

Addendum 7

The Illinois Department of Healthcare and Family Services (HFS) is issuing Addendum7 to amend the original Request for Proposals (RFP) for the above referenced project, as issued by this office on February 5, 2010 and is now considered a part thereof. Addendum 7 is being issued to publish the Department’s responses to questions received from vendors and interested parties. Any questions missing from the sequence will be answered in another Addendum.

This addendum is to be acknowledged in accordance with the RFP, Section 4, Offer to State of Illinois Acknowledgment of Amendments/Addendums. Vendors are instructed to read this entire package before attempting to complete the information required therein. All other terms and conditions of the RFP shall remain in full force and effect, unchanged except as amended hereby.

	Section Number	Page Number	Question	Submitted By:	Response
1	3.1.1	17	Under what CMS authority (State Plan, 115, 1915b, etc.) is the State pursuing this opportunity?	Value Options	State Plan
2	3.1.1.2.1.1	18	How do prospective bidders request and receive the pharmacy utilization data?	Value Options	Potential Bidders can receive the pharmacy utilization data by signing and returning the data sharing agreement to the Department contact as set forth in Section 1.0 of the RFP, along with instructions on where the Department should send the data. The link to the data sharing agreement is: http://hfs.illinois.gov/icp/

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3	3.1.2.1.2	19	Can you provide the number of slots and the current waiting list for each HCBS waiver? Will the contractor be responsible for managing slots and waiting lists as specified in your approved waiver applications?	Value Options	<p>Waiver capacities and unduplicated numbers of persons served in each waiver for FFY 2009 can be viewed in the file with the corresponding question number at: http://hfs.illinois.gov/icp/</p> <p>Only the DD waivers have waiting lists. This can be viewed at: http://www.dhs.state.il.us/page.aspx?item=31193</p> <p>No, the state will be responsible for maintaining the waiting lists.</p>
4	3.1.3	20	Is it correct to assume that all participants in the Integrated Care Management Program are excluded from the PCCM and DM populations and all required care coordination and disease management will be provided by the prospective bidder under this procurement?	Value Options	Yes

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5	3.1.3.11	25-26	<p>A) Are these waivers to be run under CMS concurrent authority?</p> <p>B) Will the existing process and entities continue to be responsible for determining eligibility, redeterminations, care plan development, etc.?</p> <p>C) Will the selected contractor be expected to contract with the existing entities for these functions?</p> <p>D) Are these current functions (examples above) claimed as medical or administrative expenses?</p> <p>E) Who will be responsible for certifying (education, training, etc.) and enrolling (i.e., Medicaid enrolled) nontraditional providers of HCBS services?</p> <p>F) Will the State provide a list of the currently enrolled providers of HCBS services by waiver?</p> <p>G) Is cost neutrality determined based on an aggregate average for each waiver and are there annual caps on personal budgets?</p> <p>H) If so, is the contractor expected to monitor and manage these caps?</p>	Value Options	<p>A) Yes</p> <p>B) Yes, the existing processes will continue for determining eligibility, conducting redeterminations and initial assessments and care plans. The HMO will work in collaboration with the waiver operating agency during transition of the cases.</p> <p>C) No, the State will maintain the contracts with the prescreening entities.</p> <p>D) Administrative.</p> <p>E) The HMO must assure providers are qualified as defined in the approved waivers.</p> <p>F) Yes. This information is available in the file with the corresponding question number at: http://hfs.illinois.gov/icp/</p> <p>G) Cost neutrality is determined in the aggregate, however, there are individual caps on some of the waivers as defined under Appendix B: Individual Cost Limits of the waivers. Those with individual cost caps include: Adults with DD (home based), physical disabilities, HIV/AIDS, Brain Injury, Medically Fragile, Technology Dependent, and the DD children's support waiver.</p> <p>H) Yes, for waiver services in accordance with waiver, but not for the waiver aggregate.</p>

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6	3.1.3.5	22	How are State Hospitals reimbursed (DRG, Per Diem, etc.)? What are their current rates and how are these determined?	Value Options	<p>There are eight State hospitals in Illinois. The University of Illinois Medical Center (UIMC), located on Chicago's west side, is a general hospital operated by the University of Illinois at Chicago. The others are psychiatric specialty hospitals operated by the Department of Human Services. Medicaid reimbursement for all State hospitals is a cost-based per diem. The per diems are calculated from filed cost reports, trended forward with an appropriate inflator. The psychiatric hospitals are subject to cost reconciliation once the cost reports are finalized by Medicare. The UIMC rates (at this time) are not reconciled. In the instance of the psychiatric hospitals, actual payment to the facilities is effected through appropriations to the Department of Human Services; first- (patient) and third-party liabilities are collected.</p> <p>Information on Per Diem and DRG rates for hospitals are included in the file with the corresponding question number at: http://hfs.illinois.gov/icp/.</p>

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7	3.1.3.6	24	How are Nursing Facilities reimbursed (Per Diem, Medicare Cost Basis, etc.)? What are their current rates and how are these determined?	Value Options	<p>NF rates are based on a Per Diem. Rates are calculated based on three separate components, nursing, capital and support. Capital and support are based on a cost report that is submitted to the Department each year. The nursing component is established annually, but may change quarterly, up or down based on Minimum Data Set clinical information. For more information see: http://www.hfs.illinois.gov/reimbursement/ltc.html</p> <p>Nursing facility rates can be viewed in the file with the corresponding question number at: http://hfs.illinois.gov/icp/.</p>
8	3.1.3.10	24	How are SODCs reimbursed (Per Diem, Cost Based, etc.)? What are their current rates and how are these determined?	Value Options	<p>There are nine State-operated development centers in Illinois—four of which are located in the geographic area covered by this RFP. Medicaid reimbursement for all is a cost-based per diem. The per diems are calculated from filed cost reports, trended forward with an appropriate inflator and are subject to cost reconciliation once the cost reports are finalized. The current per diems cover services that are not included in the reimbursement to private ICFs/MR (e.g., therapy and dental services). Actual payment to the facilities is effected through appropriations to the Department of Human Services. First- (patient) and third-party liabilities are collected. The current rates can be viewed in the file with the corresponding question number at: http://hfs.illinois.gov/icp/.</p>
9			Will the State share basic information about the composition of the evaluation committee, such as position title and department of proposed members?	HMA on behalf of CareSource	No

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10			Will the State consider awarding a contract to more than two bidders?	HMA on behalf of CareSource	No
11			In general, what is the timeline in terms of state payments to current managed care organizations?	HMA on behalf of CareSource	As of 02/22/10, the Department has made payment to the current MCOs through January 2010 capitation. The current contracts operate under a negotiated 60 day lag.
12			The RFP is silent regarding the submission of any member materials with the proposal. Please clarify whether any items, e.g., an Enrollee Handbook, are required and if so, organizationally where they should appear in the proposal.	HMA on behalf of CareSource	Sections 3.2.1.2, 3.2.2.18, and 3.2.5.4 request submission of sample member materials. In response to this section, reference labeled attachments.
13			Are their policy bulletins or user manuals available for the enrollment, billing, payment and related HMO/Department business-to-business interface?	HMA on behalf of CareSource	The Department's website, http://www.hfs.illinois.gov/medical/ lists reference materials for providers, including handbooks, bulletins, and fee schedules. The Enrollment process for the current MCOs and information regarding such can be found at: http://www.illinoisceb.com/Default.aspx . See Section 2.1.2.7 for computer system interface.
14	Section 1.2		States that proposals are due on April 15, 2010. What is the expected date when the notice of apparent awardees will be posted?	HMA on behalf of CareSource	Late May or early June
15	Section 1.3		Provides information regarding the quantity of proposals to be submitted however it provides no further specifications regarding the proposal itself. For example, is there a requirement to use a specific type font or margin width, recycled paper, to print on one or two sides of a page or to paginate the document in a particular manner?	HMA on behalf of CareSource	The only requirements are those listed.

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16	Section 1.3		Requires two copies of the proposal on CD. This section also requests “two copies of the file on CD requested in Section 3.2.2.12 [provider maps].” Please clarify whether the state is requesting that the provider map files be included on separate CDs (resulting in the submission of four CDs) or whether the provider map files should be included on the same CDs as the rest of the bidder’s proposal.	HMA on behalf of CareSource	Responses to Questions 3.2.2.11 and 3.2.2.12 may be provided on the same CD. Submit two copies of the CD(s) listing your network providers and maps. These Sections do not have to be provided in any other format. In addition, provide the entire proposal, excluding the responses to Questions 3.2.2.11 and 3.2.2.12 , on two separate CDs.
17	RFP Section 1.3	Page 2	Will formats other than Word or Excel be considered, such as Adobe Acrobat, especially for attachments that may not be available in Word and that will be easier to compile, scan and read in Acrobat?	HMA on behalf of CareSource	Attachments other than that in 3.2.2.11, the Network file, may be in Adobe Acrobat.
18	RFP Section 1.3	Page 2	This section requests “two copies of the file on CD requested in Section 3.2.2.12 [provider maps].” While Section 3.2.2.12 does not specify provision of maps on a CD, Section 3.2.2.11 references a CD listing the network. But Section 1.3 does not address the CD specified in Section 3.2.2.11. Please clarify all CD requirements. Please also clarify whether or not provider information requested in Sections 3.2.2.11 and 3.2.2.12 are required to be provided in paper form or would it be submitted on CD.	HMA on behalf of CareSource	Responses to Questions 3.2.2.11 and 3.2.2.12 may be provided on the same CD. Submit two copies of the CD(s) listing your network providers and maps. These Sections do not have to be provided in any other format. In addition, provide the entire proposal, excluding the responses to Questions 3.2.2.11 and 3.2.2.12 , on two separate CDs.
19	Section 1.3		Requires the CD versions of the proposal to be submitted in Microsoft Word and/or Excel format. Is there a particular version of Microsoft Office that the bidder should use to avoid conversion problems?	HMA on behalf of CareSource	If possible, Bidders should use Microsoft Office 2007.
20	Section 1.3		Requires proposals to be submitted in a sealed container. If necessary, may more than one sealed container be used?	HMA on behalf of CareSource	Yes

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21	Section 1.4		What happens to bid awards if contract negotiations/readiness reviews cannot be executed within 180 days?	HMA on behalf of CareSource	If contract negotiations or readiness reviews are not completed within 180 days, HFS will notify affected Bidders in writing of the extension if the Offer Firm Time.

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22	Section 1.8; Section 3; Section 4	Pages 36; Page 44	<p>Business Enterprise Program (BEP) utilization goal.</p> <ul style="list-style-type: none"> a) Please clarify if the BEP specifications are a requirement or a goal. b) Is it correct that a bidder must demonstrate a good faith effort to meet the goal in order to be determined “responsible” in regard to MBE requirements? c) Are the MBE requirements a “pass/fail” requirement (meaning a bidder is either responsible or not) or is it both a pass/fail and scored items? d) Will a bidder receive additional points for submission of a Utilization Plan that demonstrates that a specific percentage of the administrative portion of the capitation payment will be expensed for MBE qualified goods/services? e) Is it correct that if for example, an HMOs administrative portion of the capitation payment is 10% then 20% of the 10% amount must be designated to BPE certified vendors? f) If so, will the scoring be weighted by percentage, with a higher percentage being awarded a higher score? g) If the HMO is minority owned, but an out of state business, does that fact that it is minority owned count towards the BEP utilization goal of 20%? 	HMA on behalf of CareSource	<ul style="list-style-type: none"> a) The 20% amount is a goal. It is a requirement to submit a plan and to make every good faith effort to meet the goal. b) Yes c) It is a pass/fail requirement d) The BEP plan is not part of the scoring for the RFP. e) This is correct. f) The BEP plan is not part of the scoring for the RFP. g) Prime vendors can meet the BEP goal if they have gross sales of less than \$75 million annually. “A firm with gross sales in excess of this cap may apply to the Council for certification for a particular contract if the firm can demonstrate that the contract would have significant impact on businesses owned by minorities, females, or persons with disabilities as suppliers or subcontractors or in employment of minorities, females, or persons with disabilities.” See 30 ILCS 575/2(A)(10)

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23	Section 1.12		When the RFP award notice is published will it rank all bidders' responses? Will the state move down a line of succession in identifying additional awardees if the 1 st two plans are unable to meet the contract terms?	HMA on behalf of CareSource	No. Yes.
24	Section 1.13		Public Records and Requests for Confidential Treatment – Must bidders attest to the provisions in this section of the RFP in their responses?	HMA on behalf of CareSource	Yes, Bidders must indicate they request specific information exempt from the Freedom of Information Act and provide a detailed explanation which cites the relevant exemption from the FOIA. See Section 4, Request for Confidential Treatment.
25	Section 2.2.1		Identifies that State's scoring system for the responsiveness category. Please confirm that there are no minimum point requirements that apply.	HMA on behalf of CareSource	No minimum scores are required for responsiveness.
26	Section 3.1.1		Specifies the length of the contract (five years plus a potential of five additional years) however a begin date is not indicated. Please provide the anticipated timeline from proposal due date to when a successful HMO can expect to sign a contract and begin to accept new enrollees. Please include the timeframe for a readiness review in the timeline.	HMA on behalf of CareSource	The Department has a target date of June 1, 2010, to make an award. See Section 3.2.1.11 for target enrollment begin-date. See Section 2.1.28 for readiness review.

	Section Number	Page Number	Question	Submitted By:	Response
27	RFP Section 3.1.1.1	Page 17	Medical homes: The RFP refers to the ICP being built on a foundation of “well-resourced” medical homes and describes a comprehensive network of providers as well as an electronic health information exchange. The RFP also uses the term medical home when referring to the PCCM program and in another section uses the term “integrated care delivery system”. There are at the national level recognized principles of a patient centered medical home and a generally accepted definition of an integrated delivery system. Please clarify the use of the terms medical home and integrated delivery system as they pertain to the objectives of the ICP. Is the bidder to propose a medical home model or is the Department seeking a specific medical home model?	HMA on behalf of CareSource	The Bidder is to propose a medical home model. The state is not prescribing any particular model.
28	Section 3.1.1.2		Includes references to Service Packages 1, II and III and appears to refer to sections in the attached Model Contract. However it is believed the section references are stated incorrectly. Should they perhaps be 2.1. <u>11</u> .1 through 2.1. <u>11</u> .3 rather than 2.1. <u>10</u> .1 through 2.1. <u>10</u> .3? Also, in Section 3.1.1.2.3 should the reference to “Service Package II” actually be “Service Package III”?	HMA on behalf of CareSource	The citations were corrected in an addendum to the RFP. The reference to Service Package II in Section 3.1.1.2 should be Service Package III.

	Section Number	Page Number	Question	Submitted By:	Response
29	Section 2.1.1.2	Page 17	<p>Service package 1. The RFP states that the HMO will be responsible for the medical care services of Nursing Facility Residents in Service Package 1. The HMO will also be responsible for the provision of medical care services to Nursing Facility Residents and to all waiver Participants otherwise eligible for the Integrated Care Program. Please clarify the following:</p> <ul style="list-style-type: none"> a) Waiver participants means participants enrolled in a HCBS waiver (rather than some other type of Medicaid waiver); and b) That eligible HCBS waiver participants will enroll into the ICP and receive the state plan services noted in Section 2.1.1.2.1 but not HCBS waiver services, (which are part of Phases II and III depending on the HCBS waiver in which a person is enrolled). <p>In other words, is it correct that a person enrolled in the Developmental Disabilities Waiver will, during Phase I (unless otherwise excluded from enrollment), be enrolled into the ICP but DD Waiver and ICF/DD services will remain fee-for-service until Phase III?</p>	HMA on behalf of CareSource	<ul style="list-style-type: none"> a) That is correct. b) That is correct. c) The illustration is correct.

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30	RFP Section 3.1.1.2.1	Page 17	Service package I: The RFP states that short term post-acute rehabilitative stays in Nursing Facilities are not considered long term care services in the Integrated Care Program and will be the responsibility of the Contractor. Please define “short-term” based on number of days of care that are the responsibility of the Contractor.	HMA on behalf of CareSource	A short term post-acute stay is a stay of 90 days or less following a hospitalization or the first 90 days of a longer stay following hospitalization. If the Enrollee was a resident of a NF prior to the hospitalization, the first 90 days following hospitalization are not considered a short term post-acute stay.
31	Section 3.1.1.2.1	Page 17	Service package I. The RFP states that the HMO will be responsible for the medical care services of Nursing Facility Residents in Service Package I. The HMO will also be responsible for the provision of medical care services to Nursing Facility Residents and to all waiver Participants otherwise eligible for the Integrated Care Program. Please clarify if the medical services and Nursing Facility Residents in the second sentence refers to the Contractor’s responsibility to provide medical services to all NF residents for the “short-term” post-acute rehabilitative periods, even those residents who remain in a NF beyond the “short-term” period. Please also confirm that while the NF resident may remain in the facility beyond the short-term period, the contractor is no longer responsible for medical services for the NF resident once this short period ends. If this is correct will NF residents be disenrolled from the ICP if they remain in a NF beyond the short-term period?	HMA on behalf of CareSource	The references to medical care services to residents of nursing facilities in these two sentences is redundant. The HMO is responsible for medical services for nursing home residents enrolled with the HMO regardless of how long the nursing home stay is. Within Service Package I, the HMO is only responsible for nursing home costs for short term post-acute rehabilitative stays.

