Questions and Responses
Solicitation for Care Coordination Entities and
Managed Care Community Networks
For
Seniors and Adults with Disabilities
Innovations Project/2013-24-002

	Question	Section	Response	Asked By
Populations				
P-1	Are the SMI clients enrolled in the pilot program with Aetna Better Health and IlliniCare an Excluded Population per 3.1.3.5?		Yes.	DuPage County Health Dept
P-2	Which non-Priority populations are available to serve?	3.1.3.2.1	See Section 3.1.3.2.1 of the solicitation, however, the State has removed children under age 19 from the excluded population. Children are included in the non-priority population that can be served. The State is also clarifying that in Section 3.1.3.2.1, the list of counties held to the one-to-one ratio of priority to non-priority populations should have included Madison county.	Blessing Health System
P-3	What constitutes "agreeing to accept all non-excluded clients in a geography" and if we meet that criteria, does that mean we can enroll any Medicaid population including the TANF population?		In counties not held to the one-to-one ratio of priority to non-priority, a CCE may propose to serve all full benefit HFS Medicaid and CHIP enrollees, including the TANF population. However, a CCE or MCCN may not propose to serve just the TANF population and all marketing and outreach must be designed so as to promote equal enrollment of Priority populations. Enrollment of non-priority populations may be limited by HFS if there is not sufficient enrollment of the Priority population.	Southern Illinois Healthcare Foundation (SIHF)

	Question	Section	Response	Asked By
P-4	We currently have an integrated model including participation from the Medical Center, Community Mental Health Center, Substance Abuse programs and the FQHC working with the seriously mental ill (SMI) population regarding all medical co-morbidities. Is it permissible to add a non-psychiatric diabetic grouping as a target population?		Yes, within the Priority Population you may target a subpopulation of individuals with diabetes. Again, we remind you that the State may not be able to restrict enrollment to the targeted subpopulation.	Trinity Health Foundation
P-5	Health home funding: please clarify that it is limited to the disease categories delineated by CMS; are you considering any additional disease categories?		HFS may include additional chronic diseases when it submits State Plan Amendments related to Health Homes. This solicitation is not limited to any particular disease category and is not limited to individuals eligible for health homes under ACA, although the state is particularly interested in proposals that focus on those with serious mental illness. Eligibility of individuals enrolled in CCEs or MCCNs for Health Home matching rate has no effect on how a CCE operates or is funded.	SIHF
P-6	With respect to population limits as outlined in 3.1.3.2, does the one to one limit of Priority Populations to non-priority apply to those clients already being served by the PCP? Additionally, since it doesn't speak to children in the families of adults enrolled in a CCE or MCCN, would this mean that the number of non-Priority Populations would be more than one to one in those select counties due to the ability to enroll the children of the adult case holders?		A PCP may serve individuals in Illinois Health Connect only or in an MCO in addition to those enrolled in a CCE. The one-to-one ratio applies to CCE enrollment, not PCP panels. Children count as part of the non-priority population in calculation of the one-to-one ratio.	Harmony

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P-7	The Definitions specify the Priority and Target Populations as well as Other IHC Adults, but Section 3.1.3 references "Excluded" and "non-excluded" populations. Is the "non-excluded" population the same as Priority and Other IHC Adults?		Certain populations are excluded from care coordination under this solicitation; they are described in the solicitation (however see clarification under P-2). The non-excluded population is comprised of priority and non-priority populations. Most of the non-priority population is either in IHC or in a voluntary HMO or MCCN plan. The care coordination partner must specify a target population. The target populations must include members of the priority population and within limits (dependent upon county) it may include members of the non-priority populations. Definitions for population and other terms are provided in the Solicitation and our data Glossary.	Harmony
P-8	Are the same questions to be answered for the priority populations as the non-priority regarding the enrollee care plan?		To the extent the questions are relevant to non-priority populations, they should be answered. Any entity seeking to cover non-priority populations should explain their care coordination model for those populations. Entities should specify any limitation on the non-priority population they are planning to serve.	Be Well Partners in Health
P-9	How will HFS identify data specific to the developmentally disabled population? Can you do a data match with the ROCS billing system and/or the PUNS list?		We currently have three paths to identification: DD institutionalization, DD waiver services, and DD category of CDPS (based on diagnoses). The data release has been developed from HFS's enrollment and claims data. ROCS service data appears in HFS claims data.	Health Management Associates
Organizational Structure - Collaborators				
O-1	Is it likely that the successful applicant will have a linkage agreement with a local hospital or is a less formal collaborative relationship acceptable?		To be considered, a proposal must have a hospital network sufficient for the population and the hospitals must be active collaborators in the project.	Behavioral Services Center – Skokie

