Questions and Answers – **2nd Set**
Medicare-Medicaid Financial Alignment Initiative RFP
As of June 12, 2012

NOTE: The 1st set of Questions and Answers were posted to the HFS website on June 6, 2012.
They can be found at: http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/default.aspx

	Submitted By	Question	Response
86	Molina Healthcare of Illinois	In January of 2014, with implementation of the ACA Medicaid expansion to cover all individuals under 133% FPL, Medicare enrolled adults with income between 100 and 133% FPL will become Medicaid eligible. Will this new group of duals in the Greater Chicago and Central Illinois regions receive coverage from MCOs chosen by this procurement or by a future procurement?	It is anticipated that any new populations that become Medicaid eligible as a result of the ACA expansion will be either covered by existing plans at the time or, if geography, capacity or other considerations necessitate, by a new procurement.
87	Molina Healthcare of Illinois	Has the state released data indicating where the 136,000 potential enrollees under this procurement live by zip code? If so, where can this data be accessed? If not, when will the state release this data?	The State provided a geographic summary file that provides data on the distribution of the population across the zip codes within the data set. This information is broken down by age group as well. (To protect patient privacy, this information is not in the Recipient file and cannot be linked to it.)
88	Molina Healthcare of Illinois	Will the current PAS process for waiver participants continue as currently in place to determine eligibility for services through MCOs?	Recent changes in the SMART Act may require a change in pre-admission screening; however, whatever methodology is used in the fee-for-service system will also apply to MCO enrollees.
89	Molina Healthcare of Illinois	What are the current cost-sharing requirements for duals? What additional cost-sharing requirements are being considered for duals as part of the FY13 budget development process?	TBD
90	Molina Healthcare of Illinois	Will HFS allow bidder's to propose innovative arrangements to coordinate HCBS services that are managed by the bidder to enhance the HCBS received by the bidder's members?	Yes

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91	Molina Healthcare of Illinois	Are the state operated hospital services listed in Section 3.1.2.5.1 of the RFP included in the benefit package that MCOs will provide?	Yes
92	Molina Healthcare of Illinois	In Section 3.5.3, the state asks bidders to provide their most recent three years of HEDIS data. Will HFS make appropriate adjustments for the HEDIS results based on different lines of business that bidder's will report, for example, Commercial vs. Medicaid, as Commercial HEDIS numbers are almost always higher than Medicaid HEDIS numbers?	Yes
93	Kelley Vahey, IlliniCare Health Plan	Please confirm that the 500 page limit does not include financial documents such as a Form 10-K and hard copy member materials.	All attachments will be included as part of the 500 page limit, excluding the following: HEDIS Results, Geo Access Maps, Member Handbook, and Financial documents. These attachments should be placed in a separate binder and will not count toward the 500 pages.
94	Kelley Vahey, IlliniCare Health Plan	It appears that section 3.2.1.1 and its subsections 3.2.1.1.1 and 3.2.1.1.2 are used twice. Please advise your preference for referring to the numbering sequence for these questions in our proposal response?	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.
95	Kelley Vahey, IlliniCare Health Plan	How is the term "pending contract" defined?	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.
96	Mary Walker, Humana	Are there specific characteristics of the "consumer advisory board" referenced in Section 3.2.1.2.1 that the state expects to see from participating plans?	The State expects Plans to develop and propose their plans for a consumer advisory board.