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32	RFP 3.1.1.2.1	Page 17	<p>NF Residents. Upon implementation of the ICP, which of the following “types” of NF residents will be enrolled into the ICP?</p> <ul style="list-style-type: none"> a) Persons who begin a NF stay after enrollment into the ICP? b) NF residents who become newly eligible for Medicaid while residing in a NF? c) All NF residents? <p>If the answer includes all NF residents, is the Contractor’s responsibility limited to the first “short-term” period as measured in days post enrollment into the ICP (using the state’s definition of “short-term”)?</p>	HMA on behalf of CareSource	<p>All NF residents in the region will be enrolled. During the period that a Contractor is responsible for Service Package I only, it will be responsible for NF costs for short term post-acute stays of 90 days or less following a hospitalization or the first 90 days of a longer stay following hospitalization. The Contractor will not be responsible for the first 90 days of NF costs following enrollment with the Contractor for residents in a NF at the time of enrollment.</p> <p>Beginning with Service Package II, Contractors will be responsible for all NF costs.</p>
33	Section 3.1.1.2.1.1		<p>Notes that pharmacy services will, at least in the near term, be carved out of this contract. Please clarify the state’s expectations for pharmacy utilization management, e.g., will the contracted HMOs have responsibility for authorizing drugs or will this function be handled by the State’s pharmacy benefits manager? Also, how will the State assure that the contracted HMOs have access to pharmacy claims data?</p>	HMA on behalf of CareSource	<p>Processing pharmacy claims and granting prior approval will continue to be done in-house by the Department. The Department will provide drug claim files to HMOs. The Department currently does this</p>

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34	Section 2.1.1.2.1.1		Indicates that the State is requesting proposals “for management of pharmacy services and methods for sharing savings between Contractor and the Department.” It also indicates that bidders may agree to accept risk for prescription drugs at the Department’s net cost after rebates. Please confirm that the State is asking bidders for two different items in their response: (a) the State is asking all bidders to include in the proposal a description of how they will manage pharmacy services and share savings should the State carve pharmacy in during the term of the contract; and (b) the State is also asking bidders to indicate whether they are interested in accepting risk for prescription drugs at the State’s net cost as of the contract effective date. Please also advise where the information requested in (a) should be included in the proposal. It is clear that the information requested in (b) should be provided in Item #7 of Section 6 in the proposal response but it is not clear where the information requested in (a) should be included. Should this information perhaps be included in the response to Section 3.2.5.3.5?	HMA on behalf of CareSource	<p>Yes, the Department is asking for two things. First, assuming drugs are carved-out (i.e., the cost is not in the capitation rate and the state continues to process and pay in its current fee-for-service system), propose a program in which the Bidder will attempt to further manage the utilization of drugs and share in the resulting savings to the Department. This proposal should be included at 3.2.5.3.5.</p> <p>Second, the Department are asking if Bidders want to assume risk with the cost of drugs factored into the capitation rate at the Department’s cost after rebates. This should be indicated under Item 7 of Section 6.</p>

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35	RFP Section 3.1.1.2.3	Page 18	<p>a) ICFs/DD: Are State Operated Developmental Centers (SODCs), which are ICFs/DD, included in Service Package III?</p> <p>b) Are there SODCs that are not certified as ICFs/DD, or that have units or beds that are not certified as ICFs/DD?</p> <p>c) If so, would uncertified ICFs/DD or uncertified ICF/DD units or beds also be included in Service Package III?</p>	HMA on behalf of CareSource	<p>a) Yes</p> <p>b) Yes</p> <p>c) Yes</p>
36	Section 3.1.1.2.4		<p>Asks that bidders demonstrate capability of assuming responsibility for Service Packages II and III within one year of implementing Service Package I. Is it expected that these additional service packages be implemented simultaneously within the one-year period or can they be implemented separately, and if they can be separately implemented does it matter which is implemented first? Also, is implementation of Service Packages II and III pending any state or federal approvals? Please specify whether there are any circumstances that could delay the estimated one-year implementation period for these Service Packages.</p>	HMA on behalf of CareSource	<p>Service packages II and III need not, and probably will not, be implemented simultaneously. It is conceivable, but not likely, the Service Package III could be implemented prior to Service Package II. Implementation of all Service Packages for this program is pending federal approval. The Department has been, and continues to be in regular contact with federal CMS on this program and anticipates no problem with federal approval prior to targeted implementation. Yes, there are circumstances which could delay implementation of Service Packages II and III beyond one year. Contractors will need to work with the Department and stakeholders in order to finally determine the appropriate time and readiness for implementation of these service packages.</p>

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37	Sections 3.1.3 and 3.1.3.7		States that while contracted HMOs will be required to provide the services identified in the section, they will not be required to use the entities or processes described. However, in Section 3.1.3.7, in bold print, there is contradictory language. Please clarify. Further, if it is correct that the process described in Section 3.1.3.7 will continue, please explain the contracted HMO's role and responsibility related to the determination of appropriateness of nursing facility placement or participation in a home and community-based waiver program.	HMA on behalf of CareSource	The function referred to in bold print in Section 3.1.3.7 is not a function for which the HMO will be responsible.
38	RFP Section 3.1.3.4	Page 21	Community Mental Health Services. To what extent are Institutions for Mental Diseases (IMD) services included in the ICP? Stated another way, what limitations, if any, are there covering coverage of IMD services in the ICP?	HMA on behalf of CareSource	Both the individuals served in IMDs and, in Service Package II, the services directly provided by IMDs will be included in the ICP.
39	Section 3.2.1.1		Requests that bidders include accreditations, certifications and recognitions in their proposal. In responding to this section, are bidders required to provide copies of these documents or is a simple description of the accreditation/ certification/ recognition and date achieved all that is required? If copies are required is it sufficient to provide only the most recent proof, and if the bidder currently provides services in multiple states, are copies applicable to each state required?	HMA on behalf of CareSource	A simple description of the accreditation and the date it is received is all that is required.

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40	RFP Section 3.2.1.1	Page 27	The RFP asks that the bidder “Discuss the history and ownership of your organization. Include your experience in providing managed care in general, and specifically your experience providing the integrated care services that are proposed for this or similar populations.” By integrated care services, do you mean all of the covered services included in the ICP for all three Phases? If the answer is “No”, which services are you referring to specifically?	HMA on behalf of CareSource	The Department wants Bidders to detail their most relevant experience in providing managed care and integrated care, whether that be for some or all of the services this program will cover.
41	Section 3.2.1.11		Requires submission of a timetable for phased enrollment to begin no later than October 1, 2010. Is there an expectation as to the date when the phased enrollment process would be complete? Is there an expectation that the phased enrollment process will occur geographically or is it anticipated that enrollments will occur gradually over the entire service area? If one of the two contracted HMOs is determined by the Department to be ready to accept enrollees sooner than the other, will that HMO be able to accept voluntary enrollments before the other HMO? Will the HMO also be able to receive auto-assignments sooner?	HMA on behalf of CareSource	Bidders should provide the most aggressive time frame that they feel they are capable of providing in a responsible way, recognizing that the population being transitioned has many medical and behavioral health needs and careful transition is needed. The Department is requesting Bidders to indicate whether they prefer a geographic or area-wide phase-in. Voluntary enrollments to one HMO are permissible if the plan is ready to implement before the other. The Department cannot auto-assign until enrollees have a choice.

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42	Section 3.2.1.14		Requests the bidders' proposed staffing plan, including detail regarding the implementation team and how it will differ from ongoing staff. Please clarify the state's expectations regarding the implementation team versus ongoing staff. Will successful bidders be expected to have a permanent CEO and Quality Management Coordinator located in Illinois (as required in Section 3.3.1.1 and 3.3.1.3), as well as an Illinois-licensed Medical Director (as required in Section 3.3.1.2), as of the contract effective date or will these requirements not apply until the end of readiness review?	HMA on behalf of CareSource	The Department has no expectation regarding the implementation teams and no requirement that they be different than ongoing staff. However, if they are different, the Bidder must provide the experience of both. These requirements do not apply until the end of the readiness review.
43			Are there any State procurement or conflict of interest rules regarding the hiring of current or recently separated State employees by successful bidders? If so, please provide reference to the applicable statute or rule.	HMA on behalf of CareSource	See RFP Section 4.12 (Revolving Door) and RFP Section 5, (Responsibility Forms, Conflict of Interest disclosures), and the statutes cited therein.
44	Sections 1.17 and 3.2.2		Section 3.2.2 references Primary Care Providers (PCP). It is clear from the Definitions section (1.17) that a PCP can include family practitioners and specialists in obstetrics and gynecology (Women's Health Care Providers). Can other specialists serve as PCPs, based on member needs and assuming they agree to provide all preventive and primary care services? If so, please clarify the acceptable specialties. Can physician extenders (Advanced Practice Nurses or Physician Assistants) serve as PCPs and if so please indicate if there are any related conditions regarding their designation?	HMA on behalf of CareSource	Any physician willing to provide preventive, primary care and the other services of a medical home can serve as a PCP. APNs and PAs can serve as PCPs.

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45	Section 3.2.2.8		Section 3.2.2.8 asks bidders how they will “propose to evaluate the existing substance abuse and mental health Provider pool to provide covered services.” Please give additional clarification regarding the information the State is asking bidders to include in their proposals. When speaking of “existing” substance abuse and mental health providers, is the State referring to the providers identified in Section 3.1.3?	HMA on behalf of CareSource	The Department is asking for the process that will be used to review existing Medicaid providers of these services and determine whether to offer them contracts to be in the Bidder’s network. The Department will post a file of current providers on the procurement website prior to the issuance of the RFP.
46	Section 3.2.2.12	29	Please clarify what is meant by a map showing a distribution of providers. Is a plot map that reflects location of provider offices or facilities all that is required or is something else needed?	HMA on behalf of CareSource	Plot maps showing the locations of the different provider types are acceptable.
47	Section 3.2.2.16	29	Please verify that the terms “access” and “equipped” as used in this section refer to physical access and physical equipment (architectural issues, special equipment issues).	HMA on behalf of CareSource	That is correct.
48	Section 3.2.3.3	3	RFP Page 3, Section 3.2.3.3. asks that the bidder “Describe your process through which each Participant’s needs, goals and preferences are identified and strategies are developed to address those needs, goals and preferences, and who develops and completes the Enrollee Care Plan and the process for collaboration.” Please verify that the Department wants the bidder to <u>describe the process for collaboration</u> as opposed to describing “who develops and completes” the process for collaboration.	HMA on behalf of CareSource	That is correct.

	Section Number	Page Number	Question	Submitted By:	Response
49	Section 3.2.3.14	30	In the following section. “Describe your approach to Risk Mitigation and negotiation for Enrollees living in the community, but at risk of institutional care including caregiver, environment, medical, behavioral and compliance.” Does the term “behavioral” refer to behavioral “health conditions” or behavioral challenges (or perhaps both) and does “compliance” refer to an individual’s, family’s or caregiver’s compliance with the individual’s plan of care?	HMA on behalf of CareSource	This should be defined by the Bidder based on knowledge and experience with risk mitigation strategies. Behavioral would relate to both behavioral health conditions and challenges. Compliance could refer to the individual, family and caregiver.
50	Sections 3.2.4.2 through 3.2.4.4		Sections 3.2.4.2 through 3.2.4.4 refer to care plans developed by other entities. If possible and available, please provide further detail regarding the contents of these plans and/or supply sample plans.	HMA on behalf of CareSource	Appendix D: Participant Centered Planning and Service Delivery outlines an overview of the care planning process for each waiver. This can be accessed at: http://www.hfs.illinois.gov/hcbswaivers/Click on the Federal Approved Waiver.pdf
50.1	Section 3.3.1.	32 and 33	List of Individuals in an Administrative Capacity. Please clarify which positions are to be full time positions located in Illinois; which are full time positions working solely for this contract but not necessarily located in Illinois; and which are full time positions that are not required to be located in Illinois, that may work less than full time on this contract but that must devote sufficient time to the Illinois contract.	HMA on behalf of CareSource	When specific requirements are not listed, it is up to the Bidder’s discretion to determine the best location, and amount of time dedicated to the position.
51	3.4.2.3		Do the requirements in this provision limit MCOs contracting ability to Illinois Medicaid certified providers?	HMA on behalf of CareSource	Provider types currently able to enroll with the Department must enroll if they are not already enrolled. Provider types that the Department does not currently enroll (e.g., LCSWs) do not have to enroll. Enrollment does not require participation in the Medicaid FFS program.

	Section Number	Page Number	Question	Submitted By:	Response
52	3.4.2.5		What is contained in the “Lobbying Certification contained in Section 5.10 of this RFP”?	HMA on behalf of CareSource	The reference is to Section 5.10 of the Model Contract found in Section 8 of the RFP.
53	Section 3.6	34	Please clarify how the Department determines a contractor is in compliance with the following requirement: Contractor shall maintain an administrative office in Illinois from which the majority of Illinois specific administrative functions are performed. Please clarify which functions in Section 3.3.1 are “Illinois-specific functions” and what constitutes a “majority” in Section 3.6.	HMA on behalf of CareSource	The intent of 3.6 is to require the Contractor to have a substantial management presence in Illinois, including the specific personnel required to be in Illinois under Section 3.3.1. There is no mathematical formula to determine a majority.
54	Section 3.7.1		Section 3.7.1 requires a valid Certificate of Authority or proof of application for such. Please clarify what will constitute sufficient proof of application (e.g., copy of application package, confirmation of receipt, copy of the dated submission letter or something else).	HMA on behalf of CareSource	The Department will accept the Bidders assertion that it has applied for Certificate of Authority and the Department will confirm with the Department of Insurance.
55	Section 3.6		Section 6 requires the disclosure of bidder’s work location for each administrative function. Please clarify the specificity required in the response. For bidders looking to enter the Illinois health care market through this procurement opportunity, is it sufficient to identify what functions will be performed out-of-state, if any, and what functions will be performed in Illinois? Is the State looking for specific addresses? If so, may bidders indicate that the identified Illinois address(es) are pending award of the contract?	HMA on behalf of CareSource	It is sufficient to identify what functions will be performed out-of-state and what functions will be performed in Illinois. If addresses are available, the Bidders may indicate they are pending award of the contract.

	Section Number	Page Number	Question	Submitted By:	Response
56	Section 6		Section 6 indicates the required organization of proposals. Please confirm that the required responses for items six, seven and eight are simple affirmation statements with exceptions if applicable. Also, please indicate if these statements require a signature.	HMA on behalf of CareSource	Items six, seven and eight required responses are confirmation statements and the identification of exceptions with full explanation if applicable. A separate signature for each statement is not required. The required signature in Section 4 is applicable to all requirements of the solicitation and all documents contained in the solicitation.
57	Section 7		Section 7 addresses payment terms but is silent as to the timeframe within which monthly capitation payments will be made. Will the State's contract with the successful bidders include language specifying timeliness requirements for payments by the Department to the HMOs?	HMA on behalf of CareSource	Yes.
58	Model Contract Section 1.3		Does the State provide for intermediate corrective action steps prior to termination notice for any of the breaches cited in this section?	HMA on behalf of CareSource	The State may not provide an intermediate step if it determines there is jeopardy to health, safety or property.
59	Model Contract Section 2.1.1.3.2		Model Contract Section 2.1.1.3.2 indicates that auto-assignments will be handled by the enrollment broker. Please confirm if the enrollment broker will also work with the beneficiary to choose a PCP. The agreement references that it will take 12 months before the membership reaches the 50% target of the eligibles in the program. Is the Department willing to take a more aggressive approach to the assignment of members?	HMA on behalf of CareSource	<p>The algorithm used by the ICEB will select the Contractor and the most appropriate PCP or site, per federal requirements, and they will provide that information to the Contractor.</p> <p>The agreement references that the algorithm will result in each HMO receiving approximately 50% of total Enrollees by the end of the 12 month period. Since there will be two MCOs, that is approximately 100% of Enrollees. However, the phrase "by the end of the 12 month period" should read "during the first 12 month period." The Department assumes a much faster initial enrollment phase and has asked in the RFP for bidders to propose a timeline.</p>

	Section Number	Page Number	Question	Submitted By:	Response
60	Model Contract Section 2.1.1.3.3		Model Contract Section 2.1.1.3.3 indicates that the effective date of enrollment will generally be the first day of the calendar month following acceptance by the Department's database. If the new member is hospitalized as of the enrollment effective date, please clarify if the HMO has liability for the cost of any portion of the hospitalization.	HMA on behalf of CareSource	The Department's current policy is for the HMO to be responsible for hospitalizations that cross over the enrollment date in the HMO and for the Department to be responsible for hospitalizations that cross over the disenrollment date from the HMO. This policy is negotiable.
61	Model Contract 2.1.1.5		Re-Enrollment After Resumption of Eligibility - Will health plans have access to enrollee eligibility anniversary dates in the enrollment files to help support enrollee education/outreach re: the importance of timely re certification? Is the re enrollment retro to the initial date of disenrollment, ensuring no gaps in coverage? Will members be retro-enrolled with no break or re-enrolled at the next effective date?	HMA on behalf of CareSource	The Department will consider notifying the Contractor of its enrollees' medical redetermination dates for client education purposes. Re-Enrollment after resumption of eligibility is retroactive, ensuring no gap in coverage, if the enrollee is re-determined within 60 days after termination. There are some instances, due to schedule cut-off times, where there may be a one month break in MCO coverage.
62	Model Contract Section 2.1.1.8.1.4 Section 2.1.1.8.1.5		Model Contract Section 2.1.1.8.1.4 indicates that a member who is subsequently discovered to have "significant insurance coverage" will be disenrolled. Please clarify whether such disenrollment will be prospective or if it may be retroactive to the effective date of the insurance coverage. If disenrollment is retroactive, will the HMO's capitation payment be impacted? Similarly, Section 2.1.1.8.1.5 speaks to incarceration. If disenrollment due to incarceration is retroactive, will the HMO's capitation payment be impacted?	HMA on behalf of CareSource	Members who are discovered to have "significant insurance coverage" will be disenrolled prospectively; therefore, the HMO's capitation will not be impacted. If a member is disenrolled due to incarceration, the date of disenrollment is the end of the month prior to the month of incarceration. The HMO's capitation will be recouped accordingly.

	Section Number	Page Number	Question	Submitted By:	Response
63	Model Contract Section 2.1.1.9		This section indicates that the State will limit the number of enrollees according to the contractor's physical and professional capacity. Please describe the specific formula for determining the enrollment limit if such a formula exists. For example, is the enrollment limit based on a certain PCP to member ratio?	HMA on behalf of CareSource	The Department will assess network adequacy to properly serve the expected enrollment of 20,000 prior to implementation. There is no specific formula, although PCP to member ratio is an important factor.
64	Model Contract Section 2.1.6.3.3		This section outlines impermissible member gifts and incentives. Would the State consider allowing the contracted HMO to offer incentives for activities related to health and wellness, such as completing a health assessment or disease management program, even though these activities do not involve the direct receipt of preventive care? Also, please confirm that gift cards are not incentives "in the form of cash or an instrument that may be converted to cash."	HMA on behalf of CareSource	Health related incentives are generally allowable but must be prior approved by the Department. Gift cards that cannot be converted to cash are acceptable if approved by the Department.
65	Model Contract Section 2.1.10.2		Safety Net Providers - Under Safety Net Providers, reference is made to contracting with Community Mental Health Centers but the stand alone model contract states that behavioral health delivered in CMHCs is carved out. Could you please clarify?	HMA on behalf of CareSource	Services at a Community Mental Health Center are not carved out. The Department cannot find such a reference in the attached model contract, but any such reference is incorrect if it exists and will be corrected in any final contract. The list of covered services in the attached model contract clearly lists all mental health services except forensic commitments to State operated psychiatric hospitals.
66	Model Contract Section 2.1.11		Covered services do not include Nursing Facility or Waiver Programs. Please confirm that these services are only covered under Service Package II.	HMA on behalf of CareSource	These services are clearly listed in covered services for Service Package II listed at Section 2.1.12 of the Model Contract.

