Illinois Department of Healthcare and Family Services
Solicitation for Accountable Care Entities (ACE)
Reference No. 2014-24-002

Addendum #1

This addendum is issued to further define and amend the original Request For Proposal (RFP) for the above referenced project, as issued by this office on August 1, 2013, and is now considered a part thereof. This addendum is to be acknowledged in accordance with the solicitation, Proposal to State of Illinois, Acknowledgment of Amendments/Addendums. Offerors are instructed to read this entire package before attempting to complete the information required therein. All other terms and conditions of the solicitation shall remain in full force and effect, unchanged except as amended hereby.

#'s	Question		Answers
GOV 1	Should § 3.1.2.1.2 be interpreted to mean that a lead entity must be a provider or a local governmental non-Medicaid authority?		The lead entity does not need to be a provider. However, the entity must be governed by providers (owned, controlled, etc….). Please also see Section 3.1.2.1 of the Solicitation.
GOV 2	As of January 1, 2010 Illinois law permits the formation of L3Cs (low profit limited liability corporations). May a lead entity be incorporated as an Illinois L3C?		Yes.
GOV 3	Typically Consumer advisory Boards can be composed of a combination of consumer and consumer advocates. Some states have required a minimum percent of consumers on the board. Will HFS be setting any minimum percent consumer		The Department will require an entity to have a 50% consumer representation and 50% advocate representation on a Consumer Advisory Board. Yes, the Department will consider parents of ACE enrollees as meeting consumer representation.

#'s	Question		Answers
	representation? Given that the ACE will serve a large population of children, will parents of ACE enrollees be accepted as meeting consumer representation?		
GOV 4	Can the lead entity be a newly formed corporation?		Yes.
GOV 5	Can a Lead Entity serve as both a CCE and an ACE at the same time? Relative to Care Coordination Entities (CCE), does HFS anticipate ACE bidders to incorporate CCEs into network design? For example, would HFS welcome ACE proposals which sought to incorporate CCEs to provide at risk members with care coordination services? Can CCEs expand services to the ACE population?		Yes. Please note that long range the Department expects CCEs to either become fully capitated plans or merge with an ACE or HMO. If a CCE merges with an ACE, the process must be completed no later than month 36. The Department welcomes proposals that seek to incorporate CCEs into its model. However, the Department will only pay one entity for the care coordination services; the Department will not pay both entities.

#'s	Question		Answers
GOV 6	What is the expectation for physician representation on the ACE board? The Solicitation states that primary and specialty care must be represented on the board, but must they be physicians? (3.1.2.1)		Yes, the Department expects an ACE to include Physicians on its Board, as an ACE network shall include primary care, specialty care, hospitals, and Behavioral Healthcare Providers per Section 3.1.3 of the solicitation.
POP 1	Section 2703 allows the state to define, to a degree, its health home focus. Has the state established state specific criteria for health home eligibility? If so, when will that be shared with potential contractors? Section 2703 does not allow for the exclusion of dual eligibles, but they are excluded from ACE. How will the state address this?		An ACE will serve as a health home. In addition, the Department will establish health homes under other managed care programs, such as CCEs and MMPs. Utilizing multiple programs allows the Department to include populations that may be excluded from participating in an ACE. The Department is considering including all chronic diseases indentified in Section 2703 and expanding the model to include ones not identified, such as HIV/AIDS. The Department anticipates moving forward with the health home process once the overall structure is in place, which includes having all programs implemented.
POP 2	What will be the IL State specific criteria for Health Homes under Section 2703 of ACA beyond the federal requirements?		The Department is considering including all chronic diseases indentified in Section 2703 and expanding the model to include ones not identified, such as HIV/AIDS.
POP 3	After reading the ACE solicitation we are concerned that the Medicaid children with complex medical needs who are CCE eligible (CRG 6-9) are not specifically excluded in the ACE population exclusions. Can you please confirm that the CCE-eligible children are excluded?		No, CCE eligible children are not excluded from participating in an ACE.

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POP 4	If a member becomes ineligible for ACE (ex. child gains retro eligibility for SSI or TPL identified) how will plan be notified of ineligibility and will disenrollment occur at the end of the month of notification to plan?		A member with SSI will remain enrolled in the Plan unless the member requests to disenroll. A Plan will be notified via the daily enrollment file from HFS and also via the daily panel roster provided by Illinois Health Connect of enrollment and disenrollment activities and effective dates of each action.
POP 5	If a child enrolled with an ACE is taken into foster care briefly (less than 90 days) will disenrollment occur at the last day of the month the child is taken into care and will the child be auto assigned to same ACE when eligibility resumes?		This question is under review by the Department.
POP 6	Will newborns be auto assigned to mother's plan, effective on DOB?		This question is under review by the Department.

