COOK COUNTY HEALTH (CCH)

REQUEST FOR PROPOSAL (RFP) NO. H26-25-081 FOR Care Management Services *and* Value-Based Care Programs

GENERAL DESCRIPTION: CCH Health Plan Services is requesting proposals for one or more provider-based partner(s) that are compliant with federal, state and the National Committee of Quality Assurance (NCQA) standards and provides value to members and the health plan overall by fully engaging members and providers with CountyCare's benefits, improving health and quality outcomes for members and advancing health equity overall through care management and value-based care programs. References to Cook County Health (CCH) should not be understood as an offer for services beyond CountyCare.

Date Issued: August 5, 2026

Pre-Proposal Conference / Field Inspection: None

Vendor Questions: Any questions regarding this RFP should be submitted via Bonfire.
Questions submission deadline: August 19, 2026 by 2p.m. Central Time (CT)

Proposal / Response Due Date:
Proposals are due no later than 2 p.m. CT on September 10, 2026

Proposal Must be Uploaded to:
https://cookcountyhealth.bonfirehub.com/portal/?tab=openOpportunities

LATE PROPOSALS WILL NOT BE CONSIDERED

COOK COUNTY HEALTH

Erik Mikaitis, MD, MBA	**Charles A. Jones**
Chief Executive Officer	**Chief Procurement Officer**

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1. Hospital System Background

1.1 Cook County Health

Cook County Health (CCH) provides a wide range of health care services and operates the John H. Stroger Jr. Hospital of Cook County, a tertiary acute care hospital, and Provident Hospital of Cook County, a community acute care hospital. CCH is also comprised of:

- More than a dozen community health centers offering primary and specialty care and diagnostic services,
- The Cook County Department of Public Health (CCDPH), a certified local public health department serving most of suburban Cook County,
- Cermak Health Services of Cook County, which provides health care services to the detainees in the Cook County Sheriff's Department of Corrections and to the residents of Cook County's Juvenile Temporary Detention Center,
- The Ruth M. Rothstein CORE Center, a comprehensive care center for patients with HIV and other infectious diseases, and
- CountyCare, the largest Medicaid managed care plan in Cook County and one of the largest in the northeast region of the state.

CCH's history and mission to care for all, regardless of their ability to pay, dates to 1835. Since then, CCH has cared for millions of people, trained thousands of doctors and conducted important research that has contributed to modern-day practices in hospitals. We have centers of excellence in trauma, burn and emergency care, oncology, endocrinology, infectious disease and other areas. We have long been the safety net to the safety net when it comes to caring for the uninsured, a mission that remains today.

CCH is one of the largest public health systems in the United States. As a provider of care, CCH sees approximately 300,000 unique patients annually through more than 1 million outpatient visits and more than 20,000 admissions, including 77,000 detainees at the Cook County Department of Corrections and residents of the Juvenile Temporary Detention Center. We are the largest provider of HIV care in the Midwest and one of the largest in the nation. On an average day, CCH fills 20 times as many outpatient prescriptions as the average commercial pharmacy. CCDPH is a state- and nationally certified public health authority serving the majority of suburban Cook County.

1.2 Health Plan Services

Health Plan Services (HPS) is a department within CCH that manages CountyCare, a Medicaid managed care plan serving Cook County. In 2013, CCH launched CountyCare as a demonstration project through the Centers for Medicare and Medicaid Services (CMS) 1115 Waiver granted to the State of Illinois' Medicaid agency to enroll eligible low-income Affordable Care Act (ACA) adults in Cook County into a Medicaid managed care program. In July 2014, CountyCare transitioned from the federal waiver authority and subsequently became a Medicaid managed care plan under the State's County Managed Care Community Network (2018 County MCCN) rules. This transition allowed CountyCare to expand beyond the newly eligible ACA adult population to include

traditional Medicaid populations in Family Health Plans (FHP), Managed Long-Term Services and Supports (MLTSS), Special Needs Children (SNC) and Integrated Care Program (ICP).

CountyCare receives a capitated per-member (enrollee), per-month (PMPM) rate for every enrollee in its health plan. CountyCare currently has over 386,000 Medicaid enrollees. The CountyCare provider network includes all CCH facilities, every Federally Qualified Health Center (FQHC) in Cook County and more than seventy hospitals. As it develops and grows, CountyCare continues to prioritize innovation, member experience and health equity while establishing itself as a pioneering, provider-led and governed health plan.

1.3 Health Plan Services' Value-Based Care Strategy

CountyCare is committed to advancing value-based care through collaborative partnerships that improve quality, access, equity, and health outcomes for Medicaid members. CountyCare's value-based care strategy is grounded in strong primary care partnerships. All contracted primary care and women's health providers are eligible to participate in pay-for-performance incentive programs aligned with State quality priorities, including health equity, maternal and child health, behavioral health, and community health promotion. Over time, CountyCare has expanded provider participation across increasingly advanced value-based payment arrangements, resulting in substantial growth in the proportion of members attributed to providers participating in shared savings, risk-based, and capitated payment models. CountyCare supports this progression through transparent performance reporting, operational collaboration, care management integration, and multi-year investments designed to strengthen provider capabilities and improve member outcomes.

In addition to its primary care strategy, CountyCare has developed a diverse portfolio of specialty-focused value-based initiatives that address key opportunities to improve care quality, coordination, access, and cost effectiveness across the continuum of care. These efforts have included programs focused on behavioral health transitions of care, specialty services, post-acute care, and condition-specific programs, among others. CountyCare continues to evaluate emerging opportunities to partner with providers on innovative payment and delivery models that align incentives around measurable improvements in member experience, quality, utilization, and total cost of care. As value-based care remains a central component of CountyCare's long-term strategy, the organization is committed to maintaining rigorous performance oversight, fostering meaningful provider collaboration, and ensuring accountability for results while supporting the sustainability of providers serving Medicaid and other historically underserved populations.

1.4 Health Plan Services' Care Management Model and Philosophy

The overarching goal of HPS' care management program is to support members in achieving an optimal level of wellness by maximizing use of Medicaid benefits with an emphasis on evidence-based care. HPS is committed to a member-centered approach that provides high-quality, coordinated service delivery.

The primary strategies of the care management program are to:

- Cultivate innovative care management entities, integrate with providers and embed care management within the medical home and clinical treatment team wherever possible

- Assign members to the most appropriate care team, which
    - Links individuals to primary care, other outpatient services and community resources that provide evidence-based care, improve health outcomes and reduce overall hospitalizations and readmissions
    - Closes gaps in preventive care and early detection of health conditions
    - Utilizes multi-level interventions and resources to decrease inequities related to the social determinants of health
- Ensure the population receives tiered and further individualized care management interventions by
    - Identification and prioritization of member engagement through data integration and universal health-risk screening
    - Person-centered member engagement, brief interventions and/or ongoing care planning with an integrated care team
    - Maximization of independence and community living by supporting the unique needs of members eligible for long-term services and supports, particularly through strong implementation of home and community-based waiver services (HCBS)

Equity is inherent in the missions of CCH and CountyCare Health Plan, and equity is now an explicit part of the quality strategy for the Illinois Department of Healthcare and Family Services (HFS). HFS defines equity as "providing every employee, individual, community or population what is needed to succeed, so everyone can reach their full potential by examining differences in outcomes for various populations and working to mitigate negative impacts." Achieving health equity requires active alignment with health care providers, among many other stakeholders within the diverse communities served by the Medicaid program.

CountyCare's philosophy is that care coordination and complex care management are most effective when provided close to clinicians and members in their communities. This requires partnerships, particularly with care providers, to deliver the best outcomes for members. A partnership model requires standardization in basic processes and flexibility to allow teams to be adaptable at the point of care.

By aligning care management with medical homes, CountyCare is uniquely positioned for clinical and financial effectiveness. CountyCare was awarded a five-star rating for members' satisfaction with plan services by the National Committee for Quality Assurance which demonstrates the effectiveness of the plan's provider-based, integrated care management approach. CountyCare also enthusiastically embraces HFS' future plans for health equity performance measurement, which segments quality data by age, race, gender and geography, utilizing zip codes that represent an increased risk of poor health outcomes (Disproportionately Impacted Areas [DIAs]). CountyCare's philosophy and model are designed to support measurable improvements in health equity in these target areas.

1.5 Approach

Delegated Care Management (Scope 1)

The foundation of managed care is the relationship between a primary care provider (PCP) and a patient within a medical home. All CountyCare PCPs/medical homes are expected to coordinate

health services for their patients. In addition, Medicaid managed care organizations (MCOs) have enhanced care coordination and care management programmatic requirements for all members, based on their levels of need. Therefore, building upon our philosophy, CountyCare delegates these responsibilities to provider organizations that demonstrate the ability to provide these services to their patients. We also recognize that provider organizations and non-provider organizations can partner together in shared models deployed at the point of care.

Organizations with the ability to offer care coordination and care management services at the point of care can create more meaningful, lasting and clinically impactful relationships with members than the MCO can on its own. This model is also more efficient and streamlined for the member who can work directly with their provider/care team, as opposed to having a separate relationship with an insurance care coordinator.

Delegates must hire adequate staff, ensure sufficient infrastructure and training in managed care and pass a readiness assessment (or pre-delegation) for each level of services. CountyCare delegates:

- Care coordination, which is the deliberate, evidence-based organization of patient care activities among multiple participants (including patients/families) to facilitate safer, more effective, and efficient care. It involves sharing information, proactive planning, and aligning patient needs with resources to ensure the right care is provided at the right time. This is often the first level of delegation to provider organizations. Skill needs range from community-based specialized skills and knowledge, potentially through clinical credentials or licensure.
- Care management, which is an evidence-based, team-based, and patient-centered approach designed to improve health outcomes and manage costs by assisting patients—particularly those with complex, chronic conditions—and their support systems in navigating the health care system. It uses systems, science, and information to coordinate care, increase engagement, and reduce hospital readmissions. The goal is to stabilize complex health conditions, reduce risks and use the appropriate level of care and benefits. Skill needs include community-based specialized skills and knowledge and clinical credentials or licensure.

County Care does not delegate care coordination and care management responsibilities for all its populations, retaining a centralized team to manage members whose PCPs need this support from the Health Plan, members enrolled in specific state benefit programs and members who meet other criteria for ”carve-out” from delegation. Thus, CountyCare has developed a hybrid model of the centralized and delegated care management entities (CMEs), utilizing an algorithm at the Health Plan’s discretion to assign each member to the best suited CME.

Value Based Care (Scope 2)

CountyCare is seeking proposals from organizations capable of managing the care of high-risk, high-cost Medicaid populations under advanced value-based payment arrangements that include accountability for total cost of care, quality outcomes, and member experience. Applicants may propose models serving a broad population of complex members or a defined subpopulation, such as members with multiple chronic conditions, serious mental illness, substance use disorders, frequent emergency department utilization, repeated inpatient admissions, housing instability, or

other characteristics associated with elevated healthcare expenditures and avoidable utilization. The capacity to care for a minimum number of members, as defined below, will be taken into consideration to ensure financial and administrative feasibility of the program. Proposed arrangements are expected to include meaningful financial accountability through performance and/or total cost of care risk.

Proposers should describe their care model, operational capabilities, and approach to member engagement. CountyCare is interested in comprehensive, community-based models that extend beyond telephonic care management or digital chronic disease management programs. Examples may include enhanced primary care models, intensive care management programs, interdisciplinary care teams, home-based interventions, community health worker programs, behavioral health integration, transitional care services, social needs interventions, medication management, and other approaches designed to address the full spectrum of medical, behavioral, and social drivers of health. Applicants may propose serving as the member's primary care provider or operating as a wraparound care entity. Programs that are completely virtual will not be considered. Care modality options for virtual care, digital tools, and telephonic support are encouraged.

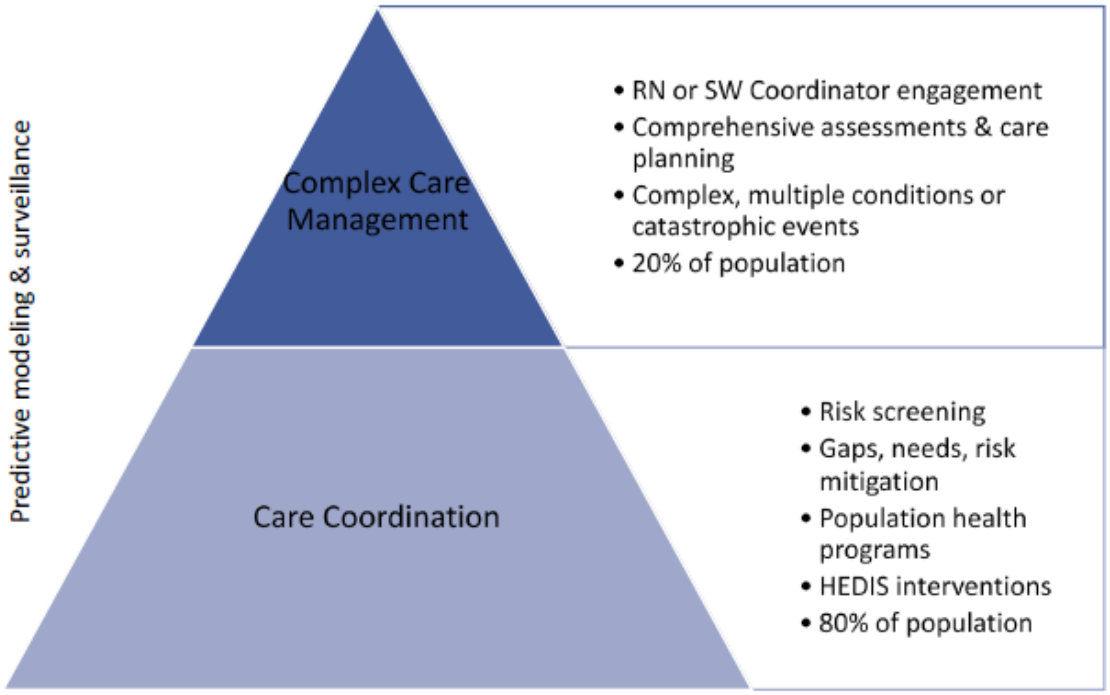
Applicants will be expected to demonstrate the ability to identify, engage, stratify, and manage complex populations while improving quality performance and reducing avoidable utilization. Proposals should clearly describe staffing models, member-to-staff ratios, geographic service capacity, care delivery sites, data and analytics capabilities, and experience managing populations under risk-based arrangements. Applicants should also describe their approach to achieving quality outcomes, including preventive care, chronic disease management, behavioral health outcomes, care transitions, member experience, health equity, and other performance measures that may be incorporated into the final payment arrangement.

Note: Proposer may apply to Scope 1, Scope 2, or both. In other words, organizations are not required to be delegated for care management (Scope 1) to be eligible for a value-based care arrangement (Scope 2).

1.6 Services and Members

The care coordination and care management program relies on the pyramid approach to population health in which tiered interventions, represented in **Figure A,** are available to the population in accordance with the stratification of members based on their needs**.**

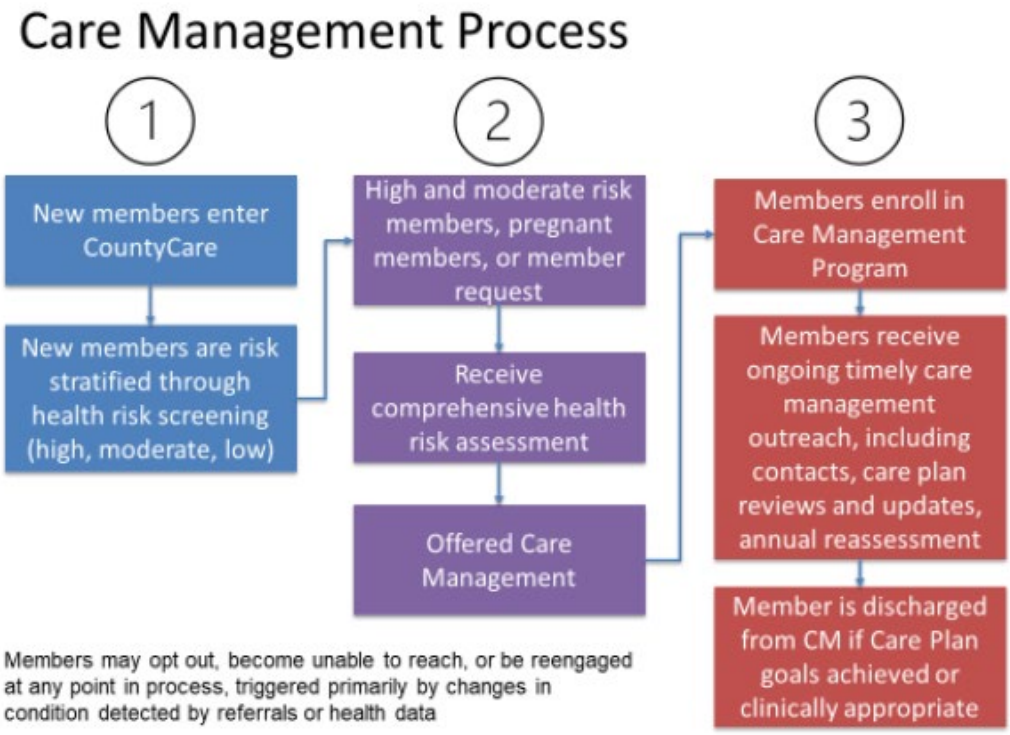
Figure A.