	Section Number	Page Number	Question	Submitted By:	Response
67	Model Contract 2.1.31.3		Model Contract Section 2.1.31.3 - The agreement indicates that any recoupments recovered are retained by the Department. Is this appropriate in light of this being a capitated program?	HMA on behalf of CareSource	This section deals with the OIG retaining the right to perform audits and reviews of network providers and initiate appropriate recoupment actions if necessary. The OIG will work with the Contractor to determine the appropriate recoupment amount and the appropriate method for recoupment whether it is the contractor or the Department actually recouping the overpayments.
68	3.4		Are providers obligated to see State FFS members for both TANF and ABD?	Molina	No.
69	3.4		<p>What are the “optical services” benefits. We are concerned that the fee schedule does not include the following specific Optometry codes when we are responsible for optometry services:</p> <ul style="list-style-type: none"> • Examinations: 92002- 92004 (Initial Visit); 92012 – 92014 (Established) • Lenses: V2100 series (Single Vision) and V2200 series (Bi-focal) <p>We recognize we are not responsible for eyeglasses and frames, but it looks like we would be responsible for contact lenses - is this correct?</p>	Molina	<p>Medical codes can be found on the Physician fee schedule, http://www.hfs.illinois.gov/reimbursement/ the exam codes are covered. The Physician fee schedule applies to physicians and Optometrist for those services.</p> <p>The Contractor is responsible for eyeglasses, other devices to correct vision, including contact lenses, and any associated supplies and equipment.</p>
70	2.1.1.1		Is it possible for HFS to adjust the notification time line to longer than 2 days?	Molina	The Department assumes you are referring to Section 2.1.1.6. Bidders may propose a reasonable alternative timeframe as an exception.

	Section Number	Page Number	Question	Submitted By:	Response
71	2.1.10		Will HFS consider a non-par fee schedule for non-affiliated (e.g. contracted) providers?	Molina	Contractors must pay at least the Department's rates to non-participating providers for emergency services. It is expected that all other services will be provided by network providers except in rare cases when the Contractor must arrange for services outside its network. In such cases it is assumed that reimbursement is agreed to as part of the arrangement.
72	2.1.11		When trying to access the following link, an error message is received. Can the state provide a new link or allow access to this information? http://www.iga.gov/commission/jcar/admincode/089/089001400A00030R.html	Molina	The correct link is: http://www.ilga.gov/commission/jcar/admincode/089/089001400A00030R.html
73	2.1.17		Can the state provide electronic versions of the state's fee schedules for hospitals and all other provider types not on their website, along with DRG conversion factors, per diem rates and all other elements tied to hospital reimbursement? For outpatient services, we need to know what codes fall into each grouping under surgery and ER.	Molina	The Department's website, http://www.hfs.illinois.gov/medical/ lists reference materials for providers, including handbooks, bulletins, and fee schedules. The Enrollment process for the current MCOs and information regarding such can be found at: http://www.illinoisceb.com/Default.aspx . Information on Per Diem and DRG rates for hospitals are included in the file with the corresponding question number at: http://hfs.illinois.gov/icp/ . For the outpatient services grouped as surgery and ER, see the file with the corresponding question number at: http://hfs.illinois.gov/icp/ .

	Section Number	Page Number	Question	Submitted By:	Response
74	3.1.1.2.1.1		Should a bidder accept pharmacy risk, could the State please provide information around the management tools that will be allowed to be employed, what mandates there might be (if any), and what UM techniques require prior approval from the State?	Molina	A contractor that accepts risk for drugs may use any appropriate management tool. All medically necessary drugs must be covered when appropriate.
75	3.1.1.2.1.1		The state suggests bidders accept risk at the State's net cost after statutory drug (Medicaid) rebates. In the information provided the State provides costs on a component basis (i.e, their rates for different drugs, dispensing fees, etc, and their average rebate yield). Under the proposed health reform, rebates are a pass through to the State. The health plan won't see or collect them. Has the Department considered allowing the health plans to accept risk exclusive of the Medicaid rebates?	Molina	As stated in the RFP, if federal law changes to allow the state to collect rebates on drugs reimbursed by capitated MCOs, the state will allow plans to accept risk at the states gross cost.
76	3.1.3.11		Do the LTC/Home and Community Based Services Providers utilize standard billing practices?	Molina	No. Currently, the providers send claims to the operating agencies in formats that vary by agency and method. The operating agencies process payments, and then send the claims through MMIS for federal match in a standard or modified proprietary format.
77	3.1.3.4		Although the PAS process will continue as currently in place, does this exclude the HMO from participating or is it assumed that the HMO is the Coordination of Care unit?	Molina	The current PAS system will continue to conduct all prescreening, annual redeterminations and initial assessments and care plans. The HMO will work in collaboration with the waiver operating agency or NF/institutions/other programs during transition of Enrollees to the MCO.

	Section Number	Page Number	Question	Submitted By:	Response
78	3.1.3.7		What is the required timeframe for the screening to be completed once an individual is identified? On average, once the completed paperwork is submitted, how long does this process take to establish eligibility for waiver services and/or nursing facility?	Molina	<p>PAS agencies will continue to conduct prescreening as persons apply or enter programs. Some will go through the PAS process before MCO Enrollment periods, for those that do not, there are screening timeframes. Aging waiver/NF/SLF screenings have the following timeframes. The CCU must complete a screening within:</p> <ul style="list-style-type: none"> • two calendar days from notification that nursing facility/supportive living facility placement is imminent from a hospital. • two calendar days from notification that nursing facility/supportive living facility placement is imminent within three calendar days from the community. • ten calendar days from notification that nursing facility/supportive living placement is not imminent of placement within three calendar days. • ten calendar days from the date of notification by the facility of the need for the screen. • within 30 calendar days from the date of request if a facility requests more than ten post-screens in a period of 24 hours. <p>For the HIV/AIDS and Brain Injury HCBS waiver, screens must be conducted within:</p> <ul style="list-style-type: none"> • two working days for prescreening referral from cooperating hospitals for interim/emergency services; • five working days for all other prescreening for interim/emergency services; • ten working days after receipt of an eligibility referral.
79	3.2.1.1.8		Please explain the difference in value of a LOI versus “Pending Contract” and your definition as to what qualifies as “Pending.”	Molina	There is no predetermined point value for the different levels of commitment.

	Section Number	Page Number	Question	Submitted By:	Response
80	3.2.1.11		Section requests implementation work plan with an estimated timetable to begin enrollment no later than October 1, 2010? What is the timeline for readiness review? Is there a lag between assignment of members and the actual implementation date? What is the implementation date?	Molina	Although the RFP states that the target time for a readiness review is 60 days after execution of a contract, this is just a target. It is critical that Bidders set forth a realistic timetable for implementation. The Department is looking for the most aggressive timeline that does not present undue risk at implementation to the continuity of care and access to care for enrollees.
81	3.2.7		Please provide more clarity around the EMR requirements? What specifically is the state looking for?	Molina	The state is asking plans to identify the capacity of their provider network.
82	3.4.3		Will the State provide FQHCs any additional reimbursement for the enrollees in this RFP?	Molina	The state will comply with section 4712 of the Balanced Budget Act of 1997 that mandates it reimburse FQHCs for the difference between 100% of reasonable costs and the reimbursement it receives under its contract with an HMO. Clinic Service Payment can be found at 89 IL Administrative Code, 140, Section 140.463.
83	5 (o)		The Dept of Human Rights Public Contract Number instructions indicate bidder must have proof of having submitted a completed application for one prior to the Solicitation opening date. Please confirm what date that represents. i.e. April 15th?	Molina	It is April 15, 2010.
84	7.4		HFS considers a gain share incentive arrangement with the Contractor if the Contractor achieves a Medical Loss Ratio (MLR) less than the target MLR?	Molina	Yes.
85	Att I		The generic ratio and rebates as a % of spending should be re-stated for the potential population. Can the state provide this information?	Molina	Bidders will be able to derive the generic ratio from the pharmacy data made available to those requesting per the response to Question #2. Due to the method of invoicing rebates, rebate percentage for the target population cannot be determined separately.

	Section Number	Page Number	Question	Submitted By:	Response
86	General		What is the anticipated contract award date? Contract effective date?	Molina	The Department expects to make an award in late May or early June. The target date for a contract is July 1, 2010.
87	General		We would like to request a count of eligible enrollees by zip code from the State	Molina	This information can be viewed in the file with the corresponding question number at: http://hfs.illinois.gov/icp/ .
88	Att I		How often will the State provide the MCOs pharmacy data in the carve-out (original) model?	Molina	The Department currently provides this data to MCOs monthly. However, the Department is willing to explore providing it more frequently.
89	General		Will detailed claims/eligibility data be made available to the potential bidders?	McKesson Health Solutions	No. It will be given to the Contractors once the award is made.
90	General		How will members who move in and out of the prescribed HMO areas be treated?	McKesson Health Solutions	An enrollee who moves out of the contracting area will be disenrolled. An individual who moves into the contracting area will be enrolled. The Department will negotiate in the contract the handling of residential placements outside the contracting area of enrollees.
91	General		How will members that live in a non-HMO area but seek care from a provider within the designated area be treated?	McKesson Health Solutions	Enrollment in the Integrated Care program is limited to residents of the contracting area. Contractors are only responsible for their enrollees. Contractors are responsible for the care of their enrollees, regardless of the location of the provider. In other words, the location of a provider is irrelevant to the issue of payment responsibility.
92	General		How will members that live in the HMO area but seek care from providers outside the HMO be treated?	McKesson Health Solutions	Duplicate question, see previous answer.
93	General		Is there a prescribed number of hospitals and providers that will be deemed a network?	McKesson Health Solutions	No

	Section Number	Page Number	Question	Submitted By:	Response
94	2.1.1.3.2 Enrollment by Auto-Assignment	3	Will existing PCP member assignments from Illinois Health Connect be used as part of the auto-assignment process?	McKesson Health Solutions	Yes
95	2.1.2 Communications with Prospective Enrollees, Potential Enrollees & Enrollees	5	Are web-based services/communications required and/or encouraged for member and provider level communications?	McKesson Health Solutions	The Department has not prescribed any standards. It is looking for proposals that best address the needs of the population, including the best method of communicating with enrollees.
96	2.1.14 Emergency Services	10	What is the definition of Emergency Services? Is this limited to specific health care events or services performed only in an Emergency Room?	McKesson Health Solutions	See the Definition Section of the RFP
97	3.1	22	As service packages are phased in, will services not covered by the HMOs continue to be covered by Healthcare and Family Services on a Fee For Service basis?	McKesson Health Solutions	Yes.
98	3.1	22	Will the dates for rollout of service package II and III be known at the time of launch? Will these dates be the same for both HMOs?	McKesson Health Solutions	It is unlikely that the dates of rollout of service packages II and III will be known at the time of implementation of Service Package I. The State may opt to begin Service Package II or III with one plan if it is ready before the other, but may also decide not to implement Service Package II or III until both plans are ready.
99	Section 7 Payment Terms and Conditions	56	A) Are start-up/implementation costs allowed to be billed to the Department? B) If not, will start-up costs be considered in the calculation of the Rates being paid to the Contractors?	McKesson Health Solutions	A) No. B) No.

	Section Number	Page Number	Question	Submitted By:	Response
100	7.1	56	A) Is it correct that the Department will determine the rate which the Contractors will be paid for the services provided? B) If so, is this rate the only payment that will be made to the Contractors, aside from the Incentive Pool Payments outlined in Section 7.3?	McKesson Health Solutions	A) Yes. B) Yes.
101	General		How will the Department perform evaluation of net savings calculations as a result of the programs?	McKesson Health Solutions	The Department plans to use a third party to evaluate the program.
102	2.1.1.9	5	What is the methodology the state will use to determine the health plan's capacity for membership?	United Healthcare	The Department will review the Bidders' entire network adequacy. The Department will be assisted by the Departments of Insurance and Public Health, who perform this function for all HMO license applications.
103	Att C		Attachment C frequently refers to "Monthly Cost Limit". Could you please provide clarification on the Monthly Cost limit, including what the actual limit is and rules surrounding it?	United Healthcare	Monthly cost limits of services vary by waiver and can be reviewed in the waiver applications under Appendix C- Participants Services under each waiver. Waivers can be accessed at: http://www.hfs.illinois.gov/hcbswaivers/ Click on the Federal Approved Waiver.pdf
104	3.1.1.2.1.1	17	1. If we are interested in accepting risk for prescription drugs, should we propose a pmpm capitation reimbursement rate? 2. Please define the reimbursement rates for those bidders that would like to accept risk for prescription drugs. How are these rates developed? 3. Will the bidders be responsible for processing claims under this scenario?	United Healthcare	The Department's actuary will develop an actuarially sound rate based on the Department's net cost of drugs for the target population. If a Contractor accepts risk, it will be responsible for claims processing and pharmacy reimbursement.

	Section Number	Page Number	Question	Submitted By:	Response
105	7.4.2	56	Will value added services provided by the contractor in addition to those required under the contract be included in the benefit expense component of the Medical Loss Ratio Calculation?	United Healthcare	Yes.
106	Model Contract 2.1.27.1	Model Contract 15	Please provide specifications regarding the expected system interfaces and data exchange software so that compatibility and interoperability requirements can be determined.	United Healthcare	There is no software required for exchanging information between the Contractor and HFS. Specifications for exchanging information are identified in Sections 2.1.27.2 – 2.1.27.10
107	1.2	2	Is the bid opening on April 15 open to the public?	Harmony	Yes.
108	1.4	2	When does the 180 days offer firm time begin - When will the bids be opened?	Harmony	The Offer Firm Time begins on the date of the Proposal Opening (Section 1.4). Currently, the Proposal Opening is scheduled on April 15, 2010 at 1:00 p.m. (Section 1.2).
109	1.12	3	What impact does a protest have upon the timing of the award of bids, as well as on the timing & status of awards?	Harmony	See 44 Illinois Administrative Code 1.5550(d). http://www.ilga.gov/commission/jcar/admincode/044/044000010R55500R.html
110	1.12	3	Will the Department be publicizing the scores and the bases on which the individual proposals are awarded or not awarded (i.e., the relative scores and determinations for each criteria for each bidder)?	Harmony	The Department will not be publishing the scores of individual proposals. The proposals will be evaluated according to the criteria listed in Section 2.0. Scores will be available as permitted under the Illinois Freedom of Information Act, 5 ILCS 140, upon request. http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=85&ChapAct=5%26nbsp%3BILCS%26nbsp%3B140%2F&ChapterID=2&ChapterName=GENERAL+PROVISIONS&ActName=Freedom+of+Information+Act%2E
111	1.13	3	When will the Offers be open to the public under the Freedom of Information Act?	Harmony	Copies of proposals from which confidential information (Section 4 Request for Confidential Treatment) has been redacted will be available as permitted under the FOIA upon request.

	Section Number	Page Number	Question	Submitted By:	Response
112	1.17.21	5	This appears to indicate that we need to provide contract business operations for the Friday after Thanksgiving, which is typically a closed office holiday. Please clarify the expectations for holiday hours.	Harmony	The Friday after Thanksgiving is considered a Business Day.
113	1.17.41	6	How are Determinations of Need stored? Will the Contractor have access to a database of historical and current DONs? Will this be maintained by the state going forward? Will this information be sent on the 834?	Harmony	<p>A. Determinations of Needs are maintained by the prescreening or operating agencies in computer systems or paper files.</p> <p>B. No</p> <p>C. HFS can provide monthly files to the HMO that include DON scores for Enrollees and explore sharing historical information.</p> <p>D. No</p>
114	1.17.41	6	Please provide a copy of the Determination of Need (DON) tool including details of how the scoring is developed per person.	Harmony	DON tools and scoring tools can be viewed in the file with the corresponding question number at: http://hfs.illinois.gov/icp/ .
115	1.17.109	9	This defines the Offer Firm Time as the 6-month period following the bid opening. However, Section 1.12 (Award) states that the notice identifying the apparent awardees “extends the Offer Firm Time” until a contract is signed or determined not to be signed. Also, this extension could apply to bidders who are not the identified as apparent awardees because they may be invited to negotiate if a contract is not reached with one or more of the initial awardees. This interpretation should be confirmed or clarified.	Harmony	If contract negotiations or readiness reviews are not completed within 180 days, HFS will notify affected vendors formally in writing of the extension of the Offer Firm Time.
116	1.17.135, 1.17.140 1.17.137, and 1.17.141	10	Could the distinctions between a Quality Assurance Plan and a Quality Management Plan be clarified? Also, the distinctions between Quality Assessment and Performance Improvement, and a Quality Program)?	Harmony	The Quality Management Plan is the Quality Assurance Plan for the Waiver Programs. For purposes of this program, it will be called the Quality Assurance Plan.