#'s	Question		Answers
POP 7	Is the member required to choose both a PCP and a HMO/ACE/CCE/MCCN or will the member select a PCP and then CES divides the members round robin based on network availability? How are patients assigned to a specific ACE? How does the assignment of enrollees work? How would patients be assigned to an ACE provider? Are these already existing patients with a provider who would be enrolled in an ACE or would these be newly enrolled patients only? How will patients be allocated through auto-assignment once MCOs and ACEs all reach the minimum guaranteed enrollment level? What parameters will be factored into the auto-assignment algorithm?		An individual will always have a voluntary choice period to select both a Plan and a PCP. If the individual does not make a selection during their voluntary choice period, the CEB will auto-assign the individual to a Plan and PCP based on an algorithm that takes into consideration at a minimum the physician history and geography of the individual and network availability of the Plan. Once minimum enrollment is met, the algorithm will divide enrollment equally among the plans based on each plans capacity.

#'s	Question		Answers
POP 8	After minimum levels by plan are achieved membership will assignment to plans be based on positive selections or other performance standards?		Positive selections are always first. If there is no positive selection, an auto-assignment algorithm will assign an individual to a Plan and PCP. Current algorithms take into consideration at a minimum the physician history and geography of the individual and network availability of the Plan. In the future the Department will include performance standard results of a Plan in the auto-assignment algorithm process. The Department has not yet determined how it will apply performance standard results in the auto-assignment process.
POP 9	Will ACE/HMO/CCE/MCCN network directories be sent to members?		No, the Enrollment Broker will mail a directory to an individual upon request only. All individuals will have access to a Plan's network through the Client Enrollment Services call center and via the Client Enrollment Services web site.
POP 10	How often will CES transmit membership files (834)? Will Pregnant women files be sent daily?		All enrollment files will be sent daily with a full refresh file on a quarterly basis. This file will include an indicator that identifies if a woman is pregnant; however, the Department is not always aware of pregnancies and an ACE should develop methods to identify pregnancy as soon as possible.
POP 11	Will there be plans for retro-eligibility based on CES cutoff dates?		No, the Department will not retro-enroll individuals into an ACE or CCE Plan.
POP 12	Will the HMO/MCCN be allowed to provide "Value Added Services" offered to members (health club memberships)?		Yes, value added services are allowed and encouraged, especially when the model has reached month 19 and is receiving a capitated rate. Any value added services during the first 18 months would be at the ACE's own cost and not included in the monthly care coordination fee. Any value added service must be approved by the Department prior to implementing the service.

#'s	Question		Answers
POP 13	Is the State willing to provide guidance as to whether a particular ACE participant operates in a "covered program" under 42 CFR Part 2?		The special confidentiality provisions in this CFR with respect to substance abuse must be followed. The Department encourages obtaining consent from the patient. The Department has no ability to change federal law and everyone must comply with it.
POP 14	If the ACE defines a service area that includes multiple counties across the state (including Cook County), will the ACE need to be capable of serving 40,000 as illustrated in the cross-service area example? Or, will the ACE need to be capable of serving the 40,000 for Cook County plus the 20,000 or 10,000 for each additional county (depending on the county)?		Per Section 3.1.3.6.5 of the solicitation, the ACE must be able to serve the minimum number of Enrollees associated with any county included in its service area. In the example provided, the ACE would be required to serve a minimum of 40,000.
POP 15	Are the chronic conditions that must be managed through the ACE care model going to be predefined, or can they be determined by the ACE based on data analysis for its specific patient population?		The Department expects the ACE to manage whatever condition the enrollee has.
POP 16	What are the criteria the State will use to assign members? If an ACE has a lot of tertiary capability; will it be assigned more patients – even if they haven't used the facility before and be penalized for its capabilities?		No, please see the response to question POP 8 above.
POP 17	Please define the difference between the CCE population and the ACE population?		The Seniors and Persons with Disabilities will be the initial population served by the CCE. An ACE will initially serve different populations as provided in the solicitation, Section 3.1.3.6., such as the Family Health Population.

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POP 18	Can proposals focus on a smaller target population than 20,000 eligible in the collar counties?		No, population minimums by region of service are as provided in the solicitation.
POP 19	I'm an optometrist and 80% of my patients are Medicaid, does that mean that only patients who chose in the same ACE as I will be participating in will stay my patients?		No. You may participate in multiple ACEs and other care coordination models. The first 18 months of an ACE is Fee-for-Service and clients can utilize providers outside the network but after that the clients must see providers in the ACE's network to ensure payment for services. ACEs shall work to establish networks that include providers that will address the diverse needs of its enrollees. Therefore, the Department encourages all provider types to work with the multiple plans in their service area to ensure that your enrollees continue to have access to needed services.
POP 20	Maximum number of members could be assigned in year 1? Will they all be assigned the first month or more gradually like for the dual eligibles?		Yes, it is anticipated that the minimum number of members provided in the solicitation by regional services area will be enrolled with an ACE during year 1. The enrollment process will be a phased in process that will occur over several months.
POP 21	If a member switches from another entity, will we be able to get the claim data for the members so we can understand their health issues? Upon entry into an ACE program, will detailed claims data be provided to an ACE to aid in care coordination?		Yes, the Department will provide each ACE with claims data for their members at the time they become members of the ACE and then on an ongoing basis through monthly member claims update files. In addition, IHC will make claims history reports available to each ACE, for their members, through the IHC Provider Portal.

