COOK COUNTY HEALTH (CCH)

REQUEST FOR PROPOSAL RFP# H21-0040

TITLE: Third Party Administrator Request for Proposal

GENERAL DESCRIPTION: Health Plan Services (HPS) seeks Third Party Administrative (TPA) services for Medicaid, Medicare, Medicare-Medicaid Alignment Initiative (MMAI), Cook Medical Group, and CareLink/Uninsured. Claims Processing, Utilization Management, Reporting and Analytics, Financial Support, Member Incentives Fulfillment, Risk Adjustment, and Encounter Data.

DATE ISSUED: October 7, 2021

VENDOR QUESTIONS DUE DATE: October 18, 2021 no later than 5:00 PM (CT)

RESPONSE/ PROPOSAL DUE DATE: November 9, 2021 no later than 5:00 PM (CT)

Responses to this RFP shall be delivered after 8:00 AM (CT) but no later than 2:00 PM (CT) to:

Cook County Health C/O John H. Stroger, Jr. Hospital
1969 West Ogden Ave., Lower Level Room # 250A
Chicago, IL 60612
Attention: Supply Chain Management Department

Please note that it takes approximately 20 minutes to pass security and walk to room 250A.

PRE-PROPOSAL CONFERENCE /FIELD INSPECTION: None

Delivery of RFP must include the RFP Acknowledgement Form included at the end of this document.

All questions regarding this RFP should be directed to purchasing@cookcountyhhs.org

The RFP and related Addenda will be posted at the http://www.cookcountyhealth.org website under the "Doing Business with Cook County Health" tab.

Contents

1. 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. Cook County Health 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 at the Cook County Jail and to the residents of Cook County's Juvenile Temporary Detention Center
- The Ruth M. Rothstein CORE Center, a comprehensive care center for care of HIV and other infectious diseases, and
- Health Plan Services (HPS) comprised of the CountyCare Health Plan, the largest Medicaid managed care plan in Cook County and one of the largest in the northeast region of the state; and MoreCare, a portfolio of Medicare Advantage products

CCH's history and mission to care for all, regardless of the ability to pay, dates back over 180 years ago. In that time, 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 despite the new healthcare environment in which we operate.

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 nearly 20 times as many outpatient prescriptions than the average commercial pharmacy. The CCDPH is a state and nationally certified public health authority serving the majority of suburban Cook County.

CCH firmly believes that to obtain the true benefits provided by the Patient Protection and Affordable Care Act (ACA) health care transformation must go beyond simply increased access to health insurance and must extend to health practice as well. The launch of CountyCare in fall 2012 under the ACA's Early Enrollment Option set the course for CCH's transformation. In the years since, CCH has seen a dramatic shift in its payer mix such that a majority of CCH Patients are now insured – the first time this has been the case in CCH's 180-year history of direct care.

1.2 Health Plan Services (HPS)

HPS is a Department within CCH that currently manages two lines of business: CountyCare, an Illinois Medicaid managed care plan, and MoreCare, a portfolio of Medicare Advantage plans including a Medicare Advantage Part D Plan, a Chronic Special Needs Plan (C-SNP) for beneficiaries with HIV, an Institutional Special Needs Plan, and an Institutional Equivalent Special Needs Plan (IE-SNP).

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 Cook County adults (ACA adults) 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 rate for every enrollee in its health plan. CountyCare currently has over 410,000 enrollees and over 650 Medicare beneficiaries in Cook County.

The CountyCare provider network includes more than 5,500 primary care providers, 26,000 specialists and over 70 hospitals in Chicago and across Cook County. For HPS, innovation remains a theme in its development and growth, with a consistent focus on establishing itself as a pioneering provider-led and government health plan.

Recently, HPS also developed a strategy to provide the system's long-standing patients with continuity of care as they age into Medicare. In January 2020, HPS launched its Medicare Advantage Program, MoreCare. At present, MoreCare has over 600 members and offers the following products to Medicare-eligible residents of Cook County:

- MoreCare for You: A Medicare Advantage plan with prescription drug coverage (MAPD)
- MoreCare+: A chronic conditions special needs plan for residents diagnosed with HIV (C-SNP/HIV-SNP)
- MoreCare Home: An institutional special needs plan for residents living in long-term care facilities/nursing homes (I-SNP)
- MoreCare at Home: An institutional equivalent special needs plan for residents who are receiving or will need nursing facility or skill nursing facility level of care but reside at home or in the community (IE-SNP)

Building off the launch of the Medicare Advantage plan in January of 2020, HPS seeks to offer a Medicare-Medicaid Alignment Initiative (MMAI) plan for plan year beginning January 1, 2023. Offering an MMAI plan aligns with the organization's core mission to support vulnerable populations in the community, capture revenue for services provided domestically, maximize care by coordinating member's Medicare and Medicaid benefits, and continue to diversify membership beyond the core Medicaid population.

MMAI is a demonstration designed to improve health care for dually eligible beneficiaries in Illinois. Jointly administered by the Centers for Medicare & Medicaid Services (CMS) and the Illinois Department of Healthcare and Family Services (HFS), MMAI allows eligible beneficiaries in Illinois to receive their Medicare Parts A and B benefits, Medicare Part D benefits, and Medicaid benefits from a single Medicare-Medicaid Plan, also known as a MMAI plan.

By integrating and coordinating individuals' health care benefits, the demonstration aims to:

- Improve quality and the beneficiary experience in accessing care;
- Promote person-centered care planning;
- Promote independence in the community;
- Rebalance long-term services and supports (LTSS) to strengthen and promote the community-based systems; and
- Eliminate cost shifting between Medicare and Medicaid

1.3 Cook Medical Group

Cook County employees, as part of their benefit plan, can select Blue Cross PPO or Blue Cross HMO for their insurance coverage. Prior to 2018, employees enrolled in the Blue Cross HMO were unable to get their medical care at a Cook County Health (CCH) facility as CCH providers were not in the Blue Cross HMO network. In 2018, CCH signed a medical service agreement (MSA) with Blue Cross HMO and because Blue Cross HMO only contracts with independent physician associations (IPA), CCH created Cook Medical Group. In this agreement, Blue Cross and Cook Medical Group share financial responsibility. Blue Cross is responsible for Inpatient Service and Pharmacy while Cook Medical Group has financial responsibility for Outpatient/Ancillary Service and all Professional Fees.

The provider network for Cook Medical Group includes all CCH facilities and providers (primary care, specialty and ancillary). The membership is distributed amongst four Blue Cross plans - HMO of Illinois, Blue Precision which are commercial insurance plans, and Blue Advantage, Blue Focus Care which are government exchange products. Membership has been increasing. In 2018, average membership was 2,924 and in 2019 it increased to 3,401.

1.4 CareLink/Uninsured

CCH offers an innovative solution for its uninsured patients, providing them a network of primary care providers (both at CCH and at FQHCs), as well as specialty and facility services at CCH facilities. We are seeking a partner who can provide a cost effective, flexible and customizable solution as CCH continues to mature this product offering. Currently, CCH has approximately 30,000 patients enrolled in its uninsured program, CareLink.

1.5 HPS Statistics

The following tables are provided to give proposers a snapshot HPS to assist in crafting responses. All data are current for the time period indicated in the headers.

1.5.1 CountyCare Membership Profile, July 2021

LOB	Members
ACA	109,441
FHP	252,578
ICP	30,312
MLTSS	7,809
SNC	7,488
IMD	322
FYIC	304
Total	408,256

1.5.2 MoreCare Membership Profile, April 2021

LOB	Members
MAPD	398
C-SNP	57
I-SNP	1
IE-SNP	213
Total	669

1.5.3 CountyCare 2020 Call Volume

Member Calls	Volume
Total Call Volume	416,737
Monthly Average	34,728
Provider Calls	**Volume**
Total Call Volume	168,451
Monthly Average	14,037

1.5.4 MoreCare 2020 Call Volume

Member Calls	Volume
Total Call Volume	3,278
Monthly Average	273

1.5.5 CountyCare 2020 Authorizations Volume

Authorizations	Volume
Total Authorizations Processed	165,891
Monthly Average	13,824

1.5.6 MoreCare 2020 Authorizations Volume

Authorizations	Volume
Total Authorizations Processed	239
Monthly Average	20

1.5.7 CountyCare 2020 Claims Volume

Claims	Volume
Medical	4,833,958
Behavioral Health	644,894
Waiver	426,599
Total	5,905,451
Average Monthly	492,120

1.5.8 MoreCare 2020 Claims Volume

Claims	Volume
Total	11,128
Average Monthly	927

1.5.9 CountyCare Providers, May 2021

Provider Type	NPI Count
PCP	5,671
Specialist	26,144

2. Purpose

CCH is seeking to identify competitive qualified proposers to contract for Third Party Administrator (TPA) services as outlined in Section 4 – Scope of Services for Medicaid, Medicare, MMAI, Cook Medical Group, and CareLink/Uninsured products

2.1 Term of Services

The term of services shall be for thirty-six (36) months with two optional two (2) year extensions. The award agreement may be terminated by CCH for convenience following one hundred twenty (120) calendar days' prior written notice of termination. Termination for convenience is an essential term to any CCH Contract.

2.2 Basis of Award

The basis of award shall be at minimum one proposer based on the highest rated proposal offering the best value to CCH that meets the specifications, terms, and conditions as assessed using the evaluation criteria set forth in section 7 of this RFP.

3. Schedule

CCH anticipates the following schedule:

Activity	Estimated Date
RFP posted to the website	10/7/2021
Proposer Inquiry Deadline	10/18/2021
CCH response to Vendor Questions-Tentative	10/28/2021
Proposal Due Date	11/09/2021
Evaluation of RFP (Tentative)	11/10/2021 - 12/15/2021
System Demonstrations (Tentative)	1/3/2021 - 1/7/2021
System References (Tentative)	1/3/2021 - 1/7/2021
Notification of Decision (Tentative)	February 2022

4. Scope of Services

4.1 Services Overview

CCH plans to select at minimum one vendor that can provide the TPA services as outlined below.

CCH is requesting proposals for TPA Services that meet the following criteria.

4.2 Qualifications:

Applicants must meet the following minimum qualifications:

	Minimum Qualifications	Response (Y/N)
1	Proposer has a minimum of five (5) years of experience in providing TPA Services for Medicaid and Medicare plans.	
2	Knowledge of and experience in Medicaid managed care	
3	Knowledge of and experience in Medicare Part D	

	Minimum Qualifications	Response (Y/N)
4	Knowledge of and experience with Medicare-Medicaid Alignment Initiative (MMAI)	
5	Flexibility to adapt to new and changing industry and regulatory standards	
6	Knowledge of and experience with exchange and marketplace products	
7	Strong references that attest to the quality, reliability, and integrity of the applicant – both in terms of its team and its products/services	
8	Knowledge of and experience with employer and commercial products	
9	NCQA Accreditation in Utilization Management	
10	Must not be owned, in full or in part, by a Medicaid health plan operating in Cook County, IL or a parent or affiliate of such a plan	
11	Substantial knowledge of, and experience working with safety net, community-based organizations, specifically Federally Qualified Health Centers (FQHCs) and Community Mental Health Centers (CMHCs).	

In addition, successful applicants will likely meet some of the following preferred qualifications:

	Preferred Qualifications	Response (Y/N)
1	Full NCQA Health Plan Accreditation	
2	NCQA Health Information Product Certification	
3	NCQA Wellness and Health Promotion Accreditation/Certification	
4	NCQA Credentials Verification Organization (CVO) Certification	
5	URAC Accreditation	
6	Experience partnering with public sector organizations	
7	Experience in the Illinois Medicaid Managed Care market	
8	Customization at the state and client level	
9	Other Industry-recognized accreditation and/or certifications (please list)	
10	Opportunities to demonstrate innovation, growth strategies, and cost saving initiatives	

Applicants should explicitly address the above qualifications in their response to this RFP. If the response is "No" to any of the above qualifications, please provide comment and additional detail in less than 3 pages single spaced.

4.3 Service Requirements and Responsibilities Matrix

Applicants should include and explicitly address in a brief narrative how they will meet the below Requirements and Responsibilities Matrix in their response to this RFP. Please use the corresponding response codes listed below in your RFP response. If the response is "D/M/T/N" to any of the below qualifications, please provide comment and additional detail.

Response code	Category
Y	Yes (operational today). This response indicates that the line item on the checklist is an operational feature that exists in a production environment. This functionality can be demoed at HPS' request.
D	Under Development. This response indicates that the line item on the checklist is currently under development is scheduled to occur within the next six months. Responses in this category should include the release date.
M	Modify. This response means that the vendor is willing to develop the feature. The cost of this enhancement should be itemized and included in the vendor'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.
N	No. Place an N in the box if none of the above descriptions are true.

4.3.1 Medicaid Requirements

Responses to Section 4.3.1 shall not exceed 75 pages.

	FUNCTIONAL REQUIREMENTS	RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.1.1	**HEALTHCHOICE ILLINOIS CONTRACTUAL REQUIREMENTS**		
4.3.1.1.1	TPA must follow contractual requirements outlined in the MCCN Contract between HFS and HPS. Model Contract can be found here: https://www2.illinois.gov/hfs/MedicalProviders/cc/Pages/ManagedCareContracts.aspx .		
4.3.1.2	**Enrollment, Disenrollment, Retention, and Eligibility**		
4.3.1.2.1	*Member Eligibility Management*		
4.2.1.2.1.1	Accept electronic eligibility.		
4.2.1.2.1.2	Process updates to enrollment/disenrollment information in all electronic systems maintained by TPA to reflect information contained in the HFS eligibility files within the regulatory timeframe.		
4.2.1.2.1.3	Process updates to member demographic information in all electronic systems maintained by TPA upon receipt of new information from any internal or external source including downstream vendors.		
4.2.1.2.1.4	Create and maintain a repository of member phone/address/contact information captured by internal and external sources including downstream vendors and providers that gives HPS and vendor staff access to up-to-date demographic information.		
4.2.1.2.1.5	Provide electronic eligibility verification technology (e.g., automated voice recognition system and secure portal) to allow providers and enrollees to confirm eligibility information without speaking to a customer service representative.		

	FUNCTIONAL REQUIREMENTS	RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.2.1.2.1.6	Actively seek and identify Coordination of Benefits (COB) information and enter all Third-Party Liability data in the Member Eligibility system to assist in claims processing.		
4.3.1.2.2	*PCP Assignment*		
4.3.1.2.2.1	Process an Enrollee's oral or written request to change PCP within the regulatory timeframe. Requests may be made telephonically or electronically as follows: • Oral request via call center(s) • Written request via an email inbox maintained by the TPA • Electronic request on the member portal or chat box		
4.3.1.2.2.2	Support efforts to assist in connecting members with PCPs, particularly new members coming into the plan, including conducting outreach.		
4.3.1.2.3	*Reporting*		
4.3.1.2.3.1	Disseminate enrollment and disenrollment information including electronic eligibility files and analytical reports to mutually agreed upon data sharing partners in the manner and frequency required by HPS and/or HFS.		
4.3.1.2.4	*Member Retention and Redetermination*		
4.3.1.2.4.1	Staff an inbound and outbound Retention Team to support retention and redetermination activities including but not limited to inbound and outbound member outreach and attending in-person outreach events as needed. Parties shall mutually agree to scope of work and any associated costs.		
4.3.1.2.4.2	Develop process for warm handoff transfer of Member Services calls to the Retention Team from members displaying dissatisfaction or eagerness to leave the plan.		
4.3.1.3	**MEMBER INCENTIVE PROGRAM/VALUE-ADDED BENEFITS.** Member Incentive Program/Value-Added Benefits are rewards and benefits approved by the Department of Healthcare and Family Services (HFS) and provided by HPS in addition to Covered Services.		
4.3.1.3.1	TPA shall administer benefits directed by HPS in the Member Incentive Program/Value-Added Benefits, including but not limited to Rewards Cards, Sleep Safe Kits, Weight Watchers Vouchers, Diaper Coupon, Home Pregnancy Tests, and Children's Book Club. The full of value-added benefits can be found here: https://countycare.com/members/benefits-rewards/		
4.3.1.3.2	Purchase, store and mail supplies and program materials, per the benefit and criteria as defined by HPS. TPA shall track and securely store all mail that is returned.		
4.3.1.3.3	Have designated staff for escalation of rewards issues, as well as to issue expedited rewards, freeze cards, order replacement cards, and other functions related to the program		
4.3.1.3.4	TPA shall inform all members of the Member Incentive Program/Value-Added Benefits during the Welcome Call process.		

	FUNCTIONAL REQUIREMENTS	RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.1.3.5	TPA shall produce reports for member incentives and value-added benefits in agreed upon format for the management and member engagement analysis.		
4.3.1.3.6	TPA will answer any member or provider questions regarding the program as part of their regular duties		
4.3.1.4	**MEDICAL MANAGEMENT (MEDICAL AND BEHAVIORAL SERVICES)**		
4.3.1.4.1	*Utilization Management*		
4.3.1.4.1.1	Employ competent and adequate staff as well as qualified licensed health professionals to conduct mutually agreed upon utilization management functions. Key positions include but are not limited to: • Medical Director who is an Illinois-licensed Physician with a minimum of five (5) years of experience practicing in internal medicine, primary care, or pediatrics. • Medical Director who is a board-certified Illinois-licensed psychiatrist with a minimum of eight (8) years of experience in mental health, substance abuse, or children services and who will serve as a full-time senior executive and be responsible for all Behavioral Health activities. • Care Management Liaison to serve as a resource to HPS' subcontracted care-management entities (CMEs).		
4.3.1.4.1.2	Maintain a Utilization Management Program that includes a utilization-review plan, a utilization-review committee, and appropriate mechanisms covering preauthorization and review requirements in accordance with current NCQA standards, the MCCN Contract and 42 CFR 456 and 42 CFR 438.404 and maintain its program Plan, Policies, Procedures, and practice accordingly. Special considerations include but are not limited to the following: • Mutually agreed upon UM decision-making criteria for substance use, transplant centers and long-term services and supports. • Mechanisms to restrict an Enrollee to a designated PCP or Provider of pharmacy services as directed by HPS and/or HFS. • Ensure direct access services such as Emergency Services, Post-Stabilization Services, family planning services, school-based health centers, and school-based dental services by-pass affiliation or authorization requirements. • Process for managing transition of Covered services in accordance with NCQA standards and the MCCN contract that includes but is not limited to identification of Enrollees deemed critical for Continuity of Care using a variety of sources including prior claim history provided by HFS and service authorizations, and stabilization and provision of uninterrupted access to Covered Services.		

	FUNCTIONAL REQUIREMENTS	RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.1.4.1.3	Prepare a Year-End Utilization Management Program Evaluation with HPS health plan level data on an annual basis. The Evaluation is used to propose amendments to utilization review procedures as necessary in order to improve said procedures.		
4.3.1.4.1.4	Prepare an Annual Utilization Management Program Description which includes, at a minimum, procedures to evaluate medical, behavioral health, and substance use necessity criteria used and the process used to review and approve the provision of medical, behavioral and substance use services.		
4.3.1.4.1.5	Implement a Utilization Review Plan that includes mechanisms to detect under- and over-utilization, mechanisms to ensure consistent application of review criteria for authorization decisions, and mechanisms to evaluate the effects of the program using data on Enrollee and Provider satisfaction.		
4.3.1.4.1.6	Work to have and create defined site of care pathways to ensure members receive services at the most appropriate site of care. These pathways should include identification of members in need of targeted transition of care services.		
4.3.1.4.1.7	Monitor and submit analytical reports for timeliness of the following and act on opportunities to improve timeliness in accordance with NCQA standards: • Nonbehavioral UM decision making • Notification of nonbehavioral UM decisions • Behavioral UM decision making • Notification of behavioral UM decisions.		
4.3.1.4.1.8	Evaluate the consistency with which health care professionals involved in UM apply criteria in decision making and act on opportunities to improve consistency in accordance with NCQA standards.		
4.3.1.4.1.9	Complete readiness reviews including but not limited to NQTL analyses to ensure mental health parity compliance and amend utilization management processes to improve said compliance.		
4.3.1.4.1.10	Adhere to HPS' Utilization Management Program through participation in committee meetings, submission of reports in formats and frequencies mutually agreed upon, reporting suspected Fraud and Abuse, making recommendations for changes to the Program when problem areas are identified, and collaboration with care management.		
4.3.1.4.1.11	Documentation system for entering and tracking UM decisions and supplying HPS with utilization information and data, and reports prescribed in its approved utilization review system as required by NCQA, MCCN contract or upon request by HPS.		
4.3.1.4.1.12	Provide the results of all authorization decisions electronically on the provider portals, to the requesting provider, Enrollee and Enrollee's assigned Care Management Entity.		

	FUNCTIONAL REQUIREMENTS	RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.1.4.1.13	Maintain sufficient and adequately trained UM resources to staff an inbound call center at least eight hours a day during normal business hours in accordance with NCQA standards and HPS policies and procedures. HPS reserves the right to change the hours as needed based on historical data or events. In addition to providing for availability of live agents during regular business hours, the UM Department shall ensure staff can receive inbound communication regarding UM issues after normal business hours via telephone, email, and/or fax in accordance with NCQA standards and HPS policies and procedures.		
4.3.1.4.2	*Care Management*		
4.3.1.4.2.1	Support Care Management Program functions and health plan regulatory reporting by compiling and reporting Care Coordination Claims Data (CCCD) from the Illinois Department of Healthcare and Family Services and care management information from the CMEs. TPA shall not be responsible for the quality of CME data.		
4.3.1.4.2.2	Maintain and update data definition specifications and logic for Care Management files.		
4.3.1.4.2.3	Create and maintain an algorithm for member assignment to Care Management Entities (CME). Assignments shall be fully validated with validation criteria, business rules, and processing logic provided to HPS.		
4.3.1.4.2.4	Adhere to HPS' Children's Mental Health Service Program through policies defining the delivery of crisis and stabilization services, which shall not require prior authorization for an established period of time post-crisis that shall not be less than thirty (30) days, communication of admission, discharge data consistent with consents and releases secured to the necessary PCP and Network Providers; and submission of State required reporting.		
4.3.1.4.2.5	Print and distribute mailings to all Enrollees enrolled in care management that may include reminders about the benefits of participating in the population health management and care-management programs as directed by HPS.		
4.3.1.4.3	*Quality Health Plan Program*		
4.3.1.4.3.1	Support the HPS Quality Health Plan Program through adherence to its policies and procedures, participation in committee and performance improvement meetings, submitting data and narrative to support annual quality and population health management program evaluations and reports to the State, revision of processes where deficiencies are identified, and collaboration on quality improvement projects.		
4.3.1.4.3.2	Provide a dedicated resource who will focus on and assist HPS on evaluating and developing interventions focused on health equity.		

	FUNCTIONAL REQUIREMENTS	RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.1.4.3.3	Process to identify and refer quality of care (QOC) incidents and health, safety, and welfare (HSW) concerns in accordance with HPS and HFS policies that arise from any of the following activities, Enrollee or Provider calls, Enrollee Grievances, Provider Complaints, Appeals, and utilization review, etc. Contractor will follow HPS policies and actively cooperate with QOC and HSW investigation procedures.		
4.3.1.4.3.4	Maintain an inventory of quality measures adapted from HEDIS® and other quality bodies for use by HPS. TPA shall program the HEDIS® Quality Measures in compliance with the HEDIS® quality measure specifications resulting in data that is consistent with actual HEDIS® certified vendor calculated data.		
4.3.1.4.3.5	Provide support for HEDIS® activities throughout the year including but not limited to: • Kick-off and external validation activities. • Consultative support such as assistance with roadmap and report completion. • Chart over-reads. • Work with providers to receive EMR supplemental data feeds to enhance quality/HEDIS data. • Contacting provider practices and updating provider practice information as needed to support the HEDIS® vendor, and evaluation of HEDIS® results. HEDIS provider data changes or corrections will be incorporated into the standard inload process and the TPA will reconcile the differences between HEDIS® requirements and the TPA's data. • TPA shall make available all HEDIS® data for plan use upon HPS request.		
4.3.1.4.3.6	Support CAHPS and Provider Satisfaction survey activities throughout the year including kick-off activities, consultative support, contacting enrollees and provider practices, updating enrollee and provide practice information as needed to support the survey vendor, and evaluation of survey results. HEDIS enrollee and provider data changes or corrections will be incorporated into the standard process.		
4.3.1.5	**APPEAL AND GRIEVANCE PROGRAM**		
4.3.1.5.1	Maintain an Appeal and Grievance Program in accordance with current NCQA standards and HFS requirements and maintain its program Plan, Policies, Procedures, and practice accordingly. TPA shall review its Appeal and Grievance procedures at least annually to amend such procedures when necessary to comply with regulatory standards.		
4.3.1.5.2	Maintain adequate staff to address all appeals and grievances, including a Manager of Appeals & Grievances responsible for direct oversight of the team, as well as reporting and quality assurance of metrics.		

	FUNCTIONAL REQUIREMENTS	RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.1.5.3	Maintain records of appeals and grievances for a minimum of 10 years or as otherwise required by law. At a minimum, the record must contain general description of reason for Grievance or Appeal, date received, date reviewed, and resolution, including date, at each level, and name of Person for whom the Grievance or Appeal was filed.		
4.3.1.5.4	Participate in the State Fair hearing process including but not limited to preparing documentary evidence within the requested timeframe; and providing a witness to offer testimony supporting the appeals decision.		
4.3.1.5.5	Ensure claims are reprocessed when the initial denial decision is overturned.		
4.3.1.5.6	Adhere to the HPS' Utilization and Quality Program through participation in committee meetings, submission of reports to HPS and HFS, and revision of processes where deficiencies are identified.		
4.3.1.5.7	Ensure accuracy of Appeal and Grievance information on the HPS public website and in all relevant member and provider communications (e.g., Member Handbook and Provider Manual).		
4.3.1.6	**CALL CENTER EXPERIENCE**		
4.3.1.6.1	*Inbound Call Center (Member and Provider)*		
4.3.1.6.1.1	Maintain a dedicated toll-free number for all Member and Provider services calls delegated as TPA functions. This number will be used at a minimum for Enrollees and Providers to file Appeals and Grievances, to request disenrollment, to ask questions, or to obtain other administrative information.		
4.3.1.6.1.2	Provide an automatic call distribution and auto-attendant (ACD-AA) telephone system where Enrollee's caller ID displays health plan name and inbound call center number.		
4.3.1.6.1.3	Manage phone tree configuration, call routing process flows and messaging.		
4.3.1.6.1.4	Staff a Call Center from 8:00 a.m. to 6:00 p.m. Central Time on Business Days, and 9:00 a.m. to 1:00 p.m. Central Time on Saturdays. HPS reserves the right to change the hours as needed based on historical data or events. In addition to providing for availability of live agents during regular business hours, the Call Center shall assure twenty-four (24)–hour telephone access to medical professionals for consultation, except during scheduled maintenance or approved downtimes.		
4.3.1.6.1.5	Adequate Call Center coverage to accommodate all non-English speaking Enrollees, Prospective Enrollees and Potential Enrollees through multilingual live staff members or a third-party interpretive services line.		
4.3.1.6.1.6	Adequate Call Center coverage in-place to accommodate overflow calls.		

	FUNCTIONAL REQUIREMENTS	RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.1.6.1.7	Adequate Call Center coverage to capitalize on every Enrollee contact to obtain and update Enrollee contact information and provide Enrollees with personalized information such as gaps in care, and to conduct warm handoff transfers of calls to other departments such as Care Management.		
4.3.1.6.1.8	Provide recorded health-education phone messages during hold times that may include health education briefs, general reminders, and health plan benefits and services information. The messaging will be changed periodically to meet identified Enrollee trends or topical issues.		
4.3.1.6.1.9	Provide continual Call Center training upon hire and continually thereafter with a focus on how to help Enrollees access Covered Services and what to do when extra help is needed.		
4.3.1.6.2	*Outbound Call Center (Enrollee)*		
4.3.1.6.2.1	Adequate resources in-place to conduct welcome calls to each new Enrollee after the Effective Enrollment Date within the regulatory timeframe. For those new Enrollees who have been successfully contacted, CSRs will provide health education, respond to questions about Covered Services and how to access them, and perform a warm transfer to the appropriate case management entity conducting the member health-risk screening. CSRs may also choose to transfer the Enrollee to the TPA retention team who will perform these duties.		
4.3.1.6.3.1	Maintain sufficient and adequately trained call center services staff in-place to conduct telephonic outreach to educate and assist targeted Enrollee populations in accessing services and managing their care or broad health promotion campaigns as directed by HPS. Calls may be conducted using Interactive Voice Response technology (IVR).		
4.3.1.6.3	*Call Center Communication Channels*		
4.3.1.6.3.1	Ability to exchange information including Enrollee documentation with Enrollees and/or Providers via mail, email, or fax in compliance with all the Federal and State laws regarding the security and privacy of personally identifiable information and Protected Health Information.		
4.3.1.6.3.2	Ability to electronically exchange information with internal staff as well as with external HPS partners in compliance with all the Federal and State laws regarding the security and privacy of personally identifiable information and Protected Health Information.		
4.3.1.6.4	*Call Center Monitoring (Enrollee and Provider)*		
4.3.1.6.4.1	Record all incoming calls for quality control, program integrity, and training purposes. Archive the recordings for no fewer than twelve (12) months or as otherwise required by law. Requests for recorded calls must be fulfilled within three (3) business days of the request with no limits on the number of requests for records.		
4.3.1.6.4.2	Maintain Enrollee Services documentation of every member and provider interaction in the TPA's Customer Relationship Management system with back-end reporting capabilities.		

	FUNCTIONAL REQUIREMENTS	RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.1.6.4.3	Maintain administrative QA and improvement policies and procedures that contain standards and a monitoring plan for all telephone access and call-center performance on an ongoing basis.		
4.3.1.6.4.4	Adequate supervisory staff to monitor calls for quality and accuracy of information provided and take immediate correction action when standards are not met.		
4.3.1.6.4.5	Analyze and report on data collected from its Customer Relationship Management and phone system as necessary to perform QA and improvement tasks and monitor compliance with performance standards in accordance with HPS and HFS requirements.		
4.3.1.6.4.6	Generate annual analytical reports evaluating the quality and accuracy of information provided to Members via the telephone against standards, and act to improve identified deficiencies, as applicable.		
4.3.1.6.5	*Email Responses (Enrollee)*		
4.3.1.6.5.1	Respond to member inquiries within one (1) business day of submission and document interaction in the TPA's Customer Relationship Management system.		
4.3.1.6.5.2	Generate NCQA compliant analytical reports evaluating the quality of email responses and turnaround times and act to improve identified deficiencies, as applicable.		
4.3.1.6.6	*Live Chat Feature on Website*		
4.3.1.6.6.1	Maintain sufficient and adequately trained Member services staff to provide members with personalized information efficiently and effectively via live chat.		
4.3.1.6.7	*24-Hour Nurse Health Information Line*		
4.3.1.6.7.1	Maintain a Nurse Healthline that offers access to qualified staff including licensed clinicians for both physical and behavioral health who can triage Enrollee concerns and crises to the appropriate resource and level of care and provide medical and behavioral consultations to Enrollees.		
4.3.1.6.7.2	Adequate resources to staff the line with a live person twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year for nurse triage, advice, and health information.		
4.3.1.6.7.3	Provide bilingual nurses and access to live interpretation services. Minimum required spoken languages (other than English) will be languages that are spoken by 5% or more of households, as determined by HFS according to published Census Bureau data		
4.3.1.6.7.4	Ability to access HPS eligibility and provider files and give access to HPS for all encounter reports to support real-time assessment and disbursement of calls.		
4.3.1.6.7.5	Record all calls and transmit electronic documentation of any advice given by nurses in the form of an Encounter Report to HPS the next Business Day.		

