Illinois Department of Healthcare and Family Services

Responses to Questions Regarding the Innovations Project

#'s	Submitter	Question	Answer
REQUIREMENTS/CRITERIA			
R/C 1	Matthew Werner Academic Medical Centers and other providers.	Since MCCNs are already allowed under the law and can participate under the existing voluntary program to serve the Family population, if a new MCCN is created under this proposal is it held to the limits of this proposal or could they also participate in the existing program?	New MCCNs will only be awarded a contract with the state in conjunction with an accepted Innovations proposal serving a target population.
R/C 2	Eddie Pont, MD ICAAP	Will the criteria for CCE and MCCN participation be similar to current requirements for MCO participation?	Specific criteria for CCE and MCCN participation will be included in the forthcoming solicitation.
R/C 3	D. Robert Arnold Executive Assistant to: Sanjoy Musunuri, State President – Illinois WellCare/Harmony Health Plan	Can CCEs have administrative processes such as referrals and authorization requirements, or must they be strictly open access FFS like the Illinois Health Connect PCCM program?	Since all medical services rendered to CCE enrollees will be paid through the current Medicaid FFS system, CCEs will not have the ability to impose prior authorization or referrals requirements in order for claims to be paid. However, we expect them to provide referrals to their enrollees when necessary and attempt to case manage enrollees in a way that limits self-referral.
R/C 4	D. Robert Arnold Executive Assistant to: Sanjoy Musunuri, State President – Illinois WellCare/Harmony Health Plan	It is our experience that when performance and quality requirements are consistently applied to all entities in a program, this ensures all clients receive a uniform focus on quality and access. Will it be intent of the Department to apply the same requirements for a CCE, MCCN or any other entity awarded contracts in either Phase I or Phase II?	There will be a core set of quality measures applied to all CCEs and MCCNs serving a like population. Additional measures may be included for particular proposals.

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R/C 5	Seniorlink Caregiver Homes	Will the Department define, or ask bidders to define and validate with data, network adequacy requirements for long-term services and supports similar to those in common use with respect to medical services (e.g. PCP access standards)?	The Department will review network adequacy with respect to any service that an entity proposed to coordinate.
R/C 6	Brian Monsen Director of Strategic Planning Molina Healthcare Inc.	HFS mentions that MCCCN's will have "different reserve requirements" than HMO's. How does HFS envision the requirements being different, particularly since MCCNs will be taking risk-based capitation payments?	Current reserve requirements for MCCN are set forth in the Department's Administrative Rules at: http://www2.illinois.gov/hfs/agency/LawsRules/Documents/143.pdf See the following question/answer for additional information.
R/C 7	D. Robert Arnold Executive Assistant to: Sanjoy Musunuri, State President – Illinois WellCare/Harmony Health Plan	An MCCN is not regulated by the DOI and the reserve requirements do not need to meet traditional RBC levels. Additionally, the stated goal is that CCEs transition to become MCCNs. How will you ensure that MCCN entities are adequately capitalized to take on risk, especially when the department requirements for MCCNs are significantly lower than traditional risk-bearing entities?	The Department is reviewing the current reserve requirements which have remained unchanged since the early 90's to determine whether they need to be increased to ensure adequate capitalization and ability to assume risk.
R/C 8	Eddie Pont, MD ICAAP	What parameters will the care coordination entities have to meet regarding adequacy of provider networks? What ratio of PCPs to patients and what ratio of specialists to patients? What ratio of mental health providers will be required? Will geographic considerations be taken into account?	The Department will not dictate a ratio of PCPs to patients different than already exists in Illinois Health Connect. However, in evaluating proposals, the Department will consider the proposed ratio of PCPs to target populations. With respect to other providers, the department does not intend to set pre-determined ratios. The department assumes that geographic considerations may cause ratios to be different in different parts of the state.

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R/C 9	Eddie Pont, MD ICAAP	The medical home is regarded as one of the most successful models to facilitate care coordination. What measures will the Department take to ensure that CCEs and MCCNs adhere to the medical home model?	A requirement for any CCE is a network of Medical Homes in Illinois Health Connect. MCCNs will also have to demonstrate an adequate network of medical homes.
R/C 10	Matthew Werner Academic Medical Centers and other providers.	On slide 28 it states that CCEs will be transitioned to full risk MCCNs. Is that 100% certain or just a desired outcome?	It is an earnestly desired outcome.
R/C 11	Eddie Pont, MD ICAAP	One of the PCCM's more popular aspects with providers is the ability to regulate panel sizes. Under phase I, will this aspect of Medicaid continue? Under phase II?	A PCPs participation in a CCE is voluntary on the part of the PCP. The governing body of the CCE will determine whether a PCP in the collaboration can restrict its panel size.
R/C 12	Jesse Rosas	With the Care Coordination Entity RFP, can a local Mental Health Authority (708) apply? As a local unit of government we are responsible for a large geographical area in the west suburbs to support Mental Health, Substance Abuse Developmental Disabilities and prevention services.	Yes, a Mental Health Authority could apply as a lead agency for a collaboration that includes all of the required partners.
R/C 13	Jennifer Henson Planning Assistant - Executive Strategy Hospital Sisters Health Systems	Information regarding the State's intention for certification and reserve requirements is needed. A timeframe for release of those requirements is requested.	Reserve requirements for CCEs will be included in the solicitation. The Department anticipates publishing any rules to update the MCCN reserve requirements prior to March 1, 2012.

