

STATE OF ILLINOIS

Solicitation for Accountable Care Entities

ACE Program – 2014-24-002

The Department of Healthcare and Family Services is soliciting Proposals from responsible Bidders to meet the State's needs for Accountable Care Entities (ACE) to serve children under age 19, parents or other caretaker relatives eligible for Covered Services under Title XIX, pregnant women and, at an ACE's option, ACA Adults. 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(a)(3)).

Public Act 98-104 requires the Department of Healthcare and Family Services (Department) to issue a solicitation for ACEs by August 1, 2013. Public Act 96-1501 requires the Department to move at least 50 percent 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. This Solicitation fulfills the legislative requirement laid out in Public Act 98-104 and helps to fulfill the statutory mandate laid out in Public Act 96-1501.

The Solicitation for Proposals to establish ACEs in Illinois facilitates a goal to allow Providers to design and implement integrated delivery systems that coordinate delivery of a broad range of health services and promote accountability for the care delivered to the populations they serve.

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", "HFS", "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

- 1.1 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 "ACE Solicitation": HFS.ACE@illinois.gov
- 1.2 FURTHER INFORMATION:** To ensure timely answers, questions regarding this Solicitation must be submitted no later than September 6th, 2013, but should be submitted as soon as possible. Written responses to all questions submitted no later than September 6th, 2013 will be posted to the Care Coordination page of the Department website and the Illinois Procurement Bulletin. The State will hold an optional webinar on the Solicitation on August 28th, 2013 from 2 to 4 PM. Please check the website (<http://www2.illinois.gov/hfs/Pages/default.aspx>) regularly for more details regarding the webinar. In addition, Bidders must submit a Letter of Intent (LOI), including a signed Data Use Agreement, to HFS between August 29th, 2013 and October 1st, 2013. The submission of a LOI is a mandatory requirement of this Solicitation and failure to submit will result in no consideration of your Proposal. Furthermore, HFS will provide a dataset on eligible individuals only to those Bidders that submit a LOI. The State may periodically post additional information about this Solicitation. You should check the website regularly: <http://www2.illinois.gov/hfs/Pages/default.aspx>
- 1.3 PROPOSAL DUE DATE, TIME AND SUBMISSION LOCATION:** Due Date: January 3, 2014
Time: 2:00 p.m. (Local Time)
- DELIVER PROPOSALS TO:** Illinois Department of Healthcare and Family Services
Attn: Amy Harris-Roberts
201 South Grand Avenue East
Springfield, IL 62763
- LABEL OUTSIDE OF ENVELOPE / CONTAINER:** ACE 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 shall not consider Proposals, modifications or withdrawals submitted after the due date and time. All times are State of Illinois local times (Central Time).
- 1.4 NUMBER OF COPIES:** You must submit one (1) signed original and seven (7) copies of the Proposal in a sealed container. In addition, you must submit one (1) copy of the Proposal on CD in the following format: Microsoft Word and/or Excel. If you are requesting confidential treatment, you must make that request in the form and manner specified in Section 1.7, Public Records and Requests for Confidential Treatment. Proposals must be no longer than 100 pages, one-sided, on 8.5" by 11" size paper, with one (1) inch margins, Times New Roman font, and no smaller than eleven (11) point font. Within the 100-page limit, Bidders must include their full narrative response to each of the questions in Section 3.2. The 100-page limit excludes attachments requested in the Solicitation, Excel documents requested in Sections 3.2.2.1 and 3.2.2.2, and the required forms in Section 3.4. If you request exempt treatment, under Section 1.7, you must submit one (1) additional hard copy and one (1) electronic copy on CD in Microsoft Word and/or Excel of the Proposal with exempt information deleted and clearly labeled as a "Redacted Copy".
- 1.5 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.
- 1.6 AWARD:** We will post a notice on the Department website and the Illinois Procurement Bulletin 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. All State contracts have certain certifications and requirements that potential awardees must agree to comply with in order to execute a Contract with the Department. In addition, Contracts may have terms specified by state or federal laws or regulations. All Contracts are subject to approval by Federal CMS for available federal matching funds. There is no predetermined number of awards; the decision to award a Contract(s) will depend upon the models proposed, the number of ACEs proposing to provide services in a given geographical area, and the likely capability of the ACE to provide services on a capitated basis by month 19 of operation. See Section 2 for an overview of how we will evaluate Proposals. The Department reserves the right to modify any requirement outlined in the Solicitation at any time during this Solicitation process and throughout the term of the Contract.
- 1.7 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 one (1) additional hard copy and one (1) electronic copy on CD in Microsoft Word and/or Excel of the Proposal with exempt information deleted and clearly labeled as a "Redacted Copy". This redacted 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.

- 1.8 MINORITIES, FEMALES, AND PERSONS WITH DISABILITIES PARTICIPATION AND UTILIZATION PLAN:** This Solicitation contains a minimum BEP goal of 5 percent of an ACE's care coordination fees for months 1 – 18, and a minimum BEP goal of 15 percent of the administrative portion of an ACE's capitation payments for months 19 - 36 for inclusion of businesses owned and controlled by minorities, females, and persons with disabilities in the State's procurement and contracting processes.

Bidders can be awarded additional points toward their total score for each percentage increase above the designated 5 percent minimum up to a maximum of 10 percent for BEP vendor participation in months 1 – 18. Each additional percentage point is equal to 5 extra points towards the total score. The BEP goal for Contracts continued 37 months and beyond will be 20 percent.

The Utilization Plan submitted with a Proposal should only cover the first 18 months of operation as an ACE. Note that for months 19 and beyond, a request for approval of BEP vendors selected to increase the utilization level as required with any additional BEP Letters of Intent must be submitted to the HFS BEP Liaison office by month 16 of operation, and at the 34th month to remain in full compliance with the contract. Failure to submit a Utilization Plan as instructed later in this Solicitation may render the Proposal non-responsive. All questions regarding the subcontracting goal must be directed to the Department Business Enterprise Program (BEP) Liaison prior to submission of Proposals.

BEP Liaison: Sharron Matthews, HFS Assistant Director and HFS BEP Liaison for CMS

Phone Number: (312) 793-4295

Email Address: Sharron.Matthews@illinois.gov

Bidders who submit Proposals for State contracts shall not be given a period after the Proposal due date to cure deficiencies in the BEP Utilization Plan and the BEP Letter of Intent, unless mandated by federal law or regulation. 30 ILCS 575(4)(e). Businesses included on BEP Utilization Plans as meeting BEP requirements as prime vendors or subcontractors must be certified by CMS as BEP vendors at the time of proposal submission. Go to (<http://www2.illinois.gov/cms/business/sell2/bep/Pages/default.aspx>) for complete requirements for BEP certification.

- 1.9 DEFINITIONS.** Whenever used in this Solicitation including 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.

- 1.9.1 ACA Adults:** Clients newly eligible for HFS Medical Programs through the Affordable Care Act (ACA) as of January 1, 2014 and pursuant to 305 ILCS 5/5-2(18).
- 1.9.2 Accountable Care Entity (ACE):** An organization comprised of and governed by its participating providers, with a legally responsible lead entity, that is accountable for the quality, cost, and overall care of its Enrollees and meets the requirements specified in this Solicitation. The ACE demonstrates an integrated delivery system, shares clinical information in a timely manner, and designs and implements a model of care and financial management structure that promotes provider accountability, quality improvement, and improved health outcomes.
- 1.9.3 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>.
- 1.9.4 Americans with Disabilities Act:** The ADA (42 U.S.C. §§ 12101 et seq.) prohibits discrimination on the basis of disability in employment, State and local government, public accommodations, commercial facilities, transportation, and telecommunications.
- 1.9.5 Behavioral Health:** This term refers to mental health and substance abuse Covered Services.
- 1.9.6 Bidder:** The ACE submitting a Proposal under this Solicitation.
- 1.9.7 Care Coordination Entity:** A CCE is a collaboration of providers and community agencies, governed by a lead entity, which receives a care coordination payment with a portion of the payment at risk for meeting quality outcome targets, in order to provide care coordination services for its members.
- 1.9.8 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).
- 1.9.9 Client:** Any individual receiving benefits under HFS Medical Programs.
- 1.9.10 Contract:** The Contract entered into between the Department and the awardee to provide the services requested by this Solicitation, including any modifications, extensions or subsequent Contracts for an ACE when it moves to full-risk capitation.
- 1.9.11 Contractor:** An ACE that has executed a Contract with the State to provide the services requested by this Solicitation.

- 1.9.12 Covered Services:** Full-benefits and services provided to Enrollees under HFS Medical Programs pursuant to the Illinois State Plan, or federal or Illinois statute and administrative rules. In this Solicitation, Covered Services excludes long-term supports and services and any partial benefit programs.
- 1.9.13 Enrollee:** A Client who is enrolled in an ACE and meets the requirements of Section 3.1.3.6.
- 1.9.14 Execution:** The point at which all the parties have signed the Contract between the Contractor and the Department.
- 1.9.15 Family Health Plan:** Clients whose eligibility has been determined on the basis of being a child, a parent or other caretaker relative eligible for Covered Services under Title XIX, or a pregnant woman.
- 1.9.16 Fee-For-Service:** The method of billing under which a Provider charges for each encounter or service rendered.
- 1.9.17 Health Insurance Portability and Accountability Act (HIPAA):** HIPAA was enacted by the U.S. Congress in 1996 (42 U.S.C. §§ 300gg et seq., P.L. 104-191). Title II, Subtitle F, of HIPAA, known as the Administrative Simplification provisions, requires the establishment of national standards for electronic health care transactions and national identifiers for Providers, health insurance plans, and employers. The Administrative Simplification provisions also address the security and privacy of health data. These provisions are promulgated in the Code of Federal Regulations (CFR) at Sections 45 CFR Part 160, 45 CFR Part 162, and 45 CFR Part 164 as amended, including HIPAA Omnibus regulations. Omnibus regulations include modifications to the HIPAA Privacy, Security, Enforcement and Breach Notification Rules under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information Nondiscrimination Act.
- 1.9.18 Health Maintenance Organization (HMO):** A health maintenance organization as defined in the Health Maintenance Organization Act (215 ILCS 125/1-1 et seq.).
- 1.9.19 Healthcare Effectiveness Data and Information Set (HEDIS®):** The Healthcare Effectiveness Data and Information Set established by the National Committee for Quality Assurance (NCQA).
- 1.9.20 HFS:** The Illinois Department of Healthcare and Family Services and any successor agency. In this Solicitation, HFS is also referred to as "Department".
- 1.9.21 ILCS:** Illinois Compiled Statutes. An unofficial version of the ILCS can be viewed at <http://www.ilga.gov/legislation/ilcs/ilcs.asp>.
- 1.9.22 Illinois Client Enrollment Services (ICES):** The entity contracted by the Department to conduct enrollment activities for Potential Enrollees, including providing impartial education on health care delivery choices, providing enrollment materials, assisting with the selection of a PCP, ACE, CCE, and MCOs and processing requests to change these entities. The following link is to the ICES website: <http://enrollhfs.illinois.gov/>.
- 1.9.23 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. The following link is to the IHC website: <http://www.illinoishealthconnect.com/>
- 1.9.24 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.
- 1.9.25 Managed Care Organization (MCO):** A HMO or MCCN that is under contract with the Department.
- 1.9.26 Marketing:** Any written or oral communication from an ACE or its representative that can reasonably be interpreted as intended to influence a Potential Enrollee to enroll, not enroll, or a Client to disenroll from an ACE.
- 1.9.27 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.
- 1.9.28 Medicaid:** The program under Title XIX of the Social Security Act that provide medical benefits to groups of low-income people.
- 1.9.29 Medical Programs:** The health care programs that HFS administers, including, but not limited to, the Illinois Medical Assistance Program administered under Articles V and XII of the Illinois Public Aid Code (305 ILCS 5/5-1 et seq.) and 5/12-1 et seq.); the Children's Health Insurance Program Act (215 ILCS 106/1 et seq.); the Covering All Kids Health Insurance Act (215 ILCS 170/1 et seq.); Medicaid, Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.); and the Children's Health Insurance Program, Title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.).
- 1.9.30 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.
- 1.9.31 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.
- 1.9.32 Potential Enrollee:** A Client who may be eligible for enrollment in an ACE, but is not yet an Enrollee of an ACE.

- 1.9.33 Primary Care Provider (PCP):** A Provider, enrolled with IHC, who within the Provider's scope of practice and in accordance with State certification requirements or State licensure requirements, including pediatricians, is responsible for providing all preventive and primary care services to his or her assigned Enrollees in the ACE.
- 1.9.34 Proposal:** A Bidder's response to the Solicitation, consisting of the technical Proposal and all required forms and certifications, as detailed in Section 2.3. All required forms and certifications must be completed, signed, and returned by the Bidder. Proposal may also be referred to as Offer.
- 1.9.35 Provider:** A Person enrolled with the Department to provide Covered Services to a Client.
- 1.9.36 Quality Measure:** A quantifiable measure to assess how well an ACE carries out a specific function or process, as further explained in Section 3.1.4.6 and Attachment C.
- 1.9.37 Solicitation:** This document plus any additional documents and clarifying questions and answers the State may publish.
- 1.9.38 State:** The State of Illinois, as represented through any agency, department, board, or commission.
- 1.9.39 State Plan:** The Illinois State Plans filed with the Centers for Medicare & Medicaid Services, in compliance with Title XIX and Title XXI of the Social Security Act.

1.10 ACRONYMS. Whenever used in this Solicitation including attachments to this Solicitation, the following acronyms will have the meanings identified below.