1.7 Care Management Process

The care management program leverages standard processes to identify and engage members, assess and stratify them into the most appropriate intervention. Analytics, predictive modeling and data mining also identify and move members into queue for these processes, depicted in **Figure B.**

Figure B.



1.8 Transition of Care Process

Transitions of care (TOC) services are part of care coordination, helping CountyCare members who are hospitalized at least 14 days post-discharge. This process triggers reassessment and re-engagement.

TOC Process Objectives:

- Facilitate efficient and effective transitions of care between settings
- Integrate resources of the member/family, treatment providers and health plan
- Maximize shared platforms (real-time alerts and utilization and care management systems)
- Ensure clear lines of communication between multiple stakeholders internal and external to organization

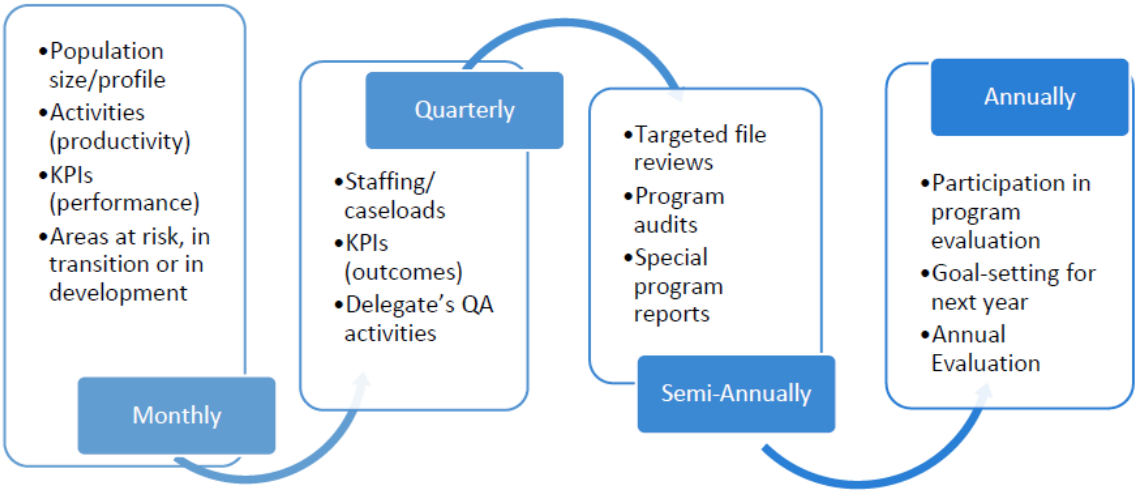
TOC Outcome Goals:

- Increase post-discharge follow-up visits and other post-acute service utilization
- Decrease avoidable readmissions through prompt and effective provider/health plan collaboration
- Improve member self-management and/or enrollment in a complex care management program

1.9 Oversight

Each CME is required to have specialized leadership and team structures to support their provision of delegated services. CountyCare has a delegated vendor oversight (DVO) program that ensures monitoring and accountability for delegated service through the governance and oversight structure. The DVO program is based on a comprehensive calendar of prescribed activities to monitor both contract compliance and performance as depicted below in **Figure C**.

Figure C.



2. Purpose

a. Term of Services

The term of services shall be for thirty-six (36) months, with two (2), two-year (2) extension options if project deliverables are met for both scopes of work.

b. Basis of Award

The basis of award shall be to a single or multiple Proposers based on the highest-rated Proposal(s) offering the best value to CCH meeting the specifications, terms and conditions in accordance with the evaluation criteria set forth in this RFP.

This RFP has two scopes of work described below: Scope 1 and Scope 2. Proposers may apply to Scope 1, Scope 2, or both.

c. Business Goals and Objectives

The goal is to complete implementation for both scopes of work by April 1, 2027.

The business need for **Scope 1** procurement is primarily driven by HPS':

- Commitment to serving as a market leader in innovation and excellence in care management

- Philosophy as a provider-sponsored health plan that member engagement, care coordination and complex care management are most effective when provided closer to clinicians and members in the member's communities
- Core value of supporting continuity of clinical care and treatment by providers through enrollees' spans of Medicaid eligibility
- Existing partnership model which requires standardization in the basic processes and flexibility to allow teams to be adaptable at the point of care
- Track record of performance (see HealthChoice Illinois Plan Report Card) demonstrating the effectiveness of the plan's provider-based, integrated care management approach
- Diversity of Medicaid-covered populations served by the Health Plan, including families and children, adults, seniors, persons with disabilities, enrollees dually eligible in Medicare, persons with LTSS, special needs children and youth formerly or currently in the custody of the Illinois Department of Children and Family Services (DCFS)
- Need for partners who are dynamic, flexible and responsive to changing populations, programs and requirements
- Expected future growth into additional lines of business
- Requirement to maintain high levels of recognition by accreditation and contract entities for compliance with standards and requirements

The business need for **Scope 2** procurement is primarily driven by HPS':

- Commitment to advancing alternative payment models that strengthen population health management capabilities, support continuous performance improvement, and align provider incentives with improved health outcomes and sustainable healthcare spending.
- Goal of expanding value-based care arrangements across additional populations, clinical service areas, and provider partnerships to increase accountability for quality, outcomes, and total cost of care.
- Goal to partner with organizations to take on risk through one of two methods: empanelment of CountyCare members to the organization's providers or by providing wraparound services to the primary care medical home. Wraparound services may include, but are not limited to, integrated specialists, ancillary services, and/or social supports to enhance care delivery and outcomes.
- Need for innovative care models designed to serve members with high utilization and medical spending by enhancing access, care coordination, health equity, quality performance, and the overall member experience.

3. Schedule

CCH anticipates the following schedule.

Activity	Estimated Date
RFP posted to the CCH website	August 5, 2026

Pre-Proposal Conference / Site Visit	None
Proposer Inquiry Deadline	August 19, 2026, by 2 p.m. CT
Response to Inquiries (Tentative)	Week of August 24, 2026
Proposal Due Date	September 10, 2026, by 2 p.m. CT

4. Scope of Services

4.1. Scope 1 – Delegated Care Management

4.1.1. Scope 1 Minimum Qualifications

Proposers bidding for Scope 1 must meet the below minimum qualifications to be considered for **Scope 1** award. Proposer should explicitly address the below qualifications in their response to section 4.1.1. Please provide comments and additional details in fewer than 20 pages single-spaced on how your organization meets the minimum qualifications. If Proposer does not describe how they meet the qualifications, CCH will not reach out for clarification, and Proposer will not be considered for award.

	Minimum Qualifications	Response (Y/N)
1	Demonstrated knowledge and five years of experience in this RFP's scope in an urban setting with underserved, multi-ethnic and multi-cultural populations.	
	Proposer's Response:	
2	Entity is not owned or operated by an MCO	
	Proposer's Response:	
3	Entity is owned or operated by *or* is contracted with PCPs and/or medical home organizations to deliver care management services as part of the medical home team	
	Proposer's Response:	
4	Entity/contracted PCPs and/or medical home organizations have a minimum of 25,000 empaneled CountyCare members at time of go-live; this membership does not include DCFS youth in care or members eligible for LTSS	
	Proposer's Response:	
5	If entity is comprised of multiple organizations, it operates within a clinically integrated network, at minimum including: a) Explicit overall quality goals and related criteria for organization participation b) Clinician involvement in governance c) Shared information technology (IT) tools for population health management, analysis and service documentation	

	d) Standardization of delivery of services as evidenced by approved policies, procedures, etc.	
	Proposer's Response:	
6	Demonstrated experience and success with care delivery within Medicaid managed care in Illinois, including expertise in relevant care managements standards like those maintained by NCQA, HFS and CMS. Please name the organizations in the Illinois Medicaid managed care market that your organization has worked with. You must provide them for at least one of your required references.	
	Proposer's Response:	
7	Care coordination staff documents activities within the PCP electronic health record (EHR) or will have access, training and bi-directional communication in the PCP EHR by the time of contract execution.	
	Proposer's Response:	
8	Care coordination staff provides, in addition to telephone contact, both video telehealth and in-person contact with members: a) Onsite within the PCP/medical home, b) In other health care facilities, c) In members' homes and d) In community locations.	
	Proposer's Response:	
9	Has a care coordination workforce diverse in ethnicity, gender and languages spoken and can meet staffing levels and qualifications identified within contract requirements or can submit a recruitment plan for hiring by the time of contract execution	
	Proposer's Response:	
10	Entity has dedicated leadership resources for implementation, project management and contract support over three-year period, including: a) Medical director or clinical management/supervisory team with adequate full-time equivalent (FTE) to support overall program, as well as commitment to direct involvement with complex cases b) Operational management for process, system and reporting activities c) IT and analytic management to support data exchanges, software system needs, reporting and data analysis d) Project management resources for implementation within three months of contract award and in the event of major transitions in population or systems	
	Proposer's Response:	
11	Entity has and will maintain NCQA Care Management Accreditation throughout the entirety of the contract with CCH.	

	Proposer's Response:	
12	Entity leases or owns/operates care management system software that is able to meet all contract requirements at time of go-live.	
	Proposer's Response:	
13	Ability to send and receive data. This includes both outbound and inbound data interfaces in standard and custom formats as required by the plan (i.e., eligibility, prior authorizations, claims, care management data)	
	Proposer's Response:	
14	Owns or leases a database or documentation system with architecture that supports scalability, segmentation and flexibility to adapt system to changing business needs and industry and regulatory standards	
	Proposer's Response:	
15	Will share and transmit health and demographic data from EHR and practice management data systems	
	Proposer's Response:	
16	Utilizes evidence-based practice guidelines	
	Proposer's Response:	
17	Has a care management program description, training program and policies and procedures that meet or will be adapted to meet contract requirements prior to go-live	
	Proposer's Response:	
18	Will commit to achieve quality metric targets set by Health Plan in alignment with statewide quality strategy	
	Proposer's Response:	
19	Has a community resource directory and referral system	
	Proposer's Response:	
20	Utilizes published library of printable and/or interactive online health education materials	
	Proposer's Response:	
21	**Cyber Liability Insurance**: Cyber liability insurance with minimum limit of $10,000,000 aggregate and no sublimits under $1,000,000. Provide evidence of insurance.	
	Proposer's Response:	
22	Proposer will not offshore any portion of the proposed services.	
	Proposer's Response:	
23	Completion of a 2025 SOC 2 Type 2 audit. Proposer must provide report upon submission of RFP proposal. Bridge letter and schedule is acceptable if SOC 2 is in progress.	
	Proposer's Response:	
24	Evidence of third-party penetration testing in 2025.	
	Proposer's Response:	

4.1.2. Scope 1 Preferred Qualifications

In addition, successful Proposers for **Scope 1** will meet some of the following preferred qualifications. Proposer should explicitly address the qualifications below in their response to section 4.1.2. Please provide comments and additional details in fewer than 15 pages single-spaced on how your organization meets the preferred qualifications.

	Preferred Qualifications	Response (Y/N)
1	Experience partnering with public sector organizations. Please name those organizations.	
	Proposer's Response:	
2	Has skip-tracing capability and access to data	
	Proposer's Response:	
3	Industry-recognized accreditation and/or certifications (please list)	
	Proposer's Response:	
4	Can establish live bi-directional IT interfaces/capacity for interoperability with external software	
	Proposer's Response:	
5	Demonstrated integration with providers in non-traditional care settings (i.e., schools, jails)	
	Proposer's Response:	
6	Entity/contracted PCPs and/or medical home organizations will provide monthly supplemental data files to Plan for purposes of HEDIS care gap closure	
	Proposer's Response:	
7	Entity/contracted PCPs and/or medical home organizations will provide limited remote electronic medical record (EMR) access to Plan staff	
	Proposer's Response:	

4.1.3. Scope 1 Requirements and Specifications

For each of the questions described below, detail the Proposer's solution. **Proposers should include and explicitly address how Proposer will meet or why Proposer cannot meet each of the below requirements in their response to this RFP.** Please use the corresponding response codes listed below in Proposer's RFP response. Responses with "T" in any of the below requirements should explicitly detail the names of the organizations that will be providing that service on Proposer's behalf. Proposers should articulate their responses in a succinct and direct manner. The responses should refrain from statements not related to the question, and general statements should be supported by factual proof points. Responses to section 4.1.3 shall not exceed fifty (50) pages.

Response code	Category Description

Y	Demonstrated (operational today). This response indicates that the process/technology described is in use by the Proposer for that product. If requested by CCH, Proposer can provide outcomes and/or examples of how the process/technology is currently deployed. If the Proposer is leveraging another organization's expertise, process or technology, then a "T" should be used.
D	Under Development. This response indicates that the process/technology described is currently under development and/or designed but is not yet operational in any of the Proposer's operational markets.
M	Modify. This response means that the Proposer is willing to develop the process/technology. Any cost of this enhancement to CCH should be itemized and included in the Proposer's projected cost of implementation.
T	Third Party. This response means that the functionality is available from a third-party partner of the vendor. If third-party products are proposed, please include an itemized list in the projected costs along with any projected costs chargeable to CCH. Additionally, indicate the name of the vendor that is performing that service.
N	This response indicates the Proposer does not have an applicable process/technology.

#	Illinois Managed Care Requirements	Response Code (Y/D/M/T/N)
	General	
1	For new enrollees transferring from another MCO, the Plan will notify Proposer of the enrollee's previous MCO, and Proposer shall request the enrollee's individual plan of care (IpoC) from that MCO.	
	Proposer's Response:	
2	New enrollees to the Health Plan (new to MCO or transition from another MCO) require outreach for an initial health risk screening or assessment within a specific timeframe as established by the HealthChoice Illinois contract. Will there be capacity to integrate the new enrollee and meet the initial requirement of the screening/assessment? Can Proposer retain the risk stratification as the member progresses through the care management process?	
	Proposer's Response:	
3	For past Enrollees who have left the Health Plan, Proposer shall provide an enrollee's IPoC within ten (10) Business Days after receiving a request for it from the MCO in which the individual is enrolled.	
	Proposer's Response:	
4	For enrollees with IPoCs, Proposer must maintain the risk level assigned by the former MCO or CME until a new assessment has been completed. Risk level and other care plan data must be used to prioritize enrollee outreach.	
	Proposer's Response:	
5	Care coordination for children's behavioral health. Proposer shall ensure that the provision of care coordination and services for children's behavioral health is compliant with attachment XXII of the plan-HFS contract. Nothing in this section or attachment XXII of the plan-HFS contract is intended to limit the children's mental health and care coordination services that are covered services. Proposer must provide children's behavioral health services to all enrolled children who meet eligibility criteria. To the extent possible, family members and natural supports of children with behavioral health conditions should be included in all planning and treatment for the child. Services may also be provided to children's family members and other natural supports when those services are related to the behavioral health conditions of the children. These services are detailed in the Community Mental Health Services Service Definition and Reimbursement Guide and will be reimbursed as services to the individual client. *See also specific requirements below from MCCN Attachment XXII.*	
	Proposer's Response:	
6	Organization has the capacity to deliver population based care management b as the Health Plan continues to develop and scale such programming. Examples include maternal-child health, behavioral health, special needs children and chronic conditions.	

