Questions and Answers
Medicare-Medicaid Financial Alignment Initiative RFP
As of June 6, 2012

| | Submitted By | Question | Response |
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| | | **Waiver-Specific** | |
| 1 | Esther M. Izaguirre Family Health Network, Inc | CCAI is familiar with the co-employer arrangement currently in place that has the individual patient/client and the State jointly employing personal assistants. Please explain the implications for health plans and individual consumers if the State contracts with a single vendor that all Contractors would pay based on the workload of their Personal Assistants as described in paragraph 3.1.1.3.4.2? Specifically, would the consumers continue to be co-employers of the personal assistants as they are now? And how would SEIU's role change, if at all? | Yes, consumers would still be co-employers. SEIU's role will not change. Plans would be responsible for paying their share of the functions of the fiscal vendor. |
| 2 | Esther M. Izaguirre Family Health Network, Inc | For beneficiaries enrolled in a Plan, will the State still serve as a co-employer as described in paragraph 3.1.2.10.3? | Yes |
| 3 | Kristen Krzyzewski HealthSpring, Inc. | RFP Attachment C – Home and Community Based Services – lists services for 4 waivers:<br>• Persons who are Elderly<br>• Persons with Disabilities<br>• Persons with HIV/AIDS<br>• Persons with Brain Injury<br><br>Should we disregard the 4/26/2012 update that indicated 5 waiver programs were going to be covered in this program, including the 4 named above, plus Persons residing in Supportive Living Facilities? Please confirm that Persons residing in Supportive Living Facilities in excluded from the MMAI. | Plans should consider the most recent information released to be the prevailing standard. Therefore the 04/26/12 update regarding the 5 waivers is the correct information. Persons residing in Supportive Living Facilities are included in MMAI. This program was listed as a service in Attachment C. See revised Attachment C on the HFS website. |
| 4 | Elissa Silber Proposal Manager Aetna | P.17 Paragraph 3.1.1.3.4.2 "Enrollees will be the co-employer of Personal Assistants with support from Plans and a fiscal vendor for timekeeping and related issues. The State is exploring – and believes there is merit in – contracting with a single vendor that all Contractors would pay based on the workload of their Personal Assistants." Will the Contractor have a role in making the decision about this vendor? Our experience is that the effectiveness of the vendor will be critical in the success of this program. | The Department anticipates that Plans will have a role in selecting the fiscal vendor. It is our hope to work out one selection process with all Plans involved. |

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|  |  | **MCCN** |  |
| 5 | Esther M. Izaguirre Family Health Network, Inc | When will the department have the MCCN application available for new MCCN? | The Proposed Rules for Managed Care Community Networks - General Provisions and Financial Requirements – has been posted on the HFS website. |
| 6 | Elissa Silber Proposal Manager Aetna | P.7 Paragraph 1.18.68 "Managed Care Community Network (MCCN): An entity, other than a HMO, that is owned, operated, or governed by Providers of health services in Illinois and that provides or arranges primary, secondary and tertiary managed health care services under contract with the Department exclusively to persons participating in programs administered by the Department." Will HMOs and MCCNs be governed by the same administrative, contracting, licensing, evaluation, assignment of members, capitation payment, capital reserves and reporting requirements?<br><br>For instance, according to 3.1.1.3.1.3 HMOs are required to cover this entire Contracting Area (Greater Chicago Area only) but MCCNs may cover this entire Contracting Area or a portion of the Contracting Area on a county-wide basis.<br><br>Will MCCNs be given preference in contract award?<br><br>Will MCCNs be required to meet the same requirements as an HMO in completing a CMS application through HPMS, including meeting CMS requirement to submit a non-binding Notice of Intent to Apply (NOIA) for the CMS 2013 Capitated Financial Alignment Demonstration Plan according to the specifications in the January 25, 2012 memo, "Guidance for Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans" by April 2, 2012? | MCCNs will operate exactly like an HMO in the counties they are contracted to serve, including requirements of CMS through the HPMS. The only difference will be that on a state basis, they are certified and regulated by the Department of Healthcare and Family Services, not the Department of Insurance.<br><br>MCCNs will not be given preference in contract award. |
| 7 | Elissa Silber Proposal Manager Aetna | P.15 Paragraph 3.1.1 "The State is seeking the services of up to five (5), and at least two (2), qualified, experienced and financially sound Plans to enter into risk-based contracts for the Medicare-Medicaid Alignment Initiative, to provide the full spectrum of Medicare and Medicaid Covered Services through an integrated care delivery system to Seniors and Adults with Disabilities who are enrolled in Medicare Parts A and B, and Medicaid (full-benefit)." Does the number of Plans (up to five (5), and at least two (2)) include contracts to MCCNs? If yes, how will MCCNs be determined "qualified, experienced and financially sound"? | Yes, the definition of Plans includes an HMO or an MCCN. MCCNs will be evaluated based on their RFP response and the MCCN application they are required to submit. |