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POP 22	Can SPD patients in non-ICP counties enroll in an ACE? If yes, will there be a different PMPM for these patients?		No.
POP 23	What if not enough patients select an ACE to get to minimum enrollment and other patients in the catchment area have a relationship with non-ACE providers so those patients get auto-assigned to their own provider with another plan or a different ACE? Will ACEs that end up with less than minimum enrollment be allowed to continue?		This question is still under review by the Department.
POP 24	What is the minimum guaranteed enrollment level for MCOs in the same geography as an ACE?		There is no minimum guaranteed enrollment level.
POP 25	Relative to PCPs, please clarify the 1800 patient limit contained within the solicitation. Is the limit a total limit on patients regardless of how many ACEs a specific PCP has a contract with to provide care?		Individual PCP participation in <u>all</u> ACE Proposals received by the Department must not exceed the 1:1800 limit, per Section 3.1.3.4 of the solicitation.

#'s	Question		Answers
RSA 1	Will the Department accept proposals from entities proposing to operate ACEs in non Managed Care Counties listed in the solicitation?		Yes. Please note that a proposal submitted for a service area outside of the managed care regions provided in the solicitation may not get priority in the award and implementation process.
RSA 2	Will multiple ACEs be approved for a service area? (3.1.1)		Yes, it is possible that the Department may award contracts to ACEs in the same service areas. The Department will consider all factors when making awards, including the number of proposals received and the service area proposed by each offeror.
RSA 3	Will ACE's qualify to operate in the new ACA market place, if so, how?		An entity needs to be an HMO or insurance company (cannot be an MCCN) to participate in the ACA market place. While ACEs may eventually become HMOs or insurance companies, HMOs and insurance companies cannot submit ACE proposals.
NET 1	If an entity does not have an obstetrics program, does this mean we would be unable to participate in ACE? If we had an OB/GYN provider on staff who would then perform the obstetrics at another institution, would this satisfy the Obstetrics requirement in the Ace Solicitation?		The Department expects more than a single hospital under an ACE due to the diverse needs of the population an ACE is intended to serve. An ACE proposal must demonstrate the necessary OB capacity among collaborating entities in order to provide the needed services to its members, and a commitment to grow the collaboration over time in order to increase access to services for its members.
NET 2	Does the Solicitation for Accountable Care Entities apply to Durable Medical Equipment providers? Are Durable Medical Equipment Providers able to submit bids? If so, where can I find more information relating to Durable Medical Equipment Providers?		A DME provider may not serve as the Lead Entity, but it is expected that an ACE will include DME providers and other provider types within its collaboration/network in order to meet the diverse needs of its members.

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NET 3	Does this ACE solicitation involve participation from pharmacies?		A pharmacy may not serve as the Lead Entity. However, participation of Pharmacies in an ACE network is expected in order to meet the needs of its members.
NET 4	Are there any "any willing provider" or significant traditional provider" requirements in network contracting? The Solicitation references providers such as housing & social services. Is there a list of all the providers an ACE must have in its network? If not, how does an ACE determine the array of services it must provide? Are there any "out of network" discounts allowed HMO/MCCN organization if providers refuse to contract (Texas allows payment at 95% of the Medicaid Allowable fee schedule and Texas provides wrap adjudication services)?		This question is under review by the Department.

#'s	Question		Answers
NET 5	While an ACE can make a good faith effort to abide by PCP capacity limits, it cannot guarantee that a PCP will not ultimately exceed capacity through contracting with other ACEs. Should HFS determine that a PCP has exceeded capacity, how will this information be shared with ACEs and what strategies is the state considering to remedy this? Will provider be allowed to direct reduction of capacity across contracted ACEs or will state impose a standard reduction to bring provider into compliance?		An ACE will be required to manage its provider network, including identifying when a PCP is near or has reached its panel capacity to ensure continued access to services for new or current members. In addition, in the initial 18 months, the IHC program will assist an ACE in managing PCP panel capacities and re-assignment of PCPs for members when panel capacities are exceeded or when PCPs are no longer available.
NET 6	Would we be able to access any Medicaid provider contracted and pay the Medicaid rates?		No, the ACE must establish a network and negotiate rates with provider when it becomes an MCCN.

