement:
  - (1) immediately if Data User is named as a defendant in a criminal proceeding for a violation of HIPAA or the HIPAA Regulations;
  - (2) immediately if a finding or stipulation that Data User has violated any standard or requirement of HIPAA, the HIPAA Regulations, or any other security or privacy laws is made in any administrative or civil proceeding in which Data User has been joined
  - (3) pursuant to Sections 4.d.(3) or 5.b. of this Agreement; or
  - (4) upon 30 days notice, irrespective of cause.
- d. Remedies. If Covered Entity determines that Data User has breached or violated a material term of this Agreement, Covered Entity may, at its option, pursue any and all of the following remedies:
  - (1) exercise any of its rights of access and inspection under Section 4.b. of this Agreement;
  - (2) take any other reasonable steps that Covered Entity, in its sole discretion, shall deem necessary to cure such breach or end such violation; and/or
  - (3) terminate this Agreement immediately.
- e. Knowledge of Non-Compliance. Any non-compliance by Data User with this Agreement or with HIPAA or the HIPAA Regulations automatically will be considered a breach or violation of a material term of this Agreement if Data User knew or reasonably should have known of such non-compliance and failed to immediately take reasonable steps to cure the non-compliance.
- f. Reporting to United States Department of Health and Human Services. If Covered Entity's efforts to cure any breach or end any violation are unsuccessful, and if termination of this Agreement is not feasible, Covered Entity shall report Data User's breach or violation to the Secretary of the United States Department of Health and Human Services, and Data User agrees that it shall not have or make any claim(s), whether at law, in equity, or under this Agreement, against Covered Entity with respect to such report(s).
- g. Return or Destruction of Records. Upon termination of this Agreement for any reason, Data User shall return or destroy, as specified by Covered Entity, the Limited Data Set that Data User still maintains in any form, and shall retain no copies of such Limited Data Set. If Covered Entity, in its sole discretion, requires that Data User destroy the Limited Data Set, Data User shall certify to Covered Entity that the Limited Data Set has been destroyed. If return or destruction is not feasible, Data User shall inform Covered Entity of the reason it is not feasible and shall continue to extend the protections of this Agreement to such Limited Data Set and limit further use and disclosure of such Limited Data Set to those purposes that make the return or destruction of such Limited Data Set infeasible.]
- h. Injunctions. Covered Entity and Data User agree that any violation of the provisions of this Agreement may cause irreparable harm to Covered Entity. Accordingly, in addition to any other remedies available to Covered Entity at law, in equity, or under this Agreement, in the event of any violation by Data User of any of the provisions of this Agreement, or any explicit threat thereof, Covered Entity shall be entitled to an injunction or other decree of specific performance with respect to such violation or explicit threat thereof, without any

bond or other security being required and without the necessity of demonstrating actual damages. The parties' respective rights and obligations under this Section 4.h. shall survive termination of the Agreement.

- i. Indemnification. Data User shall indemnify, hold harmless and defend Covered Entity from and against any and all claims, losses, liabilities, costs and other expenses resulting from, or relating to, the acts or omissions of Data User in connection with the representations, duties and obligations of Data User under this Agreement. The parties' respective rights and obligations under this Section 4.i. shall survive termination of the Agreement.

5. Miscellaneous Terms.

- a. State Law. Nothing in this Agreement shall be construed to require Data User to use or disclose the Limited Data Set without a written authorization from an individual who is a subject of the PHI from which the Limited Data Set was created, or written authorization from any other person, where such authorization would be required under state law for such use or disclosure.
- b. Amendment. Covered Entity and Data User agree that amendment of this Agreement may be required to ensure that Covered Entity and Data User comply with changes in state and federal laws and regulations relating to the privacy, security, and confidentiality of PHI or the Limited Data Set. Covered Entity may terminate this Agreement upon 30 days written notice in the event that Data User does not promptly enter into an amendment that Covered Entity, in its sole discretion, deems sufficient to ensure that Covered Entity will be able to comply with such laws and regulations.
- c. No Third Party Beneficiaries. Nothing express or implied in this Agreement is intended or shall be deemed to confer upon any person other than Covered Entity and Data User, and their respective successors and assigns, any rights, obligations, remedies or liabilities.
- d. Ambiguities. The parties agree that any ambiguity in this Agreement shall be resolved in favor of a meaning that complies and is consistent with applicable law protecting the privacy, security and confidentiality of PHI and the Limited Data Set, including, but not limited to, HIPAA and the HIPAA Regulations.
- e. Primacy. To the extent that any provisions of this Agreement conflict with the provisions of any other agreement or understanding between the parties, this Agreement shall control with respect to the subject matter of this Agreement.

