Supplemental Questions and Answers
Solicitation for Care Coordination Entities and
Managed Care Community Networks for Seniors and Adults with Disabilities
05/21/12

Supplemental Question	Question	Response
1	I have a question regarding Section 1.4 of the RFP: Public Contracts Number. If the provider members are forming a new CCE legal entity, then is it necessary that the DHR public contracts number be in the name of that new legal entity? Alternatively, is it only necessary that one of the CCE provider members has a public contracts number in its name? We are in the process of determining if any of the CCE provider members has a DHR public contracts number. If neither the new CCE legal entity nor any of its provider members have a DHR public contracts number, then what steps must be completed prior to submission of our proposal with respect to this number? Is it only necessary that an application for such a number be filed? Additionally, if a new number is required, then is it preferred that the public contracts number be in the name of the new CCE legal entity or one of the provider members?	Per Section 1.4 of the Solicitation, the entity with which the Department may eventually contract must have a DHR public contracts number or show proof of application of such at the time of proposal submission.

Supplemental Question	Question	Response
2	We anticipate creating a new LLC to serve as the Care Coordination Entity. We would anticipate creating this new entity once we are notified of the proposed award. With regard to the public contracts number, how should we address 1.4 of the Solicitation? For purposes of this submission, can we use one of our collaborations ILDHR number? Or note that we will apply for the number once the grant is awarded?	See response to Supplemental Question #1.
3	Regarding the innovations proposal, is the state expecting MCCN to only coordinate or contract with HCBS programs or is the state expecting MCCN to roll this into their care model?	It depends on what services the MCCN proposes to include in its risk based contract. The proposal (Section 3.1.2.2.1) states that an MCCN must cover the services in the Integrated care Program, service package I, with the option to exclude pharmacy and dental. The MCCN has the option of including ICP service package II covered services, which are non-DD HCBS waiver and nursing facility services. If the MCCN did not choose to include waiver services as an MCCN covered service, there would still need to be coordination with those waiver case managers and there are several questions in the solicitation directed at this.
4	I had understood that organizations applying to become a new MCCN must complete a MCCN application and submit a separate proposal. I had also understood that the MCCN application would be made available on the Department's website by February 29, 2012. Please advise of status.	The Department apologizes for the delay in posting the MCCN application and anticipates it will be posted within the next week. Please continue to check the Department's care coordination website.

Supplemental Question	Question	Response
5	The LOI we submitted indicates our collaboration intends to establish a CCE. Once the MCCN application is made available, should we decide to flip development from a CCE to a MCCN, does this present any issues?	This would not present an issue, collaborators can use this development time to decide which option they would like to pursue. The final proposal due June 15 should contain the final decision and necessary proposal submission requirements based on that decision.
6	Our provider group has very recently entered into an agreement with a current voluntary managed care organization. Will this contractual agreement with the MCO prevent us and partnering providers from being eligible to submit a CCE proposal under this Solicitation?	If the population being served through the CCE is different than the population being served by your subcontract with the voluntary MCO, then there would be no issue. The solicitation is focusing on the Seniors and Persons with Disabilities (AABD) population, while the voluntary MCOs currently serve the parents and children populations. If, as part of your CCE, you wanted to also serve the children and families of the AABD client, those clients could choose to enroll in whichever options are available to them at the time.
7	Is there any conflict with Illinois confidentiality laws if providers within a CCE sharing PHI in order to optimize care coordination?	HIPAA confidentiality and state law confidentiality provisions will apply to CCEs. These laws allow for sharing of protected health information for the purposes of providing care to clients and the integration of mental health or developmental disabilities services and physical health services, and to avoid potential dangerous drug interactions or other health risks that could arise when a treating provider does not have as complete a medical history of a recipient as is possible. However, it is necessary that each entity perform their own confidentiality compliance check, the Department does not offer legal guidance to its providers.