#'s	Question		Answers
NET 7	Will the providers be mandated to use the current Ill. MA contracted vendors?		Providers in an ACE network must be enrolled in the Illinois Medical Assistance program.
NET 8	How will the managed care work with the local PAS agencies concerning offering services?		This question is under review by the Department.
NET 9	Can the providers of an ACE be changed after existing for a period of time?		Yes, it is expected that over the term of the contract, providers participating in an ACE's network will change based on various factors. The Department will monitor the providers participating in an ACEs network throughout the term of the contract to ensure network capacity and availability. In addition, an ACE shall ensure it is committed to grow its collaboration over time in order to increase access to services for its members. Significant changes to an ACEs network would need to be reviewed by the Department to determine an ACEs capability to continue to operate as an ACE.
NET 10	Will homecare agencies have to sign on to ACE's or CCE's to provide care to Medicaid homecare patients?		Yes, once ACEs move into the second phase of operating as an MCCN.

#'s	Question		Answers
NET 11	Will Health Department's be affected regarding receiving payments for services provided whose PCP is in a ACE, however the Health Department is not? (example: immunizations for both VFC eligible patients and Adults with Medicaid)? Do Health Departments need to enroll in an ACE, or how will the implementation of ACEs affect small Rural Health Departments in the long run since we bill Medicaid as a Fee for Service?		For months 1-18 HFS will pay Medicaid rates irrespective of whether the provider has a contract with the ACE. Months 19+ health departments and providers will need a contract with the ACEs who coordinate care for their patients.
NET 12	Relative to Care Coordination Entities (CCE), does HFS anticipate ACE bidders to incorporate CCEs into network design? For example, would HFS welcome ACE proposals which sought to incorporate CCEs to provide at risk members with care coordination services? Can CCEs expand services to the ACE population?		Yes, HFS welcomes proposals that seek to incorporate CCEs into their network design by the end of contract month 36. Please also see the response to Question GOV 5 above.
NET 13	Will HFS provide a list of IHC PCPs with the number of patients currently enrolled with each PCP in specific geographic regions in order to facilitate PCP recruitment?		Provider data will be included in the data sets provided by the Department upon completion of an entities Letter of Intent and Data Use Agreement.

#'s	Question		Answers
NET 14	What happens if an existing ACE falls below the minimum enrollment standards at any point in the 3 year progression to an MCCN? (for example, a PCP partner drops out of the ACE and joins an MCO and patients continue with the PCP, or there is a higher rate of attrition than anticipated?) Is there a financial penalty if the final enrollment at the transition point from ACE to MCCN is less than the minimum enrollment number?		An ACE than falls below the minimum capacity requirements in the statute will be allowed to continue to operate. In making awards, the Department will take into consideration the number of potential enrollees in the proposed service area and the number of ACE applications for the area. May not award to all applicant in the area, but once awarded they will be able to operate even if we don't get them to their minimum statutory capacity.
NET 15	How will network adequacy be defined? What will be the look back period to determine network adequacy?		An ACE must demonstrate that it is an integrated delivery system with a network that meets the requirements in Section 3.1.3; system capacity to securely pass clinical information across its network; the ability to aggregate and analyze data in order to coordinate care; and a model of care and financial management structure that promotes provider accountability, quality improvement, and improved health outcomes. In addition, the Department will review an offerors proposed network to ensure there is substantial representation in the network of providers being proposed that have historically served the target population and included in the data provided.

#'s	Question		Answers
NET 16	Can you address the potential role of FQHCs in the Medicaid ACE Program? Would anything preclude organizations from partnering with an FQHC in the Medicaid ACE program? Are there any limitations on including FQHCs as part of a larger integrated provider network for an ACE?		An ACE must demonstrate that it is an integrated delivery system, which includes a Provider network that documents adequate capacity for its Enrollees as specified in Section 3.1.3 of the solicitation, and clearly defines roles and responsibilities of participating Providers. Therefore, the Department encourages offerors to collaborate with the various provider types, including but not limited to FQHCs, to meet the diverse needs of its Enrollees.

#'s	Question		Answers
PRO 1	Will HFS consider amending the language of the Data Use Agreement to allow for the likelihood that the bidders may form NewCos to serve as the Lead Entity? For example, many agreements reduce the administrative burdens on both parties by anticipating and approving such scenarios in advance with language such as the following: "Notwithstanding the foregoing, (i) a merger or consolidation involving the Data User, or any other event affecting control of the Data User shall not be deemed an assignment requiring such prior written consent; and (ii) Data User may assign its rights, duties and obligations under this Agreement to an affiliated entity or subsidiary designated to serve as the Lead Entity in connection with the Department's Solicitation for Accountable Care Entities.		No. However, the Department will expedite change requests.

