The State of Illinois Medicaid Managed Care Organization Request for Proposals (Rev. 2)

2018-24-001

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1 GENERAL INFORMATION

This Section identifies the purpose of *The State of Illinois Medicaid Managed Care Organization RFP* along with relevant general information regarding this RFP process.

1.1 Contents

Section	Description
1 General information	Identifies the purpose of *The State of Illinois Medicaid Managed Care Organization RFP* along with relevant general information regarding this RFP process.
2 Background and scope of RFP	Provides background information regarding the State of Illinois ("the State") and its Medicaid Managed Care Program, goals and objectives of the program moving forward, and the scope of the RFP.
3 Proposing, evaluation, and selection process	Provides Offerors with instructions on the RFP process, Proposal evaluation, and final selection. This Section provides the structure that submitted Proposals shall follow to be deemed valid.
4 Proposal Requirements	Identifies the Offeror-specific company and profile information that is required for the written submission of this Section.
5 Technical Proposal	Outlines the prompts to which Offerors shall respond regarding their approach to the scope of work in this RFP, their qualifications, and their relevant experience.
6 Financial Proposal	Identifies the requirements for the Financial Proposal, in which Offerors are required to submit Proposals on rates within predefined, actuarially sound rate ranges.

1.2 Solicitation Contact

1.2.1 The individual listed below will be the single point of contact for this solicitation.

Solicitation Contact: Lynette Schafer	Phone: 217-557-5777
Agency: Illinois Department of Healthcare and Family Services (HFS)	Fax: N/A
Street address: 201 S. Grand Avenue East	City, State, Zip: Springfield, IL 62704
E-mail: HFS.Procurement@illinois.gov	

1.2.2 Unless otherwise directed, Offerors shall communicate only with the Solicitation Contact. The State

of Illinois Department of Healthcare and Family Services ("HFS" or "the Department") shall not be held responsible for information provided by or to any other person.

1.2.3 Offerors shall not discuss, directly or indirectly, the solicitation or any Proposal with any State officer or employee other than the Solicitation Contact; evidence of this will be considered grounds for disqualification. Offerors shall immediately report suspected errors to the Solicitation Contact.

1.3 RFP timeline

The table below outlines a proposed timeline for *The State of Illinois Medicaid Managed Care Organization* RFP process. The Department reserves the right to alter the proposed timeline. Offerors will be notified of any changes.

Activity	Date/Time
Release of RFP	February 27, 2017
Offeror Conference (Round 1) (Mandatory)	March 10, 2017 (1:00 pm CT)
Deadline for submission of questions (Round 1)	March 15, 2017 (12:00 pm CT)
Release of Data Book with actuarial rate ranges	March 29, 2017
Department response to questions (Round 1)	March 29, 2017
Offeror Conference (Round 2)	April 4, 2017 (1:00 pm CT)
Deadline for submission of questions (Round 2)	April 10, 2017 (12:00 pm CT)
Department response to questions (Round 2)	April 24, 2017 (approximate)
Deadline for submission of full Proposals	May 15, 2017 (12:00 pm CT)
Oral Presentations	June 12 – June 23, 2017 (approximate)
Opening of Financial Proposals	June 26, 2017
Award announcements	June 30, 2017 (approximate)
Deadline to file protest to awards	July 14, 2017 (approximate)
Effective date of new Contracts	January 1, 2018

1.4 Communications and Q&A

1.4.1 All communications with the Department, including questions in relation to this RFP, shall be directed to the principal point of contact identified in Section 1.2. An Offeror or any of its representatives who communicates with any other employees or Contractors of the Department concerning this RFP after its issuance may be disqualified.

1.4.2 As outlined in the timeline above in Section 1.3, there will be two periods for Q&A during the RFP Process: Round 1 and Round 2.

1.4.2.1 During Round 1, Offerors may raise questions regarding Sections 1–5 of this RFP, Appendices I–VI, or Forms for Submission I–V. Any questions regarding the definitions, terms, or language in the Model Contract (Appendix I) shall be raised with the Department during this Round.

1.4.2.2 During Round 2, Offerors may raise questions related to Section 6 of this RFP, the Data Book (Appendix VII), or the Financial Proposal Template (Form for Submission VI).

1.4.3 All questions in relation to this RFP shall be submitted by email using the template provided in Form for Submission I. Questions must be received by 12:00 p.m. CT on the day of the deadline for the proper Round. The deadline for submission of questions (Round 1) and the deadline for submission of questions (Round 2) are specified above in Section 1.3. Responses to questions will be posted on the HFS Website (https://www.illinois.gov/hfs/).

1.4.4 All questions shall be submitted through the official question and answer process as described in this Section. The Department reserves the right to disregard any questions which have not been submitted through this official process. At its own discretion, the Department may respond to questions submitted after the deadline for a given Round, or during the improper Round.

1.5 Offeror Conference (Round 1)

1.5.1 Mandatory attendance: ☒ Yes ☐ No Date and time: March 10, 2017 at 1:00pm CT
Location: James R. Thompson Center, 100 W Randolph Street, Chicago, IL, 60601

1.5.2 At the Offeror Conference (Round 1), representatives of the Department will give a presentation about the RFP and take questions on the RFP process. The Department will offer oral responses to questions on the RFP process at its discretion, but will not offer oral responses to questions on the content of the RFP or the Illinois Medicaid Managed Care Program more broadly. In order to receive a response from the Department on other questions, Offerors shall submit questions in writing through the official question and answer process described above in Section 1.4. For all questions asked orally or in writing, only written answers to questions can be considered binding.

1.5.3 Attendance at the Offeror Conference (Round 1) is mandatory and any Offeror will be disqualified if the Offeror does not attend or fails to sign the attendance sheet. The Offeror shall be clearly identified when signing the attendance sheet, including by providing a regularly-monitored mailing address and regularly-monitored e-mail address. Offerors shall allow adequate time to accommodate security screenings at the site.

1.6 Data Book

1.6.1 The Data Book will be sent only to attendees of the Offeror Conference (Round 1) who have signed the attendance sheet and identified themselves as a potential Offeror. The Data Book will be sent to the mailing or email address provided by the Offeror at the Offeror Conference (Round 1).

1.6.2 Further detail on how the Data Book will be provided will be made available at the Offeror Conference (Round 1).

1.7 Offeror Conference (Round 2)

1.7.1 Mandatory attendance: ☐ Yes ☒ No Date and time: April 4, 2017 at 1:00 pm CT
Location: James R. Thompson Center, 100 W Randolph Street, Chicago, IL, 60601

1.7.2 At the Offeror Conference (Round 2), representatives from the Department's actuarial firm will be present to offer a presentation on the methodology used to produce the Data Book. The Department's actuarial firm will conduct a brief question and answer period solely on the topic of the methodology used to produce the Data Book. The Department will also offer oral responses to questions on the RFP process at its discretion, but will not offer oral responses to questions on the content of the RFP or the Illinois Medicaid Managed Care Program more broadly. In order to receive a response from the Department on other questions, Offerors shall submit questions in writing through the official question and answer process described above in Section 1.4. For all questions asked orally or in writing, only written answers to questions can be considered binding.

1.7.3 Attendance at the Offeror Conference (Round 2) is not mandatory, but strongly encouraged.

1.8 Public updates.

1.8.1 The Department will publish information related to this RFP (including updates) on the HFS Website. Necessary information may not be available in any other form or location.

1.8.2 The Offeror is responsible for monitoring the HFS Website; the Department cannot be held

responsible if the Offeror fails to receive any updates.

1.9 Right to protest

1.9.1 The Department will reserve a period of time for Offerors to protest the rejection of individual Proposals or awards.

1.9.2 Protest submissions should be concise and logically arranged, and should clearly state legally sufficient grounds of protest. The protest shall be in writing, contained in an envelope clearly labeled "Protest" and shall include, at a minimum, the following information:

1.9.2.1 The name, address and telephone number of the protesting party;

1.9.2.2 Identification of the RFP, and the Contract number or other identifier of the Contract;

1.9.2.3 A detailed statement of the legal and factual grounds for the protest, including copies of any relevant documents (the protesting party shall clearly identify any information in the protest that is confidential, proprietary or a trade secret);

1.9.2.4 A request for a ruling by the Department;

1.9.2.5 A statement as to the specific relief sought from the Department; and

1.9.2.6 Any other information the protesting party believes to be essential to the determination of the factual and legal questions at issue in the written protest.

1.9.3 A timely protest shall be considered by the Department if it is received by the Department's Office of General Counsel no later than 3:00 pm CT on the fourteenth (14th) calendar day after the announcement of Contract awards. The date used on the Department's announcement of Contract awards will be the date used to determine if a protest is submitted timely.

1.9.4 An untimely protest may be considered by the Department at its sole discretion. An untimely protest is one received by the Department's Office of General Counsel after the time period set forth in section 1.9.3.

1.9.5 All protests must be filed at the following location: Office of General Counsel, Illinois Department of Healthcare and Family Services, Prescott Bloom Building, 201 South Grand Avenue East, Springfield, IL 62763.

1.9.6 The Department's Office of General Counsel or designee shall issue written decisions on all timely protests and shall notify any protesting party who submits an untimely protest as to whether or not the protest will be considered.

1.9.7 In determining the decision, the Department's Office of General Counsel or designee, will consider the seriousness of the procurement deficiency, the degree of the prejudice to other parties or to the integrity of the competitive procurement system, the good faith of the parties, the urgency of the procurement, and the impact of the decision on the Department's mission.

1.10 Request for confidential treatment

1.10.1 Offers become the property of the State and late submissions will not be returned.

1.10.2 All Offers will be open to the public under the Illinois Freedom of Information Act (FOIA) (5 ILCS 140) and other applicable laws and rules, unless Offeror requests in its Offer that the Department treat certain information as confidential. A request for confidential treatment will not supersede the State's legal obligations under FOIA. The Department will not honor requests to keep entire Offers confidential. Offerors must show the specific grounds in FOIA or other law or rule that support confidential treatment.

1.10.3 If Offeror requests confidential treatment, Offeror must submit one (1) copy of the full Proposal (including the Financial Proposal) with proposed confidential information redacted. This redacted copy must tell the general nature of the material removed, and shall retain as much of the Offer as possible. In a separate attachment, Offeror shall supply a listing of the provisions identified by Section/subsection number for which it seeks confidential treatment and identify the statutory basis or bases under Illinois law, including a detailed justification for exempting the information from public disclosure.

1.10.4 Offeror will hold harmless and indemnify the State for all costs or damages associated with the State defending Offeror's request for confidential treatment. Offeror agrees that the Department may copy the Offer to facilitate evaluation, or to respond to requests for public records. Offeror warrants that such copying will not violate the rights of any third party.

1.11 Reservations

1.11.1 Offeror must read and understand the solicitation and tailor the Offer and all activities to ensure compliance.

1.11.2 The State is not responsible for and will not pay any costs associated with the preparation and submission of any Offer.

1.11.3 Submitting an Offer does not entitle Offeror to an award or a contract. Posting Offeror's name in a public notice does not entitle Offeror to a contract.

1.11.4 The Department reserves the right to amend any element of the RFP, including the Model Contract (Appendix I), as a result of Offeror questions, or otherwise at its discretion.

1.11.4.1 The Department will communicate to the Offerors any such amendments.

1.11.4.2 The Department will not make any such amendments between the time answers are posted to questions (Round 2) and the deadline for submission of Proposals, except any necessary amendments to the timeline as provided in section 1.3 (including the deadline for submission of Proposals itself).

1.11.5 The Department may request a clarification, inspect Offeror's premises, interview staff, request a presentation, or otherwise verify the contents of the Offer, including information about subcontractors and suppliers.

1.11.6 If an Offeror does not comply with requests for information and cooperate, the Department may reject the Offer as Non-Responsive to the solicitation.

1.11.7 The Department will make all decisions on compliance, evaluation, and terms and conditions, and will make decisions in the best interests of the State. This competitive process may require that Offeror provide additional information and otherwise cooperate with the Department.

1.11.8 Awarded Offeror(s) shall not commence, and will not be paid for any billable work undertaken prior to the date all parties to the Contract execute the Contract, unless approved in writing in advance by the State.

1.11.9 This solicitation is governed by Illinois law and rules, PROVIDED, that this solicitation is a Purchase of Care, which is exempt from the Illinois Procurement Code (30 ILCS 500/1-10(b)(3)) and Standard Procurement Rules (44 Ill. Admin. Code 1.10(a)(3)). Offeror must bring any action relating to this solicitation in the appropriate court in Illinois. This document contains statutory references designated with "ILCS". Offeror may view the full text at www.ilga.gov/legislation/ilcs/ilcs.asp.

1.12 Proposal to remain firm

1.12.1 Offerors' Proposals shall remain firm for 180 days from opening.

1.13 Proposal security

1.13.1 Proposal Bond $ 100,000.00 Performance Bond $ 1,000,000.00

1.13.2 The Offeror shall submit a Proposal Bond as a part of the Offeror's Proposal, made payable to HFS in the amount of $100,000.00.

1.13.3 The Proposal Bond must be valid beginning on the Proposal due date for 180 days and a surety licensed to do business in Illinois must issue the bond on a form acceptable to HFS. An irrevocable letter of credit is an acceptable substitute, subject to all of the same conditions in this Section.

1.13.4 If the Offeror is chosen to receive the Contract and withdraws its Proposal after HFS issues a notice of intent to award, does not honor the terms offered in its Proposal, or does not negotiate Contract terms in good faith, the Proposal Bond shall be forfeited by the Offeror.

1.13.5 A Proposal Bond submitted by an Offeror will be returned, if not forfeited for the aforementioned reasons, when the Offeror's Proposal is rejected, or the State enters into a Contract with the Offeror.

1.13.6 Contractors shall submit a Performance Bond within ten (10) days after Contract award, made payable to HFS in the amount of $1,000,000.00. A surety licensed to do business in Illinois must issue the Performance Bond on a form acceptable to HFS. The Performance Bond shall be valid for five (5) years.

1.13.6.1 A Performance Bond submitted by a Contractor shall be forfeited if, for any reason, the Contractor does not provide the services agreed upon in the Contract for the term of the Contract.

1.13.6.2 If not forfeited for the aforementioned reasons, the Performance Bond will be returned to the Contractor when the Contractor completes the term of the Contract.

1.14 Forms A and Forms B

1.14.1 Forms A and Forms B are a material part of this solicitation, and the applicable Forms must be with an Offeror's Proposal.