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R/C 14	Brian Monsen Director of Strategic Planning Molina Healthcare Inc.	Will members enrolled with CCEs and MCCNs be limited to seeing providers that are in these organizations' networks?	The current restrictions in Illinois Health Connect with respect to receiving services from a PCP other than the assigned CPP will remain in effect. Since all medical services rendered to CCE enrollees will be paid through the current Medicaid FFS system, CCEs will not have the ability to impose prior authorization or referrals requirements or to restrict patients to a limited network in order for claims to be paid. However, we expect them to provide referrals to their enrollees when necessary and attempt to case manage enrollees in a way that limits self-referral.
R/C 15	Brian Monsen Director of Strategic Planning Molina Healthcare Inc.	Does HFS plan to enroll those that will become newly eligible as a result of the ACA Medicaid expansion in 20014 only in MCOs?	No, CCEs and MCCNs may be an option for those enrollees to the extent they are consistent with other terms of the Innovation contract.
R/C 16	Brenda J. Wolf President & CEO La Rabida Children's Hospital	Can an organization be in more than 1 proposal?	A provider can participate in more than one proposal. However, enrollees will be limited to participation in one CCE or MCCN.
R/C 17	Brenda J. Wolf President & CEO La Rabida Children's Hospital	Would the Department consider alternatives to voluntary enrollment to reduce administrative burden and cost of enrollment while maintaining patient choice, e.g., default enrollment with an opt-out at any time?	Initial enrollment in CCEs will be voluntary, although he Department intends to move to mandatory enrollment in certain areas of the state once the full array of managed care options are implemented.

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R/C 18	Brenda J. Wolf President & CEO La Rabida Children's Hospital	We assume that a provider that serves a diverse set of patients apply as part of a CCE for some patients in response to January RFP, and apply in collaboration with another group to the April RFP for children with complex conditions. Please confirm.	A provider can participate in more than one proposal. However, enrollees will be limited to participation in one CCE or MCCN.
R/C 19	Chris Burnett Director of Strategic Policy Implementation I.A.R.F	Will the proposals be subject to the existing rules and regulations or other criteria?	All direct service providers for enrollees in CCEs must continue to follow all existing rules and regulations with respect to the delivery of all waiver or state plan covered services.
POPULATION			
POP 1	Matthew Werner Academic Medical Centers and other providers.	Can proposals focus narrowly on priority population persons with specific conditions? Say ventilator dependent or diabetes?	Although a proposal may focus on a narrow subset of the targeted population, the Department at this time cannot assure its ability to limit enrollment along narrow clinical lines. Further, proposers should keep in mind that the Department does not seek proposals to coordinate episodic care only and the CCE needs to be prepared to provide and coordinate all of the needed care for all of the conditions an enrollee may have.
POP 2	Connie Schroeder Blessing Corporate Services	You say the adult population contracts will be let in summer 2012, when will the contract start date be?	The Department hopes that CCEs begin providing services during calendar year 2012.
POP 3	Chris Burnett Director of Strategic Policy Implementation I.A.R.F	Can providers submit a proposal to serve dual eligibles needing mental health services in the next round solicitation?	CCEs proposing to serve dual eligibles should respond in Phase I.

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POP 4	Arthur Jones Medical Home Network	I would like to know about your plans for "Health Homes for Enrollees with Chronic Conditions" funding. 1. Do you plan to include the entire possible target population or restrict to just some of the illnesses as allowed by law? "The State may elect in its State plan to provide health home services to individuals eligible to receive health home services based on all the chronic conditions listed in the statute, or provide health home services to individuals with particular chronic conditions." At its most liberal interpretation, any Medicaid recipient with a BMI of >25 would qualify as this counts as one chronic condition and they would be at risk for a second (diabetes). Since the Feds are on the hook for 90% of the funding for the first 8 quarters, maybe we do want to take this opportunity to maximize creating health homes in Illinois and really do something creative about obesity.	We do not intend to place any restrictions on the list of chronic conditions that CMS has identified as eligible for health home enhanced federal match. However, we note that the goal of Innovations is to test models that address the most vulnerable (and most expensive) elements of the Medicaid population. Proposals that specifically address those populations will be given priority.
POP 5	Arthur Jones Medical Home Network	I know the conference was to focus on the Innovative Projects but I wanted to know how you will roll out this funding for patients who are not part of the Innovative Projects since "The population must include all categorically needy individuals who meet the State's criteria."	The 90% Health Home match is only available for payments to entities that function as health homes and provide the care coordination services to eligible individuals. At this time, there are no plans to implement health homes beyond the several stages of the Innovations Project that have been outlined.

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POP 6	Philippe Largent-Principal Largent Government Solutions, LLC	The IP states that (priority populations: adult; pp.17) the Integrated Care Program population is excluded in "Collar Counties". The exclusion also includes suburban Cook county, correct? Relative to the AABD, DD aged 19 and over population (current ICP pilot population), is HFS seeking proposals to provide care coordination and medical services to this population outside of the ICP counties?	All populations currently mandated to participate in Integrated Care are excluded from Innovations proposals. AABD eligibles age 19 and older, or subsets thereof, outside of the ICP operating area are included in the population that could be covered through the Innovations Project. Duals or other priority populations in the ICP area are also eligible for Innovations Projects.
POP 7	D. Robert Arnold Executive Assistant to: Sanjoy Musunuri, State President – Illinois WellCare/Harmony Health Plan	It was stated that clients in the ICP program are excluded, and a list of counties were included to represent where the ICP program is active. Other than duals and children, were there any other Medicaid populations excluded from the ICP program?	Population exclusions from the Integrated Care Program are: • Children under 19 years of age • Participants eligible for Medicare Part A, or enrolled in Medicare Part B • American Indians and/or Natives of Alaska (may voluntarily enroll) • Participants with spenddown • All Presumptive Eligibility (temporary benefits) Categories • Participants in the Illinois Breast and Cervical Cancer Program • Participants with high-level private health insurance (also known as Third Party Liability or TPL) Additional information regarding the Integrated Care Program can be found on the Department's website at: http://www.hfs.illinois.gov/managedcare/icfact.html