IN WITNESS WHEREOF, the parties hereto have duly executed this Agreement as of the Agreement Effective Date.

\_\_\_\_\_  
Name of Covered Entity

\_\_\_\_\_  
Name of Data User

\_\_\_\_\_  
Signature of Authorized Representative

\_\_\_\_\_  
Signature of Authorized Representative

\_\_\_\_\_  
Name of Authorized Representative

\_\_\_\_\_  
Name of Authorized Representative

\_\_\_\_\_  
Title of Authorized Representative

\_\_\_\_\_  
Title of Authorized Representative

**Section D: Request for Technical Assistance**

The Department is working with the Michael Reese Trust Fund and the Chicago Community Trust (The Trusts) to provide high-level technical assistance (TA) to entities who are interested in participating in the Innovations Project. We anticipate the TA will be in the form of a series of seminars or webinars. The Trusts and the Department would like to know about your TA needs. This request is specifically oriented toward management issues.

(We earlier requested your feedback from potential collaborators on what kind of data needs you had. We received about 125 responses and they were extremely useful in helping us focus our effort. The Trusts are already engaged in helping the Department develop and distribute the data and train entities in its use.)

Regarding other care coordination TA, which of the following are topics on which you feel your entity could benefit from Technical Assistance? [NOTE: *Technical assistance* on a topic is different from answers to various policy questions. See below.]

- a. Legal issues that CCEs and MCCNs must face \_\_\_\_\_
- b. Collaboration between medical and human service agencies \_\_\_\_\_
- c. Designing financial arrangements among collaborators \_\_\_\_\_
- d. Clinical information infrastructure \_\_\_\_\_
- e. General readiness assessment \_\_\_\_\_
- f. Other \_\_\_\_\_

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We understand that there are a number of critical policy areas where guidance from the Department is necessary. These include better understanding of financial arrangements, acceptable ways for enrolling patients, how to measure quality, and requirements for applying to be a CCE or MCCN. We are working on these issues and we have addressed as many of those as we could in this Solicitation. (Some of these take more time because the Department in turn requires guidance from Federal CMS.)

Some of these issues were addressed when we posted responses to the questions you submitted. However, some of the fundamental work of identifying potential collaborators and determining how you will work together can be started even before these questions are fully answered. It is in this spirit that we will offer technical assistance on these more general issues. Your suggestions will help.

**Attachment E**

**Table 1: CCE Collaborators**

<b>Last Name/Organization</b>	<b>First Name</b>	<b>Degree</b>	<b>Specialty/Provider Type</b>	<b>Address</b>	<b>City</b>	<b>St</b>	<b>Zip</b>	<b>County</b>	<b>PCP</b>	<b>Contract Status</b>

**Provider Network Key:**  
**Degree:** Provider's degree, if applicable, i.e. MD; DO; PhD; MSW, etc.  
**Specialty/Provider Type:** Provider specialty, i.e. internal medicine, family practice, behavioral health, hospital, pharmacy, DME, etc.  
**PCP:** Is Provider a PCP? Yes or No  
**Contract Status:** Yes, Pending, or LOI

**Table 2: MCCN Network of Providers**

Last Name/Organization	First Name	Degree	Specialty/Provider Type	Address	City	St	Zip	County	PCP	Contract Status

**Provider Network Key:**  
**Degree:** Provider's degree, if applicable, i.e. MD; DO; PhD; MSW, etc.  
**Specialty/Provider Type:** Provider specialty, i.e. internal medicine, family practice, behavioral health, hospital, pharmacy, DME, etc.  
**PCP:** Is Provider a PCP? Yes or No  
**Contract Status:** Yes, Pending, or LOI

**Attachment F  
CCE – Care Coordination Fee Template**

	Priority Populations*			
Proposed Per Member Per Month Fees (PMPMs)	Seniors	Adults with Disabilities	Other IHC Adults	Children of Enrolled Adults
Year 1				
Year 2				
Year 3				
	Target Population*			
	[Name of Target Population]	[Name of Target Population]		
Year 1				
Year 2				
Year 3				

\*Within the Priority Populations, you may propose separate care coordination fees for particular Target Populations as long as you clearly define your Target Population in Section 3.2.2.1.2 and describe in detail how you plan to engage your Target Population in Section 3.2.3.31.1. Note: A CCE may propose fees for more than one Target Population. This template is intended as a guide.