	FUNCTIONAL REQUIREMENTS	RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.1.6.7.6	Generate daily and monthly call logs with member-level detail as well as routine reports on Nurse Line activities with mutually agreed upon elements no less than monthly.		
4.3.1.6.8	*Enrollee Materials*		
4.3.1.6.8.1	Assist with development of content for enrollee communications, and include printing and distribution of materials to all eligible HPS households as approved by HPS and HFS. Examples include: enrollee handbook, newsletters, and enrollee communications letters and emails.		
4.3.1.6.8.2	Print and distribute new Enrollee Welcome Packet within the regulatory timeframe. Packet content will be determined by HPS and HFS.		
4.3.1.6.8.3	Coordinate design of Identification Cards and print and distribute ID cards to new enrollees and existing enrollees as directed by HPS and HFS.		
4.3.1.6.8.4	Print and distribute basic information when requested by an Enrollee, Prospective Enrollee or Potential Enrollee according to HPS and HFS requirements.		
4.3.1.6.8.5	Provide requested written materials in English and other prevalent languages as designated by HPS and HFS, and in accordance with Section 1557 of the Patient Protection and Affordable Care Act which outlines requirements for interpretive services, reading level, alternative methods of communication, translated materials, and font size and taglines.		
4.3.1.6.8.6	Provide certification that the translation of any written materials is accurate and complete, and that the translation is easily understood by individuals with a sixth-grade reading level and is culturally appropriate.		
4.3.1.6.8.7	Generate monthly reporting of mailings that includes returned mail information.		
4.3.1.6.8.8	Store proof of mailings and email distributions, and provide to HPS upon request.		
4.3.1.6.9	*CountyCare Public Website for Enrollees and Providers*		
4.3.1.6.9.1	Maintain and update, at a minimum, the following HPS public website features: • Provider Search Function • Secure Member Portal • Secure Provider Portal • Provider directories maintained by TPA and other vendors (e.g., pharmacy, dental, vision)		

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4.3.1.7	**PROVIDER SERVICES**		
4.3.1.7.1	*Provider Network Management*		
4.3.1.7.1.1	Ensure that all Network Providers, including out-of-state Network Providers, are enrolled in the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system prior to participation or payment.		
4.3.1.7.1.2	Ensure that only those Providers that are approved by the Department are providing Covered Services under HCBS Waivers, and that those Providers are providing Enrollees only Covered Services for which such Providers are approved and authorized, using the weekly HFS extract file containing the list of authorized Providers or through other HFS notification.		
4.3.1.7.1.3	Generate reports on geographic distribution by zip code and the number of each type of network practitioners providing primary care including but not limited to general medicine and family practice, internal medicine, and pediatrics, behavioral healthcare, and specialty care.		
4.3.1.7.1.4	Generate reports on other network adequacy indicators, such as PCP panel capacity, Enrollee and Provider Complaints and Appeals, and the cultural diversity of the network (e.g., provider gender and languages spoken).		
4.3.1.7.2	*Provider Data Management*		
4.3.1.7.2.1	Maintain a Provider Data Management (PDM) solution that tracks, centralizes, and manages provider information that resides within a provider data repository. The system must: • Automate the aggregation, collection of, and entry of provider data into the provider data repository • Maintain and centralize accurate provider data • Scan through the provider database for erroneous or duplicate source data • Provide users with access to a provider database for editing, updating, and reporting purposes		
4.3.1.7.2.2	Process contracts and configure into the web-based benefit administration and claims management platform within the agreed upon timeframe (30 days standard and 60 days custom).		
4.3.1.7.2.3	Develop and maintain rigorous data profiling and control of incoming data with generation of success/rejection and reconciliation reports, as well as quality control processes to identify and resolve any data quality issues.		

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4.3.1.7.2.4	Provide an end-to-end Provider search solution that meets all requirements including, but not limited to, requirements identified by HPS, NCQA, 305 ILCS 5/5-30.3 and 42 CFR §438.10, including but not limited to: • Web-based directory that includes search functions with accurate data; • Available in a format that can be downloaded or printed directly from the website; • Update directory with new provider information within the regulatory timeframe; and • Correct inaccurate information within the regulatory timeframe.		
4.3.1.7.2.5	Perform at minimum quarterly routine audits of provider directory and search function accuracy and correct inaccurate information within the regulatory timeframe.		
4.3.1.7.2.6	Perform, at least annually, audits of provider network appointment and afterhours availability. Audits shall measure results against HPS, NCQA, HFS and CMS current and future standards.		
4.3.1.7.3	*Provider Relations*		
4.3.1.7.3.1	Maintain a comprehensive and full-service Provider Relations and communications program to engage, educate and maintain excellent relationships with Providers, including assigning representatives to Provider groups to develop relationships and utilizing in-person, telephone, electronic, small group, and town- hall strategies as appropriate.		
4.3.1.7.3.2	Maintain sufficient and qualified trained Provider Relations staff to manage a Provider Relations department including having a Director, supervisor/manager, and dedicated Provider Relations Representatives to manage the HPS provider network across all products. The Director must be responsible for articulating provider-rep responsibilities, training staff, structuring the team, and monitoring performance and service.		
4.3.1.7.3.3	Maintain sufficient and adequately trained Provider services staff to execute a comprehensive training program for orientation of new Network Providers and subcontractors, as well as on a regular schedule to be agreed upon with HPS and ad hoc as requested by HPS and/or Providers. HPS oversees curriculum development which is updated on an annual basis or as needed based on changes in HPS operating procedures. Provider and Subcontractor attendance and/or participation is documented and maintained by the TPA and provided upon request.		
4.3.1.7.3.4	Maintain sufficient and adequately trained Provider services staff to enable Network and non-Network Providers to receive prompt resolution of their problems or inquiries as directed by HPS.		

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4.3.1.7.3.5	Maintain sufficient and adequately trained Provider services staff to collect sufficient information from Providers to assess compliance of Provider locations with the Americans with Disabilities Act.		
4.3.1.7.3.6	Maintain Provider Relations documentation of every provider interaction including office visits in the TPA's Customer Relationship Management system with back-end reporting capabilities.		
4.3.1.7.3.7	Analyze and report on data collected from Customer Relationship Management as necessary to perform QA and improvement tasks.		
4.3.1.7.4	*Provider Complaint and Resolution System*		
4.3.1.7.4.1	Maintain a complaint and resolution system for in-network and not-in-network Providers, including: (i) a claim dispute process that allows Providers to contest a payment decision after a claim has been adjudicated; and (ii) a service authorization dispute process that allows Providers to contest an authorization denial or a reduction, suspension, or termination of a previously authorized service.		
4.3.1.7.4.2	The claims dispute process will assign a sequential, unique dispute tracking number as required by HFS. Escalate any administrative decision to HPS and support HPS in providing substantive responses intended to resolve the dispute in a timely manner. All claim disputes will be investigated and resolved, with either a complete resolution or timeframe to provide complete resolution, within thirty (30) calendar days from submission by the provider.		
4.3.1.7.4.3	Submit a summary of the Complaints filed by Providers on a cadence as requested by the plan. Reporting shall include but is not limited to total Provider Grievances per/1,000 Enrollees; a summary count of any such Provider Complaints received during the reporting period.		
4.3.1.7.5	*Provider Communications*		
4.3.1.7.5.1	Draft and distribute HPS-approved Provider communications including but not limited to the Provider Manual, Provider Education Materials and Policy Changes. Materials may be mailed, faxed, emailed or uploaded to the HPS Public website.		
4.3.1.7.5.2	Store proof of mailings and email distributions, and provide to CCH upon request.		
4.3.1.7.6	*HPS Public Website for Enrollees and Providers*		
4.3.1.7.6.1	Maintain and update, at a minimum, the following HPS public website features: • Provider Search Function • Secure Member Portal • Secure Provider Portal • Provider directories maintained by TPA and other vendors (e.g., pharmacy, dental, vision)		

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4.3.1.8	**COMPLIANCE PROGRAM**		
4.3.1.8.1	Maintain a compliance program, consistent with requirements outlined in 305 ILCS 5/8A-1, 42 CFR Part 420, 42 CFR §422.503, 42 CFR §423.504, 42 CFR §§438.600-610, 42 CFR Part 455, 1156 and 1902(a)(68) of the Social Security Act (SSA) and Chapters 9/21 of the CMS Medicare Managed Care Manual (100-16).		
4.3.1.8.2	Maintain written policies, procedures, and a Standard of Conduct/Ethics that demonstrate compliance with all applicable requirements and standards under the Master Contract and all federal and state requirements related to program integrity. *Provide a listing and brief description of all compliance related standards, policies, and procedures maintained by the Proposer.*		
4.3.1.8.3	Maintain written policies and procedures that implement the operation of the compliance program. *Provide a listing and brief description of standards, policies and procedures related to operation of the Compliance Program maintained by the Proposer.*		
4.3.1.8.4	Appoint a designated Compliance Officer who is responsible for implementation of the compliance program, including developing, implementing, and disseminating policies and procedures designed to ensure compliance with Program Integrity/Fraud, Waste and Abuse (FWA) requirements and who reports directly to the Proposer's CEO and Board of Directors. *Provide a job description for the Proposer's Compliance Officer and an Organization Chart for the Proposer's Compliance department demonstrating reporting relationships for the Proposer's Compliance Officer, as well as additional Compliance Office staff.*		
4.3.1.8.5	Maintain a Regulatory Compliance Committee, consisting of members of the Board of Directors and senior management, which is responsible for oversight of the Proposer's compliance program. *Provide a committee description / charter and membership list for the Regulatory Compliance Committee.*		
4.3.1.8.6	Maintain a system of training and education for the Proposer's Compliance Officer, Board of Directors, senior managers, and employees that outlines the Proposer's obligation to comply with federal and state requirements. *Provide a description of trainings completed by Proposer's workforce to ensure compliance with federal and state law requirements, including the subject areas discussed, modality utilized for training and processes for tracking training completion.*		

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4.3.1.8.7	Maintain several modalities for effective lines of communication between the Proposer's Compliance Officer and the Proposer's employees, subcontractors and Network Providers. *Provide a description of internal processes used for reporting concerns related to compliance, integrity, FWA, mismanagement and misconduct, including options for reporting anonymously and outside of typical business hours.*		
4.3.1.8.8	Maintain effective lines of communication between Proposer's Compliance Officer, Proposer's employees and the CCH Compliance department. *Provide a description of processes used for reporting and/or escalating concerns to the CCH Compliance Officer.*		
4.3.1.8.9	Enforcement of regulatory standards and program integrity-related requirements by the Proposer through well-publicized disciplinary guidelines. *Provide a description of process for consistent adherence to well-publicized disciplinary guidelines.*		
4.3.1.8.10	Maintain a system of established and implemented procedures for 4.3.1.8.routine internal monitoring, auditing of program integrity compliance risks, prompt response to compliance issues, investigation of potential compliance problems identified in the course of self-evaluation and audits, correction of identified compliance problems through corrective action plans, and ongoing compliance with program integrity-related requirements, including the use of surveillance and utilization controls conducted by a designated Special Investigations Unit (SIU) of dedicated staff adequate in number. *Provide a description of Compliance Program processes for monitoring, auditing, and identification of compliance risks, including process for annual Work Plan and/or annual Audit Plan development, as well as tracking and documenting compliance efforts.*		
4.3.1.8.11	Maintain a system for investigation and reporting for all instances of suspected and/or actual noncompliance with laws, regulations, CCH policies / procedures (to the extent applicable), or issues related to fraud, waste, and/or abuse (FWA), including reporting to the CCH Compliance Officer or the appropriate CountyCare liaison, as appropriate. *Delineate the methods of how concerns may be submitted or communicated from personnel, providers, agents and members and investigated by Proposer's Compliance Department. Describe the investigation tracking system and the resolution process, including how issues are reported/escalated to CCH Compliance.*		

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4.3.1.8.12	Maintain a system for prompt reporting of all overpayments identified or recovered, particularly those related to potential fraud, to the Proposer's Compliance Officer and CCH Compliance. *Describe how Proposer has established and implemented methods to encourage personnel, subcontractors/FDRs, agents and providers to report overpayments identified or received related to FWA without fear of retaliation, including how reports will be escalated to CCH Compliance.*		
4.3.1.8.13	Maintain a policy of non-intimidation and non-retaliation for good faith participation in the Proposer's compliance program, including but not limited to reporting potential issues, investigating issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials. *Describe how Proposer supports a safe, non-threatening environment where individuals may ask questions about integrity and compliance, fraud, abuse and financial misconduct matters and report their concerns, including a description of how reporters are protected from retaliation and harassment.*		
4.3.1.9	**COMPLIANCE PROGRAM / PROGRAM INTEGRITY RESPONSIBILITIES**		
4.3.1.9.1	Ensure that all Proposer employees, agents, and subcontractors complete training as necessary to perform the responsibilities under the Master Contract, including the completion of Compliance/Code of Ethics, FWA and HIPAA trainings upon hire, and no less frequently than annually thereafter, as well as additional trainings utilizing compliance training materials or training sessions supplied by CCH (as needed). Training records must be provided to CCH within five (5) days of any request. *Provide a description of the required training and education completed by Proposer, including the subject areas discussed, modality utilized for training and processes for tracking training completion.*		
4.3.1.9.2	Ensure full cooperation by Proposer with any review, audit, or investigation conducted by the CCH Compliance Program or their designee (including those related to readiness activities), including the timely return of requested documentation / data and interviews with Proposer's workforce.		
4.3.1.9.3	Ensure full cooperation by Proposer with auditors conducting audits/accreditation activities or oversight of the functions, processes or operations of activities delegated to Proposer under the Master Agreement.		

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4.3.1.9.4	Prepare and adhere to a written Corrective Action Plan (CAP), in a format mutually agreed upon as requested by CCH or as required by HFS/CMS, with regard to any non-compliant activities performed that are identified in the course of audits conducted or required in the CCH Master Contract or requested pursuant to the CCH Master Contract or other entities of competent jurisdiction.		
4.3.1.9.5	Support CCH Compliance with regulator inquiries and complaints.		
4.3.1.9.6	Support CCH Compliance with necessary review and revisions to plan policies and procedures, including in the review and approval of any required changes.		
4.3.1.9.7	Develop and maintain policies and procedures for oversight of delegated services that are contracted to other organizations, including how audit and monitoring activities will be conducted of delegated functions/services. *Provide a description of the Proposer's delegate / FDR oversight process, including a listing of related policies maintained by the Proposer. Describe in detail audits of FDRs, subcontractors, agents and providers to ensure compliance with contractual and regulatory requirements, including the frequency of the activity.*		
4.3.1.9.8	Ensure the collection, assessment, storage and reporting of information related to conflict-of-interest for personnel, officers, directors, and subcontractors, and the officers, directors and personnel of any subcontractors utilized by the Proposer. *Provide a description of the conflict-of-interest process, including a listing of related policies maintained by the Proposer.*		
4.3.1.9.9	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 Department of Health and Human Services (HHS) Office of Inspector General (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) (https://sanctionssearch.ofac.treas.gov/) *Provide a description of the sanction screening process, including a listing of related policies maintained by the Proposer.*		

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4.3.1.9.10	Ensure that the Proposer, its principals and any person employed or contracted by Proposer to provide Services: (1) Are not presently debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded from covered transactions by any governmental department, agency or federally funded health care program (including Medicare and/or Medicaid); (2) Have not, within a 3-year period preceding this proposal, been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property. (3) Are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification. (4) Have not, within a 3-year period preceding this application/proposal, had one or more public transactions (Federal, State, or local) terminated for cause or default.		
4.3.1.9.11	Notify CCH immediately in the event that it or anyone performing services under the Master Contract: (1) Is convicted of a criminal offense related to health care and/or related to the provision of services paid for by Medicare, Medicaid or another federal health care program; or (2) Is excluded or debarred from participation in any federal health care program, including Medicare and Medicaid.		
4.3.1.9.12	Maintain compliance with the Illinois Human Rights Act, the U. S. Civil Rights Act, and Section 504 of the federal Rehabilitation Act.		
4.3.1.9.1	*Confidentiality/Privacy*		
4.3.1.9.1.1	Maintain administrative and management arrangements, policies and procedures, and training that comply with all federal and state regulations and statutes governing the creation, receipt, access, use, disclosure maintenance, and transmission of protected health information (PHI), including the protection of PHI and the detection and prevention of unauthorized uses and disclosures of PHI. *Provide a listing of Proposer's policies related to privacy and confidentiality of health information, including those that address HIPAA or relevant State Privacy laws.*		

	FUNCTIONAL REQUIREMENTS	RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.1.9.1.2	Maintain procedures to ensure that the Proposer and/or its subcontractors do not access, use, store, maintain, or transmit, whether electronically or otherwise for any purpose whatsoever, CountyCare PHI, documents, data, claims, guidelines, protocols, programs, financial analyses, performance measures, or other information at or to any offshore location, without receiving prior approval from CCH. *Provide a description of any of the Proposer services that will be performed by offshore operations, including any contracted services.*		
4.3.1.9.1.3	Report breaches of unsecured PHI, as defined in 45 CFR 164.402, and mitigate potential damages associated with a Breach of Unsecured PHI and with uses and disclosures in violation of HIPAA requirements and the Master Contract. *Provide a description of notification procedures between Proposer and CCH.*		
4.3.1.9.1.4	Maintain procedures to ensure that any subcontractors utilized by the Proposer will comply with applicable HIPAA privacy and security requirements, including those outlined in the Business Associate Agreement between CCH and the Proposer. *Provide a description of procedures for passing down CCH BAA requirements to subcontractors.*		
4.3.1.9.1.5	Maintain an Information Privacy program that includes, at a minimum, a designated individual who is responsible for developing and implementing policies and procedures for all standard privacy practices regarding the protection of CCH protected health information. *Provide a job description for the designated Privacy individual and a description, including organization chart, for the Information Privacy program.*		
4.3.1.9.1.6	Maintain cyber insurance. *Describe and delineate the relevant provisions and limits of Proposer's cyber insurance policy.*		
4.3.1.9.2	*Fraud, Waste, and Abuse*		
4.3.1.9.2.1	Maintain administrative and management arrangements, policies, and procedures that comply with all federal and state regulations and statutes governing the detection and prevention of Fraud, Waste, Abuse, mismanagement, and misconduct (collectively, FWA), including but not limited to 305 ILCS 5/8A-1 et. seq., 42 CFR 455, 42 CFR 438 Subpart H, and sections 1128, 1156 and 1902(a)(68) of the Social Security Act (SSA). *Provide a listing of plans, policies, and procedures related to FWA activities and operations maintained by the Proposer.*		

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4.3.1.9.2.2	Operate a full-time, dedicated Special Investigation Unit (SIU) to detect, monitor, investigate and prevent FWA, including the use of data analytics to detect potential FWA. The SIU shall be responsible for the reasonable investigation of each enrollee and provider case of suspected FWA activity and for implementation of the CountyCare FWA prevention and reduction activities under the CountyCare FWA Plan. The SIU must be able to receive referrals of FWA alleged against enrollees, providers (both contracted and out-of-network) and Subcontractors. Investigations may involve coordination with other CCH delegated entities. *Describe the Proposer's FWA Plan to detect, investigate and report suspected instances of FWA specific to a Medicaid managed care health plan. Submit a process flow diagram illustrating the process to conduct a reasonable investigation of each suspected FWA involving providers and subcontractors, Proposer's workforce and subcontractors, and enrollees. Include within the diagram the process of notification to CCH Compliance of suspected FWA and potential criminal acts.*		
4.3.1.9.2.3	Designate a dedicated SIU Liaison to provide notice of any suspected FWA to CCH Compliance within twenty-four (24) hours after receiving such report. *Identify the member of management or leadership who will function as the dedicated, day-to-day SIU Liaison to CCH Compliance and include a job description and reporting structure for that individual.*		
4.3.1.9.2.4	Conduct both pre-payment and retrospective, post-payment audits/investigations, including analysis of claims that do not generate reimbursement ("zero paid claim"). *Describe the Proposer's process for conducting pre-payment and retrospective, post-payment audits and investigations.*		
4.3.1.9.2.5	Employ Fraud, Waste and Abuse Investigators at a minimum ratio of one (1) Investigator to every 100,000 Enrollees. *Submit an organization chart outlining the dedicated Special Investigation Unit (SIU) staff, including any external staff or contracted resources utilized.*		
4.3.1.9.2.6	Maintain procedures that outline the organization's methods for identification, investigation, and referral of suspected Fraud cases in compliance with 42 CFR 455.13, 42 CFR 455.14, and 42 CFR 455.21. *Describe how the Proposer's procedures around the identification, investigation, and referral of suspected Fraud cases meet the requirements in 42 CFR 455.13, 42 CFR 455.14, and 42 CFR 455.21.*		

	FUNCTIONAL REQUIREMENTS	RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.1.9.2.7	Provide first pass FWA identification, validation, and recovery services to include, at a minimum, the following: • Mapping claims data into standard format and perform FWA analysis with analytics. • Designing FWA concepts to assess claims compliance with current coding, billing and regulatory requirements, subject to CCH prior approval before implementation. • Designing FWA concepts to identify variances in claims including but not limited: claim accuracy, aberrant billing practices, fraud detection and enrollee inconsistencies in the areas of excessive daily services, contraindicated, medically unnecessary, duplicative and/or not supported by the diagnoses and over-utilization of services, subject to CCH prior approval before implementation. • Reviewing claims identified as an overpayment and validate the overpayment prior to initiating recovery efforts. • Obtaining approval from CCH Compliance prior to recovery initiation to minimize provider abrasion and ensure compliance with Master Contract terms. *Describe how the Proposer will develop and utilize Data Analytics, based on current regulations, to help identify and address Provider and Enrollee variances, including the identification of any external resources or software utilized as part of the process.*		
4.3.1.9.2.8	Perform interviews and/or "boots on the ground" field-based investigations related to FWA/Payment Integrity initiatives, if warranted. *Describe the operations of the Proposer's local Investigation Unit that will be responsible for the investigation and remediation of FWA / Program Integrity issues, including office locations and organization chart structure.*		
4.3.1.9.2.9	Perform medical record audits on claims identified through FWA/Payment Integrity initiatives using certified coders, registered nurses and/or other medical professionals (as needed). *Provide a description of the process for auditing medical records, including the identification of any coding software they used to review facility and provider claims to ensure the claims comply with State Medicaid guidelines as well as national coding and documentation guidelines published by the Centers for Medicare and Medicaid Services (CMS), the American Medical Association and various specialty organizations.*		

	FUNCTIONAL REQUIREMENTS	RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.1.9.2.10	Coordinate and perform education for providers based on audit or investigation findings, as directed by CCH Compliance. *Provide a description of the process for providing education to providers, via multiple modalities, including examples of when provider education is appropriate.*		
4.3.1.9.2.11	Recover established overpayments due to FWA made to a provider, as directed and approved by CCH. Overpayments may be obtained from a provider directly or made from future claim payments. Where there are not sufficient claims funds, letters to a provider will be sent. *Provide a description of the process for recovering overpayments made to providers, including how efforts will be coordinated with CCH Compliance.*		
4.3.1.9.2.12	Maintain processes to grant real-time access to CCH Compliance for SIU and/or FWA Program documentation and/or software platforms for reporting and oversight purposes. *Provide a description of the process for granting/authorizing CCH Compliance access to FWA related documentation and data.*		
4.3.1.9.2.13	Identify and implement process changes and/or system configuration solutions to prevent payment of improper claims, as identified via FWA concepts and data analytics, subject to prior approval by CCH.		
4.3.1.9.2.14	Provide first level appeal management for all provider concerns with FWA activity and recoveries.		
4.3.1.9.2.15	Maintain procedures that outline the methods for prompt reporting of all overpayments identified or recovered to CCH.		
4.3.1.9.2.16	Develop and deliver monthly, quarterly and ad hoc reports to CCH Compliance regarding FWA related investigations, audits and data mining activities, in the form and format requested by CCH and in line with requirements for reporting data to HFS and HFS OIG. *Provide a description of the process for developing and delivering accurate reports to CCH Compliance, including the process for ad hoc report requests.*		
4.3.1.9.2.17	Ensure cooperation with all appropriate federal and state agencies in the detection and prevention of Fraud, Waste, Abuse, mismanagement, and misconduct, including the implementation of measures to comply with any Provider Alerts, including Payment Suspensions, or Deconfliction/Stand Down Notices received from HFS and/or HFS OIG and participation in ad hoc and regular meetings with HFS OIG, as requested by CCH.		

	FUNCTIONAL REQUIREMENTS	RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.1.9.2.18	Conduct recipient verification of services received by CountyCare members, including reporting of summary results to CCH. *Include a draft recipient verification letter and describe the process for conducting and reporting on recipient verification of services activities.*		
4.3.1.10	**CLAIMS PROCESSING, ADJUDICATION, AND PAYMENT**		
4.3.1.10.1	*Claims Processing and Encounters Submission*		
4.3.1.10.1.1	Comply with the following: • Section 6504(a) of the Affordable Care Act, which requires that claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems operated by HFS to meet the requirements of Section 1903(r)(1)(F) of the Social Security Act; • Collect data on Enrollee and Provider characteristics as specified by HFS, and on all Covered Services furnished to Enrollees through an Encounter Data system or other methods as may be specified by HFS; • Ensure that data received from Providers are accurate and complete by: • verifying the accuracy and timeliness of reported data, including data from Network Providers that HPS is compensating on the basis of Capitation payments; • screening the data for completeness, logic, and consistency; • collecting data from Providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State Medicaid quality improvement and Care Coordination efforts; and • collecting service information in standardized formats to the extent feasible and appropriate.		

	FUNCTIONAL REQUIREMENTS	RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.1.10.1.2	TPA shall: • Collect and maintain sufficient Enrollee Encounter Data to identify the Provider who delivers any item(s) or service(s) to Enrollees; and • Submit Enrollee Encounter Data to HFS at the frequency and level of detail specified by CMS and HFS, based on program administration, oversight, and program integrity needs as determined by CMS and HFS. • Investigate, correct, and resubmit any rejected encounters from HFS throughout the encounter process. • Manage the relationship between the health plan and HFS encounters team to discuss any outstanding issues and provide solutions to maintain and improve encounter submission and acceptance. • Maintain a 99% encounter acceptance rate on a quarterly basis or face penalties for not meeting the threshold.		
4.3.1.10.1.3	Adjudicate claims within the contracted rates using HPS' approved benefit design and all major payment methodologies including, but not limited to Fee-For-Service, Capitation, case rates, DRG, percentage of billed, bundling, per diems, tiered per diems, lesser of billed and calculated rates.		
4.3.1.10.1.4	TPA shall be able to administer, process, and pay prospective interim payments at the provider TIN level.		
4.3.1.10.1.5	Capacity to capture up to twenty-five (25) diagnoses codes on institutional claim types and up to twelve (12) diagnoses on professional claims.		
4.3.1.10.1.6	Capacity to load standard payment arrangements within fourteen (14) days and unique payment arrangements within twenty-five (25) days of receipt according to HPS' standard contract load process.		
4.3.1.10.1.7	Ability for direct access services such as Emergency Services, Post-Stabilization Services, family planning services, school-based health centers, and school-based dental services to be set up to by-pass affiliation or authorization requirements.		
4.3.1.10.1.8	Capacity to report on providers and their respective contracted rate, and other provider data that may be needed for HPS to audit and ensure Contractor has properly loaded provider contracts.		
4.3.1.10.1.9	Capacity to track claims turnaround times by form, type and overall annualized year-to date. The calculation shall be based on total claims processed for a given receipt date compared to the date finalized to an EOP.		
4.3.1.10.1.10	Capacity to process corrected claims and make necessary payment adjustments within thirty (30) days.		
4.3.1.10.1.11	Capacity to process claims for transition of services in accordance with 215 ILCS 134/25 and the MCCN contract.		

	FUNCTIONAL REQUIREMENTS	RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.1.10.1.12	Match claims to their referral or authorization, when required, and deny claims not properly authorized in accordance with HPS referral and prior authorization policies.		
4.3.1.10.1.13	Validate diagnosis and procedure codes reported by providers on claims in accordance with HPS requirements.		
4.3.1.10.1.14	Adequate staffing for review of first level claims appeals except where there is a request for a policy exception.		
4.3.1.10.1.15	Track and resolve complaints or disputes concerning payments for the provision of services in HPS' Provider Complaint and Resolution System.		
4.3.1.10.1.16	Capacity to configure HFS mandated changes to the universal physician fee schedule, and other policy or programs and evaluate the impact.		
4.3.1.10.1.17	Capacity to pay Providers (including the fiscal agent making payments to Personal Assistants under the HCBS Waivers) for Covered Services on a timely basis consistent with the claims payment procedure described at 42 U.S.C. § 1396a(a)(37)(A) and 215 ILCS 5/368a.		
4.3.1.10.1.18	Capacity to pay ninety percent (90%) of all clean claims from Providers for Covered Services within thirty (30) days following receipt. Contractor must pay ninety-nine percent (99%) of all clean claims from Providers for Covered Services within ninety (90) days following receipt. Contractor shall make all expedited payments in accordance with the timeframes listed in the Expedited Provider Report, which will be provided monthly by the Department.		
4.3.1.10.1.19	Capacity to accept electronic payment from HPS and shall be able to issue payments to Providers within two (2) to three (3) Business Days of receipt of claims funding from HPS through a mechanism determined by the Provider.		
4.3.1.10.1.20	Portal that allows Providers to sign up for EFT payment.		
4.3.1.10.1.21	Claims system that reflects Provider EFT preferences.		
4.3.1.10.1.22	Support bi-directional ANSI compliant or other agreed upon format for health information and Encounter Data exchange from multiple claims processors. This includes but is not limited to electronic transmission of acknowledgement of receipt of Encounter files and acceptance/rejection reports.		
4.3.1.10.1.23	Ability to track and report claims reprocessing rate with a breakdown of system configuration issue vs state rate changes.		
4.3.1.10.2	*Payment and Program Integrity*		
4.3.1.10.2.1	Oversee Coordination of Benefits (COB), Third-Party Liability (TPL), Subrogation, and claims payment integrity review of a third-party vendor for all medical and pharmacy claims. Perform reclamation from the payor when applicable.		
4.3.1.10.2.2	Analyze Coordination of Benefit (COB) and eligibility data to ensure the correct attribution of members in programs. Coordinate with CountyCare and HFS to resolve any noted discrepancies.		

	FUNCTIONAL REQUIREMENTS	RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.1.10.2.3	Perform clinical and billing audits of medical records for high dollar claims.		
4.3.1.10.2.4	Implement procedures to determine if an Enrollee has other health insurance besides Medicaid and ensure that Medicaid is the payor of last resort for Covered Services in accordance with federal regulations.		
4.3.1.10.2.5	Designate a Third-Party Liability (TPL) Benefit Coordinator to oversee issue resolution and one (1) or more recoveries specialists to investigate and process all issues related to TPL.		
4.3.1.10.2.6	Implement procedures to identify and investigate potential subrogation cases on paid claims and pursue subrogation and recover reimbursement from the Third Party for all Covered Services provided to the Enrollee in exchange for the Capitation paid hereunder.		
4.3.1.10.2.7	Supply reports of all subrogation cases being pursued and amounts of recovery.		
4.3.1.10.2.8	Screen claims for duplicate payments prior to payment.		

	FUNCTIONAL REQUIREMENTS	RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.1.11	**FINANCIAL SERVICES**		
4.3.1.11.1	*Premium Payment Management*		
4.3.1.11.1.1	Reconcile Membership to premium files and identify exceptions for reporting and follow up.		
4.3.1.11.1.3	Compare monthly enrollment records to the HFS 820 and report all discrepancies to the Enrollment Department for investigation.		
4.3.1.11.1.6	Identify Members affected by retro-termination or retro-eligibility and provide data to Claims Audit & Recovery Department to act upon these changes in accordance with HPS policies and procedures.		
4.3.1.11.2	*Management of Claims Bank Trust Accounts*		
4.3.1.11.2.1	Establish necessary bank accounts for issuing claim disbursements.		
4.3.1.11.2.2	Manage returned/rejected Electronic Funds Transfer(s) (“EFT”) including reprocessing the payment.		
4.3.1.11.2.3	Establish process to handle deceased enrollee payments; HPS and TPA will communicate with each other when notified of deceased enrollee.		
4.3.1.11.2.4	Send positive pay file to the bank daily of all checks issued.		
4.3.1.11.2.5	Manage daily reporting for checks presented for payment but not issued by bank (positive pay).		
4.3.1.11.2.6	Establish process to manage fraudulent checks; establish process to stop paid or voided checks if required.		
4.3.1.11.2.7	Maintain check registers for the claims clearing accounts and provide copies as requested, but at least monthly, to HPS.		
4.3.1.11.2.8	Reconcile claims trust accounts each month.		
4.3.1.11.2.9	Maintain copies of reconciliations and bank statements.		