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POP 8	Jennifer Henson Planning Assistant - Executive Strategy Hospital Sisters Health Systems	We would like clarification on the population requirements and the opportunity to establish focus on one specific population (subset of the priority population as long as they exceed 500, for instance, children with asthma) rather than an initial entry with all priority populations. Subsequently, for an approved CCE or MCCN with an established geographical or priority population, we seek direction on the procedural process for expanding the geographical service area and/or the priority populations served.	Although a proposal may focus on a narrow subset of the targeted population, the Department at this time cannot assure its ability to limit enrollment along narrow clinical lines. It will be permitted to market a CCE on the basis of its focus on a particular condition. However, proposals that focus on just one physical condition are less attractive to the Department. We would accept a proposal that had a pre-planned phased expansion. In addition, we would consider an expansion request by a CCE once it is operational.
POP 9	Sharon M. Rynn Associates in Nephrology S.C.	Can Medicaid Waiver Services for Individuals with Developmental Disabilities qualify as a provider lead, CCE project in Phase 1, for those who are already in the ICP program, as well as those who are not due to dual eligibility for Medicare and Medicaid?	Individuals in ICP are not eligible for innovations projects. A DD waiver service provider could be a lead provider in an Innovations proposal, but there must be partners able to coordinate all of the required services—physician, hospital and behavioral health. A proposal that only coordinated waiver services would not be comprehensive enough.
POP 10	Lynn O'Shea President/CEO Association for Individual Development	Can individuals with Serious Mental Illness who are dually eligible for Medicare and Medicaid AND live in the ICP target area, be the target for a provider lead, CCE project in Phase 1?	Yes, clients excluded from the Integrated Care Program in the ICP target area, such as dual eligibles, could be a target population.

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POP 11	Lynn O'Shea President/CEO Association for Individual Development	Can you clarify whether CCE proposals targeting persons with Developmental Disabilities receiving Medicaid Waiver services *and* who are currently enrolled in the ICP program, are eligible for CCE project consideration in Phase I of the Care Coordination Innovation Projects?	Persons currently covered through the Integrated Care Program are excluded from participation as a covered population in the Innovations Project.
POP 12	Lynn O'Shea President/CEO Association for Individual Development	Will you also clarify whether CCE proposals targeting persons with Developmental Disabilities who are dually eligible for Medicare & Medicaid, and also for Medicaid Waiver services *and* are currently enrolled in the ICP program, will be eligible for consideration in Phase II of the Care Coordination Innovation projects?	Clients that are dual eligibles with Medicaid and Medicare are excluded from the Integrated Care Program. Therefore, they could be a target population for the Innovations Project.
POP 13	Lynn O'Shea President/CEO Association for Individual Development	Lastly, will you clarify whether CCE proposals to targeting persons with Serious Mental Illness who are dually eligible for Medicare & Medicaid, *and* currently enrolled in the ICP program, will be eligible for consideration in Phase II of the Care Coordination Innovation projects?	Clients that are dual eligibles with Medicaid and Medicare are excluded from the Integrated Care Program. Therefore, they could be a target population for the Innovations Project.
POP 14	Connie L. Schroeder VP Innovation & Integration Blessing Corporate Services	Can CCE proposals target persons with Developmental Disabilities receiving Medicaid Waiver services *and* who are currently enrolled in the ICP Phase I project (but not yet in the Phase II/III of ICP project)	Persons currently covered through the Integrated Care Program are excluded from participation as a covered population in the Innovations Project.

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POP 15	Rajnish J. Mandrelle Organizational Development and HR Association for Individual Development	Can CCE proposals target persons with Developmental Disabilities who are dually eligible for Medicare & Medicaid in the ICP county area be eligible for consideration in Phase II of the Care Coordination Innovation projects?	Clients that are dual eligibles with Medicaid and Medicare are excluded from the Integrated Care Program. Therefore, they could be a target population for the Innovations Project.
POP 16	Rajnish J. Mandrelle Organizational Development and HR Association for Individual Development	Can CCE proposals target persons with Serious Mental Illness who are dually eligible for Medicare & Medicaid, in the ICP county area be eligible for consideration in Phase II of the Care Coordination Innovation projects?	Clients that are dual eligibles with Medicaid and Medicare are excluded from the Integrated Care Program. Therefore, they could be a target population for the Innovations Project.
POP 17	Arthur Jones Medical Home Network	What obligation will the state have to continue funding care coordination services at a lower match after the first 8 quarters that are covered under the Health Homes waiver? Can they narrow eligibility at that point? This impacts your decision about who to include in the initial first 8 quarters.	HFS does not intend to change the state's care coordination strategy after 8 quarters. Proposal finances should not be based on a higher fee during the first 8 quarters due to the possibility of 90% match. Projects must be sustainable and cost neutral at the fees proposed regardless of the possible match rate.
POP 18	Brenda J. Wolf President & CEO La Rabida Children's Hospital	Regarding the child population, can a CCE in Phase I exclusively serve children and if so, are there any specific population coverage requirements? Will the definition of "medically complex or special needs" children be defined prior to the January RFP so that CCEs will know which populations of children will be in what domain? Please also be sure to address whether DCFS wards are in the covered populations.	CCEs must focus on a priority population. The only children in the priority populations are children with complex health needs. The January solicitation will not cover this population. The solicitation for this population will be in the spring, by which time the Department and its stakeholders will have defined this priority population. No children will be targeted in the January population. DCFS children, while not a specific targeted population, are not excluded from Innovations for complex children.

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ELECTRONIC CAPABILITIES (EHR)			
E 1	Eddie Pont, MD ICAAP	The presentation mentions EHR, but does not specify the requirements. What office and clinical functions must be electronic in order to participate as a CCE or MCCN? Will the Department utilize federal "meaningful use" criteria?	The Department is not specifying any particular EHR system or electronic functionality. However, over time the Department intends to develop more specific criteria that will likely include the meaningful use criteria.
E 2	Philippe Largent-Principal Largent Government Solutions, LLC	The IP states that CEEs may develop "electronic" capabilities in year 1 but electronic functionality must be operational twelve months after contract execution? What does the department mean by electronic capabilities and what level of functionality will be required to meet the department's requirement? I think I can infer what the department wants, i.e. use of electronic health record, electronic claims submissions, interoperability between other systems and the state's electronic health information systems, achieved or moving towards meaningful use, etc…specificity on this topic would be helpful.	The Department will not specify any specific required electronic capability, but expects every proposal will include some electronic functionality. Recognizing the difficulty this may present to some providers, we have included a grace period before electronic systems will need to be operational. Although we will not dictate any specific capability, we will evaluate competing proposals on this basis as well as others.
PAYMENTS & REIMBURSEMENT			
$ 1	D. Robert Arnold Executive Assistant to: Sanjoy Musunuri, State President – Illinois WellCare/Harmony Health Plan	Will the PCCM admin fee currently paid to PCPs by the Department continue to be paid in a Phase I arrangement in addition to the care coordination fee that would be paid if the CCE were awarded a contract? Additionally, will the Well Child Incentive for treating qualified children still be paid to PCPs in a Phase I CCE arrangement?	The PCCM monthly care management fees ($2, $3, or $4) will continue to be paid through the PCCM program for CCE enrollees. All bonus payment currently in place for PCCM will continue.

