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

Addendum #2

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
POP 5 (Addendum 1)	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?		Yes, when HFS learns a child is taken into DCFS custody, the child will be disenrolled from an ACE as of the end of that month. Yes, if the child is no longer in DCFS care in less than 90 days the child will be re-enrolled with their previous plan.
POP 6 (Addendum 1)	Will newborns be auto assigned to mother's plan, effective on DOB?		Yes, a newborn is automatically enrolled with the mother's plan effective on the date of birth. If the child is not added to the case within 45 days, the child is retroactively disenrolled.
POP 23 (Addendum 1)	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?		Once an ACE is awarded a contract, they will be allowed to operate even if actual enrollment ends up falling short of the minimum.

#'s	Question		Answers
NET 4 (Addendum 1)	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)?		There is not an "any willing provider" requirement for ACE networks. With respect to "significant traditional provider," when establishing a provider network, an entity must use the data that will be provided by the Department to determine whether collaborating providers have historically delivered a significant portion of the care for anticipated members; this is how the Department will look at network adequacy and capacity. ACEs must cover all Medicaid covered benefits except long term services and supports. See the Department's administrative rules or the description of Service Package 1 in the ICP contracts on the Department's website. The references to other social services are because ACEs are expected to make referrals to these services when they are needed even though they are not obligated to pay for them. There are no laws or rules that specify "Out of Network discounts." There are various situations when services are provided out of network and the Department's policies are as follows: 1) Emergency services that are out of network must be paid at the Medicaid rate. 2) If a member is referred to an out of network provider ACE must negotiate a rate. 3) Non-emergency out of network services that are unauthorized do not have to be paid.
NET 8 (Addendum 1)	How will the managed care work with the local PAS agencies concerning offering services?		PAS Agencies will continue to perform assessments as they do today to determine eligibility for LTSS. LTSS are not part of the service package that ACEs are responsible for.

#'s	Question		Answers
~~HIT 11 (Addendum 1)~~	~~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 (Addendum 1)~~	~~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
FIN 29 (Addendum 1)	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?		a. The ACE will be fully responsible for the pooling charges; b. The pooling charges will be included in the total cost of care; c. The pooling charges will need to be developed and will be based on the population assigned to the ACE. It will be know in advance, but not well in advance.
FIN 31 (Addendum 1)	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?		a. Four measures will be utilized for the shared savings calculation. They are 1. Ambulatory Care Follow-up with a provider after an ED visit; 2. Childhood Immunization Status; 3. Comprehensive Diabetes Care; and 4. Follow-up Care for Children Prescribed ADHD Medication. b. HFS currently provides immunization data consolidated, from many sources, to primary care physicians and other providers serving our children. In late 2014, it is expected that all providers participating in the VFC program, including providers in the Chicago VFC program, will be required to use the I-CARE system.

#'s	Question		Answers
MISC 7 (Addendum 1)	Will there be coverage for those DD individuals receiving MH Tx services?		Yes, mental health services are covered for all individuals enrolled in an ACE.
MISC 11	If an ACE is located in a county that does not have mandatory managed care, then would they have to achieve their minimum enrollment by getting clients to choose them just like the voluntary MCOs do now?		The state is exploring enrollment options that would minimize the need to devote resources to marketing. However, no decision have been made at this time.
MISC 12	Can primary care physicians participate in multiple ACEs?		Yes. However, per Section 3.1.3.4 of the solicitation, individual PCP participation in all ACE Proposals received by the Department must not exceed the 1:1800 limit.
MISC 13	How does assignment work for the ACE?		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. Please also see Addendum #1, POP 8.
MISC 14	Is there a way to add additional counties after initial award of the contract? Or, will the contract be limited to the original counties proposed in the application?		Although the state cannot commit at this time to future expansion of an ACE's service area, expansion is a possibility. There would be a number of factors in the decision to allow expansion, including the number of entities already serving the new county and the performance of the ACE in the original counties.

#'s	Question		Answers
MISC 15	If the lead entity is a large health system with a delivery network in multiple counties/ market areas, and anticipates having different partners in different geographies based on network capability: 1. Would it be acceptable to submit multiple, distinct ACE applications for each county or market area? 2. If not acceptable, will it be possible to submit one application covering all geographies and subdivide our markets out for later discussion with the state if an ACE is determined to be more viable in certain market areas vs. others?		The state's preference would be to get one proposal that explained any regional differences. The state would be willing to negotiate on the exact service area if there were issues in one area not present in another. The state's resources are stretched and we would prefer not to have to contract with the same entity twice and duplicate file exchanges, reports, etc.