	Section Number	Page Number	Question	Submitted By:	Response
117	1.17.149	11	Will the amount of bond security be determined before April 15?	Harmony	There is no bond security for this procurement.
118	1.17.162	12	Once Service Package I is implemented (presumably on 10/1/10), what will be the timing of Service Package II & III implementation. Also, what will be the timing of renewal increases? Will the state revert back to the State Fiscal Year for increases or continue with annual increases based on the implementation dates?	Harmony	<p>Contractors are required by Section 3.1.1.2.4 of the RFP to be ready to implement Service Package II and III within 12 months after Implementation of Service Package I. Actual implementation date will be tied to stakeholder input and readiness reviews.</p> <p>When Service Package II is implemented, the capitation rates for applicable rate cells will be changed from that month forward, it will not be an “add-on” to the Service Package I rate. The same methodology will apply to the applicable rates when Service Package III is implemented.</p> <p>At this time, the Department assumes rate renewals will be based on the anniversary date of implementation.</p>
119	2.1	16	Will there be any scoring applied to 2.1.1 Administrative Compliance or 2.1.2 Responsibility, or are they simply pass/fail? If they are incorporated into the scoring, please explain how. Will references and contracts be utilized in the assessment of 2.1.2 Responsibility?	Harmony	Sections 2.1.1 and 2.1.2 are not numerically scored. They are rated as Pass/Fail. Responsibility assessment is not incorporated into the Responsiveness Score. Information obtained from references may be considered to determine Bidder responsibility such as the perceived ability to perform completely as specified the requirements of the solicitation.
120	2.1.2	16	Will the Department be seeking references outside the Offer?	Harmony	The Department may seek references outside of the Offer.
121	2.1.2	16	What is meant by the TIN being used to evaluate bidder responsibility?	Harmony	TIN is used to determine whether a Bidder is delinquent in the payment of debt to the State of Illinois (See Section 4.8 of Section 8 Model Contract.)
122	2.1.2	16	Can there be further definition of what is meant by “sufficient” financial resources?	Harmony	No.

	Section Number	Page Number	Question	Submitted By:	Response
123	2.2.1 & 3.2 global	16	How will the individual elements of Responsiveness be evaluated? What weighting will be given to the answers of each of the questions relating to the subcategories of the Responsiveness Elements?	Harmony	See Section 2.2.1.
124	3.1.1.2.1.1	17	Can we negotiate the best rate we can get with the pharmacies even if that rate is less than what IL Medicaid pays according to the fee schedule?	Harmony	Yes
125	3.1.1.2.1.1	17	How do we get the pharmacy data for Utilization management if it is carved out?	Harmony	The Department will give the Contractors access to a data set and they can download their member's pharmacy utilization monthly.
126	3.1.1.1	17	When will the plans be provided with updated enrollment following the award of the bids? When will they be provided with initial enrollment of members that have chosen them or been assigned to them?	Harmony	The target date for initial enrollment is October 1, 2010, however implementation will not happen until Contractors have passed the readiness review. Please refer to Section 3.2.1.11 of the RFP, which asks Bidders to propose phase-in of enrollment, including a timetable.
127	3.1.1.2.1	17	Section states that short term post-acute rehabilitative stays in Nursing Facilities are not considered LTC. Please provide criteria to determine when a stay is no longer short term. What is the maximum length of stay in a nursing home that would cause it to fall outside the scope of a "short term post-acute rehabilitative" stay? Is there a certain number of days that plans would be required to cover before an individual is considered to be receiving "long term care"? During the period when plans are only offering Service Package I, can plans recoup the dollars spent on a post-acute rehabilitative stay that eventually becomes a "long term care" situation? Will the data in the databook reflect this?	Harmony	A short term post-acute stay is a stay of 90 days or less following a hospitalization or the first 90 days of a longer stay following hospitalization. During the period Contractors are responsible for Service Package I only, the Contractor will not be responsible for the first 90 days of NF costs following enrollment for residents in a NF at the time of enrollment.

	Section Number	Page Number	Question	Submitted By:	Response
128	3.1.1.2.1	17	Will the medical costs of individuals in nursing homes and waiver participants be fully reflected in the utilization data for Service Package 1?	Harmony	Yes.
129	3.1.1.2.1 vs 2.1.11.1.24 and 2.1.11.1.25 (p. 10 MC)	17	Is medical care (physician services) in nursing facilities for enrollees under 21 or for all members in Service Package #1?	Harmony	Service Package I includes medical care for all Enrollees in Nursing Facilities. Section 2.1.11.1.24 is referring to in-home nursing care services required by EPSDT, which are also included in Service Package I. Section 2.1.11.1.25 is referring to short term nursing services provided by specialized providers in transitional or respite settings. The only providers certified to render these services are Maryville Children's Healthcare and Almost Home Kids.
130	3.1.1.2.1.1	17	What are the terms and conditions for the plans of Rx Carve-in, should they choose to go that route?	Harmony	Contractors will be at risk for providing drug coverage at the rate determined by the actuary. As with all services, all medically necessary services must be provided.
131	3.1.1.2.1.1	17	Does Illinois foresee having any restrictions on the PDL for the MCO's? a. Atypical antipsychotics b. Behavioral health medications c. Generic substitution - What allows a pharmacy to dispense a brand if generics are available? d. Continue to exclude cough and cold for members above 21	Harmony	Contractors will control their PDL. Cough and cold medicines are not a covered service for those over 21.
132	3.1.1.2.1.1	17	Are all pharmacy benefits carved out of this plan (i.e. Medical side - drugs administered in the physician's office)?	Harmony	No, only drugs dispensed at an outpatient pharmacy
133	3.1.1.2.1.1	17	A lot of the quality measures are pharmacy intensive. Will they still be included if pharmacy is carved out?	Harmony	Yes.

	Section Number	Page Number	Question	Submitted By:	Response
134	3.1.1.2.1.1	17	Where in the proposal should the HMO discuss its approach to pharmacy services?	Harmony	Proposals to manage the carved out benefit and share savings must be included at 3.2.5.3.5. If a Bidder wants to assume risk with the cost of drugs factored into the capitation rate at the Department's cost after rebates, this must be indicated under Item 7 of Section 6.
135	3.1.1.2.1.1	17	What access will the HMO have to real-time pharmacy data (during the contract period)?	Harmony	The Department currently provides this data to MCOs monthly. However, the Department is willing to explore providing it more frequently.
136	3.1.1.2.1.1	17	If prescription drugs are carved out of the cap rates, how will the information necessary for appropriate case management be accessed/transferred to the health plans?	Harmony	Prescription claims level data is currently provided on a monthly basis to MCOs. The Department will explore methods of providing it more frequently.
137	3.1.1.2.1.1	17	When will the State make the final decision as to whether or not pharmacy claims are carved out of the capitated rates?	Harmony	The decision has been made to carve them out unless the successful Bidders agree to assume the risk under the conditions set forth in the RFP.
138	3.1.1.2.4	18	What will be the process for demonstrating capability of administering Service Package II and III?	Harmony	This will be determined during the review of the proposals.
139	3.1.1.2.4	18	What happens at the end of the first plan year if a plan is not ready to implement Service Package II or III?	Harmony	The Contractor would be in breach of the contract.
140	3.1.1.2.4	18	Services in packages 2 and 3 will be phased in after one year. Will the rates established for those services be included in the rates to be released by the end of February?	Harmony	No.
141	3.1.2.1.2	19	Will all of the Service Packet I services be provided by the Contractor to all individuals within table 3.1.2.1.2 during the first year?	Harmony	Yes.

	Section Number	Page Number	Question	Submitted By:	Response
142	3.1.2.1.2	19	Please provide the average growth rate of membership the last few years. Bidder Clarification: Membership is the population that will be covered under this plan.	Harmony	Refer to the member months included in the data released at the Bidder Conference and posted on the Illinois Procurement Bulletin as Addendum #4.
143	3.1.2.2	20	How will the state handle terminations and recoupments for individuals who switch over into one of the excluded populations during their enrollment in the "Integrated Care Program"?	Harmony	Enrollees who switch to an excluded population will be disenrolled prospectively, therefore no capitation will be recouped from the HMO.
144	3.1.2.2.4	20	Will populations with spend-down be eligible for participation in the Integrated Care Program in the future? If so, will the state retain the responsibility of collecting the spend-down?	Harmony	There are no such plans at this time.
145	3.1.2.2.7	20	What source will be used to determine an enrollee has comprehensive third party insurance?	Harmony	The HFS Bureau of Collections is responsible for verifying and updating third party insurance in the MMIS system. Once the Enrollee is determined high level TPL, the Enrollee is disenrolled prospectively.
146	3.1.3.1 and 7.1 (p. 56)	20	The current FFS program utilizes managed care components to lower costs including a PCCM program and a Disease Management Program. The RFP notes that "Together, the programs work to achieve more appropriate and efficient utilization of medical care for Participants, reduce costs and improve health outcomes." Given that the current program is not strictly FFS, but already contains elements of managed care, how will the managed care adjustment factors used in the rate setting be adjusted to reflect this and prevent double counting of expected savings? How will the addition of these programs be considered when reviewing historic trend rates?	Harmony	The rates will be actuarially sound.

	Section Number	Page Number	Question	Submitted By:	Response
147	3.1.3.1.1	20	Please provide contact information for the current providers in Illinois Health Connect serving members who will be enrolled in the Integrated Care Program	Harmony	The contact information for the current enrolled providers was published and is available with the notice of this procurement on the IPB, #22018085.
148	3.1.3.1.2	20	There are 240,000 eligible members of the Your Healthcare Plus program for disease management. Are all the beneficiaries in the RFP population eligible for disease mgmt with Your Healthcare Plus? If not, how many are in the RFP population? Finally, are these persons “eligible” or actual members that have been placed in the program?	Harmony	All individuals eligible for the Integrated Care program under this RFP are eligible for the Your Healthcare Plus disease management program except those in the Brain Injury, HIV/AIDS, Developmental Disability and Technology Dependent Waivers. It is not possible at this time to tell the level of involvement in Your Healthcare Plus of the individuals who will actually be enrolled in the Integrated Care Program.
149	3.1.3.1.2, 3.1.3.3, 3.1.3.4, 3.1.3.5.1 and 7.1 (p. 56)	20	Since members with behavioral health issues are a significant portion of the population to be covered under this contract, please provide separate historic utilization and unit cost trends for these services to assist plans in evaluating rate adequacy.	Harmony	See the data summary from the Department’s actuary released at the Bidder Conference and posted on the Illinois Procurement Bulletin as Addendum #4.

	Section Number	Page Number	Question	Submitted By:	Response
150	1.17.158 and 3.1.2.2.4	20	<p>Please further define spend-down and excluded spend-down members. Are the following considered spend-down or spend-down members:</p> <ol style="list-style-type: none"> 1) Amounts prospective members pay before they are eligible for Medicaid coverage. 2) Once a member is enrolled in Medicaid, amounts the member pays for services before Medicaid pays for services in a given month. 3) If a member is in a LTC facility and receives a Social Security or SSI check or other form of income which is applied toward the members payment to the facility for costs of services and then Medicaid pays the rest of the cost of services, is this member considered a spend-down member? Would this member be excluded from the covered population under this program? 4) If a member is in a waiver program or not and has monthly income that he/she uses to pay for medical or HCBS services before Medicaid pays the rest of the cost of monthly services, is this member considered a spend-down member? Would this member be excluded from the covered population under this program? 	Harmony	The many intricacies of spend-down policy in Illinois are irrelevant to potential contractors. The Department's eligibility system indicates all individuals with a spend-down requirement and these individuals will not be enrolled in this program. Their costs are not being used to develop rates.
151	3.1.3.4 and 2.1.10.2 (p.9 of MC)	21	The Community Mental Health Centers/providers have not been willing to cooperate or contract with MCOs for the TANF population. How will the State work to encourage these providers to contract for this population?	Harmony	The underlying statement is not true for all CMHCs and not true for all MCOs.

	Section Number	Page Number	Question	Submitted By:	Response
152	3.1.3.5	22	A) Will the HMOs be expected to negotiate provider agreements, including rates, with the State Operated Hospitals? B) Will funding for these services be included in the capitation payment?	Harmony	A) Yes B) Yes.
153	3.1.3.6	23	Please provide more detailed information on the Participant Direction benefit. What types of services are included under this benefit and what types of members receive this benefit? Who decides how much the individuals hired by the participant are paid? Is there a limit to the number of hours per week each participant can receive for these services? How are the number of hours determined?	Harmony	Participant Direction is described in the HCBS waivers. The waivers that offer participant direction include: Brain Injury, HIV/AIDS, Physical Disabilities, Adult DD and Children’s Support DD. More information on Participant Direction can be found in Appendix E: Participant Direction of Services of the waivers. Waivers can be accessed at: http://www.hfs.illinois.gov/hcbswaivers/ Click on the Federal Approved Waiver.pdf
154	3.1.3.6	23	Once the HMOs are responsible for HCBS services, will the HMOs be required to allow members to continue to participant direct all of the services they currently direct in the various HCBS waivers? Will each participant directed service in the various HCBS waivers continue to be defined in the same way as they are currently defined?	Harmony	Guidance for Participant Direction is in Appendix E: Participant Direction of Services. http://www.hfs.illinois.gov/hcbswaivers/ Click on the Federal Approved Waiver.pdf This option is based not only on choice, but the ability and safe provision of services. No changes to Participant Direction are anticipated to the current waivers at this time.
156	3.1.3.6 and 3.1.3.11.3 (pg. 25)	23	How are Participant Direction services described in 3.1.3.6 different from the Consumer Directed Personal Assistants waiver program described in 3.1.3.11.3?	Harmony	Section 3.1.3.6 is a broader definition of Participant Direction and the 3.1.3.11.3 is a description of the waiver and how Participant Direction is a component of the waiver. Participant Direction is also a component under the waivers for persons with developmental disabilities as referenced under 3.1.3.11.5.

	Section Number	Page Number	Question	Submitted By:	Response
157	3.1.3.7	23	A) Will the current screening agencies for level of care determinations be maintained? B) Is the Contractor responsible for reimbursing the screening agency? C) Will this responsibility be transitioned to the Contractors?	Harmony	A) Yes, as designated by the state. B) No. C) No.
158	3.1.3.7	23	Will members requiring temporary skilled nursing services be required to have a completed DON?	Harmony	No, unless the person is applying for the HIV/AIDS, Brain Injury or Physical Disabilities waivers, or nursing facility admission.
159	3.1.3.7	23	Please explain the limited circumstances in which a Long-Term Facility should admit a resident without a pre-admission screening.	Harmony	See 89 Ill. Adm. Code 140.642 (c) for circumstances when a screening assessment does not apply to an individual. A post-admission screening is permitted only under the following circumstances: <ul style="list-style-type: none"> • placed from out-of-state; or • admitted from hospital emergency or outpatient services; or • has a pre-existing condition of need for a caregiver and caregiver is no longer able to provide care.
160	3.1.3.7	23	A) Is the PAS required for all Nursing facilities, including SNFs? B) If so, is the three day hospitalization waived or not?	Harmony	A) Yes B) The three day hospitalization is not applicable to nursing facility or SLF prescreening.
161	3.1.3.8	23	Section states annual assessments must be completed. Which, if any, populations does the state require to be conducted more often?	Harmony	Waivers require at least an annual redetermination and assessment under HCBS waivers. The Brain Injury, HIV/AIDS and MFTD waivers require more frequent reviews. All waivers require a more frequent assessment if the individual has a significant change in condition either improved or declined. Refer to Appendix B-6 of the waivers for detail. http://www.hfs.illinois.gov/hcbswaivers/ Click on the Federal Approved Waiver.pdf

	Section Number	Page Number	Question	Submitted By:	Response
162	3.1.3.11	25	<p>A) Once the HMOs are responsible for HCBS services, will the HMO be solely responsible for determining need and identifying services for persons receiving HCBS (separate from the PAS process)?</p> <p>B) Does the state have any expectations regarding the future role of case management agencies (e.g., HMO to contract with case management agencies, or case management agencies a "check" on HMO assessment process)?</p>	Harmony	<p>A) No, the current preadmission screening processes will remain in place.</p> <p>B) No, however, federal regulations for HCBS waivers require monitoring of assurances as outlined throughout the waiver applications..</p>
163	3.1.3.11.3	25	Will the current payroll system for Personal Assistants be maintained by the state or will the Contractors be responsible for developing a payroll system?	Harmony	Contractors will be responsible for payroll development for the Personal Assistant payroll system and the developmental disability Fiscal Management Services.
164	3.1.3.11.3	25	Children under 19 years of age are currently covered in most of the state HCBS waivers (Persons with Disabilities; Persons with HIV/AIDS; Persons with Brain Injury; Adults with Developmental Disabilities Waiver, the Residential Waiver for Children and Young Adults with Developmental Disabilities and the Support Waiver for Children and Young Adults with Developmental Disabilities). In keeping with the excluded populations list (3.1.2.2, page 20) are the children under age 19 in these waivers also excluded from Integrated Care or will an exception be made for this group?	Harmony	Children under 19 years of age currently served in HCBS waivers are excluded, as are all children.