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| | | **Proposal Requirements** | |
| 8 | Esther M. Izaguirre Family Health Network, Inc | If an applicant is bidding for both regions, can it submit just one set of proposals? (For example, 14 copies instead of 28)? | No |
| 9 | Kristen Krzyzewski HealthSpring, Inc. | Section 1.4 regarding Number of Copies requests one (1) signed original and fourteen (14) copies of the Proposal in a sealed container.<br><br>Are they required to be all together in 1 sealed container or can they be in multiple sealed containers (as long as the appropriate number is provided)? | The submission can consist of multiple sealed containers. |
| 10 | Kristen Krzyzewski HealthSpring, Inc. | Many of Illinois' Clinical Model Requirements are either the same as those required by CMS or the requirements fit nicely within CMS' 11 Element Model of Care framework. However, during the Training call on April 11th, CMS's Dr. Davenport advised to include all State Requirements at the end of the Model of Care in a separate "Element 12." Should we follow Dr. Davenport's advice and add an "Element 12" to the Model of Care for all of Illinois's requirements or use this element for only those requirements that do not fit within CMS' 11 Element Model of Care framework? If the latter, should we highlight or "call out" IL's requirements throughout the Model of Care using a different color of text or some other format? | The State is not requiring Plans to submit a unified model of care through HPMS. In the RFP, Plans should respond fully to all questions that overlap with CMS' model of care requirements. |
| 11 | Kristen Krzyzewski HealthSpring, Inc. | Our question is in regard to the following section and reference highlighted at the end:<br><br>"1.4 NUMBER OF COPIES: You must submit one (1) signed original and fourteen (14) copies of the Proposal in a sealed container. In addition, you must submit one (1) copy of the Proposal on CD in the following format: Microsoft Word and/or Excel and two (2) copies of the file on CD requested in Section 3.2.2.13."<br><br>Section 3.2.2.13 requests maps while Section 3.2.2.12 requests the CD of the Provider network listing.<br><br>Qtn: Does Section 1.4 intend to refer to 3.2.2.12 INSTEAD, or BOTH 3.2.2.12 AND 3.2.2.13? We're not sure whether to include the 3.2.2.13 maps in the print copy of our proposal, just the CD, or both. Please clarify. | It should have read, "You must submit one (1) copy of the Proposal on CD in the following format: Microsoft Word and/or Excel and two (2) copies of the file on CD requested in 3.2.2.12 (provider network listing). Do not include maps on the CD. |
| 12 | Elissa Silber Proposal Manager Aetna | P.2 Paragraph 1.4 "Proposals must be no longer than 500 pages, one-sided, on 8.5" by 11" size paper (spreadsheets may be on larger size paper), with one (1) inch margins, and no smaller than eleven (11) point font." This section indicates that the font size within submitted proposals be no smaller than eleven (11) point font. Is this requirement true of text within tables? | Fonts within tables may be a different font, as long as it is clear and easily readable. |

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| 13 | Elissa Silber Proposal Manager Aetna | P.2 & 27 Paragraph 1.4 and 3.2.2.12 "provide a CD listing of your network of Providers that are not included in HPMS, including health centers, behavioral health providers, dentists, including oral surgeons, Nursing Facilities, and Providers of LTSS. Include in this listing an analysis that demonstrates network adequacy of those Providers. If you subcontract for Case Management services, list other provider types you are contracting with. Indicate your level of commitment by describing your agreements, i.e. letter of intent, pending contract, contract. The data must be submitted in a Microsoft Excel file format including the following fields" 3.2.2.12 advises to provide this in Excel. Does the state want two CDs of 3.2.2.13 and one CD of 3.2.2.12 or two CDs that include both responses? | See response to Question #11. |
| 14 | Elissa Silber Proposal Manager Aetna | P.2 & 28 Paragraph 1.4 and 3.2.2.13 "1.4 ...and two (2) copies of the file on CD requested in Section 3.2.2.13. 3.2.2.13 Provide distinct maps indicating the distribution of all Medicare and Medicaid Providers, including PCPs, medical homes, specialist, hospitals, behavioral health Providers, dentists, oral surgeons, Nursing Facilities, Providers of LTSS, and other Providers available in the Contracting Area." Please clarify whether the maps requested in Section 3.2.2.13 are required in hard copy in addition to the required two copies of the file on CD. | See response to Question #11. |
| 15 | Elissa Silber Proposal Manager Aetna | P.24 Paragraph 3.2.1.1; 3.2.1.1.1; and 3.2.1.1.2 "3.2.1.1 Discuss the history and ownership of your organization.<br>3.2.1.1.1 Include your experience in providing managed care in general, and specifically your experience providing the services that are proposed for this or similar populations.<br>3.2.1.1.2 Explain your qualifications to respond to this RFP. Include accreditations, certifications and recognitions achieved, e.g., NCQA Health Plan Accreditation.<br>3.2.1.1 Describe your experience with implementing and using evidence-based practices, including which evidence-based practices you employ, an outline of specific goals and benchmarks, outreach strategies and sample materials, and your successes and challenges with improving outcomes for operating the following:<br>3.2.1.1.1 Disease Management Programs;<br>3.2.1.1.2 Care Coordination and Care Management programs for Chronic Health Conditions (including end-stage renal disease (ESRD)), Behavioral Health conditions, and those with SMI, substance abuse, and Developmental Disabilities;" In reviewing the RFP, we noted that Section numbers 3.2.1.1; 3.2.1.1.1; and 3.2.1.1.2 are duplicated in error, but with different questions asked in relation to each (please see column D). Will this apparent error in numbering be corrected via an RFP Addendum, or should Offerors simply repeat these Section numbers in its proposal with the appropriate respective questions as currently indicated in the RFP? | The Department apologizes for the error in numbering. To avoid confusion with re-numbering the RFP, the Department is asking Plans to use the Section numbers given and repeat in each of those first two sections the question that is being answered. |