1.14.2 Forms A and Forms B, including further conditions for completion, consequences for failure to complete, and instructions on completion, may be downloaded from the Illinois Chief Procurement Office website at the following address: https://www.illinois.gov/cpo/general/Pages/SolicitationandContractTemplates.aspx

1.15 Veteran small business participation and utilization plan

1.15.1 Does this solicitation contain a Veteran Small Business goal? ☐ Yes ☒ No

1.16 Minority, female, and persons with disability participation and utilization plan

1.16.1 Does this solicitation contain a BEP goal? ☒ Yes ☐ No If yes, the BEP goal is: 20 percent

1.16.2 This solicitation includes a specific Business Enterprise Program (BEP) utilization goal of 20 percent of the administrative portion of the capitation payments to perform anticipated direct subcontracting opportunities of this Contract.

1.16.3 Businesses included in Utilization Plans as meeting BEP requirements as prime vendors or subcontractors must be certified by CMS as BEP vendors prior to the deadline for submission of full Proposals.

Go to (*http://www.illinois.gov/cms/business/sell2/bep/Pages/default.aspx*) for complete requirements for BEP certification.

1.16.4 Offerors shall download, complete, and submit one (1) Letter of Intent per BEP vendor and one (1) Utilization Plan as a part of their Proposal. A proposal that does not provide both a Letter of Intent and a Utilization Plan may render the Offeror non-responsive.

1.16.5 Letter of Intent and Utilization Plan templates are available online at the following addresses:

Letter of Intent:
http://www.illinois.gov/cpo/general/Documents/Letter%20of%20Intent%20Template%20v.14.1.pdf

Utilization Plan:
http://www.illinois.gov/cpo/general/Documents/BEP%20Utilization%20Plan%20v.14.1.pdf

1.17 Small Business Set-Aside Program

1.17.1 ☐ Yes ☒ No. If "Yes" is marked, Offeror must be qualified by the Small Business Set-Aside Program at the time Offers are due in order for the Offer to be evaluated.

1.18 Federal funds

1.18.1 The resulting Contract may be partially or totally funded with Federal funds. Upon notice of intent to award, the percentage of goods and/or services involved that are Federally funded and the dollar amount of such Federal funds will be disclosed.

1.19 Employment tax credit

1.19.1 Offerors who hire qualified veterans and certain ex-offenders may be eligible for tax credits. 30 ILCS 500/45-67 and 45-70. Please contact the Illinois Department of Revenue (217-524-4772) for information about tax credits.

1.20 Certificate of Authority

1.20.1 In order to be eligible to propose for this RFP, the Offeror shall meet one of the following before the date of Contract award and for the entire duration of the proposed Contract period:

1.20.1.1 The Offeror meets the requirement of 89 III. Admin. Code Part 143. Offeror may be deemed by the State to be a certified managed care community network. The Offeror shall have an existing certification with the State.

1.20.1.2 The Offeror shall hold a valid certificate of authority as a health maintenance organization (HMO) under 215 ILCS 125/1-1, et seq.

2 BACKGROUND AND SCOPE OF RFP

This Section provides background information regarding the State's Medicaid Managed Care Program, goals and objectives of the State's Medicaid Managed Care Program moving forward, and the scope of the RFP.

2.1 Overview

2.1.1 For this RFP and for the duration of the RFP process, "Managed Care Organization" or "MCO" shall refer to any entity that is seeking a comprehensive risk contract with the Department to provide Covered Services under the Medicaid Managed Care Program, as per 42 CFR §438.2 (this and other definitions in Appendix 2 of this RFP), and subject to the eligibility criteria outlined in Section 1.20 of this RFP.

2.1.2 The Illinois Department of Healthcare and Family Services ("the Department") is seeking the services of no fewer than four (4) and no more than seven (7) qualified, experienced, and financially sound MCOs to enter into risk-based contracts for the Medicaid Managed Care Program. These Contractors shall provide the full spectrum of Medicaid-covered services to the general Medicaid population through an integrated care delivery system. See Section 2.3 for a detailed breakdown of covered populations and Section 2.4 for a detailed breakdown of covered services.

2.2 Background

2.2.1 Illinois is one of the largest funders of health and human services (HHS) in the country. With ~$32 billion spent across its HHS agencies[1], amounting to more than 40% of its total budget, the State is deeply invested in the health and well-being of its 12.9 million residents and 3.1 million Medicaid enrollees[2,3]. There is an urgent need to get more from this investment: the State must improve health outcomes for residents while slowing the growth of healthcare costs and putting the State on a more sustainable financial trajectory.

2.2.2 To this end, Illinois has embarked on a transformation of its HHS system. The HHS Transformation, which was announced by Governor Bruce Rauner in his 2016 State of the State address, "puts a strong new focus on prevention and public health; pays for value and outcomes rather than volume and services; makes evidence-based and data-driven decisions; and moves individuals from institutions to community care to keep them more closely connected with their families and communities."

2.2.3 The HHS Transformation seeks to improve population health, improve experience of care, and reduce costs. It is grounded in five themes:

2.2.3.1 Prevention and population health

2.2.3.2 Paying for value, quality, and outcomes

2.2.3.3 Rebalancing from institutional to community care

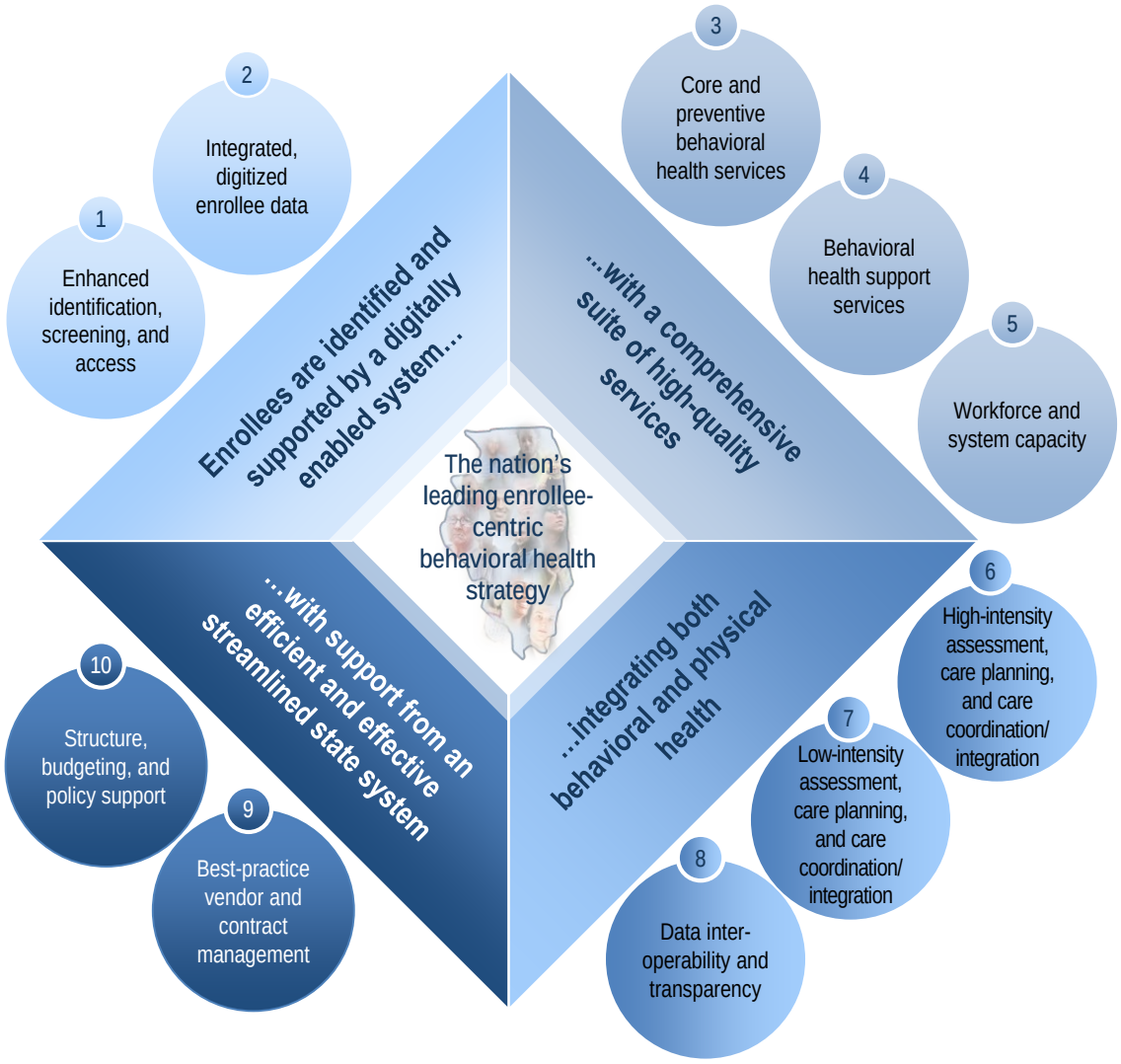
2.2.3.4 Data integration and predictive analytics

2.2.3.5 Education and self sufficiency

2.2.4 A primary focus area of the State in this HHS Transformation has been the integration of behavioral health and physical healthcare as a means to improving outcomes for the entire population, with a particular focus on those enrollees facing co-occurring behavioral and physical health challenges. In October 2016, the State of Illinois submitted to the Centers for Medicare and Medicaid Services (CMS) a Demonstration Waiver Proposal under Section 1115 of the Social Security Act (1115 Waiver), to support Illinois's vision of a transformed behavioral health system and true physical and behavioral health integration. The 1115 Waiver sets forth four (4) central approaches and ten (10) key initiatives to establish an enrollee-centric, integrated behavioral and physical healthcare system. The elements of this approach are summarized in Exhibit 1 below.

1 Based on SFY 2015 and includes HFS, IDHS, DCFS, IDoA, IDOC, IDES (Illinois Department of Employment Security), IDPH, IDVA
2 State Fiscal Year 2015 Illinois HFS claims data
3 In this RFP, Medicaid refers to both Title XIX and Title XXI of the Social Security Act.

Exhibit 1: Informed by stakeholders, Illinois envisions an enrollee-centric, integrated behavioral and physical health system enabled by 10 key elements



2.2.5 Central to this approach is the State's current effort to design and establish an integrated health homes (IHH) Model, in collaboration with MCOs, to enhance true integration of behavioral and physical healthcare that promotes accountability, rewards team-based care, and shifts away from fee-for-service toward a system that pays for value and outcomes. These IHHs will ensure care coordination to help all Medicaid enrollees, including those with complex needs, navigate the healthcare system pursuant to the Medicaid reform law (Public Acts 096-1501 and 97-689) and the federal Patient Protection and Affordable Care Act (Public Law 111-148). Additional detail on Illinois's IHH program design can be found in Appendix V.

2.2.6 Managed care is central to the success of Illinois's fully transformed system. Illinois has made significant progress since 2014 in transitioning its Medicaid population to capitated managed care.

During this time, the State migrated 2 million of 3.1 million total Medicaid enrollees into managed care, surpassing its initial goal of 50 percent managed care coverage for the Medicaid population. As of January 2017, Illinois has extended coverage to 65 percent enrollment in capitated managed care. While progress has been made in improving care coordination, the State recognizes that significant work remains to be done to fully achieve the goals of effective care coordination. Through this RFP, the State seeks to purchase the best managed care coordination services available in support of the broader HHS Transformation initiative. This purchase of care seeks to accomplish five (5) goals:

2.2.6.1 Align State and MCO objectives to enhance quality and improve outcomes;

2.2.6.2 Increase integration of behavioral and physical health;

2.2.6.3 Streamline current managed care programs and reduce complexity for enrollees and providers;

2.2.6.4 Achieve greater managed care coverage across Illinois; and

2.2.6.5 Manage costs without compromising quality or access.

2.2.7 To achieve these goals, the State will further integrate behavioral health and physical health services, combining its three (3) current managed care programs—Integrated Care Program (ICP), Family Health Plans/ACA Adults (FHP/ACA), and Managed Long Term Services and Supports (MLTSS)—into a streamlined program. (Note: The Medicaid-Medicare Alignment Initiative is not within the scope of this RFP, although the State reserves the right to further integrate this program in a subsequent RFP or contracting process.)

2.2.8 The integrated and streamlined program will cover both current enrollees and new enrollees based on population and geography. The program will continue to cover Medicaid-eligible families and children, childless adults, seniors and other persons with disabilities, and dual-eligible adults receiving LTSS. It will be extended to cover special needs children. Mandatory managed care will be extended from the current 30 counties to all 102 counties in Illinois, for all defined populations. This enhanced geographic coverage and population expansion will assist the State in achieving its goal of including 80 percent of the Medicaid-eligible population in managed care.