	Proposer's Response:	
	Coordination tools	
7	Proposer uses technology and processes that effectively integrate data from a variety of sources to profile, measure and monitor enrollee profiles. Profiles include demographics, eligibility data, claims payment information, care opportunities, care gap alerts and enrollee preferences.	
	Proposer's Response:	
8	Proposer's care coordinators use the care management system to review assessments, interventions and management of chronic health conditions to gather information to support IPoCs and identification of enrollees' needs.	
	Proposer's Response:	
9	Proposer has fully operational portals, which provide enrollees and providers access to relevant information from the care management system. Note: Health Plan provides this, but ideally, Proposer also provides portal for members and providers to their system.	
	Proposer's Response:	
	Care Management	
10	Proposer shall offer care management to the following populations: • Enrollees stratified as Level 3 (high-risk) and Level 2 (moderate-risk) as described at section 5.13.1.4.1 • Pregnant enrollees. In addition, any enrollee may request care management. Dual-eligible adult enrollees, enrollees residing in a nursing facility and enrollees who receive covered services under an HCBS Waiver also require care management. Although they will not be delegated, Proposer must offer care management to members in transition into or out of these populations. (With capacity to adjust with changing requirements for the 2027 HCI contract.)	
	Proposer's Response:	
11	Care management includes assessment of the enrollee's clinical risks and needs, medication management and health education on complex clinical conditions as appropriate to the individual needs and preferences of the enrollee.	
	Proposer's Response:	
12	If Proposer enters any contract with an entity that also administers the determination of need (DON) or prescreening required under HCBS waivers, Proposer shall immediately provide the name of that provider to the Plan.	
	Proposer's Response:	
13	Proposer implements procedures to coordinate services provided between settings of care, including timely discharge planning for hospital and institutional stays.	
	Proposer's Response:	
14	Proposer provides case management assistance to hospitals in securing timely transfer of patients from non-network hospitals to contracted facilities.	
	Proposer's Response:	

15	Outreach to all such enrollees to offer care management services as appropriate in accordance with the plan-HFS contract, using a combination of (among other appropriate methods) telephonic outreach, mailings and face-to-face visits to engage those enrollees	
	Proposer's Response:	
16	Outreach to all such enrollees identified as pregnant via the estimated delivery date provided on the 834 file from the Illinois Department of Healthcare and Family Services (Department), other pregnancy identification provided by the Plan or pregnancy identification by medical home providers, staff and enrollees, in accordance with a process to be mutually agreed upon by the Parties	
	Proposer's Response:	
17	Each enrollee who receives care management will be assigned a care coordinator. Proposer provides enrollee information on how to contact the enrollee's designated person or entity primarily responsible for coordinating services.	
	Proposer's Response:	
	Assessments and Care Planning	
18	Plan's goals, benchmarks and strategies for managing the care of enrollees in its traditional disease management programs will be included as part of Proposer's care management program.	
	Proposer's Response:	
19	Proposer uses population- and individual-based tools and real-time enrollee data to identify an enrollee's risk level.	
	Proposer's Response:	
20	Proposer has a health-risk screening tool, which includes behavioral health risk, and provides that tool to the Plan and Department upon request.	
	Proposer's Response:	
21	Proposer administers the tool to all new enrollees within sixty (60) days after enrollment to collect information about the enrollee's physical, psychological and social health. Proposer may administer a health-risk assessment in place of the health-risk screening, provided it is administered within sixty (60) days after enrollment.	
	Proposer's Response:	
22	Proposer notifies the appropriate PCP of the enrollment of any new enrollee who has not completed a health-risk screening within the time period set forth above and whom Proposer has been unable to contact.	
	Proposer's Response:	
23	Predictive modeling. Proposer utilizes claims and Care Coordination Claims Data (CCCD) provided by the Plan to risk stratify the population and to identify high-risk conditions requiring immediate care management.	
	Proposer's Response:	

24	Surveillance data. Proposer identifies enrollees through referrals, transition information, service authorizations, alerts, grievance system, memos, results of the DON or other assessment tools adopted by the State and from families, caregivers, providers, community organizations and Proposer personnel.	
	Proposer's Response:	
25	Commit to no fewer than five (5) varied outreach attempts via variety of modalities for each enrollee that is identified with an action due, such as call contact, care planning and assessment while member remains high or moderate acuity. Identify and document members who are unable to reach, opt-out, or decline to participate in any care coordination activities	
	Proposer's Response:	

<table>
<tr><td>26</td><td>Stratification. Based upon an analysis of the information gathered through the process in this section, Proposer shall stratify all enrollees to determine the appropriate level of intervention by its care management program or based on the stratification provided by the Plan, both initially and on an ongoing basis. Proposer shall systematically assign an initial risk level within the first fifteen (15) days after enrollment. Initial risk levels shall be evaluated and updated to reflect the results of a health-risk screening, health-risk assessment and other relevant tools and data. Ongoing re-stratification shall occur as described at section 5.16 of this contract.

Enrollees shall be assigned to one (1) of three (3) levels:

<table>
<tr><th>Risk Category</th><th>Description</th></tr>
<tr><td>Level 1: Low</td><td>Includes low- or no-risk enrollees to whom Proposer provides, at minimum, prevention and wellness messaging and condition-specific education materials.</td></tr>
<tr><td>Level 2: Moderate</td><td>Includes moderate-risk enrollees for whom Proposer provides problem-solving interventions.</td></tr>
<tr><td>Level 3: High</td><td>Includes high-risk enrollees for whom Proposer provides intensive care management for reasons such as acute and chronic health needs, behavioral health needs or lack of social support.</td></tr>
<tr><td>Condition Management</td><td>Includes enrollees with condition-specific health care needs for whom the Proposer provides self-care management through education, goal-setting assistance, and limited care management.</td></tr>
</table>
</td><td></td></tr>
<tr><td></td><td colspan="2">Proposer’s Response:</td></tr>
<tr><td>27</td><td>Proposer shall offer Care Management to all enrollees stratified in Level 2 and Level 3 and at a minimum, Proposer must provide Care Management to at least four (4) percent of their total enrollee attribution.</td><td></td></tr>
<tr><td></td><td colspan="2">Proposer’s Response:</td></tr>
</table>

28	Health-risk assessment. Proposer shall use its best efforts to complete a health-risk assessment within thirty (30) days for any enrollee whose health-risk screening indicates a need for further assessment. For the purpose of this section 5.13.2, HFS will define best efforts on an annual basis. However, Proposer shall complete a health-risk assessment for the following populations: All Level 3 (high-risk) or Level 2 (moderate-risk) enrollees. The assessment is conducted in-person or over the phone within ninety (90) days after identification of acuity.	
	Proposer's Response:	
29	Proposer uses its best efforts to locate all enrollees who are identified through risk stratification as being high-risk or moderate-risk. For the purpose of this section, HFS will define best efforts on an annual basis. Where appropriate, Proposer uses community-based organizations to locate and engage such enrollees.	
	Proposer's Response:	
30	Enrollee engagement and education. Proposer uses a multifaceted approach to locate, engage and educate enrollees and capitalizes on every enrollee contact to obtain and update enrollee information.	
	Proposer's Response:	
31	Proposer solicits input from enrollees and other stakeholders to help develop strategies to increase motivation for enhanced independent and healthy living.	
	Proposer's Response:	
32	Self-directed care. Proposer encourages Providers to support enrollees in directing their own care and developing an IPoC.	
	Proposer's Response:	
33	Proposer supports an interdisciplinary care team (ICT) for all enrollees stratified as moderate- or (level 2) or high-risk (Level 3), dual-eligible adult enrollees and enrollees who receive covered services under an HCBS waiver.	
	Proposer's Response:	
34	Each ICT consists of clinical and non-clinical staff whose skills and professional experience will complement and support one another in the oversight of each enrollee's needs.	
	Proposer's Response:	
35	ICT functions include providing care management for enrollees; assisting in the development, implementation and monitoring of IPoCs, including referrals to HCBS service plans where applicable; and assisting in integration of services and coordination of care across the spectrum of the health care System.	
	Proposer's Response:	
36	ICT functions include ensuring a primary care coordinator is responsible for coordination of all benefits and services the enrollee may need. (Care coordinators will have prescribed caseload limits as set forth in section 5.17.2).	
	Proposer's Response:	

37	ICT functions include assigning a care coordinator who has the most appropriate experience to support the enrollee.	
	Proposer's Response:	
38	ICT functions include using motivational interviewing techniques.	
	Proposer's Response:	
39	ICT functions include explaining alternative care options to the enrollee.	
	Proposer's Response:	
40	ICT functions include maintaining frequent contact with the enrollee through various methods, including face-to-face visits, email and telephone calls, as appropriate to the enrollee's needs and risk level or upon the enrollee's request.	
	Proposer's Response:	
41	Proposer develops a comprehensive, person-centered IPoC for enrollees stratified as Level 3 (high-risk) and Level 2 (moderate-risk) within ninety (90) days of enrollment. Proposer shall engage enrollees in the development of the IPoC as much as possible. An IPoC may not be finalized until signature from the enrollee or authorized representative has been received either by hand, e-signature or voice recording. Enrollees must be provided with a copy of the IPoC upon completion and may request a copy at any time. The IPoC is considered an enrollee-owned document.	
	Proposer's Response:	
42	The IPoC incorporates all of the enrollee's care needs, including medical, behavioral health, social and functional needs.	
	Proposer's Response:	
43	The IPoC includes identifiable short- and long-term treatment and service goals to address the enrollee's needs and preferences and to facilitate monitoring of the enrollee's progress and evolving service needs.	
	Proposer's Response:	

44	Care coordinators should incorporate the results of the health-risk assessment into the IPoC. Include, as appropriate, the following elements: 1. The member's personal or cultural preferences, such as types or amounts of services 2. The member's preference of providers and any preferred characteristics, such as gender or spoken language 3. The member's living arrangements 4. Covered services and non-covered services to address each identified need, provided that contractor shall not be required to pay for non-covered services. 5. Actions and interventions necessary to achieve the member's objectives 6. Follow-up and evaluation 7. Collaborative approaches to be used 8. Desired outcome and goals, both clinical and non-clinical 9. Barriers or obstacles 10. Responsible parties 11. Standing referrals 12. Community resources 13. Informal supports 14. Timeframes for completing actions 15. Status of the member's goals 16. Home visits as necessary and appropriate for members who are homebound (as defined in 42 U.S.C. 1395n(a)(2)), who have physical or cognitive disabilities or who may be at increased risk for abuse, neglect or exploitation 17. Back-up plan arrangements for critical services 18. Crisis plans for a member with behavioral health conditions 19. Wellness program plan	
	Proposer's Response:	
45	Proposer shall identify and evaluate risks associated with the enrollee's care. Factors include the potential for deterioration of the enrollee's health status; the enrollee's ability to comprehend risk; caregiver qualifications; appropriateness of the residence for the enrollee; and behavioral or other compliance risks. Proposer shall incorporate the results of the assessment of risks into the IPoC.	
	Proposer's Response:	
46	The enrollee or the enrollee's authorized representative must review and sign the IPoC and all subsequent revisions. Acceptable forms of signature include electronic forms, such as e-signatures and voice recordings. In the event that the enrollee refuses to sign the IPoC, Proposer shall: • Document in detail the specific reason why the enrollee refuses to sign the IPoC • Document actions taken by the care coordinator to address enrollee's concerns. • Ensure that the enrollee's IPoC is communicated to all of the enrollee's ICT members and Providers, as appropriate	

	Proposer's Response:	
47	Proposer will analyze predictive-modeling reports and other surveillance data on a monthly basis of all enrollees to identify risk-level changes. As risk levels change, assessments and reassessments will be completed as necessary and IPoCs created or updated. For enrollees whose risk level is updated to Level 3 (high-risk) or Level 2 (moderate-risk), Proposer shall make best effort to complete a health-risk assessment and IPoC within ninety (90) days of the risk-level update. Proposer shall review IPoCs of Level 3 (high-risk) enrollees at least every thirty (30) days and of Level 2 (moderate-risk) enrollees at least every ninety (90) days. Proposer shall conduct reassessments as necessary based upon such reviews. At a minimum, Proposer shall conduct a health-risk reassessment annually for each enrollee who has an IPoC. Proposer will provide updated IPoCs to providers that are involved in providing covered services to enrollee within no more than five (5) business days.	
	Proposer's Response:	
48	Care coordinators responsible for the care management of enrollees with varying risk levels shall have their overall caseload weighted and a blended overall caseload limit set. The maximum weighted caseload for a care coordinator is six hundred (600) with Level 1 (low-risk) weighted as one (1), Level 2 (moderate-risk) weighted as six (6) and Level 3 (high-risk) weighted as twelve (12). HFS may review existing caseloads at any time and may require a change in methodology or an enrollee's assignment to a caseload.	
	Proposer's Response:	
49	Caseloads of care coordinators shall not exceed the standards outlined as follows: • Maximum caseloads for care coordinators for the stratified categories identified in section 5.13.1.4.1 are defined in the table below and shall be adhered to by Proposer, unless specified in section 5.17.2.2. • Care coordinators who provide care management shall maintain contact with enrollees as frequently as appropriate. Care coordinators who provide care management to Level 3 (high-risk) enrollees shall have contact with these enrollees at least once every ninety (90) days. The care coordinator or a member of the enrollee's ICT shall have face-to-face contact at least once every six (6) months with each Level 3 (high-risk) enrollee.	
	Proposer's Response:	
	Transition of Care	

50	Transition of care process. Proposer will manage transition of care and continuity of care for new enrollees and for enrollees moving from an institutional setting to a community setting. Proposer's process for facilitating continuity of care will include: • Identification of enrollees deemed critical for continuity of care; • Communication with entities involved in enrollees' transition; • Stabilization and provision of uninterrupted access to covered services; • Assessment of enrollees' ongoing care needs; • Monitoring of continuity and quality of care and services provided; and • Medication reconciliation.	
	Proposer's Response:	
51	Transition of care plan. Proposer shall initially, and as revised, submit to the Plan and/or HFS, for the Plan and/or HFS' review and prior approval, the transition of care policies, procedures and staffing model designed to achieve a seamless, efficient transition with minimal impact to an enrollee's care.	
	Proposer's Response:	
52	Transition of care team. Proposer shall have an interdisciplinary transition of care team to design and implement the transition of care plan as part of the IPoC and provide oversight and management of all transition of care processes. The team will consist of skilled personnel with extensive knowledge and experience transitioning enrollees with special health care needs.	
	Proposer's Response:	
53	Transition of care for new enrollees. Proposer will identify new enrollees who require transition services by using a variety of sources, including: • Prior claim history as provided by the Plan and/or HFS; • IPoC provided by the previous vendor; • Health-risk screenings completed by new enrollees; • Providers requesting information and service authorizations for enrollees (existing prior authorizations for new enrollees shall be honored by Proposer); • Communications from enrollees; and • Communication with existing agencies or service providers that are supporting enrollees at the time of transition.	
	Proposer's Response:	
54	Proposer shall use a multifaceted approach to locate and engage enrollees and shall capitalize on every enrollee contact to obtain and update enrollee contact information and engage enrollees in their own care. Input will be solicited from Plan's enrollee advisory and community stakeholder committees to help develop strategies to increase motivation of enrollees to participate in their own care.	
	Proposer's Response:	

55	Proposer shall have a system dedicated to the management of information about enrollees, specifically designed to collect enrollee-related data and to process workflow needs in health care administration. The system shall have at minimum three (3) core integrated components: • Enrollee demographics tracking and information; • Means to automate, manage, track and report on workflows for outbound and outreach enrollee campaigns as well as targeted outbound interventions (such as engaging high-risk enrollees in care or disease management programs); and • Technology for use with inbound enrollee contact and query management.	
	Proposer's Response:	
56	Proposer will implement a telephonic outreach program to educate and assist enrollees in accessing services and managing their care. Calls will be made by Proposer staff to new enrollees and to targeted populations, such as enrollees who are identified or enrolled in disease or care management, who have frequent emergency room utilization or who are due or past due for services.	
	Proposer's Response:	
57	Proposer shall produce mailings to all enrollees in care management that will include reminders about the benefits of participating in the care management program and of receiving the screenings and preventive care required for their condition. The mailing shall include the Plan's toll-free phone number and the Proposer's phone number and invite enrollees to contact the ICT or the nurse advice line with any questions. Proposer's mailings shall include reminders about needed preventive services or screenings, reminders about the risks associated with progression of the enrollee's disease and information about any available incentives for receiving a needed service.	
	Proposer's Response:	
58	Proposer will offer an expansive set of health education programs that use comprehensive outreach and communication methods to effectively educate enrollees, their families and other caregivers about health and self-care and how to access plan benefits and supports.	
	Proposer's Response:	
59	Proposer's care coordinators will attempt to contact all enrollees who frequently use or recently visited an emergency room to determine whether the enrollees are experiencing barriers to primary and preventive care; to help resolve those barriers, if any; and to educate enrollees on the appropriate use of emergency room services and the enrollees' health home.	
	Proposer's Response:	