#'s	Submitter	Question	Answer
$ 2	Kristen Pavle, MSW Associate Director, Center for Long-Term Care Reform Health & Medicine Policy Research Group	Will HFS set capitation rates for MCCNs and Medical Cost Targets for CCEs similar to what HFS did for the ICP solicitation? Or, does HFS anticipate entities to submit proposals with their own proposed capitation rate or Medical Cost Targets? If we may offer a recommendation, it may be beneficial for all interested parties for HFS to establish the Fee For Service cost on a Per Member Per Month basis with expected trend for the segments or sub-segments of its priority populations. This would provide the target from which HFS expects savings. Interested entities could then assess feasibility of participation.	For MCCNs taking full risk, HFS will set the capitation rate through its actuary, which must then be approved by federal CMS. For shared savings, our actuary, working with the CMS actuary will determine baseline costs on a PMPM basis and cost trends.
$ 3	Brian Monsen Director of Strategic Planning Molina Healthcare Inc.	Will the data the state is preparing to release for MCCNs, CCEs and MCOs to use in rate development work reflect two scenarios – with and without hospital rate reform? For example will fixed hospital payments, such as quarterly payments, be included in the data on a per admission basis?	The initial data will include information based on the current hospital reimbursement system. It is simply premature to project how a revised system will look. It is most likely that the new system will not be finalized in time for the first round of proposals to be evaluated. The Department will make a retroactive adjustment to baselines based on the result of the new system.
$ 4	Maureen McDonnell Director for Business & Health Care Strategy Development TASC	Would CCE activities be reimbursed through the care coordination fee or through another vehicle?	CCEs will be reimbursed through care coordination fees and shared savings. MCCNs will receive an all-inclusive capitation rate.

#'s	Submitter	Question	Answer
$ 5	Maureen McDonnell Director for Business & Health Care Strategy Development TASC	Many people with serious mental illness are "stabilized" and treated during incarceration at county jails. Thus the medical expenses for their care are incurred in the county system, not the Medicaid system. The same is true for state hospital care. Is it allowable to include those expenditures as part of the cost savings calculation for the CCEs?	State Medicaid matchable costs in any of the settings mentioned can be included in a shared savings calculation.
$ 6	Maureen McDonnell Director for Business & Health Care Strategy Development TASC	Will outreach and engagement activities prior to enrollment be reimbursed? If so, how?	Although this is not a likely scenario, a detailed proposal would be considered. It is more likely that the Department would consider an advance payment recouped against on-going care coordination fees.
$ 7	Brenda J. Wolf President & CEO La Rabida Children's Hospital	Since simultaneously to this initiative, there will be a redesign of hospital reimbursement, how will those changes, some in mid-stream, affect cost neutrality measures. Also, costs are generally determined through paid claims data but since hospitals have received a significant portion of their payments through "add-ons" how does that get figured?	See response to $3.

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$ 8	Brenda J. Wolf President & CEO La Rabida Children's Hospital	The current CCE model envisions a care coordination fee using the existing FFS payments for all services; MCCN we assume would be a full capitation payment. Will the Department provide more detailed descriptions of successful models of payment to CCE and MCCN that we should consider prior to the RFP release or as part of the RFP? Will the Department entertain additional reimbursement models within the CCE/MCCN proposals (sub-capitation, gain-sharing, performance incentives) in addition to FFS payments?	The Department has no experience to share on CCE payments beyond the current IHC program. A factor in evaluating proposals would be the internal financial arrangements of CCEs or MCCNs, in particular how funds are used to reimburse care coordination or incent provider behavior.
PERFORMANCE MEASUREMENT			
PM 1	Rebecca Friedman Zuber IHHC Regulatory Consultant	Has HFS determined how the financial success of CCEs (& MCOs) will be measured at the end of the 3 yr demo period? Comments were made to the effect that CCEs would be expected to show a savings to the Medicaid program, or at least be budget neutral. How that savings is measured is a critically important question for providers working to develop a CCE. Does HFS intend to measure success over the entire 3 yr period, or yr by yr? What will the denominator be? Will it be total Medicaid expenditures, expenditures for the individuals participating in a CCE, etc? How soon will measurement begin--immediately or after an adjustment period? These should be answered in order for a provider to feel comfortable incurring the expense and disruption that will result from the changes required to participate. &, at least in the home health industry, providers worry about being measured against what is already a rate far below agency's costs of providing services.	The savings will be measured over the entire three year period. In general all Medicaid costs will be included in the calculations, but it is possible that certain costs will be excluded in some or all models. The exact methodology for measuring savings must be approved by federal CMS. The Department is already working with CMS on this issue and will include whatever information is available at the time the solicitation is released. Further details will be shared as soon as they are available.

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PM 2	Seniorlink Caregiver Homes	What individual beneficiary protections and population-wide quality measures will be required to ensure that Care Coordination Entities, Managed Care Community Networks, and HMOs are performing at a high level?	Working with stakeholders, the Department will specify certain common quality measures for all models serving like populations. In addition other measures may be used for particular models. All CCE contracts will have performance requirements and appropriate patient protections.
PM 3	Eddie Pont, MD ICAAP	What process does the state envision for establishing the care quality measures to be utilized for evaluating CCEs and MCCNs? Will CCEs and MCCNs get to choose the quality measures they find most important, or will they all have to adhere to the same ones?	Working with stakeholders, the Department will specify certain common quality measures for all models serving like populations. In addition other measures may be proposed to be used for particular models
LAWS & REGULATIONS			
L/R 1	Rebecca Friedman Zuber IHHC Regulatory Consultant	The kinds of arrangements that may best benefit patients of a CCE may come into conflict with anti-trust and anti-kickback laws, regulations, and advisory opinions established at the federal level. The rules adopted to implement the ACOs include a number of exceptions to these laws and regulations designed to allow things like a pre-surgical visit to a joint-replacement patient's home by a physician therapist to plan for the services and physical modifications that will be needed when the patient returns home--a service that can't currently be paid for by Medicare, but can be provided free without being construed as an inducement for a referral. Has IDHFS conducted an analysis of the goals of its Care Coordination Innovations Program to determine whether providers will come into conflict with these laws and regulations as they address themselves to the project of becoming a CCE?	The Department believes that the goals of the Innovations Program are consistent with recent guidance from federal agencies on these issues. Obviously, any CCE will have to seek their own legal counsel as to whether their proposed activities are consistent with the law and guidance.

