



# STATE OF ILLINOIS MEDICAID MANAGED CARE ORGANIZATION REQUEST FOR PROPOSALS 2018-24-001

Responses for Round 1 Q&A

March 29, 2017

## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

**1. Question:** Section 1.16.2 of the RFP includes a "Business Enterprise Program (BEP) goal of 20 percent of the administrative portion of the capitation payments."

Page 60 of the RFP, Part III (Subcontractor disclosures), provides that "[t]he maximum percentage of the goods or services...that may be subcontracted is 20% unless otherwise approved by the Department."

Please confirm that the 20% subcontracted services threshold on page 60 of the RFP is based on 20% of the total contract value and not 20% of administrative services, since if it were based on 20% of administrative services the BEP goal and the subcontracted services limitation would be equal and any Offeror who met the BEP goal would be unable to utilize additional subcontractors without Department approval.

**Answer:** *These are two different percentages. The 20% subcontracting percentage on Page 60 of the RFP is based on the total contract value. Any additional subcontracting that the Vendor would want to utilize under this Section or BEP must have prior approval by the Department.*

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**2. Question:** Does the state intend to transition care coordination functions from MCOs to IHHs? If so, what is the State's timeline for certifying and implementing IHHs?

**Answer:** *MCO care coordination will complement and provide oversight to the care coordination provided by the Integrated Health Homes. The timeline for program implementation and IHH certification is not yet finalized; further detail will be made available at the appropriate time. Preliminary materials on Integrated Health Homes are available on the HFS web site at <https://www.illinois.gov/hfs/info/1115Waiver/Pages/1115WaiverMeetings.aspx>*

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**3. Question:** Will the State please provide technical specifications for the SDEV measure?

**Answer:** *The most recent definition of the measures may be found here: [https://www.illinois.gov/hfs/SiteCollectionDocuments/HQLPS\\_ACE.pdf](https://www.illinois.gov/hfs/SiteCollectionDocuments/HQLPS_ACE.pdf)*

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**4. Question:** Is the State in negotiations with CMS on the 1115 waiver, and when does the State expect the 1115 waiver to be approved?

**Answer:** *Negotiations with CMS on the 1115 Waiver are ongoing; further detail will be made available at the appropriate time.*

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**5. Question:** How much of an impact will past quality scores have in the State's scoring of the Offeror's proposal?

**Answer:** *The scoring, evaluation criteria and process have been fully elaborated in sections 3, 4, 5 and 6 of the RFP.*

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**6. Question:** Will the State consider current/past provider partnerships in the scoring of the Offeror's proposal?

**Answer:** *The scoring, evaluation criteria and process have been fully elaborated in sections 3, 4, 5 and 6 of the RFP.*

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**7. Question:** I was wondering if the State planned to post an attendance list?

**Answer:** *A list of the potential offerors that attended the Vendor's Conference has been posted on HFS' website.*

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**8. Question:** Is there an official (public) list of the plans who attended the bidder's conference or are you guys not publishing one?

**Answer:** *A list of the potential offerors that attended the Vendor's Conference has been posted on HFS' website.*

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**9. Question:** Does HFS intent to publish a list of entities that filed a letter of intent for the MCO RFP as it has sometimes done in the past?

**Answer:** *Letters of Intent were not required for this RFP. However, a list of the potential offerors that attended the Vendor's Conference has been posted on HFS' website.*

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**10. Question:** I was looking at the MCO RFP and appendices and I cannot locate the requirements put into law in the BEST Act. By law, every network of care in Medicaid is required to have a Breast Imaging Center of Excellence (ACR designation), and an Academic Commission on Cancer accredited cancer program. There are also requirements regarding navigating cancer patients and in particular breast cancer patients. Can you point me in the right direction to find these requirements in the RFP specifications?

**Answer:** *See Section 2.2 of the Model Contract. Contractors are required to perform all services and other duties as set forth in this Contract in accordance with, and subject to, all applicable federal and State statutes, rules, and regulations.*

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**11. Question:** Could you please provide the names and organizations of the attendees at last Friday's Managed Care RFP Bidder's conference?

**Answer:** *A list of the potential offerors that attended the Vendor's Conference has been posted on HFS' website.*

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**12. Question:** Per the model contract (RFP Appendix I): 5.7.12 "Contractor shall contract with the University of Illinois and Southern Illinois University," In order to ensure compliance with this provision of the model contract WellCare Health Plans, Inc. requests clarification regarding RFP 1.2.3. regarding communications with state officers or employees. We seek clarification that it is appropriate and encouraged to engage in conversations with the universities regarding contracting for services.

**Answer:** *Section 1.2.3 of the RFP is regarding discussions with any State officer or employee other than the Solicitation Contact regarding the solicitation or any Proposal. This Section does not apply to discussions with medical providers regarding contracting for services.*

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**13. Question:** What is the impact to the scoring of the BEP Goal of 20%, and is the 20% goal related to only the administrative portion of the premium? Will the administrative portion of premium be known/published?

**Answer:** *The BEP Goal of 20% is on the administrative portion of the capitation payments. Utilizing BEP subcontractors to reach this goal is a requirement of this RFP.*

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**14. Question:** To apply for Option B, what eligibility criteria or elements must an Offeror meet or satisfy to be considered a "Minority-owned organization?"

**Answer:** *The definition is provided in Appendix II of this RFP and the instructions for Offerors who elect to submit a Proposal for Proposal Option B are provided in section 3.5 and Form for Submission II.*

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**15. Question:** Given the focus on BH Integration, can a psychiatrist be added to the list of specialists allowed to be a CMO?

**Answer:** *This language in the Model contract will be amended to allow any board certified Illinois licensed Physician with a minimum of eight years of experience practicing medicine to fulfill the role of the CMO.*

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**16. Question:** Can key positions have responsibilities or oversight of another state? As the section states that they can have other responsibilities if it does not prevent them from meeting contractual requirements of the state.

**Answer:** *No. The full-time key position may only have other responsibilities under the Contract, which by definition is specific to this MCO contract for Illinois.*

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**17. Question:** Will the State consider allowing part time employed or consulting Psychiatrists if they are licensed in the State of IL?

**Answer:** *No.*

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**18. Question:** If Contractor is an incumbent, may it forego filling the role of Transition Officer required by section 2.3.1.18?

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**Answer:** *No. Existing MCOs will still have significant transitional duties due to new responsibilities, eligible enrollees and geographic areas under the contract.*

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**19. Question:** What are the specific educational, experience and licensing/certification requirements for the eight liaison positions?

**Answer:** *If specific requirements are not listed, offeror should assume the liaison would have education, experience or licensing commensurate with the responsibilities of the position.*

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**20. Question:** In connection with Section 2.6, please confirm that Contractor may arrange for provision of services by out-of-network provider where appropriate.

**Answer:** *See Sections 5.7.6 and 5.20.1. See, generally, Sections 5.7 and 5.8.*

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**21. Question:** Within the cultural competency requirements of Section 2.7, the Model Contract requires that "all newly hired staff should clear industry-standard background check before assuming their duties with Contractor."

Is this related to Cultural Competency, or is this actually a more general provision related to all staff?

**Answer:** *This is a general provision related to all staff. The Model Contract will be amended to correct the placement of this language.*

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**22. Question:** "Subcontractor" is defined broadly in the Model Contract and could include vendors with large staffs and little, if any, contact with enrollees, such as a Contractor's pharmacy benefit manager. Please confirm that the requirement that each Subcontractor complete "Contractor's initial and annual Cultural Competence training" would be satisfied if Subcontractor staff members with direct contact with enrollees complete such training. Also, please confirm that if a Subcontractor has its own Cultural Competence training that Contractor has reviewed and approved, such training would satisfy this requirement. Otherwise, staff members of Subcontractors serving multiple Contractors would be required to take duplicative training.

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**Answer:** *Providers can complete an attestation of training form, certifying that necessary employees have completed required training including topics such as critical incidents, abuse, neglect and exploitation, ADA, and cultural competency.*

*If a Subcontractor has its own series of trainings on the required subjects, the MCO can review and approve the training in order to satisfy the requirement.*

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**23. Question:** On page 15 of the model contract it states the cultural competency plan should be submitted at least two (2) weeks prior to the departments readiness review. On page 211, it states the cultural competency plan should be submitted at least one (1) week prior to the departments readiness review. Can the timing please be clarified?

**Answer:** *Page 211 of the Model Contract will be updated to reflect the two week submission requirement for the Cultural Competence Plan.*

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**24. Question:** Will all populations (ICP, FHP/ACA, MLTSS, High-Needs Children) be identified on one enrollment file? Or will they continue to be sent on separate files as it exist today?

**Answer:** *Offerors should consider separate files will be required for development of proposals. The Department anticipates working toward a single file with successful bidders as the program develops.*

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**25. Question:** Section 4.1.2, Enrollment Generally, of the Model Contract states, "For new Enrollees transferring from another MCO, the Department will notify Contractor of the Enrollee's previous MCO, and Contractor will immediately request the Enrollee's IPoC from that MCO."

Will the Department notify the MCO of the Enrollee's previous MCO within the 834 enrollment record for that member? If not, how will the Department notify the MCO of the Enrollee's previous MCO?

As written, this requirement applies to all new members transferring from another MCO, and isn't limited to those who would have an IPoC. This is a manual process that will have a significant impact on administrative costs. Will the Department consider limiting this requirement to those Enrollees that the MCO determines to be high-risk, based on risk stratification methodology, as well as those who indicate that they had an IPoC at their previous

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MCO? Will the Department also consider altering the requirement to require the MCO to request the IPoC within a specified timeframe after the MCO determines the member is high-risk or had an IPoC at their previous MCO?

**Answer:** *It is the intent of the Department to provide this notification through coding on the 834 Audit File or 834 Daily File. The MCO will be required to request the IPoC from the previous MCO immediately upon receipt of the 834 file for all new enrollees.*

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**26. Question:** In Section 4.4 of the Model Contract, the enrollment distribution methodology is described. The contract frequently mentions that assignments or enrollments will not be made beyond the capacity of an MCO. Please provide some insight into how HFS will determine if an MCO is at their capacity in a particular region or population. Please indicate what the auto assignment algorithm will take into account (i.e. any minimum or maximum enrollment within a particular population or region).

**Answer:** *Refer to Model Contract Section 4.15.1, Capacity.*

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**27. Question:** In our current IL Medicaid contracts, we're not required to notify HFS when a member changes PCP. If the requirement is to keep a member with their PCP, each terminated MCO will need to supply HFS with information identifying the members PCPs. Please provide further clarification on how this will be managed.

**Answer:** *The Department will be requesting a one-time file containing current PCP for every member from an existing MCO that does not receive an award. The file format is not yet determined.*

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**28. Question:** Section 4.4.1 of the Model Contract states "The Department will use an algorithm that, to the extent possible, attempts to allocate the assignments and enrollments equally across the MCOs, while also attempting to maintain each Enrollee's existing PCP relationship as per 42 CFR 438.54(c)(6), but in no event will assignments or enrollments exceed the capacity of a MCO."

Does this mean that the Department will not assign a disproportionate share of "assignable" potential Enrollees to a health plan that has a lower enrollment?

**Answer:** *When assigning clients in the managed care program, the Department will consider PCP relationships, family member assignments, geography and total cost.*



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**29. Question:** Would the State please explain the difference between Section 4.4.1 of the Model Contract which states "An Enrollee who is within the scope of this section 4.4.1 will have ninety (90) days after assignment to select another MCO as provided in section 4.10.1." and Section 4.10.1 which states, "During the initial sixty (60) days after the Effective Enrollment Date, whether the Enrollee actively selected the MCO or was enrolled by automatic assignment, the Enrollee shall have the opportunity to select a different MCO."

**Answer:** *Section 4.10.1 of the Model Contract is incorrect. It will be corrected to reflect that the new enrollee has 90 days to choose another plan.*

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**30. Question:** Please supply a "Phased Enrollment" schedule.

**Answer:** *Refer to Section 2.7 of the RFP.*

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**31. Question:** Section 4.6.1 of the Model Contract states that "When an Enrollee gives birth and the newborn is added to the Case before the newborn is forty-five (45) days old, the newborn is automatically enrolled with Contractor. Contractor shall provide coverage of the newborn Enrollee retroactively to the date of birth."

Will the Department consider clarifying this language to state that the newborn's effective date with the Contractor will be the first day of the month within which the newborn was born, and where the newborn's eligibility is retroactive to the first day of the month within which the newborn was born, the Contractor will provide coverage of the newborn Enrollee retroactively to the date of birth?

**Answer:** *The intent of this paragraph is as stated.*

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**32. Question:** What is the applicable cut-off date for enrollment?

**Answer:** *The cut-off date for the enrollment to be effective the first day of the following month varies from month to month, but generally is between the 18th and the 21st of the month. The cut-off date will be shared with the MCOs in advance on a regular basis.*

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**33. Question:** In Section 4.10 of the Model Contract, can the Department confirm each enrollee will have only one enrollment period in the first year of the Contract that results from this RFP?

**Answer:** *It is the Department's intention that each Enrollee's anniversary date will be 12 months after their effective date. An Enrollee may have an additional enrollment period during a year if their eligibility status changes or the Enrollee moves out of their current MCO's service area.*

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**34. Question:** Under the Enrollee Disenrollment provisions of the Model Contract, Section 4.10.3.1 of the Contract states that "When an Enrollee is subject to voluntary managed care enrollment under the Medicaid Managed Care Program, an Enrollee may disenroll from Contractor at any time and for any reason by notifying the Contractor, orally or in writing, of the Enrollee's request to disenroll from the Health Plan; such a request shall be granted by Contractor."

Operationally, will the Contractor actually facilitate a disenrollment, or will the Client Enrollment Services vendor facilitate the disenrollment? If the latter, can this language be clarified such that it does not indicate that a disenrollment action is the responsibility of the MCO?