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O-2	May respondents submit an LOI without committing to their status as either an MCCN or CCE? The population data received from the state, after the LOI is submitted, could affect a bidder's decision as to how best they should move forward.		Yes, but the LOI must demonstrate intent for at least CCE status.	Blessing Health System
O-3	Provision that CCE must include participation from PCPs, hospitals, mental health and substance providers. What does "participation" mean? Must all provider types listed be CCE collaborators or is it acceptable for a CCE made up of several provider types to have contractual arrangements with one or two of the listed provider types?	3.1.2.1	All required provider types must be actively committed partners in the proposal with defined roles in the care coordination model. The exact legal structure of the relationship may vary.	Molina Healthcare
O-4	Provision states that CCEs may subcontract with Managed Care Organizations or Third Party Administrators for back office functions. How is "back office functions" defined? Can MCOs partner with providers to provide care coordination or to hire PCPs for co-locating arrangements? Could a CCE or MCCN contract with an MCO to use all or part of its provider network?	3.1.2.1	The overriding goal of this solicitation is for provider formed and driven organizations to have the opportunity to show their ability to coordinate care. Arrangements that appear HMO driven will not be funded. The state expects all collaborating providers to be fully involved in the care coordination model.	Molina Healthcare
O-5	Can an MCO be a partner in multiple CCE or MCCN relationships?		Yes	Harmony
O-6	If an MCO collaborates with a provider on either a CCE or MCCN proposal, will that in anyway preclude the MCO from participating in the Phase II MCO Solicitation?		No	Harmony
O-7	Will complete contracts be required for collaborators and network providers?		The proposal must set forth a demonstrable governance structure showing commitment by all necessary collaborators. The specific legal structures may vary.	Harmony

	Question	Section	Response	Asked By
O-8	In this section it is mentioned that CCE's and MCCN's must be Provider owned but back office functions can be subcontracted. Can you provide more detail on what services can be subcontracted, i.e., customer service, disease management, case management, wellness, etc.		The overriding goal of this solicitation is for provider formed and driven organizations to have the opportunity to show their ability to coordinate care. Arrangements that appear HMO driven will not be funded. The state expects all collaborating providers to be fully involved in the care coordination model.	Quantum Health
O-9	What types of existing organizations and services are included when referring to "mental health providers?"		The Priority population has a high incidence of Serious Mental Illness. Every CCE should expect to have some enrollees with SMI. The term "mental health providers" means providers qualified, willing and able to adequately serve such enrollees and meet their mental health needs.	Be Well Partners in Health
O-10	Can a "social service agency" also be a "mental health provider?" Does it matter if the organization is a non-profit or for-profit?		It is possible for an entity to be both a "social service agency" and a "mental health agency," but only if it has the qualified professional staff necessary to serve individuals with SMI. Both for-profit and non-profit organizations can be included in a CCE.	Be Well Partners in Health
O-11	Currently, a psychiatrist refers individuals to hospitals, long term care and to community placement. Should we expect the responsibility shifting to the primary care physician in a new relationship with these organizations?		The state has not prescribed any particular care coordination model. How referrals for necessary services are handled is up to the CCE or MCCN.	Be Well Partners in Health
O-12	The RFP requests co-locations of services. Is it an expectation of the state that services such as mental health and substance abuse be located in the integrated medical homes?		The state has merely pointed out that evidence indicates the advantages of co-location of mental and physical health services and asks if the bidding entity has any plans for such co-location. There is no pre-conceived notion of the best co-location model.	Be Well Partners in Health

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O-13	What is the definition of collaborators? The document uses the term potentially in ways that could delimit a potential CCE model. There could be collaborators within a CCE entity which then has collaborators that are service providers within a network of varied providers. Does HFS want these differentiated?		The term "collaborator" refers to those providers involved in the governance of the CCE. The collaboration must include the four types of providers indicated. Other provider types may also be collaborators and there may be other types of relationships with other providers.	Be Well Partners in Health
O-14	Are CCE's expected to have formal contracts with their provider partners? What level of formalization is expected?		See Response to O-7.	
Geography				
G-1	Could an integrated system of providers with a large and diverse geographic area operate more than one CCE, each in a separate geography?		Yes	SIHF
G-2	What is meant by geographical distribution and what are potential ways to define parameters of geographic distribution?		In proposing the geography a CCE or MCCN wishes to serve the area should be defined by the counties served or, in highly populated areas if a proposed service area is smaller than a county, zip codes should be used. For purposes of requesting data only, an entity may define a population as the population served by specified providers, such as a hospital and/or clinic.	Be Well Partners in Health
G-3	Once a CCE is approved for a specific target population and geography, can it expand at a later date to encompass additional populations and regions?		Yes, a plan operating successfully may request either a geographic or population expansion.	Health Management Associates