	Section Number	Page Number	Question	Submitted By:	Response
165	3.1.3.11.4	26	<p>A) This section notes that the primary services provided under this waiver are case-management services. Who provides these services?</p> <p>B) Is there a Medicaid fee schedule established for the providers?</p> <p>C) Can these services be provided by the Contractor's employees?</p>	Harmony	<p>A) As referenced in 3.1.3.11.4, the case management services for the Medical Fragile, Technology Dependent HCBS waiver are provided by The Division of Specialized Care for Children (DSCC), University of Illinois at Chicago. The reference to the primary services as case management is because each individual receives intensive case management in this waiver including at minimum monthly contacts. It is not defined as a Participant service under Appendix C of the waiver, but an administrative service. In addition, the most costly service, nursing, with the exception of respite is covered under EPSDT and not the waiver.</p> <p>B) No. It is reimbursed as an administrative service.</p> <p>C) Yes.</p>
166	3.1.3.11.4 and 7.1 (p. 56)	26	<p>3.1.3.11.4 indicates that the Contractors will be responsible for electric bills for members with specialized equipment such as respirators in their homes. How are these amounts currently paid? What is the process for receiving the bills from the utility company or the member? How is the portion of the bill that is to be paid by Medicaid determined? How will these costs be included in the rate development?</p>	Harmony	<p>HFS reimburses for a portion of the electrical bill that can be attributed to increased usage due to the medical equipment used to support the child in the home. The family provides the electrical bill prior to use of medical equipment and the DSCC care coordinator determines the electrical requirements for each piece of equipment using a special form to calculate estimated costs for operating the equipment. The estimate form, copy of the electric bill and cover letter are sent to HFS for payment processing. The information includes the electric utility provider name, address, REIN number, participant's name and electric bill account number. These costs have been included in the rate development.</p> <p>Expenditures for electrical services in the pilot area for eligibles were \$1,159.68 for two persons in FY 2008 and \$648.18 for one person in FY 2009.</p>

	Section Number	Page Number	Question	Submitted By:	Response
167	3.1.3.11.5	26	Please provide more detailed information on the Participant-directed benefit. What types of services are included under this benefit and what types of members receive this benefit? Who decides how much the individuals hired by the participant are paid? Is there a limit to the number of hours per week each participant can receive for these services? How are the number of hours determined?	Harmony	Please see responses to 153 and 154 above. Currently, the wages for the Personal Assistants in the Brain Injury, HIV/AIDS and Physical Disabilities are based on the SEIU contract. Currently the rates are: 7/1/09: \$10.45; 7/1/10: \$11.20 Under the waiver for developmental disabilities, the rates are individually established. The limits are based on service cost maximums by individuals. The hours are determined using the DON, Assessment and discussion of the service needs with the individual or representative.
168	3.1.3.11.5 and 3.1.3.6 (p. 23)	26	How are the Participant-directed services described in 3.1.3.11.5 different from the Participant Direction services described in 3.1.3.6?	Harmony	Section 3.1.3.6 is a broader definition of Participant Direction and the 3.1.3.11.5 is a description of the waiver and how Participant Direction is a component of the waivers for developmental disabilities.
169	3.2.1.1	27	Understanding the questions regarding this are somewhat exploratory, is there a specific expectation of HIT use for integrated care?	Harmony	No
170	3.2.1.3	27	Understanding the questions regarding this are somewhat exploratory, is there a specific expectation of HIT exchange functionality between the contractor and those providers with functioning EMRs as well as those without functioning EMRs?	Harmony	No
171	3.2.1.4	27	Understanding the questions regarding this are somewhat exploratory, is there a specific expectation for promoting use of HIT by providers within our network?	Harmony	No

	Section Number	Page Number	Question	Submitted By:	Response
172	3.2.1.11	28	Please clarify requirements for "phase-in." Does the state anticipate the program will be phased-in by group over a finite period of time or is everyone to begin day-one? Does the definition of phase-in refer to service package I or phase-in of the comprehensive program, including Service Packages II and III? Phase-in of populations, services, both?	Harmony	The question regarding phase-in of Potential Enrollees is not specific to a particular Service Package. The Department is seeking the Bidder's proposal on phase-in based on its experience and its proposed Integrate Care Program.
173	3.2.2.11	29	Are Contractors free to choose between subcontracting Case Management services or providing these services in house with the Contractor's employees?	Harmony	Yes.
174	3.2.2.11	29	In section 3.2.2.11, please explain the 2nd sentence "If you subcontract for Case Management services, list other provider types you are contracting with."	Harmony	"Other" in this context refers to provider types not specifically listed in the preceding sentence.
175	3.2.2.11	29	Should the HMO provide provider network data by county?	Harmony	Yes.
176	3.2.2.12	29	Is there a specific format that is requested for the 'maps' for provider distribution?	Harmony	No.
177	3.2.2.12	29	What are the GeoAccess standards for provider network density ?	Harmony	The Department will assess all proposals for network adequacy.

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178	3.2.3	29	What is the timeframe in which the state will make a level-of-care decision? How and when will the information about level-of-care be transmitted to the HMO? What information from the level-of-care (PAS) process , beyond the level-of-care decision itself, will be provided to the HMO?	Harmony	<p>Time frames vary with the waivers, some governed by rule.</p> <p>The waivers for persons who are elderly and persons with HIV/AIDS and Brain Injury have timelines regarding eligibility determination in 89 Illinois Administrative Code (ILAC) 240.640 and 89 ILAC 686.910 and 686.1010. The links are:</p> <p>http://www.ilga.gov/commission/jcar/admincode/089/08900240sections.html</p> <p>http://www.ilga.gov/commission/jcar/admincode/089/08900686sections.html</p> <p>A mechanism will need to be developed to transmit the level of care, assessment and plans of care.</p>
179	3.2.3.2	29	Does the state expect all of the existing Disease Management programs operating to continue?	Harmony	Enrollees in this program will no longer be enrolled in the Illinois Health Connect or Your Health care Plus Disease management program. The Contractor will be responsible for any needed care management or disease management. The current DM Contractor will cooperate in providing existing Care Plans.
180	3.2.3.5	30	What address information will be provided for homeless individual and how will requirements for mailing compliance incorporate allowances in these scenarios?	Harmony	The Department will provide whatever address or addresses it has on file.
181	3.2.4.2	30	Does the state expect that each member will need a care manager? If not are there requirements for which members receive a care manager?	Harmony	No, the Bidder must propose its case management plan. Upon implementation of Service Package II, each HCBS waiver participant must be assigned a case manager.

	Section Number	Page Number	Question	Submitted By:	Response
182	3.2.4.2	30	What is the Department's expectation of the relationship between the Plan and the current DM contractor after the member is enrolled in the ICP?	Harmony	Enrollees in this program will no longer be enrolled in the Illinois Health Connect or Your Health care Plus Disease management program. The Contractor will be responsible for any needed care management or disease management. The current DM Contractor will cooperate in providing existing Care Plans.
183	3.2.5.2	31	Are there any specific populations in which a Case Manager is mandated (other than PCP)?	Harmony	No, the Bidder must propose its case management plan. Upon implementation of Service Package II, each HCBS waiver participant must be assigned a case manager.
184	3.3	32	How will responses to Section 3.3 (starting on page 32) be evaluated? Are they part of Administrative Compliance, Responsibility or Responsiveness?	Harmony	Section 3.3 will be evaluated as part of the response to Question 3.2.1.14 of the RFP.
185	3.2.7.5	32	Potential contractors are constantly making changes, improvements, and enhancements to the HIT applications. What guidance can be provided on the general scope of change the department is interested in knowing about?	Harmony	The Department is interested in knowing the Bidders plans for the future.
186	3.4	33	Are there any location requirements for subcontracted entities or offshore prohibitions?	Harmony	See 3.6.2
187	3.6	34	What constitutes "majority of Illinois specific administrative functions" ?	Harmony	The intent of 3.6 is to require the Contractor to have a substantial management presence in Illinois, including the specific personnel required to be in Illinois under Section 3.3.1. There is no mathematical formula to determine a majority.
188	3.7.2.1 & 3.7.2.5	34	Are Audited Financials required for 2008 & 2009 or 2007 & 2008? Same Question for MLRs.	Harmony	The Bidder's two most recent Audited Financials and Medical Loss Ratios.
190	3.7.2.2	34	Are Balance Sheets to be provided for February or March 2010?	Harmony	The most recent month available.

	Section Number	Page Number	Question	Submitted By:	Response
191	Section 4	36	In Section 4, Offer to State of Illinois (starting on page 36), please clarify the order and category of the response forms and other information. For example, the Responsibility packet appears to include the Completed Minority, Female, and Person with Disability Status and Subcontracting form as well as Political Contributions (neither of which is listed in Section 4 as part of the Responsibility packet), and Convictions and Judgments (which is not listed in Section 4).	Harmony	Section 4, Offer to the State of Illinois, refers to the document titled Section 4, which must be completed as instructed and returned with the Bidder's proposal. Section 4 is a required State form. Section 5, Responsibility Forms, refers to the State standard forms and certifications and the specific forms and documents required for this solicitation. The Political Contributions form and Convictions and Judgments form are required state forms under Section 5. Proposals must be submitted in the order listed in Section 6, except for Minority, Female and Persons with Disability Subcontracting forms which are to be submitted in accordance with Section 1.8.
192	Section 6	55	In Section 6, Responsiveness (page 55), please clarify the references to Section 4, Offer to State of Illinois, and Section 5, Responsibility Forms. The items in Section 4 and Section 5 are not part of Responsiveness, correct?	Harmony	Section 4, Offer to the State of Illinois, refers to the document titled Section 4, which must be completed as instructed and returned with the Bidder's proposal. Section 5, Responsibility Forms, refers to the State standard forms and certifications and the specific forms and documents required for this solicitation. Sections 4 and 5 are considered under the Evaluation Categories (Section 2.1) of Administrative Compliance and Responsibility.
193	Section 6	55	Please clarify the order of the information to be provided in the Proposal. Section 4 (starting on page 36) appears to require one order and Section 6 (page 55) another.	Harmony	Proposals must be submitted in the order listed in Section 6. Section 4 is a required State form.
194	7.1	56	Is eligibility on a monthly basis or can enrollees be enrolled/ disenrolled at any time during the month?	Harmony	All enrollment/disenrollment will be effective at the first of the month/last of the month, respectively.
195	7.1	56	Have there been any significant changes to fee schedules from the experience period to the rating period?	Harmony	There have been minor changes to the fee schedule. These have been provided to the actuary.

	Section Number	Page Number	Question	Submitted By:	Response
196	7.1	56	Are there mandated reimbursement rates for any groups/categories of providers (e.g., Nursing Facilities)?	Harmony	No, with the exception that out of network Emergency Services must be paid at Department rates.
197	7.1	56	Are the Contractors allowed to contract with providers below the current Medicaid reimbursement rates?	Harmony	Yes.
198	7.1	56	Given the state budget crisis, are there any services provided to these members through other departments or programs that have been cut this year or expect to be cut in the near future causing the services to be pushed into this program? If so, how will the base experience data be adjusted to take into account these changes in services since the base period?	Harmony	There is no plan to decrease HCBS waiver services.
199	7.1	56	What administration load will be included in the rates?	Harmony	The Department will provide an opportunity for Potential Bidders to ask questions pertaining to the rates once rate information is released.
200	7.1	56	Long Term Care Facility (LTC) costs are a fixed amount once a member is admitted to a facility. There is no managed care reduction that can be applied at the point where the member is in a facility for life as the facility costs are a fixed cost. Therefore, controlling LTC costs is achieved not by reducing the rates by a managed care factor for members located in a facility, but by preventing members from entering a facility in the first place. What rate setting mechanism will the state use to incentivize the managed care plans to keep members out of a facility?	Harmony	The Department disagrees with some of the assumptions in this question. The rates will be actuarially sound.

	Section Number	Page Number	Question	Submitted By:	Response
201	7.1	56	Keeping members out of long term care facilities requires increases in the amount of home and community based services (HCBS) provided to members. What assumptions will be used to develop these new expected costs given that these costs are not in the current data?	Harmony	All community based and institutional long term care costs are in the data. Resources invested in community services produce offsetting savings in institutional services.
202	7.1	56	The state indicated that they think this program will save \$200 million dollars over the course of 5 years. What level of managed care savings does this assume? How is that savings split between acute care services and long term care services? Since long term care costs are fixed costs, there can be no managed care adjustment to these costs, so managed care savings will come through assumptions that members will not move to long term care facilities. What assumptions will be used to make these estimates?	Harmony	The \$200 million dollar savings amount in the press release was a Department estimate not based on final actuarial rates.
203	7.1	56	Please provide the current long term care facility Medicaid rates by facility. This should include rates for skilled nursing facilities, wait list beds, intermediate care facilities, and residential care facilities.	Harmony	Medicaid Rates by facility can be viewed in the file with the corresponding question number at: http://hfs.illinois.gov/icp/ . There are no wait list beds. Residential care facilities under the waivers for persons with developmental disabilities are calculated on an individual rate model. More information on CILA rates can be accessed at: http://www.dhs.state.il.us/page.aspx?item=40192 The CILA rate model is posted at: http://www.dhs.state.il.us/page.aspx?item=16043
204	7.1	56	Please provide the current Medicaid rates by home for foster homes and RACC homes.	Harmony	No individuals in the custody of DCFS are included in the Integrated Care Program. RACC is not a term applicable to Illinois.

	Section Number	Page Number	Question	Submitted By:	Response
205	7.1	56	Please provide the number of members in the covered population in each long term care facility for 2009 and current.	Harmony	The number of members in the covered population in each LTC facility can be viewed in the file with the corresponding question number at: http://hfs.illinois.gov/icp/ .
206	7.1	56	Please provide the methodology used by the state to develop Medicaid rates for long term care facilities. Are the rates developed annually or some other time period?	Harmony	NF rates are based on a Per Diem. Rates are calculated based on three separate components, nursing, capital and support. Capital and support are based on a cost report that is submitted to the Department each year. The nursing component is established annually, but may change quarterly, up or down based on Minimum Data Set clinical information. For more information see: http://www.hfs.illinois.gov/reimbursement/ltc.html
207	7.1	56	How are long term care facilities paid? A per diem? By level of ADLs? Some other methodology? Are wait list beds paid differently? Wait list beds are beds for members in an acute setting who are downgraded to an ICF level of care, but who are waiting for a bed in an ICF to become available. In some states these beds are paid at the acute rate and in others they are paid at an LTC institution type rate.	Harmony	NF rates are based on a Per Diem. Rates are calculated based on three separate components, nursing, capital and support. Capital and support are based on a cost report that is submitted to the Department each year. The nursing component is established annually, but may change quarterly, up or down based on Minimum Data Set clinical information. For more information see: http://www.hfs.illinois.gov/reimbursement/ltc.html Wait list beds are not applicable in Illinois.
208	7.1	56	What's the average length of time in a wait list bed? Please provide information on the length of time in the wait list bid for any members who have been in a wait list bed for more than 30 days.	Harmony	NA- Illinois does not have wait list beds as defined in question 207.

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209	7.1	56	How are Medicaid fee schedule increases developed for hospital, physician, emergency room and pharmacy rates? How often are each updated? What have the historical increases been back to 2006? What are the expected future increases through 2011?	Harmony	HFS has been subject to a rate freeze since 2002.
210	7.1	56	Will premium rates be prorated for members in the program for a partial month? Will rate cells for a member change mid-month if they move from one rate cell category to another (for example, from community based to a long term care facility)?	Harmony	See response to question #194.
211	7.1	56	Will there be a period after the effective date when the Contractor will not be allowed to apply management to services? For example, re-authorized of certain services on which the Contractor normally requires authorization. If so, how is this limitation being included in the rate development? If the Contractor is not able to manage care for this reason, the managed care factor applied to the rate needs to be adjusted to reflect the shortened period of management.	Harmony	See Section 3.2.4 of the RFP and the applicable laws and set forth a plan in your proposal.
212	7.1	56	What is the current rate of occupation at LTC facilities? Is there a waiting list for beds for members whose costs are covered by Medicaid?	Harmony	The current statewide occupancy rate in nursing facilities is approximately 78%. No

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213	7.1	56	Will the Department's Actuary provide the base data used to build the rates along with the rates themselves?	Harmony	<p>As discussed at the Bidder Conference, the following information will be shared with the Bidders in the data book:</p> <ul style="list-style-type: none"> • FY'07, FY'08 and FY'09 historical data • Weighting • Trends • Managed care adjustments • Administration load <p>Age will be considered through the risk adjustment tool. However, capitation rates are not being set by age.</p> <p>At this time, it is anticipated that the rates will be established for the five populations in one region, as presented in the data released at the Bidder Conference and posted on the Illinois Procurement Bulletin as Addendum #4.</p>
214	7.1	56	Will the Department's Actuary provide a set of assumptions that he used to bridge current experience to the proposed rates? These assumptions include utilization trends, unit cost trends, managed care savings and other adjustments for non-credible or missing data?	Harmony	See response to Question #213 above.
215	7.1	56	What is the span of the first plan year to which the initial rates apply?	Harmony	The initial rates to be released will be based on an October 1, 2010 implementation date. Any delay in that implementation will require adjustments to the rates. The final rates will cover 12 months from implementation date.
216	7.1	56	When will rate adjustments take place? Will the rate adjustments for all 3 Service packages take place at the same time?	Harmony	Service Package I rates will be adjusted at the start of the second year. The timing of rate adjustment for Services Packages II and III will be dependent on the implementation dates of those packages.

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217	7.2	56	Will there be any incentive from a capitation/rate setting standpoint to encourage plans to keep members out of nursing facilities and in their own home or the community?	Harmony	Yes.
218	7.2	56	How will the rates be structured? Will there be different capitation rates for nursing facility/HCBS members in addition to the risk score component?	Harmony	See the data summary from the Department's actuary released at the Bidder Conference and posted on the Illinois Procurement Bulletin as Addendum #4.
219	7.2	56	Will full Risk adjustment take place immediately, or will there be a phase in with minimum and maximum risk corridors which will widen over time and then disappear?	Harmony	Contractor will be at full risk immediately. Bidders may propose risk corridors as an exception.
220	7.3 Attachment E, F and G (e1 -g26)	56	Are the calculations for the Quality Measures and the P4P Program calculated by the Contractor or by the Department? If calculated by the Department, will the Department calculate these based on encounter data? If yes, how will the RX data be integrated with the Encounter data and at what frequency?	Harmony	They will be measured by the Department using encounter data. The Department will have complete pharmacy encounter data real time.
221	7.3 Attachment E, F and G (e1 -g26)	56	How will the bonus amount equal to 5% of the capitation be distributed? Will it be based on a higher target goal per measure than the 10% difference between the baseline score and 100% as described in 7.3.3? If so, does the Department have any insight into how high the bar will be?	Harmony	It will be based on 10% as stated in Section 7.3.3
222	7.3.1	56	Does withheld amount + bonus amount = 5% or does the withheld amount vary and the bonus amount = 5%?	Harmony	The withhold amount is a percentage of capitation paid to the Contractor. The 5% bonus is a separate amount.

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223	7.3.3	56	<p>Is the plan guaranteed additional P4P revenue if they exceed the 100% goal every year?</p> <p>Bidder's Clarification: Suppose that the year 1 P4P goal is 50% of the ultimate target. Every year the target increases by say 10% of the ultimate target until at year 6, the target is equal to 100% of the ultimate target. Supposing that in year 1 the plan achieves quality measures which would be scored at 110% of the ultimate P4P goal vs. a 50% target. The following year, the target increases to 60%, but the plan's quality measure dips to 105% of the ultimate goal. For each of the next 4 years, the plan's quality measure remains at 105% of the ultimate target.</p> <p>Would the plan still be eligible for the full additional P4P revenue in each year (since they exceeded the 100% quality target), or do they need to show improvement every year in order to obtain the full additional P4P revenue?</p>	Harmony	Yes, if a plan exceeds a P4P goal as set for that year, they earn incentive pool payment for that goal.
224	7.4.1	56	<p>Please provide an example explaining how the revenue for the calculation will be determined. This seems to indicate that the revenue will include the withhold (1%-2%) as if the plan received that for revenue, even if the plan does not earn the entire withhold back.</p>	Harmony	The withheld portion of the capitation is considered revenue whether the plan earns it back or not.