2.2.9 The State is also moving toward innovative approaches to care coordination, population health management, and value-based payment. For more information on the HHS Transformation, visit: https://www.illinois.gov/sites/hhstransformation/Pages/default.aspx

2.3 Population coverage

2.3.1 The populations covered within the scope of this RFP as part of Illinois' mandatory Medicaid Managed Care Program include:

2.3.1.1 Families and children eligible for Medicaid through Title XIX or Title XXI (Children's Health Insurance Program);

2.3.1.2 Affordable Care Act expansion Medicaid-eligible adults;

2.3.1.3 Medicaid-eligible adults with disabilities who are not eligible for Medicare;

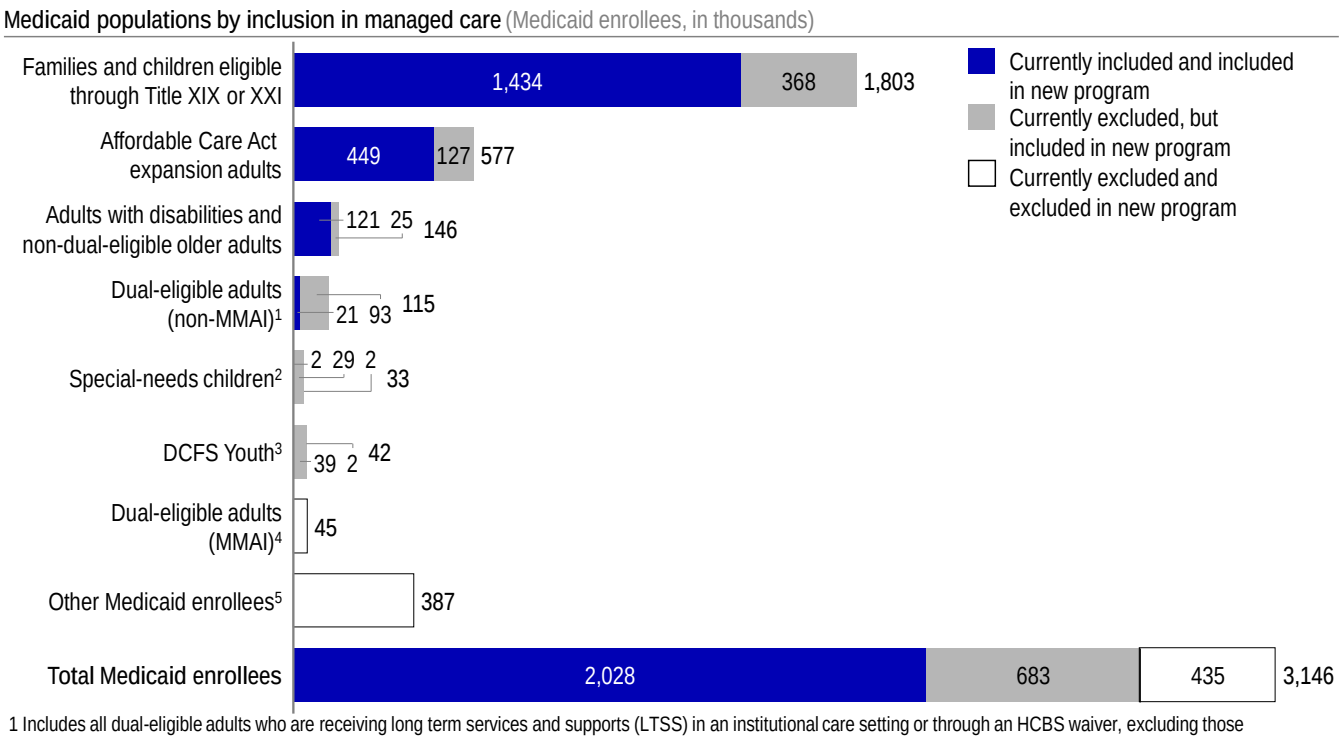
2.3.1.4 Medicaid-eligible older adults who are not eligible for Medicare;

2.3.1.5 Dual-eligible adults who are receiving long term services and supports (LTSS) in an institutional care setting or through an HCBS waiver, excluding those receiving partial benefits, and who are enrolled in the Illinois Medicare-Medicaid Alignment Initiative (MMAI), or are subject to other exclusions; and,

2.3.1.6 Special needs children, defined as Medicaid-eligible enrollees under the age of 21 who are covered under Supplemental Security Income (SSI), a disability category of eligibility, or are receiving services from the Division of Specialized Care for Children (DSCC).

2.3.2 Children in the care of the Department of Children and Family Services (DCFS Youth), including those formerly in care who have been adopted or entered a guardianship, will also be covered within the scope of this RFP through a separate Contract. Managed care will be mandatory for all DCFS Youth, though children who have been adopted or entered a guardianship will have the opportunity to opt-out of the DCFS-specific program upon enrollment with one of the statewide plans as defined in 2.6.2. Exhibit 2 provides further detail on and context for all populations.

Exhibit 2: Landscape of Illinois Medicaid enrollees



1 Includes all dual-eligible adults who are receiving long term services and supports (LTSS) in an institutional care setting or through an HCBS waiver, excluding those receiving partial benefits, and who are enrolled in the Illinois Medicare-Medicaid Alghment Initiative (MMAI), or are subject to other exclusions
2 SSI-children, disabled children, children receiving services from DSCC and DD Waiver children; includes 1,800 children currently enrolled in managed care, 29,300 children for inclusion in managed care, and 1,500 children with other exclusions (e.g., spenddown, high TPL, etc.).
3 Children aligned to Department of Children and Family Services (DCFS), including youth in care, guardianship, and adoption; includes less than 50 children currently enrolled in managed care, 39,400 for inclusion in managed care, and 2,200 with other exclusions.
4 MMAI program is currently under managed care contracts but is out of scope of this RFP.
5 Includes high TPL, spenddown, partial benefits, etc.

2.4 Covered services

2.4.1 Offerors shall provide all covered services currently funded by Medicaid through the State Plan or waivers, unless specifically excluded. Covered services are organized as three (3) Service Packages, defined as follows:

2.4.1.1 Service Package I. Service Package I includes all covered services set forth as Service Package I in the Model Contract (Appendix I). Service Package I includes all Medicaid-eligible services unless otherwise excluded in the Model Contract (Appendix I) or included in Service Packages II or III.

2.4.1.2 Service Package II. Service Package II includes all covered services set forth as Service Package II in the Model Contract (Appendix I). Service Package II includes nursing facility services and the care provided through all of the home and community–based services (HCBS) waivers operating in Illinois, with the exception of those waivers designed for individuals with developmental disabilities.

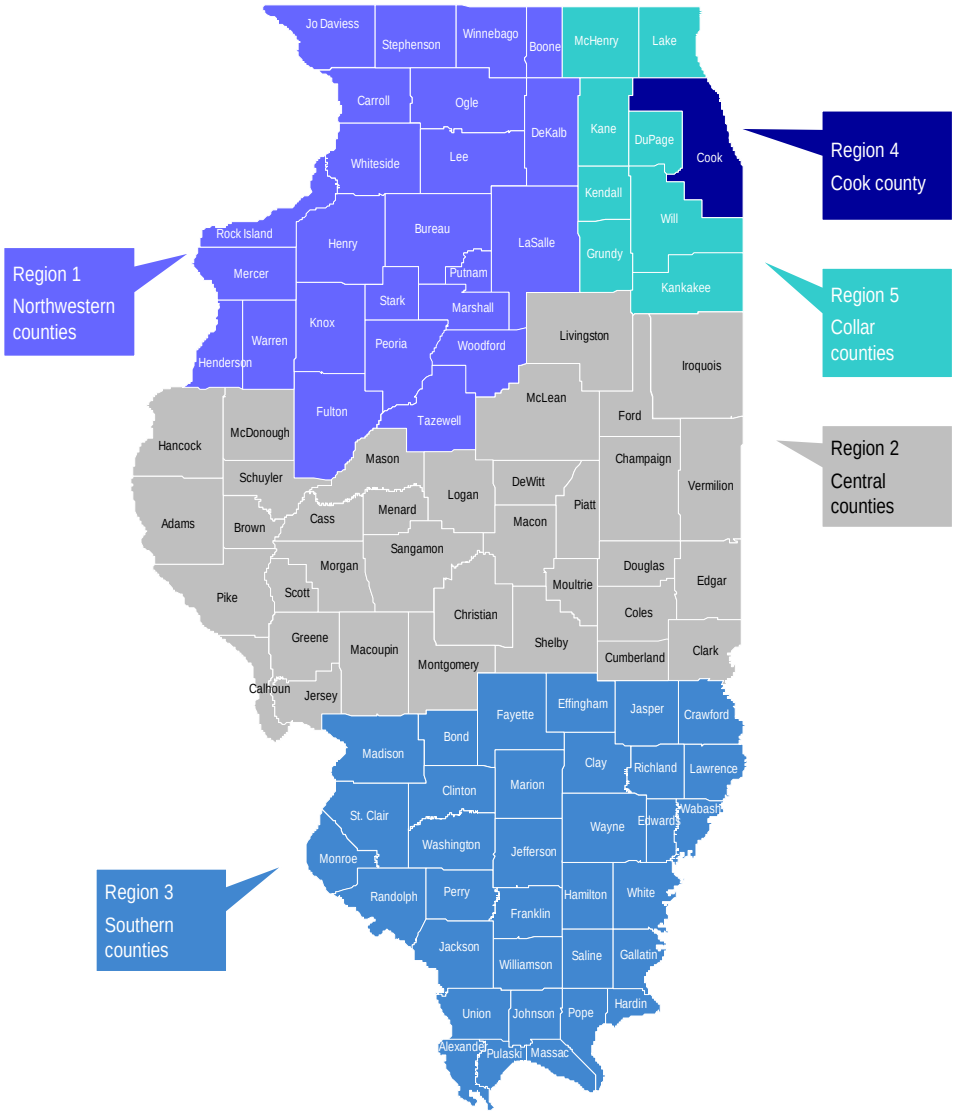
2.4.1.3 Service Package III. Service Package III includes all covered services set forth as Service Package III in the Model Contract (Appendix I). Service Package III includes the developmental disability waiver services and intermediate care facility providers for development disabilities (ICF/DD) services. See the Model Contract (Appendix I) for a more detailed description of waiver services. While the Department does not intend to include Service Package III in the scope of the Contract initially, the Offeror shall be capable of assuming responsibility for Service Package III with 180 days advance notice from the Department per the terms of the Model Contract (Appendix I).

2.5 Geographic coverage

2.5.1 In 2014, Illinois increased Medicaid managed care coverage to surpass the 50 percent goal required by State law, reaching enrollment of more than 2 million enrollees in managed care programs. Programs existed in five (5) mandatory managed care regions across the State including Rockford, Central Illinois, Metro East, Quad Cities, and Greater Chicago (inclusive of Cook County and its "collar" counties). A map that illustrates the geographic coverage of these programs as of July 2016 is available on the HFS Website at https://www.illinois.gov/hfs/SiteCollectionDocuments/CCExpansionMap.pdf

2.5.2 To achieve the State's extended goal of 80 percent Medicaid population coverage through managed care, the State now intends to extend the geographic coverage of managed care statewide, including the 72 counties not currently covered under managed care. This RFP outlines five (5) new geographic regions, for the purposes of extending managed care to all 102 counties in Illinois (Exhibit 3).

Exhibit 3: Future landscape of mandatory managed care regions in Illinois, covering all of the State's 102 counties



2.6 Proposal Options

2.6.1 An Offeror may only propose on Proposal Option A or Proposal Option B, as determined by the eligibility requirements for each Proposal Option as described below. The initial term of the contract will be four (4) years, with options to renew the contract for up to an additional four (4) years for a potential total term of eight (8) years, as specified in the Model Contract. The Model Contract is provided in Appendix I.

2.6.2 **Proposal Option A.** Proposal Option A requires Offerors to cover all 102 counties in Illinois. Services covered will initially include Services Packages I and II (as per Section 2.4) to be provided to all populations identified in Section 2.3. While the State intends to award between three (3) and five (5) contracts for Proposal Option A, the State is not obligated to award a contract for Proposal

Option A pursuant to this RFP.

2.6.2.1 Separate Contract for DCFS Youth: An Offeror on Proposal Option A shall be willing and able to comply with the requirements to serve as the sole entity to manage the care of the DCFS Youth (population identified in Section 2.3). The Department shall use the Offeror's responses to all sections of the Technical Proposal (Section 5) to evaluate the Offeror's capabilities to serve both the DCFS Youth and high-needs children in other eligibility categories. The State will select one of the successful Offerors on Proposal Option A to provide Service Packages I and II for DCFS Youth. While the State intends to award one (1) additional, separate, statewide contract to cover these services for DCFS Youth, the State is not obligated to award a contract for DCFS Youth pursuant to this RFP.

2.6.3 Proposal Option B. Proposal Option B requires Offerors to cover Cook County only. Services covered will initially include Service Packages I and II (as per Section 2.4) to be provided to all populations identified in Section 2.3. To be eligible to submit a Proposal for Option B, an Offeror shall be either a Government-owned organization or a Minority-owned organization, as defined in Appendix II of this RFP. While the State intends to award between (1) and two (2) contracts for Proposal Option B, the State is not obligated to award a contract for Proposal Option B pursuant to this RFP.

2.7 Phased implementation approach

2.7.1 The Department reserves the right to define a phased approach to implementation of the program described in this RFP.

2.7.2 The Department intends to implement the program according to the plan below. The plan below will be considered preliminary, nonbinding, and subject to change.

2.7.2.1 The Department intends to implement Service Packages I and II and conduct any necessary enrollment activity for all populations within the scope of this RFP and all geographic areas within one (1) year after the effective date of the Contract.

2.7.2.2 The Department intends to implement this program and conduct any necessary enrollment activity for all enrollees who are currently in managed care within the first ninety (90) days after the effective date of the Contract.

2.7.2.3 The Department intends to implement this program and conduct any necessary enrollment activity for all enrollees who will be new to managed care immediately following this ninety-day (90-day) period.

2.7.2.4 The Department does not intend to implement Service Package III as a component of this phased implementation, but the Department reserves the right to revisit

implementation of Service Package III at a later date.

2.7.3 The Department will notify Offerors of any further details or changes to its intention to pursue a phased implementation approach, either as an amendment to this RFP or as another official notice.

2.7.4 The Department reserves the right to introduce new populations or services for coverage by the Contractors after the effective date of the Contract, with adequate advance notice as specified in the Model Contract (Appendix I).

2.7.5 The Department reserves the right to remove populations or services from coverage by the Contractors after the effective date of the Contract, with adequate advance notice as specified in the Model Contract (Appendix I).

3 PROPOSING, EVALUATION, AND SELECTION PROCESS

This Section provides Offerors with additional instructions on how the RFP process will be conducted, how Proposals will be evaluated, and how final selection will occur.

3.1 Responsiveness

3.1.1 A responsive Offer is one that conforms in all material respects to the RFP, and includes all required forms. A responsive Offeror is an Offeror who submits an Offer that conforms in all material respects to the RFP, and includes all required forms.

3.1.2 The Department will determine whether the Offer meets the stated requirements. Minor differences or deviations that have negligible impact on the price or suitability of the service to meet the State's needs may be accepted or corrections allowed. If no Offeror meets a particular requirement, the Department may waive that requirement.

3.1.3 The Department will determine whether the Offer complied with the instructions for submitting Offers. Except for late submissions, and other requirements that by law must be part of the submission, the Department may require that an Offeror correct deficiencies as a condition of further evaluation.

3.2 Responsibility

3.2.1 A Responsible Offeror is one who has the capability in all respects to perform fully the contract requirements and who has the integrity and reliability that will assure good faith performance. The

State determines whether the Offeror is a "Responsible" Offeror; an Offeror with whom the State can or should do business. For example, the State may consider the following:

3.2.1.1 A "prohibited bidder" includes any person assisting an employee of the State of Illinois by reviewing, drafting, directing, or preparing any invitation for bids, a request for proposal, or request of information, or providing similar assistance unless such assistance was part of a publically issued opportunity to review drafts of all or part of these documents. For purposes of this Section, an employee of the State of Illinois means one who, by the nature of his or her duties, has the authority to participate personally and substantially in the decision to award a State contract. No person or business shall submit specifications to a State agency unless requested to do so by an employee of the State. No person or business that contracts with a State agency to write specifications for a particular procurement need shall submit a bid or proposal or receive a contract for that procurement need.