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| 16 | Elissa Silber Proposal Manager Aetna | P.34 Paragraph 3.5.3 “Please list: (i) your most recent three years of HEDIS results; (ii) all sanctions, penalties and corrective action plans relating to all Medicaid plans you operate in any state and all Medicare Advantage plans you operate in any state taken in the last five years, including information about the reason for the corrective action plan and the resolution; and, (iii) CMS’ past performance analysis for the most recent calendar year.” In response to part (i), is the Offeror to submit HEDIS results on all States where the Offeror has Medicare and Medicaid business? Does the last sentence of this Section 3.5.3 include plans administered by Offeror's parent organization, subsidiaries, and related organizations? Also would it be acceptable for an offeror to include the requested information 3.5.3(i) HEDIS information electronically only or is offeror required to submit it in hardcopy? | Yes, the last sentence includes plans operated by the parent organization, subsidiaries and related organizations. The audit review table is sufficient for results and should be included in the hard copy. |
| 17 | Kristen Krzyzewski HealthSpring, Inc. | In regard to the HEDIS results request in section 3.5.3 of the RFP, HEDIS submissions are very lengthy and for plans that have many contracts at the parent and subsidiary level, this request alone will exceed to 500 page limit for the entire proposal.<br><br>Will submission of the 1-page “Audit Review Table” from the NCQA IDSS template be sufficient level of information for each of our contracts? Can this information be provided on CD only and/or be excluded from the proposal page count?<br><br>Is there a maximum number of contracts for which you wish to review HEDIS submissions? If so, we can prioritize and include only the most relevant contracts related to the MMAI. | Yes, the audit review table (ART) is acceptable. Please submit the ART for your plan’s past three years of HEDIS results.<br><br>No, there is no maximum number of contracts. |
| | | **Population** | |
| 18 | Kristen Krzyzewski HealthSpring, Inc. | Are Institutions for Mental Disease (IMD) Service for Individuals 65 and over included as a covered Medicaid service in this program? | Institutions for Mental Disease are included as a covered service for the entire demonstration population. |

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| 19 | Elissa Silber Proposal Manager Aetna | P. 19 Paragraph 3.1.1.3.7.4 & 3.1.1.3.7.4.2 "Excluded Populations.<br><br>1) Participants who have a Developmental Disability and who receive services in an institutional setting or through a HCBS waiver" To avoid confusion, if DD members are excluded should the definition of Institutionalization (see 1.18.63) be amended to exclude ICF/DD settings?<br><br>Also (again to avoid confusion) should the definition of Intermediate Care Facility for the Developmentally Disabled (ICF/DD) (see 1.18.66) be deleted from the RFP?<br><br>As well as deleted from ACRONYMS (see 1.19) at 1.19.39?<br><br>Also (again to avoid confusion) should ICF/DD be deleted from section 3.1.2.8 (Pre-Admission Screening of Waiver Participants) which reads: "Federal law, 42 CFR Section 441.301(b)(1), requires that Home and Community-Based Services provided through Title XIX Medicaid waivers be provided only to individuals who would otherwise require services at a level of care in a Medicaid certified institution, specifically a hospital, nursing facility, or Intermediate Care Facility for the Developmentally Disabled (ICF/DD). In order to comply with the regulation, an assessment must be conducted and a determination must be made indicating that an individual would need services at an institutional level of care, whether it is a hospital, nursing facility, or ICF/DD; if the waiver was not otherwise available." [Emphasis added] Also (again in the interest of avoiding confusion) should reference to ICF/DD be deleted from the Model Contract, Appendix _, Quality Assurance, "n" (details its processes for determining and facilitating Enrollees needing nursing home, supportive living facility (SLF) or ICF/DD level of care, or to live in the community with HCBS supports). [Emphasis added]<br><br>There may be other references to ICF/DD that we missed, but can we assume that all references to ICF/DD should be removed from this RFP? | Yes, individuals who have a Developmental Disability and who receive services in an institutional setting or through a HCBS waiver are not included in the demonstration. Any reference to Intermediate Care Facility for the Developmentally Disabled (ICF/DD) does not apply to the operation of the MMAI. |
| 20 | Elissa Silber Proposal Manager Aetna | P.19 Paragraph 3.1.1.3.7.4 "Excluded Populations" Under Medicare Advantage, individuals with ESRD are not eligible to enroll in Medicare Advantage plans. Since CMS is regulating this Demonstration under Medicare Advantage, would you confirm whether or not individuals with ESRD will be eligible to enroll in this plan? | TBD |
| 21 | Elissa Silber Proposal Manager Aetna | P.20 Paragraph 3.1.2.5.1 "State-operated hospitals (SOHs) with acute civil units provide inpatient treatment to individuals who are eighteen years of age or older. Individuals served include those persons with Serious Mental Illness who cannot be served in a less restrictive setting. In addition, many of the individuals served also have other complicating problems such as substance abuse and Developmental Disabilities." Should the reference to Developmental Disabilities be deleted from this section? | No, only individuals who have Developmental Disabilities and receive services in an institutional setting or through a HCBS waiver are excluded from the MMAI. |