60	Enrollee support to ensure compliance. To the extent possible, Proposer shall involve the enrollee in IPoC development. Enrollee education will occur through telephone contact, face-to-face contact and educational groups and mailings. Education shall include information about monitoring daily disease-specific indicators. If appropriate, the care coordinator will link the enrollee with available community-based, disease-specific educational programs and support groups.	
	Proposer's Response:	
61	Proposer shall utilize various strategies and methodologies as appropriate to connect with transient enrollees, including the following: Face to face community contact, provider engagement, collaboration with housing entities.	
	Proposer's Response:	
62	Proposer shall verify enrollee's address and phone number during each contact.	
	Proposer's Response:	
63	Proposer shall use other methods available to locate and educate transient enrollees, such as community organizations, physicians, family, the internet, reverse phone number look-up systems to locate active phone numbers and enrollee demographics on paid claims. Proposer representatives may be dispatched to an enrollee's home when a valid phone number is not found.	
	Proposer's Response:	
	Care Coordinator Qualifications and Training Requirements	
64	Care coordinators and supervisors who serve high-needs children and special needs children must meet the applicable qualifications set forth by HFS. Care coordinators for all other enrollees must have the appropriate qualifications to address the needs of enrollees: • Bachelor's degree in nursing, social sciences, social work or a related field • One (1) year of supervised clinical experience in a human services field	
	Proposer's Response:	
65	High-needs and special needs children care coordinator and supervisors must meet the following requirements: • Master's degree in nursing, social sciences, social work or a related field • No less than three (3) years of supervised experience in a human services field	
	Proposer's Response:	
66	Care coordinators and supervisors who serve high-needs children and special needs children must meet the applicable training requirements set forth in attachment XVI. Care coordinators for all other enrollees must have the appropriate training to address the needs of enrollees.	
	Proposer's Response:	

67	All care coordinators must attend the introduction to wraparound and engagement trainings offered by a National Wraparound Institute for Children (NWIC)-certified trainer and any follow-up training modules developed and made available by the State.	
	Proposer's Response:	
68	All supervisors overseeing care coordinators and assigned to intensive/intervention-tier enrollees must be certified as wraparound coaches by a State-identified and approved entity.	
	Proposer's Response:	
	Health, Safety and Welfare Incidents	
69	Care coordinators and supervisors have specific responsibilities as part of identifying and resolving incidents and protecting enrollee health, safety and welfare, including the following:	
	Proposer's Response:	
70	Implements immediate interventions to ensure member safety	
	Proposer's Response:	
71	Reports suspected abuse, neglect and exploitation to the appropriate state agency and/or investigating authority immediately upon becoming aware of the incident	
	Proposer's Response:	
72	Submits a complete and timely health, safety and welfare report	
	Proposer's Response:	
73	Completes required follow-up actions that support the member's health, safety and welfare	
	Proposer's Response:	
74	Establishes and continues direct contact with an investigator or other representative of any state agency/investigative authority to which the incident was reported and complies with directions provided by or decisions made by investigating authorities within the timeframe given	
	Proposer's Response:	
75	Conducts a face-to-face or telephonic conversation with the member as a result of the incident and to implement incident follow-up	
	Proposer's Response:	
76	Educates the member on abuse, neglect and exploitation and other topics as applicable to the incident	
	Proposer's Response:	
77	Updates the health-risk assessment and the IpoC. For members not already enrolled in care management, the care coordinator initiates enrollment.	
	Proposer's Response:	
78	Completes required contacts and contact attempts	
	Proposer's Response:	
79	Takes action to assure ongoing health, welfare and safety of the member after an incident	
	Proposer's Response:	
80	Updates the membership of the ICT	
	Proposer's Response:	

81	Coordinates the ICT and other entities involved, including but not limited to hospitals and community agencies	
	Proposer's Response:	
82	Following the closure of an incident, maintain appropriate contact with members and engage the member in care management to maintain their health, safety and welfare	
	Proposer's Response:	
83	Documents all of the above actions	
	Proposer's Response:	
84	Proposer ensures adequate supervisor involvement in health, safety and welfare incident management	
	Proposer's Response:	
85	All care coordination staff are required to undergo annual training on health, safety, welfare, report and follow-up of incidents.	
	Proposer's Response:	
	Required Minimum Standards of Care	
86	Proposer shall provide or arrange for interconception care management services for identified high-risk women for twenty-four (24) months following delivery.	
	Proposer's Response:	
87	A chronic care action plan that is clinically based and developed in conjunction with the enrollee. A copy of this chronic care action plan shall be provided to the enrollee and members of their health care team, including specialty consultants and the assigned care coordinator.	
	Proposer's Response:	
88	Coordination with other service providers. Proposer shall encourage network providers and subcontractors to cooperate and communicate with other service providers who serve enrollees. Other service providers may include Women, Infants and Children (WIC) programs, Head Start programs, early intervention programs, day care programs and school systems, among others. Cooperation may include performing annual health examinations for school and the sharing of health information (with the consent of the enrollee, parent or legal guardian if the enrollee is underage). Annual health examinations for school, include an age-appropriate developmental screening and an age-appropriate social and emotional screening, as required by Public Act 99-927. Proposer shall coordinate with the family case management (FCM) and better birth outcomes (BBO) programs, which shall include but is not limited to coordinating services and sharing information with existing FCM/BBO providers for its enrollees.	
	Proposer's Response:	
	Children's Behavioral Health Care Coordination Requirements	

89	Proposer shall coordinate with the enrollee, their family or the Mobile Crisis Response (MCR) provider, to: • Deliver clinical and supportive services with other clinical providers (PCP, behavioral health, hospital, etc.) to the member; • Obtain a copy of the crisis safety plan developed by the MCR provider; • Communicate to the member's PCP the psychiatric resource and medication efforts performed as part of MCR service, consistent with all consents and releases; • Facilitate priority access to a psychiatric resource to provide consultation and medication management services, as medically necessary, within one (1) calendar day of a community stabilization event for a member for whom community-based services were put in place in lieu of psychiatric hospitalization and within fourteen (14) days of discharge from inpatient hospitalization; • Convene an ICT meeting for the member within fourteen (14) days after the event if the member is community-stabilized and within fourteen (14) days after discharge if the member is hospitalized. When care coordinator receives notification that the member has been designated a youth at risk by DCFS, the CME will involve DCFS with the member's ICT. • Ensure that the member has a scheduled appointment with a behavioral health provider and the PCP or psychiatric resource within thirty (30) days after the crisis event or member's discharge from hospitalization.	
	Proposer's Response:	

90	For children who are hospitalized for behavioral health, care coordinators are responsible for the following activities related to discharge and transitional planning. • Participates in planning that begins upon admission • Participates in all inpatient staffing by phone, videoconference or in person • Notifies the member's family and caregiver of key dates and events related to the admission, staffing, discharge and transition of the member. He or she shall make every effort to involve the member and the member's family and caregiver in decisions related to these processes. • Speaks directly with the member or member's family at least once each week. If the care coordinator is unable to speak with member or member's family, the care coordinator should communicate with staff directly involved with member's care. • in conjunction with provider, educate and train the member's family on how to use a crisis safety plan while the member is receiving inpatient institutional treatment. • Participates in and oversee admission, staffing, discharge, and transition processes; • Coordinates communication of admission, pharmaceutical and discharge data, consistent with secured consents and releases, to the necessary PCP and other providers to promote continuity of care.; • Coordinates all necessary follow-up appointments and referrals for the member upon transition back into the community. ;Appointments should be established prior to discharge to ensure continuity across care providers. • Provides transitional services when being discharged from higher levels of care to lower levels or community-based services and work with the involved parties to facilitate appropriate follow-up services, including the scheduling of follow-up treatment appointments • Retains accountability and responsibility for the member as the transition between levels of care occurs • Encourages the member and the member's family to contact the care coordinator whenever a physical, psychological or social intervention is required or requested • Ensures that the entry and exit from any level of care is managed effectively, efficiently and, when possible and appropriate, within the CountyCare network. When necessary, the care coordinator shall help members and member's family access non-network providers and facilitate the timely provision of necessary and appropriate records to those non-network providers. • Ensures a link with institutional-based care providers and initiate follow-up care within seven (7) days after discharge from higher levels of care (e.g., hospital, psychiatric residential treatment facility [PRTF], residential, crisis respite) and arrange for appropriate levels of	

	services • Completes a medication reconciliation (med rec) when members are discharged from higher levels of care (e.g., hospital, PRTF, residential, crisis respite) • Confirms that PCPs are made aware of any medications that have been prescribed to members during treatment at an institutional setting and confirms with the members that they have the ability to get prescribed medications • Communicates directly with the member or member's family within forty-eight (48) hours after transition and sees the member in person in the member's home or another location as mutually agreed by the member or the member's family within seven (7) days after the discharge from higher levels of care (e.g., hospital, PRTF, residential, crisis respite) • Assists the member in attending all post-discharge appointments for follow-up care • Provides appropriate care management based on concurrent assessment for an appropriate period of time following discharge, involving other parties (e.g., MCR provider, DCFS caseworker) in the care management as necessary • Upon discharge, monitors and manages the member's care as necessary	
	Proposer's Response:	
	Other Duties and Obligations	
91	Proposer will arrange transportation support for enrollees who request or require assistance with transportation to health appointments. For enrollees unable to utilize the public transportation benefit administered by the Plan, CME will provide public transportation passes and/or ride-share transportation, such as Lyft, Uber or other comparable services, and may arrange such transportation directly or through a subcontractor.	
	Proposer's Response:	
92	For enrollees unable to utilize public transportation or ride-share services, Proposer's CME will arrange for other transportation through Plan's transportation fleet, the transportation benefit manager or other resources, including arranging rides for one-time appointments or obtaining standing approval for recurring appointments.	
	Proposer's Response:	
93	Proposer will assist enrollees with receiving non-covered services that support enrollees' health, well-being and ability to self-direct their care. Where the Plan has identified approved vendors, Proposer will first attempt to utilize services provided by such vendors following processes established by the Plan.	
	Proposer's Response:	

94	Proposer will assist the enrollee and members of the ICT with utilizing services provided by the Plan, including but not limited to submission of grievances, requests for prior authorizations or appeals and requests for enrollee incentives and add-on benefits. Proposer is responsible for maintaining knowledge and understanding of health plan functions and training staff accordingly to provide effective support, resulting in appropriate and effective use of covered services while maximizing satisfaction and self-directed goal attainment.	
	Proposer's Response:	
95	Proposer shall adhere to Plan's manual for care coordinators and care coordination/care management activities.	
	Proposer's Response:	
96	Proposer and its participating providers (if applicable) will achieve NCQA Accreditation for Case Management for all populations served under this agreement by no later than the start of this contract. Once achieved, Proposer will maintain this accreditation for the duration of the contract. Proposer will perform its responsibilities in accordance with the current and relevant NCQA Health Plan Accreditation Standards.	
	Proposer's Response:	
97	Proposer will submit all documents and participate in all NCQA readiness, survey submission and on-site review activities sponsored by and reasonably requested by the Plan.	
	Proposer's Response:	
98	Proposer shall respond promptly to referrals, collaborate with the enrollee's ICT on crisis and safety plans when indicated and support enrollees in meeting their care needs by advocating, arranging, educating and linking the enrollees to resources, until the enrollees decline support or other resources are confirmed to address Enrollees' needs.	
	Proposer's Response:	
99	Proposer will cooperate with requests for information to support any investigation of grievances, quality of care concerns and health, safety and welfare incidents, including critical incidents. This includes other ad hoc investigations that reasonably relate to Proposer's obligations under this agreement. Proposer will provide timely written and verbal information when requested and will provide feedback to improve quality.	
	Proposer's Response:	
100	Proposer will collaborate with partners identified as plan subcontractors or other plan partners or programs involved in providing services to individual enrollees, all in accordance with appropriate divisions of responsibility.	
	Proposer's Response:	
101	Proposer will ensure provision of centralized mechanisms, including a central contact that can accept warm hand-offs, has the appropriate skill level to assess and prioritize urgency and can exercise clinical judgement to route the enrollee to the appropriate resolution to address enrollees' needs within an appropriate timeframe.	
	Proposer's Response:	

102	Proposer will provide 1) a monthly list of current, accurate contact names and numbers for inbound phone calls and faxes and 2) a centralized email address for referrals to Proposer. Proposer will be required to retrieve messages at least three (3) times daily, including at close of business, track and ensure completion of follow-up with respect to enrollees and escalate outstanding issues to the Plan.	
	Proposer's Response:	
103	Proposer shall ensure that care management is available to enrollees during normal business hours, Monday through Friday, from 8:30 a.m. to 5:00 p.m., excluding the following holidays: New Year's Day, Martin Luther King Jr. Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day and Christmas Day.	
	Proposer's Response:	
104	Proposer will develop mechanisms to assist Enrollees with care coordination needs outside the hours of operation to decrease barriers to engagement in care coordination. Proposer will provide to Enrollees a point of contact/resource for immediate care coordination needs on holidays and non-business hours.	
	Proposer's Response:	
105	Proposer shall have staff who are fluent in Spanish and make best efforts to recruit staff who speak other languages prevalent in the enrollee population. Additionally, Proposer shall utilize a language line to provide live interpretation services between staff and enrollees and a certified translation service for written materials.	
	Proposer's Response:	
106	Proposer is required to fulfill its responsibilities by rendering services through multiple methods of contact with enrollees, with enrollee's personal contacts and with members of the enrollees' health care and social-service provider network and shall do so in accordance with relevant health information protections laws and regulations. These methods include timely telephone contact, written communication through postal and electronic transmission and in-person, face-to-face contact in any and all of the following settings as applicable to the member: health care facilities, community locations and/or enrollees' homes or places of residence. Proposer shall document best efforts as described in the plan-department contract and/or by the Plan in its program manual.	
	Proposer's Response:	

107	Proposer will have adequate staff for leadership, management, operations, quality assurance and completion of all delegated activities. Additional required positions include designated individuals in each of the following positions: • An executive leader who is able to represent Proposer in relation to all duties and responsibilities • A clinical leader who is a full-time staff member and a licensed physician, registered nurse or other professional as approved by the Plan. The Proposer shall demonstrate that the professional possesses the experience, training and education necessary to meet the requirements for the delegated activities and is capable of ensuring adequate supervision of activities that require clinical judgement and decision making. • A medical director who is a physician with a minimum of five (5) years of relevant experience. This position shall be actively involved in all major clinical program components of Proposer's operations, including, as applicable, review of medical care provided, medical professional aspects of provider contracts and other areas of responsibility as may be designated by Proposer. This position shall devote sufficient time to Proposer's operations under this exhibit A to advise and assist with medical care plans, communication with peers involved in care coordination and ICT participation for the enrollees assigned to Proposer, including after-hours consultation as needed. • An information technology leader who serves as the primary contact for application of any care management software, for data exchanges and interfaces with the Plan and its vendors, and for analytics and reporting. • A transition coordinator or project manager who will be a primary contact and responsible for coordination when a significant transition occurs in the scope of delegation, size of delegated population or change in the Provider network.	
	Proposer's Response:	
108	Proposer will ensure adequate care coordination staff are required to support the caseload requirements for all populations requiring care management based on risk stratification or otherwise opting to participate in the care management program.	
	Proposer's Response:	
109	In addition to care coordinators with assigned caseloads of enrollees in the care management/condition management programs, Proposer will also maintain care coordination staff at a ratio of 1:2500 for all other enrollees assigned to Proposer.	
	Proposer's Response:	
1101	Proposer shall maintain its own policies and procedures to ensure safety for its staff and enrollees in relation to care management. The CME shall provide copies of such policies and procedures to the Plan upon request to ensure compliance with this exhibit A.	
	Proposer's Response:	

111	Proposer shall have care coordination and care management procedures that meet all applicable requirements in the plan-department contract, and under any applicable NCQA accreditation and/or recognition requirements.	
	Proposer's Response:	
112	Proposer's care management system will support all contracted requirements and is subject to the use of a Plan-designated system with advanced notice	
	Proposer's Response:	
113	Proposer is responsible for using program tools with enrollees that are housed within its care management system to fulfill delegated responsibilities. These program tools will be reviewed and subject to Plan approval, at minimum upon initiation of this agreement and annually thereafter and prior to initiation of a new tool or new version of a tool.	
	Proposer's Response:	
114	Proposer shall enable its care management system to provide and receive data with the Plan and its vendor systems within standard and custom formats for seamless integration of health plan data. Care manager shall ensure that data required for fulfilling plan-department contract requirements can be imported and exported to and from the care management system and transmitted securely in formats required by the Plan. When import and export capability is not possible, Proposer shall ensure that data required for fulfilling plan-department contract requirements is manually entered or extracted to and from its system and transmitted securely in a format determined by the Plan.	
	Proposer's Response:	
115	Proposer shall provide access to its care management system to Plan staff responsible for care coordination oversight, clinical program implementation and various transitions for members	
	Proposer's Response:	
116	Proposer will have and implement a structured training program for all care coordination staff encompassing both initial and ongoing training. Training must be sufficient to address requirements of this agreement, including relevant laws and regulations, evidence-based practices when available and other professional guidelines and industry standards. Proposer shall train its staff in methods that maximize communication with enrollees to achieve engagement and to foster enrollee-driven services and care planning. Training must foster the values of person-centered care coordination, diversity, equity and inclusion, cultural competence and knowledge of the stages of change model and social determinants of health. Proposer will share a review copy of its training program curriculum and documentation of training of staff, which will be reviewed within its annual review.	
	Proposer's Response:	
117	Proposer will have and implement a quality management program with goals and reports used to measure the effectiveness of its care management services and to achieve the annual population health and quality goals set for the plan in alignment with HFS' quality strategy.	