3.2.1.2 Nothing herein is intended to prohibit a vendor from bidding or offering to supply developing technology, goods or services after providing the State with a demonstration of the developing technology, goods, or services; provided the subject of the demonstration to the State represents industry trends and innovation and is not specifically designed to meet the State's needs. Nothing herein is intended to prohibit a person or business from submitting a bid or offer or entering into a contract if the person or business: (i) initiates a communication with an employee to provide general information about products, services, or industry best practices and, if applicable, that communication is documented or (ii) responds to a communication initiated by an employee of the State for the purposes of providing information to evaluate new products, trends, services, or technologies.

3.2.2 Other factors that the State may evaluate to determine Responsibility include, but are not limited to: certifications, conflict of interest, financial disclosures, taxpayer identification number, past performance in business or industry, references (including those found outside the Proposal), compliance with applicable laws, financial responsibility, insurability, effective equal opportunity compliance, payment of prevailing wages if required by law, capacity to produce or sources of supply, and the ability to provide required maintenance service or other matters relating to the Offeror's ability to deliver in the quality and quantity within the time and price as specified in this solicitation.

3.2.3 Awarded Offerors must at all times have financial resources sufficient, in the opinion of the State, to ensure performance of the contract and must provide proof upon request. The State may terminate the contract, consistent with the termination for cause provision of the contract, if the vendor lacks the financial resources to perform under the contract.

3.2.4 The State may require that an Offeror correct any deficiencies as a condition of further evaluation.

3.3 Proposal format and submission requirements

3.3.1 Offerors shall observe the proposal format and submission requirements outlined in this Section.

3.3.2 Offerors shall deliver proposals by the deadline for submission of full Proposals, May 15, 2017 at 12:00 pm CT (full timeline in Section 1.3).

3.3.3 Prior to the due date, Offerors may mail or hand-deliver Proposals, modifications, and withdrawals. Proposals may not be submitted via e-mail, fax, or other electronic means.

3.3.4 The Department must physically receive submissions as specified; it is not sufficient to demonstrate a postmark before the due date and time. The Department shall not consider Proposals or modifications submitted after the due date and time. All times are Central Time (CT).

3.3.5 Container A: Offerors shall submit one (1) printed, signed original and fifteen (15) printed copies of the full Proposal and all required forms (except the Financial Proposal) in binder(s) within a sealed container labeled “Container A” to the address of the Solicitation Contact specified in Section 1.2 of this RFP.

3.3.6 Container B: Offerors shall submit one (1) printed, signed original and two (2) printed copies of the Financial Proposal in binder(s) within a separate sealed container labeled “Container B” to the address of the Solicitation Contact specified in Section 1.2 of this RFP.

3.3.7 Redacted Proposal: If an Offeror indicates in its Proposal to the State of Illinois (Form for Submission II), that it requests confidential treatment, the Offeror shall submit one (1) printed copy of the full Proposal (including the Financial Proposal) in binder(s) within a sealed container labeled “Redacted Proposal” to the address of the Solicitation Contact specified in Section 1.2 of this RFP.

3.3.8 USB A: Offerors shall submit two (2) separate USB drives, each with one (1) electronic copy of the full Proposal and all required forms (except the Financial Proposal). All components of the Proposal shall be submitted in PDF format, with the exception of the Provider Network listing described in 4.2.6, which shall be submitted in Microsoft Excel format. Each USB drive shall be labelled “USB A” and delivered to the address of the Solicitation Contact specified in Section 1.2 of this RFP.

3.3.9 USB B: Offerors shall submit one (1) copy of the Financial Proposal on a separate USB Drive in PDF format, labeled “USB B” to the address of the Solicitation Contact specified in Section 1.2 of this RFP.

3.3.10 Offerors shall observe the proposal format specifications in the table below

Criteria	Specification
Paper size	Standard letter (8.5 x 11)
Font	12-point Times New Roman
Spacing	Single
Margins	1 inch
Pagination	Double-sided

3.4 Proposal organization and content

3.4.1 Proposals shall observe the structure, ordering, labeling, and other guidelines provided in this Section.

3.4.2 Tabs 1-4 shall be enclosed in Container A. Tab 5 shall be enclosed in Container B. Contents within each Tab shall be ordered as listed in this Section.

3.4.3 Tab 1: Transmittal letter, Proposal security, and Proposal to the State of Illinois

3.4.3.1 Transmittal letter: The transmittal letter serves as a cover letter for the Offeror's response. The transmittal letter shall be in the form of a standard business letter and shall be on the letterhead of the Offeror submitting the Proposal. The transmittal letter shall be one (1) page in length and is not a scored component of the Proposal. The transmittal letter shall be signed by an individual authorized to legally bind the Offeror.

3.4.3.2 Proposal to the State of Illinois: Offeror shall complete and submit Form for Submission II.

3.4.3.3 Proposal security: Offeror shall enclose Proposal security as per the instructions in Section 1.13.

3.4.4 Tab 2: Proposal Requirements

3.4.4.1 Financial Condition: Offeror shall provide evidence of financial sustainability as per the instructions in Section 4.1.

3.4.4.2 Offeror Profile: The Offeror shall submit elements of the Offeror Profile as described in Section 4.2.

3.4.5 Tab 3: Technical Proposal. The Offeror shall include responses to the prompts in Section 5.

3.4.5.1 Offeror's responses shall be in sequential order, labeled by subsection outlined in

Section 3.5.6.2.

3.4.5.2 Offeror's responses do not need to restate the prompt to which they respond.

3.4.5.3 Offeror's responses shall adhere to the proposal format and submission specifications in Section 3, including the subsections and page limits for each subsection outlined in Section 3.5.6.2.

3.4.5.4 Any materials submitted in response to a subsection will count against the page limit for that subsection. Responses that exceed the page limit for any subsection will only be read up to that page limit. Any content on additional pages will not be considered in the evaluation. Only contents clearly contained within the named subsection will be used in determining an Offeror's score for that subsection.

3.4.6 Tab 4: RFP Forms for Submission

3.4.6.1 State Board of Elections Registration Certificate. Offeror shall submit the State Board of Elections Registration Certificate. In accordance with Public Act 95-971, if an Offeror does not submit the State Board of Elections Registration Certificate as required, the Offeror's Proposal shall be disqualified.

3.4.6.2 Offeror shall submit Forms A or Forms B as applicable.

3.4.6.3 Offeror shall submit letters of intent for each BEP-certified vendor and a BEP utilization plan.

3.4.6.4 Offeror shall provide subcontractor disclosures using Form for Submission III.

3.4.6.5 Offeror shall confirm agreement with the Model Contract (Appendix I) and note any exceptions taken with a full explanation using Form for Submission IV.

3.4.7 Tab 5: Financial Proposal. Offeror shall submit a Financial Proposal as a component of Proposal submission. Financial Proposals shall meet the requirements outlined in Section 6, using the Financial Proposal Template (Form for Submission VI).

3.5 Proposal scoring and evaluation

3.5.1 At the time of Proposal submission, the Department will evaluate the administrative compliance of each proposal and make a determination as to the Responsiveness and Responsibility of the Offeror per the terms outlined in Sections 3.1 and 3.2.

3.5.2 Proposals that are deemed Responsive and Responsible, will be further evaluated based on four (4) components of the Proposal: Proposal Requirements, Technical Proposal, Oral Presentation,

and Financial Proposal. The Department will conduct a staged evaluation process, as outlined in this Section.

3.5.3 The Department will consider the information provided and the quality of that information when evaluating Proposals. If the Department finds a failure or deficiency, the Department may reject the Proposal or reflect the failure or deficiency in the evaluation.

3.5.4 The maximum points possible for each component of the Proposal are as follows:

Proposal component	Maximum points
Proposal Requirements	Pass / Fail
Technical Proposal	500
Oral Presentation	100
Financial Proposal	300
Proposal Total	900

3.5.5 Proposal Requirements

3.5.5.1 Proposal Requirements will be evaluated for completeness, accuracy, veracity, and quality of the information provided. Significant inaccuracies or material omissions will be grounds for an Offeror to be considered ineligible for Oral Presentations, at the discretion of the Department.

3.5.5.2 An Offeror must achieve a "Pass" rating on the Financial Condition (Section 4.1) to be considered eligible for Oral Presentations. In addition to the criteria listed in Section 3.5.5.1, the State reserves the right to assign a "Fail" rating on the Financial Condition for any current, pending, or past bankruptcy or insolvency which is deemed material to the Offeror's ability to execute the Contract.

3.5.5.3 An Offeror must receive a "Pass" rating on the Offeror Profile (Section 4.2) to be considered eligible for Oral Presentations. In addition to the criteria listed in Section 3.5.5.1, the State reserves the right to assign a "Fail" rating on the Offeror Profile for: any litigation which resulted in a fine or settlement of more than $50 million to the federal government or any state government; any instance of placement into a Corporate Integrity Agreement by the United States Department of Justice; any litigation which resulted in the Offeror being found guilty of causing significant member harm or member exposure to potential harm; any current or pending Securities and Exchange Commission enforcement action or any previous action with a penalty or settlement of over $50 million; or if selecting Proposal Option B per section 2.6.3, failing to provide attestation of its status as a Government-owned organization or a Minority-owned organization, as defined in Appendix II of this RFP.

3.5.6 Technical Proposal

3.5.6.1 An Offeror must receive a minimum score of 300 points in this Section to be considered eligible for Oral Presentations.

3.5.6.2 The maximum points possible and page limits for each subsection of the Technical Proposal are as follows:

Subsection	Maximum points	Page limit
Overall approach to improving healthcare quality, ensuring access, and controlling cost trends	100	40
Integration of behavioral and physical health	80	40
Information technology	70	40
High-needs children	50	40
Long-term services and supports	50	30
Payment reform and value-based payment	50	30
Care management and utilization management	40	30
Provider requirements	40	30
Operations	20	20
Technical Proposal Total	500	300

3.5.6.3 For each subsection listed above, only materials clearly contained within the named subsection and subjected to the corresponding page limit will be considered in the determination of an Offeror's score for that subsection.

3.5.7 Oral Presentation

3.5.7.1 The Department will host Oral Presentations after the Proposal Requirements and Technical Proposal components have been evaluated.

3.5.7.2 An Offeror must receive a "Pass" rating for the Proposal Requirements component and at least 300 points for the Technical Proposal component in order to receive an invitation for an Oral Presentation. The Department reserves the right to invite additional Offerors for Oral Presentations at its discretion, in the order of next-highest score.

3.5.7.3 No later than one (1) week prior to the date of Oral Presentations, the Department will notify Offerors whether they are invited to make an Oral Presentation.

3.5.7.4 The Department reserves the right to ask an Offeror, at the Oral Presentation, for further detail on the information it submitted as a part of the Proposal Requirements or Technical

Proposal components.

3.5.7.5 There is no minimum score for the Oral Presentation component for a Proposal to be considered eligible for evaluation of the Financial Proposal.

3.5.8 Financial Proposal

3.5.8.1 The Department will evaluate the Financial Proposals separately and after Oral Presentations are complete.

3.5.8.2 The Financial Proposal will be considered a best and final offer. There will be no additional best and final offer process.

3.5.8.3 The scoring approach for the Financial Proposal is provided in Section 6.

3.5.8.4 There is no minimum score for Financial Proposals for a Proposal to be considered eligible.

3.5.9 Recommendation of evaluation committee and awards

3.5.9.1 The Department intends to award no fewer than three (3) and no more than five (5) statewide contracts for Proposal Option A; one (1) separate contract for DCFS Youth from among Offers for Proposal Option A; and no fewer than one (1) and no more than two (2) contracts for Proposal Option B.

3.5.9.2 Successful Offerors for the integrated program will be those that meet all mandatory eligibility criteria and receive the highest cumulative total points.

3.5.9.3 If Contract negotiations prove unsuccessful with any of the awarded Offerors, the Department reserves the right to approach the next-highest scoring Offeror(s).

3.5.9.4 Award notifications for this contract will be posted on the HFS Website.

4 PROPOSAL REQUIREMENTS

This Section outlines the Offeror-specific company and profile information that is required for, and will be evaluated in, the written submission.

4.1 Financial Condition

4.1.1 The Proposal shall provide the information described below for the Offeror organization. The Offeror may also provide this information for its parent company, but not as a substitute for the

information for the Offeror organization, unless the information exists only for the parent company.

4.1.1.1 Audited financial statements for the two (2) most recent fiscal years for which the statements are available, as submitted to the relevant regulatory authorities. The statements shall include a balance sheet, an income statement, and a statement of cash flows. Statements shall be complete with opinions, notes, and management letters. If no audited statements are available, explain why not and submit unaudited financial statements.

4.1.1.2 A balance sheet for the end of March 2017.

4.1.1.3 Documentation of lines of credit that are available, including maximum credit amount and available credit amount.

4.1.1.4 Short-term and long-term debt ratings by at least one nationally recognized rating service.

4.1.1.5 Medical loss ratios (MLRs) for Medicaid lines of business, by state of operation, for the most current two (2) years. MLR is defined as total medical and hospital cost divided by total premium income.

4.1.1.6 Net underwriting gain or loss for Medicaid lines of business, by state of operation.

4.1.1.7 Any bankruptcy or insolvency during the past ten (10) years, including all relevant details on the context and proceedings.

4.2 Offeror Profile

4.2.1 The Offeror shall submit all elements of the Offeror Profile as described below.

4.2.2 Organization profile and background. The Offeror shall provide an overview of the Offeror organization, its parent organization, and its affiliate organizations, including the below information.

4.2.2.1 The organization name, e-mail address, mailing address, phone number, facsimile number, and primary Proposal contact.

4.2.2.2 The organization's type of legal entity and primary business location(s).

4.2.2.3 The number of years the organization has been in operation.

4.2.2.4 An overview of how long the organization has been providing the services required by this RFP, including populations served.

4.2.2.5 The organization's history, including any mergers, acquisitions, or sales of the organization, within the past ten (10) years, including an explanation of all relevant

details.

4.2.2.6 A statement of any pending Securities and Exchange Commission actions involving the organization as well as all such actions taken within the past ten (10) years, and all relevant details of each.

4.2.2.7 A statement of any material, pending litigation against the organization; any material, pending investigation by the United States Department of Justice; all material litigation within the past (10) years, and; any instance of placement into a Corporate Integrity Agreement by the United States Department of Justice within the past (10) years. If pending litigation or investigations exist that the organization believes could reasonably have an adverse effect on the organization's financial condition, list each separately, explain the relevant details, and attach the opinion of counsel addressing whether and to what extent it would impair the Offeror's performance in a contract pursuant to this RFP.