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| 22 | Elissa Silber Proposal Manager Aetna | P.26 Paragraph 3.2.2.1.3 "How you will ensure that frail Seniors or persons with Chronic Health Conditions (including ESRD and HIV/AIDS), Developmental Disabilities, physical disabilities, or SMI, have medical homes equipped to handle the special needs of these subpopulations" Please clarify if the reference to Developmental Disabilities in this section should be deleted because this population is excluded from participation in this program. | No, individuals with Developmental Disabilities are included in the demonstration. Only individuals with Developmental Disabilities that receive services in an institutional setting or through a HCBS waiver are excluded from the MMAI. |
| | | **Contract Requirements** | |
| 23 | Kristen Krzyzewski HealthSpring, Inc. | Please confirm that applicants are not expected to contract with Crisis Service providers for this program. | TBD |
| 24 | Shaun Butler Meridian Health Plan | Aside from English and Spanish, what other languages need to be accounted for? 3.1.1.3.4.3 p. 17 | All written materials should be made available in English and Spanish. Other prevalent languages may be determined by the Department if more than 5% of households speak a language other than English. |
| 25 | Kristen Krzyzewski HealthSpring, Inc. | Please find two questions related to the provider credentialing requirements for MMAI:<br>• Is the State is expecting MCOs to recredential contracted providers according to the IL State Single Cred Cycle vs. the flat CMS 36 month recred cycle? IL uses a cycle that is based on the last digit of the SS# and is roughly based on a 3 year cycle but is difficult to track and run concurrently with our other providers and sometimes puts us at 37-40 months between cycles vs. the required CMS 36 months. http://www.ilga.gov/commission/jcar/admincode/077/077009650B03000R.html<br>• As part of the credentialing process, will accreditation suffice for DME in place of site visits conducted by the MCO? DME providers are all accredited as a Medicare requirement. | Yes, Plans will be required to follow Illinois regulations including the cited regulation. |

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| 26 | Shaun Butler Meridian Health Plan | Must the Plan be responsible for providing medical professionals for consultation? Or does this question refer to PCP's being available? 3.2.2.21 p. 28 | The Plan is required to assure that Enrollees have 24-hour access to medical consultation. PCPs can be contractually obligated to offer 24-hour consultation or Plans may offer this in an alternative format. A Nurse Advice line may not substitute for 24-hour consultation by medical professionals. |
| 27 | Shaun Butler Meridian Health Plan | Is the Plan responsible for covering dental services? 3.2.3.4.2.14 p. 30 | Yes, however, recent legislation will reduce the scope of dental services to adults, which will be the required dental benefit under the demonstration. |
| 28 | Elissa Silber Proposal Manager Aetna | P.56 Paragraph 7 "(Offeror) hereby attests that it will… Employ customer service representatives who shall answer Enrollee inquiries and respond to Enrollee complaints and concerns;" We understand this to mean that the customer service representatives could be employed by Offeror or its approved subcontractor. Is this correct? | Yes |
| 29 | Elissa Silber Proposal Manager Aetna | P.59 Paragraph 8 "The Model Contract may change based on CMS modifications or requirements as a result of the negotiation of the memorandum of understanding between the Department and CMS." We understand that any such changes to the Model Contract made after the response deadline will be subject to the mutual agreement of CMS, the State and the Offeror. Is this correct? | Yes |
| 30 | Elissa Silber Proposal Manager Aetna | Model Contract page 6, RFP page 65 Model Contract Section 2.8 "The calculation for State Fiscal Year 2013 is Addendum A to Attachment __ and, for subsequent State Fiscal Years, additional addenda may be appended to Attachment __ upon written notice to Contractor without amendment of this Contract." We understand that any such additional addenda made after the response deadline will be subject to the agreement of the Contractor. Is this correct? | Yes |
| 31 | Elissa Silber Proposal Manager Aetna | Model Contract, Article V 68 "DUTIES OF CONTRACTOR [To Be Completed]" The Applicant would appreciate it if we could be involved in the final determination of this section of the Model Contract and have meaningful input before it is finalized. Would the State agree to considering input from the Applicant before this Article is finalized? | Yes |

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| 32 | Elissa Silber Proposal Manager Aetna | Model Contract, Article VII 70 “PAYMENT AND FUNDING [To be Completed]” The Applicant would appreciate it if we could be involved in the final determination of this section of the Model Contract and have meaningful input before it is finalized. Would the State agree to considering input from the Applicant before this Article is finalized? | Yes |
| 33 | Elissa Silber Proposal Manager Aetna | Model Contract Section 9.1.9 Model Contract page 15, RFP page 75 “Contractor shall indemnify and hold harmless the United States and the State, their agencies, officers, employees, agents and volunteers from any and all costs, demands, expenses, losses, claims, damages, liabilities, settlements and judgments, including in-house and contracted attorneys’ fees and expenses, arising out of... any act, activity or omission of Contractor or any of its employees, representatives, subcontractors or agents.” With respect to Contractor employees, representatives, subcontractors or agents, may this provision be amended to add, "in the performance of their obligations under this Contract"? | This provision is a requirement for all contracts in the State of Illinois. We do not anticipate it being amended; however, the Department is open to discussions during contract negotiation. |
| 34 | Elissa Silber Proposal Manager Aetna | 3.2.4.1 RFP page 86 or page 27 of the Model Contract “Describe how you will monitor the quality measures in Attachment D” Please clarify the reference to Attachment D means the Model Contract, Quality Assurance (QA), Attachment ___ or RFP Attachment D (see RFP page 118 or page D-1)? | The reference to Attachment D is the RFP, Attachment D. Pages RFP, Attachment D1 through D3. |
| 35 | Elissa Silber Proposal Manager Aetna | Model Contract, Attachment _, Utilization Review/Peer Review, Section 2.c.ii RFP page 95 or Model Contract page 36 “ii. Utilize practice guidelines that have been adopted, pursuant to Exhibit____.” Please clarify the location of the Exhibit mentioned in this section as we were unable to locate it in the RFP? | Model Contract, page 36 - UR/PR, Section 2.c.ii, should have read, “Utilize practice guidelines that have been adopted, pursuant to **Attachment**___ (Quality Assurance). |
| 36 | Elissa Silber Proposal Manager Aetna | Model Contract, Attachment __, Required Deliverables, Submissions and Reporting RFP page 97 or Model Contract page 38 “Required Deliverables, Submissions and Reporting [To be Completed]” The Applicant would appreciate it if we could be involved in the final determination of this section of the Model Contract and have meaningful input before it is finalized. Would the State agree to considering input from the Applicant before this Article is finalized? | Yes |
| | | **Pharmacy** | |