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97	Mary Walker, Humana	Are the Performance Improvement Projects referenced in Section 3.2.1.6 to be associated with findings from past Quality Assurance efforts?	Not necessarily, PIPs can be implemented due to past Quality Assurance Findings, but they may also be chosen through discussions with all health plans in areas plans have determined need improvement.
98	Mary Walker, Humana	Is the state seeking a geographical co-location between behavioral health and non-behavioral health care providers?	Section 3.1.1.3.3.5 states "Co-location of physical and behavioral health is accomplished through Providers working together in the same practice setting to provide a team-based approach to care delivery and immediate referral when necessary." While the State is interested in Plans pursuing co-location when feasible, Plans should propose all their arrangements to ensure integration throughout their network.
99	Mary Walker, Humana	Are the initial planning meetings referenced in 3.2.1.8.1 between the Offeror and state agencies?	Initial planning meetings can be between the Plan and any group they feel should be a part of the implementation work plan.
100	Mary Walker, Humana	Does the procuring agency referenced in 3.5.1 refer to all state procuring agencies or just Illinois?	Illinois only
101	Mary Walker, Humana	Can the state provide a general estimate of the number of enrollees that will be assigned to the health plans on the effective date of January 1, 2013, including the: (1) Estimated number of enrollees expected to affirmatively select to participate in the demonstration, and (2) Estimated number of enrollees expected to be assigned to health places resulting from PDP reassignments?	The State is currently working with federal CMS to formalize the enrollment process and to develop more specific enrollment estimates. The State will provide more detailed information when it becomes available.
102	Mary Walker, Humana	Should encounter data be reported to the state on the Medicare encounter data form?	Encounter Data reporting is still in planning stages with CMS. Once the Encounter Data reporting process has been finalized, all Plans will be made aware of decisions.
103	Mary Walker, Humana	Will the state accept the same encounter file format as CMS?	See answer to #102.

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104	Mary Walker, Humana	Will Medicare and Medicaid claims need to be indicated separately in the encounter data reporting?	See answer to #102.
105	Mary Walker, Humana	There are members already currently receiving waiver services. Is it the intent of the State of IL for those members to receive those same services on the implementation date 1/1/2013? Or, will 01/01/2013 be the date for MCO's to initiate transition?	The intent is that those members will receive those same services through the health plan on the first day of enrollment with the health plan.
106	Mary Walker, Humana	Of the services listed on Appendix C of the RFP, which will be considered for Consumer direction?	See Section 3.1.1.3.4.2.
107	Mary Walker, Humana	What is the maximum amount that will be paid to the MCO for the Community Transition Services stipend?	The State is currently working through all financial reimbursement considerations with federal CMS and will provide more information when it is available.
108	Mary Walker, Humana	In Appendix C, Case management is listed as a separate discrete service. Will Case Management be a billable service other than care coordination?	Case management is not a separate and discrete service under the demonstration.
109	Mary Walker, Humana	In Appendix C, under *Community Transition Services – Persons who are elderly and Persons with PD*, there is a notation of "MFP only". If a member declines participation in Money Follows the Person (MFP) are they excluded from the community transition stipend benefit?	Yes, if a member only qualifies for these services through MFP, Plans would not be required to provide these benefits if the client declined participation in MFP. In addition, Plans are able to propose to provide supplemental benefits that would help to transition individuals to the community as long as they are provided under the capitation rate.
110	Mary Walker, Humana	In Appendix C, under *Environmental Accessibility Adaptions - Home – Persons who are elderly*, there is a notation of "MFP only". If a member declines participation in Money Follows the Person (MFP) are they excluded from the environmental accessibility adaptions benefit?	See Response to Question #109.
111	Mary Walker, Humana	The RFP references the Client Enrollment Broker (CEB) as the entity that will facilitate enrollment. Does this mean that all transactions (enrollment and payment related transmission and reply files) will be coordinated through the CEB or should we anticipate transmitting information to and receiving information from both the CEB (for the state) and CMS?	While the details of the enrollment process are still under development, Plans should anticipate exchanging enrollment information from the CEB and CMS.
112	Mary Walker, Humana	What pre-enrollment claims information will be provided to the participating MCOs about their new members' recent diagnoses, medications, providers seen, hospitalizations, etc.?	The State will provide Plans any claims information it has once an Enrollee is assigned to the Plan.