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L/R 2	Philippe Largent-Principal Largent Government Solutions, LLC	What are or will be the reserve requirements for MCCNs? HFS states that MCCNs will be "certified" by HFS, not DOI. Where does HFS derive its statutory authority to certify MCCN's?	Authority for MCCNs is in the Public Aid Code. Additional requirements, including financial requirements, are in administrative rules. Links to both follow: Public Aid Code- 305 ILCS 5/5-11: http://www.ilga.gov/legislation/ilcs/ilcs4.asp?DocName=030500050HArt%2E+V&ActID=1413&ChapterID=28&SeqStart=11400000&SeqEnd=23893750 Administrative Rules: http://www2.illinois.gov/hfs/agency/LawsRules/Documents/143.pdf
L/R 3	Seniorlink Caregiver Homes	What mechanisms of federal authorization will the Department use to make new or substitute services available to populations that would benefit from new service and service delivery models?	The Department will file a State Plan Amendment to seek federal match for care coordination fees under the same provisions that allow for match of the services provided in the PCCM program. In addition, the Department will use the authority contained in the Health Home provisions of Section 2703 OF ACA.
L/R 4	Jennifer Henson Planning Assistant - Executive Strategy Hospital Sisters Health Systems	As a potential broad geographic and rural initiative, we need legal guidance around the regulatory implications for provider group structure (anti-trust and stark laws).	The Department cannot provide legal advice on these issues. However, it is an area in which we are attempting to secure Technical Assistance for potential bidders. We will make information available on the website as we move forward on this issue.

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L/R 5	Rebecca Friedman Zuber IHHC Regulatory Consultant	Has IDHFS had any conversations with IDPH regarding licensing issues that may arise as CCEs organize? In particular, depending on the level of direct services provided in the home, care coordination activities could cross the threshold into the delivery of home nursing or home services as defined in the Illinois Home Health, Home Services and Home Nursing Licensing Act. For example, a nurse who is providing counseling and therapeutic services to an individual with chronic mental illness in the home as part of case management or care coordination could be considered to be providing home nursing services requiring the agency under whose auspices the services are being provided to require licensing.	HFS has not had discussions with DPH on this issue. In the absence of very specific information provided to DPH, it is not possible to give any guidance on this point.
PROPOSALS			
PRO 1	Philippe Largent-Principal Largent Government Solutions, LLC	Relative to MCCN proposals, please clarify that the department is seeking MCCN proposals which include elements of care coordination, i.e. proposal which seek to "facilitate the delivery of appropriate health care and other services and care transitions among providers and community agencies…" and not just the provision of medical services? The overview presentation was not explicit on this question.	An MCCN proposal must include a detailed description of the care coordination capabilities, interventions and philosophy to the same extent as a CCE proposal.

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PRO 2	Connie Schroeder Blessing Corporate Services	Could you explain your term "solicitation"? Is that when you will provide us with the details or is it when we can start providing you with our proposals?	The Department will release a solicitation which will contain all of the requirements that the organizations must include in their proposal. As part of that solicitation, will ask for Letters of Intent (LOIs) from potential lead organizations. An LOI will be required to obtain access to data, and, based on feedback from many parties, it is hard to see how a successful proposal can be developed without data. The Department will not eliminate applicants on the basis of the LOI. However, we will give feedback if the Department feels the proposal lacks sufficient scope and direction and therefore does not have a reasonable likelihood of being accepted. Any feedback given will not be a final decision, merely a sense of how the Department views the concept as set forth in the LOI. The solicitation will contain detail on what the LOI should contain.
MARKETING			
MKTG 1	Jennifer Henson Planning Assistant - Executive Strategy Hospital Sisters Health Systems	We understand enrollment is voluntary. Clarification of the CCE or MCCN marketing and enrollment efforts for attracting members is requested.	Marketing will be allowed consistent with federal regulations. Further details on this issue will be included in the solicitation and in contracts with CCEs.

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MKTG 2	Maureen McDonnell Director for Business & Health Care Strategy Development TASC	What incentives for consumers to enroll would be permissible (or not permissible) under this initiative?	The Department will not allow incentives to be provided simply for enrolling, but would allow and be interested in proposals that contained incentives for enrollees to obtain preventive services, comply with care plans or otherwise access healthcare in a coherent fashion.
MKTG 3	Sharon M. Rynn Associates in Nephrology, S.C.	How are you going to do enough outreach to the Medicaid patients so they understand this change? I'm afraid many do not open or read mail and this is somewhat complicated so they may not understand	All enrollments will be handled through the Illinois Client Enrollment Broker (ICEB). In addition to mail, the ICEB uses outbound telephone outreach and can perform presentations to interested parties and community groups. In addition, providers participating in CCEs will be allowed to inform their patients of the CCE opportunities available to them.
MKTG 4	Maureen McDonnell Director for Business & Health Care Strategy Development TASC	Can Care Coordination Entities conduct outreach and engagement activities, then connect the consumer with the enrollment broker?	The Department does envision the CCEs will be allowed to perform some degree of education for their patients on these CCE opportunities. Exact specifications or limitation are still under development.
MKTG 5	Brian Monsen Director of Strategic Planning Molina Healthcare Inc.	Can you describe some key dates and ideas for associated enrollment activities?	Current timelines for the various phases are outlined in the Presentation on our website.