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| 38 | Kristen Krzyzewski HealthSpring, Inc. | In the "General Limitations" section of the Medicaid pharmacy handbook, Chapter 200 found in the attached link http://www.hfs.illinois.gov/handbooks/chapter200.html, it indicates "Dual Eligibles may continue to receive Medicaid coverage for the limited set of drugs excluded from coverage under Medicare Part D, such as benzodiazepines, barbiturates, and Over-the-Counter items".<br><br>At one of the stakeholders' meetings, the state indicated that there would be no additional coverage for this program beyond Medicare Part D for pharmacy benefits. Please clarify if interested plans need to cover non-Part D, IL Medicaid covered pharmacy benefits described above? | Plans will be required to cover non-Part D over-the-counter drugs and products as required in the Illinois Medicaid program. Please refer to the HFS website for a list of these drugs/products. |
| 39 | MARIAM MALIK L.E.K. CONSULTING | Will the state be releasing any additional formulary specifications? | No |
| 40 | Elissa Silber Proposal Manager Aetna | P.14 Paragraph 2.3.2 "In addition to submitting a Proposal to the State through this RFP process, each Offeror must submit the information outlined in Attachment E: Medicare Requirements through the Health Plan Management System (HPMS). Award of a Contract will be contingent upon successfully meeting the following criteria outlined in Attachment E: Medicare Requirements. Plans should also be aware that there is some information that will be collected through HPMS, but will be evaluated as part of this RFP, including, but not limited to, the medical and pharmacy networks. [Emphasis added]" Please clarify how CMS' application responses to Pharmacy Access Tables in Section 2.6 and HSD Tables in Section 2.7 of HPMS can be used in scoring the medical and pharmacy networks when CMS will allows applicants to modify the medical and pharmacy network through deficiency notices that will enable Plans to update their networks?<br><br>Will MCCNs be required to complete the Pharmacy Access Tables in Section 2.6 and the HSD Tables in Section 2.7 of HPMS? | The State will base its evaluation of Plan networks using information submitted in HPMS as of July 2, 2012. All network information (including the exception requests) should be submitted by July 2nd.<br><br>All demonstration applicants, including MCCNs, are required to complete the Pharmacy Access Tables in Section 2.6 as well as the HSD Tables in 2.7 of HPMS. |
| | | **Rates** | |
| 41 | Shaun Butler Meridian Health Plan | Will there be a separate Fee Screen provided by the State or will it mirror traditional Medicare/Medicaid Fee screens as it relates to the locality/state? | TBD |
| 42 | MARIAM MALIK L.E.K. CONSULTING | When will comprehensive rates sufficient to enable network contracting, bid modeling and economic forecasting be released by the state? | TBD |
| 43 | MARIAM MALIK L.E.K. CONSULTING | Will an Actuarial Certification document with complete rating documentation be included with the rates when they are released? | TBD |

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| 44 | MARIAM MALIK L.E.K. CONSULTING | When will HFS release risk adjustment methodology? | TBD |
| 45 | MARIAM MALIK L.E.K. CONSULTING | Will the plans be able to default to DHFS rates for non-contracted providers? | TBD |
| 46 | MARIAM MALIK L.E.K. CONSULTING | Will Contractors be required to submit any type of rating documents for this demonstration, e.g., CMS Bid Pricing Tools (BPTs) for the Medicare portion of the initiative? | TBD |
| 47 | Kristen Krzyzewski HealthSpring, Inc. | Please see our questions below regarding payment and performance benchmarks:<br>• Will the agency actuaries provide the detailed data or summary data used in the development of the pmpm capitation rates?<br>• What will be the anticipated savings built into the rates from integration and improved care management? Will the actuaries be sharing their assumptions and worksheet showing the development for these savings?<br>• Will there be one rate for both State capitation and one for CMS that will be risk adjusted, or will there be different rates categories under each that will be subject to risk adjustment?<br>• Risk adjustment will it be the same methodology but different risk factors for each program? or will there be different risk programs for each?<br>• CMS uses different risk adjustment methods for new vs existing members and different methodologies for some disease states like ESRD/Hospice, will the State and CMS do the same or use different categories?<br>• Will risk adjustment be a retrospective, concurrent or prospective methodology? Since members will be allowed to transfer monthly using retrospective does not seems appropriate. The Health Insurance Exchanges are starting to recognize this and are moving to a retrospective method.<br>• | TBD |
| 48 | Elissa Silber Proposal Manager Aetna | P.58 Paragraph 7.1 “The payment terms and conditions set forth in Section 7.1 are proposed and may change based on negotiation with CMS.” We understand that any such changes to payment terms and conditions made after the response deadline will be subject to the mutual agreement of CMS, the State and the Offeror. Is this correct? | If rates are not available prior to award, execution of a contract by awardees is contingent on acceptance of rates. If agreement on rates is not reached, the State and CMS will award to other bidders. |
| | | **Network** | |