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4.3.1.11.2.10	Provide check stock and cover the cost of postage for mailing claim checks and Explanations of Payments to providers.		
4.3.1.11.2.11	Ensure the security of check stock, ink cartridges used for printing checks, and signatories and permit access to these items only by authorized persons.		
4.3.1.11.2.12	Process missing or lost check requests in accordance with concurrent HPS policy based on inquiries sent from Customer Service. TPA accounting staff will follow up inquiries by providing check copies, stop payments, reissues, etc. to HPS.		
4.3.1.11.2.13	Communicate stop payment and check reissues transactions to the bank.		
4.3.1.11.3	*General Accounting*		
4.3.1.11.3.1	Provide financial reports on a monthly basis for all financial transactions processed by TPA.		
4.3.1.11.3.2	Financial Reporting such as bank reconciliation, aged provider receivables, finance data reports, monthly medical expense category report, claim detail report, unpaid aging report, due and unpaid report, paid aging report, and filing data report.		
4.3.1.11.3.3	Calculate, track, report, and monitor specific stop loss reinsurance according to reinsurer's requirements: a. Recommend and assist in the analysis of reinsurance contracts at the request of HPS b. Notify HPS of potential reinsurance cases c. Provide reports or copies of claims as needed for processing reinsurance cases with the reinsurer		
4.3.1.11.3.4	Provide 1099 data file for any payments processed by TPA and submit to the health plan. File will be sent in mutually agreed upon format.		
4.3.1.11.3.5	Accurately process, report, and submit 1099 files for any payments processed by TPA in the required format to the IRS following approval from the health plan.		
4.3.1.11.3.6	Research IRS mismatches for the purpose of updates and sending B notices. In the case that P notices are received from the IRS, communication, penalty fees, and resolution will be the responsibility of the TPA.		
4.3.1.11.3.7	Manage the unclaimed property process.		
4.3.1.11.3.8	Establish process to pend provider's claims for specified providers Tax IDs if notified by HPS and hold and monitor claims.		
4.3.1.11.3.9	Establish EFT and Electronic Remittance Advice capability with network providers.		
4.3.1.11.3.10	Adopt policies and strategies to communicate with and encourage providers receiving $25,000 or more in combined capitation or fee for service reimbursements accept EFT payments and ERA remittance advices.		
4.3.1.11.3.11	Provide EOPs in an electronic X12-835 format through a vendor of TPA's choice for providers desiring an EDI remittance.		

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4.3.1.12	RISK ADJUSTMENT AND QUALITY		
4.3.1.12.1	Manage the prospective risk adjustment process including but not limited to identifying payment gaps, analyzing risk score trends, and determining diagnosis coding gaps. Provide education and data to provider groups, including but not limited through EMR integration, to provide coding gaps to providers.		

	FUNCTIONAL REQUIREMENTS	RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.1.13	Information Systems		
4.3.1.13.1	Staff a full-time management information system position that oversees and maintains HPS data management system such that it is capable of valid data collection and processing, timely and accurate reporting, and correct claims payment. This individual shall be trained and experienced in information systems, data processing, and data reporting to the extent required to oversee all information system aspects identified in the MCCN Contract.		
4.3.1.13.2	Provide software reconfiguration services to meet evolving business and regulatory requirements.		
4.3.1.13.3	Software program that identifies avoidable ER admissions and potentially preventable hospital readmissions including readmissions associated with hospital acquired conditions (HACs) and other provider preventable conditions.		
4.3.1.13.4	Enable authorized users to access and utilize information systems necessary to perform job functions and provide any necessary training needed to use said systems. Rights and/or privileges shall be granted to authorized users based on a set of access rules that the covered entity is required to implement as part of 45 CFR §164.308(a)(4), the Information Access Management standard under the Administrative Safeguards section of the Rule.		

	FUNCTIONAL REQUIREMENTS	RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.1.13.5	*Claims Management System*		
4.3.1.13.5.1	Provide an automated system that is a separate instance from all other products and lines of business generally available on a 24/7 basis with reasonable permitted downtime for system upgrades and maintenance as required. The system shall: • Include Enrollee eligibility and provider master data sufficient to accurately process claims and provide certain required reports as required. • Provide for flexible, date-specific fee schedule maintenance to accurately pay claims. • Include or connects with contract data management system to validate provider IMPACT enrollment and other state and federal restrictions • Be made available to HPS staff on a view-only basis.		
4.3.1.13.6	*Customer Relationship Management System*		
4.3.1.13.6.1	Maintain a system dedicated to the management of information about Enrollees, specifically designed to collect Enrollee-related data and to process workflow needs in healthcare administration that includes a telephone system with Automatic Call Distribution and Auto-Attendant (ACD-AA) functionality. The system shall have, at a minimum, five (5) core integrated components: • Means to separately track provider and member calls; • Enrollee demographics tracking and information and ability to provide updates to demographic information directed by HPS; • Means to automate, manage, track, and report on CCH's 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); • Technology for use in inbound Enrollee contact and query management; and • Means to track performance metrics including but not limited to Average Speed of Answer and Abandonment Rate.		

	FUNCTIONAL REQUIREMENTS	RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.1.13.7	*Utilization Management System*		
4.3.1.13.7.1	Provide a system that supports required UM functions including but not limited to: • Eligibility verification • Trigger workflows • Automated approval and authorizations of medical services and procedures • Simplified or automated reviews of medical services and procedures • Aggregate clinical and financial data across the continuum of healthcare services • Automated features that provide accurate documentation for each entry and UM decision and notification timelines • Integration with Care Management Entity system(s) to request CME services and track service level interventions within the member's care plan		
4.3.1.13.8	*Appeal and Grievance System*		
4.3.1.13.8.1	Provide a system that supports required A&G functions including but not limited to: • Trigger workflows • Ability to report based on the state, NCQA and CMS required categories. • Automate A&G processes, including intelligent case routing with provisions to manage escalations and case exceptions, and auto-prioritization of standard and expedited cases • Automatic document generation, including acknowledgment and resolution letters • Automatic preparation of regulatory reports and audit universes		

	FUNCTIONAL REQUIREMENTS	RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.1.13.9	*End-User Analytic Reporting Tool*		
4.3.1.13.9.1	Create and maintain a cost and utilization tool that gives HPS access to actionable information through exportable standardized or customized reports. TPA will generate custom reports in a manner and timeframe to be mutually determined by TPA and HPS utilizing medical, behavioral health and pharmacy claims, labs, and other supplemental data. The tool will be used, at a minimum, to: • Track medical loss ratio performance • Identify high-cost member utilization and other cost drivers • Track and trend readmission rates and average lengths of stay • Segment and risk stratify enrollees into meaningful subsets for targeted interventions • Identify and track top diagnoses by place of service • Identify and trend quality performance and gaps in case • Profile physician performance on cost, utilization, and quality • Segment data by population (for example: FHP, ACA, ICP), by zip code/ region and by provider or provider group. • Compare and analyze HPS specific data to other available benchmarks • Produce analyzes, pivots trends and other display format as agreed by HPS in addition to member level detail or row data.		
4.3.1.13.10	*Secure Enrollee Portal*		
4.3.1.13.10.1	Maintain a secure, HIPAA-compliant Enrollee web portal that meets HFS requirements and NCQA standards and is accessible through individual login that shall include, at a minimum, request to select/change PCP information and personal demographic information, health-educational materials, individual Plans of Care, gaps in care, status of referrals and authorizations, and claims history.		
4.3.1.13.10.2	The portal should allow members to seamlessly: • view benefits • view/check claim status • view EOB • view accumulators • request ID card • select/change PCP • change demographics • submit email inquiries		

	FUNCTIONAL REQUIREMENTS	RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.1.13.11	*Secure Provider Portal*		
4.3.1.13.11.1	Maintain a secure, HIPAA-compliant Provider web portal that meets HFS Requirements and is accessible through individual login which shall include but is not limited to population health, quality, utilization, eligibility verification, prior authorization, listing of empaneled Enrollees that is downloadable, searchable, and filterable, and claims information for PCP Enrollee populations.		
4.3.1.13.11.2	The Provider web portal must allow Providers to submit requests for prior authorization and accompanying medical information directly to the medical management services department, and to view the results of all authorization decisions.		
4.3.1.13.12	*Prior Authorization Look-Up Tool*		
4.3.1.13.12.1	Develop and maintain a Provider-user-friendly interface that allows Providers to conduct a search of CPT codes to determine prior authorization requirements.		
4.3.1.13.13	*Find A Provider Tool*		
4.3.1.13.13.1	Maintain a Provider Directory via the HPS Public Website and in paper form upon request that meets all requirements under NCQA, 305 ILCS 5/5-30.3 and 42 CFR §438.10 including but not limited search functions that allow the user to find provider information including but the limited to provider name, provider specialty, hospital/medical group affiliations, and accepting new patients.		
4.3.1.14	**DATA WAREHOUSE AND REPORTING**		
4.3.1.14.1	Maintain a data warehouse that collects, analyzes, integrates, and reports data and can achieve the objectives of the MCCN Contract. The integrated database must at a minimum provide information on Enrollees, post-adjudication claims from both TPA and all HPS-contracted benefit managers, utilization, care coordination activities performed by HPS delegated entities, appeals and grievances, and disenrollments for reasons other than loss of Medicaid eligibility through TPA's web-based analytic reporting tool.		
4.3.1.14.2	TPA shall serve as the sole repository responsible for providing all required data including but not limited to: the 834 Audit File, 834 Daily File, 820 Payment file, 837D File, 8371 file and 837P File to all HPS partners including CCH, HFS and other MCOs, benefits managers and Care Management Entities as applicable. New data collection, data storage, interfaces, or data transmission requests will be implemented in a manner and timeframe to be mutually determined by TPA and HPS.		
4.3.1.14.3	TPA shall perform monthly reconciliations of the data warehouse to financial information, Premium (820) files, and Eligibility (834) files to ensure data and reporting accuracy within the warehouse. If discrepancies are discovered, TPA shall notify health plan within three (3) business days with plans for remediation.		

	FUNCTIONAL REQUIREMENTS	RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.1.14.4	Compile and enter into HFS MPR system all data needed to develop HFS required reports as specify on the MPR playbook and other applicable documents including data from internal systems and other HPS delegates.		
4.3.1.14.5	Means to fully validate all data prior to submission with validation criteria, business rules, and processing logic provided to CCH. TPA shall not be responsible for the quality of third-party data.		
4.3.1.14.6	*Analytics*		
4.3.1.14.6.1	TPA shall be able to capture required member- and provider-level data elements for regulatory reporting.		
4.3.1.14.6.2	TPA shall work closely with HPS to understand its specific business needs and priorities and provide data solutions and services to the extent feasible through an agreed upon formal prioritization process including but not limited to: • Canned reports with filters targeted for online and print output • Reporting controls to dynamically aggregate, group, filter and sort information for ad hoc reporting needs • More advanced solutions that enable pattern and trend discovery to meet business forecasting needs.		
4.3.1.14.6.3	TPA analytics shall be able to provide an average 70 standard reports (daily, monthly, quarterly) and up to an additional 80 ad-hoc reports on a monthly basis.		
4.3.1.14.7	*Access to Data*		
4.3.1.14.7.1	Enable authorized users the ability to access information in the primary data management system, data warehouse and TPA analytic reporting tool necessary to perform job functions and provide any necessary training needed to use the analytic reporting tool. Rights and/or privileges shall be granted to authorized users based on a set of access rules that the covered entity is required to implement as part of 45 CFR §164.308(a)(4), the Information Access Management standard under the Administrative Safeguards section of the Rule.		
4.3.1.14.7.2	Develop and maintain file transfer capabilities with HPS and HPS trading partners. TPA shall initiate and configure the SFTP site, perform any necessary firewall changes, and troubleshoot SFTP connection issues.		
4.3.1.14.8	*Security and HIPAA Compliance*		
4.3.1.14.8.1	Maintain a security program that includes, at a minimum, policies and procedures for all standard security practices regarding transmission of data; encryption of protected health information, credit card data and data transmissions and interfaces; protection of Confidential Information and firewall installation, as mutually agreed upon by all parties.		

	FUNCTIONAL REQUIREMENTS	RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.1.14.8.2	For all information systems that transmit, store, or access Protected Health Information, TPA shall establish an information security program in accordance with the FISMA (Federal Information Security Management Act), and follow the National Institute for Standards and Technology (NIST) Guidelines of the NIST Risk Management Framework (RMF), as amended. Contractor shall implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications, or other requirements of this subpart, taking into account those factors specified in 45 CFR §164.306(b)(2)(i), (ii), (iii), and (iv) [the Security Standards: General Rules, Flexibility of Approach].		
4.3.1.14.8.3	Develop a System Security Plan (SSP) in accordance with the MCCN Contract using the guidance from NIST RMF (NIST SP 800-18). The SSP shall including the following: • The requirements traceability matrix (RTM) cross-referenced to the specific system design function that meets each requirement related to system security; • A description of how the system is to be compliant with all the Federal and State laws regarding the security and privacy of personally identifiable information and Protected Health Information, including but not limited to 45 CFR 95.62; 45 CFR Parts 164, Subparts C and E; 1902(a)(7) of the Social Security Act; and 42 CFR 431.300-307; • A description of the process Contractor will use to report security breach incidents, regardless of severity or loss of actual data, to HFS within 4 hours; • A description of measures to secure data and software; • A description of how data are encrypted in transit and in storage; • A description of physical and equipment security measures; • A description of personnel security; • A description of software used for security; • A description of the user roles and the access capabilities of each role; • A description of how users are assigned certain roles; • An identification of the staff responsible for controlling the system security; • A description of contingency security procedures during a disaster recovery event; • A description of how Contractor works with HFS to conduct an annual security review; • Password security; and • Audit trails for all data access.		

	FUNCTIONAL REQUIREMENTS	RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.1.15	**DELEGATION AND SUBCONTRACTOR OVERSIGHT**		
4.3.1.15.1	TPA is responsible for oversight of subdelegates and subcontractors, including performance reporting, development oversight of KPIs, annual audits that include MCCN and NCQA requirements, and development of corrective action plans to address performance issues, as appropriate. TPA shall seek prior approval from HPS when changing or onboarding subdelegates/subcontractors.		
4.3.1.15.2	Support HPS' Delegation Oversight Program through participation in a pre-delegation audit; a quarterly delegation performance review; an annual audit; monthly joint operation meetings; formal, ongoing evaluation and monitoring of performance and compliance; and remediation if performance is substandard and/or violates the terms of this Services Agreement.		
4.3.1.15.3	TPA shall participate in other oversight meetings as requested by HPS.		
4.3.1.15.4	TPA shall participate in and provide support for external/regulatory audits as requested. This can include, but is not limited to, producing and supplying documentation, participating in file reviews, system demonstration and presenting during audits.		
4.3.1.15.5	TPA shall participate in a periodic oversight meetings with HPS. TPA will provide agenda for the oversight meeting with input from HPS.		
4.3.1.15.6	TPA shall provide monthly oversight reports on 15th of each month. Report content shall be mutually agreed upon by TPA and HPS.		
4.3.1.15.7	TPA shall notify HPS within one business day upon identifying a performance deficiency. TPA shall provide root cause of deficiency, action plan for remediation, with timelines and target dates for remediation, and responsible business owner(s).		
4.3.1.15.8	TPA shall participate in meetings with other HPS vendors as requested by Plan.		
4.3.1.15.9	TPA shall provide requested and applicable documentation for HPS' NCQA reaccreditation efforts.		
4.3.1.16	**PROJECT MANAGEMENT OFFICE (PMO)**		
4.3.1.16.1	TPA must have a project management lead that will work with HPS PMO to implement any new initiatives and projects directed by HPS		
4.3.1.16.2	TPA must have PMO office that will work on developing project plan, risks/mitigation plans, tracking key deliverables, and participating/facilitating meeting to include key stakeholders.		
4.3.1.17	**FINANCIAL ACTION PLAN**		
4.3.1.17.1	Designate resources to develop ideas and execute on initiatives related to cost saving strategies for the health plan. Team should consist of but not be limited to analysts, project managers, and a team lead.		
4.3.1.17.2	Performance outcomes on cost savings strategies could result in performance bonuses or penalties		
4.3.1.18	**GIVEAWAY MERCHANDISE**		
4.3.1.18.1	Purchase giveaway merchandise as instructed by HPS via MBE/WBE vendors.		

	FUNCTIONAL REQUIREMENTS	RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.1.18.2	Store and ship giveaway merchandise as instructed by HPS.		

4.3.2 Medicare

Responses to Section 4.3.2 shall not exceed 50 pages total.

MEDICARE FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.2.1	**SALES**		
4.3.2.1.1	Member Retention - Development and execution of a warm hand off workflow from the Member Services call center to Sales Team for existing members when needed.		
4.3.2.1.2	Conduct outbound outreach to members leaving the Health Plan to attempt retention and member continuity.		
4.3.2.1.3	Prospective Members – Ability to perform warm hand off and/or provide call back information from the Call Center to the Sales Team for any prospective member.		
4.3.2.2	**MARKETING, ADVERTISING, DISTRIBUTION & BUSINESS DEVELOPMENT**		
4.3.2.2.1	Review and comment on the Medicare Plan website to ensure accuracy for content within TPA's scope only.		
4.3.2.2.2	Deploy and maintain an online provider directory ("find-a-provider" search for medical and behavioral health providers) in accordance with CMS Requirements.		
4.3.2.2.3	Provide a website link to access the pharmacy directory which is maintained by the Pharmacy Benefits Manager, and any other vendor directories (e.g., dental, vision, etc.) not aligned with TPA's overall scope.		
4.3.2.2.4	Provide link for online "find-a-provider" search tool for the MMAI plan website		
4.3.2.2.5	Coordinate production materials, (inclusive of Member ID cards and Explanation of Benefits ("EOB") including inventory management, meeting translation requirements, reporting, and fulfill vendor oversight in alignment with CMS Requirements.		
4.3.2.2.6	Manage fulfillment (print and distribution) for Member facing materials and provide plan staff access to view member mailings for oversight.		
4.3.2.3	**ENROLLMENT, DISENROLLMENT & ELIGIBILITY**		
4.3.2.3.1	Create and maintain a repository of member phone/address/contact information captured by internal and external sources including downstream vendors and providers that gives HPS and vendor staff access to up-to-date demographic information.		
4.3.2.3.2	Receive and capture all new Member applications with Member's Primary Care Physician (PCP) selection or assign a PCP to members.		

MEDICARE FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.2.3.3	Assist member in ensuring the completeness and accuracy of the prospective Member application including collection of missing documentation such as the DON as needed.		
4.3.2.3.4	Assign PCP in M360 or other data platform within 5 business days of enrollment and load PCP into an electronic medical record software.		
4.3.2.3.5	Receive PCP information following completion of prospective Member application and support with any outreach efforts required to get the Member PCP if not provided on the initial application.		
4.3.2.3.6	Maintain membership history and PCP assignment history.		
4.3.2.3.7	Support efforts to assist in connecting members with PCPs, particularly new members coming into the plan, including conducting direct outreach.		
4.3.2.3.8	Provide electronic methods through enrollee and provider portals and interactive voice recognition (IVR) processes, for enrollees and providers to verify eligibility without talking with a Customer Service Representative within agreed upon timeline.		
4.3.2.3.9	Maintain connectivity to CMS for receipt of Online Enrollment Center (OEC) applications.		
4.3.2.3.10	Provide electronic eligibility to HPS subcontracted vendors on an agreed upon basis.		
4.3.2.3.11	Notify member in writing of the acceptance or denial of their application within 30 calendar days following the date that the application was received.		
4.3.2.3.12	When C-SNP Pre-Enrollment Qualification Assessment Tool is not fully completed by the sales team, reach out to provider to ensure the completion of the Assessment Tool.		
4.3.2.3.13	Notify C-SNP members within the first 7 calendar days of the month of enrollment if Member's eligibility cannot be verified.		
4.3.2.3.14	Verify eligibility for Medicare prior to sending enrollments to CMS.		
4.3.2.3.15	Load enrollment applications into the enrollment platform and verify eligibility using the Batch Eligibility Query (BEQ) process.		
4.3.2.3.16	Thoroughly research any eligibility discrepancies after receiving eligibility verification from CMS systems.		
4.3.2.3.17	Review the Monthly Membership Report and the Daily Transaction Reply Report (TRR) to identify members who have lost eligibility under Medicare.		
4.3.2.3.18	Provide member level reporting of enrollment status daily during Annual Enrollment Period (AEP) and upon agreed upon frequency post AEP to the sales team.		
4.3.2.3.19	Identify Coordination of Benefits (COB) information from various sources and enter applicable data in the Member Eligibility system to assist in claims processing.		
4.3.2.3.20	Issue Member ID cards in accordance with CMS requirements.		

MEDICARE FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.2.3.21	Process updates of Member demographic information – e.g. address changes, telephone number changes, and language preference – and update the Member Eligibility System, accordingly, including updates from downstream vendors (e.g. care management entities) in alignment with CMS Requirements.		
4.3.2.4	**MEMBER SERVICES**		
4.3.2.4.1	*Inbound Call Center*		
4.3.2.4.1.1	Operate a dedicated toll-free call center with live customer service representatives available to respond to Providers or Enrollees for information related to requests for coverage under Medicare, or any other service delegated to TPA, in accordance with CMS requirements.		
4.3.2.4.1.2	Customer service call center hours and days must be the same for all individuals regardless of whether they speak English, a non-English language, or use assistive devices for communication. During this time, current and prospective enrollees must be able to speak with a live customer service representative. TPA may use a voicemail box on Sundays and federal holidays in lieu of having live customer service representatives except during the period from October 1 through March 31 when the call center must operate seven (7) days a week apart from Thanksgiving and Christmas.		
4.3.2.4.1.3	Provide Customer Service staff, including 20% of staff bilingual in English and Spanish, to answer phones for Members and other callers seeking information about the Medicare plan.		
4.3.2.4.1.4	Continually provide Call Center training on the Plan and the Model of Care to each new staff member as part of the onboarding process.		
4.3.2.4.1.5	Conduct “Welcome Calls” to each new Enrollee within thirty (30) days after the effective date of enrollment. For those new Enrollees who the Contractor successfully contacts, TPA will provide health education and respond to questions about Covered Services and how to access them and conduct a warm hand off to the appropriate entity conducting the member health risk screening.		
4.3.2.4.1.6	Provide an automatic call distribution and auto attendant (ACD-AA) telephone system where Enrollee’s caller ID displays health plan name and inbound call center number as well as manage call-tree set-up and messaging.		
4.3.2.4.1.7	Maintain call center staffing adequate for average hold time per CMS Requirements.		
4.3.2.4.1.8	Limit average hold time to two (2) minutes, with the average hold time defined as the time spent on hold by the caller following the interactive voice response (IVR) system, touch tone response system, or recorded greeting and before reaching a live person.		
4.3.2.4.1.9	Provide voicemail system 24/7 for Members and Providers to call and leave messages after hours or on holidays.		

MEDICARE FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.2.4.1.10	Return Member calls within one (1) Business Day of receipt per the CMS Requirements/timelines.		
4.3.2.4.1.11	Return provider voicemails no later than three (3) Business Days of receipt.		
4.3.2.4.1.12	Provide a dedicated toll-free Member Behavioral Health Hotline.		
4.3.2.4.1.13	Establish and maintain a customer service module that is capable of capturing call center data sufficient to meet CMS Requirements.		
4.3.2.4.1.14	Record all calls and track all Member phone communications to be made available at a Member level to HPS within 3 – 5 Business Days of request. Urgent requests for cause will be expedited.		
4.3.2.4.1.15	Generate monthly call analysis reports in a format mutually agreed to upon by the Parties used for internal monitoring of call center activity.		
4.3.2.4.1.16	Implement and maintain a dedicated toll-free phone number and Interactive Voice Recognition (IVR) system that permits providers and members to inquire on Member eligibility without the need to talk with a CSR within agreed upon timeline post-go live.		
4.3.2.4.1.17	Assist Members in selecting or changing their PCP.		
4.3.2.4.1.18	Implement processes to ensure that information released to callers about Members is done in accordance with Law as defined in the Master Services Agreement. If release of information is requested from non-authorized persons, take steps to obtain an appropriate written authorization for release of information. POA forms must be stored and shared with plan partners as appropriate.		
4.3.2.4.1.19	Complete warm hand offs for Members (i.e. to care management, PBM, sales team, other), as applicable.		
4.3.2.4.1.20	Implement and maintain a system for documenting and sending grievances from Customer Service to the Grievance Department.		
4.3.2.4.2	*Member Incentives and Value-Added Benefits*		
4.3.2.4.2.1	Support agreed upon supplemental benefits that are processed via claims payment within mutual agreed upon timelines for any future changes.		
4.3.2.4.2.2	Manage and administer Member incentive over the counter card (OTC) benefit.		
4.3.2.4.2.3	Support education of Member incentive program via inbound member and provider calls, including using OTC vendor portal to assist with answering general questions about OTC, status on benefit post timing, and checking balances, HPS will provide escalation path resolution for any items that cannot be complete with first result triage by the customer service team including: reissuing replacement cards, adding value to cards, research support for discrepancies.		

MEDICARE FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.2.4.2.4	Perform outbound OTC benefit reminder calls to members who have not yet activated their OTC cards. TPA will record results of outbound OTC calls and provide results to HPS upon request.		
4.3.2.4.2.5	Purchase, store and mail supplies and program materials, per the benefit and criteria as defined by HPS. TPA shall track and securely store all mail that is returned.		
4.3.2.4.2.6	TPA shall produce reports for member incentives and value-added benefits in agreed upon format for the management and member engagement analysis.		
4.3.2.4.3	*Member Materials*		
4.3.2.4.3.1	Design, produce and fulfill Member collateral materials, as prescribed by CMS Requirements.		
4.3.2.4.3.2	Coordinate with respective fulfillment vendors for Member materials.		
4.3.2.4.3.3	Manage distribution and oversight of fulfillment where content and design are created by HPS or delegate(s).		
4.3.2.4.3.4	Oversee adequacy of collateral materials inventories to meet supply needs for any material listed as content developed by HPS or delegate(s).		
4.3.2.4.3.5	Manage delivery of collateral materials for the information mailed to new Members (“Welcome Packet”) to the fulfillment vendor.		
4.3.2.4.3.6	Report on any material listed as content developed by HPS including date stamp it was mailed.		
4.3.2.4.3.7	Member ID Card Fulfillment • Coordinate design of ID cards • Oversee fulfillment of ID cards to Member in accordance with HFS and CMS timeframes. • Re-issue ID cards to Members as necessary and or in accordance with any changes.		
4.3.2.4.3.8	Store and update member’s address changes, and preferred language or format for all materials distribution based on members selections.		
4.3.2.4.3.9	Provide or contract for services to translate and develop alternate formats (including large print and braille) for all member materials including evidence of Coverage and the formulary. Provide telephonic interpretation on materials when required.		
4.3.2.5	**PROVIDER SERVICES**		
4.3.2.5.1	*Provider Network Management and Provider Contracting*		
4.3.2.5.1.1	Maintain provider database of all essential information about the provider network based on the data provided by HPS.		
4.3.2.5.1.2	Configure payment arrangements and standard add-on payments for medical and behavioral claims (TPA delegated services) as described in contracts.		

MEDICARE FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.2.5.1.3	Capacity to load standard payment arrangements within fourteen (14) days and unique payment arrangements within twenty-five (25) days of receipt according to HPS' standard contract load process.		
4.3.2.5.1.4	Provide contract load notification file "Contract Summary" to HPS Network Team for quality review and sign-off. Corrections or modifications based on inaccurate build from provided contract details from HPS will be expedited and completed within the 10 days from receipt of corrections		
4.3.2.5.1.5	Maintain an online provider directory (medical and behavioral health providers) accessible to the public that meets CMS Requirements. A website link will be provided to access the pharmacy directory which is maintained by Pharmacy Benefits Manager (PBM), and any other vendor directories (e.g. dental, vision, etc.) not aligned with TPA's overall scope.		
4.3.2.5.1.6	Maintain "print ready" version of the provider directory that can be made available upon request for a hard copy per CMS requirements.		
4.3.2.5.1.7	Maintain an email address and toll-free phone/TTY phone number that can be used to report mistakes found on the Provider or Pharmacy Directory. a. Email address a. Toll-free phone/TTY phone number		
4.3.2.5.1.8	Conduct quality assurance of provider data against data provided to TPA by HPS, within Pipeline and downstream systems (i.e. provider directory, provider portal, and enrollment platform) managed through business rules and notification to HPS of rejects and warnings.		
4.3.2.5.1.9	Conduct quarterly reconciliation process with HPS and collaborate and remediate any discrepancies. Perform end to end focus audits quarterly on a mutually agreed upon scope of provider records.		
4.3.2.5.1.10	Support ability to ingest precluded and excluded provider holds per CMS Requirements. HPS will be responsible for provider sanction monitoring and flagging of holds via a clean provider record with all required data elements and through TPA's documented standard load process and timeline.		
4.3.2.5.2	*Provider Relations & Services*		
4.3.2.5.2.1	Perform provider site visits.		
4.3.2.5.2.2	Operate a phone system and process that permits providers to call the plan. TPA to complete warm hand-offs to provider relations.		
4.3.2.5.2.3	Maintain a unique phone number for provider inbound phone calls. Transfer of phone number to HPS upon orderly wind-down of the contract.		
4.3.2.5.2.4	Hire, train, and oversee provider relations team that proactively engage providers and resolve provider issues.		
4.3.2.5.2.5	Educate and orient providers regarding plan policies and procedures, including policies and procedures on (a) claims, (b) prior authorization and referral requirements, (c) complaints and appeals process, and (d) other administrative rules of the plan. Provider and Subcontractor attendance and/or participation is documented and maintained by the TPA and provided upon request.		

MEDICARE FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.2.5.2.6	Receive provider disputes via the provider services call center. Route to HPS provider Relations or to TPA A&G department for processing, tracking, and reporting as appropriate and per agreed upon processes.		
4.3.2.5.2.7	Adopt policies and strategies to communicate with and encourage providers to use such tools as: (a) portal for online prior authorization submission, (b) provider portal to verify member eligibility, (c) provider portal to check their own claim status, and (d) other enhancements that reduce manual workload on plan staff.		
4.3.2.6	**MEDICAL MANAGEMENT (MEDICAL AND BEHAVIORAL SERVICES)**		
4.3.2.6.1	*Utilization Management (UM)*		
4.3.2.6.1.1	Provide recommendations on services appropriate for referral and/or that will require prior authorization.		
4.3.2.6.1.2	Recruit, hire, onboard and maintain competent and adequate staff to conduct mutually agreed upon utilization management functions.		
4.3.2.6.1.3	Collaborate to create a Utilization Management Program Description		
4.3.2.6.1.4	Review the utilization review procedures, at regular intervals, but no less frequently than annually.		
4.3.2.6.1.5	Implement systems, both computerized and manual as necessary, to handle utilization management functions to ensure consistent application of review criteria for authorization decisions.		
4.3.2.6.1.6	Conduct prior authorization processes in accordance with the time frames set forth by HPS and CMS.		
4.3.2.6.1.7	Receive request for services defined by HPS and in alignment with CMS guidelines, which services may change from time to time, via telephone, FAX, online web entry, or other approved methodologies.		
4.3.2.6.1.8	Obtain all necessary information, including pertinent clinical information, and consultation with the treating Physician, as appropriate.		
4.3.2.6.1.9	Screen authorizations and requests using criteria approved by HPS.		
4.3.2.6.1.10	Provide Medical Directors to make timely denial decisions and communicate with providers on service denials or reductions.		
4.3.2.6.1.11	Clearly document the reasons for decisions and make available to the Enrollee and the requesting Provider (upon request).		
4.3.2.6.1.12	Generate denial letters/notices (IDNs) in accordance with CMS Requirements and timeframes.		
4.3.2.6.1.13	Obtain additional information that may be necessary for Medical Director to make decisions on approval or denial of requests.		
4.3.2.6.1.14	Refer any pre-defined service requests directly to Medical Director for review.		
4.3.2.6.1.15	Determine medical necessity of service based on documentation received.		