- 1.10.1** ACA: Affordable Care Act
- 1.10.2** BEP: Business Enterprise Program
- 1.10.3** CES: Client Enrollment Services
- 1.10.4** CFR: Code of Federal Regulation
- 1.10.5** CHIPRA: Children's Health Insurance Program Reauthorization Act
- 1.10.6** DCFS: Department of Children and Family Services
- 1.10.7** DHHS: The United States Department of Health and Human Services
- 1.10.8** DHR: Department of Human Rights
- 1.10.9** DSCC: Division of Specialized Care for Children
- 1.10.10** Federal CMS: Centers for Medicare & Medicaid Services
- 1.10.11** FFS: Fee-for-Service
- 1.10.12** FOIA: Freedom of Information Act
- 1.10.13** FTE: Full-time Equivalent
- 1.10.14** HEDIS: Healthcare Effectiveness Data and Information Set
- 1.10.15** HFS: The Illinois Department of Healthcare and Family Services
- 1.10.16** HIPAA: Health Insurance Portability and Accountability Act
- 1.10.17** HIT: Health Information Technology
- 1.10.18** HMO: Health Maintenance Organization
- 1.10.19** IHC: Illinois Health Connect
- 1.10.20** ILCS: Illinois Compiled Statutes
- 1.10.21** LOI: Letter of Intent
- 1.10.22** MCO: Managed Care Organization
- 1.10.23** NCQA: National Committee for Quality Assurance
- 1.10.24** PCP: Primary Care Provider
- 1.10.25** PMPM: Per Member Per Month
- 1.10.26** SSI: Supplemental Security Income

SECTION 2 – HOW WE WILL EVALUATE PROPOSALS

- 2.1 MINIMUM REQUIREMENTS:** Only Proposals that satisfy the minimum requirements specified in Attachment A of this Solicitation will be evaluated. The minimum requirements must be clearly demonstrated in the Bidder's response.
- 2.2 EVALUATION CATEGORIES:** We will only evaluate Proposals that satisfy the minimum requirements specified in Attachment A of this Solicitation using the point system described below. In addition to the point system below, the decision to award a Contract(s) will be at the State's discretion and depend upon the models proposed, the number of ACEs proposing to provide services in a given geographical area, and the likely capability of the ACE to provide services on a capitated basis by month 19 of operation.

ACE Evaluation Categories	Maximum Points
Organization/Governance	200
Network	250
Care Model	200
Health Information Technology	200
Financial	150
Total	1,000

- 2.3 PROPOSAL CHECKLIST:** The State will evaluate complete Proposals as described in Sections 2.1 and 2.2. To be complete, a Proposal must:
- 2.3.1** Satisfy the minimum requirements outlined in Section 2.1;
 - 2.3.2** Include the submission of a Letter of Intent, including a signed Data Use Agreement, to HFS in accordance with Section 3.1.1.2, Letter of Intent, and Attachment D, of the Solicitation, as early as August 29th, 2013, but no later than October 1, 2013;
 - 2.3.2** Include complete answers, including completion of applicable Attachments, to all of the questions contained in Section 3.2, Proposal Contents, of this Solicitation;
 - 2.3.3** Include a Signed Proposal, completed and signed Taxpayer Identification Number form, Disclosures and Conflicts of Interest form, and BEP Participation and Utilization Plan included in Section 3.4, Required Forms, of this Solicitation; and
 - 2.3.4** Include the submission of the original Proposal and the required copies, as specified in Sections 1.3, Proposal Due Date, Time and Submission Location and 1.4, Number of Copies, of this Solicitation.

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 qualified and financially sound Accountable Care Entity(ies) comprised of experienced providers. There is no predetermined number of awards; the decision to award a Contract(s) will depend upon the models proposed, the number of ACEs proposing to provide services in a given geographical area, and the likely capability of the ACE to provide services on a capitated basis by month 19 of operation. The ACE program is a phased approach with an ACE initially providing care coordination services within a fee-for-service system, moving to pre-paid capitation with partial risk and, thus, under Illinois law, operating as Managed Care Organizations (MCOs) by month 19, and moving to full-risk capitation by the fourth year of operation. The initial term of the Contract will be three years. The State seeks a redesigned health care delivery system that provides integrated and accountable care, improves health outcomes, and enhances patient access. In this Solicitation for ACEs, the State is seeking Proposals from ACEs organized and governed by participating providers, with a designated lead legally responsible entity, that demonstrates an integrated delivery system and the capacity to share clinical information in a timely manner; and designs and implements a model of care and financial management structure that promotes provider accountability, quality improvement, and improved health outcomes.

3.1.1.1 Background. The intent of this Solicitation is to test community interest and capacity to provide alternative models of delivering accountable care for the Family Health Plan population (children, parents or other caretaker relatives eligible for Covered Services under Title XIX, and pregnant women), and, optionally, ACA adults, organized by ACEs, while complying with Public Act 98-104, Public Act 096-1501, all other pertinent state and federal laws and regulations, and aligning with Affordable Care Act (ACA) initiatives.

3.1.1.1.1 Public Act 98-104 requires the Department to issue a solicitation for ACEs to serve children and parents or other caretaker relatives eligible for Covered Services under Title XIX. The legislation requires that an ACE demonstrate a governing structure that includes participation from Providers, is an integrated delivery system able to provide the full range of services needed by Medicaid beneficiaries, demonstrates the capacity to securely pass clinical information across participating members, and uses data analysis to coordinate care.

3.1.1.1.1.1 In the first 18 months of operation, an ACE shall be paid per member per month care coordination fees that are projected to be cost neutral to the State during the term of their payment to coordinate care for their Enrollees. Also, subject to federal approval, ACEs may be eligible to share in additional savings generated by their care coordination.

3.1.1.1.1.2 During months 19 through 36, an ACE shall be paid on a pre-paid capitation basis for all Covered Services with the Department sharing the risk through either stop-loss insurance for high cost individuals or corridors of shared risk based on the overall cost of the total enrollment in the ACE. Based on current Illinois law, this requires an ACE to be a MCCN or HMO by month 19. While an ACE will be required to be licensed as a MCCN or HMO by month 19, it must also continue to meet the requirements specific to operation as an ACE as described in law, and this Solicitation and any modifications thereto.

3.1.1.1.1.3 In the fourth and subsequent years, an ACE shall be reimbursed full-risk capitation payments.

3.1.1.1.1.4 An ACE may elect to move to full-risk capitation payments on a more expedited timetable than described above.

3.1.1.1.1.5 This Solicitation lays out the requirements to qualify as an ACE.

3.1.1.1.2 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 use the following link for the full legislative text: http://www2.illinois.gov/hfs/PublicInvolvement/cc/Documents/096_1501cc.pdf). Enrollment of Clients in an ACE helps satisfy the requirements laid out in Public Act 096-1501.

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

3.1.1.1.4 State Health Care Innovation Plan. The State received a grant from the Center for Medicare and Medicaid Innovation (CMMI) to develop a comprehensive plan that commits the State to the development of multi-

payer approaches that create new payment methodologies to incentivize providers and plans to assure high quality and cost-effective health care delivered through accountable, comprehensive, and integrated health care delivery systems. All ACEs shall implement the recommendations of the Innovation plan as related to integrated delivery systems.

3.1.1.1.5 Mandatory Managed Care. The State designated five regions in the State in which mandatory managed care will operate (mandatory managed care regions). Once the State implements mandatory managed care, Clients residing in a mandatory managed care region will be required to choose among managed care entities available in their region. Clients residing outside a mandatory managed care region will not be required to enroll with a managed care entity. In Illinois, managed care entities include Care Coordination Entities (CCEs), HMOs, MCCNs, and ACEs. In all counties in these five regions, Clients will have a choice of at least two managed care entities. The mandatory managed care regions include:

3.1.1.1.5.1 Cook and the Collars: Cook, Lake, Kane, DuPage, Will, and Kankakee counties;

3.1.1.1.5.2 Rockford: Winnebago, Boone, and McHenry counties;

3.1.1.1.5.3 Quad Cities: Rock Island, Henry, and Mercer counties;

3.1.1.1.5.4 Central Illinois: Knox, Stark, Peoria, Tazewell, McLean, Ford, Champaign, Vermilion, Piatt, DeWitt, Macon, Logan, Menard, Sangamon, and Christian counties; and

3.1.1.1.5.5 Metro East: Madison, St. Clair, and Clinton counties.

3.1.1.2 Letter of Intent (LOI). The Department is requiring Letters of Intent (LOIs) from ACEs that are anticipating – or seriously considering – submitting a Proposal for providing services in response to this Solicitation. While submitting a LOI does not commit an ACE to actually submit a Proposal, the Department will not accept Proposals from nor provide data to ACEs 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 October 1, 2013. The Department will accept LOIs between August 29th, 2013 and October 1st, 2013.

3.1.1.2.1 Data. Upon receipt of a LOI and signed Data Use Agreement, the Department will provide two years of de-identified summary service data showing the historical type and volume of services received and the cost of those services. The ACE may request the data for its proposed service area or for the entire state, from which the ACE may identify its proposed service area and regional population. The ACE will be able to separately analyze adults and children and other demographic splits.

3.1.1.3 Minimum Requirements. In order to be considered for evaluation, Proposals must meet a minimum threshold standard outlined in Attachment A. The State will only consider for formal evaluation Proposals that satisfy the minimum requirements specified in Attachment A.

3.1.2 Organization/Governance. The ACE must develop and implement an organization and governance structure that meets the guidelines outlined in this Solicitation.

3.1.2.1 ACE. An ACE is an organization comprised of and governed by its participating providers, with a designated lead legally responsible entity, that develops and implements an accountable care model that meets the guidelines described in this Solicitation. An ACE must be an integrated delivery system with a network that meets the requirements in Section 3.1.3; system capacity to securely pass clinical information across its network; the ability to aggregate and analyze data in order to coordinate care; and a model of care and financial management structure that promotes provider accountability, quality improvement, and improved health outcomes.

3.1.2.1.1 Minimum Members. An ACE must include, at a minimum, participation from primary care, specialty care, hospitals, and Behavioral Health care.

3.1.2.1.2 Lead Entity. An ACE must identify a lead entity that shall assume legal responsibility for the ACE. An ACE may identify a single lead entity or organize a network of providers through contractual relationships to develop a single lead entity. A lead entity agrees to serve as the entity responsible for executing the ACE Contract with the Department. A lead entity must be based in Illinois, 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.

3.1.2.1.3 Governance Structure. An ACE must demonstrate an established governance structure that includes the major components of the health care delivery system, including, at a minimum, one representative from each of the groups listed in Section 3.1.2.1.1. If the lead entity is a single provider, the governing body must include providers employed and not employed by the lead entity. The governing body responsibilities include setting policy, developing and implementing a model of care, establishing best practices, setting and monitoring quality goals, and assessing performance and addressing deficiencies. An ACE must have a designated medical director that oversees the development and implementation of the model of care for the integrated delivery system. The ACE must also demonstrate meaningful involvement of the medical director and front-line Providers in the ACE governance structure. The ACE must have procedures for the governing board to set policy and assure accountability back to the Providers.

3.1.2.1.4 Consumer Advisory Board. An ACE will be required to have a consumer advisory board that meets regularly and advises on ACE policies and programs including cultural competency, outreach plans, Enrollee education materials, prevention programs, Enrollee satisfaction surveys, and quality improvement programs.

3.1.2.2 ACE to MCO Work Plan. As part of its Proposal, an ACE must demonstrate a work plan that depicts how the ACE will meet the requirements laid out in Attachment B. Attachment B specifies the requirements ACEs must fulfill by implementation and the requirements ACEs must fulfill by month 19 when the ACE moves to pre-paid capitation for delivery of services. For example, by month 19, the ACE must have the capability to process claims, submit encounter data, and implement utilization control. Prior to implementation, the ACE will be required to pass a readiness review. A second readiness review test will be required prior to month 19. By month 19, an ACE will be subject to contract terms similar to a MCO. To understand the general terms and conditions applicable after an ACE moves to risk-based payment, please see the Department's current risk-based contracts for its MCCN and voluntary managed care programs (<http://www2.illinois.gov/hfs/ManagedCare/Documents/mco.pdf>) and Integrated Care Program (<http://www2.illinois.gov/hfs/PublicInvolvement/IntegratedCareProgram/Pages/Contracts.aspx>).

3.1.3 Network.

3.1.3.1 Months 1 – 18. An ACE network must include participation from primary care, specialty care, hospitals, and Behavioral Healthcare Providers, meet the requirements specified in Sections 3.1.3.3, 3.1.3.4, and 3.1.3.5, and be sufficient to meet its expected enrollment levels (See Section 3.1.3.6 for minimum enrollment levels). An ACE must have established procedures for coordinating with non-Medicaid providers such as housing and social service providers.

3.1.3.2 Months 19 forward. An ACE must continue to meet the requirements specified in Section 3.1.3.1 and also include participation from all HFS provider types that have demonstrated capacity to serve its Enrollees (See Section 3.1.3.6 for minimum enrollment levels) including primary care, specialty care, hospitals, Behavioral Healthcare, and tertiary care. An ACE will be required to pay all network providers. The ACE networks must be sufficient to provide for all Covered Services, which excludes long-term supports and services (LTSS). Specialty capacity must be adequate to meet access standards.

3.1.3.2.1 In order to move beyond month 18, an ACE will need to demonstrate a network that adequately meets all of an Enrollee's needs for Covered Services. As part of the Solicitation response, an ACE must, using data analysis, determine the percentage of Covered Services previously provided by its network Providers to its expected universe of Enrollees and include a plan for ensuring an adequate network of all HFS Provider types by month 19.

3.1.3.2.2 All Covered Services. An ACE must provide all Covered Services as medically appropriate.

3.1.3.3 Access Standards. ACE networks must meet, at a minimum, the State and federal Medicaid access standards listed below.

3.1.3.3.1 Travel Time and Distance Standards. Enrollees shall not be required to travel more than thirty (30) minutes or thirty (30) miles to receive primary health care services in urban areas, or sixty (60) minutes or sixty (60) miles to receive primary health care services in rural areas. An Enrollee may elect to travel beyond the distance standards when the Enrollee exercises choice in selecting a PCP within the ACE network or specialty care Provider. The free exercise of such choice by the Enrollee will not negatively impact the results of any reporting by the ACE on access to care.