#'s	Question		Answers
PRO 2	Will the Department consider descriptive information contained in the Letters of Intent relative to ACE participants when reviewing proposals that are submitted? In light of the 100 page length limitation applicable to the proposals, this would enable respondents to devote more space in the proposal to items such as the care model and data sharing.		No.
PRO 3	If an organization submitted a CCE application for the Integrated Care Program can the same organizational entity be used for the ACE application?		Yes.
PRO 4	What e-mail address should an entity use when submitting its LOI/DUA?		The e-mail address provided in the solicitation is incorrect. Please send LOIs/DUAs to the following e-mail address: Amy.Harris-Roberts@illinois.gov The Department will provide each entity that submits a LOI with an e-mail confirming receipt of the documents.

#'s	Question		Answers
PRO 5	If a new entity is being formed to manage the ACE, does the legal structure (e.g., LLC) need to be in place at the time of submitting the letter of intent?		No.
PRO 6	Relative to BEP utilization plan, can work performed in the development of an ACE proposal count towards a bidder's BEP utilization?		No . All services or products provided by a BEP certified vendor as a subcontractor have to be delivered post the contract award and execution from HFS to the prime contractor to count toward the BEP utilization.
HIT 1	Has the State evaluated how the information exchanges anticipated in Sections 3.2.4.1.3 and .4 will be permissible under existing confidentiality laws, including the laws cited below? Does the State intend to provide guidance regarding the permissibility of such exchanges? • Federal substance abuse confidentiality law and regulations (42 U.S.C. § 290dd-2 and 42 CFR Part 2) • Illinois Alcoholism and Other Drug Abuse and Dependency Act (20 ILCS § 301 et seq.)		An ACE must follow the law. The Department has no ability to create exceptions to federal regulations.

#'s	Question		Answers
HIT 2	In what format will the data be provided? Will the data be aggregated by pre-defined dimensions or will it be "raw", un-aggregated claims data?		Data will be aggregated by pre-defined dimensions.
HIT 3	Will the dataset be limited to only the Medicaid sub-population that qualifies for ACE (i.e., Family Health Plan)?		Yes.
HIT 4	If the data set will include other sub-populations (i.e., dual eligible, etc.), will we have the ability to easily stratify and group the separate sub-populations?		NA.
HIT 5	Will the data include Provider demographic info, including zip code?		Yes.
HIT 6	Will the data include patient demographic info, including zip code, gender, age cohort, etc?		Yes.
HIT 7	What level of detail across inpatient and outpatient services will be included for utilization and total cost of care?		There will be approximately 50 categories of inpatient and outpatient services. The metadata will include descriptions of the categories and much more.

#'s	Question		Answers
HIT 8	Can an entity receive technical assistance after we receive the data, if we have follow-up questions?		Yes. The Department has established an ACE Data website. It links to extensive metadata, including sample SQL code to illustrate how to use the data for the analyses required by the solicitation. Entities will also be provided a contact for technical questions.
HIT 9	In the proposal will we need to demonstrate the process of identifying/excluding recipients currently enrolled in Medicaid managed care?		The data provided is only for planning purposes. When enrollment occurs, the Department will make sure an individual is not enrolled in two entities. You will be provided data only for ACE eligible recipients. The data will include recipients currently enrolled in voluntary HMO contracts. Because recipients who are disabled and/or senior are not ACE eligible, the data will not include recipients currently enrolled in the mandatory Integrated Care Program. You will be provided metadata and sample SQL code to help you understand how to appropriately use the data.
HIT 10	Do you have to list a county within your proposed geography and population section of the LOI in order to be eligible to receive the state data for that county, or can you request additional counties as well that might be outside your LOI defined geography and population?		Data users can receive data for all ACE eligible recipients in the state or data for a subset of recipients as defined by county and/or zip code. If there is ambiguity regarding a potential ACEs geography the Department recommends requesting the entire state. The sample SQL code that will be provided by the Department illustrates how to parse the data to a specific geography.

#'s	Question		Answers
HIT 11	Will ACEs "have" to use the IHIE or will they be able to use other health information exchanges?		This question is under review by the Department.
HIT 12	What are the specific requirements for IT connectivity and real-time data exchange – particularly between PCPs and the ED? Can you clarifying the requirement that by month 18 that an ACE must demonstrate real-time care connectivity between ERs and PCPs? Is this EMR connectivity or notification (for example secure email) to PCPs of patients presenting in the ER? The Solicitation requires the ACE to be able to "securely pass clinically information". What are the HIT requirements? Are HIE's required? Can portals be used? In section 3.1.5.1 the RFP specifies that ACE providers must have the "ability to utilize" the IL HIE. Please clarify what is meant by "ability to utilize"? Could participation in Direct, Secure Messaging qualify?		These questions are under review by the Department.