	Proposer's Response:	
118	Proposer will support network management and relations activities for its contracted providers.	
	Proposer's Response:	
119	Proposer will develop its own population health management and medical cost management strategies.	
	Proposer's Response:	
120	Proposer will participate in initiatives that are sponsored and provided by the Plan and collaborate with its partner organizations, selected community-based entities and industry affiliates.	
	Proposer's Response:	
121	Proposer will implement mechanisms and initiatives to advance the effectiveness of its medical homes and care teams, including care improvements and integration of care coordination.	
	Proposer's Response:	
122	Proposer will advance the integration of behavioral health and physical health care at each level of care and utilize active partnerships with all Medicaid provider types.	
	Proposer's Response:	
123	Proposer will invite the Plan to participate in its governance structure, at minimum, for informational purposes.	
	Proposer's Response:	
124	Proposer shall participate in the Plan's quality assessment and performance improvement (QAPI) program, which includes, but is not limited to, performance improvement plans (PIPs) as developed by HFS or by the Plan, through surveys of enrollees and/or care coordinators, population assessments or audits of enrollee and staff records, as well as mutually agreed-upon ad hoc projects or studies.	
	Proposer's Response:	
125	Proposer will support the Plan's enrollee restriction program and will identify enrollees who may be appropriate for the program, communicate with such enrollees about the program and help identify providers to whom enrollee shall be restricted.	
	Proposer's Response:	
126	Proposer will meet regularly with the Plan and, when requested, external parties to discuss program administration, ensure compliance with the plan-department contract and collaborate on opportunities for improvement.	
	Proposer's Response:	
127	Proposer will comply with the reporting requirements set forth in the contract, which will be used in part to evaluate Proposer's performance as well as to provide required data to HFS.	
	Proposer's Response:	

128	Proposer shall achieve and maintain the KPIs set forth in the delegation agreement, which serve as target performance levels for certain required and non-required activities and which provide data to evaluate Proposer's performance. When performance does not meet or show improvement toward the target, Proposer is expected to implement improvement strategies through its quality program, and the Plan may request a corrective action plan.	
	Proposer's Response:	
129	Proposers will submit and implement corrective action plans if the Plan requires as a result of Proposer failing to submit complete, timely or accurate reports, meet KPIs or comply with any other aspect of the contract.	
	Proposer's Response:	

4.1.4. Scope 1 Data Integration Requirements

Required data integration/interface points with the vendor's care management system and enterprise data warehouse (EDW) are outlined below. Applicants must include and explicitly address their ability to integrate/interface the below data. Please use the response codes below (Y=yes, N=no) in your RFP response to the data integration requirements. If the response is "N" to any of the below, please provide a narrative response with comments and additional details in fewer than three (3) pages single-spaced for this section.

Medicaid Care Management System Data Interfaces	Source Entity	Destination Entity	Direction	Frequency	Will Interface/Integrate (Y/N)
Eligibility File	Plan	CM System	Outbound	Weekly	
Provider File	Plan	CM System	Outbound	Weekly	
Pharmacy Claims	Plan	CM System	Outbound	Daily	
Medical Claims File	Plan	CM System	Outbound	Weekly	
State Reports File	CME	Plan	Inbound	Monthly	
MCO to MCO Transition of Care – Care Plan File (for requested prior members)	CME	Plan	Inbound	Weekly	
MCO to MCO Transition of Care Goals File (for requested prior members)	CME	Plan	Inbound	Weekly	
MCO to MCO Transition of Care – Care Plan File (for new members)	Plan	CM System	Outbound	Monthly	
MCO to MCO Transition of Care –	Plan	CM System	Outbound	Monthly	

Care Plan File (for new members)					
Prior Authorization File	Plan	CM System	Outbound	Daily	
Care Plan Metafiles	CM System	Plan	Inbound	Weekly	
Care Plan PDFs	CM System	Plan	Inbound	Weekly	
Health Risk Screening Data	Text Vendor	CM System	Outbound	Daily	
Admission, Discharge, Transfer Feed	ADT Vendor	CM System	Outbound	Hourly or Real-time	
Supplemental data for HEDIS care gap closure	CM system	Plan	Outbound	Monthly	

- Eligibility Data – Member eligibility determines if a member is eligible with the Plan and provides demographic, caregiver, program and other data critical for care management. Eligibility will need to be maintained in the care management system through data exchange with the core system, at minimum weekly.
- Provider/Vendor Data – Provider/vendor elements define provider status with a health plan (e.g., participating or non-participating). Provider data will need to be maintained in the care management system through data exchange with the core system.
- Claims Data – Viewing paid and adjudicated but not yet paid claims history and the transfer of utilization data are necessary in managing patient care through the care management system and feeds from the core system. This will require the creation of a process for viewing claims and maintaining utilization data within the care management system through data feeds from the benefits administration system or data warehouse.
- Pharmacy prescription claims data - Pharmacy prescription data is critical for medication reconciliation and supporting medication adherence. It must be visible in the care management system and made available through data feeds from the pharmacy benefits manager (PBM) benefits administration system or data warehouse.
- Care Management System Reporting – Care management system must be able to support the export of care management data in a specified format, as well as care plans, goal status, outcomes and/or “gaps in care” supported via data exports for the purposes of state reporting and MCO-to-MCO transitions in care and to meet state requirements associated with posting member care plans in the member and provider portals. Additionally, the plan responses to health risk screenings and assessments.
- Authorizations – Care management system must support the importing and exporting of authorizations via data interface. Additionally, outbound authorization data must be produced in a format that allows for importing into the benefit administration system and accurate adjudication during claims processing for services authorized by care coordinators (Service Package II, home and community-based waiver services).

- Admission, Discharge and Transfer (ADT) Data – Contractor's care management system must support the integration of ADT data to ensure real-time notification of hospital admission and emergency department visits.
- EHR/Practice Management System Data – Contractor will transfer of demographic and other health data, including social determinants of health and other variables as defined by the Plan. If they are not available via the care management system, they shall be captured within the member's electronic health record and/or practice management system.

4.1.5. Care Management System Technical Requirements

Proposers should explicitly address the technical requirements in no more than ten (10) pages single-spaced, with up to five (5) additional pages for solution diagram(s). Any additional supporting information should be included in the proposer's appendix. In its narrative response, the proposer should address the following areas:

- List all interface standards that are employed (e.g. HL7, FHIR).
- Detail import/export functionality by platform and the support of external data (e.g. extracts, data dumps, file transfers, etc.).
- Describe in detail your history of integrating and interfacing with systems outside of your current system solution.

4.1.6. Care Management System Overview

Proposers must present a brief description and diagram(s) describing the components of the proposed solution, all proposed logical and physical models, expected interfaces, network infrastructure and other key elements that will help CCH's technology team better understand the proposed solution. This section must include:

- Diagram(s) depicting the required software modules and backend architecture (modules, servers, PCs, mobile devices, network, interfaces, storage components, etc.)
- Brief description of the software, including third-party components
- Other information that would help the evaluation committee determine the adequacy and advantages of the proposer's software
- Technical requirements (desktop, server, database, operating system, browser or any other required technology) to implement and support the solution

- All database and/or file management systems that your system solution works with

- Any additional products that need to be licensed with the system solution
- Other software applications, software libraries or systems that must be in place to support your system solution

4.1.7. Solution Maintenance

Proposers should describe their approach to product maintenance. At minimum, the proposer's response will address the following:

- How is the product development agenda determined, and what role does the customer play in this process?

- What is the average frequency of system solution updates and patches?

- Please explain the quality control/release management process for making these modifications.

- Describe how you support bug/issue reporting, tracking and your resolution process.

4.1.8 Scope 1 Minimum Performance Guarantees

Proposers to Scope 1 must agree to the following minimum performance guarantees, which CCH may add to during the contracting process. Proposer's standard set of guarantees must be submitted with the proposal.

Category/ Measure	Measure	Definition	Amount at Risk for Measurement Period	Amount at Risk for One Year
Risk stratification (overall)	≥ 95% of enrollees	Risk stratification of entire population	$5,000 per month	$60,000
Risk stratification – level 3 - families and children population	At least 2%	Stratification of enrollee group	$5,000 per month	$60,000
Risk stratification – level 3 - ACA adult population	At least 2%	Stratification of enrollee group	$5,000 per month	$60,000
Risk stratification – level 3 - special needs children	At least 20%	Stratification of enrollee group	$5,000 per month	$60,000

Risk stratification – level 3- seniors or persons with disabilities	At least 5%	Stratification of enrollee group	$5,000 per month	$60,000
Risk stratification – level 3 - Health Benefits for Immigrant Seniors	At least 5%	Stratification of enrollee group	$5,000 per month	$60,000
Risk stratification – level 3 - dual-eligible adults	At least 20%	Stratification of enrollee group	$5,000 per month	$60,000
Risk stratification – level 2 – special needs children	At least 40%	Stratification of enrollee group	$5,000 per month	$60,000
Risk stratification – level 2 - seniors or persons with disabilities	At least 20%	Stratification of enrollee group	$5,000 per month	$60,000
Risk stratification – level 2 - Health Benefits for Immigrant Seniors	At least 20%	Stratification of enrollee group	$5,000 per month	$60,000
Risk stratification – level 2 - dual-eligible adults	At least 90%	Stratification of enrollee group	$5,000 per month	$60,000
Health risk assessments	≥70% of all assigned Enrollees	Completion of health risk assessments (referred to in MCCN as “health risk screens”) within sixty (60) days of enrollment for new members	$5,000 per month	$60,000
Health risk assessments (comprehensive assessment)	≥70% of all new enrollees within ninety (90) days of being stratified as level 3 or 2	Completion of comprehensive health risk assessments completed within ninety (90) days of enrollee being stratified as level 3 or 2	$5,000 per month	$60,000
Health risk assessments (comprehensive assessment)	> 90% enrollees stratified to level 3	Completion of comprehensive health risk assessments for high/medium-acuity members	$5,000 per month	$60,000
Health risk assessments	>70% of eligible	Completion of comprehensive health risk	$5,000 per month	$60,000

(comprehensive assessment)	enrollees within thirty (30) days of eligibility	assessments within thirty (30) days of eligibility into the care management program (level 2 or level 3 risk)		
Care management program	> 70% of enrollees who are stratified to level 3	Enrollment in care management program for enrollees stratified to level 3	$5,000 per month	$60,000
Individualized plan of care (IPoC)	>70% of enrollees	Completion of IPoC within ninety (90) days of enrollment with vendor	$5,000 per month	$60,000
Required contracts	>75%	Completion of required contact within ninety (90) days for level 2 and 3 acuity members	$5,000 per month	$60,000
Care plan	>90%	Compliance with active care plan member signature	$5,000 per month	$60,000
IPoC sharing	>90%	Sharing IPoC with PCP	$5,000 per month	$60,000
Reassessment	>75% of enrollees every twelve (12) months	Enrollees with IPoCs re-assessment	$5,000 per month	$60,000

4.2. Scope of Work 2 – Value Based Care

4.2.1. Scope 2 - Minimum Qualifications

Proposers bidding for Scope 2 must meet the below minimum qualifications to be considered for award. Proposer should explicitly address the below qualifications in their response to section 4.2.1. Please provide comments and additional details in fewer than 20 pages single-spaced on how your organization meets the minimum qualifications. If Proposer does not describe how they meet the qualifications, CCH will not reach out for clarification, and Proposer will not be considered for award.

	Minimum Qualifications	Response (Y/N) and narrative
1	Demonstrated knowledge and five years of experience in this RFP's scope in an urban setting with underserved, multi-ethnic and multi-cultural populations.	
	Proposer's Response:	

2	Entity is not owned or operated by an MCO,	
	Proposer's Response:	
3	Entity has the capacity to serve at least 5,000 members within the proposed program or will have built this capacity within 6 months of receiving the award.	
	Proposer's Response:	
4	Demonstrated experience and success with care delivery within Medicaid managed care, including expertise in relevant standards like those maintained by NCQA, HFS and CMS.	
	Proposer's Response:	
5	If applicable, name the organizations in the Illinois Medicaid managed care market that the organization has worked with.	
	Proposer's Response	
6	Has a workforce diverse in ethnicity, gender and languages spoken (English and Spanish required). Language capabilities must extend to written materials and any other channels of member communications.	
	Proposer's Response:	
7	Entity has dedicated leadership resources for implementation, project management and contract support over three-year period, including: a) Medical director or clinical management/supervisory team with adequate full-time equivalent (FTE) to support overall program and licensed in Illinois. b) Operational management for process, system and reporting activities c) IT to support data exchanges, software system needs, reporting and data analysis d) Project management resources for implementation within three months of contract award and in the event of major transitions in population or systems	
	Proposer's Response:	
8	Ability to send and receive data. This includes both outbound and inbound data interfaces in standard and custom formats as required by the plan (i.e., eligibility, prior authorizations, claims, care management data)	
	Proposer's Response:	
9	Owns or leases a database or documentation system with architecture that supports scalability, segmentation and flexibility to adapt system to changing business needs and industry and regulatory standards	
	Proposer's Response:	
10	Utilizes evidence-based practice guidelines	
	Proposer's Response:	

11	Will commit to a percentage of compensation tied to achievement of quality metric (HEDIS) targets set by Health Plan in alignment with statewide quality strategy	
	Proposer's Response:	
12	**Cyber Liability Insurance**: Cyber liability insurance with minimum limit of $10,000,000 aggregate and no sublimits under $1,000,000. Provide evidence of insurance.	
	Proposer's Response:	
13	Proposer will not offshore any portion of the proposed services.	
	Proposer's Response:	
14	Completion of a 2025 SOC 2 Type 2 audit. Proposer must provide report upon submission of RFP proposal. Bridge letter and schedule is acceptable if SOC 2 is in progress.	
	Proposer's Response:	
15	Evidence of third-party penetration testing in 2025.	
	Proposer's Response:	

4.2.2. Scope 2 - Preferred Qualifications

In addition, successful Proposers will meet some of the following preferred qualifications. Proposer should explicitly address the qualifications below in their response to section 4.2.2. Please provide comments and additional details in fewer than 15 pages single-spaced on how your organization meets the preferred qualifications.

	Preferred Qualifications	Response (Y/N)
1	Experience partnering with public sector organizations. Please name those organizations.	
	Proposer's Response:	
2	Entity has the capability to take on 50-100% risk for total cost of care for the assigned member population.	
	Proposer's Response:	
3	Industry-recognized accreditation and/or certifications (please list)	
	Proposer's Response:	
4	Can establish live bi-directional IT interfaces/capacity for interoperability with external software	
	Proposer's Response:	
5	Demonstrated integration with providers in non-traditional care settings (e.g., schools, jails). Please describe.	
	Proposer's Response:	

6	Entity or its contracted providers will provide monthly supplemental data files to Plan for purposes of HEDIS care gap closure	
	Proposer's Response:	
7	Entity or its contracted providers will provide limited remote electronic medical record (EMR) access to Plan staff	
	Proposer's Response:	

4.2.3. Scope 2 - Program Proposal and Specifications

For each of the scope questions described below, detail the Proposer's solution. **Proposers should include and explicitly address how Proposer will meet or why Proposer cannot meet each of the below requirements in their response to this RFP.** Please use the corresponding response codes listed below in Proposer's RFP response. Responses with "T" in any of the below requirements should explicitly detail the names of the organizations that will be providing that service on Proposer's behalf. Proposers should articulate their responses in a succinct and direct manner. The responses should refrain from statements not related to the question, and general statements should be supported by factual proof points. Responses to section 4.2.3 shall not exceed fifty (50) pages.

Response code	Category Description
Y	Demonstrated (operational today). This response indicates that the process/technology described is in use by the Proposer for that product. If requested by CCH, Proposer can provide outcomes and/or examples of how the process/technology is currently deployed. If the Proposer is leveraging another organization's expertise, process or technology, then a "T" should be used.
D	Under Development. This response indicates that the process/technology described is currently under development and/or designed but is not yet operational in any of the Proposer's operational markets.
M	Modify. This response means that the Proposer is willing to develop the process/technology. Any cost of this enhancement to CCH should be itemized and included in the Proposer's projected cost of implementation.
T	Third Party. This response means that the functionality is available from a third-party partner of the vendor. If third-party products are proposed, please include an itemized list in the projected costs along with any projected costs chargeable to CCH. Additionally, indicate the name of the vendor that is performing that service.
N	This response indicates the Proposer does not have an applicable process/technology.