3.1.3.3.2 Access to Provider Locations. Provider locations shall be accessible for Enrollees with disabilities. An ACE shall collect sufficient information from Providers to assess compliance with the Americans With Disabilities Act. As necessary to serve Enrollees, Provider locations where Enrollees receive services shall

be ADA compliant. In addition, the ACE shall include within its network Provider locations that are able to accommodate the unique needs of Enrollees.

- 3.1.3.3.3 Appointments.** The ACE shall require that time specific appointments for routine, preventive care are available within five (5) weeks from the date of request for such care. Enrollees with more serious problems not deemed emergency medical conditions shall be triaged and, if necessary or appropriate, immediately referred for urgent medically necessary care or provided with an appointment within one (1) business day of the request. Enrollees with problems or complaints that are not deemed serious shall be seen within three (3) weeks from the date of request for such care. Initial prenatal visits without expressed problems shall be made available within two (2) weeks after a request for an Enrollee in her first trimester, within one (1) week for an Enrollee in her second trimester, and within three (3) days for an Enrollee in her third trimester. Affiliated Providers shall offer hours of operation that are no less than the hours of operation offered to persons who are not Enrollees. An ACE shall ensure 80 percent of Enrollees referred for specialty care are seen within 30 days and 95 percent of Enrollees are seen within 45 days. An ACE may use telephone consultation, e-consultation and other methods to screen for the appropriateness of the referral to specialty care.
- 3.1.3.4 Primary Care Provider (PCP) Requirements.** PCPs are at the core of the ACE model. Bidders must have an adequate PCP network with demonstrated capacity to serve its expected number of Enrollees (See Section 3.1.3.6 for minimum enrollment levels). For each PCP that is 100 percent FTE, a maximum 1800 limit is allowed for all of a PCP's Enrollees in any ACE with which the PCP participates. Each PCP may set an enrollment limit lower than 1800. An additional maximum 900 ACE Enrollees in any ACE with which the PCP participates is allowed for each mid-level practitioner (resident physician/ nurse practitioner/ physician assistant/ advanced practice nurse) who is 100 percent FTE.
- 3.1.3.4.1 Illinois Health Connect (IHC).** ACE PCPs must meet the IHC PCP standards and be enrolled in IHC. ACEs will be required to demonstrate their PCPs current capacity and their capacity to serve the number of expected ACE Enrollees within the 1:1800 limit. The State may investigate ACE PCP capacity through methods such as interviews, will require active acknowledgement on the part of the PCP of their involvement in the ACE, and may require a demonstration of how PCPs are splitting time between the ACE and other clients.
- 3.1.3.4.2 Other PCP Requirements.** PCPs may be enrolled in more than one ACE, but will be required to demonstrate capacity to participate in each ACE. Individual PCP participation in all ACE Proposals received by the Department must not exceed the 1:1800 limit described in Section 3.1.3.4.
- 3.1.3.5 Obstetrics Requirements.** HFS Medical Programs cover slightly more than half the births that take place in Illinois. Therefore, obstetrics is a critical service for serving the target population of an ACE. Slightly more than 25 percent of the Family Health Plan population is women of childbearing age (14-44). The Medicaid birth rate among this age group is 130 per 1000 women. Therefore, at minimum enrollment, an ACE in Cook County should expect to cover 1300 births, an ACE in the Collar Counties would cover 650 births, and an ACE in other regions should expect to cover 325 births. An ACE must show the capacity to cover these births by listing Providers with delivery privileges at a participating ACE hospital sufficient to cover the anticipated number of births based on expected enrollment and hospitals with obstetric units sufficient to handle the volume.
- 3.1.3.6 Population.** An ACE must serve the Family Health Plan population. An ACE may also choose to serve ACA adults. Populations excluded from enrollment into an ACE are DCFS foster children, children eligible for HFS Medical Programs due to a disability, children receiving SSI, Clients with high third party liability, Clients only eligible with a spend down, dual eligible Clients, children whose care is coordinated by DSCC, all presumptive eligibility categories, seniors and persons with disabilities, Clients enrolled in Veteran's Care, and Clients who are American Indian/Alaska Natives unless they voluntarily enroll in an ACE. Any other eligible group not identified here is excluded from ACE enrollment.
- 3.1.3.6.1 Cook County.** An ACE operating in Cook County must be able to serve at least 40,000 Enrollees in that county.
- 3.1.3.6.2 Lake, Kane, DuPage, or Will Counties.** An ACE operating in these counties must be able to serve at least 20,000 Enrollees in those counties.
- 3.1.3.6.3 Other Regions.** An ACE operating in other regions of the State must be able to serve at least 10,000 Enrollees in the region in which it proposes to operate.
- 3.1.3.6.4 Service Area.** An ACE must define the region it proposes to serve by county and/or zip code (service area). While an ACE may serve a partial county(s) as defined by zip codes, an ACE region must be reasonable with

respect to provider sites and may not be shaped in a way to discriminatorily exclude or include Potential Enrollees that the ACE Providers already serve. If an ACE proposes to serve a non-contiguous area, the ACE will be required to justify its service area.

3.1.3.6.5 Cross-Regional Service Areas. The ACE must be able to serve the minimum number of Enrollees associated with any county included in its service area. For example, an ACE proposing to serve southern Cook County, Will County, and Kankakee County would need to serve at least 40,000 Enrollees.

3.1.3.6.6 Without discrimination. The ACE must be able and willing to serve all Potential Enrollees in its service area, without discrimination as to health status and needs, disability, education, sex, sexual orientation, age, race, language, ethnicity, or religion.

3.1.3.6.7 Enrollment.

3.1.3.6.7.1 Mandatory enrollment. In order to comply with Public Act 96-1501, the Department intends to begin mandatory enrollment of the Family Health Plan population in July 2014 and phase in mandatory enrollment through January 1, 2015. It is the intent of the State to make ACEs an option its Clients may choose for mandatory managed care. That means that Clients residing in a mandatory managed care region (See Section 3.1.1.1.5) will be required to enroll in a managed care option available in their region, from among two or more managed care entities, including an ACE, CCE, HMO or MCCN.

3.1.3.6.7.2 Voluntary enrollment. A Client residing outside of a mandatory managed care region (voluntary managed care region) will not be required to enroll in a managed care option available in the region in which they reside. An ACE operating in a voluntary managed care region will be an option for those Clients that choose managed care.

3.1.3.6.7.3 12-months continuous eligibility. Regardless of whether an Enrollee is located in a region that mandates enrollment into a managed care option, ACE Enrollees will be locked into the ACE for 12-months from the date of enrollment. Enrollees will be able to switch managed care options with cause at any time, and without cause during the 90 days following enrollment, and at least every 12 months from enrollment.

3.1.3.6.7.4 Restrictions. Clients may only be enrolled in one ACE, CCE or MCO at any given time.

3.1.3.6.7.5 Client Enrollment Services (CES). The CES handles enrollment and disenrollment. An ACE must electronically submit files identifying its network to the CES on a regular basis. During initial periods of mandatory enrollment in managed care, the CES will apply, in mandatory managed care regions, a default assignment algorithm that ensures, if possible, an ACE reaches the minimum enrollment levels. Auto-assignment will be based on continuity of care and consider factors such as an Enrollee's link to current Providers and geographic considerations until the minimum enrollment levels are reached.

3.1.3.6.7.6 Marketing. An ACE may conduct Marketing activities consistent with Federal regulations found at 42 C.F.R. Section 438.104. Subject to the Department's prior approval, ACEs may market by mail, mass media, advertising, and community-oriented Marketing directed at Potential Enrollees. All Marketing Materials must be pre-approved by the Department.

3.1.3.6.7.6.1 Providers participating in an ACE may inform their patients of the ACE opportunities available to them, including the services provided by the ACE of which the Provider is a member. However, pursuant to Section 3.1.3.6.7.5, Potential Enrollees will be referred to the CES for Enrollment.

3.1.4 Care Model. An ACE must establish a model of care agreed to and implemented by all of its participating Providers and must, by month 19 of operation, be able to provide the full range of Covered Services needed by Enrollees. The model of care should meet standards that assure quality, improve the health of the population and, over time, reduce overall cost.

3.1.4.1 Integrated Delivery System Model of Care. An ACE must demonstrate that it is an integrated delivery system, which includes a Provider network that documents adequate capacity for its Enrollees as specified in Section 3.1.3 and clearly defines roles and responsibilities of participating Providers. The ACE must clarify its agreed upon model of care which must address the following elements:

- 3.1.4.1.1 Capacity for securely passing clinical information among participating Providers and aggregating and analyzing that information to manage care;
 - 3.1.4.1.2 Capacity to receive periodic claims data from the Department regarding Enrollees and the ability to analyze and use that data for care coordination;
 - 3.1.4.1.3 Agreement among Providers on protocols for approaches to chronic illnesses;
 - 3.1.4.1.4 Approaches to integration of primary care and Behavioral Health services based on the severity of illness and condition;
 - 3.1.4.1.5 Utilization of a schedule of evidence-based health promotion and prevention interventions for its population;
 - 3.1.4.1.6 Chronic care management at the primary care level;
 - 3.1.4.1.7 High level of access by phone, visit, email, text or other form 24/7 by primary care team or system tied to the primary care team;
 - 3.1.4.1.8 Availability of urgent care coordinated with primary care to minimize unnecessary emergency department (ED) visits;
 - 3.1.4.1.9 Transitional care coordination utilizing an evidence-based model among all Providers including inpatient and ED follow-up; and
 - 3.1.4.1.10 A quality program that supports its care model and encourages improved health outcomes and quality of care.
- 3.1.4.2 Care Management.** An ACE must be capable of providing both care coordination to its entire population, across all elements of care, with higher levels of care management provided depending upon the risk of the Enrollee. To be responsive to the Solicitation, an ACE must outline its care management model which must address the following elements:
- 3.1.4.2.1 Plan for health risk assessment and stratification; and
 - 3.1.4.2.2 Care management for multiple or high-risk patients with chronic illnesses and complex cases (including high utilizers).
- 3.1.4.3 Medical Director/Governance.** An ACE must have a designated medical director that oversees the development and implementation of the model of care for the integrated delivery system. The ACE must also demonstrate meaningful involvement of the medical director and front-line providers in the ACE governance structure. The governing body responsibilities include setting policy, developing and implementing a care model, incorporating best practices, setting and monitoring quality goals, and assessing performance and addressing deficiencies. Policies and procedures for all aspects of an ACE's model of care will be required prior to implementation.
- 3.1.4.4 Health Homes.** An ACE must meet the requirements for Health Homes in Section 2703 of the ACA. ACEs will be required to track and report health home populations to the Department. The Department is in the process of developing a methodology and frequency for ACEs to report health home populations and will provide this information as soon as it is available.
- 3.1.4.5 State Health Care Innovation Plan.** All ACEs shall implement the recommendations of the Innovation plan as related to integrated delivery systems.
- 3.1.4.6 Quality Measures.** The State will track, monitor, and report performance of an ACE using prescribed HEDIS®, HEDIS®-like, CHIPRA, birth-outcome, and other quality and outcome measures. See Attachment C for the list of Quality Measures. An ACE will be expected to have a formal quality improvement process, with assigned accountabilities. An ACE will be expected to describe their internal quality improvement/quality assurance processes, as well as how the ACE plans to use the results of quality reports the ACE will receive from the Department to drive quality improvement and health outcomes during the first 18 months. An ACE will be required to self-monitor and analyze the proscribed quality indicators in Attachment C during months 19 through 36 and incorporate said analysis into quality initiatives to drive improvement in Enrollee health and outcomes.

3.1.5 Health Information Technology. An ACE must demonstrate capacity to securely pass clinical information among its network of Providers, and to aggregate and analyze data to coordinate care. An ACE must have information technology (IT) to support care

management, HIPAA 834 enrollment and disenrollment transactions, data reporting functionality, and quality improvement. Proposals must include a description of electronic capabilities at the time of Proposal submission, and a plan for meeting the requirement in Section 3.1.5.2 18 months after Contract Execution.

3.1.5.1 All ACE Providers must have the ability to utilize the Illinois Health Information Exchange (IHIE): <http://www2.illinois.gov/gov/HIE/Pages/default.aspx#tabitem1>

3.1.5.2 Within 18 months of Contract Execution, the ACE must demonstrate real-time care connectivity between the EDs and PCPs.

3.1.6 Financial.

3.1.6.1 Financial Model. An ACE must demonstrate a reimbursement structure aimed at creating value and savings and that supports its model of care. For months 1 through 18, an ACE must propose a distribution plan for shared savings among Providers that is designed to incent practice redesign and care coordination activity. For months 19 on, the reimbursement structure must clearly delineate the flow of financial reimbursement among participating Providers down to the PCP including sharing in financial savings.

3.1.6.2 Financial Requirements. By month 19, unless an ACE chooses to convert to an HMO, an ACE must meet the current MCCN financial requirements as specified in the current MCCN regulations. The current MCCN regulations can be found here: <http://www.ilga.gov/commission/jcar/admincode/089/08900143sections.html>. If an ACE chooses to convert to an HMO, it must satisfy the HMO financial requirements by month 19.

3.1.6.3 Months 1 – 18. During months 1 through 18, an ACE will be reimbursed care coordination fees on a per member per month (PMPM) basis that are projected to be cost neutral to the State during the term of their payment. In addition, subject to federal approval, an ACE may be eligible to share in additional savings generated by their care coordination. A MCO may not assume any risk for an ACE, but may provide back office support.

3.1.6.3.1 Care Coordination Fee. The State has set forth the ACE care coordination fee below for the first 18 months of operation. The rate below is a composite rate for all Enrollees, and, since ACEs will not be required to perform many of the administrative functions of an MCO during the first 18 months, is based on approximately 50 percent of the administrative load currently paid to MCOs for Clients eligible for enrollment into an ACE.