**Answer:** *This model contract language will be updated to correctly reflect that the Illinois Client Enrollment Services is the entity to process the disenrollment.*

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**35. Question:** Section 4.14.1.4 of the Model Contract states that, for Termination of an Enrollee's coverage, "when the Department learns that a member has other significant insurance coverage or is placed in Spend-Down status. The Department shall notify Contractor of such disenrollment on the 834 Daily File. This notification shall include the effective disenrollment date."

What termination date will the Department use for these Enrollees? Since the MCO may have provided coverage of services by healthcare providers and/or care coordination to the Enrollee, would the Department consider making the termination date the last day of the month during which the Department determined the member had other significant insurance coverage or was moved into a spend-down status? Can the termination date be clarified in the Contract?

**Answer:** *The termination date will be the last day of the month in which the Department's system is updated with the change. The termination date can be clarified in the Contract.*

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**36. Question:** Section 4.14.1.5 of the Model Contract states that termination of an incarcerated Enrollee's coverage takes effect on the last day of the month prior to the month in which the Enrollee became incarcerated.

The MCO may have paid providers for services during the month that the Enrollee became incarcerated, and if the Enrollee is terminated the last day of the month prior to incarceration, the MCO will be required to recoup the payment for services provided after the Termination Date, but before the date of incarceration.

Will the Department consider changing this requirement to make the termination date the last day of the month during which the Enrollee became incarcerated?

**Answer:** *No, the MCO will have to recoup the payment for any services provided after the Termination Date but before the date of incarceration.*

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**37. Question:** Section 4.14.1.6 of the Model Contract states that an Enrollee's coverage will terminate "When an Enrollee enters DCFS custody. Termination of coverage shall take effect at 11:59 p.m. on the day prior to the day on which the court grants DCFS custody of the Enrollee."

Will the State define "DCFS custody?" Also, can the State confirm that children who are DCFS-involved, but for whom DCFS has not been granted custody, will remain Enrollees of their current MCO and will not be disenrolled based on DCFS involvement?

**Answer:** *This paragraph will apply to MCOs that do not have the separate contract for DCFS Youth. This disenrollment will be done systematically when the DCFS indicator is entered on the Department's system. DCFS-involved youth who have not formally entered DCFS custody will remain in their current plan.*

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**38. Question:** Will the State please verify that the following requirement is only applicable if the plan is not awarded the separate contract for DCFS Youth

4.14.1.6 When an Enrollee enters DCFS custody. Termination of coverage shall take effect at 11:59 p.m. on the day prior to the day on which the court grants DCFS custody of the Enrollee.

**Answer:** *This paragraph will only apply to plans that are not awarded the separate contract for DCFS Youth.*

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**39. Question:** Will the requirement to provide the name and phone number of the enrollee's PCP be excluded for MLTSS?

**Answer:** *The card for MLTSS is not required to contain the Enrollees PCP.*

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**40. Question:** Section 4.14.1.3 of the Model Contract states that when an Enrollee moves out of the MCO's service area, "Termination may be retroactive if the Department is able to determine the month in which the Enrollee moved from the Contracting Area," and "Termination may be retroactive if the Department is able to determine the month in which the Enrollee moved from the Contracting Area."

Is it the Department's intent to make the termination effective the last day of the month during which the Enrollee moved from the Contracting area, so that any services provided to the member during the month the member moved, and reimbursed by the MCO, do not have to be recouped from the health care provider who provided those services, during the month the member moved, but prior to the member's date of move?

In determining whether to make the termination retroactive, will the Department take into consideration whether the MCO continued to provide services, either by coverage of services provided by Providers and/or care coordination services, to the Enrollee during the time that the Enrollee lived outside the Contracting Area? For example, if the Enrollee moved from the Contracting area but remained enrolled with the MCO, and was in a neighboring area, such as a border state, and the MCO continued to provide services, will the Department take that provision of services/care coordination into consideration when making the determination of whether to make the Enrollee's termination date retroactive?

**Answer:** *No, the Model Contract language is clear that the termination of coverage shall take effect at 11:59 pm on the last day of the month prior to the month in which the Department determines that the Enrollee no longer resided in the Contracting Area. The Department will not consider whether services were provided in determining the effective date of the termination of coverage.*

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**41. Question:** The Model Contract does not include a listing of Service Package I Covered Services.

Does the Department intend to provide a Provider Type (PT) and Category of Service (COS) chart, as well as a description of the covered services under Service Package 1?

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**Answer:** *No, as stated in Section 5.1, services are described in 89 Ill. Adm. Code 140.*

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**42. Question:** Section 4.17.3 of the Model Contract states, “Face-to-face Marketing by Contractor directed at Participants or Potential Enrollees, including direct or indirect door-to-door contact, telephone contact, email, texting or other cold-call activities, is strictly prohibited. Events that may involve Contractor staff educating groups of Participants or Potential Enrollees shall not be considered “face-to-face” Marketing.”

Is emailing or texting members enrolled with the MCO permitted during the time they are assigned to the MCO?

**Answer:** *A Contractor is not prohibited by Section 4.17.3 from emailing or texting its Enrollees, provided that the content of such communication is not within the definition of “Marketing” found at Section 1.1.124, nor is otherwise prohibited.*

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**43. Question:** Will there be any changes to the existing Service Packages?

**Answer:** *Covered services are always subject to change throughout the term of the Contract. Contractors would be notified and rates would be adjusted accordingly.*

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**44. Question:** Section 5.2.4.6 of the Model Contract prohibits imposition of cost sharing for Enrollees who are Indians "if the Enrollees have ever received services from an IHCP."

How will the Department notify the MCO if an enrollee received services from an IHCP prior to Enrollment in the MCO?

**Answer:** *Per Article 6.4 of the Model Contract, the MCOs receive an monthly CCCD file that includes historical claims information.*

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**45. Question:** How will the department incorporate the expenses of MCOs moving to a common PDL?

**Answer:** *This question will be addressed as part of Round 2 Q&A related to Rates and Financial Proposals.*

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**46. Question:** Given that there is a single formulary under this contract covering multiple populations, will MCOs have the opportunity, with prior approval from HFS, to deviate from the established formulary?

**Answer:** *No.*

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**47. Question:** Can the Department reconsider the prohibition on the Contractor's PBM from negotiating rebates for drugs listed on the Department's PDL? This will significantly impact the cost of the program and the actuarial soundness of the rates.

**Answer:** *No.*

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**48. Question:** Will the Department provide an NDC-level listing of its preferred drugs and drugs for which it received supplemental rebates? Would the Department be willing to provide such listing monthly, since as new NDCs are released into the market for PDL and other supplemental rebate drugs, the MCOs would need to know whether those NDCs were or were not subject to supplemental rebates?

**Answer:** *Initially, the Department will provide a list of the preferred drugs on the PDL and any other drugs on which the Department has a supplemental rebate. Thereafter, the Department will supply a list of any changes that are made to the initial list. An updated list will be supplied quarterly, at a minimum.*

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**49. Question:** Section 5.3.4 of the Model Contract prohibits negotiation of rebates with drug manufacturers for drugs on the Department's Preferred Drug List (PDL) and drugs for which the Department receives supplemental rebates. It seems the intent is to prohibit PBM/MCO negotiation and collection of rebates on those drugs. However, the language is broadened to prohibit negotiation of rebate and collection of rebates on all drugs made by manufacturers who have a signed federal rebate agreement, where the language states "The Department will provide a list of manufacturers that participate in the federal Medicaid drug rebate program, which the Contractor or its Subcontractors may only negotiate with and accept rebates from in relation to non-drug items as per this section 5.3.4."

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If the prohibition is only in relation to drugs for which the Department collects supplemental rebates, can the language be clarified?

**Answer:** *The Department's intent is only to prohibit negotiation of rebates on drugs that are listed as preferred on the PDL or that have a supplemental rebate in place outside of PDL inclusion.*

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**50. Question:** Section 5.3 of the Model Contract requires MCOs to follow the Department's Preferred Drug List (PDL), and prohibits imposition of utilization controls where prohibited by the Department's PDL.

How frequently does the Department make changes to drugs listed on the PDL?

What utilization controls are prohibited by the Department's PDL, and how will those utilization controls be communicated to MCOs?

**Answer:** *Changes are made to the PDL quarterly. In the majority of cases, preferred drugs are available without a prior approval. The Department will provide a list for those drugs that are an exception to this rule, such as cases where the whole case requires a PA but some are preferred over others (preferred with PA).*

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**51. Question:** In Section 5.3 of the Model Contract, the State does not require that the MCO use only drugs manufactured by rebatable manufacturers. Is that the Department's intent?

**Answer:** *The State does require that the MCO use only drugs manufactured by rebatable manufacturers per Sec. 1927(a) of the Social Security Act [42 U.S.C. 1396r-8].*

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**52. Question:** Will the State please clarify which medications on the PDL are to be covered (preferred column and/or non-preferred column).

**Answer:** *All drugs made by a rebatable manufacturer must be covered. Preferred or non-preferred refers to how they are covered and what controls are in place.*

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**53. Question:** Will the State please clarify that if Offeror has negotiated rebates with drug manufacturers for drugs that are listed on the Department's PDL and do not interfere with the rebates authorized in Section 1927 of the Social Security Act if the Offeror may continue to accept these rebates?

**Answer:** *The Department does not believe that the Offeror can have negotiated rebates with drug manufacturers for drugs that are listed on the Department's PDL that will not interfere with the Department's rebates.*

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**54. Question:** Will the State please provide a list of drugs for which the Department has entered into a State supplemental rebate agreement with the manufacturer?

**Answer:** *Initially, the Department will provide a list of the preferred drugs on the PDL and any other drugs on which the Department has a supplemental rebate. Thereafter, the Department will supply a list of any changes that are made to the initial list. An updated list will be supplied quarterly, at a minimum.*

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**55. Question:** Please confirm whether Offerors are permitted to provide additional coverage for scripts or over the counter drugs not on the State PDL or rebate list provided at section 5.3.1.1 of the Model Contract?

**Answer:** *This additional coverage could be considered as an "added benefit" of the MCO.*

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**56. Question:** Is the MCO required to list all PDL drugs and all state rebateable drugs on formulary documents? Do PDL drugs and state rebateable drugs need to be covered at the same tier?

**Answer:** *MCOs are required to list all PDL drugs on the formulary. MCOs are not required to list other state rebateable drugs on the formulary.*

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**57. Question:** Please confirm whether the State's rebate list referenced in Model Contract section 5.3.1.2 is the same as the CMS Medicaid Rebate List.

If the list is different, what is the frequency of changes made to the State's custom rebate list?



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If the list is different, is the State's custom rebate list more or less restrictive than the CMS Medicaid Rebate list?

**Answer:** *Refer to the CMS list of rebatable manufacturers. Manufacturers must be on the CMS list to be allowed to negotiate rebates with the State.*

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**58. Question:** Please provide the expected frequency of changes to the State PDL as described in Model Contract section 5.3.1.1 and the method these updates/changes will be communicated to the Offeror.

For example, will these changes be submitted by electronic file with specific drug names and NDC number?

**Answer:** *Initially, the Department will provide a list of the preferred drugs on the PDL and any other drugs on which the Department has a supplemental rebate. Thereafter, the Department will supply a list of any changes that are made to the initial list. An updated list will be supplied quarterly, at a minimum.*

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**59. Question:** Please confirm the file format for the PDL and any subsequent changes.

For example, will MCOs be provided a full PDL file or a change file? Will it include Medispan drug file data elements (i.e. NDC, GPI, etc.)?

**Answer:** *Initially, the Department will provide a list of the preferred drugs on the PDL and any other drugs on which the Department has a supplemental rebate. An electronic change file will be provided quarterly and it will contain NDC and pertinent Medispan data elements.*

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**60. Question:** Section 5.13.14 of the Model Contract requires reporting of prospective and retrospective DUR activities to DHFS quarterly.

Would the Department consider changing this requirement to annual reporting, consistent with the Department's DUR reporting requirement?

**Answer:** *The DUR report will be required annually based on Federal Fiscal Year (October 1 through September 30). This report will be required to be submitted to the state no later than January 1 of the following year.*

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**61. Question:** 5.4.10 excludes as a service shift nursing for children enrolled in the MFTD waiver but not shift nursing for children on medicaid and not in the waiver. Can you confirm that this is the intention.

**Answer:** *The Model Contract will be amended to indicate that all shift nursing is a Covered Service.*

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**62. Question:** Are transitional services provided by Almost Home Kids for MFTD children or Medicaid children not enrolled in the MFTD waiver a covered service or excluded as shift nursing?

**Answer:** *Yes.*

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**63. Question:** In Sections 5.5.1, 5.5.2, and 5.5.3 of the Model Contract, the Department requires MCOs to complete Department-specified forms in cases of certain services.

It appears that these are forms the providers would complete, and not the MCO. Should the language state that the MCO must require that its providers complete these forms in order for the MCO to cover the service, rather than require that the MCO complete the form?

**Answer:** *The MCO may determine whether it will delegate the completion of such forms to its providers.*

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**64. Question:** Are MFTD Waiver-eligible children included or excluded from this Contract? Section 5.4.10 of the Model Contract excludes as a covered service, “shift nursing for Enrollees in the MFTD HCBS Waiver for individuals who are medically fragile and technology dependent (MFTD).” This implies that those children are covered under this contract for other services. The Service Package II attachment does not specifically list the MFTD waiver. However, it does include language around DSCC. It does not appear that those children are otherwise excluded from enrollment in this program in Attachment II. Can the State clarify?

**Answer:** *Children enrolled in the MFTD Waiver are included in the scope of this RFP. Please refer to Question #61 regarding shift nursing. The Model Contract Attachment II will be amended to include MFTD Waiver services as covered services under Service Package II.*

## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

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**65. Question:** If a service is rendered by an out-of-state provider and they enroll with HFS afterwards, will the enrollment be back dated in order that the service rendered is covered? Also, does the enrollment requirement with HFS apply to emergency services as well?