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225	7.4.2.1	56	How will the Department determine the cost of claims when currently 837 encounter claims submitted to the Department are not accepted with the pricing loop on the submission?	Harmony	This is not relevant to the bid. The Department will provide Awardees with the appropriate information.
226	7.2	56	What experience period will be used for establishing the rates and the risk scores per person?	Harmony	The Department will provide an opportunity for Potential Bidders to ask questions pertaining to the rates once rate information is released.
227	7.1	56	To appropriately evaluate the rates versus costs, Contractors need total transparency in the rate development for initial rates and for what the renewal rate process is going to look like. Please assure the Contractors that assumptions and details of the rate development will be provided.	Harmony	See response to question #213.
228	7.1	56	What profit margin will be included in the rates?	Harmony	The Department will provide an opportunity for Potential Bidders to ask questions pertaining to the rates once rate information is released.
229	7.1	56	What percent will be added to rates to account for contribution to surplus?	Harmony	The Department will provide an opportunity for Potential Bidders to ask questions pertaining to the rates once rate information is released.
230	7.2	56	Will the risk adjustment model be run within cohorts of the population (i.e., risk adjustment for nursing facility will average to 1.0, and separately, risk scores for HCBS members average 1.0, etc.)?	Harmony	Yes, the risk adjustment process will normalize to a 1.000 factor for each of the individual cohort populations.
231	7.4.4	57	If there were to be a disagreement regarding the MLR calculation, is there a process to resolve it?	Harmony	This section gives the Contractor the opportunity to review the calculations and notify the Department of any issues. The Department will make the final determination of the MLR.
232	7.4.5	57	Do the annual rate adjustments and the implementation of Service Packages II & III necessarily have to coincide with a new coverage year, or can the take place during the middle of a coverage year?	Harmony	They could take place at any time.

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233	7.4	57	Guaranteed medical loss ratio: just to confirm, this is a one-sided calculation such that if the loss ratio is low, the State is reimbursed the difference between actual and target, but if the loss ratio is high, there is no compensation made back to the Contractor?	Harmony	Yes.
234	Model Contract 1.3-1.5	1	In the model contract there is no provision for voluntary termination by the Contractor, please explain if this was the intention and if so what is the reasoning.	Harmony	This was not the intent. The Department will negotiate terms for voluntary termination by the Contractor.
235	Model Contract 2.1.1.1	2	Is the effective date of Coverage, the date with the Contractor or the effective date assigned to the PCP?	Harmony	The effective date of coverage is the date the Enrollee is assigned to the Contractor. The Department assumes that in almost every instance this will also be the date they will be assigned to the PCP.
236	Model Contract 2.1.1.3.2	3	For clarification, this indicates that the ICEB will determine the auto-assigned members' provider (PCP). Is that correct? And, will there be scenarios where the Contractors will need to auto-determine a provider assignment for a member?	Harmony	The ICEB will determine the initial PCP assignment and the MCO can modify.
237	Model Contract 2.1.1.3.4	3	Upon receipt of the 820. If the 820 and 834 files show a discrepancy, with the Medicaid population we use the state web portal to determine member eligibility with the plan. 1. Should we continue this practice, 2. Should we communicate these discrepancies to the state, if yes, is there a format?	Harmony	Yes, continue to use MEDI to verify member eligibility when there is a discrepancy. Yes, notify the Department's MCO Operations contact person.
238	Model Contract 2.1.1.4.1	3	After the initial change period, is the Enrollee locked into the HMO for the year?	Harmony	Yes

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239	Model Contract 2.1.1.8	4	If the Contractor finds that the Enrollee meets one or more criteria for termination as outlined in section 2.1.1.8, what is the mechanism for notifying the state? Is there a state preferred template?	Harmony	The Contractor will be required to submit a request in writing. The Department will notify the Contractor of the requirements of the request for termination prior to implementation of the Contract.
240	Model Contract 2.1.1.8.1.4	4	From a Coordination of Benefits perspective, section states: Termination of coverage when the Department determines that an Enrollee has other significant insurance coverage or is placed in spend-down status. How does the Department determine this and what is considered significant insurance coverage?	Harmony	The process the Department uses to determine whether an Enrollee has other significant insurance coverage is irrelevant to the Contactor. The Contractor will be notified of disenrollments.
241	Model Contract 2.1.1.8.1.4	4	Are we to assume that #20 (2.1.1.5) applies? Is termination effective per #29 (2.1.1.8.3)? May need tracking of those placed in spend-down to plan for resumption of care when reinstated. Bidder's Clarification: This refers to the eligibility termination clause for spend-down. Does the termination take effect per 2.1.1.8.3 (the last day of the month following the month that the disenrollment is processed)? Also, would 2.1.1.5 apply for spend-down terms (if eligibility reinstated within 2 calendar months the Enrollee will be placed back with the same HMO)?	Harmony	No.

	Section Number	Page Number	Question	Submitted By:	Response
242	Model Contract 2.1.1.8.1.5	4	Are we to assume that #20 (2.1.1.5) applies? Is termination effective per #29 (2.1.1.8.3)? May need tracking of those incarcerated to plan for resumption of care when reinstated. Bidder's Clarification: This refers to the eligibility termination clause for incarceration. Does the termination take effect per 2.1.1.8.3 (the last day of the month following the month that the disenrollment is processed)? Also, would 2.1.1.5 apply for incarceration terms (if eligibility reinstated within 2 calendar months the Enrollee will be placed back with the same HMO)?	Harmony	Yes.
243	Model Contract 2.1.1.8.2	4	Should clarify if this is contingent on receiving notice of term prior to the end of the payment month; otherwise state shall pay for services provided subsequent to the termination month.	Harmony	The open enrollment period ends one month before the end of the coverage year, therefore, the Contractor will receive notice prior to disenrollment prior to the end of the year.
244	Model Contract 2.1.1.8.3	4	This will apply to terms for other insurance and spend-down status (#26 - 2.1.1.8.1.4), which is too long after eligibility change. This should be retroactive to date of eligibility change.	Harmony	No.
245	Model Contract 2.1.2.1	5	Please clarify the 3rd sentence in Section 2.1.2.1 of the Model Contract (page 5) regarding key oral contacts ("Where the Participant's language is other than English or Spanish, Contractor shall offer and, if accepted by the Participant, shall supply interpretive services.") Does this mean that the HMO must have bi-lingual staff available and cannot use a language line for Spanish?	Harmony	Yes.

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246	Model Contract 2.1.2.2	5	Are there languages other than English and Spanish that the Departments currently anticipate or expects Contractors to make print materials available in?	Harmony	See section 2.1.2.4 of the Model Contract.
247	Model Contract 2.1.2.2	5	ID Cards are typically not printed in languages other than English - is it anticipated that ID Cards will also need to be made available in other languages?	Harmony	No.
248	Model Contract 2.1.2.2	5	Written materials in any language, can be requested at any time by the State, without any additional cost to the State. How much lead time will the Plan have to produce such translations ? Will there be translation certification required ? Can the list of languages be defined in a limited list ?	Harmony	The Department will give the Contractors adequate time to produce the translations. Yes, a translation certificate is required. No.
249	Model Contract 2.1.2.2	5	The requirement for written materials to Potential Enrollees, Prospective Enrollees, and Enrollees is, “The materials must be presented in a layout and manner that enhances Enrollees’ understanding of the material.” How will this be objectively measured?	Harmony	The Department will determine how it will be objectively measured.
250	Model Contract 2.1.1.10	5	Will require revised P&P. Medicaid Contract mandates card sent within 10 business days of 834 audit file.	Harmony	This statement does not pertain to this RFP.
251	Model Contract 2.1.2	5	Same as current Medicaid Contract, except that not all communications require prior approval. Should get clarification as applicability to all communications (e.g., care coordinator contacts, member service calls, face-to-face provider encounters, etc.). Will need P&P revision.	Harmony	This statement does not pertain to this RFP.

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252	Model Contract 2.1.3.1.7	6	Is the "cost share" mentioned in this section a copay/coinsurance or is it relating to a Medicaid eligibility fee (similar to spend down)?	Harmony	Co-pays/coinsurance.
253	Model Contract 2.1.3.1	6	Unlike Medicaid Contract, requires hard copies of provider directory and Certificate of Coverage to be sent to all enrollees. This should be negotiated out as we did with Medicaid to provide only on request and have availability on web site.	Harmony	This statement does not pertain to this RFP.
254	Model Contract 2.1.5	7	Medicaid Contract does not require mailing within a timeframe, but is sent with welcome packet. Conflicts with 3 BD requirements for confirmation packet.	Harmony	The requirement for the confirmation packet will be changed to 5 days during the contract development with the Awardees.
255	Model Contract 2.1.5.12	8	If the Contractor is not administering the prescription benefits, is it still required to list the preferred drug list in the handbook?	Harmony	No, but the handbook must provide an explanation of how to obtain prescription drugs.
256	Model Contract 2.1.6.1	8	Identical to Medicaid Contract, except it does not provide for selective distribution approved by the state for eligibility category or service area.	Harmony	Yes, you have correctly identified a difference between the Model Contract and the current Medicaid contract.
257	Model Contract 2.1.11.1.11	9	Please describe how all non-emergent transportation costs were appropriately collected for the experience period data used for the rates? With other states we have seen many atypical payments that need to be included such as air travel. What types of atypical services are covered under the plan?	Harmony	Air ambulance, medivac helicopters and other atypical transportation are included in Department claims data. The Department covers whatever medically necessary transportation needs to be provided.
258	Model Contract 2.1.11.1.11	9	Have there been any large shifts in transportation utilization/unit costs from the experience period to the current period?	Harmony	No.

	Section Number	Page Number	Question	Submitted By:	Response
259	Model Contract 2.1.11.1.11	9	What limitations are there on transportation services? For example, is transportation to the pharmacy to fill a prescription covered? Are members on bus routes required to use public transportation? Are trips limited per month or plan year? Is there a Medicaid fee schedule for taxi or other transportation services?	Harmony	See Transportation Handbook: http://www.hfs.illinois.gov/handbooks/chapter200.html Members are required to use the most economical mode of transportation available to meet their medical needs. There are no limits on the number of trips to covered medical care See the attached for non-emergency and emergency geographic fee schedules
261	Model Contract 2.1.11.1.11	9	What are the current types of covered transportation vehicles (e.g. taxi, bus, other)?	Harmony	All medically necessary modes are covered including, but not limited to taxi, medicar, service car, private auto, helicopter, fixed wing, mass transit, & ambulance.
262	Model Contract 2.1.12	10	Why is a discussion of Local Education Agency (LEA) services included if children will be excluded from the population served?	Harmony	There are 19 and 20 years old disabled individuals who receive services through LEAs.
263	Model Contract 2.1.12.1	10	Are physician administered pharmaceuticals covered services by the Contractor?	Harmony	Yes.
264	Model Contract 2.1.12.1	10	Are hospital administered pharmaceuticals covered services by the Contractor?	Harmony	Yes.

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265	Model Contract 2.1.17.1 and 7.1 (p. 56 / RFP)	11	If a member is in the hospital on the date the contractor takes over the program, who will be responsible for the hospital stay? If the contractor is responsible, is it only responsible for the days in the hospital since the effective date of the plan? How will costs for this be included in the rates? How will the Contractor be made aware of interim bill payments by the state to ensure that providers are no paid twice for services?	Harmony	The Department's current policy is for the HMO to be responsible for hospitalizations that cross over the enrollment date in the HMO and for the Department to be responsible for hospitalizations that cross over the disenrollment date from the HMO. This policy is negotiable.
266	Model Contract 2.1.17.1	11	Will the person be retroactively enrolled versus just Contractors paying claims retroactively? How will this appear in the data that the actuary uses to develop rates? We can see a potential for inconsistency in the rate development if the member months are not aligned appropriately between rate development and actual administration of the program.	Harmony	The person will not be retroactively enrolled. The costs will be appropriately included in rate development.
267	Model Contract 2.1.18	11	"Unavailable" will need clarification. Vacation? Leave of Absence? Sabbatical? Illness? Panel closure?	Harmony	Unavailable means the PCP is no longer able to function in that capacity and it is not a temporary coverage situation.
268	Model Contract 2.1.19	12	Page 12 of the Model Contract states that contractor must respond to PCP's request for standard authorization request within 2 business days (1 business day for urgent request) - this is not consistent with 42 CFR 438.404 which allows 14 days for standard requests.	Harmony	The standard in the Model Contract is not inconsistent with federal regulations. It is simply more stringent than the minimal federal standard. Bidders may take exception and propose a more relaxed standard that complies with federal regulations.

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269	Model Contract 2.1.23.2	12	Regarding Performance Improvement Projects (PIPs) will the state specify a certain number of PIPs or the topic areas?	Harmony	The number and topic areas for PIPS will be mutually agreed upon based on Contractor performance, outcomes measures and weaknesses identified.
270	Model Contract 2.1.23.5	13	Is HEDIS reporting a requirement in any year of the contract?	Harmony	The RFP did not require specific HEDIS reporting, however, the Department and the Contractor may contractually agree to some HEDIS reporting. The quality measures required to be reported will be based on HEDIS or HEDIS-like definitions.
271	Model Contract 2.1.23.8.1.7	14	This is a new requirement; will it follow our current AOR/POA Authorization of Representation or Power of Attorney process? Will the member be required to complete our standard form for AOR?	Harmony	This is information that would be included in the Contractors grievance procedures which are required to be submitted for Department approval pursuant to Section 2.1.23.8.1 of the RFP.
272	Model Contract 2.1.24.1.2	15	Please clarify that for this population, the Contractor does not pay the DSH payment nor the Medicaid percentage adjustments.	Harmony	Current federal law requires all DSH payments made by the state to originate from the State, therefore all DSH payments will remain the responsibility of the State. Since MPA is not considered DSH the Bidders should expect to assume this liability.
273	Model Contract 2.1.26	15	Please note that the federal regulations regarding physician incentive payments have been amended (e.g., a survey is no longer required), and the contract reference is incorrect (should be 2.1.23.4 though no longer applicable).	Harmony	The contractual cross-reference was corrected per Addendum #3. Section 2.1.23.4 requires a survey. The language in 2.1.26 simply permits the Contractor to combine surveys should revised federal regulations require one.
274	Model Contract 2.1.24	15	Does this mean IL. Providers for this population will be able to file a grievance for payment disputes?	Harmony	It means that Contractors must have a provider grievance resolution process.

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275	Model Contract 2.1.28	17	When will the contract be awarded ? What is the submission schedule for the hardcopy deliverables that are required prior to Readiness Review ? If the Readiness Review is to be “conducted” approximately 60 days after contract effective date, when will the plan know what will take place ON SITE, and what will be done via document review ?	Harmony	The target date for award is June 1, 2010. The Department will discuss timelines with awardees based on the proposals.
276	Model Contract 2.1.30.2.1	18	Please elaborate on the requirements for timely encounter data submission (e.g., 80% with X months, 90% within Y months, etc.)?	Harmony	Requirements are as stated in Section 2.1.30.2.1.
277	Model Contract 2.1.30.2.1.	18	The format for pharmacy submissions states NCPDP 1.1 was this meant to be NCPDP 5.1?	Harmony	NCPDP 1.1 is the standard for batch submissions and the Department expects pharmacy encounter data to be submitted in batches.
278	Model Contract 2.1.30.2.1.	18	Is there a completeness requirement for submitting all services?	Harmony	The Contractor must report all services.
279	Model Contract 2.1.30.2.1.	18	Are there any specific SLAs and completeness criteria for submitting encounter data	Harmony	Requirements are as stated in Section 2.1.30.2. The Department will provide a companion guide and work with Awardees on more technical specifications.
280	Model Contract 2.1.30.2.2.1	18	Is this the equivalent of the HIPAA standard SNIP edits? If so, up to what level of the SNIP edits is the State planning to apply as part of the first level of review?	Harmony	Requirements are as stated in Section 2.1.30.2. The Department will provide a companion guide and work with Awardees on more technical specifications. HIPAA standard SNIP edits 1-4 are the first level of review and level two edits are the standard claims processing edits.
281	Model Contract 2.1.30.2.4	18	Are there specific SLAs around resubmitting corrected encounters?	Harmony	Requirements are as stated in Section 2.1.30.2. The Department will provide a companion guide and work with Awardees on more technical specifications.

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282	Model Contract 2.1.30.2.4	18	In what format will the rejections from the first and second level of review be communicated to the health plans?	Harmony	The rejections from the first level of review will be sent using the ASC X12 997 and the ASC X12 824 Application Reporting transaction set. The second level of review will send the rejections on an electronic Remittance Advice.
283	Model Contract 2.1.30.2.4	18	Will the State be measuring completeness based on volume of encounters or dollars paid to the providers?	Harmony	The Department believes the Contractors will be incentivized to submit all encounter data as required since it will be used to calculate the MLR, for future rate setting, and for pay for performance incentives.
284	Model Contract 2.1.30.2.4	18	Are there specific utilization metrics around certain services e.g. inpatient services, ER etc.? Bidder's Clarification: Are there specific utilization metrics (i.e. units, claims, etc.) by service type to help understand what volume of claims/encounters the state has received that represent the historical utilization?	Harmony	No.
285	Model Contract 2.1.30.2.4	18	State of IL has specific expectations around timelines for submitting KICK related claims, is this described in another document?	Harmony	The maternity payments are included in the rate; therefore, these claims must be submitted as regular Encounter data.
286	Model Contract 2.1.31.4	21	This requirement may be a candidate for push-back. Need to clarify "xx" business days.	Harmony	The 'xx' business days means that the actual number of business days will be mutually agreed upon between the Contractor and the OIG.
287	Model Contract 2.1.32.	22	Should receive clarification and reasonable limits on access to equipment.	Harmony	Reasonable limits on access to equipment will be "during business hours".

	Section Number	Page Number	Question	Submitted By:	Response
288	Model Contract 2.1.30.2.1		How is experience related to capitated contracts to be supplied? Encounters with utilization only, encounters with payment estimate such that all payment estimates add up to the true capitation amount.	Harmony	See Section 7.4.2.1 of the RFP.
289	Attachment D	1 & 2	Will the Utilization Data be split out between all the population types? Will Service Package II & III individuals be identified for both Service Package I and Service Package II&III services? What will be the data splits that we receive from the state's actuary?	Harmony	See the data summary from the Department's actuary released at the Bidder Conference and posted on the Illinois Procurement Bulletin as Addendum #4.
290	Attachment D	1 & 2	Please provide the current Medicaid fee schedules?	Harmony	Current Medicaid fee schedules can be found at: http://www.hfs.illinois.gov/reimbursement/
291	Attachment D	1 & 2	Please provide the historical Medicaid fee schedules in effect during the period used for the base data in the rate development?	Harmony	HFS has been subject to a rate freeze since 2002. The current fee schedule applies unless new codes have been added.