3.1.6.3.1.1 Composite PMPM: \$9.00

3.1.6.3.2 Shared Savings. Shared savings calculations will compare the actual total per member per month cost of care including care coordination fees to comparable MCO capitation rates. Shared savings will not be available on ACA Adults. If the State determines there are savings in a given year, ACEs may be able to earn up to 50 percent of the savings up to a maximum of 5 percent of total healthcare cost for its Enrollees. Actual costs will be calculated following a 180-day claims run-out after the first 18 months of operation to ensure that all claims associated with an Enrollee have been received. Months 7 through 18 will be the measurement period for any shared savings. The ability to receive shared savings payments for months 7 through 18 of operation does not change the legislative requirement that the ACE move toward pre-paid capitation payments beginning in month 19. See Attachment G for the Department's draft shared savings proposal for ACEs and CCEs that is pending filing with Federal CMS.

3.1.6.3.3 Covered Services will remain under a FFS payment structure.

3.1.6.3.4 For the first 18 months, PCPs will continue to receive the IHC care management fee directly from the Department.

3.1.6.3.5 An ACE may use revenue from its reimbursement to directly pay for a non-Covered Service.

3.1.6.3.6 Exit Fee. Public Act 96-1501 requires that at least 50 percent of medical assistance Clients must be enrolled in care coordination systems with risk-based payments. During the first 18 months of operation, an ACE will receive care coordination fees and payments for shared savings, if warranted and contingent upon Federal CMS approval, with no risk to the ACE. In order for these payments to be counted toward the risk-based payments contemplated in State law, the Solicitation includes the following exit fee for an ACE that terminates its Contract or whose Contract is terminated for cause for failure to meet its Contract terms and conditions. An ACE that terminates its Contract or whose Contract is terminated for cause by the Department prior to month 31 will be subject to an exit fee that is equal to 50 percent of care coordination fees paid

during the initial 18 months of operation. There will not be an exit fee for an ACE that terminates its Contract or whose Contract is terminated by the Department between months 31 and 36. The provider(s) or entity(ies) liable for the exit fee will be finalized during Contract negotiations.

3.1.6.4 Months 19 – 36. During months 19 through 36, an ACE will be paid on a pre-paid capitation basis for all Covered Services under contract terms similar to an MCO (See Section 3.1.2.2 regarding the State's current risk-based contracts), with the Department sharing the risk through stop-loss insurance for high cost individuals and corridors of shared risk based on the overall cost of the total enrollment in the ACE. Capitation rates will be risk adjusted based on an ACE's actual enrollment and adjusted for the reinsurance arrangements described below.

3.1.6.4.1 Stop-loss. For any Enrollee for whom paid claims in a Contract year exceed \$80,000, the Department will be responsible for paying 80 percent of the costs that exceed \$80,000 and the ACE will be responsible for paying 20 percent. Costs are calculated by applying Medicaid rates to Covered Services.

3.1.6.4.2 Risk Corridors. If an ACE has a Medical Loss Ratio greater than 110 percent, the Department will be responsible for 80 percent of the costs in that corridor and the ACE will be responsible for 20 percent.

3.1.6.4.3 Pay-for-Performance: For months 19 forward, the ACE will be subject to a pay-for-performance structure similar to the pay-for-performance structure applied in the Department's managed care programs for this population (See Section 3.1.2.2 regarding the State's current risk-based contracts). The State will withhold a percentage of ACE fees from each month's payment. The ACE can earn the withheld amounts as an incentive payment by meeting Quality Measure targets. See Attachment C for the Department's proposed pay-for-performance Quality Measures.

3.1.6.5 Fourth and subsequent years. Beginning with the fourth and all subsequent years, an ACE will be reimbursed full-risk capitation payments. (See Section 3.1.2.2 regarding the State's current risk-based contracts.)

3.1.6.6 All financial models are subject to federal approval before finalization of a Contract.

3.1.6.7 The 90 percent federal match available under Section 2703 of the ACA (health homes) for qualified Enrollees and services will not affect reimbursement for an ACE. 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 an ACE. The State designed this Solicitation to allow a potential Bidder to demonstrate its understanding of operating an ACE and its ability to design, implement and operate such a program while meeting the requirements specified in Section 3.1, Attachment A, and Attachment B. The following section requires complete responses that address each question and provide any experience the Bidder has had in said area. Please include the question number and restate the question in your response and answer questions in numerical order. Proposals must adhere to the page limit requirements in Section 1.4. Please include an introduction, as a cover letter (two-page maximum limit, which does not apply to the overall page limit specified in Section 1.4) to your responses to the following questions and include:

- The name of the Accountable Care Entity (ACE);
- The number of Enrollees that you expect to serve over the initial 18 months. Distinguish between children under age 19, pregnant women, parents or other caretaker relatives eligible for Covered Services under Title XIX, and ACA Adults;
- The geographical region (service area) you propose to serve (specify by county or zip codes) and provide a map of the region. Include a justification for your service area if counties and/or zip codes are non-contiguous;
- The name and pertinent contact information of the lead entity's primary contact; and
- Any other relevant information.

3.2.1 Organization/Governance

3.2.1.1 Who are the primary members (must minimally include primary care, specialty care, hospitals and Behavioral Healthcare,) that form the ACE? List names, titles, and employer of the primary members. Give the background of the key leaders of the ACE, the role each will play, and the vision each bring to your Proposal.

3.2.1.1.1 Who is the lead entity that would be contracting with the State?

3.2.1.1.2 What experience do the primary members have in working together to deliver healthcare? Outline the experience here with respect to what care, for what populations, for how long, and for how many people.

3.2.1.1.3 What experience do the primary members have taking risk to manage the care of a population for any other payor (e.g. Medicare Accountable Care Organizations)?

3.2.1.2 Describe the governance structure of the ACE including:

3.2.1.2.1 How it represents the major components of the health care delivery system and list names and titles and employer of governing board members;

3.2.1.2.2 How the governing body sets policy, establishes best practices, sets and monitors quality goals; and addresses deficiencies;

3.2.1.2.3 Policies and mechanisms in place to share information, and ensure compliance with the model of care described in your Proposal and accountability back to the Providers; and

3.2.1.2.4 The role of the medical director and front-line Providers.

3.2.1.3 Provide a comprehensive statement of your proposed three-year staffing plan. Distinguish between existing administrative staff and new administrative staff and existing care model staff and new care model staff. List a percentage full-time equivalent dedicated to this project for all staff including a percentage FTE for the medical director. Include organizational charts and detailed job descriptions for key staff as Attachment H.

3.2.1.4 Provide a detailed work plan that delineates the steps you will take to meet the timeline and requirements laid out in Attachment B.

3.2.1.5 Describe your plan for consumer input into the operations and management of the program.

3.2.2 Network

3.2.2.1 Describe how your network meets the requirements described in Sections 3.1.3.4 and 3.1.3.5 including how it is sufficient to at least meet the minimum enrollment levels described in Section 3.1.3.6, and:

3.2.2.1.1 Provide a CD listing of your PCP network. The data must be submitted in a Microsoft Excel file format and include the fields listed below for each PCP in your network:

3.2.2.1.1.1 National Provider Identifier (NPI);

3.2.2.1.1.2 Provider Last Name;

3.2.2.1.1.3 Provider First Name;

3.2.2.1.1.4 Provider Specialty (e.g. Internal Medicine, Pediatrician);

3.2.2.1.1.5 ACE Committed Panel Size;

3.2.2.1.1.6 Number of mid-level practitioners associated with the Provider;

3.2.2.1.1.7 Mid-level Practitioner Last Name;

3.2.2.1.1.8 Mid-level Practitioner First Name;

3.2.2.1.1.9 Mid-level Practitioner Specialty (resident physician/ nurse practitioner/ physician assistance/ advanced practice nurse); and

3.2.2.1.1.10 Mid-level Practitioner Percent FTE.

3.2.2.1.2 Include a signed letter of commitment for each PCP in your network that verifies the information provided in Section 3.2.2.1.1 using the template in Attachment E.

3.2.2.1.3 Provide a CD listing of your obstetric capacity. The data must be submitted in Microsoft Excel file format and include the fields listed below for each Provider in your network with delivery privileges at a participating ACE hospital:

3.2.2.1.3.1 National Provider Identifier (NPI);

3.2.2.1.3.2 Provider Last Name;

3.2.2.1.3.3 Provider First Name;

3.2.2.1.3.4 Provider Specialty (e.g. Obstetrician, Family Practice, midwife);

3.2.2.1.3.5 Hospital(s) at which Provider has privileges; and

3.2.2.1.3.6 Number of deliveries the Provider is committed to covering for the ACE. It is assumed that in most cases a Provider cannot reasonably handle more than 300 births in a year. To the extent a Provider is listed as providing greater capacity, include in your Proposal an explanation based on past practice and other information how the Provider feels capable of greater capacity.

3.2.2.1.4 Include a signed letter of commitment for each Provider in your network that verifies the information provided in Section 3.2.2.1.3, using the template provided in Attachment F.

3.2.2.2 Provide a CD listing of your network of Providers other than those listed in Section 3.2.2.1. Indicate your level of commitment by describing your agreements, i.e. letter of intent, pending contract, existing contract that needs to be amended for ACE participation, ACE contract. The data must be submitted in a Microsoft Excel file format including the following fields:

3.2.2.2.1 Provider Last Name;

3.2.2.2.2 Provider First Name;

3.2.2.2.3 Provider Specialty(s) (e.g. neonatology, cardiology, neurology, endocrinology, gastroenterology, etc.);

3.2.2.2.4 NPI; and

3.2.2.2.5 Agreement Description.

3.2.2.3 Using data provided by the Department determine the percentage of services previously provided by your network Providers to your expected universe of Enrollees. Include a justification of how your network is sufficient and meets the requirements specified in Section 3.1.3.2, or a plan for how you will ensure your network will be sufficient and meet the requirements specified in Section 3.1.3.2 by month 19, to meet the needs of your expected universe of Enrollees (expected enrollment levels must at least meet the standards described in Section 3.1.3.6) for all Covered Services.

3.2.2.4 Provide your minimum access standards that at least meet the standards as specified in Section 3.1.3.3 including distance and travel times, minimum hours of operation, after hours availability, and minimum appointment standards for:

3.2.2.4.1 PCPs;

3.2.2.4.2 Hospitals;

3.2.2.4.3 Specialist Providers;

3.2.2.4.4 Mental Health Providers; and

3.2.2.4.5 Substance Abuse Providers.

3.2.2.5 Describe your proposed Provider to Enrollee ratios, including your plan to monitor and maintain ratios, for:

3.2.2.5.1 PCPs to Enrollees;

3.2.2.5.2 Specialist Providers to Enrollees;

3.2.2.5.3 Mental Health Providers to Enrollees; and

3.2.2.5.4 Substance Abuse Providers to Enrollees.

3.2.2.6 Describe how your network will meet the distinct needs of adults and children.

3.2.2.7 Using Department data and, if available, data from other sources to understand the population that you will serve, describe how your network will meet their linguistic and cultural needs.

3.2.3 Care Model

3.2.3.1 Provide a detailed description of your integrated delivery system model of care, how it assures access to all necessary care, improves access to specialty care, and clarifies how Providers will work together to coordinate care. Demonstrate the flow of care for an Enrollee among Providers and include in your description how your model of care meets the requirements for an integrated delivery system model of care in Section 3.1.4.1.

- 3.2.3.2** Describe how you will coordinate care for your Enrollees, across all elements of care, including:
 - 3.2.3.2.1** How you will address and monitor transitions of care, including appropriate follow-up from:
 - 3.2.3.2.1.1** Inpatient to Outpatient;
 - 3.2.3.2.1.2** PCP to mental health Providers, substance abuse Providers, specialist Providers, and vice versa; and
 - 3.2.3.2.1.3** Outpatient (PCPs, specialist Providers, mental health Providers, substance abuse Providers) to Inpatient; and
 - 3.2.3.2.2** Specifically describe your plan to coordinate with state and community-based social services; and transportation to services.
- 3.2.3.3** Describe your plans for care management including:
 - 3.2.3.3.1** Your approach, methods, and timeframes for completing health risk assessments, risk stratification, and care plan development;
 - 3.2.3.3.2** Interventions for each risk level including those with multiple chronic illnesses and complex cases (including high utilizers and high-risk pregnancies). Include a description of who receives a care coordinator, care team, and care plan;
 - 3.2.3.3.3** How you will determine and develop a care team structure that meets the individual needs of Enrollees. Describe who will lead the care team and how communication will occur among the care team, between the care team and Providers, with other social supports, and with the Enrollee and the family and/or caregiver; and
 - 3.2.3.3.4** Outline your proposed care coordinator to Enrollee ratios, including how ratios and care coordinator responsibilities may differ based on risk-level and on the needs of the Enrollees they are assigned.
- 3.2.3.4** Describe your qualifications, including educational and training requirements for care coordinators and how those requirements differ based on the needs and risk-level of the Enrollee.
- 3.2.3.5** 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.
- 3.2.3.6** Describe the process for emergency department data utilization review, identification of Enrollees with high utilization, and the strategies to address high emergency department utilization that you will implement.
- 3.2.3.7** Does your model of care include incentives to Enrollees to stay in network or to be compliant with therapies? If so, please describe.
- 3.2.3.8** Provide a detailed description of the ACE's plans for monitoring quality of care provided to Enrollees, including structure, methods, processes and accountabilities for quality assurance. Describe how you plan to incorporate the results of Department quality reports, as well as self-generated quality metrics, into actionable quality improvement initiatives.
- 3.2.3.9** Do you have any plans to provide incentives to PCPs to move toward medical home certification by a nationally recognized accrediting organization? If so, please describe.

3.2.4 Health Information Technology (HIT)

- 3.2.4.1** Describe the current technology capacity among the members at the time of Proposal submission and how you will securely pass clinical information among your network of Providers. Distinguish between technology that is currently and fully functioning, being phased in, being implemented, being acquired, or otherwise being planned. Include in your Proposal:
 - 3.2.4.1.1** PCP communication capabilities;
 - 3.2.4.1.2** Specialist Provider communication capabilities;
 - 3.2.4.1.3** Mental health Provider communication capabilities;

3.2.4.1.4 Substance abuse Provider communication capabilities; and

3.2.4.1.5 Hospital communication capabilities.

3.2.4.2 Describe the ILHIE participation of the members.

3.2.4.3 Prior to implementation, an ACE must have the capability to support care management, HIPAA 834 enrollment and disenrollment transactions, data reporting functionality, and quality improvement. Please provide a plan demonstrating how you will be prepared to perform these functions prior to implementation.