**Answer:** *The Department can backdate a provider in special circumstances such as an out-of-state emergency service.*

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**66. Question:** Will the State please clarify the requirement around contracting with sufficient HCBS waiver providers to have provided services to at least 80% of previous service recipients. Is it the intention of the State that at least 80% of HCBS waiver recipients must have access to their same HCBS waiver providers?

**Answer:** *The requirement is as stated in Model Contract Section 5.7.1.4.*

---

**67. Question:** In counties where there are less than two HCBS provider types in the service area, how should this be reflected on the Offeror's network submission file?

**Answer:** *Offerors shall submit the status of their current network in the RFP Provider Network File per RFP Section 4.2.6.*

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**68. Question:** Section 5.7.1.5.4 of the Model Contract states, "If Contractor is unable to locate waiver member within 90 days of enrollment, Contractor must, after documenting all forms of attempt to contact, contact the appropriate operating agency, provide documentation attempts, and request closure of the waiver case."

How many contact attempts and variety are required to satisfy this requirement? How should notification of the operating agency occur? In what format (i.e email, report)?

**Answer:** *A minimum of five attempts with documentation showing that a variety of methods were used to locate the HCBS member including, but not limited to, calls, letter, unannounced visits, outreach to sister agency and outreach to identified HCBS providers. Contractor will e-mail requests for waiver closure to the primary sister agency with documentation for review by that agency.*

## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

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**69. Question:** If MCO is unable to locate waiver member within 90 days of enrollment, and we document all forms of attempt to contact, how will we know what agency we are reporting to and, how will we know if the member has been disenrolled or enrolled without waiver status? To what does the "operating agency" refer? IDoA? DRS?

**Answer:** *Attachment I, Service Package II Covered Services, identifies in the column headings which agencies are responsible for which HCBS waiver. That will be the agency that the MCO must contact, with a copy to the Department. An e-mail notification will be required.*

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**70. Question:** Section 5.7.1.7 of the Model Contract prohibits payment for home healthcare services unless the provider of services provides the State with a surety bond.

How will the State communicate to MCOs that a provider of home health services has provided the State with a surety bond? Should the MCO assume that if the provider is an HFS IMPACT-approved provider listed on the Provider Extract File, the Provider has met this requirement?

**Answer:** *The MCO may use enrollment in IMPACT as a confirmation that the Provider has met the requirement.*

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**71. Question:** Section 5.7.3 of the Model Contract states, "Contractor shall ensure that all Network Providers, including out-of-state Network Providers, are enrolled in the HFS Medical Program, if such enrollment is required by the Department's rules or policy in order to submit claims for reimbursement or otherwise participate in the HFS Medical Program. Once a Contractor is aware that a Network Provider serving one-hundred (100) or more active Enrollees will be terminated, Contractor must inform the Department of this termination in writing (email or letter) within three (3) Business Days."

Would HFS consider a termination report, in a standardized format, on a regular basis, such as weekly, bi-weekly, or monthly? Can HFS provide clarity as to which termination reasons are required to be reported (i.e. voluntary, involuntary, non response to recredentialing documentation request, etc.)?

**Answer:** *The Department will consider standardizing the format. All termination reasons apply if the conditions of Model Contract Section 5.7.3 are met.*

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## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

**72. Question:** Section 5.7.7 of the Model Contract states that "The Department may define an alternative payment methodology to which Contractor must adhere to when reimbursing Providers for provided services."

Will the State confirm that this provision relates only to FQHCs and RHCs?

**Answer:** *Section 5.7.7.2 is not exclusive to FQHCs and RHCs.*

---

**73. Question:** Section 5.7.7.2 of the Model Contract states that MCOs must require providers to submit benefit expense claim data, as defined in 7.11.6.2, for all Covered Services provided to Enrollees.

Will the State confirm that this requirement applies only to those cases where the MCO has a subcapitated arrangement with the Provider?

**Answer:** *Section 5.7.7.2 is not limited to subcapitation arrangements.*

---

**74. Question:** Section 5.7.6 of the Model Contract states, "It is understood that in some instances, Enrollees will require specialty care not available from a Network Provider and that Contractor will arrange that such services be provided by a non-Network Provider. In such event, Contractor will promptly negotiate an agreement (single case agreement) with a non-Network Provider to treat the Enrollee until a qualified Network Provider is available. Contractor shall make best efforts to ensure that any non-Network Provider billing for services rendered in Illinois is enrolled in the HFS Medical Program prior to paying a claim."

If a non-network provider is not certified but the services are medically necessary, how will HFS account for these dollars in the EUM calculation? What if the provider does not have a clear Provider Type (e.g., Neurorestorative Rehab in Carbondale II)?

**Answer:** *Such instances will be worked out on a case-by-case basis with the Department, depending on the situation. In all instances, the Department does not want consideration of the EUM calculation to drive provision of care by the MCO.*

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## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

**75. Question:** Section 5.7.7.1 of the Model Contract states, “For all FQHCs and RHCs that elect to use the Department’s alternative payment methodology, Contractor shall pay contracted FQHCs and RHCs at least the Department’s full cost-based per-visit rate for Covered Services.”

Does HFS permit alternative value-based reimbursement methods for FQHCs and RHCs? How would this additional reimbursement impact their rates or wrap payments?

**Answer:** *MCOs may use other reimbursement methodologies for FQHCs and RHCs if they are approved by the FQHC or RHC, and the Department. Any such payment methodology must result in a guaranteed payment amount that is no less than the Department's encounter rate for that facility.*

---

**76. Question:** Will the State please provide the IHH Provider Network requirements?

**Answer:** *While the Integrated Health Home program design is not yet finalized, preliminary materials are available on the HFS web site at <https://www.illinois.gov/hfs/info/1115Waiver/Pages/1115WaiverMeetings.aspx>*

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**77. Question:** Per the Model Contract (RFP Appendix I): 5.7.12 “Contractor shall contract with the University of Illinois and Southern Illinois University.” In order to ensure compliance with this provision of the model contract please provide clarification regarding RFP 1.2.3. regarding communications with state officers or employees. We seek clarification that it is appropriate and encouraged to engage in conversations with the universities regarding contracting for services.

**Answer:** *Section 1.2.3 of the RFP is regarding discussions with any State officer or employee other than the Solicitation Contact regarding the solicitation or any Proposal. This Section does not apply to discussions with medical providers regarding contracting for services.*

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**78. Question:** The model contract states the requirement to contract with government providers University of Illinois and Southern Illinois University. Will there be any risk mitigation measure around these hospitals to account for higher than average utilization?

**Answer:** *This question will be addressed as part of Round 2 Q&A related to Rates and Financial Proposals.*

---

## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

**79. Question:** Under Section 5.7.12 of the Model Contract, within the Governmental Provider Entities Contracting Requirement, the Department requires MCOs to reimburse providers at rates not less than those paid by the Department.

What will be the Department's method and frequency be for providing those rates?

**Answer:** *All hospital rates, including those for Governmental Provider Entities, are posted on the Department web site at*

*<https://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/Hospital-Rate-Sheets-Effective-January-1-2016.aspx>.*

*During the course of the Contracts resulting from this RFP, the Department intends to notify Contractors of updates to these rates via e-mail.*

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**80. Question:** Section 5.7.11 of the Model Contract states that the Department will stratify the children into high risk. Once this happens, must MCOs use the Department's stratification, or can MCOs continue to use their own stratification policies and processes, including clinical judgment of clinicians?

**Answer:** *The MCOs must use the Department's stratification identifying enrollees determined to be High-Needs Children. The Contractor shall stratify within that population pursuant to Attachment XXII Section 4.b.*

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**81. Question:** Are the University of Illinois and Southern Illinois University, as noted in Section 5.7.12, the only government-owned facilities that MCOs will be required to contract with?

**Answer:** *This Section of the Model Contract will be amended to also reflect Cook County, which was inadvertently omitted. Other areas of the Contract address requirements for governmental entities such as local health departments, state operated hospitals and other safety net providers.*

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**82. Question:** Will the State please clarify the covered Medicaid services that a Child's family is eligible for related to the necessary care of the Child?

## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

**Answer:** *Contractors must comply with the Illinois Medicaid State Plan and the Community Mental Health Services Service Definition and Reimbursement Guide (SDRG-CMHS Rev 9/30/2016).*

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**83. Question:** Section 5.8.1.1.2 of the Model Contract states, “Contractor shall ensure an Enrollee has access to at least two (2) Behavioral Health service Providers within a thirty (30)–mile radius of or thirty (30)–minute drive from the Enrollee’s residence. If an Enrollee lives in a Rural Area, the Enrollee shall have access to at least one (1) Behavioral Health service Provider within a sixty (60)–mile radius of or sixty (60)–minute drive from his or her residence.”

What are the provider types that will satisfy the "Behavioral Health Service Provider" requirement?

**Answer:** *Please refer to Appendix II for definitions of Behavioral Health(care) and Provider.*

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**84. Question:** When do we expect to receive the department-defined standards as it relates to network adequacy access standards for LTSS?

**Answer:** *The Department will provide the standard in adequate time for the Contractor to meet the January 1, 2019, requirement.*

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**85. Question:** For Model Contract Section 5.8.1.2, what are the Department-defined standards to which the Contractor must adhere for LTSS provider types that travel to Enrollee to deliver services?

**Answer:** *The Department will provide the standard in adequate time for the Contractor to meet the January 1, 2019, requirement.*

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**86. Question:** Does the State intend to remove the current limitation on frequency of admissions for detoxification?

**Answer:** *At this time, that limitation is set by Illinois Public Act 097-0689.*

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## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

**87. Question:** Section 5.9.4 states: "Verification of qualifications of Providers of Covered Services under HCBS Waivers. Contractor shall ensure that only those Providers that are approved and authorized by the Department are providing Covered Services under HCBS Waivers, and that those Providers are providing to Enrollees only Covered Services for which they are approved and authorized. The Department will provide Contractor with a weekly Department extract file containing the list of such approved and authorized Providers...." When will the State provide the list of authorized HCBS Waiver providers, including provider address, service county, authorized service type(s), and NPI/ Tax ID numbers?

**Answer:** *The Department intends to make available a Provider Extract File in the near future to Potential Offerors who attended the Mandatory Round 1 Offeror's Conference. The Department will contact Potential Offerors regarding this file via the contact information provided at the Offeror's Conference.*

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**88. Question:** Regarding Section 5.9.4 of the Model Contract, can you confirm that HCBS providers are not required to be credentialed by the MCO that the MCO accepts the list from the state and then is only required to then obtain a contract from the HCBS provider? Please confirm the providers you will have fall into this category.

**Answer:** *HCBS providers are not to be credentialed by the Contractor. Approved HCBS waiver service providers will be contained in the weekly provider file available to the Contractor.*

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**89. Question:** Regarding Section 5.9.4 of the Model Contract, if you have an HCBS provider that is also a Home Health Provider can you confirm that the MCO is allowed to credential them for other services but will accept them for HCBS based on the listing that will be provided weekly.

**Answer:** *Yes.*

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**90. Question:** Please clarify the process for distribution and completion of Provider Packet as it relates to Model Contract 5.10.9. How will the MCO be notified when packets have been complete and returned to DHS-DRS?

**Answer:** *The DRS Regional Office will notify the health plan when a PA has been approved to begin working. The start date will be included.*

## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

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**91. Question:** Regarding Section 5.10.9 of the Model Contract, please describe what information will be included in the Provider education packets that the MCO is responsible for distributing and educating on?

**Answer:** *The Home Services Program (HSP) Provider Packet includes the necessary paperwork and instructions for an Individual Provider (IP) to complete prior to being approved to work for an HSP customer. There are several forms to read, complete and sign, including: the W-4, the Waiver Program Provider Agreement for Participation in the Illinois Medical Assistance Program, the I-9 (Employment Eligibility Verification), Individual Provider standards, payment policies, schedules, guidelines, how to report injuries, among others.*

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**92. Question:** Under 5.13.1.4.1 of the Model Contract, there is a requirement related to the stratification of Special Needs Children (SSI, DSCC, Disabled). Can the State clarify the definition of DSCC? Does this refer to children who are enrolled in the MFTD waiver, or is the definition more broad to include children receiving services through the CORE program? If referring to MFTD, would the Department consider clarifying the language to specifically identify MFTD waiver-enrolled children? Will there be an indicator on the 834 that identifies "DSCC" children (or potentially other DSCC-administered programs)? What is the Department's definition of "disabled" in this context? Will there be an indicator identifying SSI-eligible children on the 834?

**Answer:** *Children enrolled in the MFTD Waiver are included in the scope of this RFP. Contractors will be required to contract with DSCC to provide care coordination for this population. The Model Contract will be amended to reflect this change.*

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**93. Question:** Does the State require that anyone with a behavioral health diagnosis be considered Level 3 stratification?

**Answer:** *No. They are not required to be stratified at Level 3.*

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**94. Question:** For Model Contract Section 5.15.1, please confirm that only HCBS Waiver IPoC's require a signature in order to be considered final.

## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

**Answer:** *Per Model Contract Section 5.15.1, the IPoC is required for Level 3 high risk and enrollees in a HCBS waiver. An IPoC for any Enrollee may not be finalized until signature from the enrollee or authorized representative has been received.*

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**95. Question:** Will required caseloads and staffing ratios be the same for MCOs and Integrated Health Homes?

**Answer:** *The design of the Integrated Health Homes is not finalized and additional details will be made available by HFS at the appropriate time.*

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**96. Question:** Section 5.18.5 of the Model Contract indicates the Money follows the Person (MFP) will end on December 31, 2017, and the MCO will assume the lead role in supporting individuals transitioning from institutional settings to the community.