	Question	Section	Response	Asked By
Financial Models/ Rates				
F-1	Will it be more than two years before I receive any shared savings dollars (complete a 12 month period and then allow another 12 months for billing, plus time for DHFS and CMS to agree on the calculations)? Can payment be sped up by shorter and more frequent reconciliation periods and the use of either IBNR calculations and/or carryover of late claims to the subsequent period? Will reconciliation be based on claims paid or claims approved with payment pending at the close of the period?	3.1.6.1.1.2.1	The State is working with Federal CMS and will provide information when it is available. The Department understands the diminished incentive created by too great of a time period before the pay out.	SIHF

	Question	Section	Response	Asked By
F-2	How will shared savings be calculated? We will need to make new investments, both initial and operationally, to generate those savings but will not receive any add-on to our fee-for-service rates to compensate those expenses. Can we recover those expenses off the top before shared savings is divided up with DHFS and CMS? For example, if the ABD premium was $500 pmpm and we generated 10% savings but it cost us $30 pmpm to generate those savings, would I be eligible for up to $25 pmpm in savings (50% of the savings) or $40 pmpm (recoup my extra cost and then accessed 50% of the remaining $20 of net profit)? If not the latter, it could cost me money to be able to generate "savings" for DHFS and CMS. If I am able to recoup these new costs off of the top, will that be subject to meeting quality measures as well?		This question seems to confuse two mutually exclusive financial arrangements. Shared Savings is a separate financial model for CCEs that operate in the FFS structure. If an entity chooses a full-risk capitation payment, shared savings as describe in the solicitation are not available. To the extent an MCCN provides all necessary services at a cost less than their capitation revenue through better care coordination, it will retain savings up until the point those savings exceed the negotiated MLR.	SIHF
F-3	Will the shared savings calculations be transparent to us and is there an appeal mechanism if we disagree with those calculations?		The methodology for calculating shared savings will be transparent and CCEs will have the opportunity to review and raise concerns regarding the calculations.	SIHF
F-4	Can you specify your mechanism for risk adjusting for severity of illness in our patient population?		Not at this time. We are developing a method and need to have it approved by CMS. We recognize that thoughtful and fair risk adjustment is integral for setting appropriate base-lines, targets, shared savings calculations, and MCCN capitations.	SIHF
F-5	How will you be taking hospital fixed payments and FQHC PPS payments into account when you calculate the baseline expense used to calculate share savings?		As stated in the solicitation, the Department will release more information on Shared Savings as it becomes available from the federal government.	SIHF

	Question	Section	Response	Asked By
F-6	Provision indicates that a Care Coordination PMPM fee will be assessed for each population type. How will the State determine the population types for which PMPM rates will vary?	3.1.6.1.1.1	CCEs are to propose their Care Coordination Fees and any subpopulations of the Priority population for which it wants a distinct fee (See Attachment F). A factor in whether the state decides to pay a distinct fee for a sub-population is whether this subpopulation can be readily identified in HFS systems so as to make such a distinction feasible. Proposing to have a distinct fee for a population that it is later determined cannot be feasibly identified will not weigh against acceptance of a proposal.	Molina Healthcare
F-7	If we propose a combination of a care coordination fee and shared savings, will the care coordination fee be subtracted from the common shared savings pool before dividing up the remainder or will it come out of our portion of the shared savings pool? If the latter, if the care coordination fee exceeds our portion of the shared savings, will it need to be reduced in subsequent years to prove "cost neutrality"?		Care coordination fees will be added into the actual cost of serving a population. Therefore, savings on all other Medicaid reimbursed services must exceed the amount of fees paid for there to be identifiable savings to share. In other words, the cost of the care coordination fees comes out of the total savings pool, not just the CCE's half. If at some point during the demonstration data demonstrates a CCE will not be cost neutral at the end of three years, the State may offer the option of a reduced CCE fee rather than terminating the contract as stated in Section 3.1.6.1.3 of the solicitation.	SIHF
F-8	Can you elaborate on the risk corridor concept? Would you be wanting upside potential in exchange for downside risk protection? If we opted for stop loss protection alone, would that be limited to patient specific stop loss protection or could we get aggregate stop loss protection?		The state is willing to consider any reasonable risk sharing arrangement that is actuarially sound, acceptable to CMS and in the states best interest. This does not imply that we will accept any proposal, only that the State has not settled on a specific methodology.	SIHF