4.2.2.8 If selecting Proposal Option B per section 2.6.3, provide a statement attesting to the Offeror's status as a Government-owned organization or a Minority-owned organization, as defined in Appendix II of this RFP. Offeror may include additional supporting evidence or documentation as appropriate.

4.2.3 Offeror Experience. Offeror shall identify whether the Offeror, its parent organization, or its affiliate organizations have any current Medicaid managed care contracts in state programs (including in Illinois' current program), or have completed any such contracts over the past three (3) years.

4.2.3.1 For all such contracts, the Offeror shall provide the following information: the name, title, telephone number, and e-mail address of a relevant contact with the state in which the contract is administered; a brief description of the contract's scope of services and populations covered; and the contract term.

4.2.3.2 The existence of current or completed contracts with the State of Illinois shall not result in the addition or deduction of evaluation points.

4.2.3.3 Offeror shall identify and describe any instances of non-compliance that the Offeror, its parent organization, or its affiliate organizations have encountered as a part of any Medicaid managed care contracts (including Illinois' current program) within the past three (3) years. For each non-compliance issued, Offeror shall indicate the type of non-compliance issued (see Section 4.2.3.5), the date the non-compliance was issued, the reason the non-compliance was issued, the issuing entity, the state(s) in which the Offeror was providing services for which the non-compliance was issued, details of the sanctions applied against the Offeror as a result of the non-compliance, and the actions taken by the Offeror to address the non-compliance.

4.2.3.4 Offeror shall identify any instances of non-renewal or early termination of contracts with states. Offeror shall specify the type of contract, why the termination was initiated, and by whom it was initiated (contractor, State, mutual, or federally-imposed).

4.2.3.5 Types of non-compliance include: compliance letters (includes Warning Letters, Notices of Non-Compliance, Corrective Action Plans or similar state notices); adverse performance audits (contracts failing more than 50% of audit elements); adverse financial audits (adverse opinions or disclaimed reports); failures to maintain fiscally sound operations (negative net worth or financial loss greater than half of the contractor's total net worth); exclusions enforcement actions (imposed by CMS as an intermediate sanction); and any other significant compliance concerns.

4.2.3.6 In addition to the evaluation of Proposal Requirements described in Section 3.5.5.3, information provided in this section may be taken into consideration in the evaluation of the Offeror's response to Technical Proposal Section 5.2.1 (Overall approach to improving healthcare quality, ensuring access, and controlling cost trends).

4.2.4 List of individuals in an administrative capacity. Offeror shall provide a proposed staffing list, which shall include but not be limited to the positions outlined in the list of individuals in an administrative capacity in the Model Contract (Appendix I).

4.2.4.1 Offeror shall identify which positions are to be staffed internally or filled by a subcontractor. If a full-time staff member is required, the duties of this full-time role may not be completed by multiple part-time members.

4.2.4.2 Offeror shall include the names and résumés for all identified staff.

4.2.4.3 If a role is to be filled by a subcontractor, Offeror shall identify why a subcontractor is best suited for this role and the proposed oversight and management plan.

4.2.4.4 Offeror shall ensure that all staff have necessary certifications and licenses to conduct services as required by applicable State and federal laws.

4.2.5 References. Offeror shall provide references from established private firms or government agencies other than the procuring agencies. References shall attest to the Offeror's experience and ability to perform the contract that is the subject of this solicitation.

4.2.5.1 Six (6) total references are required, with three (3) from public sector organizations and three (3) from private or other, non-governmental, organizations.

4.2.5.2 Offeror shall provide the information regarding these references outlined in the Reference Form (Form for Submission V).

4.2.6 Provider network. Offeror shall provide a summary listing of the provider network it will utilize to deliver services in the scope of this RFP and in line with the requirements of the Model Contract (Appendix I).

4.2.6.1 At a minimum, the Offeror shall list its network of Affiliated hospitals, health centers,

PCPs, behavioral health providers, pharmacies, dentists (including oral surgeons), and ancillary providers for Service Package I, and its network of institutional and home and community-based LTSS service providers for Service Package II. Indicate the level of commitment by describing the Offeror's agreements with providers as either "Letter of Intent," "Pending Contract," or "Contract."

4.2.6.2 The data should be submitted in a Microsoft Excel format including the following fields: provider last name, provider first name, provider type, category of service, provider address, provider county, NPI, provider Medicaid ID, and level of commitment ("Letter of Intent," "Pending contract," "Contract).

4.2.6.3 In addition to the evaluation of Proposal Requirements described in Section 3.5.5.3, information provided in this section may be taken into consideration in the evaluation of the Offeror's response to Technical Proposal Section 5.2.8 (Provider Requirements).

4.3 Verification

4.3.1 The Department reserves the right to contact any organizations or individuals listed in response to this Section or elsewhere in the Offeror's Proposal to verify factual details and the authenticity of the information provided, including any examples furnished in the Offeror's Technical Proposal.

5 TECHNICAL PROPOSAL

This Section outlines the prompts to which the Offeror shall respond regarding its approach to the scope of work in this RFP and its Appendices, its qualifications, and its relevant experience.

5.1 Overall guidance to the Offeror

5.1.1 The Offeror shall respond with a single narrative for each subsection. As a part of the narrative for each subsection, the Offeror shall respond to all elements of the prompts for that subsection and, as appropriate, reference the requirements and details contained within the RFP Appendices.

5.1.2 All responses shall address the Offeror's relevant experience, where applicable, and how that experience is to be applied in the covered areas. Generally speaking, points will be awarded based on the completeness and quality of the response to each specific prompt in the below subsections; the degree to which the response demonstrates an ability to meet or exceed the requirements of the program, including those requirements set forth in the Model Contract; the degree to which the response demonstrates a thorough and thoughtful understanding of the specific needs of the enrollees described and included in the scope of this RFP; the level of innovation and types of innovative approaches to service delivery described in the response; and the alignment of the

response with the five themes of the State's HHS Transformation outlined in Section 2.2.

5.1.3 The Offeror's response to these prompts shall reflect an understanding of the requirements in the Model Contract (Appendix I), which contains the State's detailed requirements of the new managed care program. The Offeror must respond to the questions proposed in this Section 5 in a manner that addresses and supports the requirements of the Model Contract. A simple restatement of RFP of Model Contract language shall not be considered an acceptable response and may cause the response to be disqualified. Offerors shall consider the following:

5.1.3.1 The Model Contract is reflective of the State's requirements for the managed care program for all populations excluding DCFS Youth. Requirements of the Separate Contract for DCFS Youth will include all aspects of the Model Contract, as well as the requirements expressed in Appendix VI. Offerors must address the specific requirements of this population within the relevant responses;

5.1.3.2 The Model Contract provides the overall managed care program requirements to which the MCOs will be held accountable. Except in certain circumstances, it does not specify how such requirements must be executed.

5.1.3.3 The Model Contract does not specify which activities and services may be provided by an Integrated Health Home. Details of the IHH program requirements will be released to the public once they are finalized. Additional detail regarding Illinois's IHH program is provided in Appendix V; and,

5.1.3.4 The Model Contract is not a final document, and may be altered prior to execution.

5.1.4 The Offeror's response to these prompts shall reflect an understanding of all other Appendices to this RFP, including but not limited to: the State's 1115 Waiver (Appendix III), List of additional Medicaid services covered under 1115 Waiver and SPA Proposals (Appendix IV), Details on the integrated health homes vision for Illinois (Appendix V), and Care Coordination Expectations for DCFS Youth in Care (Appendix VI).

5.2 Technical Proposal structure and prompts

The Offer's Technical Proposal must contain the following sections and address the prompts listed within each section.

5.2.1 Overall approach to improving healthcare quality, ensuring access, and controlling cost trends

This Section requires the Offeror to describe the organization's overall program approach, previous experience delivering Medicaid managed care in other states, approach to implementation experience, and other components, as well as how these components align with the State's objectives for this program.	
Page limit: 40	Maximum number of points: 100

Prompts	
5.2.1.1 Approach to addressing State objectives	Describe the Offeror's overall program approach and how it will address all of the State's objectives listed in Section 2.2. Where possible, provide additional detail by stratifying the responses by the types of populations for which the Offeror will provide coverage. Specifically highlight the Offeror's: • Plan to promote achievement of the State's HHS Transformation themes; • Capabilities to support integration and coordination of care across the continuum of care and including both behavioral and physical health; • Approaches to population health and prevention; • Approaches to improving quality, including specific strategies to improve quality indicators (for example, Healthcare Effectiveness Data and Information Set [HEDIS], or Consumer Assessment of Healthcare Providers and Systems [CAHPS]); • Approaches to monitoring and evaluation; • Vision for initial and ongoing stakeholder engagement; • Vision for an ongoing relationship with the State, including meetings and committees in which both parties would participate; and • Approach to ensuring program alignment with CMS requirements and policy guidance (regulation) for managed care, including (but not limited to) the Medicaid and CHIP Managed Care Final Rule published in April 25, 2016.
5.2.1.2 Experience	Describe the Offeror's previous and ongoing relevant experience in Illinois and other states delivering Medicaid managed care across the populations and services in this program. Provide detailed case studies on the Offeror's experience delivering Medicaid managed care under at least three (3) of the contracts specified in Section 4.2.3. Highlight specifically the Offeror's: • Experience in managed care programs with a similar level of integration across needs (behavioral and physical health, functional/social needs, and long-term services and supports); • Performance indicators for quality of care, cost trends, operational performance, and any other metrics that are relevant to the goals of the Illinois program; and • Substantial challenges the Offeror has encountered in the implementation and administration of this type of program in other contexts, whether the Offeror anticipates facing them in Illinois, and the plan to address them.
5.2.1.3 Implementa-tion,	Describe how the Offeror will ensure a seamless transition in Illinois and how it will manage a major implementation, in which it may onboard many enrollees during a short period of time. Address specifically how the Offeror will manage:

delegation, and end of contract	• Enrollees who are new to the plan; • Enrollees who are new to managed care; • Existing providers, subcontractors, and ancillary service providers; and • New providers, subcontractors, and ancillary service providers. Include the Offeror's plans for: • Recruiting and developing in-house team members with the proper skill set; and • Ensuring continuity of knowledge from the implementation period through ongoing management of the program. Summarize the proposed subcontracts and key work to be delegated under the subcontracted relationship. Indicate whether any of the subcontracts are expected to be worth at least five percent (5%) of capitation payments under the contract. Describe how these subcontracting relationships will provide a seamless experience for enrollees and providers. • Provide a description of how subcontractors will be evaluated and how adherence to quality will be monitored and enforced. Address whether the Offeror intends to subcontract for care management, care coordination, behavioral health services or any other services. Describe the plan to complete the duties of the contract in the event of contract termination, especially how the Offeror would ensure continuity of care for enrollees.

5.2.2 Integration of behavioral and physical health

This Section requires the Offeror to describe the organization's experience with and capacity to collaborate with the State to meet the State's goals for the integration of behavioral and physical health for all Medicaid-covered adults and children.	
Page limit: 40	Maximum number of points: 80
Prompts	
5.2.2.1 Vignettes	Consider the below vignettes, describing potential profiles of Medicaid enrollees in Illinois. Describe how the Offeror would address the needs of the enrollees reflected in the vignettes, including specific experiences the Offeror has had in successfully addressing these needs for enrollees in Illinois and other states. Provide an example care plan for each enrollee. *Vignette #1: Tom is a 36-year-old man who is newly Medicaid eligible. He is currently sleeping on a friend's couch but will be asked to leave within a week and will have nowhere to stay. He has alcoholism and opioid use disorder, and he's showing early signs of diabetes. He sees his PCP only infrequently and doesn't have an established relationship with a substance use treatment provider. When Tom is hospitalized for opioid overdose, he often has to detox in the emergency department or*

	in an acute care hospital due to a shortage of detoxification programs for opioid addiction in his area. Upon release, he is often referred to substance abuse providers but frequently misses appointments due to a lack of transportation, and he does not have a case manager to ensure that he is adhering to his appointments and treatment. He has trouble finding employment and frequently relapses. Vignette #2: *Ashley is a 29-year-old woman living in a supportive housing unit with two children under the age of 5. She has schizophrenia and is currently pregnant with her third child. Her medications will need to be reduced during her pregnancy, potentially reducing their effectiveness. She currently sees a community mental health center but has also spent time in several other settings of care throughout her life, including nursing home institutions for mental disease and inpatient units. Ashley is not currently seeing an OB/GYN or PCP, and the negative symptoms of her schizophrenia have caused her to avoid seeking out care for her pregnancy. Furthermore, her behavioral health conditions often lead to missed appointments for her two children, as her symptoms prevent her from taking them to their appointments.*
5.2.2.2 Approach to addressing State objectives	Describe the Offeror's overall program approach and capabilities to address the State's objectives for the integration of behavioral and physical health, as laid out in the State's submitted 1115 Waiver (Appendix III). As a part of the answer, describe: • How the Offeror will work with the types of providers who are expected to serve as integrated health homes (Appendix V contains details on the State's current vision for an IHH program); and • How the Offeror will ensure that the program effectively serves all Illinois Medicaid recipients, including higher- and lower-needs enrollees. Appendix IV contains tables listing the proposed Medicaid-covered services included in the draft 1115 Waiver for Illinois's behavioral health transformation strategy and the state plan amendments (SPAs) that have been submitted to support this transformation. Describe the Offeror's approach to collaborating with the State, as well as with providers or other entities that may also perform care coordination activities (such as integrated health homes) to: • Develop these services; and • Ensure appropriate access to and uptake of these services by Medicaid enrollees with behavioral and physical healthcare needs.
5.2.2.3 Experience	Describe the Offeror's experience providing behavioral healthcare and integrating it with physical healthcare in a Medicaid managed care program, including experience covering any of the waiver/SPA services included in Appendix IV. In the response, describe: • Any health homes, patient-centered medical homes, or relevant population health management programs on which the Offeror has partnered with states to deliver; • Particular successes that would translate to Illinois; • Specific roles and responsibilities of the organization versus those of the state government or other entities, including how the Offeror collaborated with state governments to develop a

	network and provider landscape for these services; • How the Offeror ensured appropriate access to and uptake of these services (providing detail on utilization patterns and trends where possible); • How the Offeror incorporated these services into the broader continuum of care delivered for behavioral and physical health; • Specific elements of the Offeror's past approach(es) that supported this integration (for example, network development, benefit design, provider management, care management, incentive mechanisms, payment policy and oversight); • Specific health Information Technology (IT) systems and capabilities the Offeror developed as part of its management of relevant population health management program; • How the Offeror used health IT to manage different levels of enrollee need across the broad population (for example, design and implementation of – or implementation of State-designed – enrollee attribution algorithms or enrollee stratification approaches for tiering purposes); and • Custom tools developed to assist providers in these programs, such as provider reports, provider portals and care coordination tools. Describe the periodicity of reporting and the specific data elements shared with providers through these tools.