Can the State clarify whether the role will include any "MFP-specific" responsibilities, or if the role is the MCO's responsibilities with regard to transitioning a member? Can the State clarify the role of the community agencies after the MFP program ends December 31, 2017?

**Answer:** *MCOs will assume a lead role and will work in collaboration with the existing community agencies that provide MFP transition coordination services. MCOs will work with the community agencies and assist in enrolling them in their respective networks.*

---

**97. Question:** Are MCOs required to approve all IHH authorized services? Will the State provide one set of standard authorization requirements that apply to all IHHs?

**Answer:** *The design of the Integrated Health Homes is not finalized and additional details will be made available by HFS at the appropriate time.*

---

**98. Question:** Is it the State's intention to change the timeline for processing all requests for prior authorization of service from 7 days to 72 hours (with a possible extension of an additional 72 hours)?

## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

**Answer:** *Yes.*

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**99. Question:** For Local Health Departments that operate as CMHCs and offer an array of Rule 132 and other BH services, does the no prior authorization standard still apply?

**Answer:** *No. This language, as well as the language for School Based Health Centers, will be clarified in the Model Contract to make it clear that the "no Prior Authorization or referral" is for contracted providers only. This language is intended to ensure access to the preventive services through these providers. If the Local Health Department were also a CMHC it would have a separate Provider Type (PT 36), would have a contract with DMH to provide those Rule 132 services, and would bill those services separately.*

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**100. Question:** Will the State accept "other information" of this nature on a website or member portal with mobile access and only send written materials when website is not sufficient for the requestor?

**Answer:** *Yes.*

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**101. Question:** Will the State please provide their definition of "transient" members?

**Answer:** *The State's definition is the common definition.*

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**102. Question:** Section 5.29.5 states: "Contractor shall pay all Providers of HCBS Waiver services at a rate no less than the rate in effect for the Department for such Covered Services, as defined in Attachment IV." When will the State provide the fee schedule/rate file and corresponding procedure codes, e.g. HCPC, for the HCBS Waiver services?

**Answer:** *Rates for certain HCBS Waiver services are available through DHS-DRS at <http://www.dhs.state.il.us/page.aspx?item=83520>. Rates for additional HCBS Waiver services will be made available in the near future to Potential Offerors who attended the Mandatory Round 1 Offeror's Conference. The Department will contact Potential Offerors regarding this file via the contact information provided at the Offeror's Conference.*

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## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

**103. Question:** Section 5.29.5.1 states: "Contractor shall pay Provider agencies that provide in-home

services under the Persons Who are Elderly HCBS Waiver and that also offer health insurance to their in-home service workers, at a rate that includes the enhanced rate set forth at 89 Ill. Admin. Code 240.1970. If any other HCBS Waiver becomes subject to a duly promulgated State rule that includes a similar enhanced rate, contractor shall pay the affected Provider agencies at a rate that includes such enhanced rate." When will State provide the enhanced fee schedule/rate file, service codes, e.g. HCPC, and a list of eligible Provider agencies?

**Answer:** *Rates for certain HCBS Waiver services are available through DHS-DRS at <http://www.dhs.state.il.us/page.aspx?item=83520>. Rates for additional HCBS Waiver services will be made available in the near future to Potential Offerors who attended the Mandatory Round 1 Offeror's Conference. The Department will contact Potential Offerors regarding this file via the contact information provided at the Offeror's Conference.*

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**104. Question:** Will the State please define "any of the required Capitation to Contractor for four consecutive months" and will this be administered by eligible population category?

**Answer:** *The Department sees no need for definition of the phrase or further clarification at this time. .*

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**105. Question:** Regarding Section 5.29 of the Model Contract, fiscal agent, is the MCO responsible for the administrative payment to the FEA?

**Answer:** *The Department is unsure of the use of the term FEA in this question. The MCO must reimburse the fiscal agent making the Personal Assistant payments pursuant to Section 5.29 and Attachment XX.*

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**106. Question:** Regarding Article 5 of the Model Contract, please confirm whether the timeframes are business or calendar days.

**Answer:** *Please refer to Section 2.1, Rules of Construction.*

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## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

**107. Question:** Will the State please provide clarification? Section 5.30.2.3 states "Contractor's procedures must provide for only one level of Appeal by Enrollee" However, Section 5.30.4 states "at a minimum...including date, at each level."

**Answer:** *Section 5.30.2.3 limits a Contractor's procedures to only one level of Appeal. Section 5.30.4 requires a Contractor to maintain a record of Grievances and Appeals, which, in any given instance, may include documentation relating to another level, such as the resolution of an Appeal that is filled with the State fair hearing system.*

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**108. Question:** Section 5.32.13 states: "Prior to entering into a Provider agreement or subcontract, Contractor shall submit a disclosure statement to the Department specifying any Provider agreement or subcontract and Providers or Subcontractors in which any of the following have a financial interest of five percent (5%) or more: ..." Can contractor utilize its own disclosure of interest form?

**Answer:** *No.*

---

**109. Question:** Section 5.35.1.4 of the Model Contract states that with respect to Fraud, Waste, and Abuse Procedures, the Offeror shall, among other things, "form a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing Contractor's compliance program and its compliance with the Contract."

Under Offeror's existing committee structure, Offeror's Compliance Committee reports directly to its Quality Management Oversight Committee ("QMOC"), both of which are chaired and staffed by senior-management-level personnel. Offeror's QMOC, in turn, reports directly to Offeror's Board of Directors. Please confirm that this existing committee structure will meet the requirement set forth in Model Contract section 5.35.1.4. Alternatively, please modify the language in that Section from "on the Board of Directors" to "that reports up to the Board of Directors."

**Answer:** *No change will be made as this language is compliant with federal regulation.*

---

**110. Question:** Model Contract Section 5.40.2 requires a Quality Assurance Plan Committee and Section 5.40.10 requires a Quality Management Committee. Please confirm that these two

## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

requirements are in regards to the same quality committee. Should the Contractors quality committee be titled QAP Committee or Quality Management Committee?

**Answer:** *These are two different committees with different duties.*

---

**111. Question:** Model Contract Section 5.40.5 requires that the Contractor establish an Enrollee advisory and community stakeholder committee. Please clarify whether this is one committee or two.

**Answer:** *The Enrollee advisory and community stakeholder committee referenced in section 5.40.5 is one committee.*

---

**112. Question:** For Model Contract Section 5.40.8.2, please confirm that the Contractor's FLC, should include significant percentage of youth or parent/guardian representation from each geographic Region it serves versus 'all counties in the Coverage Area'.

**Answer:** *For the FLC the Contractor shall include a significant percentage of youth or parent/guardian representation from each geographic region included in its service area. The Department will amend the Model Contract to reflect this change.*

---

**113. Question:** Model Contract Section 5.40.9 requires that the Contractor establish a Community Stakeholder Council. Is this the same committee as the Community Stakeholder Committee referenced in Section 5.40.5?

**Answer:** *The Model Contract will be amended to remove 5.40.9 on the Community Stakeholder Council. The committee to be used for this purpose is the Enrollee advisory and community stakeholder committee described in section 5.40.5. Both sections will be amended to reflect this change.*

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**114. Question:** For Model Contract Section 5.40.10.4, please confirm that the Contractor's QMC should include at least one Enrollee or parent/guardian from each geographic Region it serves versus 'each of the counties in the Coverage Area'.

## State of Illinois Medicaid Managed Care Organization Request for Proposals

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**Answer:** *For the QMC the Contractor shall include a significant percentage of youth or parent/guardian representation from each geographic region included in its service area. The Department will amend the Model Contract to reflect this change.*

---

**115. Question:** Section 5.40.10.4 of the Model Contract states that “Contractor will seek to include on the QMC [Quality Management Committee] at least one Enrollee or parent/guardian of an Enrollee from each of the counties in the Coverage Area.”

Please confirm whether an Offeror submitting a proposal under Option A may meet the requirement in section 5.40.10.4 by including “at least one Enrollee or parent/guardian of an Enrollee” from each region on the QMC, as opposed to each of the 102 counties in the coverage area.

**Answer:** *For the QMC the Contractor shall include a significant percentage of youth or parent/guardian representation from each geographic region included in its service area. The Department will amend the Model Contract to reflect this change.*

---

**116. Question:** At 7.4, Risk Adjustment, the Model Contract identifies several categories of eligible members for whom risk adjustment will be calculated. Would the Department consider clarifying the language as there is some overlap between the categories, and there is some lack of clarity in regard to some of the categories.

1) The first category is adults and children eligible under Title XIX and Title XXI, which encompasses all of the remaining categories. Perhaps this category could go at the end and be clarified as all other adults and children not included in the aforementioned categories.

2) the third category of eligibles is "Medicaid-eligible older adults." Should this be interpreted to mean the same as the term “Seniors” as defined in Appendix II with the additional clarification “who are not Dual-Eligible?” 3) The fourth category is "Adults with disabilities who are not eligible for Medicare." How are “adults with disabilities” identified? Is this through a category of assistance such as AABD, or is this through claims data, or something else? Does it include ACA adults who would otherwise be eligible under AABD?

4) the 5th category is Dual Eligible Adults receiving LTSS, excluding those receiving partial benefits or enrolled in MMAI. The exclusions are not included in the scope of this Contract. For clarification, would the Department consider removing the reference to the exclusions?

5) The sixth category is "Special Needs Children – including Medicaid eligible under SSI, DSCC or through a disability category of eligibility." The term “including” implies the three subsets listed are not a complete definition of Special Needs Children. What other categories of children



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### Responses to Round 1 Q&A

are included? Eligibility for Medicaid isn't granted under DSCC; was the intent to include children who are served through the DSCC CORE program, and/or the MFTD waiver, and/or any other category of children served by DSCC? Will the state use 3M CRGs to identify these children? Is a TANF-enrolled child who is eligible for SSI included in this definition of Special Needs Children? Can the Department please clarify this language to fully define this category of children?

6) The seventh category is "Children in the care of DCFS." Does this refer to all DCFS-involved children, or only a subset for whom DCFS has been granted custody? Would the Department consider being more specific in identification of these children? If a child is in the care of DCFS, and also is receiving SSI, or is also receiving services through DSCC, under which category would the child be risk adjusted?

**Answer:** *The Department has no clarifications to the categories of eligible members at this time. The Department will take this question under advisement as part of Round 2 Q&A related to Rates and the Financial Proposals.*

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**117. Question:** Within Attachment II, included in the categories of eligibles is "special needs children, defined as members under the age of 21 who are eligible for Medicaid through Supplemental Security Income (SSI), Division of Specialized Care for Children (DSCC), or a disability category of eligibility."

Eligibility isn't granted through DSCC. Which children are being referred to where the Contract specifies "children eligible through DSCC?"

**Answer:** *Children enrolled in the MFTD Waiver are included in the scope of this RFP. Contractors will be required to contract with DSCC to provide care coordination for this population. The Model Contract will be amended to reflect this change.*

---

**118. Question:** Can the Department reconsider the requirement to mandate the use of the Department's Preferred Drug List? This severely constrains the MCO's ability to manage cost and efficacy.

**Answer:** *No.*

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## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

**119. Question:** The provisions at Sections 5.3.12.1 and 5.3.12.2 of the Model Contract regarding reporting of drug units seem to be unrelated to the provision at 5.3.12, which addresses 340B requirements. Are these provisions related to 340B?

**Answer:** *Sections 5.3.12.1 and 5.3.12.2 of the Model Contract do not relate to 340B requirements and the Model Contract will be amended to reflect this change.*

---

**120. Question:** Will the State allow for populations outside of the families and children population and ACA adult enrollees to use NP's, PA's and APN's to act as a PCP as well as list these mid-level providers in the directory as a PCP?

**Answer:** *Yes. The Model Contract will be amended to reflect this change.*

---

**121. Question:** The Model Contract states that the Department may require Contractors to delegate credentialing services to a CVO identified by the Department. The Department shall provide ninety (90) days' notice, in writing, of this change. The Department retains the right to define the scope of services required to be provided by such a CVO.

Will the Department confirm that any CVO contracted for the required use of all plans will be an NCQA accredited CVO?

**Answer:** *The Department retains the right to perform this function.*

---

**122. Question:** Will the MCO be expected to have a single Member Handbook to service all member populations?

**Answer:** *Yes, the MCO will be expected to have a single Member Handbook but the Department is willing to consider other options proposed by the MCOs.*

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**123. Question:** Section 5.40.5 of the Model Contract requires an "Enrollee advisory and community stakeholder committee," and Section 5.40.9 requires a separate "Community Stakeholder Council."

## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

Is the Department requiring two separate committees, or is the "Community Stakeholder Council" separate from the "Enrollee Advisory and Community Stakeholder Committee?"

**Answer:** *These are two different committees. The Department will modify the names of the committee to make them more distinct in the model contract.*

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**124. Question:** Does Service package 1 or Service package 2 include Adult Dental Services? If so, what specific services are included?

**Answer:** *Service package 1 includes adult dental services. All covered services are described in 89 Ill. Adm. Code 140. Further detail on covered services can be found in the provider handbooks and Dental Office Reference Manual available on the Department's website.*

---

**125. Question:** Section 5.8.1.1.4 requires Pediatric Dentist access- Would it only require board certified pediatric dentists or would any dentist who agrees to provide services to children qualify?

**Answer:** *The Department will amend the Model Contract Section 5.8.1.1.4 to refer to dentists rather than pediatric dentists.*

---

**126. Question:** The model contract is not specific to a specific risk adjustment model – Is the plan to use the UCSD CDPS+Rx model for acute medical as is used in existing Illinois managed care programs? Will there be a separate model used for long term care services, and if so, what model will be used?

**Answer:** *The Department has no further guidance at this time and will advise Contractors of the methodology in advance of the risk adjustment calculation.*

---

**127. Question:** Will the department be changing the certified rates to accommodate any changes in eligibility or benefit design, such as removal or inclusion of certain member types, removal or inclusion of new benefits, or changes in pharmacy requirements? This can be in relation to potential ACA changes as well as other non-ACA related changes.

## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

**Answer:** *This question will be addressed as part of Round 2 Q&A related to Rates and Financial Proposals.*

---

**128. Question:** Will Managed Care Community Networks (MCCNs) and/or government-owned entities be subject to a separate risk adjustment process to reflect their different funding?

**Answer:** *This question will be addressed as part of Round 2 Q&A related to Rates and Financial Proposals.*

---

**129. Question:** “Actuarially sound” is defined as providing for all “attainable costs.”

How will withhold experience be included in this? Will the greatest amount of withhold achieved by any one MCO be used as the standard as part of the revenue calculation?

**Answer:** *This question will be addressed as part of Round 2 Q&A related to Rates and Financial Proposals.*

---

**130. Question:** How will P4P work for current plans that are now covering new populations. Will the withholds vary by population or be uniform by Contractor?

**Answer:** *To be determined.*

---

**131. Question:** Will the State please provide details of the Pay For Performance Program for calendar year 2018?

**Answer:** *To be determined.*

---

**132. Question:** In Section 7.10.1 of the Model Contract, will the 85% loss ratio be applied to all populations being served by the contractors and will the MLR calculation be allowed to be combined for all products?

## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

**Answer:** *The MLR will be calculated at the contract level for all covered populations.*

---

**133. Question:** Will the state provide a specific MLR methodology including the potential use of NAIC Reporting Standards prior to the beginning of the new contract?

**Answer:** *Yes.*

---

**134. Question:** The Model contract states "The Department retains the right to adjust the minimum medical loss ratio in adherence to 42 CFS §438.8."

Under what circumstances would the Department foresee changing the MLR? Can the State confirm that the MLR requirement will not change during the first year of the contract?

**Answer:** *The Department has not contemplated the circumstances but reserves the right. The Department confirms that the MLR requirement will not change in the first year.*

---

**135. Question:** In Section 7.10.3.3 of the Model Contract, why are the contractors only allowed nine months to pay out value based and incentive payments? Since some of these arrangements are dependent on Contractor Revenue and P4P reimbursements, this does not allow the contractors adequate time to settle their liabilities if premium payments are not properly made or delayed.

**Answer:** *To achieve the provider behavior and structural changes expected from value based payments, the Department believes the payments must be as timely as possible.*

---

**136. Question:** In Sections 7.11.8 - 7.11-9 of the Model Contract, why was the runout changed to nine months for MLR calculation versus 12 months of runout in the current contract?

**Answer:** *This change was made as part of the process of harmonizing terms across contracts from the current managed care programs.*

---

## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

**137. Question:** Please explain what is meant in Section 7.11.9 of the Model Contract regarding subcapitation runoff.

**Answer:** *This exclusion of sub-capitation paid during the run-out month assumes the subcapitation is paid for the current year and not the Coverage Year.*

---

**138. Question:** Will the State please provide clarification on "recoveries outside of services covered by this contract?"

**Answer:** *The specific language quoted in the question cannot be found on page 118. If the question is regarding Section 7.21, "Recoveries from Providers", this Section relates to Providers who have received established overpayments from the Department and who are receiving payments from Contractor for services provided pursuant to the Contract.*

---

**139. Question:** In order to ensure consistency amongst the various MCO's will the state be providing a template for the information security program?

**Answer:** *No, not as part of this RFP.*

---

**140. Question:** Please confirm that the disclosure requirements specified in Model Contract section 9.2.34 are not due upon submittal of the RFP, but rather only upon Execution of the Contract or within thirty-five days after a change occurs.

**Answer:** *All requirements for submission of a Proposal are outlined in the RFP. Additional requirements included in the Model Contract are contingent upon contract award and execution.*

---

**141. Question:** Is the contractor required to contract directly with individual providers, e.g. Personal Assistant, or solely with the fiscal agent/State?

**Answer:** *The Contractor must contract directly with the Individual Provider (IP). Timekeeping and payroll of the IP is performed by DHS-DRS. The Contractor then reimburses DHS-DRS for those expenses.*

---

## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

**142. Question:** On this page, please confirm whether or not the columns within the last row, for Nursing Facility Services over the first ninety (90) days, was intentionally left blank.

**Answer:** *Yes, this was intentionally left blank. Nursing Facility Services over the first 90 days was added to the chart to reflect that these services are part of Service Package II Covered Services. The first 90 days of Nursing Facility Services are included in Service Package I.*

---

**143. Question:** What involvement will selected MCOs have in the planning, design, and development of the IHH model?

**Answer:** *While design of the Integrated Health Home program is already underway (please see response to Question #2), the Department intends to partner with MCOs who receive a Contract as a result of this RFP in the further development and implementation of the model.*

---

**144. Question:** What is the State's vision for reducing the MCO auto enrollment timeframe for the justice involved population?

**Answer:** *The Department has no further information on this topic at this time.*

---

**145. Question:** How will the Department's encounter process support MCO innovative value based provider arrangements with community based non-Medicaid providers like AAAs, YMCA, CTA, ride-sharing entities, etc.?

**Answer:** *The Department has no further information on this topic at this time.*

---

**146. Question:** Please provide an update to the filed 1115 Waiver and State Plan Amendments (SPA). If the SPA documents are not approved, please provide a copy of what was submitted to CMS so we can develop the benefit integration strategy with providers.

**Answer:** *RFP Appendix III represents the current version of the filed 1115 Waiver, which may also be found at: <https://www.illinois.gov/hfs/info/1115Waiver/Pages/default.aspx>.*

## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

*The only information on the SPAs available at this time is contained in RFP Appendix IV.*

---

**147. Question:** Per DCFS - what is the definition of an Initial Health Screening?

**Answer:** *The initial health screening shall be an unclothed physical examination to identify and treat as medically appropriate immediate health needs, document child abuse and neglect, identify communicable and contagious disease, provide medical information for informed placement and any necessary immediate referrals, and meet defined documentation and reporting requirements.*

---

**148. Question:** Do physicians need specialized training in caring for DCFS youth in care to perform the Initial Health Screening?

**Answer:** *Physicians do not require specialized training in caring for DCFS youth, but shall be trained in the care of children (e.g., pediatrics or family medicine), including how to recognize and document of signs of child abuse.*

---

**149. Question:** Will the Integrated Assessment and IM-CANS be repeated every 6 months?

**Answer:** *The IM-CANS is still in development. The current CANS, used by child welfare staff, will be completed at benchmarks in accordance with DCFS rule and procedure. The Integrated Assessment is completed when a case is opened. It is updated as needed, or, at a minimum, every six months through the assessment questions in the service plan.*

---

**150. Question:** Are nurse practitioners allowed to perform Initial Health Screenings?

**Answer:** *Yes, so long as they are trained in the care of children (e.g., pediatrics or family medicine), including how to recognize and document of signs of child abuse.*

---



## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

**151. Question:** Do physicians need specialized training in caring for DCFS youth in care to perform the Comprehensive Health Evaluation?

**Answer:** *Comprehensive health evaluations shall be conducted by a physician who has specialized training in pediatrics or family practice.*

---

**152. Question:** Will it be expected that the Child and Family Team meet every 90 days?

**Answer:** *Per DCFS procedure 315.110/.115/.120, the 14 day (Initial) Child and Family Team is held approximately 14 days after protective custody is taken. The 40-Day Child and Family Team meeting occurs approximately 40 days from protective custody. Child and Family Team Meetings shall be held at quarterly intervals throughout the life of the case. The first Quarterly Child and Family Team Meeting should occur approximately 90 days after case opening, and subsequent meetings shall be held quarterly, with every second meeting timed to occur before the next scheduled Administrative Case Review.*

---

**153. Question:** Will PCPs be expected to undergo specialized training to care for DCFS youth in care?

**Answer:** *Physicians do not require specialized training in caring for DCFS youth, but shall be trained in the care of children (e.g., pediatrics or family medicine), including how to recognize and document of signs of child abuse.*

---

**154. Question:** If the Care Coordinator is an independent entity contracted by the MCO, will DCFS SACWIS system access be allowed?

**Answer:** *No.*

---

**155. Question:** In Section 1.2.3 of the RFP, the RFP states that “Offerors shall not discuss, directly or indirectly, the solicitation or any Proposal with any State officer or employee other than the Solicitation Contact”. Did the Department intend to restrict discussions regarding the RFP with all State officers and employees or only those individual employees who, by the nature

## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

of his or her duties, has the authority to participate personally and substantially in the decision to award the State contract under the RFP?

**Answer:** *Section 1.2.3 of the RFP is correct. Offerors shall not discuss, directly or indirectly, this solicitation or any Proposal with any State officer or employee other than the Solicitation Contact.*

---

**156. Question:** In Section 1.2.3 of the RFP, the RFP states that “Offerors shall not discuss, directly or indirectly, the solicitation or any Proposal with any State officer or employee other than the Solicitation Contact”. Did the Department intend to restrict Offerors from communicating with legislators on routine matters relating to the provision of healthcare to underserved minority populations?

**Answer:** *No. Section 1.2.3 of the RFP pertains to this solicitation and any Proposal developed in response to this solicitation.*

---

**157. Question:** Will the State please provide a copy of the Offeror attendance sign in sheet for each attendee of the Offeror Conference (Round 1) or a list of those Offerors that attended and completed the attendance sheet?

**Answer:** *A list of the potential offerors that attended the Vendor's Conference has been posted on HFS' website.*

---

**158. Question:** 1.13 - The RFP requires proposers to submit a Proposal Bond of \$100,000 and a Performance Bond of \$1,000,000. Are government-owned plans required to submit the proposal and performance bond?

**Answer:** *Yes.*

---

**159. Question:** Please confirm whether the State is willing to consider waiving the bond requirements described at section 1.13 for Offerors that are large, publicly traded corporations.

**Answer:** *No.*

## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

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**160. Question:** For the minority, female, and persons with disability Business Enterprise Program (BEP) utilization goal of 20 percent of the administrative portion of the capitation payments, would spend for medical items such as durable medical equipment (DME) apply towards the goal?

**Answer:** *Payments to subcontractors who are BEP certified vendors are applicable.*

---

**161. Question:** Due to limited BEP certified vendors providing services that MCOs use, many health plans outsource jobs to certified staffing agencies rather than creating higher paying jobs with benefits. In light of this, will the state consider payroll and benefits costs related to women, disabled, and minority full-time employees to count toward the BEP goal stated in RFP Section 1.16?

**Answer:** *In order to be considered under the BEP goal, the vendor must be certified as a BEP subcontractor.*

---

**162. Question:** Is it permissible for the health plans currently contracted with IDHFS to utilize existing BEP LOIs for this procurement? If not, please provide the membership number that should be used to assign BEP utilization percentages.

**Answer:** *New Letters of Intent (LOIs) must be submitted with the Offeror's proposal along with a new BEP Utilization Plan.*

---

**163. Question:** To allow for new entrants, and given the short timeframe between RFP release and contract award (less than four months), would the State consider revising Section 1.20.1 to read “..Offeror shall meet one of the following within 90 days after date of contract award and for the entire duration of the proposed contract period”?

**Answer:** *No.*

---

## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

**164. Question:** What will be the process/criteria for a “phased approach to implementation of the program” if the state elects the option for a phased in approach?

**Answer:** *The phased approach reserved in the RFP Section 2.7.1 is further defined in the RFP Section 2.7.2. No other process or criteria is defined at this time.*

---

**165. Question:** Please clarify whether children covered under the medically fragile/technology dependent waiver are covered pursuant to this Model Contract as outlined in section 2.3.1.6 of the RFP.

**Answer:** *Children enrolled in the MFTD Waiver are included in the scope of this RFP. Please refer to Question #61 regarding shift nursing. The Model Contract Attachment II will be amended to include MFTD Waiver services as covered services under Service Package II.*

---

**166. Question:** Section 1.12.1 of the RFP states that Offerors' Proposals shall remain firm for 180 days from opening. According to the RFP timeline, the proposal submission deadline is May 15, 2017, and the opening of financial proposals is June 26, 2017.

Please clarify the date from which the 180 days begins accruing.

**Answer:** *The 180 days begins at the time the proposals are opened, which is May 15, 2017.*

---

**167. Question:** Section 1.9 of the RFP sets forth a protest process indicating that protests should be filed to DHFS; section 1.12.9, however, states that "Offeror must bring any action relating to this solicitation in the appropriate court in Illinois." Please clarify whether protests submitted as a result of this RFP should be initially submitted with the DHFS and whether disappointed Offerors will be required to exhaust the process outlined in section 1.9 before bringing action in the appropriate Illinois court, or, whether disappointed Offerors may proceed directly to the appropriate Illinois court.

**Answer:** *The Department's protest process is outlined as intended in the RFP Section 1.9.*

---

**168. Question:** What are the other criteria that will be used to determine the Option A awardee for the DCFS Youth contract?

## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

**Answer:** *This process is fully elaborated in sections 2.6.2.1 and 3.5.*

---

**169. Question:** If a vendor has filed for Illinois Medicare-Medicaid Alignment Initiative (MMAI) expansion for 2018, will the outcome of the RFP drive the State's approval?

**Answer:** *This RFP does not include MMAI.*

---

**170. Question:** RFP Section 2.2.7 references combining the three current managed care programs (ICP, FHP/ACA, and MLTSS). Will MCOs be required to report quality improvement metrics (CAHPS/HEDIS) across all three of these populations separately, or will this RFP integrate all populations in to a singular reporting demographic for quality improvement scoring?

- What HEDIS benchmarks will be used to evaluate quality performance based on this integration of lines of business?
- Will there be separate benchmarks for both the ICP and FHP/ACA population?
- Will there be separate quality indicators, similar to the current program, or will new integrated performance metrics be chosen that are relevant to both populations?
- Will there be separate quality measures related to the addition of the Special Needs Children population?