	Question	Section	Response	Asked By
F-9	Will we expect a patient specific capitation rate that is risk adjusted similar to the Medicare RAP program? Will it be updated when patients develop new illnesses? If so, what will be the lag time between the occurrence of those new illnesses and adjustment of premium? How will you risk adjust a patient who is new to ABD or dual coverage?		Patient specific capitation rates will not be used. New patients will be given average risk scores.	SIHF
F-10	Will the State guarantee payments of the actuarially sound MCCN Capitation within the month of enrollment?		The state would expect capitation payments to be paid on a schedule similar to that used in the Integrated Care Program, although this is an item subject to negotiation. In light of the cash flow problems the comptroller has experienced in recent years, the state cannot guarantee payments will always be made on schedule.	Blessing Health System
F-11	Which independent Actuary will be used by the State to develop the rates for the MCCN?		Our current actuary is Milliman. The state is in the process of re-procuring actuarial services for a term beginning July 1, 2012. The vendor that will be selected is unknown at this time	Blessing Health System
F-12	In the case of care coordination models that serve those dually eligible for Medicaid and Medicare, will baseline amounts include Medicaid and Medicare costs? Will cost neutrality calculations recognize Medicare as well as Medicaid savings from baseline amounts?	3.1.6.1.3	Initially baseline data and savings and cost neutrality will be based on Medicaid costs only since the State does not yet have access to Medicare. The Department hopes that at least some of the CCEs serving dual eligibles will be approved by federal CMS for the managed fee-for-service realignment initiative. If that happens, Medicare costs and savings may be included in the calculations.	Molina Healthcare
F-13	We are interested submitting a LOI in collaboration with 2 hospitals and 2 other centers that serve children and adults with disabilities. While I've done a quick review of the project information, I've not (yet) found how much funding is available per project. Where might I find this information?		There is not set amount of funding available. See Section 3.3.1.2 and Attachment F. Also, please note the statement in Section 3.1.6.1.8 that gross CCE fees proposed must be sustainable and cost neutral.	Little City – Beverly Saiz

	Question	Section	Response	Asked By
F-14	Will we be able to access network financial performance on a monthly basis as far as the shared savings pool?		Yes, to the extent claims have reached HFS. Of necessity, this will always lag behind reality—in some cases significantly so. But we cannot report on information we do not have. For this reason, applicants need to think carefully about internal reporting needs they might have. Collaborating providers have some control over the timing of the availability of this data by billing timely for services.	SIHF
F-15	For CCE's proposing a care coordination fee, will that fee be proposed by the CCE or established by the Department? If the latter, will such rates be developed at the county level, zip code level or some other stratification? Can CCE's serving the same populations within the same county have different care coordination fees?		CCEs are required to propose a care coordination fee or fees using Attachment F. However, final fees will be negotiated with the Department. Care coordination fees will be developed per CCE with no variation by geography. CCEs servicing the same populations within the same county may have different care coordination fees due to variation in the care coordination model proposed.	Harmony
F-16	How will baselines developed for purposes of shared savings calculations be done? Will it include all claims for specific populations, such as LTC services for institutional members?	3.1.6.1.1.2.1	The State is working with Federal CMS and will provide information when it is available.	Harmony
F-17	Can CCEs use the care coordination fees to pay specialists or hospitals more than the State payment?		Yes.	Harmony
F-18	Section 3.1.2.1 states that MCOs may not bear any financial risk for CCEs, however, can MCOs bear any financial risk for MCCNs?	3.1.2.1	No, HMOs may not bear any financial risk for MCCNs.	Harmony
F-19	The solicitation did not seem to indicate a minimum amount of the at risk capitation payments paid to a MCCN that must be used for medical expenses. Does the Department intend to prescribe such a minimum in this program?		Yes. The amount of the MLR will be determined during contract negotiation.	Harmony

	Question	Section	Response	Asked By
F-20	This section states that MCO's may not bear any financial risk for CCE's. Can subcontractors that are not MCO's be paid on a shared-savings or performance basis? Is there any limitation on the percentage of contract dollars that must go to Providers vs. non-Provider subcontractors.		Subcontractors may be paid on a shared savings or performance basis. There is no limitation on the percentage of contract dollars that must go to providers vs. non-provider subcontractors.	Quantum Health
F-21	Will there be more guidance regarding acceptable ranges of fees?		Not that we anticipate at this time.	Be Well Partners in Health
F-22	How does the Department plan to risk adjust for the developmentally disabled, particularly those who are already chronically institutionalized despite concerted attempts to get them into home based care.		See response to question F-4.	Health Management Associates
F-23	Please elaborate on how the Department will allow applicants to incorporate Medicare savings into their financial model. Specifically, what Medicare data will be made available to applicants who are proposing to serve dual eligibles and will the data be made available on the same timeline as Medicaid data?		See response to question F-12.	Health Management Associates
F-24	How will shared savings be calculated? Can we recover expenses off the top before shared savings are divided up with HFS and CMS? If we propose a combination of a care coordination fee and shared savings, will the care coordination fee be subtracted prior to distributing the savings?		See response to question F-4 regarding shared savings calculations. If by "expenses" you mean any cost of coordinating care that exceeds your care coordination fees, the answer is no. See response to question F-7 regarding distribution of savings.	Health Management Associates