MEDICARE FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.2.6.1.16	Enter authorizations into agreed upon system and issue authorization numbers to providers and maintain history of authorizations by Member and by provider.		
4.3.2.6.1.17	Perform concurrent review activities on inpatient admissions and document Level of Care authorizations.		
4.3.2.6.1.18	Coordinate and manage inpatient level of services, facilitate identification of alternative levels of care, and management of non-par services in association with utilization management requests.		
4.3.2.6.1.19	Maintain UM denials log in accordance with CMS requirements for TPA specified services.		
4.3.2.6.1.20	Report monthly UM statistics as per standard TPA UM reporting package. Custom requests will be developed through Analytics prioritization process.		
4.3.2.6.1.21	Implement utilization management criteria appropriate for the management of applicable populations. Create a written UM Plan consistent with policies of HPS to govern the activities of nurses and staff.		
4.3.2.6.1.22	Work to have and create defined site of care pathways to ensure members receive services at the most appropriate site of care. These pathways should include identification of members in need of targeted transition of care services.		
4.3.2.6.1.23	Singe Case Agreements: a. Submit contract via standard contract load process for single case agreements outside 100% Medicare reimbursement. b. Process single case agreements at 100% Medicare reimbursement through standard out of network rate if appropriate prior authorization received.		
4.3.2.6.1.24	Attend HPS UM Committee and QI Committee meetings.		
4.3.2.6.1.25	Complete (2) medical and behavioral health evaluation studies annually that analyze pressing problems and solutions.		
4.3.2.6.1.26	Support the review and improve the peer review procedures, at regular intervals, but no less frequently than annually.		
4.3.2.6.1.27	Provide a Behavioral Health Medical Director to directly support activities as it relates to Behavioral health services.		
4.3.2.6.1.28	Coordinate review of medically necessary cases with Behavioral Health Medical Director.		
4.3.2.6.1.29	Send prior authorization information to care management entities no less frequent than daily.		
4.3.2.6.1.30	Monitor behavioral health services that require prior authorization against the behavioral health benefit.		
4.3.2.6.1.31	Issue adverse benefit determination notices to members ten (10) days in advance of the date of its action.		
4.3.2.6.1.32	Ensure parity of medical and behavioral health utilization management.		
4.3.2.6.2	*Care Management (CM)*		
4.3.2.6.2.1	Develop UM to CM workflow.		

MEDICARE FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.2.6.2.2	Flag and refer complex Members for care management if applicable from the utilization management team.		
4.3.2.6.3	*Quality Health Plan Program*		
4.3.2.6.3.1	Provide a dedicated resource who will focus on and assist HPS on evaluating and developing interventions focused on health equity.		
4.3.2.6.3.2	Make referrals on potential Quality of Care (QOC) cases and Health, Safety, and Welfare incidents that require follow up and investigation.		
4.3.2.6.3.3	Upon mutual review and agreement, complete all activities within the QAP that require improvements to services provided within TPA's scope.		
4.3.2.6.3.4	Provide support for HEDIS® activities throughout the year including but not limited to: • Kick-off and external validation activities; • Consultative support such as assistance with roadmap and report completion; • Chart over-reads; • Work with providers to receive EMR supplemental data feeds to enhance quality/HEDIS data; and • Contacting provider practices and updating provider practice information as needed to support the HEDIS® vendor, and evaluation of HEDIS® results. HEDIS provider data changes or corrections will be incorporated into the standard inload process and the TPA will reconcile the differences between HEDIS® requirements and the TPA's data. • TPA shall make available all HEDIS® data for plan use upon HPS request.		
4.3.2.6.3.5	Conduct the Consumer Assessment of Healthcare Providers and Services (CAHPS) survey annually according to CMS Requirements • With certified vendors • Meeting required timeframes • Reporting results and strategies		
4.3.2.6.3.6	Complete HEDIS Roadmap in partnership with HPS related to TPA Health scope of services.		
4.3.2.6.3.7	Conduct the Health Outcomes Survey (HOS) project according to CMS Requirements.		
4.3.2.6.3.8	Maintain data integration for quality admin data: a. Medical claims data b. Enrollment/disenrollment c. Member and provider reported grievances d. Medical/behavioral health appeals data e. Provider disputes f. HFS reported grievances		
4.3.2.6.3.9	Achieve 100% Overreads for Negative Charts in selected categories and work to close out P2 & P3 Pends or new vendor equivalent of "Member Not Seen Here" and "Incorrect Office Demographics" errors.		

MEDICARE FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.2.6.3.10	Create visualization of monthly provider report cards from HEDIS vendor data. HPS to supply HEDIS vendor data in agreed upon format including summary data and member level data.		
4.3.2.6.3.11	Attend meetings with workstream leads with dedicated time for Executive report-out. Additional quarterly on-site performance and strategy review to chart adjustments as needed.		
4.3.2.7	**APPEALS AND GRIEVANCES**		
4.3.2.7.1	*Medical and Behavioral Health Grievances*		
4.3.2.7.1.1	Perform medical and behavioral pre-service, post-service appeals and provider disputes as it relates to agreed upon services.		
4.3.2.7.1.2	Process Member grievances for Part C, dental/vision, and non-emergent medical transportation grievances including calls received via customer service, through 1-800 Medicare, and electronically on the medicare.gov site in accordance with CMS, HFS, and HPS Requirements.		
4.3.2.7.1.3	Intake and provide Member with a standard response letter regarding a Quality of Care (QOC) and Civil Rights grievances received and captured on universes.		
4.3.2.7.1.4	Send QOC and Civil Rights grievances to HPS Quality Leadership for investigation via agreed upon workflow.		
4.3.2.7.1.5	Support research of CTMs and provide information to HPS compliance in a timely manner.		
4.3.2.7.1.6	Provide all CMS reporting in alignment with CMS Requirements for all Part C appeals and grievances		
4.3.2.7.1.7	Track and provide required reports, ancillary documentation, and participate in CMS audits for appeals and grievances that are delegated to TPA.		
4.3.2.7.1.8	Receive, document, and track all Member grievances sent to the plan via orally or in writing for complaint investigation and resolution		
4.3.2.7.1.9	Complete all resolution steps in investigation and resolution of grievances delegated to TPA within appropriate timeframes. • 24 hours for expedited grievance • 30 calendar days for standard grievance		
4.3.2.7.1.10	Implement and maintain a grievance tracking system that documents all aspects of the grievance in alignment with CMS Requirements. Submit grievance procedures to Department for prior approval.		
4.3.2.7.1.11	Implement and oversee UM Appeals processes in accordance with CMS requirements.		
4.3.2.7.1.12	Perform Complaints and Appeals resolutions by obtaining additional information from HPS where appropriate or through providing further information from TPA's UM criteria sets.		
4.3.2.7.2	*Pre and Post Service Appeals & Provider Disputes*		
4.3.2.7.2.1	*Pre and Post Service Appeals*		
4.3.2.7.2.1.1	Implement and oversee pre and post service appeal processes for Medicare Non-Part D, Part C and Appeals in accordance with CMS Requirements.		

MEDICARE FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.2.7.2.1.2	Render appeals decisions in adherence with CMS Requirements.		
4.3.2.7.2.1.3	Send all adverse Medicare appeal decisions (not in the Enrollee's favor or within the relevant timeframe) regarding Medicare services to the IRE for a new and impartial review.		
4.3.2.7.2.1.4	Provide written notice to the Enrollee of the final decision of the Appeal, which shall include: 1) Results of the Appeals; 2) Date of the Appeal resolution; 3) Right to request and how to request a State Fair Hearing; 4) Right to continued benefits pending a State Fair Hearing, and how to request continued benefits; 5) Notice that the Enrollee may be liable for the cost of any continued benefits if the Contractor's action is upheld at the State Fair hearing.		
4.3.2.7.2.1.5	Issue a notice of all applicable Medicare appeal rights to members that has been approved by CMS and in accordance with the Agencies' requirements.		
4.3.2.7.2.1.6	Track and report on appeals. Create a monthly and quarterly report summarizing all Appeals filed by Enrollees and the responses to and disposition of those matters, including decisions made following an external independent review.		
4.3.2.7.2.2	*Provider Disputes*		
4.3.2.7.2.2.1	Create and maintain an intake for all provider disputes. System should adequately document, track and report the detail. Support intake, documentation, tracking and reporting of provider disputes.		
4.3.2.7.2.2.2	Provide reporting as appropriate to the Provider Relations and Operations teams. Review dispute reporting for disputes overturned to identify issues such as global configuration errors or opportunities to improve.		
4.3.2.7.2.2.3	Assign staff to review, work, and resolve the provider disputes. Escalate any administrative decisions to the plan as appropriate.		
4.3.2.7.2.2.4	Issue claim appeal denials to provider in cases where the appeal is denied, and original claim decision is being upheld by the IRE or State.		
4.3.2.7.2.2.5	Reprocess claims affected by overturning the original claim decision.		
4.3.2.8	**RISK ADJUSTMENT**		
4.3.2.8.1	Establish connectivity directly with CMS for Risk Adjustment Processing,		
4.3.2.8.2	Deliver formatted RAPS/EDPS flat files for submission to CMS		
4.3.2.8.3	Build Process to create delete files based on Health Plan identified deletes (this applies to retrospective RA submissions performed by TPA for MMAI)		
4.3.2.8.4	De-duplicate already submitted HCCs and HCCs accepted by CMS using complete data files provided by HPS (all RAPS/EDPS files sourced from a single RA vendor)		
4.3.2.8.5	Reconcile RAPS/EDPS return files (as provided by a single RA vendor) to understand variance (if any) and mitigation options		

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4.3.2.8.6	TPA is required to report and return any overpayment that has been identified for all overpayment categories in alignment with CCH policies and procedures. Report an identified overpayment beginning on the day after the applicable Part C reconciliation date and submit any overpayment to RAPS in alignment with CMS Requirements.		
4.3.2.8.7	Support RADV Audit through gathering required documentation.		
4.3.2.8.8	Upload all files, including the Chart Chase Lists, to vendor file transfer protocol (the "SFTP") site and notify vendor project manager when the upload is complete.		
4.3.2.8.9	Continuously load patient chart data in approved formats into secure repositories for analytics and workflow enablement.		
4.3.2.8.10	Approve and load medical coder team credentials to use Retrospective Workflow tools.		
4.3.2.8.11	Review and confirm schedule/timelines for supplemental risk coding findings prior to submission to payors and/or regulatory authority (CMS).		
4.3.2.8.12	Perform Risk Coding Gap analysis study which informs the patient chart approach.		
4.3.2.8.13	Send Patient record acquisition letters to providers.		
4.3.2.8.14	Estimate and confirm budget for patient chart activities, including copy service fees associated with manual chart capture.		
4.3.2.8.15	Review and confirm schedule/timelines specific to in-scope Lines of Business (LOBs) including review of supplemental risk coding findings prior to submission to regulatory authority (CMS).		
4.3.2.8.16	Apply Natural Language Processing (NLP) to efficiently evaluate patient charts and to support prioritization of workload ahead of medical coder reviews.		
4.3.2.8.17	Review acquired patient charts using automated, secured workflow that adheres to CMS-provided guidelines for retrospective review.		
4.3.2.8.18	Perform any necessary quality audits (based on the standards set forth in the Coding Guidelines) to ensure accuracy of chart reviews for both added and deleted diagnoses.		
4.3.2.8.19	Manage down chart review vendor(s) as needed at the conclusion of retrospective program.		
4.3.2.8.20	Provide ongoing reporting to inform TPA-led campaigns' governance (e.g., coder productivity, HCCs identified, ongoing meetings to manage retrospective process).		
4.3.2.8.21	Attend regular governance events (e.g., meetings) to report on RA retrospective progress.		
4.3.2.8.22	Upon request, provide estimates of financial impact to client to support budget activities including any pass-through costs of vendors used.		
4.3.2.8.23	Sign and submit any attestations regarding the veracity/accuracy of risk coding reviews.		
4.3.2.9	**CLAIM MANAGEMENT – CLAIMS PROCESSING, ADJUDICATION AND PAYMENT (PART C)**		
4.3.2.9.1	*Claims Processing & Encounters Submission*		

MEDICARE FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.2.9.1.1	Establish processes with HPS, including but not necessarily limited to, electronic communication methods (e.g. SharePoint application) to exchange information, policies and procedures, and directives regarding how claims should be paid and how benefits should be set up.		
4.3.2.9.1.2	Process all claims and encounters in accordance with CMS Requirements, including but not limited to claims from physicians, hospitals, clinics, ancillary providers, and other health care providers. Includes screening the data for completeness, logic, and consistency.		
4.3.2.9.1.3	Investigate, correct, and resubmit any rejected encounters from HFS throughout the encounter process.		
4.3.2.9.1.4	Maintain a 99% encounter acceptance rate on a quarterly basis or face penalties for not meeting the threshold.		
4.3.2.9.1.5	Attain certification and support encounter submissions for all medical and behavioral, vision, and transportation encounters in alignment with CMS Requirements. Distinguish and submit encounters for services primarily covered by Medicare on separate files from those benefits traditionally covered by Medicaid.		
4.3.2.9.1.6	Manage reconciliation processes to maintain accuracy of data between claims and membership system. Report any variances to the health plan with solution and timeframe included.		
4.3.2.9.1.7	Support Medicare encounter submission to CMS and Medicaid encounter submission to HFS for sub-delegates as a passthrough in MMAI compliant 837 encounter data sets for the following non-pharmacy sub-delegates: • Non-Emergent Medical Transportation • Dental/Vision		
4.3.2.9.1.8	Establish and maintain post office boxes for claims to be mailed to HPS including reporting on volume and return/ undelivered mail.		
4.3.2.9.1.9	Match claims to their referral or authorization, when required, and deny claims not properly authorized in accordance with HPS referral and prior authorization policies.		
4.3.2.9.1.10	Validate diagnosis and procedure codes reported by providers on claims in accordance with HPS requirements.		
4.3.2.9.1.11	Review, as necessary, medical management annotations in the authorization system to ensure that services billed match the services authorized and that inpatient levels of care match the levels of care authorized under the plan's Utilization Management criteria, and process in accordance with HPS level of care procedures or other applicable payment methodologies.		
4.3.2.9.1.12	Implement, based on HPS contracts, the fee schedules and payment methods that will apply to each provider and communicate internally for system configuration.		
4.3.2.9.1.13	Create fee schedules within the Claims System and process claims in accordance with provider reimbursement contractual agreements.		

MEDICARE FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.2.9.1.14	Process non par claims and determine the applicable non par fee schedule based on CMS and/or HFS Requirements and/or relevant HPS policy. If current policy does not apply, contact HPS for instructions on how the non-par claim should be processed. Follow all rules for non-par payments promulgated by HPS.		
4.3.2.9.1.15	Process corrected claims and make necessary payment adjustments.		
4.3.2.9.1.16	Process claims in accordance with single case agreements to ensure member continuity of care.		
4.3.2.9.1.17	Track benefit limits as they apply to program claims and adjudicate claims in accordance with prescribed limits and notify provider of the reason for denial.		
4.3.2.9.2	*Payment and Program Integrity*		
4.3.2.9.2.1	Ability to process COB claims including: • Support ability to accept Member COB status information from MMIS system in HIPAA standard formats. • Support ability to apply adjudication logic if there is a secondary payer besides Medicaid or Medicare. • If claim paid as primary, but Member has secondary, process recovery for claim		
4.3.2.9.2.2	Designate the following positions: • Third Party Liability (TPL) Benefit Coordinator to serve as contact person for benefit coordination issues • One or more recoveries specialists to investigate and process all issues related to TPL		
4.3.2.9.2.3	Subrogation Claim Management: • Provide a claim data feed to Subrogation Vendor to identify and investigate potential involving subrogation situations on paid claims. • Support HPS' model of "Pay and Chase" for claims related to subrogation. • Oversee collection of subrogation dollars by Subrogation Vendor. • Document, track, and report subrogation dollars through periodic reports.		
4.3.2.9.2.4	Screen claims for duplicate payments prior to payment.		
4.3.2.9.3	*Funding, Recovery, & Claims Audit*		
4.3.2.9.3.1	Maintain copies, on paper or in electronic format, of claims and attachments submitted by providers.		
4.3.2.9.3.2	Establish mechanisms to adjust claims or to recoup payments deemed appropriate after initial payment based on written policies prepared by HPS and provided to TPA.		
4.3.2.9.3.3	Prepare a claims pre-release report for HPS, and/or its designee, to review claims that are scheduled for payment.		
4.3.2.9.3.4	Implement processes to operationalize HPS written policies, provided in advance to TPA, regarding claim audits to be performed prior to final payment of claims.		

MEDICARE FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.2.9.3.5	Perform, or cause to be performed, medical record audits on claims identified through payment integrity initiatives listed above where applicable.		
4.3.2.9.3.6	Issue timely claims payment with the EOP to providers in accordance with requirements set forth in the providers' contract and in accordance with clean claims payment CMS Requirements and based on available funds.		
4.3.2.9.3.7	Calculate interest due on claims not paid in accordance with CMS Requirements prompt pay policies. Issue checks, either separately or as part of the EOP, for interest.		
4.3.2.9.3.8	Establish internal processes for review of CMS bulletins that may require changes to claims processing or other operational processes.		
4.3.2.9.3.9	Communicate and collaborate with HPS Compliance to support required changes of CMS bulletins within TPA's delegated services.		
4.3.2.9.3.10	Coordinate retro-deletes and retro-adds to claims. Prepare reports to identify claims that will need to be recouped or reprocessed based on retroactivity.		
4.3.2.9.3.11	Take timely steps, consistent with HPS policies and procedures, to recoup or reprocess already-adjudicated claims affected by retro-add or retro termination.		
4.3.2.9.3.12	Perform random audits of up to 3% of claims paid and provide a quarterly report of claim audit results to CCH. Timing of claims audit will be dependent on release of funds.		
4.3.2.9.3.13	Process corrected claims and make necessary payment adjustments.		
4.3.2.9.3.14	Process refund checks in accordance with HPS policy within the Claims System so that the claim is properly reflected in the TPA system		
4.3.2.9.3.15	Update electronic data interchange ("EDI") standards and processes in accordance with industry and/or CCH updates as required by applicable contract Law.		
4.3.2.10	**COMPLIANCE / PROGRAM INTEGRITY/ FRAUD, WASTE & ABUSE**		
4.3.2.10.1	*Compliance Program Structure/Elements*		
4.3.2.10.1.1	Maintain a compliance program, consistent with requirements outlined in 305 ILCS 5/8A-1, 42 CFR Part 420, 42 CFR §422.503, 42 CFR §423.504, 42 CFR Part 455, 1156 and 1902(a)(68) of the Social Security Act (SSA) and Chapters 9/21 of the CMS Medicare Managed Care Manual (100-16).		
4.3.2.10.1.2	Maintain written policies, procedures, and a Standard of Conduct/Ethics that demonstrate compliance with all applicable requirements and standards under the Master Contract and all federal and state requirements related to program integrity. *Provide a listing and brief description of all compliance related standards, policies, and procedures maintained by the Proposer.*		

MEDICARE FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.2.10.1.3	Maintain written policies and procedures that implement the operation of the compliance program. *Provide a listing and brief description of standards, policies and procedures related to operation of the Compliance Program maintained by the Proposer.*		
4.3.2.10.1.4	Appoint a designated Compliance Officer who is responsible for implementation of the compliance program, including developing, implementing, and disseminating policies and procedures designed to ensure compliance with Program Integrity/Fraud, Waste and Abuse (FWA) requirements and who reports directly to the Proposer's CEO and Board of Directors. *Provide a job description for the Proposer's Compliance Officer and an Organization Chart for the Proposer's Compliance department demonstrating reporting relationships for the Proposer's Compliance Officer, as well as additional Compliance Office staff.*		
4.3.2.10.1.5	Maintain a Regulatory Compliance Committee, consisting of members of the Board of Directors and senior management, which is responsible for oversight of the Proposer's compliance program. *Provide a committee description / charter and membership list for the Regulatory Compliance Committee.*		
4.3.2.10.1.6	Maintain a system of training and education for the Proposer's Compliance Officer, Board of Directors, senior managers, and employees that outlines the Proposer's obligation to comply with federal and state requirements. *Provide a description of trainings completed by Proposer's workforce to ensure compliance with federal and state law requirements, including the subject areas discussed, modality utilized for training and processes for tracking training completion.*		
4.3.2.10.1.7	Maintain several modalities for effective lines of communication between the Proposer's Compliance Officer and the Proposer's employees, FDRs and Network Providers. *Provide a description of internal processes used for reporting concerns related to compliance, integrity, FWA, mismanagement and misconduct, including options for reporting anonymously and outside of typical business hours.*		
4.3.2.10.1.8	Maintain effective lines of communication between Proposer's Compliance Officer, Proposer's employees and the CCH Compliance department. *Provide a description of processes used for reporting and/or escalating concerns to the CCH Compliance Officer.*		

MEDICARE FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.2.10.1.9	Enforcement of regulatory standards and program integrity-related requirements by the Proposer through well-publicized disciplinary guidelines. *Provide a description of process for consistent adherence to well-publicized disciplinary guidelines.*		
4.3.2.10.1.10	Maintain a system of established and implemented procedures for routine internal monitoring, auditing of program integrity compliance risks, prompt response to compliance issues, investigation of potential compliance problems identified in the course of self-evaluation and audits, correction of identified compliance problems through corrective action plans, and ongoing compliance with program integrity-related requirements, including the use of surveillance and utilization controls conducted by a designated Special Investigations Unit (SIU) of dedicated staff adequate in number. *Provide a description of Compliance Program processes for monitoring, auditing, and identification of compliance risks, including process for annual Work Plan and/or annual Audit Plan development, as well as tracking and documenting compliance efforts.*		
4.3.2.10.1.11	Maintain a system for investigation and reporting for all instances of suspected and/or actual noncompliance with laws, regulations, CCH policies / procedures (to the extent applicable), or issues related to fraud, waste, and/or abuse (FWA), including reporting to the CCH Compliance Officer or the appropriate CountyCare liaison, as appropriate. *Delineate the methods of how concerns may be submitted or communicated from personnel, providers, agents and members and investigated by Proposer's Compliance Department. Describe the investigation tracking system and the resolution process, including how issues are reported/escalated to CCH Compliance.*		
4.3.2.10.1.12	Maintain a system for prompt reporting of all overpayments identified or recovered, particularly those related to potential fraud, to the Proposer's Compliance Officer and CCH Compliance. *Describe how Proposer has established and implemented methods to encourage personnel, subcontractors/FDRs, agents and providers to report overpayments identified or received related to FWA without fear of retaliation, including how reports will be escalated to CCH Compliance.*		

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4.3.2.10.1.13	Maintain a policy of non-intimidation and non-retaliation for good faith participation in the Proposer's compliance program, including but not limited to reporting potential issues, investigating issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials. *Describe how Proposer supports a safe, non-threatening environment where individuals may ask questions about integrity and compliance, fraud, abuse and financial misconduct matters and report their concerns, including a description of how reporters are protected from retaliation and harassment.*		
4.3.2.10.2	*Compliance Program /Program Integrity Responsibilities*		
4.3.2.10.2.1	Ensure that all Proposer employees, agents, and subcontractors complete training as necessary to perform the responsibilities under the Master Contract, including the completion of Compliance/Code of Ethics, FWA and HIPAA trainings upon hire, and no less frequently than annually thereafter, as well as additional trainings utilizing compliance training materials or training sessions supplied by CCH (as needed). FWA training should parallel CMS training materials for "Medicare Parts C and D General Compliance Training" and "Combating Medicare Parts C and D Fraud, Waste and Abuse". Training records must be provided to CCH within five (5) days of any request. *Provide a description of the required training and education completed by Proposer, including the subject areas discussed, modality utilized for training and processes for tracking training completion.*		
4.3.2.10.2.2	Ensure full cooperation by Proposer with any review, audit, or investigation conducted by the CCH Compliance Program or their designee (including those related to readiness activities), including the timely return of requested documentation / data and interviews with Proposer's workforce.		
4.3.2.10.2.3	Ensure full cooperation by Proposer with auditors conducting audits/accreditation activities or oversight of the functions, processes or operations of activities delegated to Proposer under the Master Agreement.		
4.3.2.10.2.4	Prepare and adhere to a written Corrective Action Plan (CAP), in a format mutually agreed upon as requested by CCH or as required by CMS, with regard to any non-compliant activities performed that are identified in the course of audits conducted or required in the CCH Master Contract or requested pursuant to the CCH Master Contract or other entities of competent jurisdiction.		
4.3.2.10.2.5	Support CCH Compliance with regulator inquiries and complaints.		
4.3.2.10.2.6	Support CCH Compliance with necessary review and revisions to plan policies and procedures, including in the review and approval of any required changes.		

MEDICARE FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.2.10.2.7	Develop and maintain policies and procedures for oversight of delegated services that are contracted to other organizations, including how audit and monitoring activities will be conducted of delegated functions/services. *Provide a description of the Proposer's delegate / FDR oversight process, including a listing of related policies maintained by the Proposer. Describe in detail audits of FDRs, subcontractors, agents and providers to ensure compliance with contractual and regulatory requirements, including the frequency of the activity.*		
4.3.2.10.2.8	Ensure the collection, assessment, storage and reporting of information related to conflict-of-interest for personnel, officers, directors, and subcontractors, and the officers, directors and personnel of any subcontractors utilized by the Proposer. *Provide a description of the conflict-of-interest process, including a listing of related policies maintained by the Proposer.*		
4.3.2.10.2.9	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 Department of Health and Human Services (HHS) Office of Inspector General (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) (https://sanctionssearch.ofac.treas.gov/) *Provide a description of the sanction screening process, including a listing of related policies maintained by the Proposer.*		
4.3.2.10.2.10	Notify CCH immediately in the event that it or anyone performing services under the Master Contract: (1) Is convicted of a criminal offense related to health care and/or related to the provision of services paid for by Medicare, Medicaid or another federal health care program; or (2) Is excluded or debarred from participation in any federal health care program, including Medicare and Medicaid.		
4.3.2.10.2.11	Maintain compliance with the Illinois Human Rights Act, the U. S. Civil Rights Act, and Section 504 of the federal Rehabilitation Act.		
4.3.2.10.3	*Confidentiality/Privacy*		

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4.3.2.10.3.1	Maintain administrative and management arrangements, policies and procedures, and training that comply with all federal and state regulations and statutes governing the creation, receipt, access, use, disclosure maintenance, and transmission of protected health information (PHI), including the protection of PHI and the detection and prevention of unauthorized uses and disclosures of PHI. *Provide a listing of Proposer's policies related to privacy and confidentiality of health information, including those that address HIPAA or relevant State Privacy laws.*		
4.3.2.10.3.2	Maintain procedures to ensure that the Proposer and/or its subcontractors do not access, use, store, maintain, or transmit, whether electronically or otherwise for any purpose whatsoever, CountyCare PHI, documents, data, claims, guidelines, protocols, programs, financial analyses, performance measures, or other information at or to any offshore location, without receiving prior approval from CCH. *Provide a description of any of the Proposer services that will be performed by offshore operations, including any contracted services.*		
4.3.2.10.3.3	Report breaches of unsecured PHI, as defined in 45 CFR 164.402, and mitigate potential damages associated with a Breach of Unsecured PHI and with uses and disclosures in violation of HIPAA requirements and the Master Contract. *Provide a description of notification procedures between Proposer and CCH.*		
4.3.2.10.3.4	Maintain procedures to ensure that any subcontractors utilized by the Proposer will comply with applicable HIPAA privacy and security requirements, including those outlined in the Business Associate Agreement between CCH and the Proposer. *Provide a description of procedures for passing down CCH BAA requirements to subcontractors.*		
4.3.2.10.3.5	Maintain an Information Privacy program that includes, at a minimum, a designated individual who is responsible for developing and implementing policies and procedures for all standard privacy practices regarding the protection of CCH protected health information. *Provide a job description for the designated Privacy individual and a description, including organization chart, for the Information Privacy program.*		
4.3.2.10.3.6	Maintain cyber insurance. *Describe and delineate the relevant provisions and limits of Proposer's cyber insurance policy.*		
4.3.2.10.4	*Fraud, Waste, Abuse (FWA)*		

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4.3.2.10.4.1	Maintain administrative and management arrangements, policies, and procedures that comply with all federal and state regulations and statutes governing the detection and prevention of Fraud, Waste, Abuse, mismanagement, and misconduct (collectively, FWA), including but not limited to 305 ILCS 5/8A-1 et. seq., 42 CFR 455, 42 CFR 438 Subpart H, and sections 1128, 1156 and 1902(a)(68) of the Social Security Act (SSA). *Provide a listing of plans, policies, and procedures related to FWA activities and operations maintained by the Proposer.*		
4.3.2.10.4.2	Operate a full-time, dedicated Special Investigation Unit (SIU) to detect, monitor, investigate and prevent FWA, including the use of data analytics to detect potential FWA. The SIU shall be responsible for the reasonable investigation of each enrollee and provider case of suspected FWA activity and for implementation of the CountyCare FWA prevention and reduction activities under the CountyCare FWA Plan. The SIU must be able to receive referrals of FWA alleged against enrollees, providers (both contracted and out-of-network) and Subcontractors. Investigations may involve coordination with other CCH delegated entities. *Describe the Proposer's FWA Plan to detect, investigate and report suspected instances of FWA specific to a Medicaid managed care health plan. Submit a process flow diagram illustrating the process to conduct a reasonable investigation of each suspected FWA involving providers and subcontractors, Proposer's workforce and subcontractors, and enrollees. Include within the diagram the process of notification to CCH Compliance of suspected FWA and potential criminal acts.*		
4.3.2.10.4.3	Designate a dedicated SIU Liaison to provide notice of any suspected FWA to CCH Compliance within twenty-four (24) hours after receiving such report. *Identify the member of management or leadership who will function as the dedicated, day-to-day SIU Liaison to CCH Compliance and include a job description and reporting structure for that individual.*		
4.3.2.10.4.4	Conduct both pre-payment and retrospective, post-payment audits/investigations, including analysis of claims that do not generate reimbursement ("zero paid claim"). *Describe the Proposer's process for conducting pre-payment and retrospective, post-payment audits and investigations.*		

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4.3.2.10.4.5	Provide first pass FWA identification, validation, and recovery services to include, at a minimum, the following: • Mapping claims data into standard format and perform FWA analysis with analytics. • Designing FWA concepts to assess claims compliance with current coding, billing and regulatory requirements, subject to CCH prior approval before implementation. • Designing FWA concepts to identify variances in claims including but not limited: claim accuracy, aberrant billing practices, fraud detection and enrollee inconsistencies in the areas of excessive daily services, contraindicated, medically unnecessary, duplicative and/or not supported by the diagnoses and over-utilization of services, subject to CCH prior approval before implementation. • Reviewing claims identified as an overpayment and validate the overpayment prior to initiating recovery efforts. • Obtaining approval from CCH Compliance prior to recovery initiation to minimize provider abrasion and ensure compliance with Master Contract terms. *Describe how the Proposer will develop and utilize Data Analytics, based on current regulations, to help identify and address Provider and Enrollee variances, including the identification of any external resources or software utilized as part of the process.*		
4.3.2.10.4.6	Perform interviews and/or "boots on the ground" field-based investigations related to FWA/Payment Integrity initiatives, if warranted. *Describe the operations of the Proposer's local Investigation Unit that will be responsible for the investigation and remediation of FWA / Program Integrity issues, including office locations and organization chart structure.*		
4.3.2.10.4.7	Perform medical record audits on claims identified through FWA/Payment Integrity initiatives using certified coders, registered nurses and/or other medical professionals (as needed). *Provide a description of the process for auditing medical records, including the identification of any coding software they used to review facility and provider claims to ensure the claims comply with State Medicaid guidelines as well as national coding and documentation guidelines published by the Centers for Medicare and Medicaid Services (CMS), the American Medical Association and various specialty organizations.*		

MEDICARE FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.2.10.4.8	Coordinate and perform education for providers based on audit or investigation findings, as directed by CCH Compliance. *Provide a description of the process for providing education to providers, via multiple modalities, including examples of when provider education is appropriate.*		
4.3.2.10.4.9	Recover established overpayments due to FWA made to a provider, as directed and approved by CCH. Overpayments may be obtained from a provider directly or made from future claim payments. Where there are not sufficient claims funds, letters to a provider will be sent. *Provide a description of the process for recovering overpayments made to providers, including how efforts will be coordinated with CCH Compliance.*		
4.3.2.10.4.10	Maintain processes to grant real-time access to CCH Compliance for SIU and/or FWA Program documentation and/or software platforms for reporting and oversight purposes. *Provide a description of the process for granting/authorizing CCH Compliance access to FWA related documentation and data.*		
4.3.2.10.4.11	Identify and implement process changes and/or system configuration solutions to prevent payment of improper claims, as identified via FWA concepts and data analytics, subject to prior approval by CCH.		
4.3.2.10.4.12	Provide first level appeal management for all provider concerns with FWA activity and recoveries.		
4.3.2.10.4.13	Maintain procedures that outline the methods for prompt reporting of all overpayments identified or recovered to CCH.		
4.3.2.10.4.14	Develop and deliver monthly, quarterly and ad hoc reports to CCH Compliance regarding FWA related investigations, audits and data mining activities, in the form and format requested by CCH and in line with requirements for reporting data to HFS and HFS OIG. *Provide a description of the process for developing and delivering accurate reports to CCH Compliance, including the process for ad hoc report requests.*		
4.3.2.10.4.15	Ensure cooperation with all appropriate federal and state agencies in the detection and prevention of Fraud, Waste, Abuse, mismanagement, and misconduct.		
4.3.2.10.4.16	Conduct recipient verification of services received by CountyCare members, including reporting of summary results to CCH. *Include a draft recipient verification letter and describe the process for conducting and reporting on recipient verification of services activities.*		
4.3.2.11	**FINANCIAL SERVICES**		
4.3.2.11.1	*Premium Payment Management*		
4.3.2.11.1.1	Reconcile Membership to premium files and identify exceptions for reporting and follow up to health plan and when necessary, CMS.		