**Answer:** *Quality measures will be similar to the current MCO measures. Offerors should plan on separate reporting by population but not assume those populations will be the same groupings as the current separate programs.*

---

**171. Question:** For existing MMAI plans that do not bid or are not awarded a contract during this procurement what happens to their ICP membership?

**Answer:** *Any current MCO in the ICP program that does not get an award under the RFP will have its ICP contract terminated and its enrollees re-assigned pursuant to Section 4.4.1 of the Model Contract.*

---

## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

**172. Question:** Regarding RFP Section 2.2.8, are non dual adults receiving LTSS included in this RFP?

**Answer:** *Any non-dual adult receiving LTSS would be included if their eligibility category is included (FHP, ACA or AABD).*

---

**173. Question:** Section 2.3, Population Coverage, of the RFP indicates that children who are eligible for Medicaid through DSCC will be included in the populations served under the contracts resulting from this RFP. Eligibility for Medicaid is not granted through DSCC.

Can the Department clarify what is meant by "children who are eligible for Medicaid through DSCC?"

**Answer:** *Children enrolled in the MFTD Waiver are included in the scope of this RFP. Contractors will be required to contract with DSCC to provide care coordination for this population. The Model Contract will be amended to reflect this change.*

---

**174. Question:** Will the State consider more than one MCO to cover DCFS Youth?

**Answer:** *No.*

---

**175. Question:** Will the State continue to cover the expansion population at the regular FMAP rate, if the American Health Care Act is passed and the enhanced FMAP for the expansion population is eliminated?

**Answer:** *The Department has no additional information at this time.*

---

**176. Question:** 2.3.1.6 Although this section says "eligible for Medicaid through SSI or DSCC" can we assume it means "eligible for Medicaid and SSI or DSCC services?"

**Answer:** *Yes.*

---

## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

**177. Question:** 2.3.1.6 Can you confirm that children enrolled in the MFTD waiver will be enrolled in plans and not care coordinated by DSCC?

**Answer:** *Children enrolled in the MFTD Waiver are included in the scope of this RFP. Contractors will be required to contract with DSCC to provide care coordination for this population. The Model Contract will be amended to reflect this change.*

---

**178. Question:** Section 2.4 requires us to have a network that provides all covered Medicaid services. When will the state provide a comprehensive file of all Medicaid providers in the state, including provider Tax Identification Number, NPI and Medicaid ID along with provider type and specialty?

**Answer:** *The Department intends to make available a Provider Extract File in the near future to Potential Offerors who attended the Mandatory Round 1 Offeror's Conference. The Department will contact Potential Offerors regarding this file via the contact information provided at the Offeror's Conference.*

---

**179. Question:** Will the State please clarify the renewal options for this contract. The Proposal states "options to renew the contract twice in increments of two (2) years" while the Model Contract states in section 8.2 Renewal "8.2.1 one renewal covering the entire renewal allowance, 8.2.2 individual one-year renewals up to and including the entire renewal allowance, 8.2.3 any combination of single- and multi-year renewals up to and including the entire renewal allowance"

**Answer:** *The RFP will be amended to reflect the same language as the Model Contract.*

---

**180. Question:** How will the State decided between three and five contractors, and what criteria will be used to make that decision?

**Answer:** *The scoring, evaluation criteria and process have been fully elaborated in sections 3, 4, 5 and 6 of the RFP.*

---

## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

**181. Question:** Which Illinois State agency determines an organization's (Offeror's) status as a "Minority-owned organization?"

**Answer:** *The definition is provided in Appendix II of this RFP and the instructions for Offerors who elect to submit a Proposal for Proposal Option B are provided in Section 3.5 and Form for Submission II.*

---

**182. Question:** Given the concentration of DCFS children in Cook County, will HFS consider allowing option B bidders the opportunity for a second DCFS contract for Cook County only?

**Answer:** *No.*

---

**183. Question:** 2.7.2.2 - When will Enrollees receive notice of their choice period?

**Answer:** *Refer to Section 4.4 and 4.5 of Appendix I, Model Contract.*

---

**184. Question:** Per RFP Section 2.6.2.1, can Offerors determine if they wish to bid on DCFS Youth, or will the State select one without input?

**Answer:** *HFS has no additional details to share on the selection process for the separate Contract for DCFS Youth. All Offerors must comply with the proposal and submission requirements provided in the RFP.*

---

**185. Question:** Per RFP Section 2.7, what does the Department anticipate the implementation schedule to be for areas and populations new to managed care? Will new populations be enrolled simultaneously with the geographical roll-out?

**Answer:** *Refer to Section 2.7 of the RFP.*

---



## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

**186. Question:** With regards to HFS' anticipated phased implementation schedule, please provide the expected timing of enrollment activity by population and region (or more granular levels, if available).

**Answer:** *Refer to Section 2.7 of the RFP.*

---

**187. Question:** When will the State provide an implementation timeline for 4/1/18 - 12/31/18?

**Answer:** *Refer to Section 2.7 of the RFP.*

---

**188. Question:** For Option B, the Department specifically restricts potential Offerors to those Offerors that are either a Government-owned organization or a Minority-owned organization, as defined in Appendix II of the RFP. In requesting bids for Option B, did the Department intend to exclude not-for-profit entities that are not Government-owned, such as Family Health Network, Inc., a non-profit MCO owned by five (5) premier safety net hospitals in Chicago?

**Answer:** *The Department drafted the RFP to best serve the needs of Illinois citizens enrolled in the Medical Assistance Program.*

---

**189. Question:** For Option B, the Department specifically restricts potential Offerors to those Offerors that are either a Government-owned organization or a Minority-owned organization, as defined in Appendix II of the RFP. In requesting bids for Option B, did the Department intend to exclude those entities that are owned by women and/or persons with a disability (as those terms are defined in the Illinois Business Enterprise for Minorities, Females, and Persons with Disabilities Act, 30 ILCS 575/1 et. seq)? Did the Department also intend to exclude not for profit entities that have a mission to serve under represented, minority residents of Cook County, where those not for profit entities have demonstrated a commitment to concentrate their resources back into the minority communities they serve?

**Answer:** *The Department drafted the RFP to best serve the needs of Illinois citizens enrolled in the Medical Assistance Program.*

---

## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

**190. Question:** In limiting potential Offerors for Option B to those Offerors that are either a Government-owned organization or a Minority-owned organization, did the Department conduct a disparity study with respect to the State's history of awarding risk-based contracts for the Medicaid Managed Care Program to organizations owned by minorities, as such term is defined in Appendix II of the RFP? Alternatively, did the Department consider other anecdotal evidence in its determination to limit the potential Offerors for Option B to those Offerors that are either a Government-owned organization or a Minority-owned organization? Will the Department make such study and/or evidence available to Offerors?

**Answer:** *The Department drafted the RFP to best serve the needs of Illinois citizens enrolled in the Medical Assistance Program.*

---

**191. Question:** Has the Department previously considered and/or implemented any Medicaid Managed Care Program contracting opportunities tailored to be more accessible to minority-owned organizations?

**Answer:** *No.*

---

**192. Question:** For both Option A and Option B, does the Department prohibit a MCO from contracting with another MCO to form a joint venture to provide the services under the State's Medicaid Managed Care Program?

**Answer:** *No.*

---

**193. Question:** Section 2.3, Population Coverage, of the RFP does not include individuals covered under programs funded with State-Only funds.

Will those populations be excluded from coverage under the contracts resulting from this RFP?

**Answer:** *Funding source is not a criteria for coverage.*

---

**194. Question:** Section 2.6.1 of the RFP states that the initial contract term is four years, "with options to renew the contract twice in increments of two (2) years."

## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

Article VIII, sections 8.2.1, 8.2.2, and 8.2.3. of the Model Contract state that the four total renewal years may be exercised in one of three ways: (1) one renewal covering the entire four-year renewal allowance; (2) individual one-year renewals up to and including the entire renewal allowance; and (3) any combination of single and multi-year renewals up to and including the entire renewal allowance. Please clarify whether there will be two options to renew in increments of two years as set forth in section 2.6.1 of the RFP or whether the renewal options set forth in Model Contract section 8.2 apply.

**Answer:** *The RFP will be modified to reflect the same language as the Model Contract.*

---

**195. Question:** Please provide additional detail on how proposals will be evaluated for the separate contract for DCFS Youth.

**Answer:** *HFS has no additional details to share on the selection process for the separate Contract for DCFS Youth. All Offerors must comply with the proposal and submission requirements provided in the RFP.*

---

**196. Question:** Following the selection of Offerors, does the Department intend to prohibit existing MCOs that are not selected through the RFP process from entering into a business transaction that could include the acquisition, sale or transfer of membership?

**Answer:** *No.*

---

**197. Question:** Should Offerors provide an electronic copy of the redacted proposal in addition to the electronic copy requested?

**Answer:** *Offerors may provide an electronic copy of the redacted proposal. If providing an electronic copy, the redacted proposal should be delivered on a separate USB from USB A and USB B and clearly labeled as such.*

---

**198. Question:** RFP Section 3.4.3.2 references Form for Submission IV in regards to the Proposal to the State of Illinois form.

Does the Department mean Form for Submission II?

## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

**Answer:** *Yes. The RFP will be amended to reflect this change.*

---

**199. Question:** Section 3.3.10 specifies “font 12-point Times New Roman” Is it permissible to use a smaller yet readable font for graphics, diagrams, tables, headers/footers, and organization charts (such as 9pt Arial)?

**Answer:** *Graphics, diagrams, tables, and organizational charts may be submitted with a smaller yet readable font, but no smaller than 9pt Arial.*

---

**200. Question:** Will the State please confirm Offerors are permitted to transfer the technical proposal prompts to the Offeror's standard proposal templates modified to align with the requirements as outlined in 3.4.1.

**Answer:** *Yes.*

---

**201. Question:** Will the State please provide any mandatory elements that should be included within the transmittal letter?

**Answer:** *All specifications are provided in Section 3.4.3.*

---

**202. Question:** Will the State please provide format requirements for graphics including tables and charts Offerors may include within the proposal?

**Answer:** *Graphics, diagrams, tables, and organizational charts may be submitted with a smaller yet readable font, but no smaller than 9pt Arial.*

---

**203. Question:** Please confirm whether the State will permit submission of graphics on 11" x 17" paper folded to 8.5" x 11".

**Answer:** *No.*

## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

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**204. Question:** Please clarify whether the Times New Roman, 12-point font and size requirement is applicable to graphics, organizational charts, system diagrams, and tables the Offeror may choose to include, or whether the Offeror is permitted to use an alternative font and size for such items.

**Answer:** *Graphics, diagrams, tables, and organizational charts may be submitted with a smaller yet readable font, but no smaller than 9pt Arial.*

---

**205. Question:** Who will be responsible for evaluating RFP responses and what qualification and experience will the evaluators have? How will potential conflicts of interest be avoided?

**Answer:** *At the Department's discretion, the evaluators will be chosen based on their expertise, and conflicts of interest will be avoided.*

---

**206. Question:** Will proposals be evaluated individually by assigned evaluation committee member section or will the evaluation occur in a collaborative setting allowing evaluators to discuss the review?

**Answer:** *The proposals will be evaluated individually.*

---

**207. Question:** What variables will contribute to the scoring for: the Offeror profile, the network, the oral presentation, clinical quality and behavioral health integration, LTSS, and IT?

**Answer:** *The scoring, evaluation criteria and process have been fully elaborated in sections 3, 4, 5 and 6 of the RFP.*

---

**208. Question:** Section 3.5.5.3 provides that the state reserves the right to assign a Fail rating on the Offeror Profile (section 4.2) for ... "any instance of placement into a Corporate Integrity Agreement" (CIA) but it is unclear where in Section 4.2 such information should be disclosed.

## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

Should such agreements be reported in response to section 4.2.3.3.? Where should a CIA related to a Medicare contract be disclosed?

**Answer:** *The RFP will be amended to clarify where such information shall be disclosed.*

---

**209. Question:** Section 3.5.5.3 of the RFP indicates that the State “reserves the right to assign a ‘Fail’ rating on the Offeror Profile” for, among other things, certain types of litigation, placement into a Corporate Integrity Agreement or Securities and Exchange Commission enforcement actions. Please confirm that the State will exercise this right, if at all, consistently with respect to all proposals received in response to the RFP.

**Answer:** *This is fully elaborated in section 3.5.5.3.*

---

**210. Question:** Per RFP Section 3.5.5.3, will Offerors receive a “fail” rating if they (or their parent) have had a fine or settlement of more than \$50 million from the federal or state government?

**Answer:** *This is fully elaborated in section 3.5.5.3.*

---

**211. Question:** Will the Department provide an agenda for the Oral Presentation at the same time Offeror is notified to present?

**Answer:** *HFS will provide additional details for the Oral Presentation at the time the Offeror is invited to provide an Oral Presentation.*

---

**212. Question:** Upon selection for oral presentation will the Department be prescriptive on the area of expertise and limit of the number of attendees by each Offeror?

**Answer:** *HFS will provide additional details for the Oral Presentation at the time the Offeror is invited to provide an Oral Presentation.*

---

## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

**213. Question:** Are addendums and/or attachments included in the page count limits of each section?

**Answer:** *In order to be considered in the scoring, all content that is part of the response to the prompts in RFP Section 5 must be included in the appropriate location and subjected to the page limits for that section. Other addendums or attachments may be provided but will only be evaluated based on the criteria outlined in Section 3.*

---

**214. Question:** What variables will affect the score for the Technical proposal?

**Answer:** *The scoring, evaluation criteria and process have been fully elaborated in sections 3, 4, 5 and 6 of the RFP.*

---

**215. Question:** What scoring criteria will HFS use to evaluate the oral presentation related to the vignettes?

**Answer:** *HFS will provide additional details for the Oral Presentation at the time the Offeror is invited to provide an Oral Presentation.*

---

**216. Question:** What variables will be used for scoring the Financial proposal?

**Answer:** *The full details and evaluation criteria for the Financial Proposal are described in Section 6 and will be further elaborated in the forthcoming Data Book and Financial Proposal template.*

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**217. Question:** Section 4.1.1.2 asks bidders to provide a balance sheet "as of the end of the month immediately preceding the month in which the Proposal is submitted." With proposals due May 15, 2017, this would be a balance sheet as of April 30, 2017. This timing is not realistic given that bidders need to allow for production time, shipping, etc. May bidders instead submit a balance sheet as of March 31, 2017, the end of the first quarter of calendar year 2017?