#'s	Question		Answers
CM 1	Will data be available from ALL models (IHC, HMO, etc.) by Aid category, provider, provider type, member demographics, and all adjudicated cost?		Yes. All of this data and more will be provided for all ACE eligible recipients for 2010 and 2011 enrollment and services. We will provide sample SQL code to illustrate how to use the data for the analyses required by the solicitation.
CM 2	Will the ACE be required to perform Utilization Review or Prior Authorizations in the first 18 months? If not, can the UR and PA approvals be transmitted to the ACE real time?		No, however, the Department encourages an ACE to develop these processes during this time. The Department is in the process of determining how quickly it can provide data on PA/UR. In addition, the Department will post the current list of services that require PA on the HFS web site under the ACE link.
CM 3	May an ACE refuse to provide or make referrals for certain Medicaid covered services based on moral or religious objections.		Yes. Several state and federal laws prohibit the state from discriminating against health care entities based on the entities refusal to participate in certain services based on moral or religious objections. An ACE meets the definition of "health care entity." Any ACE that asserts such an objection must promptly notify the Department in its proposal or whenever it adopts the policy during the term of the contract of its intent to exercise the objection and information about the services it will not cover. Further, the Ace must provide the information, consistent with the provisions of 42 C.F.R. 438.10, to Eligible Beneficiaries before and during enrollment; and to Enrollees within 90 days after adopting the policy with respect to any particular service.
CM 4	How will the state determine our enrollment of 40,000, or our capability of rendering care to 40,000 enrollees?		The Department will conduct a series of readiness reviews, as provided in Attachment B Anticipated ACE to MCO Timeline, of the solicitation, to determine the capability of each ACE to coordinate care for Enrollees.

#'s	Question		Answers
FIN 1	Shared Savings - For the total cost of care calculation, will the claims be re-priced according to the FFS equivalent for the following providers: 1) CCHHS, 2) UIC and 3) FQHC PPS payments?		No.
FIN 2	What is the expected payment cycle once the ACE moves to capitated payments?		Depending on the annual budget the Department is projecting 30 days.
FIN 3	Shared Savings - What kind of identified data can we expect to receive to manage the population and to administer shared savings? What frequency? What is the process lag time?		You can expect to receive identified, detailed claims level data. You will receive two years of adjudicated claims history (and 7 years of immunization history) when a recipient first enrolls and monthly updates thereafter. You will receive the data the week after the last Friday of a month.
FIN 4	Shared Savings - Are maternity costs in the aggregated premium, or will this be a separate covered payment to MCOs?		With the move to more mandatory managed care, the Department is putting these costs back in the capitation payments.
FIN 5	Shared Savings - What are the four quality parameters required to earn the 40% of shared savings? Are they the same P4P measures listed in Attachment C?		Yes, the 4 shared savings quality parameters are the same as the P4P measures listed in Attachment C of the solicitation.
FIN 6	Shared Savings - Since the State will continue to pay PCCM fees for the 1st 18 months, are those fees included in the Total Cost of Care for the ACE when calculating shared savings?		Yes, these fees are included.

#'s	Question		Answers
FIN 7	Is the shared savings maximum of 5% based on total actual health care cost or from the MCO rate? For example, if total actual health care cost=$90 PMPM but the MCO rate is $100 PMPM, the savings = $10 PMPM. Is the 5% calculated from the $90 (up to $4.50 PMPM) or the $100 PMPM cap (up to $5.00 PMPM)?		5% of the baseline in the solicitation is the MCO rate. Please see Attachment G of the solicitation for more information about Shared Savings.
FIN 8	Pay-for Performance - What percent will the State withhold?		The withhold amount will be one percent (1%) in the first measurement year, one and a half percent (1.5%) in the second measurement year and two percent (2%) in the third measurement year.
FIN 9	Pay-for-Performance - Does Public Act 98-104 or any other Illinois law provide statutory immunities for ACEs similar to the Statutory Shield and Indemnity Program and the qualified immunities that exist for Medicare contractors? Is the State providing any safe harbors (through statute, regulation, or some other mechanism) exempting ACEs from state laws on restraint of trade, fee-splitting, self-referral or anything else?		No, there are currently no statutory protections for ACE's. the possibility of proposing such protections is being discussed.

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FIN 10	Will HFS consider sharing the MCO data book/rate build up against which the ACE will be compared for shared savings? This is also important to determine areas of savings as required under Section 3.2.5.2.		The relevant MCO rates will be those developed for the mandatory program for the Family Health Population. This should be released in the spring of 2014, before any ACE has enrollment.
FIN 11	If a member is placed in a long term care facility, at what point will member be disenrolled? What will be financial obligations of ACE for that long term facility stay?		The individuals in facilities are not excluded from the population, but LTSS is excluded from the service package that the ACE is responsible for paying.
FIN 12	For months 1-18, would the state consider running the current $2 PMPM Care Coordination Fee paid to PCPs through the ACE and adding that to the composite PMPM and allowing ACE to set quality benchmarks for distribution? This would allow ACEs greater leverage with medical home providers.		No.
FIN 13	The shared saving model of actual ACE expenditures to MCO capitation rate is inherently flawed. The majority of the Medicaid population is in the IHC system and adversely selects the IHC system to MCO system. The share savings calculation should be based on saving from a consistent before/after methodology.		The MCO rate will be based upon the Fee-For-Service experience of the eligible population which is a consistent methodology.