Supplemental Question	Question	Response
8	Will the companies awarded contracts be required to follow the state's PDL, or will they be allowed to create their own PDLs? Will any services be carved out? It does not appear so, based on the solicitation, but I wanted to check. Thank you for your help.	CCEs will not actually be responsible for reimbursing for covered services; these will continue to be reimbursed through the current fee-for-service system. Assuming this question pertains to MCCNs under the current solicitation, if an MCCN chooses to cover pharmacy, it will be able to establish and maintain its own formulary; however, entire classes of drugs currently covered cannot be removed entirely from the formulary.
9	Are there page limits for the proposal and attachments? If so, what are they?	No.

Supplemental Question	Question	Response
10	Can you please confirm the general distinction between beneficiaries eligible for Medicaid vs. Dual Eligible. Is there a chart or description of what types of services are paid under each? If so could you provide? Essentially, are the Dual eligible beneficiaries only going to be seniors, or primarily seniors? If this is the case, should the CCE decide not to service the Dual eligible population, is the CCE essentially deciding not to include seniors in its target population? Any guidance/clarifications you can provide in this regard would be most helpful.	A dual eligible beneficiary is eligible to receive both Medicare and Medicaid benefits, whereas beneficiaries that are only Medicaid-eligible receive all benefits through Medicaid. Dual eligible beneficiaries are generally seniors or individuals with disabilities under the age of 65. About 90% of Medicaid seniors have some sort of Medicare (a somewhat smaller percentage of both Part A and Part B – qualifying them as 'full dual'). While somewhat more than half of our non-seniors with disabilities don't have Medicare, a portion of them are Medicare eligible and will have Medicare after they satisfy the 2 year post-Social Security disability waiting period. Their non-dual status is therefore transient. Please see your data set for further population data. Generally, Medicare covers medical (including inpatient, outpatient, hospice, home health) and pharmacy services and Medicaid covers nursing facility and other home and community-based long-term services, and provides assistance with Medicare premiums and cost sharing. The State indicated that dual eligible beneficiaries are a priority population for CCEs due to the fact that dual eligible beneficiaries often have multiple chronic conditions and/or disabilities and could benefit from enhanced care coordination efforts. Enhanced care coordination and care management, particularly among nursing home residents and those receiving long-term services and supports in the community, can help to improve a dual eligible beneficiary's overall health and functional health status, reduce hospital readmissions, and emergency room visits, and improve use of community-based services.

Supplemental Question	Question	Response
11	We understand that the state has submitted an application to participate in the Section 2703 program of the ACA. Is this correct? If, so, has the state been approved for participation? We did not think so and therefore, questioning whether CCEs are currently able to operate a health home and serve clients under this program. Essentially, we are trying to decide whether this section of the CCE application is to be completed.	As stated in the solicitation, the state will pursue the enhanced match for CCEs that qualify as Health Homes. Therefore, CCEs should endeavor to meet the qualifications of 2703. If a CCE or MCCN plans to implement the Health Homes Option in Section 2703 of the ACA, the Proposal must include the services and meet the requirements defined in Section 2703. The State is not putting restrictions on which chronic conditions to manage; however, priority will be given to those CCEs or MCCNs that propose to serve the most vulnerable and expensive populations. CCEs and MCCNs will be required to track and report health home populations. The State is in the process of developing a methodology for CCEs and MCCNs to report health home populations and will provide this information as soon as it is available."
12	Can a current PHO which has commercial HMO business become a MCCN to participate in the State's Innovation Project **or** one has to form a separate MCCN entity contracted to do exclusively the State's HFS Department' business ?	A PHO can apply to be an MCCN if it can meet all of the requirements of an MCCN.
13	I saw a provision in Section 143.200 (Organizational Structure) of the MCCN information which states that you can form a County MCCN without establishing a separate entity. If that is the case, can that entity (County MCCN) be contracted with commercial HMOs to provide care to commercial HMO patients?	The Department of Insurance regulates HMOs for commercial business.