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113	Mary Walker, Humana	When will information be shared with the MCO relative to the new enrollee's enrollment effective date and how many months/years of available pre-enrollment data will be shared?	Plans will be notified approximately seven days before their effective date. Five days after the Enrollee's effective date, the State will share two-years worth of claims history data.
114	Mary Walker, Humana	What prior encounter information (if any) will be made available when a member switches into a demonstration plan from another coordinated care plan?	See Response to Question #113.
115	Mary Walker, Humana	The state references the requirement for submission of the MOC to CMS by May 24th, 2012. Given that this deadline was recently delayed, does the state expect MOC submission by the Proposal due date (June 18th, 2012) or should we wait?	The State does not expect the plans to submit the MOC in the application to CMS by June 18, 2012. The State does expect Plans to respond to all RFP questions by the RFP due date of June 18, 2012, even those that overlap with the MOC requirements in the CMS application.
116	Sheryl-Anne Murray WellCare Health Plans, Inc.	The RFP states that Enrollees will be able to maintain existing PCP arrangements for 180 days but also allows plans to transition to a network provider. If a PCP elects not to participate with a plan, and the member is not in an existing course of treatment, can the plan choose to transition if an available medical home can be offered?	The 180 days applies to existing PCP arrangements, not just those in an existing course of treatment.
117	Sheryl-Anne Murray WellCare Health Plans, Inc.	RFP states that a maximum of 5,000 enrollees per month per plan will be assigned. Will this limit be inclusive of members that select a plan and if so, what happens if more than 5K select a plan.	The health plans will receive all members that voluntary select them in the application month, even if that number is over 5,000. However, if less than 5,000 clients select a health plan in a given month, passive enrollment will be used to bring total enrollment for that month up to no more than 5,000.
118	Sheryl-Anne Murray WellCare Health Plans, Inc.	The RFP outlines that the maximum number of eligibles to be assigned will be 5,000 for the Central region. With only 18K total eligibles in the county, will the plan be to complete the assignment process in the Central region faster than 6 months, or will the number per month be closer to 2K?	The plan is to complete the passive enrollment process in the central region in less than 6 months.

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119	Sheryl-Anne Murray WellCare Health Plans, Inc.	This section states that letters of intent can be used to represent a network. Will there be a requirement to have an LOIs converted to binding service agreements by the readiness review or any other date certain prior to an award date?	Yes, it will be necessary for LOIs to convert to binding service agreements prior to the readiness review.
120	Sheryl-Anne Murray WellCare Health Plans, Inc.	Will the plans awarded to each region be allowed to move their current MA dual membership into the program automatically, or will that be left entirely to the each individual's choice. Please describe in detail what options current MA plans and their members have with regards to enrollment into the Medicare-Medicaid Alignment initiative.	It is the intent of the Department and CMS to maintain continuity of care for enrollees whenever possible. Therefore in cases where a plan participates in both MA and MMAI, the passive enrollment will be programmed to maintain such relationships to the extent known.
121	Sheryl-Anne Murray WellCare Health Plans, Inc.	Will the proposal Due date be amended to allow the bidders sufficient times to analyze the proposed capitation rates and submit clarifying questions pertaining to the databook and the proposed rates?	No
122	Sheryl-Anne Murray WellCare Health Plans, Inc.	Do the waiver populations currently have member waitlists to qualify for those services? Will the State be applying to CMS to have the waiver slots increased to serve additional members when the program begins?	There are no waiting lists for the waivers for the elderly and for persons with disabilities, HIV, and brain injury. The state does not anticipate increasing slots in these programs as a result of this initiative.
123	Sheryl-Anne Murray WellCare Health Plans, Inc.	When do you expect the proposed capitation rates to be published? Will it be before or after the June 18th deadline?	The rates will be published after the June 18th proposal due date.
124	Sheryl-Anne Murray WellCare Health Plans, Inc.	Will the State's actuaries provide the bidders with a databook consisting of all program costs split by different populations and categories of service? Will the bidders be afforded the opportunity to revise their bid status based upon the published rates?	Yes, the State will provide a databook. TBD