#'s	Question		Answers
FIN 14	Risk adjustment is a complicated science and while most systems are directionally correct, they lack accuracy in low dollar and high dollar frequencies. What is the Risk Adjustment system HFS will use and what is the vetting process to determine accuracy?		Yes, risk adjustment is complicated and lacks accuracy at the individual-recipient level. Fortunately, in order to be effective for shared savings, it only has to be accurate at the population-average level. HFS currently uses CDPS-Rx for its managed care contracts. This may change in the future.
FIN 15	Will any categories of services, such as behavioral health drugs, be carved out from risk adjustment?		No.
FIN 16	With Presumptive eligibility or emergency retro qualification, when does the HMO/MCCN economic responsibility begin? After discharge? After HMO/MCCN selection by the member?		Enrollments will be prospective, not retro-active. Retro eligibility is never the responsibility of a capitated plan.
FIN 17	What are the threshold targets for P4P? Will the targets be based on (a) a level of improvement similar to the targets established under the ICP contract or (b) a specific percentile similar to the voluntary MCO contracts?		Targets will be based on the method applied to the ICP contracts – a baseline will be utilized and a Plan must demonstrate improvement to earn a P4P.
FIN 18	Will the state use administrative data only for calculation of quality outcome measure performance? Will the state accept hybrid from the plans in calculations?		Yes, the State will use administrative data. The State will accept the hybrid method as applicable if the Plan is willing to pay for the audit process and as agreed to contractually.

#'s	Question		Answers
FIN 19	In determining payment and the appropriate capitation rates; will the state take into account whether the patients have a higher acuity level		Yes, capitation rates will be based on the Fee for Service expenses and utilization which is correlated with the acuity of the membership.
FIN 20	For risk corridors, does that mean that when the Medical loss ratio for the full ACE for the calendar year is over 110.0%, then the State will pay 80% of the amount over 110.0%? Is that in addition to the $80,000 stop loss?		Although both protections are offered, the amount the state pays for the individual stop loss are not part of the medical expenses under the MLR calculation since it is not an expense of the ACE.
FIN 21	Shared Savings - What is the methodology of that has been submitted for approval and what is the status of the approval? (Section 3.1.1.1.1, and Attachment G).		The methodology detailed in the ACE RFP is the same as the methodology expected to be submitted for CMS approval by September 30, 2013.
FIN 22	Under the shared savings methodology, 40% of shared savings is based on meeting quality metrics listed in Attachment C. Is the ACE required to meet all the relevant metrics, or a subset of the metrics?		The ACE can earn 10% of the shared savings for each of the quality metrics it meets.

#'s	Question		Answers
FIN 23	Will you share further details on how and when the capitation rate will be determined? Will this be finalized and agreed to prior to entrance into the ACE program? How will cap payment be allocated to provider?		Capitated payments for months 19+ will be developed to be actuarially sound and will be based on the Fee for Service experience of the assigned ACE membership. These rates will be developed and finalized with the ACE prior to conversion to an MCCN. Distribution of payments within an ACE are determined by the ACE.
FIN 24	Is there a minimum savings rate requirement to share in shared savings? Appendix G references 4% for Medicare ACOs. Is this the minimum savings rate requirement after which will savings be first dollar?		Consistent with our MCO rating, the ACE target rate will include a 4% savings. ACEs get first dollar shared savings when their costs are below target.
FIN 25	Please describe or define the term "pre-paid capitation" in section 3.1.6.4? As used in this section is pre-paid capitation different from a standard per member, per month capitation rate paid under a capitated MCO contract?		Pre-paid capitation is the same as the per member per month capitation rate paid under a capitated MCO contract.
FIN 26	Will the Care Coordination PMPM fees be paid directly to PCPs or to the ACE?		The monthly PMPM fees will be paid to the ACE to manage their members care.

#'s	Question		Answers
FIN 27	Please clarify the shared savings threshold in regards to the stated 4% MCO discount rate.		There is not shared savings threshold in addition to the 4% MCO discount rate. The 4% discount rate is the threshold.
FIN 28	Please clarify whether or not nursing home costs will be included or excluded from the shared savings calculations. Please clarify "the MCO rate is a 4% discount on the FFS equivalent." a. Does the ACE's savings need to exceed 4% before savings are shared? b. Will the Total Cost of Care Target be the MCO cap rate (excluding admin) or 4% less than the MCO cap rate (excluding admin)?		Long term nursing home will not be included. Short-term rehabilitation stays in nursing homes (under 90 days) will be included. The MCO rate is a 4% discount on the FFS equivalent. The ACE savings will need to exceed the 4% discount. The total cost of care target will be the MCO cap rate. Please note that the total cost of care includes the coordination fees.