MEDICARE FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.2.11.1.2	Prepare the monthly Enrollment Data Validation (EDV) Package for Reed & Associates Retroactive Processing Contractor (RPC) submission consisting of the monthly sample review of enrollment related transactions submitted to CMS.		
4.3.2.11.1.3	Compare monthly enrollment records to the CMS eligibility and MMR files and report all discrepancies to the Enrollment Department for investigation.		
4.3.2.11.1.4	Research and provide updated transactions to CMS via accreditation file or the RPC for retroactive transactions as defined by CMS.		
4.3.2.11.1.5	Approve initial attestation that all data from the combination of daily TRRs for the previous month have been completed timely and that all required transactions were accepted, disputed or have been processed and that all required correspondence was issued. Unresolved discrepancies, along with the Enrollment Transaction Certification, will be provided to HPS.		
4.3.2.11.1.6	Identify Members affected by retro-termination or retro-eligibility and provide data to Claims Audit & Recovery Department to act upon these changes in accordance with HPS policies and procedures.		
4.3.2.11.2	*Management of Claims Bank Trust Accounts*		
4.3.2.11.2.1	Establish necessary bank accounts for issuing claim disbursements.		
4.3.2.11.2.2	Manage returned/rejected Electronic Funds Transfer(s) (“EFT”) including reprocessing the payment.		
4.3.2.11.2.3	Establish process to handle deceased Member payments; HPS and TPA will communicate with each other when notified of deceased Member.		
4.3.2.11.2.4	Send positive pay file to the bank daily of all checks issued.		
4.3.2.11.2.5	Manage daily reporting for checks presented for payment but not issued by bank (positive pay).		
4.3.2.11.2.6	Establish process to manage fraudulent checks; establish process to stop paid or voided checks if required.		
4.3.2.11.2.7	Maintain check registers for the claims clearing accounts and provide copies as requested, but at least monthly, to HPS.		
4.3.2.11.2.8	Reconcile claims trust accounts each month.		
4.3.2.11.2.9	Maintain copies of reconciliations and bank statements.		
4.3.2.11.2.10	Provide check stock and cover the cost of postage for mailing claim checks and Explanations of Payments to providers.		
4.3.2.11.2.11	Ensure the security of check stock, ink cartridges used for printing checks, and signatories and permit access to these items only by authorized persons.		
4.3.2.11.2.12	Process missing or lost check requests in accordance with concurrent CCH policy based on inquiries sent from Customer Service. TPA accounting staff will follow up inquiries by providing check copies, stop payments, reissues, etc. to HPS.		
4.3.2.11.2.13	Communicate stop payment and check reissues transactions to the bank.		
4.3.2.11.3	*General Accounting*		

MEDICARE FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.2.11.3.1	Provide financial reports and General Ledger feeds monthly for all financial transactions processed by TPA.		
4.3.2.11.3.2	Financial Reporting such as bank reconciliation, aged provider receivables, finance data reports, monthly medical expense category report, claim detail report, unpaid aging report, due and unpaid report, paid aging report, and filing data report.		
4.3.2.11.3.3	Calculate, track, report, and monitor specific stop loss reinsurance according to reinsurer's requirements: a. Recommend and assist in the analysis of reinsurance contracts at the request of HPS b. Notify HPS of potential reinsurance cases c. Provide reports or copies of claims as needed for processing reinsurance cases with the reinsurer		
4.3.2.11.3.4	Provide 1099 data file for any payments processed by TPA and submit to the health plan. File will be sent in mutually agreed upon format.		
4.3.2.11.3.5	Accurately process, report, and submit 1099 files for any payments processed by TPA in the required format to the IRS following approval from the health plan.		
4.3.2.11.3.6	Research IRS mismatches for the purpose of updates and sending B notices. In the case that P notices are received from the IRS, communication, penalty fees, and resolution will be the responsibility of the TPA.		
4.3.2.11.3.7	Manage the unclaimed property process.		
4.3.2.11.3.8	Establish process to pend provider's claims for specified providers Tax IDs if notified by HPS and hold and monitor claims.		
4.3.2.11.3.9	Establish EFT and Electronic Remittance Advice capability with network providers.		
4.3.2.11.3.10	Adopt policies and strategies to communicate with and encourage providers receiving $25,000 or more in combined capitation or fee for service reimbursements accept EFT payments and ERA remittance advices.		
4.3.2.11.3.11	Provide EOPs in an electronic X12-835 format through a vendor of TPA's choice for providers desiring an EDI remittance.		
4.3.2.12	**INFORMATION SYSTEMS**		
4.3.2.12.1	*Systems and Interfaces*		

	MEDICARE FUNCTIONAL REQUIREMENTS	RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.2.12.1.1	Provide an automated **Claims Management System** that is a separate instance from all other products and lines of business generally available on a 24/7 basis with reasonable permitted downtime for system upgrades and maintenance as required. The system shall: • Include Member eligibility and provider master data sufficient to accurately process claims and provide certain required reports as required. • Provide for flexible, date-specific fee schedule maintenance to accurately pay claims. • Be made available to HPS staff on a view-only basis. TPA will make the necessary enhancements to ensure the claims management system is able to meet all CMS Requirements.		
4.3.2.12.1.2	Configuration updates/corrections and enhancements to the claims management system will be summarized via "Claims / Configuration" tracker and provided, at minimum, monthly.		
4.3.2.12.1.3	Provide a **Customer Service System** including a telephone system with Automatic Call Distribution and Auto-Attendant (ACD-AA) functionality, sufficient to: (a) separately track provider and members calls, (b) provide information on the nature of calls being received by the health plan, (c) document incoming calls and maintain history or log of such calls in system, and (d) meet CMS Requirements and performance metrics regarding call statistics and quality.		
4.3.2.12.1.4	Make the necessary enhancements to ensure the call center system can meet all CMS Requirements.		
4.3.2.12.1.5	**Utilization Management System (Medical/Behavioral)**: Provide a system to conduct Utilization Management provided as is. Review standard configuration on an ongoing basis (e.g., workflows, assessments, dropdowns, etc.). TPA will make the necessary enhancements to ensure the UM system is able to meet all CMS Requirements for medical/behavioral health.		
4.3.2.12.1.6	**Population Health System:** Provide a system to calculate compliance with HEDIS or HEDIS-like quality measures. Update quality measure logic based on annual HEDIS logic and utilize medical claims, pharmacy claims, and lab data onboarded according to required specifications.		
4.3.2.12.1.7	**Analytics System**: Provide a system for self-service cost and utilization reporting as is. Support reporting on standard eligibility, medical claims, and pharmacy claims data elements, as well as HPS-defined custom analysis variables.		
4.3.2.12.1.8	Software program that identifies avoidable ER admissions and potentially preventable hospital readmissions including readmissions associated with hospital acquired conditions (HACs) and other provider preventable conditions.		

MEDICARE FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.2.12.1.9	Maintain a **Provider Portal(s)** that meets HFS and CMS Requirements – either directly or through a sub-vendor – that allow for providers to: • view Member/patient eligibility with history and benefits, • view claim status, • View Explanations of Payments (EOP) • submit electronic authorizations requests and/or review status of authorization requests • view PCP panel roster, as applicable • View other data and information as determined by mutual agreement of the Parties.		
4.3.2.12.1.10	Maintain **Member Portal(s) that meets HFS and CMS Requirements** – either directly or through a sub-vendor – that allow for: • view benefits • view/check claim status • view EOB • view accumulators • request ID card • select/change PCP • inquiries via free text		
4.3.2.12.1.11	Maintain an **Online Provider and Pharmacy Network Directory** that meets CMS Requirements that includes medical, behavioral, LTC facilities, DME, and other providers as supplied by HPS in TPA standard format. A website link will be provided to access the pharmacy directory which is maintained by the Pharmacy Benefits Manager, and any other vendor directories (e.g. dental, vision, etc.) not aligned with TPA's overall scope.		
4.3.2.13	**DATA WAREHOUSE AND REPORTING**		
4.3.2.13.1	Support a Data Warehouse for capturing claims data, eligibility data, provider data, historical information, and other data, as deemed relevant by TPA, used for analytics. Any data elements not directly derived from claims, eligibility, or provider data will be discussed and prioritized by TPA and Cook County Health		
4.3.2.13.2	Provide HPS with data extracts according to EVH standard file format from data warehouse on a mutually agreed upon time schedule via SFTP		
4.3.2.13.3	Manage user access and resolve technical operations and data issues impacting access and use for said systems in TPA scope.		
4.3.2.13.4	Provide functionality improvements for TPA provided systems and tools as part of the normally scheduled TPA release schedule and with mutually agreed upon communication and change management procedure		
4.3.2.13.5	*Accounting Systems*		
4.3.2.13.5.1	Provide information to feed HPS General Ledger.		
4.3.2.13.5.2	Provide tracking system for Member and provider Grievances and disputes and Appeals.		

MEDICARE FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.2.13.6	*HPS Trading Partner Interfaces*		
4.3.2.13.6.1	Develop and maintain file transfer capabilities with HPS trading partners.		
4.3.2.13.6.2	Complete sftp set up, provide file specifications, provide test data, and maintain data interfaces set up on mutually agreed upon schedule.		
4.3.2.13.7	*Security and HIPAA Compliance*		
4.3.2.13.7.1	Develop and maintain – or cause to be developed and maintained – written Disaster Recovery and Business Continuity plans for all systems used to perform work for the MMAI Plan in accordance with the Services Agreement.		
4.3.2.13.7.2	Develop and maintain system backup plans, consistent with industry standards that are sufficient to ensure the protection of HPS data in all systems provided by TPA in the performance of its duties under this Services Agreement.		
4.3.2.13.7.3	Develop and maintain – or cause to be developed and maintained – processes, procedures, and systems that allow for user-specific access – or lack of access – to data modules provided by TPA in the performance of its duties under this Services Agreement.		
4.3.2.13.7.4	To the fullest and best of its ability, comply with all system security provisions required by HPS housed in systems provided by TPA in the performance of its duties.		
4.3.2.13.7.5	Maintain records of TPA staff training compliance, and all other training in alignment with HPS CMS Requirements.		
4.3.2.13.8	*Communications, Computer Equipment, and Software Applications and Licenses*		
4.3.2.13.8.1	Provide authorized HPS staff and Affiliates as appropriate to full access to MIS products provided by or used by TPA in the performance of its responsibilities under this Services Agreement.		
4.3.2.13.8.2	Provide dedicated telecommunications lines, internet access, and hardware and software, as required, to TPA staff or TPA Affiliates performing duties under this Services Agreement.		
4.3.2.13.8.3	Provide an Automatic Call Distribution / Auto-Attendant (ACD/AA) system to Customer Service where Enrollee's caller ID displays health plan name and inbound call center number that meets the requirements of HPS for tracking inbound calls and reporting call center information to HPS.		
4.3.2.13.8.4	Provide an ACD/AA system to the utilization management nurses, technicians, and case managers that meets the requirements of HPS for tracking inbound calls and reporting call center information to HPS.		
4.3.2.13.9	*Database Design, Setup and Maintenance*		
4.3.2.13.9.1	Implement reasonable system requirements and specifications necessary to operationalize the business rules identified by TPA or provided by HPS.		
4.3.2.13.9.2	Provide training to TPA or HPS staff or Affiliates on the use of MIS databases or systems provided by TPA under this Services Agreement where applicable.		

MEDICARE FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.2.13.9.3	Provide ongoing oversight of the accuracy of system information and communicate changes that need to be implemented to ensure that the systems or databases contain accurate information needed to operate HPS' programs.		
4.3.2.14	**REGULATORY AUDITS**		
4.3.2.14.1	Cooperate with auditors conducting audits or oversight of the functions, processes or operations of activities delegated to TPA under this Services Agreement.		
4.3.2.14.2	Conduct audits of delegated functions/services. Auditing or monitoring activities will be determined through a risk assessment and in accordance with the MMAI Addendum.		
4.3.2.14.3	As requested by HPS or as required by CMS, prepare a written Corrective Action Plan (CAP), in a format mutually agreed upon, with regard to any non-compliant activities performed that are identified in the course of audits conducted or required in the HPS contract or requested pursuant to the HPS or other entities of competent jurisdiction.		
4.3.2.14.4	Coordinate all communications with auditors to ensure that all deliverables are provided, and that all information provided to auditors is reasonably correct and accurate.		
4.3.2.15	**ANALYTICS & REPORTING (PART C)**		
4.3.2.15.1	Designate dedicated analytics resources specifically to support MMAI and analytics and reporting requests will be prioritized by HPS in collaboration with TPA.		
4.3.2.15.2	Maintain an algorithm that supports assignment of Members to Care Management Entities (CME).		
4.3.2.15.3	Own document of all specifications for the algorithm of CME assignment and maintain business requirements document (BRD).		
4.3.2.15.4	Create impact analysis and quality assurance protocol following each change to the CME algorithm or any analyses that have downstream or operational implications.		
4.3.2.15.5	Provide 1.5 FTE to support regulatory reporting. 1.5 FTE have been estimated based on understanding of current CMS Requirements for analytics needs based on TPA scope of services.		
4.3.2.15.6	Effective procedure to develop, compile, evaluate, and report information to CMS in the time and manner that CMS requests. Regulatory reporting includes but is not limited to: • Part C Reporting sections Grievances, Organization Determinations / Reconsiderations, Enrollment/Disenrollment, Payments to Providers, Telehealth Benefits • Part D Reporting section Enrollment/Disenrollment • Timeliness Monitoring Project ODAG audit universes		

MEDICARE FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.2.15.7	Use CMS data validation principles to ensure Part C and Part D regulatory reports are reliable, valid, complete, comparable, and timely prior to CMS submission; and participate in the annual CMS data validation process including but not limited to completion of the Organization Assessment Instrument and participation in the onsite review.		
4.3.2.15.8	Participate in Part C Organization Determinations, Appeals, and Grievances (ODAG) audit process including but not limited to universe and supplemental documentation file submission, webinar reviews, completing an impact analysis.		
4.3.2.15.9	Provide MMP Core Reporting and Illinois State Specific Reporting.		
4.3.2.16	**DELEGATION AND SUBCONTRACTOR OVERSIGHT**		
4.3.2.16.1	Support HPS' Delegation Oversight Program through participation in a pre-delegation audit; a quarterly delegation performance review; an annual audit; monthly joint operation meetings; formal, ongoing evaluation and monitoring of performance and compliance; and remediation if performance is substandard and/or violates the terms of this Services Agreement.		
4.3.2.16.2	TPA shall participate in other meetings as requested by HPS.		
4.3.2.16.3	TPA shall participate in and provide support for external/regulatory audits as requested. This can include, but is not limited to, producing and supplying documentation, participating in file reviews, system demonstration and presenting during audits.		
4.3.2.16.4	TPA shall participate in a periodic oversight meetings with HPS. TPA will provide agenda for the oversight meeting with input from HPS.		
4.3.2.16.5	TPA shall provide monthly oversight reports on a mutually agreed upon date. Report content shall be mutually agreed upon by TPA and HPS.		
4.3.2.16.6	TPA shall notify HPS within one business day upon identifying a performance deficiency. TPA shall provide root cause of deficiency, action plan for remediation, with timelines and target dates for remediation, and responsible business owner(s).		
4.3.2.16.7	TPA shall participate in meetings with other HPS vendors as requested by Plan.		
4.3.2.16.8	TPA shall notify HPS within one business day upon identifying a performance deficiency. TPA shall provide root cause of deficiency, action plan for remediation, ETA for remediation, and responsible business owner.		
4.3.2.16.9	TPA shall participate in meetings with other HPS vendors as requested by Plan.		
4.3.2.17	**PROJECT MANAGEMENT OFFICE**		
4.3.2.17.1	TPA must have a project management lead that will work with HPS PMO to implement any new initiatives and projects directed by HPS		

MEDICARE FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.2.17.2	TPA must have PMO office that will work on developing project plan, risks/mitigation plans, tracking key deliverables, and participating/facilitating meeting to include key stakeholders.		
4.3.2.18	**FINANCIAL ACTION**		
4.3.2.18.1	Designate resources to develop ideas and execute on initiatives related to cost saving strategies for the health plan. Team should consist of but not be limited to analysts, project managers, and a team lead.		
4.3.2.18.2	Performance outcomes on cost savings strategies could result in performance bonuses or penalties		

4.3.3 MMAI Requirements

Responses to Section 4.3.3 shall not exceed 50 pages.

MMAI FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.3.1	**MMAI CONTRACTUAL REQUIREMENTS**		
4.3.3.1.1	TPA must follow contractual requirements outlined in the MCCN Contract between HFS and HPS. Model Contract found here https://www2.illinois.gov/hfs/MedicalProviders/cc/mmai/Pages/default.aspx .		
4.3.3.2	**MEMBER RETENTION**		
4.3.3.2.1	Member Retention - Development and execution of a warm hand off workflow from the Member Services call center to Retention Team for members displaying dissatisfaction or eagerness to leave the plan.		
4.3.3.2.2	Conduct outbound outreach to members leaving the Health Plan to attempt retention and member continuity.		
4.3.3.2.3	Support of retention, redetermination, and outreach efforts as requested within the scope above. Parties will mutually agree to items deemed out of scope and any associated costs.		
4.3.3.3	**MARKETING, ADVERTISING, DISTRIBUTION & BUSINESS DEVELOPMENT**		
4.3.3.3.1	Review and comment on the website for the MMAI plan to ensure accuracy for content within TPA's scope only.		
4.3.3.3.2	Deploy and maintain an online provider directory ("find-a-provider" search for medical and behavioral health providers) in accordance with CMS and HFS Requirements.		
4.3.3.3.3	Provide a website link to access the pharmacy directory which is maintained by the Pharmacy Benefits Manager, and any other vendor directories (e.g., dental, vision, etc.) not aligned with TPA's overall scope.		
4.3.3.3.4	Provide link for online "find-a-provider" search tool for the MMAI plan website.		

MMAI FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.3.3.5	Coordinate production materials, (inclusive of Member ID cards and Explanation of Payment (“EOP””) including inventory management, meeting translation requirements, reporting, and fulfill vendor oversight in alignment with CMS and HFS Requirements.		
4.3.3.3.6	Manage fulfillment (print and distribution) for Member facing materials.		
4.3.3.4	**ENROLLMENT, DISENROLLMENT & ELIGIBILITY**		
4.3.3.4.1	Maintain connectivity to HFS/CES for applications.		
4.3.3.4.2	In load of enrollment information, including effective date from HFS, CMS, and Client Enrollment System (CES) systems no less frequently than daily except for holidays.		
4.3.3.4.3	In load enrollment information, including disenrollment date from HFS, CMS, and Client Enrollment System (CES) systems no less frequently than daily. Disenrollments received by the CES or received by CMS by the last calendar day of the month will be effective on the first calendar day of the following month.		
4.3.3.4.4	Receive and capture all new Member enrollments with Member’s PCP selection as applicable.		
4.3.3.4.5	When member has not selected a PCP within the State Client Enrollment System (CES), member will be auto-assigned to a PCP and able to make a choice in PCP and/or change PCP at any time. TPA will support efforts to assist in connecting members with PCPs, particularly new members coming into the plan, including direct outreach.		
4.3.3.4.6	Maintain Membership history and PCP assignment history		
4.3.3.4.7	Provide electronic methods through provider and member portals or interactive voice recognition (IVR) processes, for providers and members to verify eligibility without talking with a Customer Service Representative within agreed upon timeline.		
4.3.3.4.8	Provide electronic eligibility to HPS subcontracted vendors on an agreed upon basis.		
4.3.3.4.9	Disseminate enrollment and disenrollment information to mutually agreed upon data sharing partners within 1 day prior to the 1st day of each month whenever possible and no later than 1 day after information is received for HFS/CES.		
4.3.3.4.10	Notify the plan of any member any individual who is no longer eligible to remain enrolled in the Demonstration Plan per CMS Medicare-Medicaid Plan Enrollment and Disenrollment Guidance.		
4.3.3.4.11	Review 834 daily files to identify Members who have lost eligibility due to plan termination.		
4.3.3.4.12	Transfer Enrollee record information promptly to the new Provider upon written request signed by the disenrolled Enrollee.		
4.3.3.4.13	Provide Member adds and terms reporting daily.		
4.3.3.4.14	Identify Coordination of Benefits (COB) information from various sources and enter applicable data in the Member Eligibility system to assist in claims processing.		

MMAI FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.3.4.15	Process updates of Member demographic information – e.g., address changes, telephone number changes, and language preference – and update the Member Eligibility system, accordingly, including updates from downstream vendors (e.g., care management entities) in alignment with CMS and HFS Requirements.		
4.3.3.4.16	Create and maintain a repository of member phone/address/contact information captured by internal and external sources including downstream vendors and providers that gives HPS and vendor staff access to up-to-date demographic information.		
4.3.3.5	**MEMBER SERVICES**		
4.3.3.5.1	*Inbound Call Center*		
4.3.5.5.1.1	Operate a dedicated toll-free call center with live customer service representatives available to respond to Providers or Enrollees for information related to requests for coverage under Medicare or Medicaid, and Medicare and Medicaid appeal or any other service delegated to TPA.		
4.3.5.5.1.2	Provide toll free number for Members to contact the health plan in accordance with HFS and CMS Requirements. Comply with timeframes specified for Illinois MMP plans (seven (7) days a week, at least from 8 a.m. to 8 p.m. CT) except as provided below.		
4.3.5.5.1.3	Customer service call center hours and days must be the same for all individuals regardless of whether they speak English, a non-English language, or use assistive devices for communication. During this time period, current and prospective enrollees must be able to speak with a live customer service representative. TPA may use a voicemail box on Sundays and federal holidays in lieu of having live customer service representatives unless regulatory requirements are more stringent.		
4.3.5.5.1.4	Establish a toll-free advice line, available twenty-four (24) hours a day, seven (7) days a week, through which Enrollees may obtain medical guidance and support from a nurse.		
4.3.5.5.1.5	Provide Customer Service staff, including 20% of staff bilingual in English and Spanish, to answer phones for Members and other callers seeking information about the MMAI plan.		
4.3.5.5.1.6	Continually provide Call Center training on the Plan and the Model of Care to each new staff member as part of the onboarding process.		
4.3.5.5.1.7	Conduct “Welcome Calls” to each new Enrollee within thirty (30) days after the effective date of enrollment. For those new Enrollees who the Contractor successfully contacts, TPA will provide health education and respond to questions about Covered Services and how to access them and conduct a warm hand off to the appropriate entity conducting the member health risk screening.		

MMAI FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.5.5.1.8	Provide an automatic call distribution and auto attendant (ACD-AA) telephone system where Enrollee's caller ID displays health plan name and inbound call center number as well as manage call-tree set-up and messaging.		
4.3.5.5.1.9	Maintain call center staffing adequate for average hold time per HFS and CMS Requirements.		
4.3.5.5.1.10	Provide the following general plan information to prospective enrollees including Demographic and contact information (services area, phone numbers, website, etc.), types of benefits included (Medicare/Medicaid requirements), how to enroll (transfer to Illinois Client Enrollment Services.), and other calls to be forwarded to Illinois Client Enrollment Services. Informational calls that become enrollment calls (at the proactive request of the beneficiary) will be transferred to the state's client enrollment services.		
4.3.5.5.1.11	Limit average hold time to two (2) minutes, with the average hold time defined as the time spent on hold by the caller following the interactive voice response (IVR) system, touch tone response system, or recorded greeting and before reaching a live person		
4.3.5.5.1.12	Operate voicemail outside of normal business hours that follows HFS and CMS Requirements in accordance with MMAI Contract 2018 01 01; 2.10.3.1		
4.3.5.5.1.13	Return Member calls within one (1) Business Day of receipt per the CMS Requirements/timelines.		
4.3.5.5.1.14	Return provider voicemails no later than three (3) Business Days of receipt.		
4.3.5.5.1.15	Provide a dedicated toll-free Member Behavioral Health Hotline.		
4.3.5.5.1.16	Establish and maintain a customer service module that is capable of capturing call center data sufficient to meet HFS and CMS Requirements.		
4.3.5.5.1.17	Record all calls and track all Member phone communications to be made available at a member level to HPS within 3 – 5 Business Days of request. Urgent requests for cause will be expedited.		
4.3.5.5.1.18	Generate monthly call analysis reports in a format mutually agreed to upon by the Parties used for internal monitoring of call center activity.		
4.3.5.5.1.19	Provide electronic methods through enrollee and provider portals and interactive voice recognition (IVR) processes, for enrollees and providers to verify eligibility without talking with a Customer Service Representative within agreed upon timeline.		
4.3.5.5.1.20	Assist Members in selecting or changing their PCP.		

MMAI FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.5.5.1.21	Implement processes to ensure that information released to callers about Members is done in accordance with Law as defined in the Master Services Agreement. If release of information is requested from non-authorized persons, take steps to obtain an appropriate written authorization for release of information. POA forms must be stored and shared with plan partners as appropriate.		
4.3.5.5.1.22	Complete warm hand offs for Members (i.e. to care management, PBM, other), as applicable.		
4.3.5.5.1.23	Implement and maintain a system for documenting and sending grievances from Customer Service to the Grievance Department.		
4.3.5.5.2	*Member Incentives and Value-Added Benefits*		
4.3.5.5.2.1	Support agreed upon supplemental benefits that are processed via claims payment within mutual agreed upon timelines for any future changes.		
4.3.5.5.2.2	Manage and administer Member incentive over the counter card (OTC) benefit.		
4.3.5.5.2.3	Support education of Member incentive program via inbound member and provider calls, including using OTC vendor portal to assist with answering general questions about OTC, status on benefit post timing, and checking balances, HPS will provide escalation path resolution for any items that cannot be complete with first result triage by the customer service team including: reissuing replacement cards, adding value to cards, research support for discrepancies.		
4.3.5.5.2.4	Perform outbound OTC benefit reminder calls to members who have not yet activated their OTC cards. TPA will record results of outbound OTC calls and provide results to HPS upon request.		
4.3.5.5.2.5	Purchase, store and mail supplies and program materials, per the benefit and criteria as defined by HPS. TPA shall track and securely store all mail that is returned.		
4.3.5.5.2.6	TPA shall produce reports for member incentives and value-added benefits in agreed upon format for the management and member engagement analysis.		
4.3.5.5.3	*Member Materials*		
4.3.5.5.3.1	Design, produce and fulfill Member collateral materials, as prescribed by CMS & HFS Requirements.		
4.3.5.5.3.2	Coordinate with respective fulfillment vendors for Member materials.		
4.3.5.5.3.3	Manage distribution and oversight of fulfillment where content and design are created by HPS.		
4.3.5.5.3.4	Oversee adequacy of collateral materials inventories to meet supply needs for any material listed as content developed by HPS.		

MMAI FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.5.5.3.5	Manage delivery of collateral materials for the information mailed to new Members ("Welcome Packet") to the fulfillment vendor and ensure that enrollees who self-select into the demonstration the welcome packet for receipt no later than ten (10) calendar days from receipt of CMS confirmation of enrollment or by the last day of the month prior to the effective date, whichever occurs later. When passively enrolled, the Contractor shall provide the welcome packet for receipt no later than thirty (30) days prior to the effective date.		
4.3.5.5.3.6	Report on any material listed as content developed by HPS including date stamp it was mailed.		
4.3.5.5.3.7	Member ID Card Fulfillment • Coordinate design of ID cards • Oversee fulfillment of ID cards to Member in accordance with HFS and CMS timeframes. • Re-issue ID cards to Members as necessary and or in accordance with any changes.		
4.3.5.5.3.8	Provide or contract for services to translate and develop alternate formats (including large print and braille) for Member-facing materials. Provide telephonic interpretation on required materials when required.		
4.3.3.6	**PROVIDER SERVICES**		
4.3.3.6.1	*Provider Network Management and Provider Contracting*		
4.3.3.6.1.1	Maintain provider database of all essential information about the provider network based on the data provided by HPS.		
4.3.3.6.1.2	Configure payment arrangements and standard add-on payments for medical and behavioral claims (TPA delegated services) as described in contracts.		
4.3.3.6.1.3	Capacity to load standard payment arrangements within fourteen (14) days and unique payment arrangements within twenty-five (25) days of receipt according to HPS' standard contract load process.		
4.3.3.6.1.4	Provide contract load notification file "Contract Summary" to HPS Network Team for quality review and sign-off. Corrections or modifications based on inaccurate build from provided contract details from HPS will be expedited and completed within the 10 days from receipt of corrections		
4.3.3.6.1.5	Maintain an online provider directory (medical and behavioral health providers) accessible to the general public that meets CMS and HFS Requirements. A website link will be provided to access the pharmacy directory which is maintained by Pharmacy Benefits Manager, and any other vendor directories (e.g. dental, vision, etc.) not aligned with TPA's overall scope.		