#'s	Submitter	Question	Answer
CLIENT ENROLLMENT BROKER			
CEB 1	Jennifer Henson Planning Assistant - Executive Strategy Hospital Sisters Health Systems	Can you provide additional information regarding expectations and roles between the CCE or MCCN and the enrollment broker structure in the coordination of patient assignments (enrollments and disenrollments). Will the brokers be expected to manage all aspects of the enrollment and disenrollment process, and if so, what would be the role (if any) of the CCE or MCCN in this function? Would the CCE or MCCN be able to coordinate with the brokers in making sure that patient assignments are accurate and timely? Would the CCE or MCCN be able to enroll or disenroll patients directly, without going through the broker structure?	All enrollments and disenrollment will be handled through the Illinois Client Enrollment Broker (ICEB), as required by federal law. CCEs and MCCNs will not be able to enroll people directly. The CCEs and MCCNs will receive electronic file notifications of enrollments and disenrollments. There will be a process to ensure accuracy of enrollment and disenrollments. CCEs will be able to educate and market to clients under published guidelines and state and federal regulations.
CEB 2	Maureen McDonnell Director for Business & Health Care Strategy Development TASC	Please describe more fully the activities of the enrollment broker.	All enrollments will be handled through the Illinois Client Enrollment Broker (ICEB). In addition to mail, the ICEB uses outbound telephone outreach and can perform presentations to interested parties and community groups.
CEB 3	Maureen McDonnell Director for Business & Health Care Strategy Development TASC	What will the timeline be for the enrollment broker RFP and award? Ideally the CCE applicants would know who the enrollment brokers would be prior to submission of their RFP responses, as this will affect service delivery plans.	The current Illinois Client Enrollment Broker is administered by Automate Health Systems. That contract expires 06/30/12. The Department is currently in the procurement process to obtain a new contract for the ICEB. It will not be known until Spring 2012 who the selected ICEB vendor will be. The Department does not believe that the identity of the enrollment broker is in any way relevant to development of CCE proposals.

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CEB 4	Maureen McDonnell Director for Business & Health Care Strategy Development TASC	What types of organizations or individuals will be eligible to be enrollment brokers for Care Coordination Entity projects?	Requirements for Enrollment Brokers can be found in federal regulation at 42 CFR 438.810. Per this C.F.R. and Section 1903(b)(4) of the Social Security Act, the same organization cannot act as the CEB and a CCE if there is a conflict of interest.
CEB 5	Maureen McDonnell Director for Business & Health Care Strategy Development TASC	We are interested in serving individuals with serious mental illness. Significant outreach and engagement efforts will be needed to enroll these consumers. Will the enrollment brokers be expected to serve that function as well?	All enrollments will be handled through the Illinois Client Enrollment Broker (ICEB). In addition to mail, the ICEB uses outbound telephone outreach and can perform presentations to interested parties and community groups. CCEs will be allowed to inform their patients of enrollment opportunities available to them but the CEB will handle the actual education and enrollment.
CEB 6	Maureen McDonnell Director for Business & Health Care Strategy Development TASC	Will enrollment brokers be expected to go wherever eligible consumers are to conduct their activities? For example, will they be expected to go into jails and hospitals (inpatient and ER) to facilitate enrollment? Or is it a phone/passive process?	The basic structure of the ICEB is a mail and telephone enrollment process. The ICEB can and does do outreach and education at various provider and community locations.
CEB 7	Rajnish J. Mandrelle Organizational Development and HR Association for Individual Development	Who is eligible to become a Client Enrollment Broker?	Requirements for Enrollment Brokers can be found in federal regulation at 42 CFR 438.810.

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RELATIONSHIPS			
REL 1	Jennifer Henson Planning Assistant - Executive Strategy Hospital Sisters Health Systems	Once Illinois is live with Health Insurance Exchanges (HIE) (as required by the Affordable Care Act), understanding the anticipated relationship between the state, brokers, and CCE or MCCN would be helpful.	While there are many uncertainties with regard to how this relationship will work, the operating assumption is that once initial eligibility for Medicaid (as opposed to Exchange eligibility) is determined, the client will be treated identically to any other Medicaid client. We anticipate that any Navigators funded by the Exchange would be generally knowledgeable about Medicaid enrollment issues, but that would not be the main focus of that group.
REL 2	Brian Monsen Director of Strategic Planning Molina Healthcare Inc.	A bullet on slide 13 of Director Hamos' October 13 presentation, titled "What is a Care Coordination Entity?" points out that health plans can work with CCEs for "back office" functions. There are many ways that our plan could help hospitals, primary care providers, mental health and substance abuse providers and we welcome these opportunities. For example, a plan could provide a CCE help with encounter data. Or, a plan could provide startup capital to CCEs. Does the Department plan to issue more specific guidance with respect to how far relationships between CCEs and health plans can go? If so, when will that guidance be available?	The primary feature of a CCE is that the collaborating providers have agreed to specific joint behavior to coordinate care. The model must be provider sponsored and governed. MCOs can be contracted to help provide various functionalities to make the coordination possible.

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REL 3	Brian Monsen Director of Strategic Planning Molina Healthcare Inc.	Would a partnership between a CCE and a plan (involving various "back office", financial or other assistance) preclude the plan from offering an MCO product in the same geographical area in Phase 2? While we do not for see this as an issue, we would appreciate the opportunity to discuss the situation if the Department has any concerns. If not, would such a product eventually count as a second option if HFS were to move to mandatory enrollment in low population density areas that have two managed care options?	An MCO serving as a subcontractor to a CCE would not be precluded from obtaining its own contract in later phases.
REL 4	Lynn O'Shea President/CEO Association for Individual Development	We need to know how the Care Coordination Innovations Project will work with the Community Care Program and the Case Coordination Unit's. Will we really be partners? Will there no longer be Department on Aging Community Care Program?	How Case Coordination Units are integrated into a CCE is determined by the collaborating entities in the CCE. The Department on Aging Community Care Program will continue.
REL 5	Rita E. Downs Director Adult Comprehensive Human Services	We would like to know where this is going and what types of agency's you intend to partner with? Much more information is needed at this time.	A formal solicitation will be released in January 2012 that will contain additional information and requirements of the proposals. The presentation was meant as an initial education on the upcoming Innovations Project to give entities time to think about the basic requirements and possibly come up with some coordination opportunities. Proposers will have several months to develop their proposal after the solicitation is released.
REL 6	Rita E. Downs Director Adult Comprehensive Human Services	Can a health plan be a co-owner with providers of a "new corporate entity" that puts forth a proposal as a CCE or MCCN?	No.