	Section Number	Page Number	Question	Submitted By:	Response
292	Attachment C	13	Personal Assistant – A) What are the details of how the contractual arrangement between the consumer and the Personal Assistant. B) What is the Plan’s role in assisting with this private employment arrangement? C) Will background checks be required for Personal Assistants? If so, to what extent? D) Are there different skill levels of Personal Assistants? E) Can family members be hired to be Personal Assistants?	Harmony	<p>The following refers to Personal Assistants in the waivers operated by the Department of Human Services, Division of Rehabilitation Services: Persons with a physical disabilities, HIV/AIDS, or Brain Injury.</p> <p>A. There is a contract [Form IL488-1947], signed and dated by both the consumer and provider. B. The Bidder must to provide whatever assistance is needed to the consumer to complete the private employment arrangement. C. All consumers are to be informed of and given the option to complete background checks on personal assistants, at no cost to the consumer, the Bidder would assume the cost of the background check. D. There are no defined skill levels. E. Legally responsible family members cannot be paid as a care provider.</p> <p>More information on Personal Assistants services can be found in Appendix C: Participant Services and Appendix E: Participant Direction of Services in the waivers listed above at the following site: http://www.hfs.illinois.gov/hcbswaivers/ Click on the Federal Approved Waiver.pdf</p>

	Section Number	Page Number	Question	Submitted By:	Response
293	Attachment C and 7.1 (p. 56)	22	Are there waitlists for HCBS services (i.e., members in queue to receive services once the waiver program receives additional funding)? If so, how many members are on the waitlists? Will those members be eligible for HCBS services upon implementation of this program? How will this be reflected in the rate development?	Harmony	<p>A. Yes, only for the HCBS waivers for developmental disabilities.</p> <p>B. The number of people on the wait list is not applicable because the HMO is only responsible for Enrollees in the waiver.</p> <p>C. No, unless meet priorities for the waiver.</p> <p>D. Service Package III rates will reflect the costs for waiver services paid for every Enrollee eligible for the waiver services.</p>
294	Attachment C and 7.1 (p. 56)	22	<p>A) Are the services described in Attachment C expected to be covered only for the populations indicated with an X after administration of Service Package II is delegated to the Contractor?</p> <p>B) If so, how will the Contractors be able to identify the separate populations?</p> <p>C) Will the state continue to assign members to a specific population and notify the Contractor of which waiver the enrollee is eligible for (e.g., the state continues to maintain an eligibility list of the DHS-DRS Persons with Brain Injury population and sends this info on the 834)?</p> <p>D) If not, will anybody enrolled in the program now be eligible for the services?</p> <p>E) How will that be included in the rate development?</p>	Harmony	<p>A. Yes, Attachment C was provided to show the Bidders all the HCBS waiver services on one chart with definitions, standards and service limits by waiver. The Contractor could choose to provide these services to others.</p> <p>B. Each waiver is identified by a distinct indicator on the eligibility segment. These codes will be shared with the Contractor.</p> <p>C. Yes.</p> <p>D. The MCO will be notified of enrollees.</p> <p>E. The rate will include consideration for these services.</p>
295	Attachment C	22	What documentation will be required to support the requirement to provide training to individuals who provide unpaid support ? Will these individuals be required to proved understanding of the training via a test, or just be able to acknowledge in writing of the training that was received?	Harmony	The Bidder should define how training will be provided to unpaid support and the department will review in the proposal.

	Section Number	Page Number	Question	Submitted By:	Response
296	Attachment C		Will the Waiver services (HCBS services) change with the implementation of the new program? That is, will there be different rules around what services are covered for whom?	Harmony	No, however, waivers can be amended at any time, but any changes would be shared with the Contractor before adoption. No
297	N/A		What are the expected member and provider call center hours and service levels?	Harmony	Please indicate your plans in your proposal.
298	Section 2		While Contractors are delivering Service Package I services only, how will the case managers for the other services (services to later be delivered in Service Package II and III) coordinate with the Contractors?	Harmony	The proposals should include strategies on communication and information sharing. Case managers will be informed of consumers in the Integrated Care model.
299	Page 1, 1st Paragraph and at bottom of page. Also, Section 5, page 52.		Even though it is pointed out that the procurement is a “purchase of care” and therefore exempt from the procurement Code, it is further pointed out that they have chosen to solicit contractors by means of the RFP process in the code, and that the procurement “need not strictly comply with the code...”. That being said, the need to comply with new requirements for state contractors to register with the State Board of Elections is highlighted in large bold font at the bottom of page 1. Also, in Section 5 (Responsibility Forms), page 52, there is a form for indicating whether the bidder is registered or not. Even though the same form was filed for the Medicaid and ILCRx contracts checked as not needing to be registered, we should request confirmation that AABD bidders will also not be required to register or comply with the statute.	Harmony	If the Bidder has no other state contract or pending bids to which P.A> 95-971 applies, the Bidder will not be required to register with the State Board of Elections. However, the Bidder must complete the required state form by marking the appropriate box.

	Section Number	Page Number	Question	Submitted By:	Response
300			Are there limits on the number of members receiving chore services in place currently and will it be removed after commencement?	Harmony	Service limits are outlined in Appendix C: Participant Services of each waiver. Chore services are not a specifically defined service in any of the waivers. There are no plans to change other services such as personal assistants or Homemaker services that are currently approved waiver services. For more information on services see: http://www.hfs.illinois.gov/hcbswaivers/Click on the Federal Approved Waiver.pdf
301			Please describe the current reimbursement process of atypical providers where a traditional health care claim is not produced (i.e., home modification Contractors, private nursing flights to tertiary hospitals, crisis services, etc.). Are these services paid by invoice?	Harmony	These services are described in Appendix C: Participant Services of each waiver. See: http://www.hfs.illinois.gov/hcbswaivers/Click on the Federal Approved Waiver.pdf One example under the MFTD waiver is a requirement for three bids to be obtained for services over \$2,000 with the requirement for a medical justification. Once approved and the service is provided, the DSCC care coordinator verifies the service, obtains the bill and the department pays by invoice.
302			To encourage providers to sign agreements with the Contractors, will the state allow the Contractors to pay non-participating providers at a level below 100% of the Medicaid fee schedule, similar to what other states do when implementing mandatory managed care?	Harmony	Contractors must pay at least the Department's rates to non-participating providers for emergency services. It is expected that all other services will be provided by network providers except in rare cases when the Contractor must arrange for services outside its network. In such cases it is assumed that reimbursement is agreed to as part of the arrangement.

	Section Number	Page Number	Question	Submitted By:	Response
303			Does the state intend to submit a Section 1115 demonstration waiver in order to implement Service Packages II and III? If so, what else will the state seek to accomplish through the waiver (e.g. inclusion of duals or children with special needs)? Has the state submitted any documents in relation to an 1115 demonstration waiver to CMS?	Harmony	No.
304			Once the HMOs are responsible for HCB Services, will the concept of slots continue? Will HMOs have the discretion to provide HCB Services to members who do not meet level-of-care but whom they determine to be at-risk for institutionalization?	Harmony	Yes Yes
305			For those HCBS services that are participant directed, who (e.g., state vendor or HMO) will handle the financial management services?	Harmony	The HMO.
306			If the HMO contracts with case management agencies, will payments to these agencies for case management be considered a medical expense for purposes of the MLR? What about case management provided by HMO staff?	Harmony	No.
307			Please provide enrollment information by zip code so that we can geomap our network.	Harmony	See response to question #87.
308			Please provide the current needs assessment tools used by the state.	Harmony	These can be viewed in the file with the corresponding question number at: http://hfs.illinois.gov/icp/ . 1) Aging Needs Assessment 2) DD Needs Assessment 3) DRS Needs Assessment
309			Does the state draw a distinction between care coordination and case management?	Harmony	These terms are used interchangeably.

	Section Number	Page Number	Question	Submitted By:	Response
310			Please describe how care coordination and/or case management are applied differently for different populations.	Harmony	Care coordination/case management is described in several sections of the waivers. Please see Appendix D: Participant-Centered Planning and Service Delivery as well as Appendix E: Participant Direction of Services, Appendix G: Participant Safeguards and Appendix H: Quality Management Strategy. The waivers can be accessed at: http://www.hfs.illinois.gov/hcbswaivers/Click on the Federal Approved Waiver.pdf
311			Are there requirements for elements included in the care plan?	Harmony	Yes. See Appendix D: Participant-Centered Planning of each waiver. Waivers can be accessed at: http://www.hfs.illinois.gov/hcbswaivers/Click on the Federal Approved Waiver.pdf
312			When and how will rates for Service Packages II and III be developed?	Harmony	The rates will be developed in an actuarially sound manner. The rates for Service Packages II and III will be developed well before implementation of each Service Package.
313			How will post-eligibility treatment of income be handled? Will HMOs be able to delegate this function to facilities? How many HCBS waiver participants have post-eligibility treatment of income? What is the average monthly amount for these individuals?	Harmony	Family Community Resource Centers (FCRCs) will continue to handle post-eligibility treatment of income with respect to determination of an individual's contribution toward the cost of care. Currently, residents pay this amount directly to facilities. How Contractor's arrange for the collection of this amount can be negotiated with facilities. The cost of nursing facility care shown in the material presented by the actuary is the Department's cost net of patient contribution. Therefore, the average amount is not relevant at this time.

	Section Number	Page Number	Question	Submitted By:	Response
			Does the state anticipate amending the contract when Service Packages II and III are included to incorporate additional requirements?	Harmony	The initial contract will be written to cover inclusion of Services Packages II and III. If needed, the contract will be amended to address any additional terms needed for implementation of those Service Packages.
315			Is there a minimum number of case management hours required for certain types of members each month/year?	Harmony	For members in the home based supports programs under the Adults with Developmental Disabilities (DD) waiver and the Support Waiver for Children and Young Adults with DD, the support plans and service agreements must set aside at least two hours per month to allow for Service Facilitation activities. Refer to Service Facilitation in Appendix C: Participant Services, Waiver Service Specifications section of the waivers.
316			Once LTC costs are included in the program, will there be a limit to the time a member is in the Contractor's plan before the member moves back to FFS Medicaid, or is the plan to have all permanent LTC members under the risk contract?	Harmony	There is no time limit on MCO enrollment for enrollees receiving long term care services.
317			Will retroactive enrollment be allowed?	Harmony	No.
318			Will plans be at risk for the presumptive eligibility period?	Harmony	No.
319			If prescription drugs are included in the rates (not carved out), will prescription drug experience be required to be submitted by the health plans?	Harmony	Complete encounter data, including for prescription drugs will be required.

	Section Number	Page Number	Question	Submitted By:	Response
320			Can we get a listing of the significant traditional providers that currently serve the proposed Integrated Care Plan beneficiaries including the number of units delivered by each (or a paid \$ amount)? The purpose of this request is to ensure that we build a provider network that as closes replicates the state network as possible.	Harmony	The list of currently enrolled providers with HFS, and for DMH and DASA was published with the notice of this procurement on the IPB, #22018085.
321			Is the facility address (if institutionalized) the permanent address to pull members?	Harmony	Yes
322			It does not seem as if the actuary is aware of how the data was pulled to how the plan will be administered, how can he state rates correctly without this knowledge?	Harmony	All data has been pulled in consultation with the actuary.
323			Will you use state specific factors in cdps and med rx?	Harmony	To be determined.
324			What will the original rate period be for service package one? One year or longer than one year?	Harmony	It will be for Service Package I for one year.
325			How did you identify spend down members in the data?	Harmony	They will be excluded from data.
326			Are short-term long term care stays included in service package one?	Harmony	Yes
327			Is the 5% bonus part of the manage care savings? That is, if cap rates are expected to be lower than fee for service costs are cap rates defined to include the 5% quality bonus?	Harmony	No.
328			For the members whose services are retro-paid before the eligibility dates, are these services included in the data based on incurred (hospital admission date) or during another period?	Harmony	The data was pulled in a manner to account for these costs.

	Section Number	Page Number	Question	Submitted By:	Response
329			The actuary mentioned that he will make an adjustment for third party liability coverage since third party liability members are excluded, what reductions will be made?	Harmony	The Department will provide an opportunity for Potential Bidders to ask questions pertaining to the rates once rate information is released.
330			What is the average monthly skilled nursing facility cost for members in the facility for an entire month?	Harmony	The mean total rate (1/1/2010 rates) for the nursing facilities in the ICP area, weighted by FY08 paid claim days is \$125.31. Since third party liability is normally 15% to 20%, the average daily cost is \$100.25 to \$106.50 and the average monthly cost is \$3,047 to \$3,238.
331			Service package two trend for nursing facility members appears understated. Why is this trend so low?	Harmony	These are the costs for the last three years.
332			Average nursing facility Medicaid monthly rates are over \$3,800 dollars. Why is the pmpm in the data for nursing facility members much less than that number?	Harmony	The costs only include the Department's liability, not the resident's responsibility.
333			When will service package two and three rates be released?	Harmony	To be determined.
334			Mental health members in the community are underserved today given info at the bidders conference. How will this pent up demand be adjusted for in the rate development? Jim Parker acknowledged at the bidders conference that he expects there to be pent up demand that will be in the first year costs.	Harmony	The Department believes that some services are over-utilized and others are under-utilized, due to deficiencies in current care management practices. Successful integration of care will allow reallocation of financial resources to address any such pent up need.

	Section Number	Page Number	Question	Submitted By:	Response
335			Is it the expectation of the state that the Contractor reimburse FQHC's using the full encounter rate that the state pays these providers for services rendered, or to pay them similar to how the Contractor pays other providers for the same services with the state providing a wrap payment? If the Contractor is to pay the full encounter rate, how is this being factored into the base rates?	Harmony	The relationship between Contractors and FQHCs is contractual. The state has not dictated any terms.
336			Please explain further the pricing of the tow hospitals in the data. Bidder's Clarification: Please explain further the current state payment methodology of the two hospitals mentioned at the Bidder's Conference that the actuary repriced before including in the data summaries.	Harmony	The methodology for paying Cook County and U of I hospital was recently changed and claims we repriced to the new methodology.
337			During the bidders conference it was noted that there are 1,400 members on a waitlist for mental health and substance abuse services. Please define how those members will be served in the program when the contractor takes over.	Harmony	The statement was made by a provider. The Department has no knowledge of the Medicaid eligibility of those individuals and no knowledge of the accuracy of the statement.
338	General	N/A	Has the State Plan been amended and approved by CMS to allow for Managed Care as described in the RFP?	Aetna	No. However, the Department has been in regular communication with federal CMS in the development of this program and RFP and expects that there will be no difficulties in having a State Plan Amendment approved prior to implementation.

	Section Number	Page Number	Question	Submitted By:	Response
339	General	N/A	Would the Contractor be permitted to use the State's FFS schedule to reimburse non-participating providers?	Aetna	Contractors must pay at least the Department's rates to non-participating providers for emergency services. It is expected that all other services will be provided by network providers except in rare cases when the Contractor must arrange for services outside its network. In such cases it is assumed that reimbursement is agreed to as part of the arrangement.
340	General	N/A	Will the State provide a list of current Medicaid/FFS providers?	Aetna	The list of currently enrolled providers with HFS, and for DMH and DASA , was published with the notice of this procurement on the IPB, #22018085.
341	2.1.11.1.26	Model Contract, page 10	Please provide definitions for the Medicaid Clinic Option and the Medicaid Rehabilitation Option? Please provide information as to what is included in these Options.	Aetna	Please see links under 3.1.3.4.2 of the RFP that include links with descriptions of Mental Health Services.
342	1.17.170	page 12	How are providers identified as Women's Health Care Provider (WHCP) by HFS? Is this a certification from the State or determined by their training in obstetrics, gynecology or family practice?	Aetna	There is no certification process. It is determined by their training.
343	3.1.2.1.2 (Information in Table)	Page 19	At this point in time, the table shows only one Enrollee in a supportive living facility. Is this a preferred method of housing of the enrollees in the waiver programs, secondarily to their own home?	Aetna	The preferred method of housing is the least restrictive setting chosen by the enrollee. At this time, SLFs are not available to individuals with Developmental Disabilities of Mental Illness.
345	3.2.2.2	pg. 28	Are there currently hospitalist/SNFist providers in place, serving the Integrated Care Program population. If so, would you please identify them in the form of a list?	Aetna	The Department does not carry these designations in its Provider database.
346	3.3.1.8	33	The RFP specifies the identification of a Member Services Director and Member Services staff but does not include member service requirements, duties or responsibilities. Please clarify the Member service performance requirements.	Aetna	The Department will not identify specific duties or responsibilities of the individuals in administrative capacity other than what is provided in the RFP.

	Section Number	Page Number	Question	Submitted By:	Response
347	3.4.2.3	page 33	Does the State have an electronic application process for providers to use, so they may obtain a State Medicaid identification number to enable providers to provide services to enrollees? If so, can you please provide the link?	Aetna	Information on provider enrollment can be found at: http://www.hfs.illinois.gov/enrollment/
348	2.1.6	Model contract page 8 (pdf page 66)	Do press releases, targeted at the general public and not members specifically, have to be approved by the state?	Aetna	If a press release targeted at the public are in regards to health education, it does not have to be approved by the Department; however, if the press release is in regards to information about your plan, it must be approved by the Department.
349	2.1.6.2	Model contract page 8	Is the contractor allowed to participate in and distribute materials at health fairs and similar events, and if so, are our representatives allowed to answer questions about our services?	Aetna	Yes. However, they may not be involved in assisting members in the enrollment process.
350	2.1.2.2.	Model contract page 5	This is a subjective statement; can the state provide more specificity as to what it wants to see in the materials to accomplish this objective? Does the state have samples of materials that have met this objective in the past?	Aetna	The Department uses the Fry Graph to determine 6 th grade reading level. There are other tools available to check reading level. See Code of Federal Regulation for Information requirements: http://frwebgate.access.gpo.gov/cgi-bin/get-cfr.cgi
351	2.1.5	Model contract page 7	This is a subjective statement; can the state provide more specificity as to what it wants to see in the materials to accomplish this objective? Does the state have samples of materials that have met this objective in the past?	Aetna	See Code of Federal Regulations for Information requirements: http://frwebgate.access.gpo.gov/cgi-bin/get-cfr.cgi
352	2.1.30.8.2	Model contract page 19	For submission, is text only enough, or is a design layout required?	Aetna	During the term of the contract, the Contractor is required to submit both text and layout for Department approval.