**Answer:** *Section 4.1.1.2 of the RFP will be amended to the following: A balance sheet for the end of March 2017.*

## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

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**218. Question:** 4.1.1.5 - MLR definition in the RFP is different from the one used by HFS in the current contracts, as well as the one provided in the model contract. Will HFS accept a plan's prior MLR, as calculated by current contractual definitions?

**Answer:** *The Offeror may provide a plan's prior MLR as calculated by current contractual definitions, or an alternative generally-accepted MLR calculation, so long as the Offeror provides a clear definition and description of the methodology used in its calculations.*

---

**219. Question:** 4.1.1.5 - Please define 'total medical and hospital costs' noting what can be included (e.g. care coordination, IBNP, P4P).

**Answer:** *The Offeror may provide a plan's prior MLR as calculated by current contractual definitions, or an alternative generally-accepted MLR calculation, so long as the Offeror provides a clear definition and description of the methodology used in its calculations.*

---

**220. Question:** Per RFP Section 4.1.1.6, can the State define the calculation of “net underwriting gain?”

**Answer:** *Please refer to the Illinois Insurance Code (315 ILCS 5/ et. Seq).*

---

**221. Question:** Per RFP Section 4.1, are there any page limitations to the financial proposal?

**Answer:** *Offerors must use the forthcoming Financial Proposal Template to submit their Financial Proposals. Additional questions may be asked as part of Round 2 Q&A.*

---

**222. Question:** Per RFP Section 4.1.1.1, 2016 financial statement close between April and May.

Does the State wish to see Statements from 2015 & 2016? Or would Statements from 2014 & 2015 be sufficient?

**Answer:** *Financial Statements from 2014 & 2015 will be sufficient.*



## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

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**223. Question:** Per RFP Section 4.1.1.2, does the State wish to see the balance sheet from April since the proposal is due in May? Or would the balance sheet from March be sufficient?

**Answer:** *Section 4.1.1.2 of the RFP will be amended to the following: A balance sheet for the end of March 2017.*

---

**224. Question:** Per RFP Section 4.1.1.6, does the State just want to see a local health plan's financial information, or is the Department requesting the financial information of the parent company as a whole?

**Answer:** *See section 4.1.1.*

---

**225. Question:** Does reference to "Medicaid Lines of Business" include MMP/MMAI products?

**Answer:** *Yes.*

---

**226. Question:** Please confirm that failure to win a reprourement is not a "non-renewal" of a contract for purposes of Section 4.2.3.4.

**Answer:** *Correct.*

---

**227. Question:** Specific to RFP requirement 4.2.3.1, is HFS looking for a the Medicaid state program relevant contact to be an internal plan employee or a contract within the Department administering the program?

**Answer:** *Contact information is required for all such contracts specified in Section 4.2.3. This contact must be an individual employed by the State with which the Offeror has contracted.*

---

## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

**228. Question:** Will the State please provide a definition of "materiality" of litigation that must be reported?

**Answer:** *Any litigation that, according to generally accepted accounting principles, is deemed significant to an applicant's financial health and would be required to be referenced in the applicant's annual audited financial statements, report to shareholders or similar documents.*

---

**229. Question:** Is it the Department's expectation for all litigation categories to be reported on?

**Answer:** *All categories of material litigation in 4.1. and 4.2.*

---

**230. Question:** Will the State please describe what is defined as "relevant" details?

**Answer:** *All information and documentation reasonably believed to be associated with reporting requirements under 4.1 and 4.2.*

---

**231. Question:** Does reference to "any Medicaid managed care contracts" include MMP/MMAI products?

**Answer:** *Yes.*

---

**232. Question:** Section 4.2.2.7 of the RFP requests information regarding pending and past litigation against the Offeror. Please confirm that the disclosure required by this section is limited to information regarding the bidding entity only, and that information from affiliate and parent organizations of the Offeror is not required for purposes of this section, even if parent and affiliate organizations are discussed in response to other subsections of section 4.2 or elsewhere in the Offeror's proposal response.

**Answer:** *Language of Section 4.2.2 will be clarified. The submitted proposal must include information regarding the Offeror, its parent organization and any affiliate organizations.*

---

## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

**233. Question:** Section 4.2.2.7 of the RFP asks for "material, pending litigation" and "all such litigation within the past (10) years." Please confirm that "litigation within the past 10 years" requested is also limited to material litigation.

**Answer:** *Confirmed.*

---

**234. Question:** Section 4.2.2.7 of the RFP requests information about "material, pending litigation against the organization." That section further asks Offerors to provide specified information if any "pending litigation exists that the organization believes could reasonably have an adverse effect on the organization's financial condition," including an "opinion of counsel addressing whether and to what extent it would impair the Offeror's performance in a contract pursuant to this RFP." Given this language, please confirm that the definition of "material" for purposes of this litigation disclosure is whether the organization believes the litigation "could reasonably have an adverse effect on the organization's financial condition" such that it would "impair the Offeror's performance in a contract pursuant to this RFP."

**Answer:** *Confirmed.*

---

**235. Question:** If DHFS's response to another question submitted by this Offeror indicates that section 4.2.2.7 of the RFP extends to affiliate and parent organizations of the Offeror, please confirm that, consistent with the disclosures required in section 4.2.3, section 4.2.2.7 is also limited to information from parent organizations' or affiliate organizations' Medicaid line of business only.

**Answer:** *Section 4.2.2 refers to all lines of business of the Offeror, its parent organization and any affiliate organizations. Section 4.2.3 refers to Medicaid managed care contracts in state programs only.*

---

**236. Question:** For RFP Section 4.2.5, please clarify the definition of "public sector organizations".

**Answer:** *An institution of government at any level.*

---

## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

**237. Question:** For RFP Section 4.2.5, will the Department be contacting the References submitted for this section? If so, is there an anticipated timeframe in which this will be done?

**Answer:** *See Section 4.3.1. HFS reserves the right to contact any organizations or individuals listed any time between the submission of a Proposal and the announcement of an Award.*

---

**238. Question:** Can a specific definition of ‘procuring agencies’ be provided? For example, if an Offeror has a contract to serve the Department of Medicaid in a particular state that was officially procured through the Department of Procurements in the same state, which of those departments is considered a procuring agency? Additionally, If an Offeror has a contract to serve the Department of Medicaid in a particular state, can the Department of Behavioral Health in that same state provide a public sector reference?

**Answer:** *Yes, any individual that has first-hand knowledge of the contract's scope of services, populations covered and the contract term is acceptable to use as a reference contact.*

---

**239. Question:** What specific specialties should be included under these provider types; Affiliated Hospitals, health centers, PCPs, behavioral health providers, pharmacies, dentists (including oral surgeons), and ancillary providers in the summary listing for 4.2.6? (For example, Provider Type PCP – Specialties: General Practice, Family Practice, Internal Medicine, Geriatrics, OB/GYN; Provider Type Hospital – Specialties: Critical Access Hospital, General Hospital, Long Term Acute Care Hospital, Pediatric Hospital, Psychiatric Inpatient Hospital, Rehabilitative Hospital, etc.)

**Answer:** *The Offeror must include the primary specialty of each provider.*

---

**240. Question:** In reference to section 4.2.6.2, would the State prefer a "provider type" column be added to designate Affiliated Hospitals, health centers, PCPs, behavioral health providers, pharmacies, dentists (including oral surgeons), and ancillary providers?

**Answer:** *The provider file from the Department to the Offerors will include the Medicaid ID number, Provider Type and Category of Service for all Medicaid enrolled providers. This information must be included in the Provider Network submission. The RFP will be amended to reflect these requirements.*

---

## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

**241. Question:** Are providers allowed to be listed more than once to accommodate for multiple practice locations and multiple specialties?

**Answer:** *Only if they are enrolled such that they have separate Medicaid Provider IDs for each location.*

---

**242. Question:** Would the State please clarify that the Offeror is to submit a summary listing of the provider network information in Microsoft Excel format on the USB A only and not within the technical proposal in Box A? If this is to be submitted within the Technical Proposal please provide detailed instructions on how and where this should be included.

**Answer:** *The provider network shall be included both electronically on USB A and in hard copy in Box A. The provider network table shall be included in Tab 2 as described in RFP Section 3.4.4.*

---

**243. Question:** Are bidders permitted to provide additional letters of recommendation as supplemental appendices that do not count towards the page limits of the RFP, as evidence of qualification for providing the services as outlined within the contract?

**Answer:** *Additional references will not be considered in the evaluation of Proposals.*

---

**244. Question:** In Section 4.2.6.2, Please clarify what constitutes a "Pending Contract."

**Answer:** *A pending contract is an agreement with specific terms that is in the negotiations stage, but has not yet been signed. It requires more than simply offering a contract to the Provider.*

---

**245. Question:** RFP Section 4.2.6.2 requires that the data should be submitted in a Microsoft Excel format including the following fields: provider last name, provider first name, provider specialty, provider address, provider county, NPI, provider tax ID, and level of commitment ("Letter of Intent," "Pending contract," "Contract).

## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

If the provider services more than one county (such as a personal care provider), should we list the provider multiple times (one row for each county they serve) or one time with multiple counties listed in the county field?

**Answer:** *Please list each individual physical location of the provider as a unique row in the table.*

---

**246. Question:** Sections 4.2.6.1 and 4.2.6.2 require us to indicate the level of provider commitment as Letter of Intent, Pending Contract or Contract. Please clarify the definition of Pending Contract.

**Answer:** *A pending contract is an agreement with specific terms that is in the negotiations stage, but has not yet been signed. It requires more than simply offering a contract to the Provider.*

---

**247. Question:** Will the State need to review and approve the HCBS LOI document before use?

**Answer:** *No.*

---

**248. Question:** Will the State need to review and approve the HCBS base agreement and the payment appendix before use?

**Answer:** *No.*

---

**249. Question:** If the Department takes into consideration the providers submitted within this section will the Department assign a higher score to those providers listed as "Contract" and a lower score to those with either "Letter of Intent" or "Pending Contract"?

**Answer:** *The scoring, evaluation criteria and process have been fully elaborated in sections 3, 4, 5 and 6 of the RFP.*

---

**250. Question:** Will the State please define "Pending Contract"

## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

**Answer:** *A pending contract is an agreement with specific terms that is in the negotiations stage, but has not yet been signed. It requires more than simply offering a contract to the Provider.*

---

**251. Question:** Do diagrams count towards page limits?

**Answer:** *Yes, per Section 3.5.6.3 of the RFP.*

---

**252. Question:** Will the State please further define reference firm, government agency and organization as it pertains to Offeror references?

**Answer:** *See Section 4.2.5 of the RFP.*

---

**253. Question:** Section 4.1.1 requests financial documentation to be submitted.

Due to the length of audited financial statements, is it permissible to submit the requested financials in electronic-only format on the required USB?

**Answer:** *No.*

---

**254. Question:** Please clarify whether the non-compliance information required by RFP sections 4.2.3.3 and 4.2.3.5. is limited to the Offeror's Medicaid programs.

**Answer:** *Section 4.2.2 refers to all lines of business of the Offeror, its parent organization and any affiliate organizations. Section 4.2.3 refers to Medicaid managed care contracts in state programs only.*

---

**255. Question:** Please clarify whether using April 1, 2014 through April 1, 2017 is a responsive date range for reporting the issues of non-compliance as required by RFP sections 4.2.3.3 and 4.2.3.5.

**Answer:** *Yes.*

## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

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**256. Question:** Please clarify whether a template grid will be provided for reporting the issues of non-compliance as required by RFP sections 4.2.3.3 and 4.2.3.5, or whether the Offeror is permitted to assemble its own method of responding to these sections.

**Answer:** *The Offeror is permitted to assemble its own method of responding to these Sections.*

---

**257. Question:** When does the Department and/or State expect the requirements of the Integrated Health Home (IHH) program will be finalized and then subsequently released to the public, as indicated in Section 5.1.3.3? In the interim, could the Department provide to MCOs the specific activities, services, and other detailed requirements that are currently under consideration, as well as the likelihood that each requirement will ultimately be implemented?

**Answer:** *While the Integrated Health Home program design is not yet finalized, preliminary materials are available on the HFS web site at <https://www.illinois.gov/hfs/info/1115Waiver/Pages/1115WaiverMeetings.aspx>*

---

**258. Question:** Does HFS have an available crosswalk document between the RFP and the Model Contract?

**Answer:** *No.*

---

**259. Question:** 5.2.1.2 If a plan has only Illinois experience can you clarify that they should answer based on Illinois experience and that the fact that there only experience is in Illinois in itself does not disadvantage them compared to other bidders?

**Answer:** *Confirmed.*

---

**260. Question:** Please confirm that the definition of “subcontractor” in the subcontractor disclosures document is the definition of subcontractor applicable to section 5.2.1.3 and elsewhere in the technical proposal.



## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

**Answer:** *The definition of Subcontractor provided in RFP Appendix II Section 1.1.192 is the definition applicable to RFP Section 5.2.1.3 and elsewhere unless otherwise stated. The language of Form for Submission III, Subcontractor disclosures, will be amended to more closely align with this definition.*

---

**261. Question:** In Section 5.2.1.2, the State asks for relevant experience “in other states.” Is the State intentionally excluding incumbent descriptions of experience in Illinois?