3.2.4.4 What is the expected HIT functionality of the members (including PCPs, hospitals, specialist Providers, mental health Providers, substance abuse Providers, and others) 18 months after Contract Execution and how will this capacity support your model of care?

3.2.4.4.1 Describe your plans to attain real-time connectivity between EDs and PCPs within 18 months; and

3.2.4.4.2 Describe how you will address issues of privacy and confidentiality. Describe how your organization will be HIPAA compliant in meeting privacy and security requirements, and how workforce will receive HIPAA training and education.

3.2.4.5 Describe any resources you plan to provide to network Providers in the area of HIT.

3.2.5 Financial

3.2.5.1 Provide as Attachment I a detailed three-year budget that supports implementation of your model of care and demonstrates how the ACE plans to meet the MCO financial requirements specified in Section 3.1.6.2 and include:

3.2.5.1.1 Revenue sources;

3.2.5.1.2 Costs (staffing, IT, and other operational needs of an ACE); and

3.2.5.1.3 Provide the most recent audited financial statements of the lead entity as Attachment J.

3.2.5.2 Using data provided by the Department, other data as available, and healthcare management research prepare a financial plan that demonstrates how you expect to reduce healthcare costs by an amount equal to or greater than your care coordination fees for months 1 through 18. Cite your data and research sources.

3.2.5.3 For months 1 through 18, an ACE must propose a distribution plan for shared savings among Providers that is designed to incent practice redesign and care coordination activity. For months 19 on, the reimbursement structure must clearly delineate the flow of financial reimbursement among participating Providers down to the PCP including sharing in financial savings. Describe your reimbursement structures for months 1 through 18 and months 19 through 36.

3.3 Compliance with Federal and State Law, regulation, and policy. ACE Contracts must be compliant with federal laws, regulations, and policies including but not limited to the regulations found at 42 C.F.R. Part 438 and any federal policy interpreting these regulations. See http://www.access.gpo.gov/nara/cfr/waisidx_02/42cfr438_02.html for the federal regulations. ACE Contracts must also be compliant with state laws, regulations and policies including but not limited to, by month 19, MCCN and HMO statutes and regulations.

3.4 Required Forms. Consistent with Section 2, all Bidders must complete and submit the following forms:

3.4.1 Proposal to the State of Illinois (Signed Proposal)

3.4.2 Taxpayer Identification Number

3.4.3 Disclosures and Conflicts of Interest

3.4.4 BEP Participation and Utilization Plan

PROPOSAL TO STATE OF ILLINOIS (Signed Proposal)

Project Title: ACE Program Reference # 2014-24-002

The undersigned authorized representative of the identified ACE does hereby submit this Proposal to perform in full compliance with the subject Solicitation. By completing and signing this Form, the ACE is making a Proposal to the State of Illinois that the State may accept. The ACE is also certifying to compliance with the various requirements of the Solicitation including Attachment A and Attachment B and the documents contained in the Solicitation including but not limited to the requirements that are not being evaluated but which are specified in Section 3.1.

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

The ACE has:

- Reviewed the Proposal Form, including the Solicitation instructions, filled in all relevant blanks, provided any requested information, and
- Signed on the space(s) provided.

Acknowledgment of Amendments

- The ACE acknowledges receipt of any and all amendments to the Solicitation and has taken those into account in making this Proposal.

Proposal Response Forms: Accompanying and as part of this Proposal you will find:

For all Proposals

- Designated number of copies
- Electronic copies
- Completed Forms:
 - Disclosures and Conflicts of Interest
 - Completed and Signed Taxpayer Identification Number form
 - BEP Participation and Utilization Plan

Exceptions: In preparing the Proposal, the ACE has taken (check one)

- No Exceptions
- Exceptions to the State's language or requirements in the following sections of the Proposal:
 - Required forms
 - Details of the exceptions are shown (check one)
 - in the text of each section of the Proposal
 - on a separate labeled attachment

Request for Confidential Treatment (check one)

- The ACE is not requesting confidential treatment for this Proposal.
- The ACE is seeking confidential treatment for portions of this Proposal. The ACE has supplied, as an attachment to this Proposal, a listing of the provisions identified by section number for which the ACE seeks confidential treatment along with the statutory basis under Illinois law for exempting that information from public disclosure. The ACE is including a detailed justification to support the statutory basis under Illinois law for exempting that information from public disclosure. **The ACE has supplied an additional copy of the Proposal, both hardcopy and on CD, with confidential information deleted.** In the event the designation of confidentiality of this information is challenged, the undersigned

hereby agrees to provide legal counsel or other necessary assistance to defend the designation of confidentiality and agrees to hold the State harmless for any costs or damages arising out of the State agreeing to withhold the materials based on the ACE's request.

Negotiations

If the ACE is selected for award, the ACE understands that does not entitle the ACE to a Contract. The ACE further understands the award is conditioned on favorable resolution of successful negotiation of terms and conditions.

ACE Contact Person: The contact person for purposes of responding to any questions the State may have is:

Printed Name Title

Address

Phone Fax

Email

(ACE name and DBA)

(Signature of party authorized to bind the named ACE)

Printed Name Title

Address

Phone Fax

Email

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

The State of Illinois has engaged Health Management Associates, Inc. (HMA) to assist in the development of a State Health Care Innovation Plan and Model Testing proposal pursuant to the federal Center for Medicare and Medicaid Innovation (CMMI) initiative (Contract #OHIT2013-012) under the State Innovation Model Grant (Grant). The contract is between the State of Illinois Office of Health Information Technology (OHIT) and HMA with HFS as a signatory for financing purposes. The CMMI Grant is monitored by OHIT. The Project Manager is Michael Gelder, who is housed within the Office of the Governor.

As part of this Grant, consistent with the goals of the CMMI Grant and contract, HMA dedicated a team of three specific individuals who assisted HFS with the ACE Program Solicitation (Solicitation) required by PA 98-104, which also required that this Solicitation be posted by August 1, 2013. The specific individuals are Pat Terrell, Terry Conway, and Doug Elwell. HMA will have no involvement with evaluating the responses to this Solicitation. HMA has notified the State that HMA may assist one or more providers in preparing responses to this Solicitation. As part of its normal course of business, to protect the State's confidentiality, strategy and proprietary information, HMA has set up a firewall where none of the three specifically named HMA individuals will assist providers with responses to this Solicitation. This means that there will be no disclosure, discussion or exchange of information between Pat Terrell, Terry Conway, and Doug Elwell and any HMA teams or individuals assisting providers with responses to the Solicitation. These firewalls and safeguards are meant to protect all parties involved and ensure that work efforts and work products remain separate. These firewalls and safeguards will continue in effect until the State determines that it is no longer necessary.

In their Proposals, Bidders must disclose and identify the nature of any affiliations or relationships, including but not limited to business and contractual relationships with HMA. Additionally, Bidders must disclose the specific members of HMA who assisted Bidders with responses. It is not prohibited for any members of HMA who are not the three specifically named HMA individuals above to assist any Bidders with Proposals, provided the firewall remains in place. Certain affiliations or relationships may prevent the State from accepting a Proposal if the Bidder is determined by the State to be a prohibited Bidder. If the affiliations or relationship is not disclosed, your Proposal may be rejected as described below.

DISCLOSURES AND CONFLICTS OF INTEREST

Instructions: Bidder shall disclose potential conflicts of interest and contract information as a condition of receiving an award or Contract. Failure to fully disclose shall render the Contract, bid, Proposal, subcontract, or relationship voidable by the State if the State deems it in the best interest of the State of Illinois. 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 Proposal is awarded.

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

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

Name of Bidder: _____

D/B/A (if used): _____

Name of any Parent Organization: _____

Section 1: Current and Pending Contracts *(All Bidders must complete this section).*

Does the Bidder have any contracts, pending contracts, bids, proposals or other ongoing procurement relationships with units of State of Illinois government, or with the State’s consultant, HMA? 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 or HMA by showing, with respect to the units of State of Illinois government, agency name and other descriptive information such as bid number, project title, purchase order number or contract reference number and, with respect to HMA, all pertinent information including but not limited to effective date, term, short description including scope of work, whether the contract is an extension, amendment, or renewal.

Section 2: Business Relationships with State’s Consultant

Does the Bidder have any affiliations or relationships, including but not limited to business relationships, with the State’s consultant, HMA? Yes No

If yes, please identify the nature of the affiliation or relationship, including whether HMA assisted with the preparation of your Bid. Please identify the duration, whether compensation is paid, the specific individual(s) within HMA with whom you have had contact, the nature of the contact, the time period of the contact, and any other fact you deem relevant.

Section 3: Debarment

Has Bidder or any member of the ACE’s governing body ever been barred, suspended, proposed for debarment, declared ineligible or voluntarily excluded from participation in any Federal or State program by any Federal or State department or agency?

If yes, provide a written description of each offense causing the exclusion, the date(s) of the offense, the action(s) causing the offense(s), any penalty assessed or sentence imposed, and the date any penalty was paid or sentence completed.

This Disclosure is signed and made under penalty of perjury

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

Name of Authorized Representative: _____

Title of Authorized Representative: _____

Signature of Authorized Representative: _____

Date: _____

BEP PARTICIPATION AND UTILIZATION PLAN

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

Contract Goal to be Achieved by the Bidder: This Solicitation includes a specific BEP utilization goal of 5% of an ACE's care coordination fees for months 1 through 18, 15 percent of the administrative portion of an ACE's capitation payments for months 19 through 36, and 20 percent of the administrative portion of an ACE's capitation payments for months 37 forward based on the availability of BEP certified vendors to perform or provide the anticipated services and/or supplies required by this Solicitation. The Utilization Plan submitted with a Proposal should only cover the first 18 months of operation as an ACE. In addition to the other award criteria established for this Solicitation, the Department will award this Contract to a Bidder that meets the goal or makes good faith efforts to meet the goal. This goal is also applicable to change orders and allowances within the scope of work provided by the BEP certified vendor. If Bidder is a BEP certified vendor, the entire goal is met and no subcontracting with a BEP certified vendor is required; however, the Bidder must submit a Utilization Plan indicating that the goal will be met by self-performance.

Following are guidelines for the Bidder's response to the Utilization Plan. A format for the Utilization Plan is included in this section. Bidder should include any additional information that will add clarity to the Bidder's proposed utilization of BEP certified vendors to meet the targeted goal. The Utilization Plan must demonstrate that the Bidder has either: (1) met the entire Contract goal; (2) made good faith efforts towards meeting the entire goal; or (3) made good faith efforts towards meeting a portion of the goal. Any submission of good faith efforts by the Bidder shall be considered as a request for a full or partial waiver.

At the time of Proposal submission, the subcontractor must be certified with CMS Business Enterprise Program. Visit (www.sell2.illinois.gov/bep/Business_Enterprise.htm) for complete requirements and applications forms for certification in the Business Enterprise Program. Bidders who submit bids or offers for State contracts shall not be given a period of time after the Proposal is submitted to cure deficiencies in the Utilization Plan, Good Faith Effort documentation or the BEP Letter of Intent, unless mandated by federal law or regulation. 30 ILCS 575(4)(c). Failure to complete a Utilization Plan and/or provide Good Faith Effort Documentation may render the Proposal non-responsive or not responsible.

1. If applicable where there is more than one prime vendor, the Utilization Plan should include an executed Joint Venture Agreement specifying the terms and conditions **of the relationship between the parties and their relationship and responsibilities to the Contract. The Joint Venture Agreement must** clearly evidence that the BEP Certified vendor will be responsible for a clearly defined portion of the work and that its responsibilities, risks, profits and contributions of capital, and personnel are proportionate to its ownership percentage. It must include specific details related to the parties' contributions of capital, personnel, and equipment and share of the costs of insurance and other items; the scopes to be performed by the BEP Certified vendor under its supervision; and the commitment of management, supervisory personnel, and operative personnel employed by the BEP Certified vendor to be dedicated to the performance of the Contract. Established Joint Venture Agreements will only be credited toward BEP goal achievements for specific work performed by the BEP Certified vendor. **Each party must execute the bid or offer prior to submission of the Proposal to the Department.**
2. An agreement between a Bidder and a BEP certified vendor in which a BEP certified vendor promises not to provide subcontracting or pricing quotations to other vendors is prohibited. The Department may request additional information to demonstrate compliance. The Bidder agrees to cooperate promptly with the Department in submitting to interviews, allowing entry to places of business, providing further documentation, and to soliciting the cooperation of a proposed BEP certified vendor. Failure to cooperate by Bidder and the BEP Certified vendor may render the Bidder non-responsive or not responsible. **The Contract will not be finally awarded to Bidder unless the Bidder's BEP Utilization Plan is approved.**
3. **BEP Certified Vendor Locator References:** Bidders may consult CMS' BEP Certified Vendor Directory at (www.sell2.illinois.gov/bep/Small_and_Diverse_Businesses.htm), as well as the directories of other certifying agencies, but **BEP Bidders and subcontractors must be certified by CMS as BEP certified vendors at the time of submission of the Proposal for utilization approval.**
4. **Bidder Assurance:** The Bidder shall not discriminate on the basis of race, color, national origin, sexual orientation or sex in the performance of this Contract. Failure by the Bidder to carry out these requirements is a material breach of this Contract, which may result in the termination of this Contract or such other remedy, as the Department deems appropriate. This assurance must be included in each subcontract that the Bidder signs with a subcontractor or supplier.
5. **Calculating BEP Certified Vendor Participation:** The Utilization Plan documents work anticipated to be performed, or goods/equipment provided by all BEP certified vendors and paid for upon satisfactory completion/delivery. Only the value of payments made for the work actually performed by BEP certified vendors is counted toward the Contract goal. Applicable guidelines for counting payments attributable to Contract goals are summarized below:
 - 5.1. The value of the work actually performed or goods/equipment provided by the BEP Certified Vendor shall be counted towards the goal. The entire amount of that portion of the Contract that is performed by the BEP Certified Vendor, including supplies

purchased or equipment leased by the BEP Certified Vendor shall be counted, except supplies purchased and equipment rented from the Prime Vendor submitting this Proposal.