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| 49 | Shaun Butler Meridian Health Plan | Does the network have to completely pass CMS and HFS for approval or if there are deficiencies in the HSD upload and ACC reports from CMS, is the State willing to apply its own review process to determine adequacy? (Section 2.3.2 p. 14) | TBD |
| 50 | Shaun Butler Meridian Health Plan | Will the state of Illinois verify that providers that are not part of the Illinois Medical Assistance Program can be submitted and used in situations where Medicare is the Primary payor? (Section 3.1.1.3.2.3 p. 16) | For purposes of evaluating responses to the RFP, the State will evaluate networks for services where Medicare is the primary payor based on network Providers being enrolled in the Medicare program, and for services where Medicaid is the primary payor, network Providers must at least be enrolled in the Medicaid Program. However, by implementation, providers may be required to enroll in both programs. |
| 51 | MARIAM MALIK L.E.K. CONSULTING | Will there be incremental state-mandated contractual language required above and beyond CMS's application guidelines for provider contracting? | Yes |
| 52 | MARIAM MALIK L.E.K. CONSULTING | Will provider participation in the demonstration program subsequently require these providers to also service Medicaid beneficiaries outside of the demonstration program? | No. |

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| 53 | Elissa Silber Proposal Manager Aetna | P.16 Paragraph 3.1.1.3.2.3 "The State and CMS will negotiate network adequacy requirements for areas of overlap between the two programs, such as home health care services. Network adequacy will be measured, in part, based on the information provided through HPMS. The State will evaluate networks on the basis that, for services where Medicare is the primary payor, network Providers must at least be enrolled in the Medicare program and, for services where Medicaid is the primary payor, network Providers must at least be enrolled in the Medicaid Program." Please clarify if the evaluation of the Plan's network as described in this section will be performed during readiness review? | The State will evaluate network adequacy during the RFP process, requiring letters of intent only from participating network providers. Plans are encouraged to indicate if there is a pending contract or contract signed with a network provider in its response to the RFP.<br><br>Plans will be required to have signed contracts with network providers during readiness review. |
| 54 | Elissa Silber Proposal Manager Aetna | P.27 Paragraph 3.2.2.12 " Indicate your level of commitment by describing your agreements i.e. letter of intent, pending contract, contract." Please define a "pending contract" | Pending contract means that the provider has agreed in principle to all substantial contract terms with the Plan; however, the Plan has not yet received a signed contract from the provider. |
| 55 | Elissa Silber Proposal Manager Aetna | P.27 Paragraph 3.2.2.12 "As part of your Proposal, provide a CD listing of your network providers that are not included in the HPMS, including health centers, behavioral health providers…" Please define a "health center." | Health center refers to Federally Qualified Health Centers, Community Mental Health Centers, Community Substance Abuse Providers, and Rural Health Clinics. |

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| 56 | Elissa Silber Proposal Manager Aetna | P.27 Paragraph 3.2.2.12.8 "Agreement Description" Please clarify if the State is looking for a Letter of Agreement, Letter of Intent or Contract as the description of our agreements. | The State will evaluate network adequacy during the RFP process, requiring letters of intent only from participating network providers. Plans are encouraged to indicate if there is a pending contract or contract signed with a network provider in its response to the RFP.<br><br>Plans will be required to have signed contracts with network providers during readiness review. |
| 57 | Elissa Silber Proposal Manager Aetna | P.33 Paragraph 3.4.4 "Prior to entering into a Provider Agreement or subcontract, contractor shall submit a disclosure statement to the Department…" Please clarify if the disclosure is required prior to every provider agreement or contract or only if the provider, owner, family, director, etc. have a 5% financial interest. | Only if the interest exists. |
| | | **Quality Measures** | |
| 58 | Kristen Krzyzewski HealthSpring, Inc. | • When will the base line for P4P measures be available? These will be important to know in assuming the expectation of bonus payments which will drive what supplemental benefits can be offered?<br>• When will the allocation or points by P4P categories be available?<br>• The statement "After the initial year, Contractor will not be eligible for any Incentive Pool payment if it fails to meet a minimum performance standard. The minimum performance standard will require the Contractor to score at or above the base line on all P4P measures". Does this imply that if a contractor falls below the baseline on just one category that they are not eligible for any Bonus on the categories where they are above the benchmark?<br>• Can you identify the quality data period that will be used for the quality bonus payment? For example, are we going to be using P4P quality data from incurred services in 2013 and reported through 2014 for 2015 quality payments or will the 2013 quality payment be paid in CY 2015 for 2013 FY? | Yes, a contractor must meet the minimum performance standard in order to receive any bonus payments. |