#'s	Question		Answers
FIN 29	How will pooling charges be handled? a. Excluded from shared savings or is the ACE fully responsible for the pooling charge? b. Will pooling charges be netted out of recoveries, and thereby incorporated into the Measurement Year PMPM for the savings calculation, or will the charge be explicitly paid as an administrative fee, outside of the savings calculation? c. What is the anticipated charge, and will it be known in advance, or applied retroactively?		This question is under review by the Department.

#'s	Question		Answers
FIN 30	Currently, the MCO capitation rates incorporate adjustments for managed care utilization, managed care costs and selection adjustments. a. How will the target MCO capitation rate be calculated for purposes of calculating ACE shared savings? b. Is the ACE expected to meet the same managed care utilization and cost assumptions? c. How will selection be factored into the rate?		a. Target MCO rates will be risk adjusted based on differences in the acuity of the ACE population relative to the MCO. b. The Department expects ACEs to exceed the utilization and cost assumptions of the MCO. That is how the ACE will receive shared savings. c. By adjusting for actual acuity of the assigned population, the Department expects that selection will be factored into the rates.

#'s	Question		Answers
FIN 31	Childhood immunization status: a. There are many sub-measures – which one(s) will ACEs be measured for shared savings calculations? b. Will a statewide immunization database or registry (that is well-populated by ALL providers) be available to ACEs? Will the state mandate that all providers of immunizations provide data to this state registry?		This question is under review by the Department.
FIN 32	How will baseline and benchmark targets for all quality measures be established?		They will be based on historical results of the actual assigned populations to each ACE.

#'s	Question		Answers
MISC 1	What are the specific CMMI Innovation Plan recommendations that relate to the ACE? The Solicitation requires implementation of the "State Health Care Innovation Plan". What are these requirements and what is the citation to this statute or regulation? Relative to the State Health Care Innovation Plan, when and how will ACE solicitation bidders become aware of the recommendations of the innovation plan? Does HFS anticipate communicating those recommendations prior to the proposal deadline or will ACEs be required to implement recommendations after ACE awards are made? How much time will ACEs be given to implement pertinent integrated delivery system recommendations?		The Department anticipates that the recommendations will be posted for public comment during the month of September.
MISC 2	Is this solicitation covered by a waiver approved by CMS?		No, a waiver is not required.

#'s	Question		Answers
MISC 3	Has there been an antitrust review? Has a waiver for the anti- kickback issues been proposed? Is the State intending to secure any federal waivers of any federal fraud and abuse laws or advisory opinions concerning those laws in order to allow providers to coordinate care and share savings in ACEs without violating fraud and abuse laws? For purposes of this question "fraud and abuse laws" includes the physician self-referral law (Stark), the federal anti-kickback law, and the civil monetary penalty.		An ACE after the first 18 months operates as an MCO and has all of the protection of an MCO in coordinating care. In the first 18 months, an ACE is operating as an enhanced PCCM program, a model recognized and approved under federal law.
MISC 4	Will ACE applicants have an opportunity to negotiate any of the ACE agreement terms? If so, when will this negotiation period occur?		If a term listed in the solicitation as a requirement, the Department does not anticipate negotiating those terms. Any negotiations beyond the terms of the solicitation would occur after an entity received an award and before contract approval.
MISC 5	For mental health services, will IL Rule 132 be adhered to and enforced including the full array of services offered and documentation requirements?		Yes.

#'s	Question		Answers
MISC 6	Will there be a requirement for a SASS crisis evaluation prior to a minor accessing inpatient psychiatric services per the Children's Mental Health Act of 2003?		During the first 18 months the current SASS process remains in place. Once the ACE becomes an MCCN, the current MCO process becomes in effect, meaning the MCO must operate a mental health crisis program.
MISC 7	Will there be coverage for those DD individuals receiving MH Tx services?		This question is under review by the Department.
MISC 8	How will providers be able to identify Family Health Plan population vs SPD population on their IHC panel rosters so that they can appropriately estimate their total ACE capacity?		Currently there is no mechanism or indicator included on the IHC panel rosters. A provider could look up each individual in the MEDI system to obtain category of service. You will, however, be able to identify the ACE-eligible population by IHC primary care physician using the data that HFS will provide you after you submit a Letter of Intent , inclusive of a Data Use Agreement.
MISC 9	When persons assets dwindle down and they begin the application process for "Public Aid", it takes months to over a year to be approved. During this time of nonpayment to Nursing Homes, who will pay for the time from nonpayment to approval, which could be over a year?		LTSS are carved out of the service package for ACEs.

#'s	Question		Answers
MISC 10	If a Nursing Home signs a contract with one "Exchange" and the residents have not signed any contract, where will the money come from for their care?		LTSS are carved out of the service package for ACEs. Therefore questions about handling of nursing facility payments are not relevant.