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F-25	How can we "borrow" from start-up costs when we don't know how many members we will have to borrow from? How much will we be allowed to borrow?		The State is developing guidelines on start up costs and hopes to issue them before proposals are due. However, the State's precarious budget prospects for State Fiscal Year 2013 make it difficult to definitively say what we will be able to offer in this regard.	Health Management Associates
MCCN				
M-1	If an entity chooses to become an MCCN, can its design mirror an HMO operational design with authorizations, in-network requirements, and referrals? The CCE is to be an open access design according to the Solicitation; however, can a MCCN have HMO-like features?		Yes.	Harmony Health Plan
M-2	Will FQHCs be eligible for wrap payments as is the case with the only active MCCN in the state currently?		FQHCs in an MCO will receive supplemental payments in accordance with federal law in situations where the law requires them.	SIHF
M-3	Could a MCCN forward approved claims to DHFS for payment, in essence using you as the MSO?		No	SIHF
M-4	Can a MCCN access current Medicaid fee-for-service rates for out-of-network providers in both emergent and non-emergent situations?		MCOs must pay out of network providers at least Medicaid rates for emergency services. MCOs that agree to non-emergency services being provided are expected to negotiate those rates with the providers. The state does not dictate what the negotiated rate should be.	SIHF
M-5	Currently there are MCOs/MCCNs operating in Illinois that implement marketing enrollment brokers and if an MCCN is awarded the proposed Innovations bid, are they still able to use Marketing Enrollment brokers for the other populations they serve? Or will this be addressed in later RFPs released in the summer?		Nothing in this solicitation changes the current contract terms of MCCNs or HMOs currently under contract. An award to an existing MCCN under this solicitation will result in a new contract with its own terms.	Blessing Health System

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M-6	Will the PCP Site registration process remain the same through HFS - Site A/B Forms?		At this time the site enrollment process for MCCNs will remain the same as the current voluntary MCO program.	Blessing Health System
M-7	Does the State anticipate changes to current MCCN capitalization requirements? What would be the basis for these changes?	3.1.2.2	Yes. New rules are under development to update those requirements.	Molina Healthcare
M-8	With the inclusion of Pharmacy, are MCCNs able to assign members into a Pharmacy Lock-in program for non-compliance?		Yes.	Blessing Health System
Enrollment/ Disenrollment				
E-1	Voluntary enrollment: are you open to passive enrollment based on IHC membership with voluntary disenrollment for either the CCE or MCCN? Would you consider mandatory enrollment in certain geography if there were at least two managed care options once the CCE or MCCN was operational? If not now, when?		Mandatory enrollment will not be implemented until the full array of care coordination options has been implemented.	SIHF
E-2	Are you proposing passive enrollment to the duals with a voluntary opt-out and if so, how does that impact this RFP?		Not under this solicitation.	SIHF
E-3	Provision indicates that the Illinois Client Enrollment Broker will determine eligibility and enrollment. To what eligibility and enrollment does this refer? Is it CCE/MCCN eligibility and enrollment?	3.1.6.1.2	Both CCE and MCCN enrollment will be through the Client Enrollment Broker.	Molina Healthcare

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E-4	Will the disenrollment process be similar to the current process with HFS for our TANF population? (members living out of service area, TPL, etc.)		The automatic disenrollment process will be identical to the current MCO and IHC disenrollment process for beneficiaries that become an Excluded Population due to change in circumstance. Any enrollee may voluntarily disenroll during the first 90 days of enrollment or at their annual open enrollment period. Finally, disenrollment "for cause" will be allowed per federal regulation.	Blessing Health System
E-5	If a member elects to drop out of a chosen MCCN within 90 days and picks another CCE or MCCN option, do they then get an additional 90 day grace period to drop out without cause?		Initially, yes. This may change after programs mature.	Blessing Health System
E-6	Initial participation is stated to be voluntary much like the implementation of the ICP, will the CCP follow a similar timeline in moving towards mandatory - approx. 4-5 months allowing members to choose and then auto assign? If not is there a timeline in mind?		The ICP program has had mandatory enrollment since initial implementation. Enrollment in CCEs and MCCNs funded pursuant to this solicitation will be voluntary. No timeline for moving to mandatory enrollment has been set. It is reasonable to assume that at some point mandatory enrollment will be established in many areas of the State.	Blessing Health System
E-7	What are the criteria for provider disenrollment of a "locked in" member, such as when he poses a threat to a provider?		They will be the same as current MCO rules.	SIHF
Dual Eligibles				
D-1	Will the time frame for implementation of the duals integration be dependent on CMS approval and if so, can you project a time frame?		Yes, it will depend on CMS approval. The timeframe is being discussed with CMS.	SIHF
D-2	Will you be offering the fee-for-service duals option in all areas of the state or just in those without the managed care option?		The State will consider proposals for the fee-for-service dual option statewide.	SIHF