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| 59 | Elissa Silber Proposal Manager Aetna | P.17 Paragraph 3.1.1.3.5 "The State's proposed pay-for-Performance Measures are under consideration by CMS and the final measures to be used as pay-for-performance may change based on negotiations with CMS." Please clarify how much notice the Contractor will receive should the Pay-for-Performance Measures need to be adjusted for any reason? | TBD |
| | | **IT/Data** | |
| 60 | Shaun Butler Meridian Health Plan | Will the state provide historical claims and disease management data for the dual eligible members or will the stratification be based on HRA data alone? (Section (Section 3.1.1.3.3.2 p. 16) | TBD |
| 61 | Shaun Butler Meridian Health Plan | What are the standards (if any) for EDI exchange of clinical data; i.e., HL7 or CCD? 3.1.1.3.3.4 p.17 | The state is not setting standards for this section but asking plans their capabilities. |
| 62 | Shaun Butler Meridian Health Plan | How will the Plan receive notification of members enrolled in the HCBS waiver programs? 3.2.3.4.5 p. 30 | If member is enrolled in a waiver, the HIPAA 834 audit file will include a code to designate the type of waiver. |
| 63 | Shaun Butler Meridian Health Plan | What standards are going to be used for the exchange of clinical data? 3.2.5 p. 31 | The state is not setting standards for this section but asking plans their capabilities. |
| 64 | MARIAM MALIK L.E.K. CONSULTING | The Department has released Medicaid data for the potential recipients in the Medicare-Medicaid Alignment Initiative Demonstration. Will Medicare data for these potential recipients be released prior to the release of actuarially sound rates? | TBD |
| | | **Enrollment/Disenrollment** | |
| 65 | Shaun Butler Meridian Health Plan | Is there a timeline for when IL and CMS will develop a single unified enrollment process? 3.1.1.3.6 p. 18 | The single unified enrollment process is under development now. There is no timeframe. |
| 66 | Shaun Butler Meridian Health Plan | Will the excluded groups listed in this section be flagged on the enrollment file from the state? 3.1.1.3.7.4 p. 20 | The daily enrollment file includes only those enrolled in the program; it will not include excluded populations. |

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| 67 | Elissa Silber Proposal Manager Aetna | P.18 Paragraph 3.1.1.3.6 "Enrollment. Participation in the demonstration is voluntary. The State will implement a unified, passive enrollment process that provides beneficiaries the opportunity to enroll or disenroll from a Plan at any time. Potential Enrollees will have the opportunity to choose from at least two Plans serving the entire geographic area in addition to any selected MCCN serving a limited geographic area, or to choose to remain in Medicaid fee-for-service (FFS)." Please clarify this section. Will Enrollees have the option of remaining with a Medicare Advantage or Medicare FFS? | If a current Illinois Medicare Advantage Plan is awarded one of the contracts, enrollees currently receiving services from that Plan will have the option of remaining with that Plan. Enrollees who want to remain with Medicaid/Medicare FFS or a non-demonstration Medicare Advantage plan must actively make that choice. |
| | | **Scoring** | |
| 68 | Elissa Silber Proposal Manager Aetna | P.14 Paragraph 2.3.1 "2.3.1 The chart below shows the elements of Responsiveness that we will evaluate, their relative weights in point format and any minimum point requirements. The total number of points for Responsiveness is 1,000" How will the Maximum Points be distributed by question within each of the responsiveness elements? | Further breakdown of the scoring criteria will not be released. |
| 69 | Elissa Silber Proposal Manager Aetna | P.14 Paragraph 2.3.2 "In its review of an Offer, the State will consider a Plan's past performance in the Medicare Program and in any state's Medicaid program, using CMS' past performance analysis and star rating system as well as HEDIS scores. In the State's determination to make an Award, the State will consider whether a Plan has a history of consistently poor performance." Please clarify the weight the State will give to a Plan's past performance in the Medicare Program or in any state's Medicaid program? | Further breakdown of the scoring criteria will not be released. However, plans not eligible for passive enrollment under Medicare standards at the time of award will not be eligible for award. |
| | | **Miscellaneous** | |
| 70 | MARIAM MALIK L.E.K. CONSULTING | Given that the absolute number and geographical distribution of dual eligibles is significantly different from that of Medicare beneficiaries, how will the state adjust adequacy requirements for duals? | Network adequacy review takes into account the number of potential enrollees and their geographic distribution. |
| 71 | Kristen Krzyzewski SVP, Business Development HealthSpring, Inc. | • RFP Attachment B includes reference to the "Mental health services provided under the Medicaid Clinic Operation or Medicaid Rehabilitation Option". Do these correspond to the existing programs described in Section 3.1.2.4, Community Mental Health Services, and 3.1.2.5, State Operated Hospitals? If not, please point to the websites/administrative code references where we can learn more about these programs since we have not been able to identify them on the HFS website. | TBD |