Supplemental Question	Question	Response
14	I heard that the State is removing Dual Eligibles from the Priority Populations for Innovation Project. Currently the State "Solicitation for CCE and MCCN" document under section 3.1.3.3. (page 8) states that Dual Eligibles are considered as Priority Population. Are Dual Eligibles included or excluded from the Innovation project?	Dual eligibles are still included in the CCE/MCCN solicitation. Please refer to the notice of 4/20/12 posted on the Department Care Coordination website for complete details. Per this update, Medicare savings will not be available for sharing with any Care Coordination Entities (CCE) that serves dual eligibles. CCEs targeting dual eligibles will need to take into account only Medicaid savings they can generate in anticipating shared savings revenue they receive, and in proposing care coordination fees that are cost neutral.
15	Although CCEs will not be eligible to receive shared medical savings with regard to dual eligible patients, will a CCE be able to enroll dual eligibles in the CCE and receive a care coordination fee for such individuals?	Yes.
16	"… the Department has determined that Illinois is not in a position to pursue the Managed FFS Option of the Medicare/Medicaid Dual Alignment Initiative. Therefore, Medicare savings will not be available for sharing with any Care Coordination Entities (CCE) that serves dual eligibles. CCEs targeting dual eligibles will need to take into account only Medicaid savings they can generate in anticipating shared savings revenue they receive, and in proposing care coordination fees that are cost neutral." Does this mean? That the CCE project applicants from Kane County cannot choose the PMPM option since it is a fee for service one? or CCE project applicants from Kane county can choose the PMPM option but they would not be able to receive credit for Medicare savings?	See response to Supplemental Question #14.

Supplemental Question	Question	Response
17	Will the Department be seeking a waiver to allow 21 to 65 year old Medicaid recipients to be treated at Free-Standing Psychiatric facilities as part of Phase I of the Innovations Project?	No.
18	Will HFS be awarding ten (10) contracts within Cook County in total, inclusive of both MCCNs and CCEs? Or will you award contracts to each of 10 CCEs and 10 MCCNs in Cook County?	The Department will award a total of up to 10 contracts in Cook County under this solicitation.
19	I wanted to gain some clarity on the CCE side. Is a CCE allowed to bill for services: primary medical and behavioral health, all of the current billable services, **and** request a per member per month fee for case management? Or is it that if a PMPM is paid to the CCE, all services must be covered under that payment? There appears to be a disconnect based on the call today.	Services provided to enrollees of a CCE will continue to be reimbursed through the current fee-for-service system. Per section 3.1.6.1of the solicitation, CCEs may propose reimbursement for their care coordination from one or more of three risk-based options: care coordination fee, shared savings, or an innovative Interagency Payment Flexibility Proposal.
20	Based on the April 20th email - will DHFS (still) pay the Per Member Per Month care coordination fee for each population?	Yes, if that is the reimbursement option proposed and agreed upon with the Department.
21	Will dual eligibles be able to choose CCEs during the open enrollment period?	Enrollment in CCEs is open to dual eligibles. Enrollment in CCEs will be on a voluntary basis, with a 12-month lock-in. There will be an annual open enrollment period in which CCE enrollees may choose a different health care delivery option.
22	Does the 1-to-1 match between priority populations and non-priority populations still exist for CCEs in light of the fact that most seniors and adults with disabilities (priority populations for the Medicaid Proposal) are duals who will be enrolled in a MCO?	Yes.

Supplemental Question	Question	Response
23	On Page 12 of RFP section 3.2.2.5, what level of detail would you like to see in the draft implementation work plan?	The minimum requirements for the work plan are included in section 3.2.2.5. The work plan should contain sufficient detail to convey an entity understands the requirements of the solicitation and actions necessary to complete these requirements.
24	Can we propose to use one of the existing 31 quality measures noted in the RFP that is not yet connected with pay-for-performance as our fifth pay-for-performance measure? Or do we have to propose measures that are not at all being measured yet?	Yes, you may use one of the existing quality measures as a proposed pay for performance measure.
25	Do the quality measures we propose have to be measurable through claims data? Or can we propose a measure that has to be tracked by the CCE?	The Department is open to creative proposals regarding quality measures.
26	Are proposals due at close of business day or at 2 PM on Friday June 15, 2012.	Proposals are due Friday, June 15, 2012 by 2:00 p.m.