MMAI FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.3.6.1.6	Maintain "print ready" version of the provider directory that can be made available upon request for a hard copy per CMS and HFS requirements.		
4.3.3.6.1.7	Maintain an email address and toll-free phone/TTY phone number that can be used to report mistakes found on the Provider or Pharmacy Directory.		
4.3.3.6.1.8	Conduct quality assurance of provider data against data provided to TPA by HPS, within Pipeline and downstream systems (i.e. provider directory, provider portal, and enrollment platform) managed through business rules and notification to HPS of rejects and warnings.		
4.3.3.6.1.9	Conduct quarterly reconciliation process with HPS and collaborate and remediate any discrepancies. Perform end to end focus audits quarterly on a mutually agreed upon scope of provider records.		
4.3.3.6.1.10	Support ability to ingest precluded and excluded provider holds per HFS and CMS Requirements. HPS will be responsible for provider sanction monitoring and flagging of holds via a clean provider record with all required data elements and through TPA's documented standard load process and timeline.		
4.3.3.6.2	*Provider Relations & Services*		
4.3.3.6.2.1	Perform provider site visits to support ongoing provider engagement as well as to resolve provider issues and to address member complaints. Visits should be documented and documentation stored and shared with HPS upon request.		
4.3.3.6.2.2	Operate a phone system and process that permits providers to call the plan. TPA to complete warm hand-offs to provider relations.		
4.3.3.6.2.3	Maintain a unique phone number for provider inbound phone calls. Transfer of phone number to HPS upon orderly wind-down of the contract.		
4.3.3.6.2.4	Hire, train, and oversee provider relations team that proactively engage providers and resolve provider issues.		
4.3.3.6.2.5	Educate and orient providers regarding plan policies and procedures, including policies and procedures on (a) claims, (b) prior authorization and referral requirements, (c) complaints and appeals process, and (d) other administrative rules of the plan. Provider and Subcontractor attendance and/or participation is documented and maintained by the TPA and provided upon request.		
4.3.3.6.2.6	Receive provider disputes via the provider services call center. Route to HPS provider Relations or to TPA A&G department for processing, tracking, and reporting as appropriate and per agreed upon processes.		
4.3.3.6.2.7	Adopt policies and strategies to communicate with and encourage providers to use such tools as: (a) portal for online prior authorization submission, (b) provider portal to verify member eligibility, (c) provider portal to check their own claim status, and (d) other enhancements that reduce manual workload on plan staff.		
4.3.3.7	**MEDICAL MANAGEMENT (MEDICAL AND BEHAVIORAL SERVICES)**		

MMAI FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.3.7.1	*Utilization Management (UM)*		
4.3.3.7.1.1	Provide recommendations on services appropriate for referral and/or that will require prior authorization.		
4.3.3.7.1.2	Recruit, hire, onboard and maintain competent and adequate staff to conduct mutually agreed upon utilization management functions.		
4.3.3.7.1.3	Collaborate to create a Utilization Management Program Description		
4.3.3.7.1.4	Review the utilization review procedures, at regular intervals, but no less frequently than annually.		
4.3.3.7.1.5	Implement systems, both computerized and manual as necessary, to handle utilization management functions to ensure consistent application of review criteria for authorization decisions.		
4.3.3.7.1.6	Conduct prior authorization processes in accordance with the time frames set forth by HPS and CMS.		
4.3.3.7.1.7	Receive request for services defined by HPS and in alignment with CMS and HFS guidelines, which services may change from time to time, via telephone, FAX, online web entry, or other approved methodologies.		
4.3.3.7.1.8	Obtain all necessary information, including pertinent clinical information, and consultation with the treating Physician, as appropriate.		
4.3.3.7.1.9	Screen authorizations and requests using criteria approved by HPS.		
4.3.3.7.1.10	Provide Medical Directors to make timely denial decisions and communicate with providers on service denials or reductions.		
4.3.3.7.1.11	Clearly document the reasons for decisions and make available to the Enrollee and the requesting Provider (upon request).		
4.3.3.7.1.12	Generate denial letters/notices (IDNs) in accordance with CMS and HFS Requirements and timeframes.		
4.3.3.7.1.13	Obtain additional information that may be necessary for Medical Director to make decisions on approval or denial of requests.		
4.3.3.7.1.14	Refer any pre-defined service requests directly to Medical Director for review.		
4.3.3.7.1.15	Determine medical necessity of service based on documentation received.		
4.3.3.7.1.16	Enter authorizations into agreed upon system and issue authorization numbers to providers and maintain history of authorizations by Member and by provider.		
4.3.3.7.1.17	Perform concurrent review activities on inpatient admissions and document Level of Care authorizations.		
4.3.3.7.1.18	Coordinate and manage inpatient level of services, facilitate identification of alternative levels of care, and management of non-par services in association with utilization management requests.		
4.3.3.7.1.19	Maintain UM denials log in accordance with CMS and HFS requirements for TPA specified services.		
4.3.3.7.1.20	Report monthly UM statistics as per standard TPA UM reporting package. Custom requests will be developed through Analytics prioritization process.		

MMAI FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.3.7.1.21	Implement utilization management criteria appropriate for the management of applicable populations. Create a written UM Plan and medical necessity criteria consistent with policies of HPS to govern the activities of nurses and staff.		
4.3.3.7.1.22	Work to have and create defined site of care pathways to ensure members receive services at the most appropriate site of care. These pathways should include identification of members in need of targeted transition of care services.		
4.3.3.7.1.23	Singe Case Agreements: a. Submit contract via standard contract load process for single case agreements outside 100% Medicare reimbursement. b. Process single case agreements at 100% Medicare reimbursement through standard out of network rate if appropriate prior authorization received.		
4.3.3.7.1.24	Attend HPS UM Committee and QI Committee meetings.		
4.3.3.7.1.25	Complete (2) medical and behavioral health evaluation studies annually that analyze pressing problems and solutions.		
4.3.3.7.1.26	Support the review and improve the peer review procedures, at regular intervals, but no less frequently than annually		
4.3.3.7.1.27	Provide a Behavioral Health Medical Director to directly support activities as it relates to Behavioral health services.		
4.3.3.7.1.28	Coordinate review of medically necessary cases with Behavioral Health Medical Director.		
4.3.3.7.1.29	Send prior authorization information to care management entities no less frequent than daily.		
4.3.3.7.1.30	Monitor behavioral health services that require prior authorization against the behavioral health benefit.		
4.3.3.7.1.31	Issue adverse benefit determination notices to members ten (10) days in advance of the date of its action.		
4.3.3.7.1.32	Ensure parity of medical and behavioral health utilization management.		
4.3.3.7.2	*Care Management (CM)*		
4.3.3.7.2.1	Develop UM to CM workflow.		
4.3.3.7.2.2	Flag and refer complex Members for care management if applicable from the utilization management team.		
4.3.3.7.3	*Quality Health Plan Program*		
4.3.3.7.3.1	Provide a dedicated resource who will focus on and assist HPS on evaluating and developing interventions focused on health equity.		
4.3.3.7.3.2	Make referrals on potential Quality of Care (QOC) cases and Health, Safety, and Welfare incidents that require follow up and investigation.		
4.3.3.7.3.3	Upon mutual review and agreement, complete all activities within the QAP that require improvements to services provided within TPA's scope.		

MMAI FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.3.7.3.4	Provide support for HEDIS® activities throughout the year including but not limited to: • Participate in On-Site Audit and vendor meetings • Chart abstraction/Interrater reliability • Include Medical Record Reviews for hybrid measures • Reporting results and strategies • Work with providers to receive EMR supplemental data feeds to enhance quality/HEDIS data. • Contacting provider practices and updating provider practice information as needed to support the HEDIS® vendor, and evaluation of HEDIS® results. HEDIS provider data changes or corrections will be incorporated into the standard inload process and the TPA will reconcile the differences between HEDIS® requirements and the TPA's data. • TPA shall make available all HEDIS® data for plan use upon HPS request.		
4.3.3.7.3.5	Conduct Consumer Assessment of Healthcare Providers and Services (CAHPS) survey annually according to CMS and HFS Requirements • With certified vendors • Meeting required timeframes • Reporting results and strategies		
4.3.3.7.3.6	Complete HEDIS Roadmap in partnership with HPS related to TPA Health scope of services.		
4.3.3.7.3.7	Conduct the Health Outcomes Survey (HOS) project according to CMS Requirements.		
4.3.3.7.3.8	Maintain data integration for quality admin data: a. Medical claims data b. Enrollment/disenrollment c. Member and provider reported grievances d. Medical/behavioral health appeals data e. Provider disputes f. HFS reported grievances		
4.3.3.7.3.9	Achieve 100% Overreads for Negative Charts in selected categories and work to close out P2 & P3 Pends or new vendor equivalent of "Member Not Seen Here" and "Incorrect Office Demographics" errors.		
4.3.3.7.3.10	Create visualization of monthly provider report cards from HEDIS vendor data. HPS to supply HEDIS vendor data in agreed upon format including summary data and member level data.		
4.3.3.7.3.11	Meet with workstream leads with dedicated time for Executive report-out. Additional quarterly on-site performance and strategy review to chart adjustments as needed.		
4.3.3.8	**APPEALS AND GRIEVANCES**		
4.3.3.8.1	*Medical and Behavioral Health Grievances*		
4.3.3.8.1.1	Perform medical and behavioral pre-service, post-service appeals and provider disputes as it relates to agreed upon services.		

MMAI FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.3.8.1.2	Process Member grievances for Part C, dental/vision, and non-emergent medical transportation grievances including calls received via customer service in accordance with CMS, HFS, and HPS Requirements.		
4.3.3.8.1.3	Intake and provide Member with a standard response letter regarding a Quality of Care (QOC) and Civil Rights grievances received and captured on universes.		
4.3.3.8.1.4	Send QOC and Civil Rights grievances to HPS Quality Leadership for investigation via agreed upon workflow.		
4.3.3.8.1.5	Support research of HFS or CMS reported grievances and provide information to HPS compliance in a timely manner.		
4.3.3.8.1.6	Provide all CMS reporting in alignment with CMS Requirements for all Part C appeals and grievances		
4.3.3.8.1.7	Track and provide required reports, ancillary documentation, and participate in CMS and HFS audits for appeals and grievances that are delegated to TPA.		
4.3.3.8.1.8	Receive, document, and track all Member grievances sent to the plan via orally or in writing for complaint investigation and resolution		
4.3.3.8.1.9	Complete all resolution steps in investigation and resolution of grievances delegated to TPA within appropriate timeframes. • 24 hours for expedited grievance • 30 calendar days for standard grievance		
4.3.3.8.1.10	Implement and maintain a grievance tracking system that documents all aspects of the grievance in alignment with CMS and HFS Requirements. Submit grievance procedures to Department for prior approval.		
4.3.3.8.1.11	Perform Complaints and Appeals resolutions by obtaining additional information from HPS where appropriate or through providing further information from TPA's UM criteria sets.		
4.3.3.8.2	*Pre and Post Service Appeals & Provider Disputes*		
4.3.3.8.2.1	*Pre and Post Service Appeals*		
4.3.3.8.2.1.1	Perform medical and behavioral pre-service, post-service appeals as it relates to agreed upon services.		
4.3.3.8.2.1.2	Acknowledge receipt of each Enrollee Appeal within 3 business days.		
4.3.3.8.2.1.3	Issue an integrated notice of all applicable Demonstration Medicare and Medicaid appeal rights to members that has been approved by CMS and HFS and in accordance with the Agencies' requirements.		
4.3.3.8.2.1.4	Implement and oversee pre and post service appeal processes for Medicare Non-Part D, Part C and Medicaid Appeals in accordance with CMS and HFS Requirements.		
4.3.3.8.2.1.5	Render appeals decisions in adherence with CMS and HFS Requirements.		
4.3.3.8.2.1.6	Send all adverse Medicare appeal decisions (not in the Enrollee's favor or within the relevant timeframe) regarding Medicare services to the IRE for a new and impartial review.		

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4.3.3.8.2.1.7	Track and report on appeals. Create a monthly and quarterly report summarizing all Appeals filed by Enrollees and the responses to and disposition of those matters, including decisions made following an external independent review.		
4.3.3.8.2.1.8	Provide written notice to the Enrollee of the final decision of the Appeal, which shall include: 1) Results of the Appeals; 2) Date of the Appeal resolution; 3) Right to request and how to request a State Fair Hearing; 4) Right to continued benefits pending a State Fair Hearing, and how to request continued benefits; 5) Notice that the Enrollee may be liable for the cost of any continued benefits if the Contractor's action is upheld at the State Fair hearing.		
4.3.3.8.2.2	*Provider Disputes*		
4.3.3.8.2.2.1	Maintain a complaint and resolution system for Network and non-Network Providers. Maintain a claim dispute process that allows Providers to contest a payment decision after a claim has been adjudicated.		
4.3.3.8.2.2.2	The claims dispute process will assign a sequential, unique dispute tracking number as required by HFS. Escalate any administrative decision to HPS and support HPS in providing substantive responses intended to resolve the dispute in a timely manner. All claim disputes will be investigated and resolved, with either a complete resolution or timeframe to provide complete resolution, within thirty (30) calendar days from submission by the provider.		
4.3.3.8.2.2.3	Submit a summary of the Complaints filed by Providers on a cadence as requested by the plan. Reporting shall include but is not limited to total Provider Grievances per/1,000 Enrollees; a summary count of any such Provider Complaints received during the reporting period.		
4.3.3.8.2.2.4	As applicable, assist in the resolution of provider disputes.		
4.3.3.8.2.2.5	Issue claim appeal denials to provider in cases where the appeal is denied, and original claim decision is being upheld by the IRE or State.		
4.3.3.8.2.2.6	Reprocess claims affected by overturning the original claim decision		
4.3.3.9	**RISK ADJUSTMENT**		
4.3.3.9.1	Establish connectivity directly with CMS for Risk Adjustment Processing,		
4.3.3.9.2	Deliver formatted RAPS/EDPS flat files for submission to CMS		
4.3.3.9.3	Build Process to create delete files based on Health Plan identified deletes (this applies to retrospective RA submissions performed by TPA for MMAI)		
4.3.3.9.4	De-duplicate already submitted HCCs and HCCs accepted by CMS using complete data files provided by HPS (all RAPS/EDPS files sourced from a single RA vendor)		
4.3.3.9.5	Reconcile RAPS/EDPS return files (as provided by a single RA vendor) to understand variance (if any) and mitigation options		

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4.3.3.9.6	TPA is required to report and return any overpayment that has been identified for all overpayment categories in alignment with HPS policies and procedures. Report an identified overpayment beginning on the day after the applicable Part C reconciliation date and submit any overpayment to RAPS in alignment with CMS Requirements.		
4.3.3.9.7	Support RADV Audit through gathering required documentation.		
4.3.3.9.8	Upload all files, including the Chart Chase Lists, to vendor file transfer protocol (the "SFTP") site and notify vendor project manager when the upload is complete.		
4.3.3.9.9	Continuously load patient chart data in approved formats into secure repositories for analytics and workflow enablement.		
4.3.3.9.10	Approve and load medical coder team credentials to use Retrospective Workflow tools.		
4.3.3.9.11	Review and confirm schedule/timelines for supplemental risk coding findings prior to submission to payors and/or regulatory authority (CMS).		
4.3.3.9.12	Perform Risk Coding Gap analysis study which informs the patient chart approach.		
4.3.3.9.13	Send Patient record acquisition letters to providers.		
4.3.3.9.14	Estimate and confirm budget for patient chart activities, including copy service fees associated with manual chart capture.		
4.3.3.9.15	Review and confirm schedule/timelines specific to in-scope Lines of Business (LOBs) including review of supplemental risk coding findings prior to submission to regulatory authority (CMS).		
4.3.3.9.16	Apply Natural Language Processing (NLP) to efficiently evaluate patient charts and to support prioritization of workload ahead of medical coder reviews.		
4.3.3.9.17	Review acquired patient charts using automated, secured workflow that adheres to CMS-provided guidelines for retrospective review.		
4.3.3.9.18	Perform any necessary quality audits (based on the standards set forth in the Coding Guidelines) to ensure accuracy of chart reviews for both added and deleted diagnoses.		
4.3.3.9.19	Manage down chart review vendor(s) as needed at the conclusion of retrospective program.		
4.3.3.9.20	Provide ongoing reporting to inform TPA-led campaigns' governance (e.g., coder productivity, HCCs identified, ongoing meetings to manage retrospective process).		
4.3.3.9.21	Attend regular governance events (e.g., meetings) to report on RA retrospective progress.		
4.3.3.9.22	Upon request, provide estimates of monetary impact to client to support budget activities including any pass-through costs of vendors used.		
4.3.3.9.23	Sign and submit any attestations regarding the veracity/accuracy of risk coding reviews.		
4.3.3.10	**COMPLIANCE/PROGRAM INTEGRITY/CONFIDENTIALITY/FWA**		

MMAI FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.3.10.1	**Compliance Program Structure/Elements**		
4.3.3.10.1.1	Maintain a compliance program, consistent with requirements outlined in 305 ILCS 5/8A-1, 42 CFR Part 420, 42 CFR §422.503, 42 CFR §423.504, 42 CFR §§438.600-610, 42 CFR Part 455, 1156 and 1902(a)(68) of the Social Security Act (SSA) and Chapters 9/21 of the CMS Medicare Managed Care Manual (100-16).		
4.3.3.10.1.2	Maintain written policies, procedures, and a Standard of Conduct/Ethics that demonstrate compliance with all applicable requirements and standards under the Master Contract and all federal and state requirements related to program integrity. *Provide a listing and brief description of all compliance related standards, policies, and procedures maintained by the Proposer.*		
4.3.3.10.1.3	Maintain written policies and procedures that implement the operation of the compliance program. *Provide a listing and brief description of standards, policies and procedures related to operation of the Compliance Program maintained by the Proposer.*		
4.3.3.10.1.4	Appoint a designated Compliance Officer who is responsible for implementation of the compliance program, including developing, implementing, and disseminating policies and procedures designed to ensure compliance with Program Integrity/Fraud, Waste and Abuse (FWA) requirements and who reports directly to the Proposer's CEO and Board of Directors. *Provide a job description for the Proposer's Compliance Officer and an Organization Chart for the Proposer's Compliance department demonstrating reporting relationships for the Proposer's Compliance Officer, as well as additional Compliance Office staff.*		
4.3.3.10.1.5	Maintain a Regulatory Compliance Committee, consisting of members of the Board of Directors and senior management, which is responsible for oversight of the Proposer's compliance program. *Provide a committee description / charter and membership list for the Regulatory Compliance Committee.*		
4.3.3.10.1.6	Maintain a system of training and education for the Proposer's Compliance Officer, Board of Directors, senior managers, and employees that outlines the Proposer's obligation to comply with federal and state requirements. *Provide a description of trainings completed by Proposer's workforce to ensure compliance with federal and state law requirements, including the subject areas discussed, modality utilized for training and processes for tracking training completion.*		

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4.3.3.10.1.7	Maintain several modalities for effective lines of communication between the Proposer's Compliance Officer and the Proposer's employees, subcontractors and Network Providers. *Provide a description of internal processes used for reporting concerns related to compliance, integrity, FWA, mismanagement and misconduct, including options for reporting anonymously and outside of typical business hours.*		
4.3.3.10.1.8	Maintain effective lines of communication between Proposer's Compliance Officer, Proposer's employees and the CCH Compliance department. *Provide a description of processes used for reporting and/or escalating concerns to the CCH Compliance Officer.*		
4.3.3.10.1.9	Enforcement of regulatory standards and program integrity-related requirements by the Proposer through well-publicized disciplinary guidelines. *Provide a description of process for consistent adherence to well-publicized disciplinary guidelines.*		
4.3.3.10.1.10	Maintain a system of established and implemented procedures for routine internal monitoring, auditing of program integrity compliance risks, prompt response to compliance issues, investigation of potential compliance problems identified in the course of self-evaluation and audits, correction of identified compliance problems through corrective action plans, and ongoing compliance with program integrity-related requirements, including the use of surveillance and utilization controls conducted by a designated Special Investigations Unit (SIU) of dedicated staff adequate in number. *Provide a description of Compliance Program processes for monitoring, auditing, and identification of compliance risks, including process for annual Work Plan and/or annual Audit Plan development, as well as tracking and documenting compliance efforts.*		
4.3.3.10.1.11	Maintain a system for investigation and reporting for all instances of suspected and/or actual noncompliance with laws, regulations, CCH policies / procedures (to the extent applicable), or issues related to fraud, waste, and/or abuse (FWA), including reporting to the CCH Compliance Officer or the appropriate CountyCare liaison, as appropriate. *Delineate the methods of how concerns may be submitted or communicated from personnel, providers, agents and members and investigated by Proposer's Compliance Department. Describe the investigation tracking system and the resolution process, including how issues are reported/escalated to CCH Compliance.*		

MMAI FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.3.10.1.12	Maintain a system for prompt reporting of all overpayments identified or recovered, particularly those related to potential fraud, to the Proposer's Compliance Officer and CCH Compliance. *Describe how Proposer has established and implemented methods to encourage personnel, subcontractors/FDRs, agents and providers to report overpayments identified or received related to FWA without fear of retaliation, including how reports will be escalated to CCH Compliance.*		
4.3.3.10.1.13	Maintain a policy of non-intimidation and non-retaliation for good faith participation in the Proposer's compliance program, including but not limited to reporting potential issues, investigating issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials. *Describe how Proposer supports a safe, non-threatening environment where individuals may ask questions about integrity and compliance, fraud, abuse and financial misconduct matters and report their concerns, including a description of how reporters are protected from retaliation and harassment.*		
4.3.3.10.2	*Compliance Program / Program Integrity Responsibilities*		
4.3.3.10.2.1	Ensure that all Proposer employees, agents, and subcontractors complete training as necessary to perform the responsibilities under the Master Contract, including the completion of Compliance/Code of Ethics, FWA and HIPAA trainings upon hire, and no less frequently than annually thereafter, as well as additional trainings utilizing compliance training materials or training sessions supplied by CCH (as needed). FWA training should parallel CMS training materials for "Medicare Parts C and D General Compliance Training" and "Combating Medicare Parts C and D Fraud, Waste and Abuse". Training records must be provided to CCH within five (5) days of any request. *Provide a description of the required training and education completed by Proposer, including the subject areas discussed, modality utilized for training and processes for tracking training completion.*		
4.3.3.10.2.2	Ensure full cooperation by Proposer with any review, audit, or investigation conducted by the CCH Compliance Program or their designee (including those related to readiness activities), including the timely return of requested documentation / data and interviews with Proposer's workforce.		
4.3.3.10.2.3	Ensure full cooperation by Proposer with auditors conducting audits/accreditation activities or oversight of the functions, processes or operations of activities delegated to Proposer under the Master Agreement.		

MMAI FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.3.10.2.4	Prepare and adhere to a written Corrective Action Plan (CAP), in a format mutually agreed upon as requested by CCH or as required by HFS/CMS, with regard to any non-compliant activities performed that are identified in the course of audits conducted or required in the CCH Master Contract or requested pursuant to the CCH Master Contract or other entities of competent jurisdiction.		
4.3.3.10.2.5	Support CCH Compliance with regulator inquiries and complaints.		
4.3.3.10.2.6	Support CCH Compliance with necessary review and revisions to plan policies and procedures, including in the review and approval of any required changes.		
4.3.3.10.2.7	Develop and maintain policies and procedures for oversight of delegated services that are contracted to other organizations, including how audit and monitoring activities will be conducted of delegated functions/services. *Provide a description of the Proposer's delegate / FDR oversight process, including a listing of related policies maintained by the Proposer. Describe in detail audits of FDRs, subcontractors, agents and providers to ensure compliance with contractual and regulatory requirements, including the frequency of the activity.*		
4.3.3.10.2.8	Ensure the collection, assessment, storage and reporting of information related to conflict-of-interest for personnel, officers, directors, and subcontractors, and the officers, directors and personnel of any subcontractors utilized by the Proposer. *Provide a description of the conflict-of-interest process, including a listing of related policies maintained by the Proposer.*		
4.3.3.10.2.9	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 Department of Health and Human Services (HHS) Office of Inspector General (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) (https://sanctionssearch.ofac.treas.gov/) *Provide a description of the sanction screening process, including a listing of related policies maintained by the Proposer.*		

MMAI FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.3.10.2.10	Ensure that the Proposer, its principals and any person employed or contracted by Proposer to provide Services: (1) Are not presently debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded from covered transactions by any governmental department, agency or federally funded health care program (including Medicare and/or Medicaid). (2) Have not, within a 3-year period preceding this proposal, been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property. (3) Are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification. (4) Have not, within a 3-year period preceding this application/proposal, had one or more public transactions (Federal, State, or local) terminated for cause or default.		
4.3.3.10.2.11	Notify CCH immediately in the event that it or anyone performing services under the Master Contract: (1) Is convicted of a criminal offense related to health care and/or related to the provision of services paid for by Medicare, Medicaid or another federal health care program; or (2) Is excluded or debarred from participation in any federal health care program, including Medicare and Medicaid.		
4.3.3.10.2.12	Maintain compliance with the Illinois Human Rights Act, the U. S. Civil Rights Act, and Section 504 of the federal Rehabilitation Act.		
4.3.3.10.2.13	Disclose to CCH Compliance information related to ownership and control of Proposer, certain business transactions and activities by excluded individuals, pursuant to MMAI contract requirements.		
4.3.3.10.2.14	Report to CCH Compliance any Adverse Benefit Determinations that are taken for Fraud, integrity, and /or quality reasons or purposes.		
4.3.3.10.3	*Confidentiality / Privacy*		

MMAI FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.3.10.3.1	Maintain administrative and management arrangements, policies and procedures, and training that comply with all federal and state regulations and statutes governing the creation, receipt, access, use, disclosure maintenance, and transmission of protected health information (PHI), including the protection of PHI and the detection and prevention of unauthorized uses and disclosures of PHI. *Provide a listing of Proposer's policies related to privacy and confidentiality of health information, including those that address HIPAA or relevant State Privacy laws.*		
4.3.3.10.3.2	Maintain procedures to ensure that the Proposer and/or its subcontractors do not access, use, store, maintain, or transmit, whether electronically or otherwise for any purpose whatsoever, CountyCare PHI, documents, data, claims, guidelines, protocols, programs, financial analyses, performance measures, or other information at or to any offshore location, without receiving prior approval from CCH. *Provide a description of any of the Proposer services that will be performed by offshore operations, including any contracted services.*		
4.3.3.10.3.3	Report breaches of unsecured PHI, as defined in 45 CFR 164.402, and mitigate potential damages associated with a Breach of Unsecured PHI and with uses and disclosures in violation of HIPAA requirements and the Master Contract. *Provide a description of notification procedures between Proposer and CCH.*		
4.3.3.10.3.4	Maintain procedures to ensure that any subcontractors utilized by the Proposer will comply with applicable HIPAA privacy and security requirements, including those outlined in the Business Associate Agreement between CCH and the Proposer. *Provide a description of procedures for passing down CCH BAA requirements to subcontractors.*		
4.3.3.10.3.5	Maintain an Information Privacy program that includes, at a minimum, a designated individual who is responsible for developing and implementing policies and procedures for all standard privacy practices regarding the protection of CCH protected health information. *Provide a job description for the designated Privacy individual and a description, including organization chart, for the Information Privacy program.*		
4.3.3.10.3.6	Maintain cyber insurance. *Describe and delineate the relevant provisions and limits of Proposer's cyber insurance policy.*		
4.3.3.10.4	*Fraud, Waste, Abuse (FWA)*		

MMAI FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.3.10.4.1	Maintain administrative and management arrangements, policies, and procedures that comply with all federal and state regulations and statutes governing the detection and prevention of Fraud, Waste, Abuse, mismanagement, and misconduct (collectively, FWA), including but not limited to 305 ILCS 5/8A-1 et. seq., 42 CFR 455, 42 CFR 438 Subpart H, and sections 1128, 1156 and 1902(a)(68) of the Social Security Act (SSA). *Provide a listing of plans, policies, and procedures related to FWA activities and operations maintained by the Proposer.*		
4.3.3.10.4.2	Operate a full-time, dedicated Special Investigation Unit (SIU) to detect, monitor, investigate and prevent FWA, including the use of data analytics to detect potential FWA. The SIU shall be responsible for the reasonable investigation of each enrollee and provider case of suspected FWA activity and for implementation of the CountyCare FWA prevention and reduction activities under the CountyCare FWA Plan. The SIU must be able to receive referrals of FWA alleged against enrollees, providers (both contracted and out-of-network) and Subcontractors. Investigations may involve coordination with other CCH delegated entities. *Describe the Proposer's FWA Plan to detect, investigate and report suspected instances of FWA specific to a Medicaid managed care health plan. Submit a process flow diagram illustrating the process to conduct a reasonable investigation of each suspected FWA involving providers and subcontractors, Proposer's workforce and subcontractors, and enrollees. Include within the diagram the process of notification to CCH Compliance of suspected FWA and potential criminal acts.*		
4.3.3.10.4.3	Designate a dedicated SIU Liaison to provide notice of any suspected FWA to CCH Compliance within twenty-four (24) hours after receiving such report. *Identify the member of management or leadership who will function as the dedicated, day-to-day SIU Liaison to CCH Compliance and include a job description and reporting structure for that individual.*		
4.3.3.10.4.4	Conduct both pre-payment and retrospective, post-payment audits/investigations, including analysis of claims that do not generate reimbursement ("zero paid claim"). *Describe the Proposer's process for conducting pre-payment and retrospective, post-payment audits and investigations.*		

MMAI FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.3.10.4.5	Maintain procedures that outline the organization's methods for identification, investigation, and referral of suspected Fraud cases in compliance with 42 CFR 455.13, 42 CFR 455.14, and 42 CFR 455.21. *Describe how the Proposer's procedures around the identification, investigation, and referral of suspected Fraud cases meet the requirements in 42 CFR 455.13, 42 CFR 455.14, and 42 CFR 455.21.*		
4.3.3.10.4.6	Provide first pass FWA identification, validation, and recovery services to include, at a minimum, the following: • Mapping claims data into standard format and perform FWA analysis with analytics. • Designing FWA concepts to assess claims compliance with current coding, billing and regulatory requirements, subject to CCH prior approval before implementation. • Designing FWA concepts to identify variances in claims including but not limited: claim accuracy, aberrant billing practices, fraud detection and enrollee inconsistencies in the areas of excessive daily services, contraindicated, medically unnecessary, duplicative and/or not supported by the diagnoses and over-utilization of services, subject to CCH prior approval before implementation. • Reviewing claims identified as an overpayment and validate the overpayment prior to initiating recovery efforts. • Obtaining approval from CCH Compliance prior to recovery initiation to minimize provider abrasion and ensure compliance with Master Contract terms. *Describe how the Proposer will develop and utilize Data Analytics, based on current regulations, to help identify and address Provider and Enrollee variances, including the identification of any external resources or software utilized as part of the process.*		
4.3.3.10.4.7	Perform interviews and/or "boots on the ground" field-based investigations related to FWA/Payment Integrity initiatives, if warranted. • *Describe the operations of the Proposer's local Investigation Unit that will be responsible for the investigation and remediation of FWA / Program Integrity issues, including office locations and organization chart structure.*		

MMAI FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.3.10.4.8	Perform medical record audits on claims identified through FWA/Payment Integrity initiatives using certified coders, registered nurses and/or other medical professionals (as needed). *Provide a description of the process for auditing medical records, including the identification of any coding software they used to review facility and provider claims to ensure the claims comply with State Medicaid guidelines as well as national coding and documentation guidelines published by the Centers for Medicare and Medicaid Services (CMS), the American Medical Association and various specialty organizations.*		
4.3.3.10.4.9	Coordinate and perform education for providers based on audit or investigation findings, as directed by CCH Compliance. *Provide a description of the process for providing education to providers, via multiple modalities, including examples of when provider education is appropriate.*		
4.3.3.10.4.10	Recover established overpayments due to FWA made to a provider, as directed and approved by CCH. Overpayments may be obtained from a provider directly or made from future claim payments. Where there are not sufficient claims funds, letters to a provider will be sent. *Provide a description of the process for recovering overpayments made to providers, including how efforts will be coordinated with CCH Compliance.*		
4.3.3.10.4.11	Maintain processes to grant real-time access to CCH Compliance for SIU and/or FWA Program documentation and/or software platforms for reporting and oversight purposes. *Provide a description of the process for granting/authorizing CCH Compliance access to FWA related documentation and data.*		
4.3.3.10.4.12	Identify and implement process changes and/or system configuration solutions to prevent payment of improper claims, as identified via FWA concepts and data analytics, subject to prior approval by CCH.		
4.3.3.10.4.13	Provide first level appeal management for all provider concerns with FWA activity and recoveries.		
4.3.3.10.4.14	Maintain procedures that outline the methods for prompt reporting of all overpayments identified or recovered to CCH.		
4.3.3.10.4.15	Develop and deliver monthly, quarterly and ad hoc reports to CCH Compliance regarding FWA related investigations, audits and data mining activities, in the form and format requested by CCH and in line with requirements for reporting data to HFS and HFS OIG. *Provide a description of the process for developing and delivering accurate reports to CCH Compliance, including the process for ad hoc report requests.*		

MMAI FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.3.10.4.16	Ensure cooperation with all appropriate federal and state agencies in the detection and prevention of Fraud, Waste, Abuse, mismanagement, and misconduct, including the implementation of measures to comply with any Provider Alerts, including Payment Suspensions, or Deconfliction/Stand Down Notices received from HFS and/or HFS OIG and participation in ad hoc and regular meetings with HFS OIG, as requested by CCH.		
4.3.3.10.4.17	Conduct recipient verification of services received by CountyCare members, including reporting of summary results to CCH. *Include a draft recipient verification letter and describe the process for conducting and reporting on recipient verification of services activities.*		
4.3.3.11	**CLAIM MANAGEMENT – CLAIMS PROCESSING, ADJUDICATION AND PAYMENT (PART C)**		
4.3.3.11.1	*Claims Processing & Encounters Submission*		
4.3.3.11.1.1	Establish processes with HPS, including but not necessarily limited to, electronic communication methods (e.g., SharePoint application) to exchange information, policies and procedures, and directives regarding how claims should be paid and how benefits should be set up.		
4.3.3.11.1.2	Process all claims and encounters in accordance with CMS and HFS Requirements, including but not limited to claims from physicians, hospitals, transportation, long term and support organization (LTSS) clinics, ancillary providers, and other health care providers. Includes screening the data for completeness, logic, and consistency.		
4.3.3.11.1.3	Investigate, correct, and resubmit any rejected encounters from HFS throughout the encounter process.		
4.3.3.11.1.4	Maintain a 99% encounter acceptance rate on a quarterly basis or face penalties for not meeting the threshold.		
4.3.3.11.1.5	Attain certification and support encounter submissions for all medical and behavioral, vision, dental and transportation encounters in alignment with CMS and HFS Requirements. Distinguish and submit encounters for services primarily covered by Medicare on separate files from those benefits traditionally covered by Medicaid.		
4.3.3.11.1.6	Support Medicare encounter submission to CMS and Medicaid encounter submission to HFS for sub-delegates as a passthrough in MMAI compliant 837 encounter data sets for the following non-pharmacy sub-delegates: • Non-Emergent Medical Transportation • Dental/Vision		
4.3.3.11.1.7	Establish and maintain post office boxes for claims to be mailed to HPS.		
4.3.3.11.1.8	Match claims to their referral or authorization, when required, and deny claims not properly authorized in accordance with HPS referral and prior authorization policies.		
4.3.3.11.1.9	Validate diagnosis and procedure codes reported by providers on claims in accordance with HPS requirements.		