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D-3	To be clear, are Dual Eligibles included in this proposal? They are listed in the Populations and Priority Populations as well as Care Coordination Model detailed in this RFP. The progenitor to this question is because HFS stated there will be a separate RFP for Dual Eligibles coming out in April.		This solicitation does include the duals. The separate RFP will be for HMOs to serve the duals.	Blessing Health System
D-4	What is the updated timeline for the Phase 2 solicitation (Integrated Care for Dual Eligibles)? What is the status of HFS's negotiations with CMS on the Dual Eligible Demonstration?		The timeline is still under negotiation with CMS.	Healthspring, Inc.
D-5	Will a dual that is served through this program have the ability to enroll in a Medicare Advantage plan for their Medicare benefits?		No, a dual eligible already enrolled in a Medicare Advantage Plan would not be allowed to enroll in a CCE, as the Medicare Advantage plan is already paid to coordinate the care of its enrollees. A dual eligible enrolled in a CCE that enrolls in a Medicare Advantage Plan will be disenrolled from the CCE.	Harmony
Quality Measures				
Q-1	Population definition: will the members in the denominator for the various parameters that determine P4P and shared savings access be defined at the beginning of each fiscal period or will clients be rolling in and out of the denominator during the period based on new enrollment and disenrollment?		Parameters for quality measures are defined in detail on the State's website at: http://www2.illinois.gov/hfs/PublicInvolvement/cc/Documents/Perfomance.pdf	SIHF
Q-2	How will you measure the "medication review" parameter for shared savings access and how will you set a baseline for this measure?		The state is still considering the mechanics of measuring this outcome. If this measure is retained, there will be no baseline, just a target.	SIHF

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Q-3	When will you release the baseline measures for each parameter and what are you basing it on?		Due to the need to risk adjust in at least some circumstances; baselines cannot be set until enrollment is complete. However, for informational purposes, the State will post on this website in the next few days the baselines for the AABD population in suburban Cook and the collar counties that were developed in the Integrated Care Program.	SIHF
Q-4	Will we be able to access client specific performance on the target population for each measure regularly during the fiscal period? Can we get provider specific performance data?		The only data made available will be the claims data referenced in the response to question F-14. This claims data may be less than ideal for care management. The difficulty is with the lag inherent in HFS claims data. The CCE is better off monitoring its own client and provider performance on a more real-time basis.	SIHF
Q-5	Is there an appeal mechanism if our records do not match with your records in calculating compliance?		The issues here vary depending on whether the MCCN or CCE model is chosen. In the MCCN model, the primary source of measurement will be encounter data submitted to HFS in order to create a strong incentive to submit complete and accurate encounter data. In the CCE model, claims data will be used and the opportunity for discrepancy will be less. In any event, CCEs and MCCNs will have an opportunity to explore and reconcile discrepancies.	SIHF
Q-6	Your proposed resetting of the threshold seems to penalize providers who not only exceed the threshold to attain savings but do significantly better than that. Can you reconsider this "disincentive" for achieving excellence? Would you consider adding improved access to dollars for super performance?		The state does not consider this a disincentive for excellence, but considers it an incentive for continuous quality improvement.	SIHF

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Q-7	Attachment A lists the 31 measures that will be monitored for performance. Attachments B & C identify the selected P4P measures. What will be your requirement for reporting the 31 total measures and the P4P measures? How often? By what mechanism?		In the CCE model, the State will measure and report all measures based on claims data. In the MCCN model, the state will measure and report based on encounter data.	Blessing Health System
Q-8	Provisions include 5 pay for performance quality measures and 4 shared savings measures. Are these two separate sets of measures or do they overlap? How do the two sets of measures relate to each other?	3.4.1.1.1 and 3.4.1.2.1	These are two separate sets of Pay-for-Performance measures, one for the withheld portion of the Care Coordination Fees and one for the Shared Savings model. A CCE must meet all of these measures if it wants to maximize revenue by earning withheld Care Coordination Fees and sharing in savings.	Molina Healthcare
Q-9	Tables 1 and 2 list CCE pay for performance measures. What is the difference between these two tables?	Attach-ment B	Table1 is to earn withheld Care Coordination Fees and Table 2 is to earn Shared Savings. See Sections 3.4.1.1.1 and 3.4.1.2.1	Molina Healthcare
Q-10	Section 3.4.1.1.1 references quarterly measurement and payments for quality measures, and then Section 3.4.1.4.1 references quarterly target goals but also references a baseline measurement year. Are the quarterly targets to be re-set each quarter, or do they stay fixed for the year?		The baseline is set each year. In order to allow for faster payments based on quarterly measurements, quarterly targets are set. The target increases above the annual baseline each quarter. Pay for performance payments paid on a quarterly basis will be reconciled to annual performance	Harmony
Q-11	Sections 3.4.1.4.1 and 3.4.1.4.2 reference a "highest baseline". What does this mean?		It means that the baseline used for setting targets for subsequent measurement periods can never be lower than any previous baseline used. In other words, performance below a baseline does not set a lower baseline for the next measurement period.	Harmony