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125	Sheryl-Anne Murray WellCare Health Plans, Inc.	Will the plans be responsible for collecting the member cost share or will that function be retained by the State? If the plans will be responsible, can they assign the cost share collection to the providers?	Plans are responsible for determining how to collect cost sharing from Enrollees and may assign the collection to the providers. Plans also have the option to waive co-pays for enrollees.
126	Sheryl-Anne Murray WellCare Health Plans, Inc.	What steps will the states take to reconcile eligibility for Medicare vs. eligibility for Medicaid? Will the state pay the Medicaid portion of services at the same time as Medicare, or is there potential for the payments to be made at different times?	There is potential for the payments to be made at different times.
127	Sheryl-Anne Murray WellCare Health Plans, Inc.	Are there other payments/settlements made outside of the claims system that will be the responsibility of the plans? If so, will these be built into the rates? Are any of them fixed dollar pass-through amounts or are they all variable based on utilization?	TBD
128	Sheryl-Anne Murray WellCare Health Plans, Inc.	Please provide the average growth rate of membership the last few years for each category of assistance.	TBD
129	Sheryl-Anne Murray WellCare Health Plans, Inc.	Will health plans receive copies of existing care plans for waiver enrollees as well as historical claims data prior to implementation? This will assist the plan during the transition of care period as well as gaining important information about the needs of our enrollees.	Yes, the health plans will receive copies of existing care plans for waiver enrollees. See Response to Question #113 regarding historical claims data.
130	Sheryl-Anne Murray WellCare Health Plans, Inc.	Note that there are two headers for "3.2.1.1". Should the second header be labeled "3.2.1.2" and the remaining headers be renumbered accordingly? Or, can we answer the first section under 3.2.1.0?	See Response to Question #94.
131	Sheryl-Anne Murray WellCare Health Plans, Inc.	Is the state looking for the health plan's experience with consumer direction programs as well as what the plan envisions for the IL program?	Yes

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132	Sheryl-Anne Murray WellCare Health Plans, Inc.	Once a health plan develops an individualized care plan for enrollees, can the health plan offer new or additional services within the 180 day transition of care period as long as the existing PCP arrangements are preserved for 180 days (refer to section 3.1.1.3.4)? Or, does the health plan have to authorize all services located in the enrollee's current plan of care for the 180 day transition period regardless of whether or not the health plan has developed a new care plan for the enrollee?	The care plan can be modified during the initial 180 day transition of care period if the Enrollee approves of the modifications
133	Sheryl-Anne Murray WellCare Health Plans, Inc.	Please confirm Certificate Holder below is correct: Illinois Department of Healthcare and Family Services, Attn: Michelle Maher, 201 South Grand Avenue, East Springfield, IL 62763	The question is unclear. If the question is in reference to the Certificate of Authority that must be included in the proposal (Section 3.7.1), the IL Department of Insurance oversees that function. Information can be found here: http://insurance.illinois.gov/HMO_CertAuth/hmo_certAuth.asp
134	Sheryl-Anne Murray WellCare Health Plans, Inc.	Why is RFP requesting certificate of insurance adding the United States as additional insured?	Please disregard the United States reference as additional insured.
135	Sheryl-Anne Murray WellCare Health Plans, Inc.	What type of documentation of lines of credit, maximum credit amount and availability is required? Our public SEC filings contain this information, is this sufficient?	TBD
136	Kristen Krzyzewski HealthSpring, Inc.	Attachment D to the RFP –Quality Measures of the RFP presents a combination of HEDIS and State required measures. HEDIS measures have recently been updated and this update impacts some of the HEDIS measures in the RFP. In addition, some of the State requested measures are not fully defined, which presents a difficulty determining the ability and resources required to capture and report on these metrics. With this in mind, will the MCOs be able to discuss and negotiate the definition and inclusion/exclusion of some of the impacted metrics?	The State and CMS, with the input from the Plans and stakeholders, will determine the final quality measures.