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REL 7	D. Robert Arnold Executive Assistant to: Sanjoy Musunuri, State President – Illinois WellCare/Harmony Health Plan	For a CCE you mention that a model must include PCP, hospitals and BH/MH providers. Does that mean that a CCE can use the state network of specialists and ancillary providers, and that a cohort of providers does not have to be part of a CCE proposal?	The collaborating providers in a CCE do not have to be capable of rendering all necessary services. They must coordinate those services, and, accordingly, accept some degree of responsibility for the resulting costs.
REL 8	Maureen McDonnell Director for Business & Health Care Strategy Development TASC	Some of the partners we would like to include in our CCE projects are not currently billing Medicaid for behavioral health services. Is it allowable to include them in the project? Is it allowable to include their activities in cost savings calculations? We expect that their direct services would be paid through existing DHS contracts. One advantage we see in this approach is that it will incentivize behavioral health providers with expertise in serving seriously mentally ill clients to move into Medicaid certification and billing compliance, and give them experience interacting within a health network and with an electronic health record system.	Such providers may be included in a CCE. To the extent that their participation helps reduce costs to Medicaid, saving calculations would reflect that.
REL 9	Maureen McDonnell Director for Business & Health Care Strategy Development TASC	Substance abuse treatment providers who currently bill Medicaid do so as an agency through DHS/DASA, rather than as individual credentialed providers. When they partner in CCEs, will that arrangement continue?	Yes.

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SERVICES			
SERV 1	Maureen McDonnell Director for Business & Health Care Strategy Development TASC	Will the CCE projects be restricted to existing Medicaid-eligible services + care coordination provided by the CCE? Or can new services be proposed for Medicaid reimbursement?	In the CCE model, all medical services continue to be paid thru the existing FFS system. The Department would be unable to add a covered service but restrict it to enrollees of a particular CCE. Due to budget constraints, it is unlikely that the Department would add a statewide covered service at this time. A CCE is free to use revenue from its care coordination fees to directly pay for a non-covered service.
SERV 2	Brad Wasson Group Vice President, Health Systems Solutions Group	Could retail pharmacies and retail based clinics be included in the Innovations Project as access points for patients to become educated about their health status through diagnostic screening and educational services provided by pharmacists and nurse practitioners?	Such entities may participate as part of a much wider collaboration that includes the required primary care, hospital and behavioral health partners. Whether such providers are the appropriate site for the particular services mentioned is a question for the specific collaboration.
SERV 3	Brad Wasson Group Vice President, Health Systems Solutions Group	Would HFS consider pilot programs which would utilize pharmacists as an essential provider of medication counseling and pharmacies as an open access point that would allow patients to get screenings for chronic conditions so they may better get treatment?	See above answer.

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		CONSUMER MINIMUM	
C-MIN 1	D. Robert Arnold Executive Assistant to: Sanjoy Musunuri, State President – Illinois WellCare/Harmony Health Plan	It was mentioned that an entity in Phase I can only serve an equal number of priority and non-priority population clients, and that there must be a minimum of 500 clients served from the priority group. Since there are 4-5 times more non-priority clients than priority clients, does this mean we can expect only 20% of the total non-priority (e.g., TANF) population to be served in Phase I? Also, since the minimum is 500, for geographies where that concentration is not met, does a participant have to expand the service area, such as additional zip codes or counties, until the minimum level of eligible members are included?	The estimate for the maximum number of the non-priority population expected to be served seems reasonable, although it could end up being higher or lower. Yes, in less populated areas, CCEs should plan to extend their service area enough to encompass the necessary minimum target population. Also, please see response to C-MIN 4 below.
C-MIN 2	Brian Monsen Director of Strategic Planning Molina Healthcare Inc.	How does HFS contemplate administering the CCE requirement for 500 minimum members? Will this requirement be enforced at contract inception or will CCEs have time to build enrollment to 500? How much time might be allowed?	CCEs must have a service area large enough to make reaching the minimum enrollment reasonable. They will not be expected to reach that level immediately. A CCE that fails after a reasonable time to attract a sufficient population may have its contract terminated.
C-MIN 3	Maureen McDonnell Director for Business & Health Care Strategy Development TASC	Is HFS expecting that 500 consumers will be enrolled at the beginning of each project? Or is the expectation that CCEs enroll a minimum of 500 consumers by the end of the three year project?	Although CCEs will not have to have 500 enrollees immediately, they will be expected to reach that level in a relatively short time.

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C-MIN 4	Sabah Freitas Lessabah Arts Center, NFP.	Slide 17 from the Oct 13th presentation says that a proposal can only serve a number of persons in the Family categories equal to that served in the priority populations? So a CCE or MCCN under this proposal that serves 1,000 priority population individuals can only serve 1,000 individuals in other categories? Since this is a voluntary program will this limit be handled by the CEB?	CCEs serving Cook, DuPage, Lake, Will, or Kane counties or St. Clair/Madison counties will be limited to the 1:1 ratio in serving non-priority populations. In other counties CCEs that agree to accept all Medicaid enrollees in their geographic service area will not be held to this ratio, although enrollment will be controlled to ensure that it does not have a disproportionate share of non-priority populations based on the ratio of priority to non-priority populations in the service area. All enrollment and enrollment limitations will be handled by the CEB.
C-MIN 5	Matthew Werner Academic Medical Centers and other providers.	Does HFS intend to hit the 50% target just through phase 1 and 2 of this initiative?	No.