	Value-Based Care Proposal

Response Code	Organization Overview	Response Code (Y/D/M/T/N)
1	Proposer organization legal entity type and, if applicable, Provider Type classification in Illinois Medicaid IMPACT system.	
	Proposer's Response:	
2	Describe the Proposer's organization mission and scope of work. Include a description of the type of entity and how the organization would interact with CountyCare members (i.e. direct care, care management, etc)	
	Proposer's Response:	
3	Describe the Proposer's current geographic service areas. Include details about presence in the local Cook County area such as practice locations and provider FTE counts. Also include any plans for expansion of geographic coverage and scale.	
	Proposer's Response:	
4	Describe the payer mix of the current panel, if applicable.	
	Proposer's Response:	
5	List subcontracted entities involved in care management, analytics or population health.	
	Proposer's Response:	
6	Describe any major organizational changes anticipated over the next 24 months.	
	Proposer's Response:	
	Value-Based Care Delivery	**Response Code (Y/D/M/T/N)**
7	Describe the organization's prior value-based care experience. Include the models, payment methods, and populations served.	
	Proposer's Response:	
8	Provide an overview of the Proposer's value-based care program as designed for CountyCare members.	
	Proposer's Response:	
9	Define the CountyCare member population to be served by the value-based care program (i.e. age range, demographics, condition-specific considerations, etc.). Please describe any Medicaid member populations that are <u>not</u> appropriate for your model.	
	Proposer's Response:	
10	Describe how the Proposer plans to identify appropriate members for the value-based care program.	
	Proposer's Response:	

11	Describe how the Proposer will engage eligible or assigned members in the care model. Include description of patient engagement channels and available data on historical patient engagement.	
	Proposer's Response:	
12	Describe the care delivery model and setting for the value-based program. Include capabilities for brick-and-mortar locations, in home care, virtual care, rounding at facilities and any other modalities used.	
	Proposer's Response:	
13	Describe the approach to preventative care.	
	Proposer's Response:	
14	Describe the approach to chronic disease management. If the proposed program has a specific clinical focus, include details on disease management for that patient population.	
	Proposer's Response:	
15	Describe the behavioral health integration strategy. Include if behavioral health clinicians are embedded in the care team.	
	Proposer's Response:	
16	Describe the maternal health program, if applicable.	
	Proposer's Response:	
17	Describe the approach to social determinants of health. Include details about screenings, referrals, and direct social support available.	
	Proposer's Response:	
18	Describe the transitions of care strategy. Include details on staffing in or relationships with post-acute facilities such as home health, rehabilitation, and/or nursing facilities.	
	Proposer's Response:	
	Staffing Model	**Response Code (Y/D/M/T/N)**
19	Describe the leadership and staffing model at the Proposer organization that will support the value-based care program. Include who will be responsible for executive support, program management, and patient care/management. An organizational chart may be included in the Appendix.	
	Proposer's Response:	
20	Describe the dedicated value-based care leadership, staff, and oversight strategy.	
	Proposer's Response:	
21	Describe the care team structure. If applicable, include average PCP panel size and care manager panel size. For all model types, include all licensed roles that participate in member care.	

	Proposer's Response:	
22	Describe the language capabilities for member-facing staff.	
	Proposer's Response:	
23	Are PCPs aligned with specific hospitals? If yes, list the hospitals in the Cook County area.	
	Proposer's Response:	
	Operations	**Response Code (Y/D/M/T/N)**
24	Describe the population health technology platforms.	
	Proposer's Response:	
25	Describe HEDIS care gap closure capabilities and outcomes.	
	Proposer's Response:	
26	Describe the visit and outreach cadence for patients in the program. Include a description of the visit/outreach modality. Provide data on visit availability.	
	Proposer's Response:	
27	If the Proposer operates brick-and-mortar locations, describe the member transportation support available.	
	Proposer's Response:	
	Financial Readiness	**Response Code (Y/D/M/T/N)**
28	Describe the preferred payment model(s). NOTE: Specific payment model terms must be provided in the separate table below.	
	Proposer's Response:	
29	Will Proposer accept downside risk for this Scope? Please describe past experience with downside risk, including full risk and/or capitated arrangements.	
	Proposer's Response:	
30	Describe any financial protections required (e.g. maximum dollars exposure, maximum percentage exposure)	
	Proposer's Response:	
31	If the Proposer takes downside risk, does the Proposer carry its own stop-loss (reinsurance)?	
	Proposer's Response:	

4.2.4. Demonstrate Outcomes

Please complete the table below regarding the top five metrics the Proposer has used to evaluate outcomes in a similar population to the proposed program. Metrics of interest may include, but are not limited to, quality/HEDIS measures, per member per month cost or total

cost of care, ED visits/inpatient admissions/readmissions, net promoter score (NPS), or other clinical, financial, or member experience data. If needed, provide additional context about the methodology used or the population being measured.

Metric	Data Source *(i.e. claims, EHR, Care Management software, other)*	Population Demographics *(age range, payer mix, risk tier, diagnoses, etc)*	Timeframe	Outcomes
Example: 30 Day Readmission Rate	*Claims*	*High Risk Medicaid Adults 18+*	*2025*	*17%*

4.2.5. Proposed Rates

CountyCare and HFS align value-based medical spending to the nationally recognized HCP-LAN framework. Complete the table below, indicating the preferred pricing model(s), benchmarks, and rates for the proposed program.

As defined in the HCP-LAN framework, Category 3 and 4 models are expected to include quality measures within the payment design. In the table below, please explicitly include under "Financial Terms" the quality metrics proposed for the chosen payment model. List the metrics that will be attached to the risk-based payment and, if available, the proposed portion of payment tied to quality.

HCP-LAN Category	Payment Model	Description	Proposed for CountyCare? (Y/N)	Proposed Financial Terms
Category 3A	Shared Savings (Upside Only)	Opportunity to earn a percentage of savings generated against a defined benchmark. No downside risk.		

Category 3B	Shared Savings & Downside Risk	Two-sided arrangement with opportunity for both shared savings and shared losses against a total cost of care benchmark.		
	Episode-Based Payment (Upside/Downside Risk)	Accountability for quality and cost of a defined episode of care.		

HCP-LAN Category	Payment Model	Description	Proposed for CountyCare? (Y/N)	Proposed Financial Terms
Category 4A	Condition-Specific Population-Based Payment	Prospective payment covering care for members with a defined condition or clinical population.		

	Primary Care Capitation / Population-Based Payment	Prospective payment covering primary care services for an attributed population.		
Category 4B	Comprehensive Population-Based Payment (Partial Risk)	Prospective payment covering a broad range of services with accountability for quality and total cost of care.		

NOTE: REQUIREMENTS BELOW MUST BE ANSWERED FOR ALL PROPOSERS (SCOPE 1 AND/OR SCOPE 2).

The below questions apply to all scopes of work.

4.3. Hosting

Proposers must provide at a minimum:

- Brief description of the hosting provider
- Diagram and/or description of Tier III data centers addressing:
- Location of at least two geographically diverse data centers that do not share common threats (i.e., data centers cannot be in the same earthquake zone, likely hurricane path, same flood zone, etc.)
- Hardware redundancy
- Power redundancy
- Telecommunications redundancy
- Building integrity (HVAC, security, fire suppression, etc.).

4.4. Audit Requirements

Proposers must review each of the following and state whether their firm can meet the requirements or describe the reason why it cannot meet them.

- Proposer can provide annual SOC 2 audit reports to CCH or otherwise upon CCH's request.
- Proposer can provide corrective action plans or actions taken to resolve any exceptions, material weaknesses and/or control deficiencies identified in the SOC report.

- CCH will have the right to access and audit proposer's system and hosting.
- CCH will have the right to request reasonable adjustments at Proposer's expense where those requests are based upon audit findings pertaining to the system or hosting.

4.5. Hosting Transition Out and Exit Requirements

In the event the vendor-client contractual relationship ends, Proposers must provide the procedure to import and transition all CCH data to a location of choice from the vendor's hosted solution as well as CCH responsibilities in the event CCH would want to transition to on-premise hardware. This section does not require a detailed plan, but it does require:

- A bulleted list of expectations, including documentation and estimated costs in the event of a transition
- Commitment that, upon termination of the contract and at CCH's request, Proposer will transition and then destroy CCH data, including backups and copies thereof, according to all applicable standards or as otherwise directed by CCH
- Proposer shall automatically and without limitations transfer all CCH data in a format specified by CCH.

4.6. Backup and Disaster Recovery

Proposers must describe the proposed automatic backup and recovery capability for data and applications, ensuring continuous operation without interruption or degradation of services, including, at minimum, the information listed below.

Description of the backup and recovery plan, including:

- Data backup and recovery capabilities
- Application backup and recovery approach and capabilities
- Backup and recovery testing frequency
- Backup and recovery plan execution procedure (in the event of an incident), including:
- Key tasks
- Key roles and responsibilities for CCH and for Proposer
- Proposed recovery time objective (RTO) and recovery point objective (RPO)

In the event of a technology or other failure at the primary data center, Proposer should state if the alternate system can meet the requirement listed or one of the following, for which CCH's use should be identical, regardless of which location is processing CCH's work. If Proposer cannot meet this requirement, it must state its proposed tiers.

Category	Alternate system characteristics
High Availability	Continuous operation without interruption or degradation in service.
Standard Availability	Available for CCH use within 48 hours with no degradation in service.

Non-Critical Availability	Available for CCH use within 96 hours with no degradation in service.

4.7. Data Security

Proposer must also provide a reasonably detailed explanation as to how the proposal protects the system and CCH data within each of the following additional data security categories.

- Describe how security roles are defined within the system solution, including definitions and modification of roles by administrator.
- Password configurations (e.g., complexity, aging, etc.)
- Authentication configurations (e.g., active directory, encrypted data exchange, hash, etc.)
- Encryption configurations (e.g., symmetrical AES-256, asymmetrical RSA 2048, etc.) for both data at rest and data in motion
- Logging/auditing capabilities (e.g., verbose user tracking and reporting, etc.)
- Personnel security (e.g., extensive background checks, annual recheck, etc.)
- Physical security (e.g., 24-hour security, alarms, restricted access, etc.)
- Web application configurations (e.g., SQL injection protection, buffer overflow, etc.)
- Network transmission security (LAN and VPN)
- Data that is to be transmitted off-site must be encrypted end to end.
- Proposer shall confirm that, under its proposal, all data at rest will not be stored outside of the continental United States.

4.8. Remote Security

CCH only permits secure connectivity between a vendor and CCH. All transmitted data must be encrypted. This type of connection is referred to as a “nailed-up” connection and requires a one-time setup. Vendor access to CCH for purposes of support, either application or network hardware, is achieved by the use of Cisco’s remote-access VPN client and Cisco’s VPN adaptive security appliance (ASA) firewalls. This allows for encrypted data to traverse between the remote client and the specific CCH network device or application. All time-reporting data that is transmitted to and from devices must be encrypted. Data that is to be transmitted off-site must be encrypted end to end. Access to hosted applications either internal or external to CCH must be securely connected using a non-standard TCP port, and the devices will be limited to only the necessary site(s). CCH reserves the right to impose more restrictive network access controls.

4.9. HIPAA and Regulatory Compliance

The Selected Proposer may have access to confidential information, including PHI, to perform the functions, activities or services for or on behalf of CCH as specified in this RFP. Proposer must acknowledge that, if awarded, there is a high likelihood that the Selected Proposer may have access to PHI in paper or electronic form, and thus, it must sign a business associate agreement with CCH. As a business associate, the Selected Proposer will agree to comply with all federal and state privacy, confidentiality and security laws and regulations, including but not

limited to HIPAA, HITECH, Medicare confidentiality regulations, as defined herein, and all other applicable rules and regulations. Proposer must commit to requiring all staff and subcontractors to complete HIPAA training upon hire and no less frequently than annually thereafter. CCH reserves the right to review and accept the training program prior to implementation or require Proposer to use HIPAA materials or training sessions supplied by CCH.

Describe how Proposer's company is HIPAA compliant.

4.9.1 Has Proposer had a third-party (independent) company confirm and certify Proposer as HIPAA compliant? If yes, which company provided the certification, and when was the certification obtained? Please provide the certification and any relevant SOC or HITRUST reports (or similar).

4.9.2 Provide a listing of Proposer's current HIPAA Privacy, Security and Breach Notification policies and procedures, including date of creation and date of last revision.

4.9.3 Describe Proposer's staff training programs for privacy and security awareness, including frequency of training completion and how training completion is tracked.

4.9.4 List and provide short descriptions of all software and/or applications used by Proposer that will create, receive, access, use, disclose, maintain and transmit CountyCare PHI.

4.9.5 List the number of HIPAA incidents reportable to the HHS Office for Civil Rights (OCR) during the past five (5) years. Please include the aggregated incident count and the associated individual count by year.

4.9.6 Has Proposer's company been cited or fined or been notified of pending citation or financial penalties within the last five (5) years for federal or state privacy law violations and/or failure to implement privacy regulations? If yes, explain in detail.

4.9.7 What is Proposer's defined process for transmitting and storing PHI, and how does it comply with both the content requirements and disclosure restrictions of all applicable state, federal and public health laws? Provide documentation.

4.9.8 Provide a summary of any cyber insurance policies held by Proposer, including information regarding minimum or aggregate limits and sublimits.

4.9.9 Provide an explanation of whether Proposer and/or its subcontractors access, use, store, maintain or transmit CountyCare PHI, documents, data, claims, guidelines, protocols, programs, financial analyses, performance measures or other information at or to any offshore location, including a description of any Proposer services that will be performed by offshore operations and any contracted services. Include Proposer's processes for review, auditing and monitoring its offshore staff or subcontractors and the frequency of review and/or auditing and monitoring activities.

4.9.10 Provide an explanation of how Proposer will ensure that any vendor or subcontractors utilized by Proposer will comply with applicable HIPAA privacy and security requirements, including those outlined in the business associate agreement between CCH and Proposer.

4.9.11 How does Proposer stay updated on current laws, compliance issues and HFS and/or CMS changes to the Medicaid program, including those related to communication requirements and guidelines? How does Proposer implement any necessary changes throughout the organization and ensure accuracy and timeliness? How does Proposer

communicate these changes to clients and work with clients to update processes as needed?

4.9.12 Has Proposer's company been cited or fined or been notified of pending citation or financial penalties within the last five (5) years for federal or state law violations and/or failure to implement regulations? If yes, explain in detail.

4.10. Compliance Requirements

Compliance requirements are intended to demonstrate Proposer's capability to adhere to the detailed compliance requirements that CCH, through its Medicaid health plan, CountyCare, must follow. Each respondent must demonstrate implementation of an effective compliance program that meets the regulatory requirements set forth in the CMS Medicaid Managed Care Program Integrity requirements (42 CFR 438.608), in addition to requirements for operating an HMO in Illinois.

Note: Failure to complete the section in its entirety will disqualify your proposal. This section is specific to corporate compliance requirements of a health plan and its vendors. It does not address contract compliance requirements referenced elsewhere within this RFP.

4.10.1 Compliance Program

Proposer must provide an explanation, along with tangible examples and/or submitted collateral material, of Proposer's compliance program, including how its compliance plan incorporates the seven elements of an effective compliance program as mandated by the CMS Medicaid Managed Care Program Integrity requirements. Policies, procedures or other documentation submitted may include Proposer's code of ethics/code of conduct, compliance plan, a listing of compliance policies or procedures and Proposer's organization chart, including the reporting or relationship hierarchy for the compliance program.

4.10.2 Written Policies, Procedures and Code of Ethics.

Proposer must submit a description of current compliance-related policies, procedures or other documentation where available, including a description of how Proposer disseminates its code of ethics, policies and procedures to all personnel, agents, subcontractors and delegated vendors. The explanation should include the frequency of the dissemination of materials and the methodology for tracking receipt.

4.10.3 Compliance Officer and Compliance Oversight Committee(s)

If available, Proposer should provide two (2) organizational charts, the first demonstrating the organizational hierarchy with the compliance officer, privacy officer and security officer. A second organizational chart demonstrates the reporting structure of the compliance program team, including staffing numbers and roles in addition to HIPAA privacy and security personnel.

4.10.4 Effective Training and Education

Proposer must describe the initial and continuing (i.e., annual) compliance and privacy education/training programs that are completed by staff and vendors, including specific detail on the following topics:

- Code of ethics/compliance program,
- HIPAA privacy and security,

- Fraud, waste and abuse (FWA)
- Critical incident/abuse, neglect and exploitation training (as applicable); and
- Cultural competency.

For each of the training topics listed above:

- Identify the audience for training completion (e.g., personnel, agents, providers, subcontractors, first tier, downstream related entities [FDRs]).
- Specify the modality for delivering each training topic above, the frequency of training delivery and the mechanism used to track training completion.
- Provide a summary of how Proposer ensures that personnel, agents, providers, subcontractors and delegated vendors complete training as mandated by regulatory and contractual obligations.
- Provide record retention policies and procedures for maintaining training records.

4.10.5 Effective Lines of Communication

- Provide an explanation of Proposer's expectations for reporting concerns related to compliance, integrity, FWA and financial misconduct by employees and vendors.
- Describe Proposer's compliance hotline. Include the days and hours of operation and whether Proposer manages the hotline internally or externally through a third party. If a third party is used, identify the vendor. Delineate the intended recipients of the hotline (members, personnel, agents, providers, subcontractors, vendors) and the procedures to review, investigate and act on, if warranted, all hotline reports.