5.2.3 Information technology

This Section requires the Offeror to describe how its IT system will support the administration of this program and meet the needs of enrollees, providers, and the State of Illinois.	
Page limit: 40	Maximum number of points: 70
Prompts	
5.2.3.1 Systems & data exchange	Provide a general systems description with diagrams that illustrate how the Offeror's IT systems will be organized and will interact with the Department's Medicaid IT systems. Ensure that the diagrams and descriptions demonstrate: • The full scope of information in the system and any planned upgrades; • Point-to-point interfaces, information flows, internal controls, and networking arrangement; • How medical data are transmitted and stored internally, including technology to ensure access to medical record and controls to ensure confidentiality in compliance with HIPAA requirements; • How identical or closely related data elements in different systems are named, formatted, and maintained;

	• All exchanges of data among key productions systems; • How each data exchange is triggered, including whether it is a manually initiated process or an automated process; • The frequency/periodicity of each data exchange, including whether it is real-time or periodically triggered by a system (specify that period); • How the systems will share data with providers through secure and HIPAA-compliant connections; • How the systems will share and exchange data with the Department's Medicaid IT systems, including claims, MLR, encounter, and utilization data; • How the systems will share and exchange data with the IT systems of other State agencies (e.g., DCFS child-information systems); and • How the Offeror will coordinate with the Department to ensure daily enrollments and disenrollments are monitored, as well as how this will trigger activity to engage new enrollees.
5.2.3.2 Care management IT	Describe the care management technology system used by the Offeror's organization. Describe how this system will generate a comprehensive view of the enrollee, the enrollee's history, and the enrollee's needs. Address specifically: • Which systems and sources of data the Offeror will pull from to generate this comprehensive view; • How frequently each source of data will be updated; • How this view of the enrollee will be used to coordinate care and facilitate communication among the Offeror, providers, enrollees, and care managers; • How the Offeror will share data with other health plans' systems in the case of enrollee transfer, especially enrollees with moderate or high needs; • How the Offeror will participate in the State's initiative to implement an admission, transfer, and discharge (ADT) system, including its willingness to maintain, improve, and ensure sustainability of the system into the future and any experience the Offeror has utilizing ADT messaging technology to enhance care coordination and improve outcomes in states; and • How the Offeror will promote the use of health information exchange (HIE) in Illinois.
5.2.3.3 Data submission & reporting	Describe how the Offeror will submit high quality claims data to the Department. Highlight specifically: • What the Offeror's encounter data submission experience has been in other states, including (for Illinois or any other state in which the Offeror currently operates a similar

	program) what percent of its total financial medical claim spend the Offeror has been able to successfully submit as encounters for the most recent program year available; • The dedicated encounter data team the Offeror will put in place in Illinois, including the skills or credentials of that team, and the leadership that will be accountable for their performance; and • How the Offeror's approach to submission of encounter data will ensure alignment with all related CMS requirements and policy guidance (regulation) for managed care, including (but not limited to) the Medicaid and CHIP Managed Care Final Rule published in April 25, 2016. Describe the Offeror's reporting capabilities, including generation of reports: • As prescribed in the Contract (see Appendix I Section 5.28 and Attachment XIII); • Upon request of the Department; and • From the Offeror's systems by authorized Department staff in a static, secure, updated, and compartmentalized environment.
5.2.3.4 Implementation	Describe the Offeror's approach to demonstrating the readiness of its information systems to the Department prior to the start date of operations. At a minimum, the description must address and describe associated business rules for: • Provider Contract loads; • Eligibility/enrollment data loads; • Claims processing and adjudication logic; and • Encounter generation and validation prior to submission to the Department. Describe how the Offeror will ensure continuity of expertise and experience within its dedicated IT teams and IT leadership from the implementation period into the ongoing administration of the program.

5.2.4 High-needs children

This Section requires the Offeror to describe how it will collaborate with the State to serve high-needs children covered as a part of the Illinois Medicaid Managed Care Program. High-needs children include but are not limited to: SSI children, children who are blind or disabled, children who are in the care or were formerly in the care of DCFS, and other Medicaid enrollees under the age of 21 who are stratified as high-risk. The Offeror's response shall reflect an understanding of the requirements in both the High-Needs Children Minimum Standards of Care (Attachment XXII of the Model Contract, which is Appendix I to this RFP) and Care Coordination Expectations for DCFS Youth in Care (Appendix VI). The Offeror's response shall clearly indicate which elements of the response will apply only to DCFS Youth and which elements will apply to high-needs children more broadly (inclusive of DCFS Youth).

Page limit: 40	Maximum number of points: 50
Prompts	
5.2.4.1 Vignettes	Consider the below vignettes, which describe potential profiles of Medicaid enrollees in Illinois. Describe how the Offeror would address the needs of the enrollees reflected in the vignettes, including specific experiences the Offeror has had in successfully addressing these needs for enrollees in Illinois and other states. Provide an example care plan for each enrollee. *Vignette #3: Jane is a nine-year-old girl living in foster care who has been diagnosed with both attention deficit hyperactivity disorder (ADHD) and oppositional defiant disorder (ODD). She entered the DCFS system due to neglect and has repeatedly witnessed her father physically assault her mother. She receives outpatient treatment for her conditions and is assigned a social worker from the school system, but the social worker has numerous clients so her interaction is sporadic, with engagement only during times of stress. Moreover, her outpatient provider overuses expensive ADHD medications, and it is possible that many of her symptoms that present as ADHD and ODD could actually be trauma reactions that have been misdiagnosed and mistreated. Since her outpatient provider maintains limited hours, her foster family frequently brings her to the emergency department for mild behavioral health episodes. Furthermore, Jane's foster mother often misses her regular treatment and check-up appointments because she is concerned with the stigma associated with taking Jane to receive behavioral health treatment.* *Vignette #4: Connor is a 14-year-old boy who has severe aggression that has resulted in multiple psychiatric hospitalizations. Connor's inpatient stays often last longer than necessary and his school performance suffers due to suspensions and missed days from hospitalizations. Connor had been screened multiple times and has been linked to a community mental health center that offers medication management but few other mental health services. Connor's CMHC does not offer evidence-informed practices to address his aggression and prescribes adult anti-psychotic meds to control his behavior. Connor's inpatient psychiatrists do not effectively communicate with his family, his caseworker or his CMHC to optimize his care during his inpatient stays. During his most recent hospitalization, Connor's parents determined that they would not arrange for care upon Connor's discharge. Connor remained at the hospital until a residential placement was located and may remain in congregate care until he reaches 21. He maintains Medicaid eligibility but lacks the skills needed to find a job and housing.* *Vignette #5: Jerry is a two-year-old boy who is at risk of developing behavioral health conditions. He lives with his mother, who recently left her abusive husband and who has severe depression and substance abuse issues, which if not properly treated and controlled could threaten her ability to continuously provide the care that Jerry needs. Jerry has not yet received any screening, prevention, or treatment services related to his behavioral health and does not have an existing pediatric or primary care relationship.*
5.2.4.2 Experience	Describe the Offeror's experience and capabilities to manage care for high-needs children. In particular, highlight how the Offeror has:

	• Engaged high-needs children who will be new to Medicaid managed care; • Engaged and supported families of high-needs children and other caregivers, to unburden and empower them in coordinating and ensuring children receive the care they need; and • Overcome any anticipated challenges in implementation informed by the Offeror's experience implementing other programs for similar populations.
5.2.4.3 Behavioral health	Describe how the Offeror will ensure adequate and timely (within contracted timeframes) evaluation, screening, and interventions for enrollees with behavioral health conditions. Address specifically how the Offeror will: • Ensure access to evidence-informed behavioral health services to address enrollees' identified conditions; • Employ a process for medication review and metabolic screening when an enrollee is prescribed a psychotropic medication, including who will be involved in this process at the provider and MCO levels; • Ensure that children who are on psychotropic medications are receiving the appropriate dosage with the appropriate frequency for their age; • Apply evidence-based practices such as metabolic screening to avoid over- or under-utilization or misuse of medications; and • Incorporate trauma-informed care (TIC) in the Offeror's approach, including by determining the impact of trauma on an enrollee, and the best course of treatment to address its impact and the resulting conditions; and providing interventions to develop resilience in enrollees who have experienced trauma.
5.2.4.4 Coordination of services and transitions	Describe how the Offeror will coordinate with State agencies, stakeholders (for example, caseworkers, court personnel, behavioral health providers, foster parents, birthparents), and among the Offeror's staff to coordinate care for high-needs children. Address specifically how the Offeror will: • Integrate medical and social models of care; • Ensure that children receive all services required under Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) regulations; • Include individuals and family members using a Wraparound Model; • Provide assistance in navigating the child-serving service environment; • Account for cultural norms and family background; • Facilitate development of a plan of care of each enrollee with that enrollee's child and family team;

	• Ensure that the plan of care developed for DCFS Youth in Care is consistent and supportive of the Permanency Goal in the Service Plan; • Assure timely and effective transfer of information to identify and overcome barriers (for example, tracking referrals and outcomes); • Ensure that enrollee information is available in a timely manner for PCPs, specialists, behavioral health providers, caseworkers, and caregivers; and • Ensure that the exchange of personal health information (PHI) is conducted in a HIPAA-compliant manner. Describe how the Offeror will support transitions from one setting of care to another or from another plan onto its plan, including how the Offeror will: • Ensure access and adherence to care, especially by expediting authorization for immediate access to medications, supplies, and services; and • Assist young adults who are transitioning from foster care to independence, ensuring support in seeking physical and behavioral health services.
5.2.4.5 Training	Describe how the Offeror will develop an ongoing training program to ensure that MCO staff and contracted providers, including hospitals, pharmacies, and specialty providers, receive thorough training on this program. Address specifically how the Offeror will: • Educate the abovementioned groups on what does and does not constitute an allowable exchange of information in a HIPAA-compliant organization; • Ensure that contracted providers are aware of the requirements of the managed care program for foster children and adoption support, as well as the trainings that the Offeror will offer to its provider network regarding TIC; and • Reach out to current foster children and former foster youth in the 18- to 26-year-old age group to educate them about the benefits available to them in managed care. For each of the meetings and training programs described, indicate the frequency with which they will be held and describe how the Offeror will evaluate the success of these trainings.

5.2.5 Long-term services and supports

This Section requires the Offeror to describe how the Offeror will collaborate with the State to meet its objectives to improve the outcomes, satisfaction with Medicaid managed care services, and overall quality of life for its enrollees receiving long-term services and supports (LTSS). The State of Illinois is committed to expanding access to and utilization of HCBS, especially as a component of rebalancing the LTSS system between HCBS and institutional care, to maximize opportunities for community living, community integration, and employment. It seeks to improve care coordination for LTSS enrollees, especially through the integration of LTSS with physical and behavioral health and

social/functional needs.	
Page limit: 30	Maximum number of points: 50
Prompts	
5.2.5.1 Vignette	Consider the below vignette, which describes potential profile of a Medicaid enrollee in Illinois. Describe how the Offeror would address the needs of the enrollee reflected in the vignette, including specific experiences the Offeror has had in successfully addressing these needs for enrollees in Illinois and other states. Provide an example care plan for the enrollee. *Vignette #6: Cynthia is a 79-year-old, dual-eligible enrollee who lives with her adult son, who is her primary caregiver. She suffers from anxiety, depression, obesity, and heart failure. She is nonambulatory, and most caregivers are unable to transfer Cynthia to a chair due to her weight and the fact that her bedroom is too small to use a Hoyer lift. She uses a Foley catheter and has been admitted to the hospital several times over the past six months for cardiac arrhythmia and urinary tract infections. Each time, she has to be transported by a nonemergency ambulance on a stretcher because of her medical equipment and size. This transportation cannot always be found in her local area. Cynthia is authorized for up to 16 hours per day of skilled nursing care, but capable nurses are not always available in her area. While Cynthia's son is trained in providing home care, he is often at odds with her home nursing agency because he wants the nurses to provide care that is either not ordered by her physician or is contrary to her physician's orders. He does not believe his mother needs to take her antidepressants, and when the nurses are not around he does not administer this medication. Cynthia's irregular antidepressant usage further exacerbates her physical health conditions. While Cynthia's son wants to keep her at home for as long as possible, there is often frustration on the part of both son and nursing agency in safely meeting her needs within the community.*
5.2.5.2 Approach to addressing State objectives	Describe the Offeror's approach and capabilities to collaborate with the State to meet its objectives to improve the outcomes, satisfaction with Medicaid managed care services, and overall quality of life for its enrollees receiving LTSS by: expanding access to and utilization of HCBS, especially as a component of rebalancing the LTSS system between HCBS and institutional care, to maximize opportunities for community living, community integration, and employment; and improving care coordination for LTSS enrollees, especially through the integration of LTSS with physical and behavioral health and social/functional needs.
5.2.5.3 Experience	Describe the Offeror's previous or ongoing experiences serving LTSS enrollees in Illinois and other states, focusing on how the Offeror's experience and achievements align with State's objectives for the LTSS program outlined in Section 5.2.5 above and supporting this emphasis and these achievements with data evidence. • Address specifically any rebalancing strategies the Offeror has employed in Illinois or other state programs, provide data on the results achieved through these strategies, and explain how the Offeror will apply, adapt, and improve these strategies in Illinois.

5.2.5.4 Care coordination and transitions	Describe the Offeror's approach to care coordination for LTSS enrollees, including how the Offeror will: • Integrate the medical and social models of care; • Ensure individual choice and rights; • Include individuals and family members using a person-centered model; • Provide assistance in navigating the service environment; and • Assure timely and effective transfer of information to identify and overcome barriers (for example, tracking referrals, transitions, and outcomes). Describe how the Offeror will support seamless transitions between treatment settings, including how the Offeror will: • Identify enrollees who are good candidates for transition to a lower- or higher-acuity setting of care; • Ensure that enrollee will is respected, with specific measures; and • Ensure that enrollee safety is preserved, with specific measures.