- 5.2. A vendor shall count the portion of the total dollar value of the BEP contract equal to the distinct, clearly defined portion of the work of the Contract that the BEP Certified Vendor performs toward the goal. A vendor shall also count the dollar value of work subcontracted to other BEP certified vendors. Work performed by the non-BEP certified party shall not be counted toward the goal. **Work that a BEP certified vendor subcontracts to a non-BEP certified vendor will not count towards the goal.**
- 5.3. A Bidder shall count toward the goal 100% of its expenditures for materials and supplies required under the Contract and obtained from a BEP certified vendor manufacturer, regular dealer, or supplier. A Bidder shall count toward the goal the following expenditures to BEP certified vendors that are not manufacturers, regular dealers, or suppliers:
 - 5.3.1. The fees or commissions charged for providing a bona fide service, such as professional, technical, consultant or managerial services and assistance in the procurement of essential personnel, facilities, equipment, materials or supplies required for performance of the Contract, provided that the fee or commission is determined by the Department to be reasonable and not excessive as compared with fees customarily allowed for similar services.
 - 5.3.2. The fees charged for delivery of materials and supplies required by the Contract (but not the cost of the materials and supplies themselves) when the hauler, trucker, or delivery service is not also the manufacturer or a supplier of the materials and supplies being procured, provided that the fee is determined by the Department to be reasonable and not excessive as compared with fees customarily allowed for similar services. The BEP Certified vendor's trucking firm must be responsible for the management and supervision of the entire trucking operation for which it is responsible on the contract, and must itself own and operate at least one fully licensed, insured and operational truck used on the contract.
 - 5.3.3. The fees or commissions charged for providing any bonds or insurance specifically required for the performance of the contract, provided that the fee or commission is determined by the Department to be reasonable and not excessive as compared with fees customarily allowed for similar services.
- 5.4. BEP certified vendors who are performing on contract as second tier subcontractors may be counted in meeting the established BEP goal for this Contract as long as the Bidder can provide documentation indicating the utilization of these vendors.
- 5.5. A Bidder shall count towards the goal only expenditures to firms that perform a commercially useful function in the work of the Contract.
 - 5.5.1. A firm is considered to perform a commercially useful function when it is responsible for execution of a distinct element of the work of a contract and carries out its responsibilities by actually performing, managing, and supervising the work involved. The BEP Certified Vendor must also be responsible, with respect to materials or supplies used on the contract, for negotiating price, determining quality and quantity, ordering the materials or supplies, and installing the materials (where applicable) and paying for the material or supplies. To determine whether a firm is performing a commercially useful function, the Department shall evaluate the amount of work subcontracted, whether the amount the firm is to be paid under the contract is commensurate with the work it is actually performing and the credit claimed for its performance of the work, industry practices, and other relevant factors.
 - 5.5.2. A BEP certified vendor does not perform a commercially useful function if its role is limited to that of an extra participant in a transaction or contract through which funds are passed through in order to obtain BEP certified vendor participation. In determining whether a BEP certified vendor is such an extra participant, the Department shall examine similar transactions, particularly those in which BEP certified vendors do not participate, and industry practices.
- 5.6. A Bidder shall not count towards the goal expenditures that are not direct, necessary and related to the work of the Contract. Only the amount of services or goods that are directly attributable to the performance of the Contract shall be counted. Ineligible expenditures include general office overhead or other Bidder support activities.
6. **Good Faith Effort Procedures:** If the Bidder cannot meet the stated goal, the Bidder must document in the Utilization Plan its good faith efforts that could reasonably have been expected to meet the goal. Bidders must submit utilization forms that meet or exceed the published goal or submit utilization forms that describe a percentage participation that is less than the goal and submit documentation regarding good faith efforts at the time of bid or offer submission. **Bidders will not be permitted to correct goal deficiencies after the Proposal due date.** The Business Enterprise Council ("Council") or its delegate will consider the quality, quantity, and intensity of the Bidder's efforts.

- 6.1.** The following is a list of types of action that the Council or its delegate will consider as evidence of the Bidder's good faith efforts to meet the goal. Other factors or efforts brought to the attention of the Council or its delegate may be relevant in appropriate cases.
- 6.1.1.** Soliciting through all reasonable and available means (e.g., attendance at a vendor conference, advertising and/or written notices) the interest of BEP certified vendors that have the capability to perform the work of the Contract. The Bidder must solicit this interest within sufficient time to allow the BEP certified vendors to respond to the solicitation. The Bidder must determine with certainty if the BEP certified vendors are interested by taking appropriate steps to follow up initial solicitations and encourage them to submit a bid or proposal. The Bidder must provide interested BEP certified vendors with adequate information about the plans, specifications, and requirements of the Contract in a timely manner to assist them in responding promptly to the solicitation.
 - 6.1.2.** Selecting portions of the work to be performed by BEP certified vendors in order to increase the likelihood that the goal will be achieved. This includes, where appropriate, breaking out contract work items into economically feasible units to facilitate BEP certified vendor participation, even when the Bidder might otherwise prefer to perform these work items with its own forces.
 - 6.1.3.** Making a portion of the work available to BEP certified vendors and selecting those portions of the work or material needs consistent with their availability, so as to facilitate BEP certified vendor participation.
 - 6.1.4.** Negotiating in good faith with interested BEP certified vendors. Evidence of such negotiation must include the names, addresses, and telephone numbers of BEP certified vendors that were considered; a description of the information provided regarding the plans and specifications for the work selected for subcontracting and evidence as to why additional agreements could not be reached for BEP certified vendors to perform the work. A Bidder using good business judgment may consider a number of factors in negotiating with BEP certified vendors and may take a firm's price and capabilities into consideration. The fact that there may be some additional costs involved in finding and using BEP certified vendors may not be in itself sufficient reason for a Bidder's failure to meet the goal, as long as such costs are reasonable. Bidders are not required to accept higher quotes from BEP certified vendors if the price difference is excessive or unreasonable.
 - 6.1.5.** Thoroughly investigating the capabilities of BEP certified vendors and not rejecting them as unqualified without documented reasons. The BEP certified vendor's memberships in specific groups, organizations, or associations and political or social affiliations are not legitimate causes for the rejection or non-solicitation of bids and proposals in the Bidder's efforts to meet the goal.
 - 6.1.6.** Making efforts to assist interested BEP certified vendors in obtaining lines of credit or insurance as required by the Department.
 - 6.1.7.** Making efforts to assist interested BEP certified vendors in obtaining necessary equipment, supplies, materials, or related assistance or services.
 - 6.1.8.** Effectively using the services of available minority/women community organizations; minority/women vendors' groups; local, state, and federal minority/women business assistance offices; and other organizations that provide assistance in the recruitment and placement of BEP certified vendors.
 - 6.1.9.** Utilize the Sell2Illinois website: (www.Sell2.illinois.gov) to identify BEP certified vendors.
- 6.2.** In evaluating the Bidder's good faith efforts, Council or its delegate may consider whether the ability of other bidders or offerors to meet the Contract goal suggests that good faith efforts could have resulted in Bidder meeting the goal.
- 6.3.** If the Council or its delegate determines that the Bidder has made good faith efforts to meet the goal, the Department may award the Contract provided that the Bidder is otherwise eligible for award.
- 6.4.** If the Council or its delegate determines that good faith efforts have not been met, the bid or offer may be determined to be non-responsive by the Chief Procurement Office.

7. Contract Compliance:

This Solicitation contains a minimum BEP goal of 5 percent of an ACE's care coordination fees for months 1 – 18, and a minimum BEP goal of 15 percent of the administrative portion of an ACE's capitation payments for months 19 - 36 for inclusion of businesses owned and controlled by minorities, females, and persons with disabilities in the State's procurement and contracting processes.

Bidders can be awarded additional points toward their total score for each percentage increase above the designated 5 percent minimum up to a maximum of 10 percent for BEP vendor participation in months 1 – 18. Each additional percentage point is equal to 5 extra points towards the total score. The BEP goal for Contracts continued 37 months and beyond will be 20 percent.

The Utilization Plan submitted with a Proposal should only cover the first 18 months of operation as an ACE. Note that for months 19 and beyond, a request for approval of BEP vendors selected to increase the utilization level as required with any additional BEP Letters of Intent must be submitted to the HFS BEP Liaison office by month 16 of operation, and at the 34th month to remain in full compliance with the Contract. Failure to submit a Utilization Plan as instructed in this Solicitation may render the Proposal non-responsive. All questions regarding the subcontracting goal must be directed to the Department Business Enterprise Program (BEP) Liaison prior to submission of Proposals.

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

- 7.1. Those who submit Proposals for State contracts shall not be given a period after the Proposal is submitted to cure deficiencies in the Proposal unless mandated by federal law or regulation. 30 ILCS 575/4(e).
- 7.2. The Utilization Plan may not be amended after Contract Execution without the Department's prior written approval.
- 7.3. **The Bidder may not make changes to its contractual BEP certified vendor commitments or substitute BEP certified vendors without the prior written approval of the Department.** Unauthorized changes or substitutions, including performing the work designated for a BEP certified vendor with the Bidder's own forces, shall be a violation of the utilization plan and a breach of the Contract, and shall be cause to terminate the Contract, and/or seek other Contract remedies or sanctions. The facts supporting the request for changes must not have been known nor reasonably should have been known by the parties prior to entering into the subcontract. The Bidder must negotiate with the BEP certified vendor to resolve the problem. Where there has been a mistake or disagreement about the scope of work or goods/equipment, provided the BEP certified vendor can be substituted only where agreement cannot be reached for a reasonable price or schedule for the correct scope of work, goods or equipment.
- 7.4. Substitutions of a BEP certified vendor may be permitted under the following circumstances:
 - 7.4.1. Unavailability after receipt of reasonable notice to proceed;
 - 7.4.2. Failure of performance;
 - 7.4.3. Financial incapacity;
 - 7.4.4. Refusal by the BEP Certified vendor to honor the bid or proposal price or scope;
 - 7.4.5. Material mistake of fact or law about the elements of the scope of work of a solicitation where a reasonable price cannot be agreed;
 - 7.4.6. Failure of the BEP Certified vendor to meet insurance, licensing or bonding requirements;
 - 7.4.7. The BEP Certified vendor's withdrawal of its bid or offer; or
 - 7.4.8. Decertification of the BEP Certified vendor.
- 7.5. If it becomes necessary to substitute a BEP certified vendor or otherwise change the Utilization Plan, the Bidder must notify the Department in writing of the request to substitute a BEP certified vendor or otherwise change the Utilization Plan. The request must state specific reasons for the substitution or change. The Department will approve or deny a request for substitution or other change in the Utilization Plan within five business days of receipt of the request.
- 7.6. Where the Bidder has established the basis for the substitution to the Agency's/University's satisfaction, it must make good faith efforts to meet the Contract goal by substituting a BEP certified vendor. Documentation of a replacement BEP certified vendor,

or of good faith efforts to replace the BEP certified vendor, must meet the requirements of the initial Utilization Plan. If the goal cannot be reached and good faith efforts have been made, the Bidder may substitute with a non-BEP certified vendor or the Bidder may perform the work.

- 7.7. If a Bidder plans to hire a subcontractor for any scope of work that was not previously disclosed in the Utilization Plan, the Bidder must obtain the approval of the Department to modify the Utilization Plan and must make good faith efforts to ensure that BEP certified vendors have a fair opportunity to submit a bid or offer on the new scope of work.
- 7.8. A new BEP certified vendor agreement must be executed and submitted to the Department within five business days of the Bidder's receipt of the Department's approval for the substitution or other change.
- 7.9. The Bidder shall maintain a record of all relevant data with respect to the utilization of BEP certified vendors, including but without limitation, payroll records, invoices, canceled checks and books of account for a period of at least three years after the completion of the Contract. Full access to these records shall be granted by the Bidder upon 48 hours written demand by the Department to any duly authorized representative thereof, or to any municipal, state or federal authorities. The Department shall have the right to obtain from the Bidder any additional data reasonably related or necessary to verify any representations by the Bidder. After the performance of the final item of work or delivery of material by the BEP Certified Vendor and final payment to the BEP Certified Vendor by the Bidder, but not later than 30 calendar days after such payment, the Bidder shall submit a statement confirming the final payment and the total payments made to the BEP Certified Vendor under the Contract.
- 7.10. The Department will periodically review the Bidder's compliance with these provisions and the terms of its Contract. Without limitation, the Bidder's failure to comply with these provisions or its contractual commitments as contained in the Utilization Plan, failure to cooperate in providing information regarding its compliance with these provisions or its Utilization Plan, or provision of false or misleading information or statements concerning compliance, certification status or eligibility of the BEP Certified Vendor, good faith efforts or any other material fact or representation shall constitute a material breach of this Contract and entitle the Department to declare a default, terminate the Contract, or exercise those remedies provided for in the Contract or at law or in equity.
- 7.11. The Agency reserves the right to withhold payment to the Bidder to enforce these provisions and the Bidder's contractual commitments. Final payment shall not be made pursuant to the Contract until the Bidder submits sufficient documentation demonstrating compliance with its Utilization Plan.

8. UTILIZATION PLAN

[Click here to enter text.](#) submits the following Utilization Plan as part of our Proposal in accordance with the requirements of the Minority, Female, Persons with Disability Status and Participation and Utilization Plan section of the Solicitation for [Click here to enter text.](#), Illinois Procurement Bulletin Reference Number [Click here to enter text.](#) We understand that all subcontractors must be certified with the CMS Business Enterprise Program at the time of submission of all Proposals. We understand that compliance with this section is an essential part of this Contract and that the Utilization Plan will become a part of the Contract, if awarded. We understand that we will not be given a period after the Proposal is submitted to cure deficiencies in the Utilization Plan and the BEP Letter(s) of intent, unless mandated by federal law or regulation. 30 ILCS 575/4(e).