4.10.6 Disciplinary Standards

- Identify ramifications for failure to report a violation. Provide supporting policy or procedure documentation on sanctions and describe the levels of disciplinary action.
- Describe how violations of the code of ethics or policies and procedures will result in disciplinary action or sanctions and provide policies and procedures explaining the process.

4.10.7 Monitoring, Auditing and Identification of Compliance and FWA Risks

- Describe Proposer's compliance program for identifying, monitoring, auditing and remediating compliance-related risks, including compliance and FWA risks that are specific to value-based care arrangement (for example, coding and risk adjustment integrity, financial arrangements and incentive structures and risk based claims analytic monitoring).
- Describe the process for annual Work Plan or Audit Plan development.
- Describe how the Proposer will detect, investigate and report suspected instances of FWA that impact the IL Medicaid program. Submit a process flow diagram illustrating the process for conducting a reasonable investigation of each suspected FWA involving providers and subcontractors, Proposer's workforce and subcontractors, and members.

Include within the diagram the process of notification to CCH Compliance of suspected FWA and potential criminal acts.

- Where applicable, describe how the Proposer will develop and utilize data analytics to help identify and address provider and member variances / outliers that may be indicative of potential FWA, including the identification of any external resources or software utilized as part of the process.
- Describe the process for tracking and documenting compliance auditing and investigation efforts.
- Describe in detail audits or monitoring schedules of providers and vendors, subcontractors, agents used by Proposer to ensure compliance with contractual and regulatory requirements. Include the frequency of the activity.
- Provide an explanation and/or policy that addresses how Proposer will ensure full cooperation with any review, audit or investigation conducted by the CCH compliance program or their designee (including those related to readiness activities) or any regulator/oversight entity (HFS, HFS OIG, etc.).

4.10.8 Prompt Responses to Detected Offenses

Describe how Proposer has established and implemented methods and programs that encourage personnel, subcontractors, vendors, agents and providers to report program non-compliance and potential compliance issues without fear of retaliation. Describe the investigation tracking system and the resolution process, including how issues may be reported/escalated to CountyCare Compliance.

4.10.9 Reporting Compliance Concerns

- Describe how Proposer supports a safe, non-threatening environment where individuals may ask questions about integrity and compliance, FWA and financial misconduct matters and report their concerns.
- Delineate the methods of how concerns may be submitted from personnel, providers, agents and members and describe the tracking system and the resolution process.
- Identify how reporters are protected from retaliation and harassment.

4.10.10 Exclusion Screening

- Describe how Proposer avoids employing, engaging, contracting, reimbursing or agreeing with any individual or entity who is excluded or sanctioned from participation in a federal or state health care program or who is debarred from participation in federal or state procurement or non-procurement programs for the provision of goods or services.
- Describe the system Proposer has in place to screen all current and prospective employees, contractors and subcontractors, prior to engaging their services and at least monthly thereafter, by reviewing the list of sanctioned persons through:
    - The HHS OIG List of Excluded Individuals/Entities (LEIE) searchable database (https://exclusions.oig.hhs.gov),
    - HFS OIG exclusion (available at http://www.state.il.us/agency/oig),

  - The Excluded Parties List System (EPLS)/System of Award Management (SAM) maintained by the U.S. government (available at https://www.sam.gov/portal/SAM/##11) and
  - The Office of Foreign Assets Control (OFAC) Specially Designated Nationals (SDN) List (https://sanctionssearch.ofac.treas.gov/)
- Provide a description of the exclusion screening process, including a list of related policies maintained by Proposer. If a third party is used to perform exclusion screening, identify the vendor.

4.10.11 Incident Reporting

Describe the process and procedures in place for Proposer to receive reports of adverse events, including critical incidents, and the internal reporting system for tracking the reporting and responding to critical incidents and analyzing the event to determine if there is a need for individual or systemic changes.

4.10.12 Conflict of Interest

Describe the system Proposer has in place to collect, assess, store and report information related to conflict of interest surveys for personnel, officers, directors and subcontractors and the officers, directors and personnel of Proposer's subcontractors and vendors.

5. Subcontractor Services

The below sections must be completed if Proposer is seeking to utilize a subcontractor to perform services on behalf of CCH and/or CountyCare for this contract.

PART I - Subcontractor Information (Organization level)	
Name of the Vendor that contracted the Subcontractor to perform services for CountyCare:	
Subcontractor Name:	
Subcontractor Address:	
Additional addresses (including any offshore locations):	
Effective date of the agreement with the Vendor and the Subcontractor:	
Please include below a description of the work being performed under the agreement with the Subcontractor, including a listing of any services and deliverables that will be provided to CountyCare:	
Will the Subcontractor perform any services under its agreement/contact with Cook	

County Health in an offshore location? **Please note that services performed offshore must be approved by CountyCare.** If **yes**, please describe the services that will be performed in the offshore location:	
Will the Subcontractor utilize any vendors, contractors, and/or subcontractors located in an offshore location to perform any services under its agreement/contact with Cook County Health? If **yes**, please name the vendors used and describe the services to be performed in the offshore locations:	

PART II: Principal Members of Subcontractor Organization.

A. Please name the principal members of the Subcontractor organization including the following positions: officers, directors, owners, and board members.

Note: If more space is required for the listing of Principal Members, please add extra rows or attach additional documentation.

Name	Title

B. Do any of the principal members of the Subcontractor organization listed above have a *relative*[1] or *close friend*[2] who works at Cook County Health (CCH)?

Yes ☐ or No ☐

If yes, please provide the name of their relative/friend below and describe the relationship.

[1] *Relative* is defined as an individual's spouse, domestic partner, civil-union partner, parent, step-parent, child, step-child, grandparent, sibling, step-sibling, uncle, aunt, great aunt, great uncle, first cousin, nephew, niece, grandson, granddaughter, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, half-brother, or half-sister, and all of the preceding forms of relation to the individual's spouse, domestic partner, or civil union partner (if any).
[2] Examples of a *close friendship* include attending regular personal dinners and vacationing together on personal trips.

PART III: Individuals with Management or Supervisory Responsibilities for Subcontractor Organization

A. Please list all individuals with management or supervisory responsibilities working for the Subcontractor that will be dedicated to CountyCare services and deliverables:

Note: If more space is required for the listing of individuals with management or supervisory responsibilities, please add extra rows or attach additional documentation.

Name	Title

B. Do any of the principal members of the Subcontractor organization listed above have a *relative* or *close friend* who works at Cook County Health (CCH)?

Yes ☐ or No ☐

If yes, please provide the name of their relative/friend below and describe the relationship.

PART IV: Information Technology and Data Privacy Leads for Subcontractor Organization.

Please name the Information Technology and Data Privacy Leads for the Subcontractor, including all individuals responsible for safeguarding CountyCare data and protected health information (PHI).

Note: If more space is required for the listing of informational technology and data privacy leads, please add extra rows or attach additional documentation.

Name	Title

Part V. Subcontractor Conflict of Interest Disclosure

Does the Subcontractor employ or have a contract with any former employee of Cook County Health?

Yes ☐ or No ☐

If you select **"Yes,"** please provide the name, title, and date of termination at CCH. **If more space is required, please add extra rows or attach additional documentation.**

Name	Title	Date of Termination at CCH

6. Submission of Proposal

6.1 Instructions for Submission

6.1.1 Electronic Submission

Proposers are required to electronically submit their proposal to https://cookcountyhealth.bonfirehub.com/portal/?tab=openOpportunities no later than the time and date indicated in the RFP.

The Proposer is responsible for ensuring the electronic copy is complete.

6.1.2 Time for Submission

Proposals shall be submitted no later than the due date and time indicated in this RFP. Late submittals may not be considered.

6.1.3 Late Proposals

Proposer remains responsible for ensuring that its proposal is received at the time, date, place and office specified in this RFP. CCH assumes no responsibility for any proposal not so received, regardless of the cause of delay.

6.1.4 Schedule of Revisions to RFP Schedule

Should Proposer consider that changes in the CCH's RFP schedule are required, Proposer shall submit a revised summary schedule with an explanation for the revision for CCH's review. CCH will be under no obligation to accept revised schedules.

6.1.5 Complete Proposals

Proposers are advised to carefully review all the requirements and submit all documents and information as indicated in this RFP. Incomplete proposals may lead to a proposal being deemed non-responsive. Non-responsive proposals will not be considered.

6.2 Submission Requirements

This RFP provides potential Proposers with sufficient information to enable a Proposer to prepare and submit proposals. CCH is supplying a base of information to ensure uniformity of responses. It must be noted, however, that the guidelines should not be considered so rigid as to stifle the creativity of any Proposer responding.

This RFP also contains the instructions governing the submission of a Proposal and the materials to be included therein, which must be met to be eligible for consideration. All proposals must be complete as to the information requested in this RFP to be considered responsive and eligible for award. Proposers providing insufficient details will be deemed non-responsive. CCH expects all responses to reflect exceptional quality, reasonable cost and overall outstanding service.

Any page of a proposal that Proposer asserts to contain confidential proprietary information, such as trade secrets or proprietary financial information, shall be clearly marked "CONFIDENTIAL PROPRIETARY INFORMATION" at the top of the page. Additionally, the specific portions of the page that are asserted to contain confidential proprietary information must be noted as such. However, note that ONLY pages that are legitimately confidential should be marked "confidential." CCH will return proposals that mark all pages as confidential or are copyrighted. All proposals submitted to CCH are the property of CCH.

Further, Proposer is hereby warned that any part of its proposal or any other material marked as confidential, proprietary or trade secret can only be protected to the extent permitted by Illinois statute.

Proposals shall not contain claims or statements to which Proposer is not prepared to commit contractually. The information contained in the proposal shall be organized as described in this section.

6.2.1 Cover Letter

The cover letter shall be signed by an authorized representative of Proposer. The letter shall indicate Proposer's commitment to providing the services proposed at the price and schedule proposed. Proposer shall provide information on its point of contact for its proposal to include at a minimum: name, title, address, phone number and email address.

6.2.2 Executive Summary

The executive summary should include a brief overview of the services and the key personnel who will be responsible for the services to be provided. The summary shall also identify the members of the team that comprise the Proposer. Indicate the organizational relationship of the team members and include an organization chart for the project.

6.2.3 Qualifications of the Proposer

Include a description of the organization's track record, including history, number of employees, number of years in business and a list of projects relevant to this RFP. Provide a list of references where relevant projects were implemented. Include the name of the contact person, name of the organization, project dollar value, address, telephone number and email address. Please provide at least three (3) references, preferably with a large hospital/health care system. In addition, for each firm included in the proposal, provide at least three (3) references that are relevant to the project scope. Proposers who do not provide references with complete information as outlined below in their initial proposal submission will be disqualified from further consideration.

Reference 1

Required Information	Details
Name of the organization	
Name of the contact person (title, email and phone number. Email must be from an organization, not a personal email.)	
Date contracted	
Line of business	
Hospital/health system (yes/no)	
Current client/terminated client	
Scope of services	

Reference 2

Required Information	Details
Name of the organization	
Name of the contact person (title, email and phone number. Email must be from an organization, not a personal email.)	

Date contracted	
Line of business	
Hospital/health system (yes/no)	
Current client/terminated client	
Scope of services	

Reference 3

Required Information	Details
Name of the organization	
Name of the contact person (title, email and phone number. Email must be from an organization, not a personal email.)	
Date contracted	
Line of business	
Hospital/health system (yes/no)	
Current client/terminated client	
Scope of services	

6.2.4 Proposed Plan of Action, Implementation and Solution

Provide your response to the Scope of Services, Section 4. Provide a detailed proposed plan of action indicating how all requirements will be met, the methodology for proposed recommendations and the implementation plan to successfully meet the goals of CCH. In addition, the proposed plan of action shall include key milestones, staff and schedule and the ability to deliver value with a solution evidenced by cost savings.

6.2.5 Key Personnel

Proposer must identify the key personnel that will be assigned to the project. The chief procurement officer reserves the right to reject any key personnel proposed if it is determined to be in CCH's best interest. Provide a chronological resume for each of the key personnel proposed. Each key personnel member shall have three (3) references. In addition, provide the time commitment for each key personnel member. Indicate the level of their commitment to other projects if any.

6.2.6 Minority Business Enterprise and Women Business Enterprise (MBE/WBE) Participation

For each MBE/WBE-certified firm proposed, provide the name of the MBE/WBE firm(s), level of participation, the role that the subcontractor(s) will perform, the type of services that it will provide and a brief background and resumes of proposed personnel and submit the **MBE/WBE Utilization Plan Forms** (**see Attachment A**). CCH may only award a contract to a responsible and responsive Proposer. If Proposer does not meet the MBE/WBE participation goal stated by CCH for this procurement, Proposer must nevertheless demonstrate that it undertook good faith efforts to satisfy the participation goal. Evidence of such efforts may include but shall not be limited to documentation demonstrating that Proposer made attempts to identify, contact and solicit viable MBE/WBE firms for the services required, that certain MBE/WBE firms did not respond or

declined to submit proposals for the work or any other documentation that helps demonstrate good faith efforts. Failure by Proposer to provide the required documentation or otherwise demonstrate good faith efforts will be taken into consideration by CCH in its evaluation of Proposer's responsibility and responsiveness.

Consistent with Cook County, Illinois Code of Ordinances (Article IV, Division 8, and Section 34-267), CCH has established a goal that MBE/WBE firms retained as subcontractors receive a minimum 35% MBE/WBE of this procurement. **The Office of Contract Compliance has determined that the MBE/WBE participation goal for this specific contract is 35% combined MBE and WBE participation.**

6.2.7 Financial Status

7 Provide the audited summary financial statements for the last two fiscal years. State whether Proposer or its parent company has ever filed for bankruptcy or any form of reorganization under the Bankruptcy Code, and, if so, the date and case number of the filing.

8 State whether Proposer or its parent company has ever received any sanctions or is currently under investigation by any regulatory or governmental body.

6.2.8 Conflict of Interest

Provide information regarding any real or potential conflict of interest. Failure to address any potential conflict of interest upfront may be cause for rejection of the RFP.

6.2.9 Contract, Master Service Agreement (MSA)

A sample Contract (Master Service Agreement) is available in (**see Attachment B, CCH Sample Master Service Agreement**). Execution of the Contract is not required at the time the proposal is submitted. In the event Proposer disagrees with any Contract provisions, or is proposing alternate language, Proposer shall include the language for consideration by submitting the proposed redlines on the sample MSA document. CCH will not consider any exceptions or proposed alternate language to the MSA if the Proposer does not include these objections or alternate language with the proposal. CCH shall not be deemed to have accepted any requested exceptions by electing to engage a Proposer in negotiations of a Contract.

6.2.10 Legal Actions

Provide a list of any pending litigation in which Proposer may experience significant financial settlement and include a brief description of the reason for legal action.

6.2.11 Confidentiality of Information

Proposer may have access to confidential information, including PHI, to perform the functions, activities or services for or on behalf of CCH as specified in this RFP. Proposer must acknowledge that, if awarded, there is a high likelihood that Proposer may have access to PHI, in paper or electronic form, and thus, it shall sign a business associate Agreement with CCH. As a Business Associate, the selected Proposer will agree to comply with all federal and state confidentiality and security laws and regulations, including HIPAA, HITECH, Medicaid confidentiality regulations, as defined herein, and all other applicable rules and regulations. Proposer must commit to requiring all staff, including

drivers, attendants, other personnel and subcontractors, to complete HIPAA training upon hire and no less frequently than annually thereafter. CCH reserves the right to review and accept the training program prior to implementation or require the selected Proposer to use HIPAA materials or training sessions supplied by CCH.

6.2.12 Economic Disclosure Statement

Execute and submit the Economic Disclosure Statement (EDS) (**see Attachment C**). In the event any further clarification is required on any of the information provided, CCH reserves the right to make any necessary communication with Proposer for such purpose. Such communication, if made, may include a deadline by which time any necessary clarifying information must be submitted.

6.2.13 Addenda

The **Addenda Acknowledgement Form** (**see Attachment D**) must be signed by an authorized Proposer representative and returned with the proposal on or before the proposal due date. Failure to sign and return all addenda acknowledgments may be grounds for rejection of the proposal.

6.2.14 Price Proposal

Proposer must complete and submit a price proposal for the required services. If your company has specific, unique and/or innovative ideas to implement this system that are outside of the parameters defined on the pricing proposal, please provide your firm's recommendations on a separate sheet. In addition, the price proposal may include a breakdown of personnel rate card and the number and level of staffing for the services.

CCH makes no guarantee that the services or products identified in this RFP will be required. Proposer must provide sufficient pricing details to permit CCH to understand the basis for the RFP.