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137	Kristen Krzyzewski HealthSpring, Inc.	Members often receive behavioral health services through PCPs and state licensure/scope of practice allows PCPs to deliver these services. Will the metrics requiring follow-up care or the initiation and engagement of treatment for behavioral health services allow for PCP delivery of these services as meeting the required services?	There are two measures that address this: Measure 1 – the percentage of new members who completed a BH risk assessment that had a positive finding who received a follow-up visit with a mental health provider within 30 days requires a mental health practitioner. Measure 3 – Follow up with a provider within 30 days after an initial behavioral health diagnosis requires any practitioner.
138	Taira Green-Kelley, Aetna Medicaid	Does this include mandatory submission requirements such as HEDIS data in Section 3.5.3, Financial Statements required in 3.7.2 or Geo Access Maps required in 3.2.2.13. The examples submission requirements referenced above alone can take several pages to fulfill. We recommend exempting these materials and any other required materials as part of the page count. Will the state agree to exempt these attachments in the 500 page limit?	See response to Question #93.
139	Kristen Krzyzewski HealthSpring, Inc.	We originally understood the RFP instructions to mean that we should only provide copies of the BEP Utilization Plan and Letter of Intent (original and 1 copy) in separate sealed envelope in our Proposal container. See Section 1.4 and Section 1.9. Upon further examination, we are now wondering if we are supposed to include a copy of the BEP documents in "Section 5 – Responsibility Forms" in all Proposal submissions (1 signed original, 14 copies, 1 copy on CD), in addition to providing the BEP documents sealed in the separate envelope as described above. We would appreciate your clarification.	Your original understanding is correct.
		ADDITIONAL FOLLOW-UP FROM THE FIRST SET OF MEDICARE-MEDICAID FINANCIAL ALIGNMENT RFP QUESTIONS (Originally posted June 6, 2012) **As of June 12, 2012**	

	Submitted By	Question	Response
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
23	Kristen Krzyzewski HealthSpring, Inc.	Please confirm that applicants are not expected to contract with Crisis Service providers for this program.	Plans are required to contract with Crisis Service providers because they will be required to provide all Behavioral Health services.
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?	The State is working with federal CMS to develop rates for the demonstration, but anticipates that the rates will be sufficient to support a successful demonstration.
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?	The state expects to provide this document.
44	MARIAM MALIK L.E.K. CONSULTING	When will HFS release risk adjustment methodology?	The State anticipates that it make the risk adjustment methodology available when it publishes the rates. The State is working with federal CMS to develop rates for the demonstration. However, the State does not anticipate that rates will be available prior to the RFP due date of June 18, 2012.
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

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47	Shaun Butler Meridian Health Plan	Please see our questions below regarding payment and performance benchmarks: • Will the agency actuaries provide the detailed data or summary data used in the development of the pmpm capitation rates? • 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? • 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? • Risk adjustment will it be the same methodology but different risk factors for each program? or will there be different risk programs for each? • 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? • 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.	The State is working with federal CMS to develop rates for the demonstration. The State will provide this information when it is available. However, the State does not anticipate that rates will be available prior to the RFP due date of June 18, 2012.
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)	Network adequacy, including exception requests, will have to pass CMS and HFS approval. Network adequacy review will apply Medicare standards for medical services and prescription drugs and Medicaid standards for long-term care services. For areas of overlap (e.g. home health, hospice), CMS and the State will negotiate the network adequacy standards.
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?	The State expects to work with federal CMS, stakeholders, and Plans to develop the pay-for-performance measures to be used in the demonstration.

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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)	The Department will provide two years worth of any claims data it has upon enrollment. This data should be used to assist with stratification of enrollees.
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?	The State is currently working with CMS to request Medicare data; however, it is unlikely Medicare data on the potential recipients will be released prior to the release of the rates.
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.	Please refer to the following website for more information about these services: http://www.ilga.gov/commission/jcar/admincode/059/05900132sections.html
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
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
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?	No, MCOs are not responsible for services that are provided in a state facility operated as a psychiatric hospital as a result of a forensic commitment.