MMAI FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.3.11.1.10	Review, as necessary, medical management annotations in the authorization system to ensure that services billed match the services authorized and that inpatient levels of care match the levels of care authorized under the plan's Utilization Management criteria, and process in accordance with HPS level of care procedures or other applicable payment methodologies.		
4.3.3.11.1.11	Implement, based on HPS contracts, the fee schedules and payment methods that will apply to each provider and communicate internally for system configuration.		
4.3.3.11.1.12	Create fee schedules within the Claims System and process claims in accordance with provider reimbursement contractual agreements.		
4.3.3.11.1.13	Process non par claims and determine the applicable non par fee schedule based on CMS and/or HFS Requirements and/or relevant HPS policy. If current policy does not apply, contact HPS for instructions on how the non-par claim should be processed. Follow all rules for non-par payments promulgated by HPS.		
4.3.3.11.1.14	Process corrected claims and make necessary payment adjustments.		
4.3.3.11.1.15	Process claims in accordance with single case agreements to ensure member continuity of care.		
4.3.3.11.1.16	Track benefit limits as they apply to program claims and adjudicate claims in accordance with prescribed limits and notify provider of the reason for denial.		
4.3.3.11.2	*Payment and Program Integrity*		
4.3.3.11.2.1	Ability to process COB claims including: • Support ability to accept Member COB status information from MMIS system in HIPAA standard formats. • Support ability to apply adjudication logic if there is a secondary payer besides Medicaid or Medicare. • If claim paid as primary, but Member has secondary, process recovery for claim		
4.3.3.11.2.2	Designate the following positions: • Third Party Liability (TPL) Benefit Coordinator to serve as contact person for benefit coordination issues • One or more recoveries specialists to investigate and process all issues related to TPL		
4.3.3.11.2.3	Subrogation Claim Management: • Provide a claim data feed to Subrogation Vendor to identify and investigate potential involving subrogation situations on paid claims. • Support HPS' model of "Pay and Chase" for claims related to subrogation. • Oversee collection of subrogation dollars by Subrogation Vendor. • Document, track and report subrogation dollars through periodic reports.		

MMAI FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.3.11.2.4	Screen claims for duplicate payments prior to payment.		
4.3.3.11.3	*Funding, Recovery, & Claims Audit*		
4.3.3.11.3.1	Maintain copies, on paper or in electronic format, of claims and attachments submitted by providers.		
4.3.3.11.3.2	Establish mechanisms to adjust claims or to recoup payments deemed appropriate after initial payment based on written policies prepared by HPS and provided to TPA.		
4.3.3.11.3.3	Prepare a claims pre-release report for HPS, and/or its designee, to review claims that are scheduled for payment.		
4.3.3.11.3.4	Implement processes to operationalize HPS written policies, provided in advance to TPA, with regard to claim audits to be performed prior to final payment of claims.		
4.3.3.11.3.5	Perform, or cause to be performed, medical record audits on claims identified through payment integrity initiatives listed above where applicable.		
4.3.3.11.3.6	Issue timely claims payment with the EOP to providers in accordance with requirements set forth in the providers' contract and in accordance with clean claims payment CMS and HFS Requirements and based on available funds.		
4.3.3.11.3.7	Calculate interest due on claims not paid in accordance with CMS and HFS Requirements prompt pay policies. Issue checks, either separately or as part of the EOP, for interest.		
4.3.3.11.3.8	Establish internal processes for review of CMS and HFS bulletins that may require changes to claims processing or other operational processes.		
4.3.3.11.3.9	Communicate and collaborate with HPS Compliance to support required changes of CMS and HFS bulletins within TPA's delegated services.		
4.3.3.11.3.10	Coordinate retro-deletes and retro-adds to claims. Prepare reports to identify claims that will need to be recouped or reprocessed based on retroactivity.		
4.3.3.11.3.11	Take timely steps, consistent with HPS policies and procedures, to recoup or reprocess already-adjudicated claims affected by retro-add or retro termination.		
4.3.3.11.3.12	Perform random audits of up to 3% of claims paid and provide a quarterly report of claim audit results to HPS. Timing of claims audit will be dependent on release of funds.		
4.3.3.11.3.13	Process corrected claims and make necessary payment adjustments.		
4.3.3.11.3.14	Process refund checks in accordance with HPS policy within the Claims System so that the claim is properly reflected in the TPA system		
4.3.3.11.3.15	Update electronic data interchange ("EDI") standards and processes in accordance with industry and/or HPS updates as required by applicable contract Law.		
4.3.3.12	**FINANCIAL SERVICES**		
4.3.3.12.1	*Premium Payment Management*		

MMAI FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.3.12.1.1	Reconcile Membership to premium files and identify exceptions for reporting and follow up.		
4.3.3.12.1.2	Prepare the monthly Enrollment Data Validation (EDV) Package for Reed & Associates Retroactive Processing Contractor (RPC) submission consisting of the monthly sample review of enrollment related transactions submitted to CMS.		
4.3.3.12.1.3	Compare monthly enrollment records to the HFS 820 and report all discrepancies to the Enrollment Department for investigation.		
4.3.3.12.1.4	Research and provide updated transactions to CMS via accreditation file or the RPC for retroactive transactions as defined by CMS.		
4.3.3.12.1.5	Approve initial attestation that all data from the combination of daily TRRs for the previous month have been completed timely and that all required transactions were accepted, disputed or have been processed and that all required correspondence was issued. Unresolved discrepancies, along with the Enrollment Transaction Certification, will be provided to CCH.		
4.3.3.12.1.6	Identify Members affected by retro-termination or retro-eligibility and provide data to Claims Audit & Recovery Department to act upon these changes in accordance with HPS policies and procedures.		
4.3.3.12.2	*Management of Claims Bank Trust Accounts*		
4.3.3.12.2.1	Establish necessary bank accounts for issuing claim disbursements.		
4.3.3.12.2.2	Manage returned/rejected Electronic Funds Transfer(s) (“EFT”) including reprocessing the payment.		
4.3.3.12.2.3	Establish process to handle deceased Member payments; HPS and TPA will communicate with each other when notified of deceased Member.		
4.3.3.12.2.4	Send positive pay file to the bank daily of all checks issued.		
4.3.3.12.2.5	Manage daily reporting for checks presented for payment but not issued by bank (positive pay).		
4.3.3.12.2.6	Establish process to manage fraudulent checks; establish process to stop paid or voided checks if required.		
4.3.3.12.2.7	Maintain check registers for the claims clearing accounts and provide copies as requested, but at least monthly, to HPS.		
4.3.3.12.2.8	Reconcile claims trust accounts each month.		
4.3.3.12.2.9	Maintain copies of reconciliations and bank statements.		
4.3.3.12.2.10	Provide check stock and cover the cost of postage for mailing claim checks and Explanations of Payments to providers.		
4.3.3.12.2.11	Ensure the security of check stock, ink cartridges used for printing checks, and signatories and permit access to these items only by authorized persons.		
4.3.3.12.2.12	Process missing or lost check requests in accordance with concurrent HPS policy based on inquiries sent from Customer Service. TPA accounting staff will follow up inquiries by providing check copies, stop payments, reissues, etc. to HPS.		
4.3.3.12.2.13	Communicate stop payment and check reissues transactions to the bank.		

MMAI FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.3.12.3	*General Accounting*		
4.3.3.12.3.1	Provide financial reports and General Ledger feeds on a monthly basis for all financial transactions processed by TPA.		
4.3.3.12.3.2	Financial Reporting such as bank reconciliation, aged provider receivables, finance data reports, monthly medical expense category report, claim detail report, unpaid aging report, due and unpaid report, paid aging report, and filing data report.		
4.3.3.12.3.3	Calculate, track, report, and monitor specific stop loss reinsurance according to reinsurer's requirements: a. Recommend and assist in the analysis of reinsurance contracts at the request of HPS b. Notify HPS of potential reinsurance cases c. Provide reports or copies of claims as needed for processing reinsurance cases with the reinsurer		
4.3.3.12.3.4	Provide 1099 data file for any payments processed by TPA and submit to the health plan. File will be sent in mutually agreed upon format.		
4.3.3.12.3.5	Accurately process, report, and submit 1099 files for any payments processed by TPA in the required format to the IRS following approval from the health plan.		
4.3.3.12.3.6	Research IRS mismatches for the purpose of updates and sending B notices. In the case that P notices are received from the IRS, communication, penalty fees, and resolution will be the responsibility of the TPA.		
4.3.3.12.3.7	Manage the unclaimed property process.		
4.3.3.12.3.8	Establish process to pend provider's claims for specified providers Tax IDs if notified by HPS and hold and monitor claims.		
4.3.3.12.3.9	Establish EFT and Electronic Remittance Advice capability with network providers.		
4.3.3.12.3.10	Adopt policies and strategies to communicate with and encourage providers receiving $25,000 or more in combined capitation or fee for service reimbursements accept EFT payments and ERA remittance advices.		
4.3.3.12.3.11	Provide EOPs in an electronic X12-835 format through a vendor of TPA's choice for providers desiring an EDI remittance.		
4.3.3.13	**INFORMATION SYSTEMS**		
4.3.3.13.1	*Systems and Interfaces*		

MMAI FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.3.13.1.1	Provide an automated **Claims Management System** that is a separate instance from all other products and lines of business generally available on a 24/7 basis with reasonable permitted downtime for system upgrades and maintenance as required. The system shall: • Include Member eligibility and provider master data sufficient to accurately process claims and provide certain required reports as required. • Provide for flexible, date-specific fee schedule maintenance to accurately pay claims. • Be made available to HPS staff on a view-only basis. TPA will make the necessary enhancements to ensure the claims management system is able to meet all CMS and HFS Requirements.		
4.3.3.13.1.2	Configuration updates/corrections and enhancements to the claims management system will be summarized via "Claims / Configuration" tracker and provided, at minimum, monthly.		
4.3.3.13.1.3	Provide a **Customer Service System** including a telephone system with Automatic Call Distribution and Auto-Attendant (ACD-AA) functionality, sufficient to: (a) separately track provider and members calls, (b) provide information on the nature of calls being received by the health plan, (c) document incoming calls and maintain history or log of such calls in system, and (d) meet CMS and HFS Requirements and performance metrics regarding call statistics and quality.		
4.3.3.13.1.4	Make the necessary enhancements to ensure the call center system can meet all CMS and HFS Requirements.		
4.3.3.13.1.5	**Utilization Management System (Medical/Behavioral)**: Provide a system to conduct Utilization Management provided as is. Review standard configuration on an ongoing basis (e.g., workflows, assessments, dropdowns, etc.). TPA will make the necessary enhancements to ensure the UM system is able to meet all CMS and HFS Requirements for medical/behavioral health.		
4.3.3.13.1.6	**Population Health System:** Provide a system to calculate compliance with HEDIS or HEDIS-like quality measures. Update quality measure logic based on annual HEDIS logic and utilize medical claims, pharmacy claims, and lab data onboarded according to required specifications.		
4.3.3.13.1.7	**Analytics System**: Provide a system for self-service cost and utilization reporting as is. Support reporting on standard eligibility, medical claims, and pharmacy claims data elements, as well as HPS-defined custom analysis variables.		
4.3.3.13.1.8	Software program that identifies avoidable ER admissions and potentially preventable hospital readmissions including readmissions associated with hospital acquired conditions (HACs) and other provider preventable conditions.		

MMAI FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.3.13.1.9	Maintain a **Provider Portal(s)** that meets HFS and CMS Requirements – either directly or through a sub-vendor – that allow for providers to: • view Member/patient eligibility with history and benefits, • view claim status, • View Explanations of Payments (EOP) • submit electronic authorizations requests and/or review status of authorization requests • view PCP panel roster, as applicable • View other data and information as determined by mutual agreement of the Parties.		
4.3.3.13.1.10	Maintain **Member Portal(s) that meets HFS and CMS Requirements** – either directly or through a sub-vendor – that allow for: • view benefits • view/check claim status • view EOB • request ID card • select/change PCP • inquiries via free text		
4.3.3.13.1.11	Maintain an **Online Provider and Pharmacy Network Directory** that meets CMS and HFS Requirements that includes medical, behavioral, LTC facilities, DME, and other providers as supplied by HPS in TPA standard format. A website link will be provided to access the pharmacy directory which is maintained by the Pharmacy Benefits Manager, and any other vendor directories (e.g., dental, vision, etc.) not aligned with TPA's overall scope.		
4.3.3.14	**DATA WAREHOUSE AND REPORTING**		
4.3.3.14.1	Support a Data Warehouse for capturing claims data, eligibility data, provider data, historical information, and other data, as deemed relevant by TPA, used for analytics. Any data elements not directly derived from claims, eligibility, or provider data will be discussed and prioritized by TPA and Cook County Health		
4.3.3.14.2	Provide HPS with data extracts according to EVH standard file format from data warehouse on a mutually agreed upon time schedule via SFTP		
4.3.3.14.3	Manage user access and resolve technical operations and data issues impacting access and use for said systems in TPA scope.		
4.3.3.14.4	Provide functionality improvements for TPA provided systems and tools as part of the normally scheduled TPA release schedule and with mutually agreed upon communication and change management procedure		
4.3.3.14.5	*Accounting Systems*		
4.3.3.14.5.1	Provide information to feed HPS General Ledger.		
4.3.3.14.5.2	Provide tracking system for Member and provider Grievances and disputes and Appeals.		
4.3.3.14.6	*HPS Trading Partner Interfaces*		

MMAI FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.3.14.6.1	Develop and maintain file transfer capabilities with HPS trading partners.		
4.3.3.14.6.2	Complete sftp set up, provide file specifications, provide test data, and maintain data interfaces set up on mutually agreed upon schedule.		
4.3.3.14.7	*Security and HIPAA Compliance*		
4.3.3.14.7.1	Develop and maintain – or cause to be developed and maintained – written Disaster Recovery and Business Continuity plans for all systems used to perform work for the MMAI Plan in accordance with the Services Agreement.		
4.3.3.14.7.2	Develop and maintain system backup plans, consistent with industry standards that are sufficient to ensure the protection of HPS data in all systems provided by TPA in the performance of its duties under this Services Agreement.		
4.3.3.14.7.3	Develop and maintain – or cause to be developed and maintained – processes, procedures, and systems that allow for user-specific access – or lack of access – to data modules provided by TPA in the performance of its duties under this Services Agreement.		
4.3.3.14.7.4	To the fullest and best of its ability, comply with all system security provisions required by HPS housed in systems provided by TPA in the performance of its duties.		
4.3.3.14.7.5	Maintain records of TPA staff training compliance, and all other training in alignment with HPS CMS and HFS Requirements.		
4.3.3.14.8	*Communications, Computer Equipment, and Software Applications and Licenses*		
4.3.3.14.8.1	Provide authorized CCH staff and Affiliates as appropriate to full access to MIS products provided by or used by TPA in the performance of its responsibilities under this Services Agreement.		
4.3.3.14.8.2	Provide dedicated telecommunications lines, internet access, and hardware and software, as required, to TPA staff or TPA Affiliates performing duties under this Services Agreement.		
4.3.3.14.8.3	Provide an Automatic Call Distribution / Auto-Attendant (ACD/AA) system to Customer Service that meets the requirements of HPS for tracking inbound calls and reporting call center information to HPS		
4.3.3.14.8.4	Provide an ACD/AA system to the utilization management nurses, technicians, and case managers that meets the requirements of HPS for tracking inbound calls and reporting call center information to HPS.		
4.3.3.14.9	*Database Design, Setup and Maintenance*		
4.3.3.14.9.1	Implement reasonable system requirements and specifications necessary to operationalize the business rules identified by TPA or provided by HPS		
4.3.3.14.9.2	Provide training to TPA or HPS staff or Affiliates on the use of MIS databases or systems provided by TPA under this Services Agreement where applicable.		

MMAI FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.3.14.9.3	Provide ongoing oversight of the accuracy of system information and communicate changes that need to be implemented to ensure that the systems or databases contain accurate information needed to operate HPS' programs.		
4.3.3.15	**REGULATORY AUDITS**		
4.3.3.15.1	Cooperate with auditors conducting audits or oversight of the functions, processes or operations of activities delegated to TPA under this Services Agreement.		
4.3.3.15.2	Conduct audits of delegated functions/services. Auditing or monitoring activities will be determined through a risk assessment and in accordance with the MMAI Addendum.		
4.3.3.15.3	As requested by HPS or as required by CMS and HFS, prepare a written Corrective Action Plan (CAP), in a format mutually agreed upon, with regard to any non-compliant activities performed that are identified in the course of audits conducted or required in the HPS contract or requested pursuant to the HPS or other entities of competent jurisdiction.		
4.3.3.15.4	Coordinate all communications with auditors to ensure that all deliverables are provided, and that all information provided to auditors is reasonably correct and accurate.		
4.3.3.16	**ANALYTICS & REPORTING (PART C)**		
4.3.3.16.1	Designate dedicated analytics resources specifically to support MMAI and analytics and reporting requests will be prioritized by HPS in collaboration with TPA.		
4.3.3.16.2	Maintain an algorithm that supports assignment of Members to Care Management Entities (CME).		
4.3.3.16.3	Own document of all specifications for the algorithm of CME assignment and maintain business requirements document (BRD).		
4.3.3.16.4	Create impact analysis and quality assurance protocol following each change to the CME algorithm or any analyses that have downstream or operational implications.		
4.3.3.16.5	Provide 1.5 FTE to support regulatory reporting. 1.5 FTE have been estimated based on understanding of current CMS and HFS Requirements for analytics needs based on TPA scope of services.		
4.3.3.16.6	Responsible for the timely regulatory reporting of delegated services.		
4.3.3.16.7	Use CMS data validation principles to validate Part C regulatory reporting prior to submission.		
4.3.3.16.8	Provide regulatory reporting of Part D Enrollment and Disenrollment universe.		
4.3.3.16.9	Participate in the MMP Service Authorization Requests, Appeals, and Grievances (SARAG) audit process including but not limited to universe and supplemental documentation file submission, webinar reviews, completing an impact analysis.		
4.3.3.16.10	Provide MMP Core Reporting and Illinois State Specific Reporting.		

MMAI FUNCTIONAL REQUIREMENTS		RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.3.16.11	Provide regulatory reporting of Risk Adjustment Data into the Risk Adjustment Processing System (RAPs) and Risk Adjustment Data Validation (RADV) Audit submissions.		
4.3.3.17	**DELEGATION AND SUBCONTRACTOR OVERSIGHT**		
4.3.3.17.1	Support HPS' Delegation Oversight Program through participation in a pre-delegation audit; a quarterly delegation performance review; an annual audit; monthly joint operation meetings; formal, ongoing evaluation and monitoring of performance and compliance; and remediation if performance is substandard and/or violates the terms of this Services Agreement.		
4.3.3.17.2	TPA shall participate in other meetings as requested by HPS.		
4.3.3.17.3	TPA shall participate in and provide support for external/regulatory audits as requested. This can include, but is not limited to, producing and supplying documentation, participating in file reviews, system demonstration and presenting during audits.		
4.3.3.17.4	TPA shall participate in a periodic oversight meetings with HPS. TPA will provide agenda for the oversight meeting with input from HPS.		
4.3.3.17.5	TPA shall provide monthly oversight reports on a mutually agreed upon date. Report content shall be mutually agreed upon by TPA and HPS.		
4.3.3.17.6	TPA shall notify HPS within one business day upon identifying a performance deficiency. TPA shall provide root cause of deficiency, action plan for remediation, with timelines and target dates for remediation, and responsible business owner(s).		
4.3.3.17.7	TPA shall participate in meetings with other HPS vendors as requested by Plan.		
4.3.3.17.8	TPA shall notify HPS within one business day upon identifying a performance deficiency. TPA shall provide root cause of deficiency, action plan for remediation, ETA for remediation, and responsible business owner.		
4.3.3.17.9	TPA shall participate in meetings with other HPS vendors as requested by Plan.		
4.3.3.18	**PROJECT MANAGEMENT OFFICE**		
4.3.3.18.1	TPA must have a project management lead that will work with HPS PMO to implement any new initiatives and projects directed by HPS		
4.3.3.18.2	TPA must have PMO office that will work on developing project plan, risks/mitigation plans, tracking key deliverables, and participating/facilitating meeting to include key stakeholders.		
4.3.3.19	**FINANCIAL ACTION PLAN**		
4.3.3.19.1	Designate resources to develop ideas and execute on initiatives related to cost saving strategies for the health plan. Team should consist of but not be limited to analysts, project managers, and a team lead.		
4.3.3.19.2	Performance outcomes on cost savings strategies could result in performance bonuses or penalties		

4.3.4 Cook County Medical Group Requirements

Responses to Section 4.3.4 shall not exceed 10 pages total.

	FUNCTIONAL REQUIREMENTS	RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.4.1	**INFORMATION SYSTEMS**		
4.3.4.1.1	Provide an automated Claims Management system - with current and historical information. The system will also be made available to CCH staff on a view-only basis.		
4.3.4.1.2	Provide a Data Warehouse for capturing claims data, eligibility data, provider data, and other relevant data used for analytics.		
4.3.4.1.3	Provide a Reporting Tool that allows reporting from the Data Warehouse.		
4.3.4.1.4	Provide CCH access to the Reporting Tool for CCH to perform data analytics on ad hoc basis		
4.3.4.1.5	Promulgate HIPAA-compliant processes, procedures, and systems that protect Patient Health Information (PHI) in manners prescribed by HIPAA and facilitate sharing of or transmission of data by and between trading partners, sub-vendors, agents, or employees of CCH.		
4.3.4.1.6	Provide authorized CCH staff and affiliates to view-only access to MIS products provided by or used by TPA in the performance of its responsibilities under this MSA.		
4.3.4.1.7	Set up and maintain accurate data files and tables in system applications provided by or used by TPA under this MSA consistent with the documentation provided by CCH under I.D.3.		
4.3.4.1.8	Provide training to CCH staff or affiliates on the use of MIS databases or systems provided by TPA under this MSA.		
4.3.4.2	**FINANCIAL SERVICES**		
4.3.4.2.1	Prepare the following financial reports for ongoing prudent financial management of the plan:		
4.3.4.2.1.1	Monthly Financial Statements and statistics including GAAP, income, and expenses relevant to contract.		
4.3.4.2.1.2	Monthly claim triangles in TPA standard format including restated monthly enrollment.		
4.3.4.2.1.3	Monthly IBNR analyses.		
4.3.4.2.1.4	Monthly bank statement maintenance for the Wells Fargo CMG claim funding account.		
4.3.4.2.1.5	Monthly Operations Dashboard Report as mutually determined.		
4.3.4.2.1.6	Annual financial pro forma development as requested based on a mutually agreed upon format.		

	FUNCTIONAL REQUIREMENTS	RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.4.2.1.7	Prepare Management Reports and PCP reports required by Blue Cross: - Quarterly income statements and balance sheets are due to CCH within sixty (60) days after the end of the quarter for submission to Blue Cross. - Annual financial statements are to be submitted within one-hundred fifty (150) days after the end of the CCH fiscal year.		
4.3.4.2.2	Cooperate with auditors conducting audits or oversight of the functions, processes or operations of activities delegated to TPA under this MSA. This includes assigning adequate staff to provide timely responses to audit deliverable requests or to prepare documents or reports needed within the scope of the audit to the extent that such deliverables, documents, or reports are relevant to TPA's duties under this MSA.		
4.3.4.2.3	Prepare a written Corrective Action Plan (CAP) with regard to any non-compliant activities performed by TPA that are identified in the course of audits conducted or required in the CCH contract.		
4.3.4.2.4	Establish bank account for issuing claim disbursements		
4.3.4.2.5	Provide monthly reports to CCH of checks issued, voided, cancelled, or adjusted		
4.3.4.2.6	Maintain check registers for the claims disbursement account and provide copies monthly, to CCH.		
4.3.4.2.7	Reconcile claims disbursement account each month.		
4.3.4.2.8	Provide a request for funding (RFF) to include claims detail for CCH to review claims that are scheduled for payment.		
4.3.4.2.9	Fund claims disbursement account in amounts sufficient to cover the payments being made in each check release.		
4.3.4.2.10	Receive monthly Blue Cross capitation report that provides member eligibility from Blue Cross in accordance with the Blue Cross's delivery schedule.		
4.3.4.2.11	Review eligibility file prior to loading into TPA MIS to reasonably ensure accuracy and completeness of data.		
4.3.4.2.12	Load valid membership into TPA MIS.		
4.3.4.2.13	TPA will reconcile membership to Blue Cross monthly capitation report and identify exceptions for reporting and CCH to follow up with Blue Cross.		
4.3.4.3	**CLAIMS MANAGEMENT**		
4.3.4.3.1	Load authorized benefit plans and fee schedules and maintain them as changes are promulgated.		
4.3.4.3.2	Update fee schedules in MIS as required or deemed appropriate by CCH.		
4.3.4.3.3	Match claims to their referral or authorization, when required, and deny claims not properly authorized in accordance with standard TPA claim edits, and/or CCH referral and prior authorization policies.		
4.3.4.3.4	Create fee schedules within the claims system and process claims in accordance with CCH- defined fee schedules and payment methods.		
4.3.4.3.5	Provide monthly claim extracts to Blue Cross.		

	FUNCTIONAL REQUIREMENTS	RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.4.3.6	Maintain copies, on paper or in electronic format, of claims and attachments submitted by providers.		
4.3.4.3.7	Issue timely claims payment with Explanation of Payment (EOP) or electronic remittance advice (ERA) to providers in accordance with requirements set forth in the CCH's Blue Cross contract, subject to CCH timely funding claims payment accounts.		
4.3.4.3.8	Establish Electronic Funds Transfer (EFT) and Electronic Remittance Advice capability with network providers via the TPA provider settlement vendor as applicable.		
4.3.4.3.9	Reprocess claims identified through retro-terms and retro-adds to recoup or pay claims whose payment changes based on the retroactivity.		
4.3.4.3.10	Process refund checks in accordance with CCH policy within the claims system so that the claim is properly reflected in the TPA system.		
4.3.4.3.11	Submit a weekly Maximum Out-of-Pocket Expense report as required by Blue Cross.		
4.3.4.3.12	Submit a monthly condition coding gap report for Blue Precision HMO and Blue Focus Care HMO.		
4.3.4.4	**MEMBER AND PROVIDER SERVICES**		
4.3.4.4.1	Load enrollment files.		
4.3.4.4.2	Maintain membership history and PCP assignment history in TPA MIS.		
4.3.4.4.3	Process updates of member demographic information - e.g. address changes or telephone number changes - and update the Member Eligibility system accordingly.		
4.3.4.5	**MEDICAL MANAGEMENT – UTILIZATION REVIEW**		
4.3.4.5.1	Maintain CCH's Medical Director and make Medical Director available to CCH or Blue Cross for all medical management decisions.		
4.3.4.5.2	Develop and maintain UM policies, protocols, procedures, and annual UM plan; TPA is responsible for administering policies, protocols, and procedures as indicated by annual UM plan.		
4.3.4.5.3	Determine services that will require referral and/or prior authorization.		
4.3.4.5.4	Implement systems, both computerized and manual as necessary, to handle utilization management, concurrent review, case management, and disease management functions. The processes shall at a minimum include:		
4.3.4.5.4.1	Conduct prior authorization processes in accordance with the time frames set forth by Blue Cross.		
4.3.4.5.4.2	Receive referrals for services defined by CCH, which services may change from time to time, via telephone, fax, online web entry, or other approved methodologies.		
4.3.4.5.4.3	Screen authorizations and referrals using criteria for medical necessity.		
4.3.4.5.4.4	Enter authorizations into TPA MIS and issue authorization numbers to providers and maintain history of authorizations by member and by provider.		

	FUNCTIONAL REQUIREMENTS	RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.4.5.4.5	Perform concurrent review activities on inpatient admissions and document Level of Care authorizations.		
4.3.4.5.4.6	Coordinate and manage: 1) ongoing patient care, 2) discharge planning, 3) social services interfaces, 4) alternate level of care facilities, 5) member transfers to more appropriate facilities, and 6) non-par services.		
4.3.4.5.4.7	Maintain statistics on financial appeals.		
4.3.4.5.4.8	Maintain UM denials log in accordance with CCH/Blue Cross requirements.		
4.3.4.5.4.9	Report monthly UM statistics to UM committee as required to manage medical services.		
4.3.4.5.4.10	Create a written UM Plan in partnership with CCH and consistent with policies of CCH to govern the activities of TPA nurses and staff.		
4.3.4.5.4.11	Alert CCH of out of network admission in accordance with coordinated, mutually agreed upon process		
4.3.4.5.4.12	Assist CCH in Complaints and Appeals resolutions by obtaining additional information at request of CCH or through providing further information from TPA' s UM criteria sets.		
4.3.4.5.4.13	Operate the Complaints, Grievances and Appeals program. TPA will support the appeals process by providing necessary information regarding utilization management decisions upon request.		
4.3.4.5.4.14	Conduct all activities assigned to CCH or TPA, pursuant to written policies and procedures that reasonably relate to Behavioral Health Services.		
4.3.4.5.4.15	Analyze behavioral health and substance abuse authorization data and report on trends.		
4.3.4.5.4.16	Provide outbound data feeds to CCH's case management vendor, including claims, authorization, provider, and eligibility at an interval agreed upon by both parties.		
4.3.4.5.4.17	Provide reports, on schedules mutually agreed to between the parties, to analyze trends in utilization.		
4.3.4.5.4.18	Communicate Management Report data to CCH committees.		
4.3.4.5.4.19	Recommend utilization management guidelines related to concurrent, prospective and retrospective review.		
4.3.4.6	**QIRA SUBMISSIONS**		
4.3.4.6.1	Submit monthly QIRA files to BCBS in a format acceptable to Blue Cross and agreed to by TPA. Data required currently includes but is not limited to, laboratory, provider services, emergency room, ancillary services. Data must currently include Provider s Type I and Type II NPI numbers, valid specialty code for Physician services and all applicable diagnosis codes.		
4.3.4.6.2	Correct rejected files and resubmit rejected records to Blue Cross no later than ten (10) days from Blue Cross notification to TPA of rejection. Data submitted to Blue Cross must be in HIPAA mandated standard formats.		
4.3.4.7	**MEETINGS**		

	FUNCTIONAL REQUIREMENTS	RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.4.7.1	Attend monthly Finance Committee meeting		
4.3.4.7.2	Attend Annual Board Committee meeting		
4.3.4.7.3	Attend Medical Management Committee meetings		
4.3.4.7.4	Prepare Medical Management Committee meeting minutes		
4.3.4.8	**KEY PERFORMANCE INDICATORS**		
4.3.4.8.1	The scope of the work in the Contract will identify Key performance measures that the Proposer must meet, including but not limited to compliance with all requirements of the Blue Cross Blue Shield Master Services Agreement, cost-savings and timely submission of claims and reports.		