[Click here to enter text.](#) makes the following assurance and agrees to include the assurance in each agreement, subcontract and/or purchase order with a subcontractor or supplier utilized on this Contract: We shall not discriminate on the basis of race, color, national origin, sexual orientation or sex in the performance of this Contract. Failure to carry out these requirements is a material breach of this Contract, which may result in the termination of this Contract or such other remedy, as the Department deems appropriate.

Bidder submits the following statement: [Choose an item.](#)

8.1. DEMONSTRATION OF GOOD FAITH EFFORTS TO ACHIEVE BEP UTILIZATION GOAL AND REQUEST FOR WAIVER

If the BEP utilization goal was not achieved, the Good Faith Efforts Procedures and Guidelines will be used to evaluate submitted utilization plans (Section 8.1.1.). Bidders providing Good Faith Effort documentation and request for waiver must complete and submit the Good Faith Effort Contact Log (Section 8.1.2.) with the Proposal. Failure to complete Section 8.1.2. in its entirety may render the Bidder's Proposal non-responsive or not responsible and cause it to be rejected or render the Bidder ineligible for Contract award.

8.1.1. GOOD FAITH EFFORTS PROCEDURES AND GUIDELINES

Please read the following guidelines carefully.

Below is a checklist of items that may be used to evaluate a Bidder's Demonstration Good Faith Efforts and Request for Waiver. If any of the following items are not completed, please attach a detailed written explanation indicating why such item was not completed. If any other efforts were made to obtain BEP participation in addition to the items listed below, attach a detailed description of such efforts.

- Soliciting through all reasonable and available means (e.g., attendance at a vendor conference, advertising and/or written notices) the interest of BEP certified vendors that have the capability to perform the work of the Contract. The Bidder must solicit this interest within sufficient time to allow the BEP certified vendors to respond to the solicitation. The Bidder must determine with certainty if the BEP certified vendors are interested by taking appropriate steps to follow up initial solicitations and encourage them to submit a bid or proposal. The Bidder must provide interested BEP certified vendors with adequate information about the plans, specifications, and requirements of the Contract in a timely manner to assist them in responding promptly to the solicitation.
- Selecting portions of the work to be performed by BEP certified vendors in order to increase the likelihood that the goal will be achieved. This includes, where appropriate, breaking out contract work items into economically feasible units to facilitate BEP certified vendor participation, even when the Bidder might otherwise prefer to perform these work items with its own forces.
- Making a portion of the work available to BEP certified vendors and selecting those portions of the work or material needs consistent with their availability, so as to facilitate BEP certified vendor participation.
- Negotiating in good faith with interested BEP certified vendors. Evidence of such negotiation must include the names, addresses, and telephone numbers of BEP certified vendors that were considered; a description of the information provided regarding the plans and specifications for the work selected for subcontracting and evidence as to why additional agreements could not be reached for BEP certified vendors to perform the work. A Bidder using good business judgment may consider a number of factors in negotiating with BEP certified vendors and may take a firm's price and capabilities into consideration. The fact that there may be some additional costs involved in finding and using BEP certified vendors may not be in itself sufficient reason for a Bidder's failure to meet the goal, as long as such costs are reasonable. Bidders are not required to accept higher quotes from BEP certified vendors if the price difference is excessive or unreasonable.

- Thoroughly investigating the capabilities of BEP certified vendors and not rejecting them as unqualified without documented reasons. The BEP certified vendor's memberships in specific groups, organizations, or associations and political or social affiliations are not legitimate causes for the rejection or non-solicitation of bids and proposals in the Bidder's efforts to meet the goal.
- Making efforts to assist interested BEP certified vendors in obtaining lines of credit or insurance as required by the Department.
- Making efforts to assist interested BEP certified vendors in obtaining necessary equipment, supplies, materials, or related assistance or services.
- Effectively using the services of available minority/women community organizations; minority/women vendors' groups; local, state, and federal minority/women business assistance offices; and other organizations that provide assistance in the recruitment and placement of BEP certified vendors.
- Utilize the Sell2Illinois website: (www.Sell2.illinois.gov) to identify BEP certified vendors.

8.1.2. GOOD FAITH EFFORTS CONTRACT LOG FOR SOLICITING BEP CERTIFIED VENDOR PARTICIPATION.

Use this Log to document all contracts and responses (telephone, e-mail, fax, etc.) regarding the Solicitation of BEP certified vendors. Duplicate as needed. **It is not necessary to show contacts with BEP vendors who are identified on the Letter of Intent (as identified in Section 8.2).**

Name of BEP Certified Vendor	Date and Method of Contact	Scope of Work Solicited	Reason Agreement Was Not Reached

8.2. LETTER OF INTENT (LOI) BETWEEN PRIME VENDOR AND BEP CERTIFIED VENDOR

Instructions: The responsive Bidder is required to submit a separate, signed BEP LOI from each identified BEP certified vendor. BEP LOIs must be submitted with the Proposal and must be signed by both parties. The Prime Bidder shall not prohibit or otherwise limit [Click here to enter text](#). from providing subcontractor quotes to other potential bidders/vendors. Each BEP LOI shall include the negotiated amount/percentage and scope of work to be performed by each identified BEP certified vendor. All BEP LOI's shall be subject to Department approval.

Any changes involving or affecting identified the BEP certified vendor(s) may not be permitted without written approval of the Department.

Project Name: [Click here to enter text](#). Project/Solicitation Number: [Click here to enter text](#).

Name of Bidder: [Click here to enter text](#).

Address: [Click here to enter text](#).

City, State and Zip: [Click here to enter text](#).

Telephone: [Click here to enter text](#). Fax: [Click here to enter text](#). Email: [Click here to enter text](#).

Name of BEP Certified Vendor: [Click here to enter text](#).

Address: [Click here to enter text](#).

City, State and Zip: [Click here to enter text](#).

Telephone: [Click here to enter text.](#) Fax: [Click here to enter text.](#) Email: [Click here to enter text.](#)

Type of agreement: Services Supplies Both Services/Supplies

Anticipated start date of the BEP Certified Vendor: [Click here to enter a date.](#)

Proposed Subcontract Amount \$ [Click here to enter text.](#) or Proposed % of Contract to be performed by the BEP Certified Vendor [Click here to enter text.](#)

NOTE: In instances where the contract award amount is unknown, you must indicate the percentage of the estimated Contract award that will be subcontracted to the BEP Certified Vendor.

Description of work to be performed or goods/equipment to be provided by the BEP Certified Vendor: [Click here to enter text.](#)

The Bidder and the BEP Certified Vendor above hereby agree that upon the execution of a Contract for the above-named project between the Bidder and the State of Illinois, the BEP Certified Vendor will perform the scope of work for the price/percentage as indicated above.

Bidder (Company Name and D/B/A):

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

[Click here to enter text.](#)

[Click here to enter text.](#)

Signature

Signature

Printed Name: [Click here to enter text.](#)

Printed Name: [Click here to enter text.](#)

Title: [Click here to enter text.](#)

Title: [Click here to enter text.](#)

Date: [Click here to enter text.](#)

Date: [Click here to enter text.](#)

Attachment A

To be considered for formal evaluation, Proposals must satisfy the minimum requirements specified below. The minimum requirements must be clearly demonstrated in the Bidder's response to the associated Solicitation question(s) identified in the Solicitation Question column in the chart below.

Evaluation Category	Solicitation Question	Minimum Requirements
Organization/Governance	Sections 3.2.1.1; 3.2.1.2	<ol style="list-style-type: none"> 1) An established governance structure with an identified lead entity as described in Section 3.1.2.1; 2) Individuals on the governing board that represent all participating provider types including primary care providers, hospitals, Behavioral Health providers, and specialists as described in Section 3.1.2.1.3. List names and titles and employer of governing board members; 3) If the lead entity is a single provider, the governing body must include providers employed and not employed by the lead entity; and 4) Procedures for the governing board to set policy and assure accountability back to the Providers.
Network	Sections 3.2.2.1, 3.2.2.2, and 3.2.2.3	<ol style="list-style-type: none"> 1) A PCP and Obstetrics network that meets the requirements in Sections 3.1.3.4 and 3.1.3.5; 2) A network that can adequately serve the expected ACE enrollment levels (See Section 3.1.3.6 for minimum enrollment level requirements) and includes all Provider types required in Section 3.1.3.1 including PCPs, specialists, hospitals, and Behavioral Health Providers. Include, for each participating Provider, signed letters indicating their level of agreement to participate in the ACE network; and 3) A network that is sufficient, or a plan for how you will ensure your network will be sufficient by month 19, to meet the needs of your expected universe of Enrollees for all Covered Services as specified in Section 3.1.3.2.
Care Model	Section 3.2.3.1	<ol style="list-style-type: none"> 1) A model of care that meets the requirements in Section 3.1.4.1.
Health Information Technology	Section 3.2.4.1	<ol style="list-style-type: none"> 1) Capacity to securely pass clinical information among its network of Providers as specified in Section 3.1.5.
Financial	Section 3.2.5.1	<ol style="list-style-type: none"> 1) A financial plan that supports implementation of your model of care and reasonably demonstrates how the ACE will meet the MCO financial requirements specified in Section 3.1.6.2.

Attachment B Anticipated ACE to MCO Timeline

- **April 2014**
 - ACE Desk Readiness Review: Review written policies/ procedures for on-site items in *ACE On-Site Readiness Review* below

- **May 2014**
 - *ACE On-Site Readiness Review*: Interview and demonstration on functionality to include at a minimum:
 - PCP Capacity
 - Access standards for all provider types
 - Medical home development and education
 - Written agreements
 - Cultural competency
 - Privacy provisions
 - Care Management Identification strategies: predictive modeling/risk assessment
 - Enrollee engagement and education
 - Enrollee material: such as a welcome packet, member hand guide, and member identification cards
 - Model of care: integrated delivery system, flow of care, use of evidence-based practices for care coordination and care management policies and procedure, care coordination staffing
 - Role of Medical director and participating Providers in ACE governance structure
 - Staff hiring and training adequacy
 - Complaint and grievance procedures
 - Information technology to support enrollment/disenrollment, evidence-based care, care management, data reporting functionality, quality improvement
 - Quality Assurance Program (QAP)
 - Monitoring policies and procedures
 - Program-specific website, TTY number, an Enrollee services line, and an after-hours helpline
 - Cultural competency plan

- **July 1, 2014**
 - ACE Enrollment effective

- **September 2015**
 - MCO Desk Readiness Review: Review written policies and procedures for on-site items in *MCO On-Site Readiness Review* below

- **November, 2015**
 - *MCO On-site Readiness Review*: All ACE above items in *ACE On-site Readiness Review* will be reassessed in terms of MCO adequacy, as well as additional items including at a minimum:
 - Financial qualification
 - Network development and access to include all Provider types
 - Provider credentialing/ recredentialing
 - Utilization Management program, including utilization review and authorization requirements
 - Coordination of benefits
 - Financial incentives
 - Enhanced QAP
 - Fraud and abuse program
 - Enrollee materials including all basic information
 - Provider handbook
 - Claims processing functionality
 - Out of network reimbursement
 - Information technology that supports utilization, appropriate referrals to specialty care, grievance and appeals, enrollment and disenrollment, health information reporting and encounter data reporting functionality

- **January 1, 2016** – MCO Effective date

Attachment C relates to Quality Measures. The Department will use the Quality Measures listed in Attachment C to monitor performance. Four of the Quality Measures in Attachment C, indicated in the P4P Measure column, are targeted to be used as shared savings measures for months 7 – 18 and pay-for-performance measures for months 19 forward where full payment is based on meeting targets associated with these measures.

**Attachment C
Quality Measures**

Category	Acronym	Performance Measure	Specification Source	P4P Measure
Access and Utilization Measures	AAP	Adults' Access to Preventive/Ambulatory Health Services	HEDIS	--
	CAP	Children and Adolescents' Access to Primary Care Practitioners	HEDIS	--
	AMB	Ambulatory Care - ED Visits only	HEDIS	--
	IAPE	Ambulatory Care Follow-Up with a Provider within 14 Days of Emergency Department (ED) Visit	State	Yes
	IAPI	Ambulatory Care Follow-Up with a Provider within 14 Days of Inpatient Discharge	State	--
	W15/W34	Well-Child Visits in the First 15 Months and the Third, Fourth, Fifth, and Sixth Years of Life	HEDIS	--
	AWC	Adolescent Well-Care Visits	HEDIS	--
	IIHR/IIMR	Inpatient Hospital and Mental Hospital 30-Day Readmission Rates	State	--
Prevention and Screening Measures	ABA	Adult BMI Assessment	HEDIS	--
	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	HEDIS	--
	CIS	Childhood Immunization Status	HEDIS	Yes
	IMA	Immunizations for Adolescents	HEDIS	--
	HPV	Human Papillomavirus (HPV) Vaccine for Female Adolescents	HEDIS	--
	BCS	Breast Cancer Screening	HEDIS	--
	CCS	Cervical Cancer Screening	HEDIS	--
	COL	Colorectal Cancer Screening	HEDIS	--
	DEV	Developmental Screening In the First Three Years of Life	Oregon Health and Science University	--
Appropriate Care Measures	CDC	Comprehensive Diabetes Care [Hemoglobin A1c (HbA1c) testing, LDL-C screening and Medical attention for nephropathy only]	HEDIS	Yes
	PA1C	Annual Pediatric Hemoglobin (A1c) Testing	NCQA	--
	MMA	Medication Management for People with Asthma	HEDIS	--
	PCE	Pharmacotherapy Management of COPD Exacerbation	HEDIS	--
	PBH	Persistence of Beta-Blocker Treatment After a Heart Attack	HEDIS	--
	ICHF	Congestive Heart Failure	State	--
Behavioral Health Measures	FUH	Follow-Up After Hospitalization for Mental Illness	HEDIS	Yes
	AMM	Antidepressant Medication Management	HEDIS	--
	SAA	Adherence to Antipsychotics for Individuals with Schizophrenia	HEDIS	--
	IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	HEDIS	--
Maternity Measures	PPC	Prenatal and Postpartum Care	HEDIS	--
	FPC	Frequency of Ongoing Prenatal Care	HEDIS	--

Attachment D Letter of Intent (LOI)

In order to allow for appropriate planning around this component of the ACE Program, the Department is requiring a Letter of Intent (LOI) from each entity that anticipates or is seriously considering submitting a Proposal for providing services under the ACE Program. While submitting a LOI does not commit an entity to actually submit a Proposal, HFS will not accept a Proposal from nor provide data to an entity that has not submitted a LOI by the due date of October 1, 2013.