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| 72 | Kristen Krzyzewski HealthSpring, Inc. | On the Conflict of Interest Disclosure (page 41 – 44) – we are required to submit info for the offerer and the parent. Can the state clarify whether parent means the immediate parent or the ultimate parent? | TBD |
| 73 | Elissa Silber Proposal Manager Aetna | RFP Attachment A - Mandated Reporting 101 "Mandated reporters are required to report suspected maltreatment immediately when they have reasonable cause to believe that an individual known to them in their professional or official capacity may be Abused or Neglected. Although anyone may make a report, mandated reporters are professionals who may work with children, elderly, or persons with disabilities. The following outlines the Abuse, Neglect and exploitation reporting requirements for Illinois citizens." Please clarify how the Applicant should work within this section's requirements to report on enrollees Under the Age of 18 and Age 18 through 59 when the RFP expressly limits the population to age 21 and over [see section 3.1.1.3.7 of the RFP] | Obviously, plans will not have enrollees, under the age of 21. However, network providers may still come across evidence of abuse of someone under 21. |
| | | **CMS/Model of Care Questions** | |
| 74 | MARIAM MALIK L.E.K. CONSULTING | CMS has delayed the collection of the Model of Care narrative from the original May 24th deadline, however, attachment E in the RFP outlines a due date of May 24th. Will HFS follow CMS guidance and delay collection? Can you provide any further guidance as to when CMS / HFS expects to collect the narrative? | For the CMS application only, Plans should follow CMS deadlines for submission of the CMS model of care requirements and narrative.<br><br>Plans should adhere to the HFS deadline of June 18, 2012 for response to all of the HFS RFP requirements.<br><br>Note: HFS is not requiring a unified model of care submission to CMS through HPMS. All HFS required elements should be addressed in your response to the RFP. |

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| 75 | Elissa Silber Proposal Manager Aetna | P.14 Paragraph 2.3.2 “There will also be questions that Offerors need to answer as part of the Model of Care section of the application submitted through HPMS that appear in this RFP. Plans should provide consistent or the same answers where applicable.” Please clarify the State's intent regarding the Model of Care for this purpose when CMS has delayed the requirement for the submission of Model of Care until some time in the future? | Since CMS has delayed MOC submission, Plans’ responses to all questions should be thorough and complete to encompass information that may also be submitted in the MOC in the future.<br><br>See also response to #74. |
| 76 | Elissa Silber Proposal Manager Aetna | P.28 Paragraph 3.2.3.1.1 “For this question, you may provide the information included in your application to CMS for Model of Care component 4a and 4b and supplement as necessary.” Please clarify how the Applicant should respond to this question since CMS has delayed submission of the Model of Care? | See response to #75. |
| 77 | Elissa Silber Proposal Manager Aetna | P.28 Paragraph 3.2.3.1.3 “For this question, you may provide the information included in your application to CMS for Model of Care component 5d and supplement as necessary.” Please clarify how the Applicant should respond to this question since CMS has delayed submission of the Model of Care? | See response to #75. |
| 78 | Elissa Silber Proposal Manager Aetna | P.29 Paragraph 3.2.3.2.1.1 “Who completes the Individualized Care Plan. For this question, you may provide the information included in your application to CMS for Model of Care component 8a and 8c and supplement as necessary” Please clarify how the Applicant should respond to this question since CMS has delayed submission of the Model of Care? | See response to #75. |
| 79 | Elissa Silber Proposal Manager Aetna | P.29 Paragraph 3.2.3.2.1.2 “How the interdisciplinary care team is involved in developing and maintaining the Individualized Care Plan. For this question, you may provide the information included in your application to CMS for Model of Care component 8c and supplement as necessary;” Please clarify how the Applicant should respond to this question since CMS has delayed submission of the Model of Care? | See response to #75. |
| 80 | Elissa Silber Proposal Manager Aetna | P.29 Paragraph 3.2.3.2.1.7 “How any changes to the Individualized Care Plan are communicated to the interdisciplinary care team, Providers and Enrollees. For this question, you may provide the information included in your application to CMS for Model of Care component 8e and supplement as necessary;” Please clarify how the Applicant should respond to this question since CMS has delayed submission of the Model of Care? | See response to #75. |
| | | **Services** | |
| 81 | Kristen Krzyzewski SVP, Business Development HealthSpring, Inc | • For Medicaid covered services, can the MCO utilize InterQual criteria as appropriate, or are MCOs required to utilize other criteria for determination of medical necessity (ex. ASAM for substance abuse or other state requirements)? | TBD |

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| 82 | Kristen Krzyzewski SVP, Business Development HealthSpring, Inc | • Rule 132 allows providers to request reconsideration for denied services. If the MCO has an appeals process, is this sufficient or must a reconsideration be made available prior to the appeal? | The MCO's appeals process is sufficient. MCOs do not need to offer a reconsideration prior to an appeal. |
| 83 | Kristen Krzyzewski SVP, Business Development HealthSpring, Inc | • For substance abuse residential treatment, are the MCOs responsible for paying for room and board or does that payment come from DASA? | The MCO is responsible for room and board of residential treatment. |
| 84 | Kristen Krzyzewski SVP, Business Development HealthSpring, Inc | • Are the MCOs responsible for payment for involuntary commitments? If the MCOs are required to pay, are the MCOs able to apply medical necessity criteria right away? | TBD |
| | | **BEP** | |
| 85 | Sheryl-Anne Murray, MBA Director Medicaid Expansion, Solutions Group WellCare Health Plans, Inc. | requesting clarification regarding the Business Enterprise program utilization goal. The State of Illinois Medicare-Medicaid Alignment Initiative Request for Proposal states "This solicitation includes a specific Business Enterprise Program (BEP) utilization goal of 20% of the Administrative Allowance of the Capitation payments based on the availability of certified vendors to perform the anticipated direct subcontracting opportunities of this contract."<br><br>Can you please clarify the following :<br><br>1. What is included in "administrative allowance"?<br>2. In the absence of capitation rates, what amount should we use for the administrative allowance?<br>3. Can projected payments to BEP-certified providers be included in calculating our utilization percentage? | In response to the third question, yes, plans can project the payments to BEP certified providers if they know them. |