5.2.6 Payment reform and value-based payment

This Section requires the Offeror to describe how it will design and execute value-based payment (VBP) and payment innovation within Illinois's managed care program, across its populations and services.	
Page limit: 30	Maximum number of points: 50
Prompts	
5.2.6.1 Design and execution	In the design and execution of value-based payment (VBP) and payment innovation within Illinois managed care program, address specifically how the Offeror will conduct: • Objective setting, strategy, payment model design; • Provider outreach, adoption, and readiness; • Selection of measurement methodologies to complement the approach; • Collection and processing of quality and other performance data from providers; • Timely execution of provider payments; and • The role of the Offeror's organization and the role of the Department (and other stakeholders) in each of the preceding activities.

5.2.6.2 Experience	Describe the Offeror's current use of VBP within its provider network by provider type and by line of business. In the response: • Define what types of arrangements that the Offeror's program considers to be VBP; • Identify the percentage of total medical expenses the Offeror paid as VBP payments for the 2016 calendar year (outline the Offeror's methodology for calculating this percentage and break out the contributions to this percentage of each type of value-based arrangement the Offeror employs); and • Provide examples in Illinois and other states in which the Offeror has implemented VBP approaches, including the results the Offeror achieved and how the Offeror will drive similar results for Illinois.
5.2.6.3 Implementation	Describe, based on the Offeror's relevant experience in Illinois and other states, what percentage of payments to providers the Offeror will commit to conducting as VBP in the first, second, and third years of the Contract. In the response: • Define what types of arrangements the Offeror's program considers to be VBP; • Outline the Offeror's methodology for calculating this percentage and break out the contributions to this percentage of each type of value-based arrangement the Offeror intends to employ; and • Discuss the circumstances or conditions that might support higher or accelerated commitments—or that conversely may impede the achievement of these goals. Describe the impact the Offeror anticipates on provider network requirements, access standards for care, behavioral health integration with primary care, and health promotion as a result of a shift to VBP. Address specifically: • How the Offeror has dealt with these types of impact in the past, how the Offeror adjusted its approach to strengthen the results of VBP, and how the Offeror plans on approaching this for Illinois; and • How the Offeror will report to the Department on the adoption of innovative payment models over time and which metrics the Offeror will use.

5.2.7 Care management and utilization management

This Section requires the Offeror to describe its organization's approach and capabilities to perform comprehensive care management activities appropriate to the needs of all populations covered in the scope of this RFP. Consider in the response the requirements of the Model Contract (RFP Appendix I) regarding adherence to the Department's Preferred Drug List (PDL) for pharmacy formulary management.	
Page limit: 30	Maximum number of points: 40

Prompts	
5.2.7.1 Intake and engagement	Describe how the Offeror will conduct initial health screenings and comprehensive risk assessments, including: • Criteria the Offeror will use to determine whether a comprehensive risk assessment is necessary; • Tools the Offeror proposes to use, highlighting any elements that differentiate the Offeror's tools from those of other Offerors; and • Timeframes in which the Offeror proposes to complete these activities. Describe how the Offeror will stratify enrollees by risk, including: • How the Offeror will use predictive modeling; and • How the Offeror will ensure that past claims data and other sources of data for new enrollees feed into risk stratification. Describe by what means the Offeror will engage enrollees who cannot easily be contacted by traditional means, such as by telephone or by mail, including how the Offeror will: • Work directly with community organizations or State agencies who are also seeking to engage the enrollee (if possible, specify which organizations/agencies); and • Employ incentives to create value for the enrollee and activate enrollee engagement.
5.2.7.2 Care plan development and monitoring	Describe how the Offeror will develop care plans with enrollees and ensure that: • The process is individualized and person-centered; • The enrollee and the enrollee's family, advocates, caregivers, and/or legal guardians are actively involved in both development of the care plan and initial screening and assessment; and • The resulting care plan can be understood and followed by the enrollee. Describe any additional populations or enrollees for which the Offeror will require a care plan, which have not already been required in the Model Contract (Appendix I), and any alternative tools the Offeror proposes to use for care management. Describe the Offeror's system to track, monitor, and remediate if the enrollee is not receiving the recommended care, including how the Offeror will: • Trigger reevaluation of enrollees; • Identify and address overutilization of emergency services; and • Change enrollee behavior.

	Describe how the Offeror will engage inpatient providers on post-discharge planning and ensure that enrollees receive the services they need beginning immediately upon discharge, including how the Offeror will: • Make exceptions to the standard prior authorization approval schedule to accommodate these cases; and • Monitor and analyze patient data related to length of stay and inpatient readmissions. Provide cases of strategies of care plan development, monitoring, or discharge planning employed and data on outcomes achieved in Illinois and in other states, if possible.
5.2.7.3 Utilization management	Describe the Offeror's organization's approach to utilization management. Describe how the Offeror's approach to utilization management (UM) differentiates the Offeror, including any proposed elements that go beyond traditional UM activities. Consider in the response the requirements of the Model Contract (RFP Appendix I) regarding adherence to the Department's Preferred Drug List (PDL). Highlight the Offeror's specific approaches to the following covered services: • Physical health; • Behavioral health; • Inpatient stays, including how the Offeror will support and amplify the State's policy to reduce potentially preventable readmissions (PPRs); • Pharmacy; • HCBS; and • Skilled nursing facilities. Describe the Offeror's prior authorization process, including how the Offeror will ensure that it is automated and intuitive for providers to submit electronically. Address specifically the Offeror's willingness to commit to a shorter standard or expedited timeline than required in the Model Contract (Appendix I). Identify whether the Offeror will delegate any utilization management functions to a subcontractor. If any functions will be delegated, describe how the Offeror will: • Monitor performance of the subcontractor for compliance with the Contract; and • Integrate the subcontractor's performance data with the Offeror's own data for performance management.

5.2.8 Provider requirements

This Section requires the Offeror to describe how its organization will develop a provider network, work with providers over time, and ensure adequate access to necessary services by all covered populations, meeting the requirements of the Model Contract (Appendix I).	
Page limit: 30	Maximum number of points: 40
Prompts	
5.2.8.1 Provider recruitment and network adequacy	Describe the approach the Offeror has taken to building the provider network submitted in response to Proposal Requirements Section 4.2.6, including a discussion of: • How this network ensures adequate provision of covered services across all geographic areas included in scope of the Offeror's selected Proposal Option (Section 2.6); • The network's current level of compliance with the network adequacy standards set forth in the Model Contract (Appendix I); and • Any current gaps in the network and the Offeror's plan to address them in building a robust provider network prior to the effective date of the Contract in the event of award. Describe how the Offeror will continually recruit providers and scale to build its network over time, including how the Offeror will: • Attract, evaluate, and contract with providers in both urban and rural areas; and • Work with provider associations. Describe how the Offeror will monitor its provider network to ensure ongoing compliance with the network adequacy standards set forth in the Model Contract (Appendix I). Highlight specifically the Offeror's approaches to: • Cadence and staffing model for conducting outreach to providers; • Specific approaches to PCPs, OB/GYN, behavioral health specialists, orthopedists, pain specialists, other specialists, nursing facilities, and HCBS providers; and • Rural areas, with an emphasis on how the Offeror will engage federally qualified health center (FQHCs) and rural health centers. Describe how the Offeror will proactively report to the Department and its quality monitoring organization on the status of its network. Provide a typical example of the Offeror's approach from prior experience. Address in the description and example how the Offeror will: • Share data with the Department's quality monitoring organization to certify the adequacy of the Offeror's network; • Notify the Department of any provider termination that impacts 100 or more enrollees; • Notify the Department of any provider termination or other event that results in

	noncompliance with the network adequacy standards set forth in the Model Contract (Appendix I); • Manage disruption for enrollees and ensure a swift return to compliance; and • Ensure compliance with all related CMS requirements and policy guidance (regulation) for managed care, including (but not limited to) the Medicaid and CHIP Managed Care Final Rule published in April 25, 2016.
5.2.8.2 Provider relations, education, and management	Describe how the Offeror will conduct provider relations and provider education, both at the time of initial contracting and on an ongoing basis. Describe specifically: • How the Offeror will collaborate with providers to ensure the Offeror has an updated and accurate provider directory; • How the Offeror will ensure providers understand billing requirements and its prior authorization program and policies, as well as how the Offeror will be responsive to ongoing issues with claims; and • How the Offeror will ensure that it will have dedicated staff with billing experience who provide billing education to providers. Describe how the Offeror will manage and collaborate with providers to improve outcomes and experiences for enrollees. Describe how clinical data received will be used to: • Assess care being provided and manage providers; • Implement evidence-based best practices; and • Conduct care coordination.

5.2.9 Operations

This Section requires the Offeror to describe its organization's approach to the operational requirements of the program.	
Page limit: 20	Maximum number of points: 20
Prompts	
5.2.9.1 Enrollee services	Describe how the Offeror will use its enrollee services to enhance quality and improve outcomes. Discuss specifically any proposed: • Enrollee Web portals for self-service, including what functions they will serve and how the Offeror will ensure ease of use by enrollees; and • Enrollee mobile applications for self-service, including what functionality they will have relative to the Web portal and how the Offeror will encourage use by enrollees.

	Describe how the Offeror will communicate with enrollees, including for care management, in a culturally appropriate and language-appropriate manner. Address specifically how the Offeror will: • Identify enrollees who require contact in a different language or format; and • Ensure that contact is initiated and maintained in this format.
5.2.9.2 Grievances and appeals	Describe how the Offeror will conduct its grievances and appeals processes. Highlight specifically how the Offeror will: • Implement and maintain the appropriate systems and personnel to ensure timely resolution timeframes, as per requirements in the Model Contract (Appendix I).
5.2.9.3 Program integrity	Describe the Offeror's approach to program integrity, including its organization-wide experience, capabilities, and plan to bring its solutions to Illinois. Highlight specifically how the Offeror will: • Manage third-party liability in provider billing; • Avoid fraud, waste, and abuse, including how the Offeror's internal controls will ensure payments are made properly and how the Offeror will verify whether services reimbursed were actually rendered to enrollees as billed; • Detect fraud, waste, and abuse, including by monitoring provider utilization practices and identifying those outside the norm; • Report suspected fraud, waste, and abuse to the State; and • Educate employees, providers, and enrollees on fraud, waste, and abuse.
5.2.9.4 Staff and training	Describe the Offeror's staffing model and training capabilities, including how the Offeror will: • Avoid employee turnover; • Onboard new employees on an ongoing basis; and • Hire enrollee-facing staff who have lived experience that reflects the lived experience of the enrollees they serve.

6 FINANCIAL PROPOSAL REQUIREMENTS

This Section identifies the requirements for the Financial Proposal, where Offerors are required to submit bids for rates within predefined, actuarially sound rate ranges.

6.1 Purpose and overall guidance to the Offeror

6.1.1 The Financial Proposal shall indicate the reimbursement rate at which the Offeror's organization

can fulfill the obligations for the entire scope of service, including all services defined in this RFP and the Model Contract (Appendix I) for the one (1) year period beginning January 1, 2018.

6.1.2 All monetary amounts shall be in US currency and limited to two (2) places to the right of the decimal point.

6.1.3 The Financial Proposal shall remain valid for 180 days subsequent to the date of the Financial Proposal opening and thereafter in accordance with any Contract resulting from this RFP.

6.2 Rate-setting

6.2.1 The State of Illinois shall establish rate ranges based on the methodology that has been used historically used by the State and approved by Federal CMS. The rate ranges that will be provided will be based on the Data Book. The State is prepared to actuarially certify any rate for any rate cell for any Contract award that is within the published actuarial range.

6.2.2 A rate range will be developed for each population, each region (as indicated in Exhibit 3) and each rate cell. Prospective Offerors will be provided with estimated enrollee months for each rate cell. For each rate cell, a midpoint capitation rate will be established based on the average of the low and high capitation rate. Enrollees will be classified into one of the following populations:

6.2.2.1 Non-disabled children and adults;

6.2.2.2 Disabled children;

6.2.2.3 Disabled adults;

6.2.2.4 Affordable Care Act expansion adults;

6.2.2.5 Managed long-term services and supports; and

6.2.2.6 DCFS Youth.

6.2.3 A composite rate range will be calculated for each population based on the underlying regions, rate cell rate ranges and estimated member months. Two (2), separate sets of composite rate ranges will be developed in alignment with the two Proposal Options described in Section 2.6. One (1) set of composite rate ranges will be for Offerors selecting Proposal Option A (statewide), and one (1) set of composite rate ranges will be for Offerors selecting Proposal Option B (Cook County).

6.2.4 The DCFS Youth in Care population will not be included in the scoring of the Financial Proposal. If the Offeror is awarded the separate Contract for this population, the Offeror will be paid at the bid rate provided for this population in the Offeror's Financial Proposal.

6.2.5 For a description of the methodology used in setting rates, as well as details on rate adjustments, incentive payments, withholds, and other payment terms and conditions, see Article VII: Payment Terms and Conditions of the Model Contract (Appendix I).

6.3 Development

6.3.1 Offerors shall review the Data Book (forthcoming RFP Appendix VII) and submit a bid for each population between the low and high rate ranges.

6.3.2 In 2018, for each rate cell within a population, Offeror will be paid based on its bid relative to the composite rate range for that population. For example, if the rate range for the Affordable Care Act expansion adult population was set between $291 and to $314 and the Offeror bid $299, the Offeror would be paid at the 35th percentile for each rate cell within that population. The below illustrative example shows the development of the Offeror-specific rate by rate cell.

Exhibit 4: Illustrative example – Offeror rate calculation

[Population]	Member Months	Low Rate	High Rate	Midpoint Rate		Offeror Bid
Composite rate range	**1,450,000**	**$291.00**	**$314.00**	**$302.50**		**$299.00**
			Offeror Bid Percentile:			**35%**
[Population] Rate Cells	**Member Months**	**Low Rate**	**High Rate**	**Midpoint Rate**		**Offeror Rate**
A	500,000	$190.00	$212.60	$201.30		$197.86
B	250,000	225.00	240.00	232.50		230.22
C	300,000	325.00	350.00	337.50		333.70
D	400,000	433.00	460.00	446.50		442.39

6.3.3 These per-member, per-month rates shall be multiplied by the projected member months to yield anticipated managed care spending for the entirety of the region covered by the selected Proposal Option (Section 2.6).

6.3.4 A minimum and maximum projected amount of spending for each region is determined by multiplying the Data Book's minimum and maximum rate values by the projected annual member months for the specified region.

6.4 Submission

6.4.1 The Financial Proposal must be submitted using the Financial Proposal Template (Form for Submission VI), which will be provided as an appendix to this RFP at the time of the release of the Data Book, and which will provide composite rate ranges.

6.4.2 The Financial Proposal shall be signed, in the space on Form for Submission VI, by an individual empowered to bind the Offeror to the agreed-upon rates, to the provisions of this RFP, and to any

Contract awarded pursuant to it.