4.3.5 CareLink/Uninsured Requirements

Cook County Health is evaluating offering an innovative solution for its uninsured patients, providing them a network of primary care providers (both at CCH and at FQHCs), as well as specialty and facility services at Cook County Health facilities. We are seeking a partner who can provide a cost effective, flexible and customizable solution as CCH develops this product offering. Currently, CCH has approximately 30,000 patients enrolled in its uninsured program called CareLink. We are looking for a partner to provide the below services for this product. Responses to Section 4.3.5 shall not exceed 10 pages total.

	FUNCTIONAL REQUIREMENTS	RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.5.1	**FINANCIAL SERVICES**		
4.3.5.1.1	Prepare the following financial reports for ongoing prudent financial management of the plan:		
4.3.5.1.1.1	Monthly Financial Statements and statistics including GAAP, income, and expenses relevant to contract.		
4.3.5.1.1.2	Monthly claim triangles in TPA standard format including restated monthly enrollment.		
4.3.5.1.1.3	Monthly IBNR analyses.		
4.3.5.1.1.4	Monthly bank statement maintenance for the claim funding account		
4.3.5.1.1.5	Monthly Operations Dashboard Report as mutually determined		
4.3.5.1.2	Cooperate with auditors conducting audits or oversight of the functions, processes or operations of activities delegated to TPA under this MSA. This includes assigning adequate staff to provide timely responses to audit deliverable requests or to prepare documents or reports needed within the scope of the audit to the extent that such deliverables, documents, or reports are relevant to TPA's duties under this MSA.		
4.3.5.1.3	Prepare a written Corrective Action Plan (CAP) with regard to any non-compliant activities performed by TPA that are identified in the course of audits conducted or required in the CCH contract.		
4.3.5.1.4	Establish bank account for issuing claim disbursements		

	FUNCTIONAL REQUIREMENTS	RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.5.1.5	Provide monthly reports to CCH of checks issued, voided, cancelled, or adjusted		
4.3.5.1.6	Maintain check registers for the claims disbursement account and provide copies monthly, to CCH.		
4.3.5.1.7	Reconcile claims disbursement account each month.		
4.3.5.1.8	Provide a request for funding to include claims detail for CCH to review claims that are scheduled for payment.		
4.3.5.1.9	Fund claims disbursement account in amounts sufficient to cover the payments being made in each check release.		
4.3.5.1.10	Review eligibility file prior to loading into TPA MIS to reasonably ensure accuracy and completeness of data.		
4.3.5.1.11	Load valid membership into TPA MIS.		
4.3.5.1.12	TPA will reconcile membership to claims and identify exceptions for reporting will recover funds from network providers.		
4.3.5.2	**CLAIMS MANAGEMENT**		
4.3.5.2.1	Load authorized benefit plans and fee schedules and maintain them as changes are promulgated.		
4.3.5.2.2	Update fee schedules in MIS as required or deemed appropriate by CCH.		
4.3.5.2.3	Match claims to their referral or authorization, when required, and deny claims not properly authorized in accordance with standard TPA claim edits, and/or CCH referral and prior authorization policies.		
4.3.5.2.4	Create fee schedules within the claims system and process claims in accordance with CCH- defined fee schedules and payment methods.		
4.3.5.2.5	Provide monthly claim extracts to Blue Cross.		
4.3.5.2.6	Maintain copies, on paper or in electronic format, of claims and attachments submitted by providers.		
4.3.5.2.7	Issue timely claims payment with Explanation of Payment (EOP) or electronic remittance advice (ERA) to providers, subject to CCH timely funding claims payment accounts.		
4.3.5.2.8	Reprocess claims identified through retro-terms and retro-adds to recoup or pay claims whose payment changes based on the retroactivity.		
4.3.5.2.9	Process refund checks in accordance with CCH policy within the claims system so that the claim is properly reflected in the TPA system.		
4.3.5.3	**MEMBER & PROVIDER SERVICES**		
4.3.5.3.1	Load enrollment files.		
4.3.5.3.2	Maintain membership history and PCP assignment history in TPA MIS.		
4.3.5.3.3	Process updates of member demographic information - e.g. address changes or telephone number changes - and update the Member Eligibility system accordingly.		
4.3.5.4	**MEDICAL MANAGEMENT – UTILIZATION REVIEW**		
4.3.5.4.1	Maintain CCH's Medical Director and make Medical Director available to CCH for all medical management decisions.		

	FUNCTIONAL REQUIREMENTS	RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.5.4.2	Develop and maintain UM policies, protocols, procedures, and annual UM plan; TPA is responsible for administering policies, protocols, and procedures as indicated by annual UM plan.		
4.3.5.4.3	Determine services that will require referral and/or prior authorization.		
4.3.5.4.4	Implement systems, both computerized and manual as necessary, to handle utilization management, concurrent review, case management, and disease management functions. The processes shall at a minimum include:		
4.3.5.4.4.1	Conduct prior authorization processes in a timely manner as established by CCH		
4.3.5.4.4.2	Receive referrals for services defined by CCH, which services may change from time to time, via telephone, fax, online web entry, or other approved methodologies.		
4.3.5.4.4.3	Screen authorizations and referrals using criteria for medical necessity.		
4.3.5.4.4.4	Enter authorizations into TPA MIS and issue authorization numbers to providers and maintain history of authorizations by member and by provider.		
4.3.5.4.4.5	Perform concurrent review activities on inpatient admissions and document Level of Care authorizations.		
4.3.5.4.4.6	Coordinate and manage: 1) ongoing patient care, 2) discharge planning, 3) social services interfaces, 4) alternate level of care facilities, 5) member transfers to more appropriate facilities, and 6) non-par services.		
4.3.5.4.4.7	Maintain statistics on financial appeals.		
4.3.5.4.4.8	Maintain UM denials log in accordance with CCH requirements.		
4.3.5.4.4.9	Report monthly UM statistics to UM committee as required to manage medical services.		
4.3.5.4.4.10	Create a written UM Plan in partnership with CCH and consistent with policies of CCH to govern the activities of TPA nurses and staff.		
4.3.5.4.4.11	Alert CCH of out of network admission in accordance with coordinated, mutually agreed upon process		
4.3.5.4.4.12	Assist CCH in Complaints and Appeals resolutions by obtaining additional information at request of CCH or through providing further information from TPA' s UM criteria sets.		
4.3.5.4.4.13	Operate the Complaints, Grievances and Appeals program. TPA will support the appeals process by providing necessary information regarding utilization management decisions upon request.		
4.3.5.4.4.14	Conduct all activities assigned to CCH or TPA, pursuant to written policies and procedures that reasonably relate to Behavioral Health Services.		
4.3.5.4.4.15	Analyze behavioral health and substance abuse authorization data and report on trends.		

	FUNCTIONAL REQUIREMENTS	RESPONSE CODE (Y/D/M/T/N)	BIDDER COMMITS TO PROVIDING (Y/N)
4.3.5.4.4.16	Provide outbound data feeds to CCH's case management vendor, including claims, authorization, provider, and eligibility at an interval agreed upon by both parties.		
4.3.5.4.4.17	Provide reports, on schedules mutually agreed to between the parties, to analyze trends in utilization.		
4.3.5.4.4.18	Communicate Management Report data to CCH committees.		
4.3.5.4.4.19	Recommend utilization management guidelines related to concurrent, prospective and retrospective review.		
4.3.1.18	**GIVEAWAY MERCHANDISE**		
4.3.1.18.1	Purchase giveaway merchandise as instructed by HPS via MBE/WBE vendors.		
4.3.1.18.2	Store and ship giveaway merchandise as instructed by HPS.		

4.3.6 Innovation

4.3.6.1 Strategic Goals

HPS is seeking a third-party administrator that will provide innovative solutions to addressing the following strategic goals:

Strategic Goals:
Domain: Growth, Innovation, and Disruption (Grow to Serve and Compete)
1. Grow: Expand HPS products and populations to attain at least 450K members across all lines of business by the end of year 2022.
2. Retain: Achieve an enrollee retention rate of 92%.
Domain: Health Equity, Community Health and Integration
1. Improve demographics data for improved health programming to achieve 75% of member data includes with a race, language, address and phone numbers.
2. Launch a training and communication strategy to create a culture of health equity and non-bias.
3. Achieve NCQA Distinction in Multicultural Health Care by 2022
4. Decrease the number of members experiencing homelessness by at least 150 members.
5. Implement a supplier diversity program and achieve a Business Enterprise Program target of at least $20 million.
6. Employ ***innovative solutions*** including an on demand, instant transportation option to reduce transportation gaps for our members.
Domain: Optimization and Systemization
1. Improve member and provider experience (i.e. increase in clean claims adjudication, improved provider directory) with >90% clean provider data records.
2. Implement at least two new systems vendors to optimize member care management and workflows and increase member access to health care information.
Domain: Quality, Performance, and Improvement
1. Achieve at least one State target in each Pillar of the State's Quality Strategy.
2. Obtain 3.5 STAR rating for Part C, Part D and Overall STARS rating.
Domain: Patient (Member) Experience
1. Improve the member experience at all touchpoints resulting in an increase in satisfaction by 5% (Note: as measured by CAHPS and Provider Surveys)

Domain: Fiscal Resilience
1. Improve domestic spend: Increase overall domestic spend by 10%.
2. Reduce plan risk.
3. Be financially sustainable across all lines of business by proposing and collaborating on Medical Cost initiatives across the health plan.

The proposer should provide a response describing how they will address the above strategic goals using innovative solutions. This section shall not exceed four (4) pages.

4.3.6.2 Health Equity

The Illinois Department of Healthcare and Family Services aims to identify, evaluate, and reduce health disparities based on age, race, ethnicity, sex, primary language, and disability status and has developed the following new goals for its Quality Strategy to focus improvement efforts on the reduction of health disparities: 1. Identify and prioritize reducing health disparities. 2. Implement evidence-based interventions to reduce disparities. 3. Invest in the development and use of health equity performance measures. 4. Incentivize the reduction of health disparities and achievement of health equity.

As the flagship of the health care safety net for metropolitan Chicago, HPS is uniquely positioned to address health disparities and their impact on health and health care access. HPS is seeking a third-party administrator that will employ ***innovative solutions*** to identify and reduce disparities. HPS will require the selected TPA to, at minimum, provide the following services to support HPS equity initiatives:

1) Have a dedicated health equity individual for HPS

2) Utilize analytics to identify disparities among communities to assist in identification and intervention development

The proposer's response should not exceed one (1) page.

4.3.6.3 Quality Pillars

In Illinois, future Medicaid quality improvement activities will address improving services and health outcomes within the five population-focused pillars measured through an equity lens: (1) adult behavioral health, (2) children's behavioral health, (3) maternal and child health, (4) improving opportunities for people to be treated in their communities, and (5) improving health equities around breast cancer, cervical cancer screenings, high blood pressure, and access to primary care.

HFS' performance and improvement staff members actively work with Illinois' contracted health plans in order to understand their approaches to quality, identify additional areas for improvement, and spread best practices. HFS will continue to actively support its contracted health plans in the pursuit of quality by fostering opportunities for learning and collaboration, providing coaching resources for quality improvement activities, and providing a clear vision for improving the care of Illinoisans.

HPS is looking for a third-party administrator that will provide ***innovative solutions*** to addressing the aforementioned pillars. The proposer should provide their responses to the below pillars and P4P Measures that HPS is focusing on for HEDIS MY 2021 and beyond. This section shall not exceed three (3) pages.

Measure Abbreviation	P4P Measures
Aim: Better Care	
Pillar: Adult Behavioral Health	
FUH	1. Follow-Up After Hospitalization for Mental Illness: 7-Day

FUA	2. Follow-Up After Hospitalization for Mental Illness: 30-Day
	3. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: 7 day
	4. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: 30 day
Pillar: Child Behavioral Health	
FUH	1. Follow-Up After Hospitalization for Mental Illness: 7-Day (6-17 years of age)
	2. Follow-Up After Hospitalization for Mental Illness: 30-Day (6-17 years of age)
FUM	3. Follow-Up After Emergency Department Visit for Mental Illness:7-day (6-17 years of age)
	4. Follow-Up After Emergency Department Visit for Mental Illness: 30-day (6-17 years of age)
Pillar: Maternal and Child Health	
PPC	1. Prenatal and Postpartum Care: Timeliness of Prenatal Care
	2. Prenatal and Postpartum Care: Postpartum Care
CIS	3. Childhood Immunization Status (Combo 3) - (CIS)
Aim: Healthy People/Healthy Communities	
Pillar: Equity	
BCS	1. Breast Cancer Screening
CCS	2. Cervical Cancer Screening
CBP	3. Controlling High Blood Pressure
AAP	4. Adults' Access to Preventive/Ambulatory Health Services

4.3.6.4 Implementation

Proposer must outline their implementation plan for all lines of business outlined in this RFP. Implementation plans must at a minimum include business owners, descriptions of actions taken to implement, estimated timeframes for completion.

5. Required Proposal Content

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 guidelines are not intended to stifle the creativity of any proposer response.

This RFP also contains the instructions governing the submittal 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 in order 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 Confidential or are copyrighted. All proposals submitted to CCH are the property of CCH.

Further, the 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 the proposer is not prepared to commit contractually. The information contained in the proposal shall be organized as described in this section.

5.1 Executive Summary/Cover Letter

Please limit this to one page. The cover letter shall be signed by an authorized representative of the proposer. The letter shall indicate the proposer's commitment to provide the services proposed at the price and schedule. Do not forget to sign your cover letter.

5.2 Response to Scope of Services

Please insert your response to the Scope of Services, Section 5 in this section.

5.3 Proposer's Profile and Track Record

Proposer must include a ***description*** of the organization's track record as follows:

Company Profile	Response
a. Legal Name	
b. Assumed Names if any	
c. Legal Structure (e.g. sole proprietor, partnership, corporation, joint venture)	
d. If a subsidiary, provide the same RFP about the Parent Company as required in this table format.	
e. Date and State where formed.	
f. Proposer's principals/officers including President, Chairman, Vice Presidents, Secretary, Chief Operating Officer, Chief Financial Officer, and related contact RFP.	
g. Point of contact for this RFP including contact information	
h. Proposer Business background and description of current operations	
i. Number of employees	
j. Number of years in business	
k. Total number of years providing the proposed services	
l. Is Proposer a licensed business to perform the work in scope? If so, please specify relevant certifications.	
m. Proposer's Federal Employee Identification Number (or Social Security Number, if a sole proprietorship)	
n. Is proposer authorized to conduct business in Illinois? Provide Registration Number issued by the Illinois Secretary of State, a copy of the Certificate of Good Standing, and include Cook County Assumed Business Name Certificate, if applicable.	
Product Portfolio	**Response**
a. Total current customers:	
b. Percent of customers across various products:	
c. Total membership supported by your products/services:	
d. Percent of total membership supported across product/service lines:	
e. Lines of Business supported by your products/services:	

5.4Key Personnel

5.6.1 Provide a table with the following information:
- 5.6.1.1 Proposed project resources
- 5.6.1.2 Roles
- 5.6.1.3 High level skills (project alignment)
- 5.6.1.4 Proposed work location for each resource (onsite/offsite)
- 5.6.1.5 Time commitment to the project if awarded

5.6.2 Describe internal standards, policies and procedures regarding hiring, training and professional development.

5.6.3 Provide copies of each associates current job description

The Chief Procurement Officer reserves the right to reject any key personnel proposed if it is determined not to be in CCH's best interest. The evaluation of proposals includes the qualifications of the personnel proposed; therefore, proposers must name key personnel as part of their response. Key Personnel must not be replaced during the project without the approval of the Chief Procurement Officer.

5.5 MBE/WBE Participation

The Proposer may be comprised of one or more firms as to assure the overall success of the project. The proposer must present a team chart that clearly identifies each team member and specify their role in the project (this should be more detailed than the information provided in the executive summary). For each subcontractor, provide the name of the firm(s), brief company background, level of participation, MBE or WBE if applicable, the type of services each resource, from each firm, will provide. For each MBE/WBE certified firm proposed, provide the appropriate information in the Economic Disclosure Statement Forms (in a separate envelop).

The Chief Procurement Officer reserves the right to accept or reject any of the team members if in The Chief Procurement Officer's sole opinion replacement of the team member, based on skills and knowledge, is in the best interest of the County. Consistent with Cook County, Illinois Code of Ordinances (Article IV, Division 8, and Section 34-267), and 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 participation for this specific contract is **35% MBE/WBE participation.**

The Proposer shall make good faith efforts to utilize MBE/WBE certified firms as subcontractors. In the event that the Proposer does not meet the MBE/WBE participation goal stated by CCH for this procurement, the proposer must nonetheless 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 the 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 the proposer to provide the required documentation or otherwise demonstrate good faith efforts will be taken into consideration by CCH in its evaluation of the proposer's responsibility and responsiveness.

5.6 Cost Proposal

Proposers must submit the attached pricing workbook, **Attachment A, PBM Financial Workbook**, in a separate sealed envelope clearly marked with the RFP number and the label "Pricing RFP." Proposers are required to submit one (1) paper copy (original) and one (1) electronic copy emailed to the email addresses specified on the cover page)**.** The workbook must be filled out completely. Failure to complete each tab and each requested item may result in disqualification. Each tab contains its own set of instructions for the Proposer to follow.

The pricing information must include any supplemental options or schedules offered by the proposer. All pricing ***must include all assumptions*** to facilitate Analysis. Proposers should include elements or references to the pricing RFP **only in this section and separate the pricing RFP according to the Instructions above**.

Summarize all costs using the workbook and show a clear breakdown of all itemized costs. All costs must be accounted for.

CCH makes no guarantee that the services or products identified in this RFP will be required. The 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 the proposer, nor to enter into an agreement with any one proposer.

5.7 Financial Status

A. Provide the audited summary financial statements for the last two fiscal years. State whether the 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.
B. Provide a copy of an independent report showing the financial condition of your company (e.g., Dun & Bradstreet).
C. State whether the proposer or its parent company has ever received any sanctions or is currently under investigation by any regulatory or governmental body.

5.8 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.

If no conflicts of interest are identified, simply state "[Company X] has no conflict of interest."

5.9 Contract

A representative Master Services Agreement is attached to this RFP, **Attachment B, CCH Master Services Agreement**. CCH reserves the right to make modifications to its form agreement during contract negotiations. Execution of the Contract is not required at the time the qualifications are submitted. However, Proposer's redlined response to the CCH Master Services Agreement is required at the time of RFP submission. Proposer's response to the Master Services Agreement will be considered during the selection process. CCH will not consider any exceptions or proposed alternate language to the Contract General Terms and Conditions 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 possible Contract. CCH acknowledges that the Master Services Agreement may not address all substantive legal requirements applicable to PBM contracts. Proposer should, as part of its redlined response include as proposed Exhibits to the Master Services Agreement any additional terms and conditions it wishes CCH to consider. To the extent that those proposed Exhibits conflict with the terms in the Master Services Agreement, appropriate changes

to the Master Services Agreement must be redlined. Changing the Order of Precedence is not permitted. NOTE: Please do not renumber the template document. If a Proposer believes that an entire provision is inapplicable to its business, CCH Requests that Proposers "[Reserve]" such section and provide appropriate comment in support of that position in a comment box. **All responses must be provided in a Microsoft Word compatible format with redline.** Contract responses must be printed with the Proposer's RFP response and submitted per the instructions in section 8.3 to: purchasing@cookcountyhhs.org.

5.10 Legal Actions

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

If no Legal actions are identified, simply state "[Company X] has no pending legal actions in which our firm will experience any significant impact to this Contract."

History of Legal Actions for the last 36 months:

Action	Date

5.11 Confidentiality of Information

The Selected proposer may have access to confidential RFP, including Protected Health Information (PHI) to perform the functions, activities, or services for, or on behalf of, CCH as specified in this RFP. The 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 shall sign a Business Associate Agreement with CCH on CCH's standard Business Associate Agreement form. 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, the Medicaid Confidentiality Regulations, as defined herein, and all other applicable rules and regulations. The proposer must commit to require 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 the selected proposer to use HIPAA materials or training sessions supplied by CCH.

5.12 Economic Disclosure Statement

Execute and submit the Economic Disclosure Statement ("EDS"). The EDS form can be found at https://cookcountyhealth.org/about/doing-business-with-cook-county-health/. The EDS must be submitted with the pricing proposal in a separate envelope.

5.13 Security Questionnaire

The Proposer must complete the Security Questionnaire in **Attachment C**. The Security Questionnaire allows Cook County Health to determine the level of risk the organization may be assuming by engaging with a vendor or partner and to make suggestions to improve security practices and enhance the service provided. The Proposer must include the completed Security Questionnaire with the RFP response.

5.14 Addenda

Since all Addenda become a part of the proposal, all Addenda must be signed by an authorized proposer representative and returned with the proposal. Failure to sign and return any and all Addenda acknowledgements shall be grounds for rejection of the proposal. Addenda issued prior to the proposal due date shall be made available via Cook County Health website: http://www.cookcountyhealth.org/about-Cook County Health/doing-business-with-Cook County Health/

6 Evaluation and Selection Process

An Evaluation Committee comprised of the CCH and County personnel will evaluate all responsive Proposals in accordance with the selection process detailed below.

6.1 Proposal Assessment

The Evaluation Committee will review all Submittals to ascertain that they are responsive to all submission requirements.

6.1.1 Proposal Evaluation

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. CCH will evaluate the Proposals to establish a list of qualified Proposer for Shortlist.

6.1.2 Shortlist Proposer Presentation

The Evaluation Committee, at its option, may invite one or more proposers to make presentations and/or demonstrations. The Evaluation Committee may request that all or a shortlisted group of proposers engage in proactive pricing feedback, submit clarifications, schedule a site visit of their premises (as appropriate), provide additional references, respond to questions, or consider alternative approaches.

6.1.3 System Demonstrations

Bidders will be requested to perform or display a number of scenarios during the demonstration designed to test key processes, test vendor responses to the RFP and provide vendors a forum to display their product functionality. Some scenarios will be provided to the Bidder no later than one (1) week prior to the demonstration being scheduled. Vendors will be invited to select their demonstration date in the order that RFP's were received, such that the vendor who submits their RFP first selects their demo date first and so on. Demonstrations will also be conducted to determine application integration. Bidders will receive adequate notification to prepare for the demonstration of scenarios. Bidder demonstrations must be performed only with software products that are currently available on the market. If the Bidder is demonstrating different distinct applications as part of the overall solution, the integration of the various components must also be currently available. Bidder demonstrations must not be a Power Point presentation or other presentation application; rather, Bidders must show actual screen functionality and features in real time.

6.1.4 Site Visits/Reference Calls

HPS may request a reference site visit and/or conference call with an existing client utilizing the proposed system(s). Bidders are requested to provide three (3) current clients for potential site visits and/or reference calls that have been live on the proposed product as well as one (1) that is engaged in the implementation of the product for at least one (1) year from this RFP date. The third reference is at the discretion of the Bidder. These clients should match the profile of HPS in terms of

membership volume, population, and strategic direction. Those vendors that do not provide references will be disqualified from further consideration.

6.2 Right to Inspect

CCH reserves the right to inspect and investigate thoroughly the establishment, facilities, equipment, business reputation, and other qualification of the 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 the 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.

6.3 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 Board. 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.

7 Evaluation Criteria

7.1 Responsiveness of Proposal

The Proposal(s) will be reviewed for compliance with and adherence to all submittal requirements requested in this RFP. Proposal(s) which 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 Proposal in accordance with the evaluation criteria detailed below.

7.1.1 Criteria Proposal

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

7.1.1.1 Ability to achieve the CCH's business goals, objectives, and Scope of Work described in this RFP, by providing a succinct and feasible description of the proposed implementation approach.

7.1.1.2 Qualifications and experience of the 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.

7.1.1.3 Relevant Experience

7.1.1.4 Reasonableness of Overall Price

7.1.1.5 Price will be evaluated separately for overall reasonableness and competitiveness.

7.1.2 In addition, the Evaluation Committee may review and consider the information and evidence Proposer's responsiveness to the following categories:

7.1.2.1 MWBE Utilization Plan (EDS forms);
7.1.2.2 Financial Status;
7.1.2.3 Conflict Interest;
7.1.2.4 Insurance Requirements;
7.1.2.5 Redlined Response to the CCH General Terms and Conditions as represented in the attached Master Services Agreement (willingness to work on this template, comply with CCH terms, demonstration of appropriate redlining and submission of Proposer Exhibits);
7.1.2.6 Legal Actions;
7.1.2.7 Addenda acknowledgement (See Addenda Section)

8 Instructions to Proposers

These instructions to proposers contain important RFP and should be reviewed carefully prior to submitting the Required RFP Content. Failure to adhere to the procedures set forth in these instructions, failure to provide positive acknowledgement that the proposers will provide all services and products or failure to provide acceptable alternatives to the specified requirements may lead to disqualification of the submitted RFP.

8.1 Questions and Inquiries

Questions regarding this RFP will be submitted in writing to the contact(s) email listed on the cover page of this RFP no later than the date stated in the Schedule.

Question must be submitted in the following format**, in MS Excel**, and the subject of the email should reference the RFP#, Title and Proposer's Name.

ID	Vendor Name	RFP Section	Question
1.			
2.			
3.			

Should any proposer have questions concerning conditions and specifications, or find discrepancies in or omissions in the specifications, or be in doubt as to their meaning, they should notify the Supply Chain Management Office via the email provided on the cover sheet no later than the date stated on the Schedule and obtain clarification prior to submitting a RFP. Such inquires must reference the RFP due date and CCH RFP number.

8.2 Number of Copies

Proposers are required to submit one (1) original hard copy, and one (1) electronic copy (emailed to the email addressed on the cover page) and no later than the time and date indicated in the RFP.

NOTE: One (1) paper copy of the pricing proposal and one (1) EDS copy must be submitted separate from the rest of the response.

Each submission must then be separated as follows:

1. One (1) technical hard copy - the original - excluding Pricing and EDS forms;
2. One (1) Pricing and EDS hard copies in a separate envelope;

3. One (1) complete electronic response package (including excel pricing file and EDS) emailed to the email addresses on the cover page. The technical response must be a single electronic file (do not submit a file per RFP section). The email must clearly indicate the RFP Number and Title.

Please see the Proposal Receipt Acknowledgement form at the end of this file for the form required at delivery time.

8.3 Format

Hardcopies of the RFPs should be submitted in a separate envelop (or electronic file) except pricing which may be submitted in a separate envelop. Material should be organized following the order of the Required RFP Content Section separated by **labeled tabs**. Expensive paper and bindings are discouraged since no materials will be returned. **Numbered titles and pages are required**.

CCH reserves the right to waive minor variances.

8.4 Time for submission

RFP shall be submitted no later than the date and time indicated on the cover page of this RFP. **Late submittals will not be considered.**

8.5 Packaging and Labeling

The outside wrapping/envelope shall clearly indicate the RFP title, proposer's Name, proposers address, and point of contact RFP. **The Price RFP and EDS shall be submitted in a separate sealed envelope.** The envelope shall clearly identify the content as "Price RFP". All other submission requirements shall be included with the Technical RFP.

8.6 Timely delivery of RFP

The RFP(s) must be either delivered by hand or sent to CCH through U.S. Mail or other available courier services to the address shown on the cover sheet of this RFP. Include the RFP number on any package delivered or sent to CCH and on any correspondence related to the RFP. If using an express delivery service, the package must be delivered to the designated building and drop box. Packages delivered by express mail services to other locations might not be re-delivered in time to be considered. CCH assumes no responsibility for any RFP not so received.

8.7 Availability of Documents

CCH publishes competitive bid, RFP, and other procurement notices, as well as award RFP, at www.CookCountyheath.org under the "Doing Business with CCH" tab. Proposers intending to respond to any posted solicitation are encouraged to visit the web site above to ensure that they have received a complete and current set of documents.

8.8 Alteration/Modification of Original Documents

The 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 alternates 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.

8.9 Cost of Proposer Response

All costs and expenses in responding to this RFP shall be borne solely by the proposer regardless of whether the 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 the proposer's responsibility.

8.10 Proposer's Responsibility for Services Proposed

The proposer must thoroughly examine and read the entire RFP document. Failure of proposers fully to 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.

8.11 RFP Interpretation

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

8.12 Specifications and Special Conditions

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

8.13 Errors and Omissions

The 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 the proposer suspect any error, omission, or discrepancy in the specifications or instructions, the proposer shall immediately notify CCH in writing, and CCH will issue written corrections or clarifications. The 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 reasonably discovered by the proposer in the process of putting the RFP together.

8.14 Proposal Material

The material submitted in response to the RFP becomes the property of CCH upon delivery to the Supply Chain Management Office and may become part of a Contract.

8.15 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 in the near future. Following such actions, the contents of RFP submitted in response to this RFP may be disclosed in response to requests made pursuant to the provisions of the Illinois Freedom of Information Act ("FOIA"). If a proposer wishes to preserve the confidentiality of specific proprietary information set forth in its RFP, it must request that the RFP be withheld by specifically identifying such information as proprietary in its RFP. CCH shall have the right to determine whether it shall withhold RFP upon receipt of a FOIA request, and if it does so pursuant to a proposer request, the proposer requesting confidential treatment of the RFP shall bear the costs of asserting that there is a proper exemption justifying the withholding of such information as proprietary in any court proceeding which may result. This notwithstanding, proposer is on notice that the CCH is subject to the FOIA and that any documents submitted to the CCH by the proposer may be released pursuant to a request under the FOIA.

8.16 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 so stated in the proposal.

8.17 CCH Rights

CCH reserves the right to reject any and all offers, to waive any informality in the offers and, unless otherwise specified by the 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.

8.19 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.

9 Definitions

Definitions not otherwise defined in this RFP are defined in the Master Service Agreement, including all of its Addenda, Attachments, Schedules, or Exhibits.

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

“Appeal” means a request for review of a decision made by proposer with respect to an Action, he is following definitions shall apply to this RFP:

"Addendum” or “Addenda" shall refer to a one or more documents posted to the website by which modifies this Request for Proposal or provides additional information.

“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 of 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 HPS.

"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 into as a result 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 mean the terms and conditions in the CCH Master Services Agreement attached to this RFP.

"**Procurement Director**" or “System SCM Director” shall mean the System Director of Supply Chain Management who serves as chief procurement officer for the CCH.

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

"**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 HPS that may lead to the negotiation of a Contract

10 Appendix A – RFP Receipt Acknowledgement Form

RFP Receipt Acknowledgement Form

This acknowledgement of receipt should be signed by a representative of Supply Chain Management located at Stroger Hospital, 1969 W. Ogden Avenue, lower level (LL) Room 250A, Chicago IL, 60612.

The outside wrapping shall clearly indicate the RFP Number and Title, Proposer's Name, Proposers Address, and Point of Contact RFP. **Prefill the first two lines prior to submission**.

Solicitation Number and Title:		
Vendor Name:		
Accepted By:		
Date:		
Time (if time machine is not available, hand write the time):	A.M	P.M

RFP shall be submitted no later than the date and time indicated on the cover page of the RFP. **Late submittals will not be considered. Proposers must cut this sheet in two. SCM will time-stamp top and bottom sections. SCM will keep one section and the proposer will keep the other section.**

Time Stamp Here

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Time Stamp Here

11 List of Attachments

The following Attachments are included electronically to this RFP.

Proposer(s) may access the following attachments by 1) download and save this RFP file to a local drive and 2) open the RFP document using Adobe application, 3) expand the navigation pane (left of window) and click on the paper-clip icon.

1. **Attachment A – TPA Financial Workbook**
   Proposer(s) must complete the Financial Workbook in the file named ***H21-0040_TPA_Financial-Workbook.xlsx***. The workbook must be filled out completely. Failure to complete each tab and each requested item may result in disqualification.

2. **Attachment B – CCH Master Services Agreement**
   Proposer(s) may review a representative Master Services Agreement, *file name* ***CCH_Master-Service-Agreement_091521.docx***. Proposer's redlined response to the CCH Master Services Agreement is required at the time of RFP submission. All responses to the Master Services Agreement must be submitted in a Microsoft Word compatible format with redline and included in electronic form as a separate file with the Proposal.

3. **Attachment C – Security Questionnaire**
   The Proposer must complete the Security Questionnaire in the file, ***CCH_Information-Security-Questionnaire.xlsx***. Proposer(s) must include the completed Security Questionnaire with the RFP response.