CCH is neither obligated to purchase the full quantities proposed by Proposer, nor to enter into an agreement with any one proposer.

7. Evaluation and Selection Process

7.1 Proposal Assessment

7.1.1 Responsiveness Review

CCH personnel will review all proposals to ascertain that they are responsive to all RFP requirements.

7.1.2 Acceptance of Proposals

The Chief Procurement Officer reserves the right to reject any or all proposals or any part thereof, to waive informalities and to accept the proposal deemed most favorable to CCH.

7.2 Evaluation Process

An evaluation committee comprised of CCH and/or CountyCare personnel will evaluate all responsive proposals in accordance with the selection process detailed below.

The RFP provides requirements and data, which will be used as a basis for a written presentation of qualifications of the firm(s) and proposed staff, project approach, systems and methodologies for delivery of the project.

This evaluation process may result in a shortlist of proposals. The evaluation committee, at its option, may request that all or short-listed proposers make a presentation, share other customer testimonials, submit clarifications, schedule a site visit of their premises (as appropriate), provide a best and final offer, provide additional references, respond to questions or consider alternative approaches.

7.2.1 Shortlist Proposer Presentation

CCH reserves the right but is not obligated to request and require each proposer to provide a formal presentation of its proposal at a date and time to be determined. If required by CCH, it is anticipated that such presentation will not exceed four (4) hours. No proposer will be entitled to present during or otherwise receive any information regarding any presentation of any other proposer.

7.2.2. Right to Inspect

CCH reserves the right to inspect and investigate thoroughly the establishment, facilities, equipment, business reputation and other qualifications of Proposer and any proposed subcontractors and to reject any RFP, regardless of price, if it shall be administratively determined that, in CCH's sole discretion, Proposer is deficient in any of the essentials necessary to assure acceptable standards of performance. CCH reserves the right to continue this inspection procedure throughout the life of the contract that may arise from this RFP.

7.2.3. Best and Final Offer

CCH reserves the right to request a best and final offer from finalist proposer(s), if it deems such an approach necessary. In general, the best and final offer will consist of updated costs as well as answers to specific questions that were identified during the evaluation of proposals.

If CCH chooses to invoke this option, proposals will be re-evaluated by incorporating the information requested in the best and final offer document, including costs and answers to specific questions presented in the document. The specific format for the best and final offer would be determined during evaluation discussions. Turnaround time for responding to a best and final offers document is usually brief (i.e., five (5) business days).

7.3 Selection Process

Upon review of all information provided by shortlisted proposers, the evaluation committee will make a recommendation for selection to the Chief Procurement Officer for concurrence and submission to the CCH Board of Directors. CCH reserves the right to check references on any projects performed by Proposer whether provided by Proposer or known by CCH.

The selected proposal will be submitted for approval to the CCH Board. CCH intends to select a proposal that best meets the needs of CCH and provides the best overall value. Upon approval of the selected proposer, a contract will be prepared by CCH and presented to the selected proposer for signature.

7.4 Consideration for Contract

Any proposed contract, including all negotiations, shall be subject to review and approval of CCH management, CCH Legal and CCH's Board of System. Proposed contracts are also subject to review by the Cook County Office of Contract Compliance.

Following finalization of contract documents to the satisfaction of CCH executive management, CCH shall secure appropriate reviews and may approve the proposed contract for execution in its sole discretion. The identity of the successful Proposer shall be posted on the website.

8. General Evaluation Criteria

8.1 Responsiveness of Proposal

Proposal(s) will be reviewed for compliance with and adherence to all submission requirements requested in this RFP. Proposal(s) that are incomplete and missing key components necessary to fully evaluate the RFP may, at the discretion of the Chief Procurement Officer or designee, be rejected from further consideration due to non-responsiveness and rated non-responsive.

Proposer must be compliant with all the submission requirements of the RFP. The evaluation committee will evaluate all responsive proposals in accordance with the evaluation criteria detailed below.

8.1.1 Criteria Proposal

Proposals will be reviewed and selected based on the qualifications of Proposer to successfully perform the services for CCH throughout the course of the contract as evidenced by the following criteria:

a. Ability to achieve CCH's business goals, objectives and scope of services described in this RFP by providing a succinct and feasible description of the proposed implementation approach
b. Qualifications and experience of Proposer to successfully perform and provide the services described in this RFP, as evidenced by the successful provision of similar services in similar environments and in compliance with all applicable laws
c. Relevant experience
d. Applicability of MBE/WBE utilization plan

In addition, the evaluation committee may review and consider the information and evidence of Proposer's responsiveness to the following categories:

1. Financial status
2. Conflict of interest
3. Insurance requirements.

4. Contract terms and conditions (objections and/or suggested alternate language)
5. Legal actions
6. Addenda acknowledgement (See addenda section)

Should the following be requested, the evaluation committee may consider:

1. Oral presentations evaluated based on the following criteria: Proposer addressed all topics, question and concerns of the evaluation committee
2. Best and final offer evaluated based on the following criteria: degree to which the best and final offer decreases the original price proposal for the proposed scope of services.

9. Instructions to Proposers

This RFP provides potential proposers with sufficient information to prepare and submit proposals. This RFP also contains the instructions governing the submission of a proposal and the materials to be included therein, including CCH requirements, which must be met to be eligible for consideration. All proposals must be complete as to the information requested in this RFP to be considered responsive and eligible for award. Proposers providing insufficient details will be deemed non-responsive. CCH is not obligated to purchase the full services or the products proposed by the Proposer, nor to enter into an agreement with any one proposer.

9.1 Pre-Proposal Conference (if Applicable)

CCH will hold a pre-RFP conference call on the date, time and location indicated on the cover page. Representatives of CCH will be present to answer any questions regarding the goods or services requested or RFP procedures. If a mandatory pre-RFP conference is required, Proposer must sign the pre-RFP conference or site inspection sheet and include a copy of this sign-in sheet in the response to the RFP.

9.2 Availability of Documents

CCH publishes competitive bid, RFP and other procurement notices, as well as awarded RFP, information, at:

www.cookcountyhealth.org under the "Doing Business with CCH" tab.
https://cookcountyhealth.bonfirehub.com/portal/?tab=openOpportunities

Interested proposers should note that, unless otherwise stated in the bid or RFP documents, there is no charge or fee to obtain a copy of the bid documents and respond to documents posted for competitive solicitations. Proposers intending to respond to any posted solicitation are encouraged to visit the website above to ensure that they have received a complete and current set of documents. Some procurement notices may provide a downloadable version of the pertinent documents and any amendments to them, which will be available to proposers after they have completed a simple registration process.

Any proposers receiving a copy of procurement documents from a bid referral service and/or other third party are solely responsible for ensuring that they have received all

necessary procurement documentation, including amendments and schedules. CCH is not responsible for ensuring that all or any procurement documentation is received by any proposer that is not appropriately registered with CCH.

9.3 Questions and Inquiries

All questions regarding this RFP will be submitted in writing **no later than the specified questions due date** via the link below:
https://cookcountyhealth.bonfirehub.com/portal/?tab=openOpportunities

9.4 Submitting the Proposal Package

The proposal and the pricing proposal shall be submitted to the CCH Office of Supply Chain Management Chief Procurement Officer electronically as per the instructions in **Appendix 1-Instructions for Submitting an Electronic Bid/Proposal/Qualification**. The Office of Supply Chain Management Chief Procurement Officer will not accept hardcopy proposals. Proposer remains responsible for ensuring that its proposal is received at the time, date and manner specified. CCH assumes no responsibility for any proposal not received. **Late proposals will not be accepted.**

9.5 Uniformity

To provide uniformity and to facilitate comparison of proposals, all information submitted must clearly refer to the page number, section or other identifying reference in this RFP. All information submitted must be noted in the same sequence as its appearance in this RFP. CCH reserves the right to waive minor variances or irregularities.

9.6 Proposal Material

The proposal material submitted in response to the RFP becomes the property of CCH upon receipt by the Office of Supply Chain Management Chief Procurement Officer and will be part of any contract document for the goods or services which are the subject of this RFP.

9.7 Addenda

Should any proposer have questions concerning conditions and specifications, find discrepancies or omissions in the specifications or be in doubt as to their meaning, they should notify the Office of Supply Chain Management Chief Procurement Officer no later than the questions due date and time listed on this RFP to obtain clarification prior to submitting a proposal. Such inquiries must reference the proposal due date and the CCH RFP number.

Any clarification addenda issued to Proposer prior to the proposal due date shall be made available to all proposers. Since all addenda become a part of the proposal, **the Addenda Acknowledgement Form (found in Attachment E) must be signed by an authorized Proposer representative and returned with the proposal on or before the proposal opening date. Failure to sign and return all addenda acknowledgments may be grounds for rejection of the proposal.**

Interpretations that change the terms, conditions or specifications/scope will be made in the form of an addendum to the solicitation by CCH. If issued, CCH will post the addenda on CCH's website: https://cookcountyhealth.bonfirehub.com/portal/?tab=openOpportunities.

9.8 CCH RFP Format

All proposers will use this solicitation format for submitting their proposals. Variations or exceptions from the specifications and general conditions should be submitted in writing. Such variations or exceptions may be considered in evaluating the offers received. Any exception taken must be noted and included in the proposal. Failure to comply with this requirement may cause Proposer's proposal to be considered "non-responsive."

9.9 Pricing

All price and cost information requested in this solicitation should be provided by Proposer. While price is a factor in the evaluation of responses received, the relevant importance of price may vary based on the nature of the purchase and the related significance of other criteria as may be expressed elsewhere in this solicitation. In evaluating price, CCH may consider all costs of ownership factors relevant to determine the total final cost to CCH, including but not limited to the administrative costs of issuing multiple awards. CCH will be the sole determinant of the relevant and appropriate cost factors to be used in evaluating any base or alternate offers and/or options.

9.10 Period of Firm Proposal

Prices for the proposed service must be kept firm for at least one hundred and twenty (120) days after the time specified for submitting proposals. Firm proposals for periods of fewer than this number of days may be considered non-responsive. Proposer may specify a longer period of firm price than indicated here. If no period is indicated by Proposer in the proposal, the price will be firm until written notice to the contrary is received from Proposer.

9.11 Alteration/Modification of Original Documents

Proposer certifies that no alterations or modifications have been made to the original content of this bid/RFP or other procurement documents (either text or graphics and whether transmitted electronically or hard copy in preparing this RFP). Any alternatives or exceptions (whether to products, services, terms, conditions or other procurement document subject matter) are apparent and clearly noted in the offered RFP. Proposer understands that failure to comply with this requirement may result in the RFP being disqualified and, if determined to be a deliberate attempt to misrepresent the RFP, may be considered as sufficient basis to suspend or debar the submitting party from consideration from future competitive procurement opportunities.

9.12 Cost of Proposer Response

All costs and expenses in responding to this RFP shall be borne solely by Proposer, regardless of whether Proposer's RFP is eliminated or whether CCH selects to cancel the RFP or declines to pursue a contract for any reason. The cost of attending any presentation or demonstration is solely Proposer's responsibility.

9.13 Proposer's Responsibility for Services Proposed

Proposer must thoroughly examine and read the entire RFP document. Failure of proposers to fully acquaint themselves with existing conditions or the amount of work involved will not be a basis for requesting extra compensation after the award of a contract.

9.14 RFP Interpretation

Interpretation of the wording of this document shall be the responsibility of CCH and that interpretation shall be final.

9.15 Specifications and Special Conditions

The specifications in this RFP provide sufficient guidance for proposers to devise a plan and provide pricing. Minor variations from those specifications will be considered if proposers identify any instance in which their services specifications differ from those set forth in the RFP documents.

9.16 Errors and Omissions

Proposer is expected to comply with the true intent of this RFP taken as a whole and shall not avail itself of any errors or omission to the detriment of the services or CCH. Should Proposer suspect any error, omission or discrepancy in the specifications or instructions, Proposer shall immediately notify CCH in writing, and CCH will issue written corrections or clarifications. Proposer is responsible for the contents of its RFP and for satisfying the requirements set forth in the RFP. Proposer will not be allowed to benefit from errors in the document that could have been discovered by Proposer in the process of putting the RFP together.

9.17 Confidentiality and Response Cost and Ownership

All information submitted in response to this RFP shall be confidential until CCH has executed a contract with the successful proposer or has terminated the RFP process and determined that it will not reissue the RFP. **Any page of a proposal that Proposer asserts to contain confidential proprietary information, such as trade secrets or proprietary financial information, shall be clearly marked "CONFIDENTIAL PROPRIETARY INFORMATION" at the top of the page. Additionally, the specific portions of a page that are asserted to contain confidential proprietary information must be noted as such. However, note that ONLY pages or specific information that are/is legitimately confidential should be marked confidential and proprietary. CCHHS will return proposals that mark all pages confidential or are copyrighted. All proposals submitted to CCHHS are the property of CCHHS.**

Further, Proposer is on notice that any part of its proposal or any other material marked as confidential, proprietary or trade secret can only be protected to the extent permitted by Illinois law, including but not limited to the Illinois Freedom of Information Act [5 ILCS 140 *et seq.*].

9.18 Awards

CCH may, at its discretion, evaluate all responsive proposals. CCH reserves the right to make the award on an all or partial basis or split the award to multiple proposers based on the highest-rated proposer and best value to CCH meeting the specifications, terms and

conditions in accordance with the evaluation criteria set for in this RFP. If a split award impacts the outcome of the project, it must be stated in the proposal.

9.19 CCH Rights

CCH reserves the right to reject all offers, to waive any informality in the offers and, unless otherwise specified by Proposer, to accept any item in the offer. CCH also reserves the right to accept or reject all or part of your RFP in any combination that is in the best interest of CCH.

9.20 Cancellation of RFP; Requests for New or Updated Information

CCH, in its sole discretion, may cancel the RFP at any time and may elect to reissue the RFP later. CCH may also issue an addendum modifying the RFP and may request supplemental RFP or updated or new RFP.

10. Definitions

The following definitions apply to this RFP:

“Abuse” means (i) a manner of operation that results in excessive or unreasonable costs to federal or state health care programs, generally used in conjunction with fraud; or (ii) the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish, generally used in conjugation with neglect.

"Addendum” or “addenda" shall refer to one or more documents posted to the website that modify this RFP or provide additional information.

“Appeal” means a request for review of a decision made by Proposer with respect to an action.

“Board” or “Cook County Health” shall refer to the board of directors of the Cook County Health or Cook County Health and Hospitals System.

"Contract" shall mean a properly executed contract that has been negotiated between CCH and a proposer for some or all the deliverables described in this RFP.

“Contractor(s)” and “selected proposer” shall mean the individuals, businesses or entities that have submitted a proposal and have negotiated a contract that has been properly executed on behalf of the contractor and CCH.

"County" shall mean the County of Cook, Illinois, a body politic and corporate.

“Deliverables” shall refer to the items, supplies, equipment or services that will be provided pursuant to any contract entered because of this RFP.

“Fraud” means knowing and willful deception or a reckless disregard of the facts with the intent to receive an unauthorized benefit.

“**General Conditions”** shall refer to the terms and conditions included with this RFP.

"**Proposal**" shall mean the document(s) submitted by Proposer(s) in response to this RFP that constitute Proposer's offer to enter a contract with CCH under terms consistent with this RFP, subject to the negotiation of a contract and approval by the board.

"**Procurement Director**" or “system SCM director” shall mean the chief procurement officer of supply chain management who serves as chief procurement officer for the CCH.

"**Proposer(s)"** shall mean the individuals or business entities, if any, submitting a proposal in response to this RFP.

"**Request for Proposals**" or "RFP" shall refer to this solicitation of proposals by CCH that may lead to the negotiation of a contract.

11. List of Attachments

The following Attachments are included electronically to this RFP.

7 **Attachment A - MBE/WBE Utilization Plan**

8 **Attachment B – CCH Master Services Agreement**

9 **Attachment C - Economic and Disclosures Statement**

10 **Attachment D - Addenda Acknowledgement Form**

12. Appendix 1-Instructions for Submitting an Electronic Bid/Proposal/Qualification

INSTRUCTIONS FOR SUBMITTING AN ELECTRONIC BID/PROPOSAL/QUALIFICATION

For electronic submissions, firms shall use the following link to submit bids/proposals/qualifications electronically:

https://cookcountyhealth.bonfirehub.com/portal/?tab=openOpportunities

Follow the steps listed in the below article to access the opportunity and submit your bid/proposal.

https://support.gobonfire.com/hc/en-us/articles/360011034814-Creating-and-Uploading-a-Submission-for-Vendors-

There is also a video on vendor registration and submission at this link:

https://support.gobonfire.com/hc/en-us/articles/203903356-Vendor-Registration-and-Submission-

If you have questions or technical issues accessing or submitting your bid/proposal, please reach out to Bonfire at:

support@gobonfire.com
1 (800) 354 8010 Extension #2