	Question	Section	Response	Asked By
Q-12	Why are the quality targets lower for the Care Coordination Fee model than for the Shared Savings model or the MCCN model?		Because the CCE targets are quarterly and not annual like the shared savings. They are exactly one fourth of the annual targets for Shared Savings. In the end, performance will be measured annually and quarterly payments reconciled to the annual performance.	Harmony
Q-13	When will the quality measure baselines (CY 2010) be determined and made available?		Due to the need to risk adjust in at least some circumstances; baselines cannot be set until enrollment is complete. However, for informational purposes, the State will post on this website in the next few days the pay-for-performance measure baselines for the AABD population in suburban Cook and the collar counties that were developed in the Integrated Care Program.	Harmony
Q-14	Please clarify how many pay for performance quality measures will be required? How many set by the State, and how developed by the CCE?		Please see Section 3.4.1.1.1 for the answer with respect to Pay-for-Performance related to withheld Care Coordination Fees and Section 3.4.1.2.1 for Pay-for-Performance with respect to Shared Savings.	Be Well Partners in Health
Q-15	Will the CCE be expected to collect and report data on the quality measures that cannot be measured via encounter data?		Yes.	Health Management Associates
Q-16	Is the Department planning to collect all 31 quality measures regardless of the size and characteristics of a CCE's target population? Are there concerns about getting statistically significant data on measures that only apply to a small subgroup of a relatively small membership?		The Department will run claims data for all measures for all CCEs through the program that calculates performance on each measure. Whether the numbers are statistically significant can then be determined.	Health Management Associates
Start-Up Costs				
U-1	How can we borrow from fees for start-up costs when we don't even know how many members we will have to borrow from?		The State will negotiate any advances based on reasonable estimates of enrollment in light of all known information.	SIHF

	Question	Section	Response	Asked By
U-2	How much can we borrow?		This has not been determined and will be subject to negotiation.	SIHF
U-3	What if we can't pay you back?		Any advanced fees will be withheld from monthly payments of future fees.	SIHF
Information Systems/Technical Assistance				
IT-1	Please elaborate on IT expectations; what constitutes its ability to communicate with other providers?		The respondent will have to indicate how it intends to share clinical information among the network participants. How such sharing is done initially will be up to the CCE, but HFS will consider the probable effectiveness of any method in determining contracts. Over time, HFS expects to see a migration to integrated clinical information.	SIHF
IT-2	It is stated the "CCE or MCCN must have or develop electronic capabilities no later than 12 months after Contract Execution." What is the definition of electronic capabilities?		At a minimum, the appropriate CCE collaborators must be meeting federal requirements for the demonstration of "meaningful use". Also, see response to IT-1.	Blessing Health System
IT-3	What format should be used for the request for technical assistance?		The Letter of Intent format offers an opportunity to request assistance.	Be Well Partners in Health
IT-4	How is HFS going to insure that any technical assistance provided to the potential competitors is done in a fair and equitable manner? How is HFS going to assure that the technical assistance will not provide an unfair competitive advantage based on the varying manners and individuals who might provide the technical assistance?		Technical Assistance will be offered via seminars and webinars provided by third parties and accessible to all who have submitted credible letters of intent.	Be Well Partners in Health
IT-5	IT expectations are not well-defined. What are the Department's expectations with respect to IT connectivity?		See answers above.	Health Management Associates

	Question	Section	Response	Asked By
Solicitation/Contract Requirements				
S-1	Is there a deadline for project implementation?		Implementation should be targeted for January 1, 2013. It is possible that slightly earlier or later implementation will be considered for some projects.	SIHF
S-2	What if we have a new question after 2/10/2012?		Please submit it through the same format and the State will continue to answer as soon as possible.	SIHF
S-3	Term of the contract: why is the potential term of the contract limited to 10 years?		Due to the limitations of state contracts. This does not mean that successful models cannot extend past that time.	SIHF
S-4	Is there a limitation on the number of pages for each section or for the entire LOI?		No.	Proviso Township Mental Health Commission
S-5	Since all of the forms are only available in pdf format, can copies of the Proposal on CD be submitted in pdf format?		No, the proposal must be submitted in Microsoft Word and/or Excel, as appropriate. The State will make any forms that need to be completed as part of the proposal submission available in those formats. The only exception to this is referenced in response to question S-13.	TASC of Illinois
S-6	Is there a preferred format for submission of the proposal contents other than 1 original with 14 hard copies along with 2 CD versions in word or excel documents?		The proposal submission should follow the format explained in section 2.3, Proposal Checklist. Each section of the proposal or answer to a solicitation question should maintain the solicitation numbering. The State would also appreciate if the proposal was organized through the use of a table of contents or index.	Blessing Health System
S-7	When will the data request be met?		We are ready to send data. You can receive data as soon as your Letter of Intent is submitted and approved and you have specified a target population in sufficient detail for our IT staff to extract the data from our data mart. We have already posted significant data documentation at Data Release: http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/DataRelease.aspx	Blessing Health System