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MISC			
MISC 1	Philippe Largent-Principal Largent Government Solutions, LLC	The Innovations Project Overview (IP) presentation seems to suggest that HFS expects CCEs to include "community based service providers". Is the Department referring to other community health care providers and/or social service/case management service providers? Can community based social services providers (non-medical/non health care) be part of the CCE on the front end, i.e. part of the proposed network or lead proposed network? The IP seems to want the development of the CCEs/MCCNs to be provider driven only. Is there room for an inverted approach?	A CCE is required to have a partnership that includes hospital, physician care and behavioral health. A collaboration that includes a wider array of providers is more attractive. The collaborating providers in a CCE do not have to be capable of rendering all necessary services. They must coordinate those services, and, accordingly, accept some degree of responsibility for the resulting costs. A non-medical community based provider could be lead partner. The Department does not completely understand the reference to an "inverted" approach, but the premise that the development of CCEs and MCCNs are intended specifically to be provider-driven is correct.
MISC 2	Karen Batia, Ph.D. Executive Director/Vice President Heartland Health Outreach/Heartland Alliance	Can have the risk adjustment methodology that was used for the Integrated Care Program in the collar counties? This will help us in our planning processes in the creation of a CCE/MCCN.	The Department's actuary applied the Chronic Illness and Disability Payment System (CDPS) +Rx version 5.1to adjust the actuarially sound base capitation rates for the AABD population for each Contractor.

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MISC 3	Kristen Pavle, MSW Associate Director, Center for Long-Term Care Reform Health & Medicine Policy Research Group	In the Presentation HFS refers to Medicare Advantage HMOs when discussing CMS Financial Models to Integrate Care (Duals) implying this opportunity is only available to MA Plans. Based on our recent inquiry to CMS and information CMS has released on the initiative, there appears to be no Federal requirement that Duals Integration be limited to MA Plans. Is HFS imposing this restriction or will other entities have the opportunity to bid on this option?	This opportunity is not restricted to existing MA plans.
MISC 4	Maureen McDonnell Director for Business & Health Care Strategy Development TASC	It is also possible that the best provider of outreach, engagement, and care management services for this population will not be a current Medicaid provider agency. Can such providers be included in CCE projects?	Yes.
MISC 5	Matthew Werner Academic Medical Centers and other providers.	This sounds very much like the Accountable Care Organizations that are being developed by Medicare and various hospitals. Why are you calling it something else?	Yes, these are similar to ACOs as other payers are developing. However, to avoid confusion with the specific set of regulatory principles that Medicare has adopted, we have used the more generic term "Care Coordination Entities.
MISC 6	Karen Batia, Ph.D. Executive Director/Vice President Heartland Health Outreach/Heartland Alliance	Since we know that there are such negative connotations with the term "managed care", we were wondering why the state would name Phase two of the Innovations Project as such.	It is the most understandable term for the entities we will be seeking in phase two. Moreover, the Department notes that the Managed Care programs being offered today are different from previous versions and we anticipate they will be valuable partners as we move forward with our strategy to maximize the number of Medicaid clients in some form of care coordination.

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MISC 7	Brad Wasson Group Vice President, Health Systems Solutions Group	Does HFS believe that expansion of healthcare access by leveraging non-traditional means (e.g. pharmacies and retail based clinics) may enable patients to efficiently become aware of their health status and thus improve their health outcome?	We are not aware of any data to reach this conclusion but to the extent some CCE wants to incorporate such an approach the Department will certainly consider it.
MISC 8	Jennifer Henson Planning Assistant - Executive Strategy Hospital Sisters Health Systems	The HFS utilization data is vital to the continued development of a proposal. The timeframe for release of data is requested. Information on the ability to customize the data request would be helpful.	Potential CCEs will be able to request data for their population of interest by specifying a variety of population parameters (geography, disability, specific chronic disease, etc.). The data will include a broad array of utilization measures. The measures will be common across all populations.
MISC 9	Brian Monsen Director of Strategic Planning Molina Healthcare Inc.	In the presentation and orally, there was some identification and discussion of future "stakeholder meetings". Can you share when you generally anticipate these stakeholder meetings to happen?	Interested parties should sign up to receive notifications of upcoming meetings through the Department's website at: http://www2.illinois.gov/hfs/PublicInvolvement/Pages/Registration.aspx
MISC 10	Chris Burnett Director of Strategic Policy Implementation I.A.R.F	How will the Innovations Project be funded?	While there is some small amount of additional funding through Federal waivers, we anticipate funding these projects through current State resources. It is our intention that these projects will improve quality and efficiency of care and, accordingly, reduce costs over time.

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MISC 11	Maureen McDonnell Director for Business & Health Care Strategy Development TASC	Will the cost savings baseline be the particular costs for the particular enrolled consumers? A broader population profile? Or another approach?	The cost savings baseline will be risk adjusted for the specific profile of the enrolled population.
MISC 12	Brenda J. Wolf President & CEO La Rabida Children's Hospital	Does the baseline for cost savings have to be the same set of patients the provider is currently caring for? If the provider was already engaging in some level of care coordination, this would put the provider at a disadvantage for attaining cost-neutrality or cost-savings. Is there another baseline of a similar population that the provider would be able to use?	The expected costs for the shared savings will be based on the expected costs, on a risk adjusted basis, of the population that the CCE enrolls. We will utilize population-wide, not provider specific, data in setting the risk adjusted expected costs.
MISC 13	Brenda J. Wolf President & CEO La Rabida Children's Hospital	Will the Department provide more detailed descriptions of successful models for CCE and MCCN that we should consider prior to the RFP release or as part of the RFP?	No.
MISC 14	Seniorlink Caregiver Homes	What is the Department's vision for its role, along with the Illinois Department of Aging and other agencies, in continued innovation during the course of the Innovations Project?	The question is not clear. The Department will monitor Innovation Projects and will continue to work with sister agencies around relevant clients. However, we do note that Innovations Projects are considered pilot programs and over time we expect the successful programs to become simply part of the portfolio of delivery options supported by Medicaid.

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MISC 15	Seniorlink Caregiver Homes	Recognizing that Illinois has submitted a Letter of Intent to CMS for both the Managed Fee-for- Service and Capitation options, what is the Department's plan and expected timing for the introduction of greater financial risk to Care Coordination Entities and Managed Care Community Networks? What is the Department's expectation about how those entities and networks will, in turn, introduce risk to their provider networks?	The Department's participation in the Medicare financial realignment demonstration does not affect the risk expected for other CCEs. We have no expectations at this time on how MCOs in the Medicare/Medicaid demonstration will introduce risk to their provider networks.