	Section Number	Page Number	Question	Submitted By:	Response
353	Attachment G	122-147	Where measures approximate, but are not exactly equivalent to, HEDIS measures, are you open to using the HEDIS definitions? If not, will you consider including minimum eligibility criteria for each of the measures? For example, it would be unfair to compare a member who was eligible for one month of the year with a member eligible all 12 months.	Aetna	The Department is open to using HEDIS definitions or negotiating alternative definitions of continuous enrollment.
354	Attachment G	122-147	Does the State expect the contractor to produce the clinical P4P metrics, or will those be produced by the State?	Aetna	Those metrics that can be measured by encounter data will be calculated by the Department. The Department will work with Contractors to develop the method for measuring other metrics.
355	3.7.1	34	Section 4 page 36 states: Certificate of Authority or proof of application for a Certificate of Authority. Please confirm if the State wants the COA application or proof of submission of the COA application. If the latter, what is considered proof of submission?	Aetna	The Department will accept the Bidders assertion that they have applied for Certificate of Authority and will confirm with the Department of Insurance.
359	First Paragraph of Solicitation Document AND 1.5	1 2	The first paragraph of the Solicitation Document provides that the procurement is exempt from the Procurement Code and Standard Procurement Rules, and need not strictly comply with the Code and Rules. Section 1.15, however, states that the Code and Rules are applicable to this solicitation. Should bidders assume that all provisions of the Code and Rules apply to this Solicitation? If not, please identify which provisions of the Code and Rules will apply.	Aetna	This procurement is a Purchase of Care, which is exempt from the Procurement Code (30 ILCS 500/1-10(b)(3)) and Standard Procurement Rules (44 Ill. Admin. Code 1.10(d)(3)). However, HFS is requesting Proposals under the Competitive Sealed Proposals process, (30 ILCS 500/20-15) and Rules (44 Ill. Admin Code 1.2015). Section 1.2005(q) of the Procurement Rules allows HFS to not comply strictly with the requirements of the competitive process. HFS will award the two contracts in accordance with Section 2, How We Will Evaluate Offers. Provisions of the Code and Rules cited in the solicitation document are applicable, except as described above.

	Section Number	Page Number	Question	Submitted By:	Response
360	4.4 (Model Contract) AND 3.1.3.11.3	Model Contract, Page 25 AND Page 25	<p>If a bidder conditions acceptance of the contract on deleting or otherwise refusing to comply with the provisions set forth in Section 4.4 of the Model Contract or Section 3.1.3.11.3 of the Solicitation Document:</p> <p>a) Will the State decline to award a contract to that bidder?</p> <p>b) If the State does not decline to award a contract, will the State deduct points from the proposal submitted by that bidder, or otherwise take action adverse to that bidder? If so, how many points will be deducted, or what other adverse action will be taken?</p>	Aetna	A Bidder that declines to provide the services in 3.1.3.11.3 will not be offered a contract.
361	2.1.28 (Model Contract)	Model Contract, Page 17	<p>Please advise:</p> <p>a) How is “Contract Effective Date” defined?</p> <p>b) What is the earliest date by which Contractor must have secured fully countersigned provider contracts (as opposed to letters of intent) with providers in its network?</p>	Aetna	The term refers to the date of execution of the contract. However, the reference here should be considered a target. The Bidder must propose an implementation timeline. The contractor must have fully executed network contracts by the readiness review.
362	1.9	Page 3	Is the “opening” referring to the proposal opening which would take place on April 15, 2010 as provided in Section 1.2 of the Solicitation Document? If not, what is the “opening” referring to and on which date will the “opening” take place?	Aetna	Yes.
363	3.1.1.2.1 and 3.1.3.9	Page 17 and Page 24	To avoid confusion it would be helpful if the Department could provide a breakout of the services that the Bidder would be required to cover (be at risk for).	Aetna	Those services listed in 3.1.3.9 are in Service Package II.

	Section Number	Page Number	Question	Submitted By:	Response
364	3.1.3	20	Will the Contractor for this program absorb and manage the Health Connections and DM Programs or will these programs continue as currently run, and the Contractor would build on them?	Aetna	Enrollees in this program will no longer be enrolled in the Illinois Health Connect of Your Health care Plus Disease management program. The Contractor will be responsible for any needed care management or disease management.
365	3.1.3.7	Page 23	Please provide a copy of the Pre-Admission Screening that is used for Nursing Facility and Waiver Participants and information on how long this PAS process takes.	Aetna	Pre-Admission Screening tools can be viewed in the file with the corresponding question number at: http://hfs.illinois.gov/icp/ . <ul style="list-style-type: none"> • PAS Level I • DD PAS • MH PAS
366	3.1.1.1	Page 17	Please describe the current electronic health information exchange(s) technology, funding, plans and systems that exist today.	Aetna	Information regarding the Department's current HIE status can be found at : http://www.hie.illinois.gov/
367	3.1.3.1.1	Page 20	How many Participants, as of January 2010, were enrolled with a medical home in the service area referenced for this RFP?	Aetna	The list of currently enrolled Illinois Health Connect PCPs and the number of the targeted population assigned to each was published as an addendum to the notice of this procurement on the IPB, #22018085.
368	Various	Various	What level of cooperation can the Bidder expect from these contractors or agencies during the transition phase? Are these entities required to cooperate with the Bidder during the transition process?	Aetna	These entities are required to cooperate and Bidders should expect full cooperation, including any available care plans and patient histories.
369	2.1.6.3.2 and 2.1.6.3.3	Model Contract, Pg 8	Please provide clarification as to the incentives the Contractor would be permitted to provide. Specifically, in reference to number (2) of Section 2.1.6.3.3.	Aetna	Gift cards that cannot be converted to cash are acceptable.

	Section Number	Page Number	Question	Submitted By:	Response
370	2.1.12.2.	Model Contract, pg 10	In the event that an Enrollee has a medical condition as well as a mental health condition and is in a State Operated psychiatric hospital, would required medical services be provided within the SOH as well?	Aetna	The services required to treat a medical condition will be the responsibility of the Contractor. Whether the services are provided within, or by the resident staff of, the State facility is a contractual matter between the Contractor and the State facility.
371	2.1.1.3.5	Model Contract, pg 3	Please clarify what the Contractor would be required to submit as it relates to a "Certificate or Document of Coverage".	Aetna	The Department will accept the Bidders assertion that they have applied for Certificate of Authority and will confirm with the Department of Insurance.
372	2.1.1.2.2	Model Contract, pg 2	Is this requirement referencing updates to the Provider file only, or is the State expectation that the Contractor would submit their entire Provider File on a weekly basis?	Aetna	The State is expecting the entire Provider File to be submitted to the CEB at least weekly.
373	2.1.1.2.2	Model Contract, pg 2	Please provide the schedule that the State references in this Section.	Aetna	As this section states, the contractor shall submit this file weekly. The exact day of the week shall be determined during development stages of the operations with the contractors.
374	2.1.5.12	Model Contract, pg 8	In the event that the Contractor does not wish to assume risk for prescription medications, will the State provide their PDL to the Contractor for inclusion with Enrollee materials?	Aetna	Yes.
375	2.1.22	Model Contract, pg 12	Please verify that this Section is referring to an internal audit process to be performed by the Contractor.	Aetna	Yes, it is.
376	3.2.2.5	Pg 28	Is it the State's expectation that individual network laboratories would send lab values electronically via their own EMR, or via a central repository where this information could be exchanged with the Contractor? Is this functionality something that exists in the current program?	Aetna	It is the Department's belief that this functionality exists in the marketplace.
377	3.1.3.1.2	Pg 20	Are the State's expectations that the Contractor supply the same services (at minimum) as in the current DM program?	Aetna	It is for the Bidder to propose its Disease Management program, if any.

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378	2.1.1.3.5 and 2.1.5	Model Contract, Pg 3 and Model Contract, Pg 7	These statements are contradictory, please confirm if we mail out the confirmation packet with the Enrollee Handbook within 3 or 5 days of receipt of the 834 new enrollment file	Aetna	The requirement for the confirmation packet will be changed to 5 days during the contract development with the Awardees.
379	3.5.1	Pg 34	Please provide the definition of "private firm".	Aetna	Any non-governmental payer.
380			Is there any prohibition against a singular minority company being included in more than one response to the Integrated Care Program REP?	JLP Consulting	No.
381			Will providers without HER systems in place be eliminated from consideration or will the Managed Care Organization (MCO) be required to assist in this process?	Grand Prairie Services	There is no requirement that all providers have any particular level of health IT or that MCOs provide any level to providers.
382			It appears that there is no provision that the MCO's utilize current safety net providers within their networks. Given that, will current consumers of DASA and DMH services be offered the choice to remain with their current provider to complete their treatment?	Grand Prairie Services	The Illinois Managed Care Reform and Patient Rights Act on transition of care apply. Bidders are asked in the RFP to describe how they will handle transition of care.
383			Will the selected MCO's give preference to contracting with collaborating/affiliated community behavioral healthcare providers?	Grand Prairie Services	We expect that the MCOs will reach out to and include those current providers that can help them meet the goals of the Integrated Care Program. Inclusion of an individual provider within the network of a given Contractor is the subject of discussions between that provider and the Contractor.

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384	3.1.2	19	Please advise whether there is a wait list of participants relative to each HCBS Waiver mentioned in the RFP. If so, would those wait-listed participants be eligible for the Integrated Care program? How many of the community residents (28,659 listed in 3.1.2 - page # 19 in the RFP) are currently on a waiting list for a HCBS waiver program?	Aetna	<p>Only the waivers for persons with developmental disabilities have a wait list operated through the Prioritization of Urgency of Need for Services (PUNS) data base. More information on the PUNS can be found at: http://www.dhs.state.il.us/page.aspx?item=31193</p> <p>The Department estimates that there are 1,789 currently on the waiting list who would be eligible for the Integrated Care Program.</p>
385	Bidder Conf		Regarding third party liability members. You were going to actually take off for the person's TPL and people were excluded from that population. So when you are saying you are going to adjust for that, what are you adjusting for? One of the excluded member groups is participation with comprehensive third party insurance. So is there a third party adjustment already in the data?	Wellcare/ Harmony	<p>See response to # 145. Since individuals with high level TPL are not included in the Integrated Care Program, their costs were not included in the information for the actuary.</p> <p>However, there are individuals with lower levels of TPL who are included and the actuary will adjust for these individuals.</p>
386	Bidder Conf		You have mentioned that you have taken a look at Cook County. Is that Cook County inpatient and outpatient hospital claims only or does it include FQHCs?	CareSource	See response to Question #336. The FQHC claims have been re-priced as well.
387	Bidder Conf		Will there be an extension in the opportunity to ask additional questions and have the Department answer them?	Harmony Health Plan	Pursuant to Section 1.1 of the RFP, questions received after the deadline will be answered at the department's discretion. The department's goal is to provide as much relevant information as needed.

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388	Bidder Conf		Is it the state's intent to not include marketing in the administrative load factor?	Meridian Health Plan, Inc.	It is the state's intention to ban face-to-face marketing in the contract. Pursuant to Section 2.1.6 of the Model Contract, marketing by mail, mass media advertising and community oriented Marketing directed at Potential Enrollees will be allowed subject to the Department's Prior Approval.
389	Bidder Conf		When you are rolling out Phase 2 and Phase 3 and the rates subcontractors will be looking at for the bonus program, will you consider the rates and adjust for quality to the bonus program for Phase 1, Phase 2 and Phase 3? And is there a different level of service required for the population?	CareSource	The Department will have bonus quality measures for each phase. There are only limited measures in the current RFP and model contract for the LTC population because this is what we want to develop with the stakeholders before these Service Packages are implemented.
390	Bidder Conf		When you look at the population that you are including, while the duals are eligible, at what point are you cutting off their claims data from what you are including in the rates? Because given that it takes them about 90 days to 120 days before they get certified as a dual and that claims information is going to be fee for service, have you factored that in?	CareSource	If they were dual eligible in a month, they were excluded from per member, per month and the claims data for the entire month of exposure.
391	Bidder Conf		Are we doing partial month eligibility for any members? Can they come in during the middle of the month and start then? And if they did, could you get that information so that you can adjust the member month by half?	Harmony	Enrollees will be assigned for the entire month. They will not come in during the middle of the month. They will start on the first of the month and be eligible for the entire month with the health plan.
392	Bidder Conf		All terminations are the same way (as the previous question)? Death? Terminating for any other reason?	Harmony	The capitation rate is established for the entire month. And the member is eligible with the health plan for the entire month.

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393	Bidder Conf		When is the start date of the P4P measurement year?	Aetna	This will be determined when the actual implementation date is confirmed. If the target implementation date of October 1, 2010 is achieved, the Department may prefer to wait until January 1, 2011 to begin the measurement period on a calendar year basis. If the start date ends up being January 1, 2011, then the Department would likely want to start it right away. In any event, the Department will negotiate the start date with the caveat that there will be P4P measurement in the initial year.
394	Bidder Conf		We serve persons with developmental disabilities and people who are mentally ill. And – in Will County and in Kankakee County. And I was wondering -- I believe come October 1 people who are mentally ill will be included and people who have substance abuse issues; is that correct?	Cornerstone Services	Mental health services and substance abuse services are a part of Service Package 1.
395	Bidder Conf		And so people who are not served now who are mentally ill who meet the eligibility criteria and live in Will County and Kankakee County, they will now be served; is that correct?	Cornerstone Services	The HMOs will be responsible for providing all of the needed services of their Enrollees. If they need mental health services or substance abuse services, the HMOs will be required to provide those to their Enrollees.
396	Bidder Conf		In our agency alone, we have a waiting list of over 1,400 people who are mentally ill that need residential support. They need psychiatric support, medication and counseling. And that number would include kids, too. How are you going to handle that number of people.	Cornerstone Services	The waiting list referred to is not a Department waiting list. From the statements made at the Bidders Conference it appears to include many individuals not eligible for this program, including children. As stated, the Contractors will be required to provide all needed services to their enrollees.

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397	Bidder Conf		How are you going to get savings out of our field when under this plan in this six county area it is going to grow substantially?	Cornerstone Services	The Department cannot state whether the assumption underlying this question is accurate. However, the Department does not assume that this program will generate savings in every service line or every service package. There are assumptions that will be increased utilization of certain services and decreased utilization of other services.
398	Bidder Conf		And then IMDs. My understanding is that they are not covered and Kankakee County probably has 500 people who are mentally ill. Maybe more. Why aren't they covered? For mental health services?	Cornerstone Services	They are included as a covered service.
399	Bidder Conf		So somebody who say lives in Kane County or in DeKalb County who is developmentally disabled can move into one of these counties and get served or some people who are mentally ill who live in Chicago who aren't getting served can come out to Will County and get served; is that correct?	Cornerstone Services	Enrollment in the plan is based on their residence at the time.
400	Bidder Conf		So they come out and they go to a shelter and then we enroll them and they can be served?	Cornerstone Services	If an otherwise eligible individual's residence changes to one of the counties in the contracting area, they will be eligible for the Integrated Care Program.
401	Bidder Conf		You mentioned earlier that subcontractors or the minority patients could be satisfied through providers that are certified I assume?	Awakened Alternatives	Yes
402	Bidder Conf		Also, I want to know are there any restrictions that any of us should be aware of that prohibit a subcontractor from participating in the core business meaning clinical management?	Awakened Alternatives.	No, there are no restrictions. The qualifying subcontractors do not have to work on a necessarily administrative function. They could work on the core medical direct services, also. And subcontract that they have with a certified vendor under this program qualifies for the goal.

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403	Bidder Conf		We're the community mental health provider in Kankakee County. And I wanted to follow up on the comments that were made earlier. As the community mental health provider to a large Medicaid population, I guess what we want to make clear is that the potential bidders on this contract know the full spectrum of services and needs of our population and --and we can help them to understand what the needs of our consumers are. And the RFP doesn't really expand on that. And I know that it sounds like that you intentionally did that so that they could develop the program in the way that they feel is met the soonest. So is there some way that we can avail ourselves to them to help them understand what the needs of our populations are?	Helen Wheeler Center	The names and contact information of all of the attendees at the Bidder's Conference have been posted to the Illinois Procurement Bulletin, addendum # 5 to the RFP. Information regarding a meeting between potential subcontractors and the potential Bidders has been scheduled, details have been posted on the Illinois Procurement Bulletin, addendum # 6 to the RFP
404	Bidder Conf		Is it just going to be two MCOs that will be selected or is it at least two?	Cornerstone Services.	Refer to response to Question #10.
405	Bidder Conf		In the RFP where it's mentioned about enrollment cap and that has to be more with MCOs capable of running the organization versus again an agency like Cornerstone being able to continue to enroll people who are mentally ill or developmentally disabled with the criteria?	Cornerstone Services.	Refer to response to Question #63.

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406	Bidder Conf		Cornerstone is has been around for over 40 years. And there are other agencies that have been around a long time, too. And I think that the RFP or the intent should be that people who aren't going to select us should show cause why they would not. So I mean personally I'm insulted that it sounds like an MCO could come in and go with whoever they want. We have been in the community. We have community relationships. We have fund raising. We have federal money that matches our state money. I mean it's -- I take offense to the -- to the tone of the RFP.	Cornerstone Services	It is the Department's philosophy that it will not mandate Contractors to subcontract with any particular provider.
407	Bidder Conf		You said at the end of this meeting that you are going to have a meeting with the prime vendors so that you can arrange for them to meet with the subcontractors. What is the process for making sure that you are or whoever the subcontractors are that you are arranging a meeting with the subcontractors?	Awakened Alternatives	The detail of this meeting has been posted on the Illinois Procurement Bulletin as Addendum #6.
408	Bidder Conf		Is there an intention of putting something in the contract in regards to timely payment?	Meridian Health Plan	The contract will have payment terms which will include a timely payment provision.