	Question	Section	Response	Asked By
S-8	What format should one use for requesting data?		The Letters of Intent must include the Data Use Agreement. For more information on the Data Request Procedures, please see the instructions on the State's Care Coordination website Data Release referenced in response to question S-8.	Be Well Partners in Health
S-9	Can HMOs interested in the Phase 2 solicitation gain access to the data published as a part of Phase 1? If yes, do we need to submit an LOI for Phase 1 even though HMOs are not eligible to participate in Phase 1?		No, data will not be available to HMOs through this solicitation.	Healthspring, Inc.
S-10	Please confirm that Letters of Intent for the Innovations Project can be emailed to you by February 29, 2012		Yes they can.	TASC of Illinois
S-11	Please confirm that LOI for the project can be submitted in pdf format.		Yes it can.	TASC of Illinois
S-12	The RFP asks for two copies of the proposal on a CD in Microsoft Word and/or Excel, how does one then submit copies of organizational articles of incorporation and by-laws? Will it be acceptable to use PDF format incorporated within the Microsoft Word document?		Yes, organizations articles of incorporation and by-laws may be submitted in a PDF or other scanned format incorporated within the Microsoft Word document. We would prefer one Word document. The supporting portions of the document can be imported from other software as an image. Material from most any software can be converted to .jpg (or another image format) and then imported into Word.	Be Well Partners in Health
S-13	There are four categories by which each proposal will be reviewed and scored. Can the State provide more detailed information on weighted areas within each category?		There is no more detailed weighting.	Be Well Partners in Health
S-14	When the RFP asks for organizational charts and detailed job descriptions for key staff, should this be part of the attachments and if so should it be labeled as Attachment L.	3.2.3.3	This information may be included in the response to Section 3.2.3.3. Lengthy material such as detailed job descriptions or organizations charts may be referenced in the response to this section and attached at whatever sequentially numbered Attachment is appropriate.	Be Well Partners in Health

	Question	Section	Response	Asked By
S-15	When the RFP asks for sample materials related to Enrollee health education plans should these be included as an attachment?		Yes.	Be Well Partners in Health
S-16	When the RFP discusses outreach and engagement plan, does this include marketing plans?		Yes.	Be Well Partners in Health
S-17	Does HFS desire the care coordination staffing plan and job descriptions to be included as an attachment or as part of the narrative?		No preference.	Be Well Partners in Health
S-18	How does one request confidential treatment of their response? Does one include a separate cover letter? Is there a specific required format?		All responses will be treated confidentially until awards are made. If a bidder wants confidential treatment of a portion of its response after awards, please follow the instructions in Section 1.6.	Be Well Partners in Health
Miscellaneous				
Misc-1	When do you anticipate opening the market to MCOs not currently contracted to serve the Medicaid population? Can you clarify which MCOs are currently able to serve each of our 11 counties now?		A solicitation for HMOs is expected sometime in the next year, although an exact date has not been determined. For information on the service areas of current MCOs, see the HFS website at http://www.hfs.illinois.gov/managedcare/	SIHF
Misc-2	Definition of "Adults with Disabilities" indicates that an individual's Medicaid eligibility be based on meeting the federal disability definition. Has there been any change to the requirement that a disability adjudication be performed to be considered to have Medicaid eligibility based on disability?	7.1	No.	Molina Healthcare

	Question	Section	Response	Asked By
Misc-3	Provision states that a CCE or MCCN may target a particular Priority Population or specified sub-population for outreach. What does "outreach" mean here?	3.1.3.4	The point of this section is to allow a CCE to design a care model specific to a subpopulation (e.g., SMI) and then target outreach for enrollment to that subpopulation. The responsibility is on the CCE to reach out to members of the population and convince them to enroll.	Molina Healthcare
Misc-4	On page 7, 3.1.1 the first sentence uses the adjective experienced to describe a potential CCE or MCCN. Does this mean that HFS expects that an entity applying is required to have provided care coordination previously to responding to the RFP?		We want to know the experience, if any, of the collaborators in care coordination efforts. We realize that entities bidding will almost all be newly formed and will not have experience as an entity.	Be Well Partners in Health
Misc-5	Once an individual is enrolled in a CCE after 90 days, what information systems/protocols will the State implement to alert non-network providers that an individual seeking their services should be re-diverted/referred to their own medical home/ neighborhood?		The MEDI electronic eligibility verification system will identify the CCE or MCCN enrollment of all enrollees. Entities proposing to be a CCE must understand that non-collaborating providers will be allowed to bill for services to CCE enrollees through the FFS system. Only the current edits preventing IHC PCPs from billing for individuals assigned to non-affiliated PCPs will be in place. For individuals enrolled in an MCCN, all claims to the HFS will be rejected.	Be Well Partners in Health