6.4.3 Documentation must be attached to evidence the signing individual's authority to legally bind the Offeror accordingly.

6.5 Scoring

6.5.1 The score for the Financial Proposal will be determined by comparing the result of the Offeror's Proposal for each population (excluding DCFS Youth) and the resulting projected managed care spending to the Data Book's minimum and maximum projections. Comparisons will be calculated as described below.

6.5.2 Each Offeror's Financial Proposal score will be expressed as the ratio of the MCO Offeror cost spread for the selected Proposal Option, divided by Data Book cost spreads for that Proposal Option, multiplied by 300 total possible points.

6.5.3 MCO Offeror cost spread is the difference between the product of the maximum composite rate range values and Data Book member months, and the product of the Offeror's composite bid values and the Data Book member months.

6.5.4 Data Book cost spread is the difference between the product of the maximum composite rate range values and the Data Book member months, and the product of the minimum composite rate range values and the Data Book member months.

6.5.5 If the Offeror bid for any population is below the minimum of the State's actuarial range or above the maximum of the State's actuarial range, the Offeror will receive zero (0) points for its entire Financial Proposal.

6.5.6 If the Offeror submits a Proposal with the minimum values of the composite rate ranges for all populations across the entire region specified by the selected Proposal Option, then the Offeror will receive the maximum 300 points for the cost Proposal.

6.5.7 If the Offeror submits a Proposal with the maximum values of the composite rate ranges for all populations, the Offeror will receive zero (0) points for the Financial Proposal

6.5.8 An illustration of the score calculation methodology is provided below.

The minimum composite projection for managed care spending for Proposal Option A per Department's actuaries = $1.97B

The maximum composite projection for managed care spending for Proposal Option A per Department's actuaries = $2.03B

The Offeror's composite projection for managed care spending for Proposal Option A per the Offeror's Financial Proposal = $2.0B

The State's Data Book cost spread = $2.03B – $1.97B = $0.06B

The MCO Offeror cost spread = $2.03B - $2.0B = $0.03B

The MCO Offeror cost spread / Data Book cost spread = $0.03B / $0.06B = 0.5

The Offeror's point total for the Financial Proposal = 0.5*300 = 150 points

6.6 Adjustments and resetting

6.6.1 To the extent emerging data, policy or program changes, legislative changes, or other factors impact the underlying costs of the managed care populations that will be covered in 2018 at any time following the Proposal submission deadline provided in Section 1.3, the State's actuarial firm may adjust the published rate range values.

6.6.2 To the extent this occurs, the midpoint rate (the average of the low and high rate) will be adjusted for each rate cell by the State's actuarial firm. The Offeror will receive for each rate cell its original rate, adjusted by the percentage change in the midpoint rate. The below exhibit illustrates this calculation.

Exhibit 5: Illustrative example – Adjusted 2018 Offeror rate calculation

Rate Cell	Offeror Member Months	Original Midpoint Rate	Adjusted Midpoint Rate	% Change in Midpoint Rate		Original Offeror Rate	Adjusted Offeror Rate
A	100,000	$201.30	$202.40	0.55%		$197.86	$198.94
B	50,000	232.50	231.43	-0.46%		230.22	229.16
C	75,000	337.50	345.33	2.32%		333.70	341.44
D	100,000	446.50	450.25	0.84%		442.39	446.11
Composite	**325,000**	**$312.98**	**$316.11**	1.00%		**$309.43**	**$312.52**

6.6.3 In subsequent calendar years, a midpoint rate will be calculated for each region and rate cell. The Offeror shall receive a capitation rate equivalent to the Offeror's prior year rate, multiplied by the percentage change in the midpoint rate relative to the current year. The below exhibit illustrates this calculation.

Exhibit 6: Illustrative example – 2019 Offeror rate calculation

Rate Cell	Member Months	2018 Midpoint Rate	2019 Midpoint Rate	% Change in Midpoint Rate		2018 Adjusted Offeror Rate	2019 Offeror Rate	Offeror Rate Change %
A	110,000	$202.40	$207.43	2.49%		$198.94	$203.89	2.49%
B	51,000	231.43	234.11	1.16%		229.16	231.81	1.16%
C	80,000	345.33	351.24	1.71%		341.44	347.28	1.71%
D	120,000	450.25	470.25	4.44%		446.11	465.92	4.44%
Composite	**361,000**	**$320.56**	**$330.43**	**3.08%**		**$316.95**	**$326.71**	**3.08%**

7 APPENDICES

I. Model Contract

II. Definitions, abbreviations and acronyms

III. Pending Behavioral Health Transformation 1115 Waiver

IV. List of additional Medicaid services covered under pending 1115 Waiver and SPAs

V. Vision for integrated health homes in Illinois

VI. Managed care program requirements for DCFS Youth

VII. Data Book

8 FORMS FOR SUBMISSION

I. Question submission template

Template posted as separate Microsoft Excel workbook.

II. Proposal to the State of Illinois

The undersigned authorized representative of the identified Offeror hereby submits this Offer to perform in full compliance with the subject solicitation. By completing and signing this Form, the Offeror makes an Offer to the State of Illinois that the State may accept.

Offeror shall use this Form as a final check to ensure that all required documents are completed and included with the Offer. Offeror shall mark each blank below as appropriate. Offeror understands that failure to meet all requirements is cause for disqualification.

GENERAL REQUIREMENTS

SOLICITATION AND CONTRACT REVIEW: Offeror reviewed the Request for Proposal, including all referenced documents and instructions, completed all blanks, provided all required information, and demonstrated how it will meet the requirements of the State of Illinois.

☐ Yes ☐ No

APPENDICES AND FORMS FOR SUBMISSION: Offeror acknowledges receipt of any and all appendices and forms for submission to the solicitation and has taken those into account in making this Offer.

☐ Yes ☐ No

OFFEROR CONFERENCE: Offeror attended the mandatory Offeror's Conference (Round 1) and signed in as required.

☐ Yes ☐ No

OFFER SUBMISSION: Offeror is submitting the correct number of copies, in a properly labeled containers, to the correct location, and by the due date and time.

☐ Yes ☐ No

REQUEST FOR CONFIDENTIAL TREATMENT: Offeror is submitting a request for confidential treatment and has submitted its redacted Proposal as specified.

☐ Yes ☐ No

PROPOSAL OPTION SELECTION: Offeror is submitting its Proposal for which Proposal Option:

☐ Proposal Option A ☐ Proposal Option B

If selecting Proposal Option B, Offeror has submitted attestation of its status as a Government-owned organization or a Minority-owned organization, as defined in Appendix II of this RFP, in its response to the Offeror Profile requirements as outlined in Section 4.2.

☐ Yes ☐ No

TAB 1: TRANSMITTAL LETTER, PROPOSAL TO THE STATE OF ILLINOIS, AND PROPOSAL SECURITY

TRANSMITTAL LETTER: Offeror is submitting a transmittal letter as specified in this RFP

☐ Yes ☐ No

PROPOSAL TO THE STATE OF ILLINOIS: Offeror is submitting this completed form as specified in this RFP.

☐ Yes ☐ No

PROPOSAL SECURITY: Offeror is submitting its Bid Bond as specified in this RFP

☐ Yes ☐ No

TAB 2: PROPOSAL REQUIREMENTS

FINANCIAL CONDITION: Offeror is submitting its Financial Condition as specified in this RFP.

☐ Yes ☐ No

OFFEROR PROFILE: Offeror is submitting its Offeror Profile as specified in this RFP, including each of the following components:

4.2.2	Organization profile and background	☐ Yes ☐ No
4.2.3	Offeror experience	☐ Yes ☐ No
4.2.4	List of individuals in an administrative capacity	☐ Yes ☐ No
4.2.5	References (See Form for Submission V)	☐ Yes ☐ No
4.2.6	Provider network (Excel format)	☐ Yes ☐ No

TAB 3: TECHNICAL PROPOSAL

TECHNICAL PROPOSAL: Offeror is submitting its responses to the Technical Requirements Section as specified in this RFP.

☐ Yes ☐ No

TAB 4: RFP FORMS FOR SUBMISSION

STATE BOARD OF ELECTIONS REGISTRATION CERTIFICATE: Offeror is submitting its Registration Certificate as specified in this RFP.

☐ Yes ☐ No

FORMS A or FORMS B: Offeror is properly submitting either Forms A or Forms B, but not both.

☐ Yes ☐ No

FORMS A

11.1	Business and Directory Information	☐ Yes ☐ No
11.2	Illinois Department of Human Rights Public Contracts Number	☐ Yes ☐ No
11.3	Standard Certifications	☐ Yes ☐ No
11.4	Disclosure of Business Operations in Iran	☐ Yes ☐ No
11.5	Financial Disclosures and Conflicts of Interest	☐ Yes ☐ No
11.6	Taxpayer Identification Number	☐ Yes ☐ No

FORMS B

12.1	Illinois Procurement Gateway Registration # with expiration date	☐ Yes ☐ No
12.2	Certifications Timely to this Solicitation	☐ Yes ☐ No
12.3	Disclosures of Lobbyists and Pending Contracts	☐ Yes ☐ No

BEP UTILIZATION PLAN: Offeror is submitting its Minorities, Females, Persons with Disabilities Participation and Utilization Plan(s) as specified in this RFP. ☐ Yes ☐ No

SUBCONTRACTOR DISCLOSURES: Offeror is submitting its Subcontractor Disclosures as specified in this RFP (See Form for Submission III).

☐ Yes ☐ No

AGREEMENT WITH THE MODEL CONTRACT: Offeror is submitting its agreement to the terms of the Model Contract and noting any exceptions taken with a full explanation, as specified in this RFP (See Form for Submission IV).

☐ Yes ☐ No

TAB 5: FINANCIAL PROPOSAL

FINANCIAL PROPOSAL: Offeror is submitting its Financial Proposal as specified in this RFP.

☐ Yes ☐ No

Signature of Authorized Representative: _____

Printed Name of Signatory: _____

Offeror Name: _____

Date: _____

III. Subcontractor disclosures

Will the Offeror utilize Subcontractors? ☐ Yes ☐ No

Will subcontractors be utilized for care management services? ☐ Yes ☐ No

Will subcontractors be utilized for care coordination services? ☐ Yes ☐ No

Will subcontractors be utilized for behavioral health services? ☐ Yes ☐ No

Will subcontractors be utilized for other services? ☐ Yes ☐ No

A Subcontractor is a person or entity, other than a Network Provider, that enters into a contractual agreement with a person or entity who has a contract with the State of Illinois pursuant to which the person or entity provides some or all of the goods, services, real property, remuneration, or other monetary forms of consideration that are the subject of the primary State contract, including subleases from a lessee of a State contract. The full definition of a Subcontractor is available in Appendix II.

The maximum percentage of the goods or services that are the subject of this Offer and the resulting contract that may be subcontracted is 20% unless otherwise approved by the Department. All contracts with Subcontractors must include Standard Certifications completed and signed by the Subcontractor.

Identify below subcontracts with an annual value of $50,000 or more that will be utilized in the performance of the contract, the names and addresses of the Subcontractors, and a description of the work to be performed by each.

1. Subcontractor Name: _____

Anticipated/Estimated Amount to Be Paid: _____

Address: _____

Description of Work: _____

2. Subcontractor Name: _____

Anticipated/Estimated Amount to Be Paid: _____

Address: _____

Description of Work: _____

If additional space is necessary to provide Subcontractor information, please use an additional page.

For the Subcontractors identified above, the Offeror must provide each Subcontractor's Financial Disclosures and Conflicts of Interest to the State. If the Subcontractor is registered in the Illinois Procurement Gateway (IPG) and the Offeror is using the Subcontractor's Standard Certifications or Financial Disclosures and Conflicts of Interest from the IPG, then the Offeror must also provide a completed Forms B for the Subcontractor.

By: _____

Signed: _____

Position: _____

Offeror Name: _____

Date: _____

IV. Confirmation of agreement with the Model Contract

The Department discourages taking exceptions. State law shall not be circumvented by the exception process. Exceptions may result in rejection of the Offer.
The Offeror agrees with the terms and conditions set forth in the State of Illinois Request for Proposal (Reference Number: 2018-24-001), including the standard terms and conditions, Department supplemental provisions, certifications, and disclosures, with the following exceptions:

	Excluding certifications required by statute to be made by the Offeror, both Parties agree that all of the duties and obligations that the Offeror owes to the Department for the work performed shall be pursuant to the solicitation, the resulting contract, and any exception(s) thereto that the Offeror sets forth in this Section if such exception(s) are accepted by the Department.
	EXCEPTIONS TO TERMS AND CONDITIONS
Section/ Subsection #	State the exception such as "add," "replace," and/or "delete."
	ADDITIONAL OFFEROR PROVISIONS
New Provision(s), # et. seq.	Section/Subsection New Number, Title of New Subsection: State the new additional term or condition.

If additional space is necessary to note exceptions or additional provisions, please use an additional page.

By: _____

Signed: _____

Position: _____

Offeror Name: _____

Date: _____

V. Reference Form

Provide references from established firms or government agencies other than the procuring agency that can attest to Offeror's experience and ability to perform the contract that is the subject of this solicitation.

1) Reference Firm/Government Agency/Organization (name): _____

Contact Person (name, email address, address, and phone): _____

_____

Date of Supplies/Services Provided: _____

Type of Supplies/Services Provided: _____

2) Reference Firm/Government Agency/Organization (name): _____

Contact Person (name, email address, address, and phone): _____

_____

Date of Supplies/Services Provided: _____

Type of Supplies/Services Provided: _____

3) Reference Firm/Government Agency/Organization (name): _____

Contact Person (name, email address, address, and phone): _____

_____

Date of Supplies/Services Provided: _____

Type of Supplies/Services Provided: _____

4) Reference Firm/Government Agency/Organization (name): _____

Contact Person (name, email address, address, and phone): _____

_____

Date of Supplies/Services Provided: _____

Type of Supplies/Services Provided: _____

5) Reference Firm/Government Agency/Organization (name): _____

Contact Person (name, email address, address, and phone): _____

_____

Date of Supplies/Services Provided: _____

Type of Supplies/Services Provided: _____

6) Reference Firm/Government Agency/Organization (name): _____

Contact Person (name, email address, address, and phone): _____

_____

Date of Supplies/Services Provided: _____

Type of Supplies/Services Provided: _____

By: _____

Signed: _____

Position: _____

Offeror Name: _____

Date: _____

VI. Financial Proposal Template

Template will be provided as a separate Microsoft Excel workbook at the time of Data Book release as specified in Section 1.3.