The Department wants one LOI per entity, irrespective of the number of members within the entity. The organization and person submitting the LOI will be the Department's primary contact unless the contact information 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:

- Section A (Contact Information)
- Section B (Proposal Summary/Self-Assessment Form)
- Section C (HIPAA Data Use Agreement*)

** 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.*

Other than sections marked with < > symbols, you must sign the Data Use Agreement without changes to format or language. We have provided a separate Word document for your use. Remove the < > symbols and content and insert your content as instructed.

The expected high-level timeline of the ACE Program is as follows:

- Last date to submit LOI – October 1, 2013
- Data sharing – As the LOI are received
- Proposals due – January 3, 2014
- Award Announcement – Anticipate February 2014
- Contract Start – Anticipate July 2014

Please send the completed LOI to Amy Harris at Amy.Harris@illinois.gov. If you have questions about the LOI submission, please contact Amy Harris.

Section A: Contact Information

Name of Accountable Care Entity (ACE) (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 and C must be completed and returned along with the document in which you answer the questions below.

1. **Geography and Population.** Define your service area by county or zip code. Describe, at a high level, the anticipated number of Enrollees (i.e. minimum and maximum) and your plan for recruiting Potential Enrollees. If different than your expected service area, specify the county(ies) or zip codes for which you are requesting data.
2. **Organization/Governance.** List and describe the background of any primary members of the ACE and their responsibilities. Provide a high-level description of your expected governance structure including who will participate on the governing board and the responsibilities of the governing board. What are the main operating agreements that will have to be developed with the primary members? To what extent has work started on developing these arrangements? When will the remaining work be completed?
3. **Network.** Provide a high-level summary of the Providers who have agreed to participate in your network and a summary of other Providers that the ACE plans on recruiting to participate in their network.
4. **Financial.** Please provide a description of the financial resources available to the ACE including the sources of funding for upfront expenses.
5. **Care Model.** Give an outline of your care model, including your plan for care coordination and care management and how your governance structure and financial reimbursement structure support your care model. At this point, we are not expecting a full description of your care model, just a high-level summary of the major components of your expected Proposal.
6. **Health Information Technology.** How will clinical data be exchanged? ACEs must have the capacity to securely pass clinical information among its network of Providers, and to aggregate and analyze data to coordinate care, both to make clinical decisions and to provide feedback to Providers.

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 ACEs.

Section C: HIPAA Limited Data Set Agreement

Illinois Department of Healthcare and Family Services
And

< Name of ACE or Responsible Lead Entity >

DATA USE AGREEMENT

This Data Use Agreement (the "Agreement") is effective as of __<Date of Signature>__ (the "Agreement Effective Date") by and between Illinois Department of Healthcare and Family Services ("Covered Entity"/"Department") and _< Name of ACE or Responsible Lead Entity>_ ("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. Purpose and Use of Data.

- a. Data will be used exclusively to consider and prepare a Proposal in response to the Department's Solicitation for Accountable Care Entities (ACE Program - 2014-24-002) and to build an Accountable Care Entity, including identifying geographic service areas, estimating the number of Potential Enrollees, and building Provider networks to serve Potential Enrollees. The authorization to use the data will terminate, the earliest of one of the following occurring: 1) the potential ACE does not submit a proposal by the Solicitation due date, 2) the potential ACE is informed by the Department that their Proposal did not meet minimum requirements, 3) the potential ACE is notified by HFS that they have not been awarded a Contract, 4) the potential ACE does not sign a Contract with HFS by the deadline for doing so, 5) the potential ACE otherwise withdraws, voluntarily or involuntarily, from ACE development, or 6) the potential ACE signs an ACE Contract with the Department (a new data use agreement will be embedded into the Contract).

3. 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, the services that they have used, and the Providers that have provided the services. 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.

4. 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 considering and preparing a Proposal in response to the Department's Solicitation for Accountable Care Entities and to build an Accountable Care Entity 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:
< Name who will use the data. You may use individual names or list ACE organizational roles. Outside consultants must be named by individual or organizational name. You will need to amend this DUA to add other users.>

- 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 alone or in combination with other data to identify or contact any individual who is the subject of the PHI from which the Limited Data Set was created.
- e. Covered Entity Approval of 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 under HIPAA to prevent unauthorized 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. In the event that prior written consent is provided by Agency, 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 individuals eligible for enrollment in an ACE.
- 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.

5. 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 2.a. or 5.c. except as otherwise specified in this Agreement, including but not limited to Section 5.i.
- 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 5.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 5.d.(4) or 6.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 5.b. of this Agreement;
 - (2) require Data User to pay all costs associated with the breach, including but not limited to costs associated with investigation of the breach, costs of notification to individuals affected by the breach, costs associated with mitigation and monitoring, including providing credit monitoring to the affected individuals.
 - (3) 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
 - (4) 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 the 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 5.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 5.i. shall survive termination of the Agreement.

6. 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. Any assignment of this Data Use Agreement by contractor/Data User to an assignee or successor is void without HFS' prior written consent.
- 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.

IL Department of Healthcare and Family Services

Insert Contractor name

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

**Attachment E
PCP Commitment Letter**



**Pat Quinn, Governor
Julie Hamos, Director**

201 South Grand Avenue East, Springfield, IL 62763-0002 • (217) 782-1200 • (800) 526-5812 TTY

To the _____ (Name of ACE) _____ :

This letter documents the commitment of all Providers listed below to fully participate as Primary Care Providers in the Medicaid Accountable Care Entity (ACE) _____ (name of ACE) _____, to implement its mutually agreed upon model of care and to actively contribute to the development of this integrated delivery system. The Providers listed below and on an attached form* (if applicable) will provide primary care within the ACE and the description of capacity is a truthful description of availability and commitment of capacity to the network.

Signatures: Include in the last column signatures of all Providers listed or, if all can be bound by a single signature, check below so indicating and show title:

[] I represent that by my signature below I have the authority to bind all of the Providers listed below.

Signature

Title

Printed Name

Name of Group Practice, Clinic, Etc.

Provider name	Specialty (Pediatrics, Family Practice, APN, etc.)	PCP panel capacity committed to be provided for ACE	NPI	Number of Mid-level Practitioners and total percent FTE	Signature

* If you need more space, please include the information requested above as an attachment to this letter.

**Attachment F
Obstetrics Commitment Letter**



**Pat Quinn, Governor
Julie Hamos, Director**

201 South Grand Avenue East, Springfield, IL 62763-0002 • (217) 782-1200 • (800) 526-5812 TTY

To the _____ (Name of ACE) _____:

This letter documents the commitment of all Providers listed below to fully participate as Providers of obstetrical care in the Medicaid Accountable Care Entity (ACE) _____ (name of ACE) _____, to implement its mutually agreed upon model of care and to actively contribute to the development of this integrated delivery system. The Providers listed below and on an attached form* (if applicable) will provide obstetrical care within the ACE and the description of capacity is a truthful description of availability and commitment of capacity to the network.

Signatures: Include in the last column signatures of all Providers listed or, if all can be bound by a single signature, check below so indicating and show title:

[] I represent that by my signature below I have the authority to bind all of the Providers listed below.

Signature

Title

Printed Name

Name of Group Practice, Clinic, Etc.

Provider name	Specialty (OB, Family Practice, Midwife, etc.)	Number of deliveries annually that can be provided for ACE	Hospitals at which Provider has delivery privileges	Signature

* If you need more space, please include the information requested above as an attachment to this letter.

Attachment G Shared Savings Proposal

Coordinating Entities Shared Savings Methodology

Overview

Illinois is working to form alternative models of delivering care to Medicaid Clients through provider-organized networks, initially organized around the needs of our most complex Clients who are Seniors and Persons with Disabilities (SPD) and expanding to other populations. These provider-based networks will be organized as Care Coordination Entities (CCEs) or Accountable Care Entities (ACEs). These entities will coordinate care for the target population for a monthly fee, while the payment for their medical services will initially be fee-for-service. These entities will have an opportunity to participate in a shared savings program to share any savings realized through their care coordination efforts, in excess of the cost of the program. Illinois' proposal for calculating such shared savings is detailed below.

General Methodology

Illinois will compare health care and administrative costs for each CCE or ACE, on a per-member-per-month basis, to capitation rates paid to the MCOs who cover the same population for the same year. Integrated Care is a managed care program that serves the same SPD population as the CCEs, and so serves as a control group against which to measure costs. Similarly, the state's actuary will develop rates for MCOs serving the same population as ACEs in a mandatory program set to begin in July 2014. The MCO rate is a 4% discount on the FFS equivalent and therefore provides the minimum savings threshold Medicare ACOs must meet in order to not pay out savings based on random variation. If the monthly cost of care per Client in the CCE or ACE is, on a risk adjusted basis, less than the monthly capitation rate for the comparable MCO program, the difference will be multiplied by the enrolled months for the particular CCE or ACE to calculate total savings. CCEs and ACEs 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 and ACEs will be required to meet Quality Measure targets. There will be four Quality Measure targets, and CCEs and ACEs will have the ability to earn 10 percent of calculated savings per measure. The maximum amount of shared savings payments a CCE or ACE may receive per year is 50 percent, up to a maximum of 5 percent of total health care costs for the population. Depending on the CCE care model, costs of Long Term Supports and Services will be included or excluded from the calculation of total health care costs. Capitated rates for MCOs are developed separately for the LTSS. In all cases, costs for blood factor will be removed from the measurement of actual costs and the MCO rates will be adjusted accordingly.

Savings Calculation

CCE and ACE costs for each measurement year will be calculated for all Clients enrolled with each CCE or ACE by summarizing the fee-for-service claims for each entity's population. Care coordination fees paid to the CCE or ACE will be added to these costs and the result expressed as a per-member per month rate, which will be the Measurement Year PMPM. The Measurement Year PMPM will include member months for all Clients, regardless of length of enrollment with the CCE. This inclusion will remove any disincentive to the CCE or ACE to manage only Clients enrolled from the beginning of the measurement year. A comparison PMPM using the MCO capitation rates will be developed by stratifying the population into groups that correspond to the capitation rate cells. The capitation rate will then be weighted based on the CCE or ACE population to which it is being compared to arrive at a comparison capitation rate.

In order to account for any selection bias or differences in the groups of Clients who choose a CCE or ACE over the available MCOs, Illinois will work with our consulting actuaries to risk adjust the CCE and ACE enrolled population PMPM rate. Relative risk will be determined using a publicly or commercially available risk management tool which uses diagnostic and/or pharmaceutical data to determine the relative risk of the given population. If there is a significant difference in the risk profile of a CCE or ACE as compared to the overall population, the CCE's or ACE's Measurement Year PMPM will be adjusted accordingly to make the two rates comparable.

The Measurement Year PMPM will be deducted from the MCO capitation rate PMPM to derive the Savings PMPM. If the result is positive and therefore savings have been realized, the Savings PMPM will be multiplied by the enrolled months for all Clients assigned to the given CCE or ACE during the measurement year. The resulting dollar amount, Total Savings, will be the savings achieved by the CCE or ACE. The CCE or ACE will be eligible to share in up to 50% of the savings. The CCE or ACE will qualify for 10% of the total savings automatically; the remaining 40% will be contingent on the CCE or ACE achieving improvements in certain clinical measures as detailed in the contract of each CCE or ACE. If the CCE or ACE does not achieve any savings, the CCE or ACE will not be eligible to share in any savings.

Adjustments specific to CCEs and ACEs

Regional Adjustments

CCEs and ACEs will operate in several areas of the state. Likewise, the MCOs whose rates will be used for comparison operate in several regions of the state. MCO capitation rates are set regionally. Each CCE's or ACE's PMPM will be compared to the capitation rates for their respective region.

Cost cap

Claims costs for each year will be capped at a specified level per enrollee. For any enrollee for whom paid claims in a Contract year exceed \$80,000, 80% of the costs that exceed \$80,000 will be excluded from the calculation of actual costs. This cap will serve to eliminate the effect of outlier costs associated with Clients experiencing a catastrophic medical event during the year, or who incur excessive expenses related to end of life care. Costs in excess of the \$80,000 per person limit will be totaled, and a pooling charge will be applied to the Measurement Year PMPM to allow for comparison to the MCO capitation rates whose calculation had no such limit applied. Costs are calculated by applying Medicaid rates to covered services.

Schedule

Savings calculations will be done annually. Capitation rates for the MCOs to be used for comparison are calculated prospectively, in advance of each calendar year. Measurement years will be set for each CCE or ACE based on the calendar year, in order to align with capitation rates to be used for comparison.

Measurement Year PMPMs will be calculated at the beginning of the third quarter after the end of each measurement year, to allow for claims incurred during the measurement year to be submitted and adjudicated for payment. Illinois requires claims to be submitted within 6 months of the date of service, and we will wait an additional month to allow the claims to be adjudicated for payment through Illinois' MMIS system. Each CCE or ACE may have a start up period of up to 6 months of which no experience will be utilized for shared savings.

Offsets

There is no provision in this methodology for the CCEs or ACEs to repay any portion of their fees if no savings are realized.