**Answer:** *RFP Section 5.2.1.2 will be amended to include "relevant experience in Illinois and other states."*

---

**262. Question:** As care plans for complex members can be quite lengthy, please confirm that the example care plans requested for the vignettes are excluded from the section page limits.

**Answer:** *Example care plans are subjected to the page limits for each section. The Offeror may consider providing a summary care plan that highlights the most relevant details for each individual described in the vignettes.*

---

**263. Question:** RFP Section 5.2.2.2 states that "Appendix V contains details on the State's current vision for an IHH program." Appendix V talks about member assignment based on tiering.

Can the State detail who performs the risk assessment and tiers the member (the State or the MCO)? Is there a standard methodology that will be used and, if so, what is it?

**Answer:** *While the Integrated Health Home program design is not yet finalized, preliminary materials are available on the HFS web site at <https://www.illinois.gov/hfs/info/1115Waiver/Pages/1115WaiverMeetings.aspx>*

---

**264. Question:** Will the State please provide initial measurement guidelines for how it will measure "the program Effectively serving" those enrolled in an IHH, as well as measurements for effectiveness at each level of stratification?

## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

**Answer:** *While the Integrated Health Home program design is not yet finalized, additional preliminary materials are available on the HFS web site at <https://www.illinois.gov/hfs/info/1115Waiver/Pages/1115WaiverMeetings.aspx>*

---

**265. Question:** Please share the implementation prioritization of IHH across all populations including the transition of care coordination functions from MCOs to IHHs. Will the State please share the IHH certification and process?

**Answer:** *While the Integrated Health Home program design is not yet finalized, preliminary materials are available on the HFS web site at <https://www.illinois.gov/hfs/info/1115Waiver/Pages/1115WaiverMeetings.aspx>*

---

**266. Question:** 5.3.2.3 Please provide background on the ADT system the state intends to implement that is referenced?

**Answer:** *This will be developed in partnership with the MCOs and providers. The Department is interested in the experience of the Offerors and their commitment to the program.*

---

**267. Question:** The RFP references an ADT notice initiative at the State level, can HFS provide any specific detail on the ADT initiative?

**Answer:** *This will be developed in partnership with the MCOs and providers. The Department is interested in the experience of the Offerors and their commitment to the program.*

---

**268. Question:** The RFP references the requirements for the Offeror to promote the use of health information exchange (HIE) in Illinois, can HFS provide information on specific initiatives and standards that HFS is promoting?

**Answer:** *This will be developed in partnership with the MCOs and providers. The Department is interested in the experience of the Offerors and their commitment to the program.*

---

## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

**269. Question:** What is the expected turnaround time for "expediting authorization for immediate access?"

**Answer:** *As defined in the Model Contract section 5.19.7.*

---

**270. Question:** Can you clarify if "immediate access" also refers to medications that require a prior authorization? The current turn-around time for medication prior authorizations is 24 hrs.

**Answer:** *As defined in the Model Contract section 5.19.7.*

---

**271. Question:** In RFP Section 5.2.1.3, the language states, "Describe the plan to complete the duties of the contract in the event of contract termination."

Is the State referring to the MCO contract or a provider/sub-contractor contract?

**Answer:** *The Department is referring to the MCO Contract.*

---

**272. Question:** Can the State define which systems it refers to in RFP Section 5.2.3.1? This appears to be limited to enrollment, eligibility, and claims. Can the State confirm?

**Answer:** *This section is primarily referencing enrollment, eligibility, and claims. However, other technical interfaces and exchanges of data may be needed between a contractor and the State. The contractor must explain its ability to handle any interface and data exchange in a secure and HIPAA compliant manner.*

---

**273. Question:** Will the State please define "point to point interfaces"?

**Answer:** *A secure and HIPAA compliant data connection between the end point of the contractor and the end point of the State or any State designee.*

---

## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

**274. Question:** Regarding the "...descriptions demonstrate all exchanges of data among key production systems."

Does this include exchanges with trading partners?

**Answer:** *Yes.*

---

**275. Question:** Is it acceptable for the technical encounter data team to be located outside the State of IL?

**Answer:** *Yes.*

---

**276. Question:** Will the State please define a "static, secure, updated, and compartmentalized environment"?

**Answer:** *These are commonly understood technology terms which are intended to stand-alone in meaning to IT professionals. The Offeror should consult with its technology experts.*

---

**277. Question:** Where can additional information be obtained about "the State's initiative to implement an admission, transfer, and discharge (ADT) system"?

**Answer:** *This will be developed in partnership with the MCOs and providers. The Department is interested in the experience of the Offerors and their commitment to the program.*

---

**278. Question:** 5.2.4 - For Offerors excluded from serving DCFS youth in care (i.e. Option B Offerors), is it fair to assume that we are not required to identify which elements "will apply only to DCFS Youth?"

**Answer:** *Yes.*

---

## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

**279. Question:** 5.2.4.3 - Please provide a definition for trauma-informed care (TIC) to ensure consistency in our proposed approaches with HFS' expectations.

**Answer:** *From DCFS procedure 315.15(f), DCFS has stated the following vision for a trauma-informed practice model: the vision of the practice model is to identify, intervene, and mitigate the effects of adverse and traumatic experiences of children who are entering protective care or currently living in a substitute care placement. This vision also continues with efforts to reduce, if not alleviate, secondary trauma experienced by children while living in out-of-home care.*

---

**280. Question:** 5.2.4.4 - Please provide a definition for "Wraparound Model" to ensure consistency in our proposed approaches with HFS' expectations. The current definitions include "Wraparound Fidelity Assessment System" but it is not clear if this is the same as "Wraparound Model" or not.

**Answer:** *Please refer to the definition of "High Fidelity Wraparound" in Appendix II. The Wraparound Fidelity Assessment System is a means to assess the fidelity and quality of the wraparound model chosen by the Offeror.*

---

**281. Question:** 5.2.4.4 - Please provide a definition for "Permanency Goal" to ensure consistency in our proposed approaches with HFS' expectations.

**Answer:** *Please refer to Department procedures 305, Client Service Planning, and 315, Permanency Planning, for a list of child welfare permanency goals and their definitions.*

---

**282. Question:** 5.2.5.1 - Within the vignette, it states that the member is a "dual-eligible enrollee." Given that MMAI is out of scope for this RFP, is it fair to assume that our response is limited to MLTSS-specific service plan only?

**Answer:** *Yes.*

---

**283. Question:** 5.2.6.3 5.2.1.2 If a plan has only Illinois experience can you clarify that they should answer based on Illinois experience and that the fact that there only experience is in Illinois in itself does not disadvantage them compared to other bidders?

## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

**Answer:** *The RFP will be amended to include "relevant experience in Illinois and other states."*

---

**284. Question:** Will the State please clarify if bullets one and two are limited to IL Medicaid experience only or if this can be for any line of business or service area?

**Answer:** *It is unclear to which bullet points the question refers. Questions in Section 5.2.6.2 should include all lines of business and geographic service areas.*

---

**285. Question:** Please confirm whether the reference in RFP section 5.2.6.2 to “use of VBP within its provider network” refers to the Offeror's local or national network?

**Answer:** *Questions in Section 5.2.6.2 should include all lines of business and geographic service areas.*

---

**286. Question:** Are nurse practitioners allowed to be a PCP?

**Answer:** *Yes. The Model Contract will be amended to reflect this change.*

---

**287. Question:** Section 5.7.12 of the Model Contract requires the contractor to contract with the University of Illinois and Southern Illinois University physician groups. Will the MCOs have Government Provider contracting requirements for facilities similar to those in the current contract? Please provide a summary of any changes related to government contracting requirements compared to the current contract.

**Answer:** *The Department is not able to share a comparison to the current MCO contract as a part of the RFP.*

---

**288. Question:** Will the current Government Provider Risk Pool continue into 2018 incurred dates? If so, will the same providers and services be a part of this pool?

## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

**Answer:** *Further detail will be provided with the data book and the financial proposal template. Further questions may be asked in Round 2.*

---

**289. Question:** Will the State please define "other sources of data" as it relates to risk stratification?

**Answer:** *The Offeror may include in its response a description of any data sources besides those specifically listed that it may use in risk stratification.*

---

**290. Question:** Will the State please describe the current tools other managed care organizations (potential Offerors) use in health screenings and comprehensive risk assessments?

**Answer:** *No.*

---

**291. Question:** Please confirm that for purposes of the subcontractor disclosures, Network Providers are not considered subcontractors.

**Answer:** *Confirmed.*

---

**292. Question:** Must the Offeror submit a GEO Access Network Adequacy report to demonstrate its current adequacy? If so, will the State allow the Offeror to submit this as an attachment that would not count towards the page limit of this section?

**Answer:** *A GEO Access Network Adequacy report is not a requirement of this RFP.*

---

**293. Question:** 5.2.9.3 - Please confirm whether the request for Offeror to describe how we will "manage third-party liability in provider billing" is referring to our subrogation efforts.

**Answer:** *Confirmed.*

---

## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

**294. Question:** How does the State of Illinois define or what Illinois State law or regulation defines a "Minority-owned organization?"

**Answer:** *The definition is provided in Appendix II of this RFP and the instructions for Offerors who elect to submit a Proposal for Proposal Option B are provided in section 3.5 and Form for Submission II.*

---

**295. Question:** How and within what timeframe will material changes to the model contract be communicated with Offerors?

**Answer:** *See RFP Section 1.11.4.2*

---

**296. Question:** Please confirm whether the State intends to count the response to each case study required by RFP section 5.2.1.2 toward the total page count for section 5.2.1, or whether the State prefers to have the case studies included as appendices to the response.

**Answer:** *All required information submitted in a Proposal will count against the section page limits unless specifically excluded in the RFP. Information must be submitted in the format described in the RFP.*

---

**297. Question:** Please confirm whether the State intends to count the diagrams required by section 5.2.3.1 toward the total page count for section 5.2.3.1, or whether the State prefers to have the diagrams included as appendices to the response.

**Answer:** *All required information submitted in a Proposal will count against the section page limits unless specifically excluded in the RFP. Information must be submitted in the format described in the RFP.*

---

**298. Question:** 5.2.4 defines high needs children with respect to SSI, AABD and DSCC (as does the definition in 2.3.1.6 of "Special Needs Children". These categories are likely to identify children with significant physical health issues. However, the vignettes and Attachment XXII to the Model Contract on "Minimum Standards of Care for High Needs Children" all have a heavy



## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

emphasis on children with behavioral health issues. Does HFS intend to use some other method of identifying children with high behavioral health needs not captured by SSI, AABD or DSCC?

**Answer:** *The MCOs will stratify all children, which should identify as high-risk children that do not fall into the SSI, AABD or DSCC categories. The Department reserves the right to develop other stratification methodologies as part of the behavioral health transformation.*

---

**299. Question:** Please confirm that the HCBS waivers currently covered by existing State contracts are also included in coverage pursuant to the Model Contract.

**Answer:** *Confirmed.*

---

**300. Question:** Regarding RFP Section 5.2.8, at what point in the readiness review do the health plans need to demonstrate that the provider network has been fully contracted?

**Answer:** *A date has not yet been determined.*

---

**301. Question:** Please confirm whether the State intends to count responses to the vignettes required by RFP sections 5.2.2.1, 5.2.4.1, and 5.2.5.1 toward the total page count for the applicable section, or whether the State prefers to have the vignettes included as appendices to the response.

**Answer:** *All required information submitted in a Proposal will count against the section page limits unless specifically excluded in the RFP. Information must be submitted in the format described in the RFP.*

---

**302. Question:** Please confirm whether the State intends to count the example care plans associated with the vignettes required by RFP sections 5.2.2.1, 5.2.4.1, and 5.2.5.1 toward the total page count for the applicable section, or whether State prefers to have the example care plans included as appendices to the response.

**Answer:** *All required information submitted in a Proposal will count against the section page limits unless specifically excluded in the RFP. Information must be submitted in the format described in the RFP.*

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## State of Illinois Medicaid Managed Care Organization Request for Proposals

### Responses to Round 1 Q&A

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**303. Question:** Does the Department anticipate the Integrated Health Homes requirements being released prior to the May 15 proposal response submission deadline?

**Answer:** *While the Integrated Health Home program design is not yet finalized, preliminary materials are available on the HFS web site at <https://www.illinois.gov/hfs/info/1115Waiver/Pages/1115WaiverMeetings.aspx>*

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**304. Question:** May separate rates be submitted for current managed care geographies versus fee for service?

**Answer:** *Further detail will be provided with the data book and the financial proposal template. Further questions may be asked in Round 2.*

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**305. Question:** Please clarify what documentation is needed as evidence of signing individual's authority to legally bind the offeror

**Answer:** *Documentation deemed sufficient by HFS to prove individual is an agent of the Offeror.*

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**306. Question:** If a prime contractor with an existing Illinois HMO license, intends to engage a subcontractor through a sub-capitated contracting arrangement, do State of Illinois Insurance statutes require that the subcontractor also have a similar HMO license at the commencement of business activities?

**Answer:** *The Department will not provide legal advice to Offerors.*

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**307. Question:** Page 60 of the RFP, Part III (Subcontractor disclosures), states that "[t]he maximum percentage of goods and services....that may be subcontracted is 20% unless otherwise approved by the Department." The majority of services contemplated by this RFP will consist of medical services performed by Network Providers as defined in Appendix II, Section 1.1.135. If

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the services performed by Network Providers count toward the 20% subcontracted services threshold described on page 60 of the RFP, Part III, those services alone would cause Offerors to exceed the 20% threshold in that section.

DHFS has excluded medical providers performing healthcare services from the definition of subcontractors in connection with prior subcontractor disclosures relating to an existing Illinois Medicaid contract.

In addition, "Network Providers" are expressly excluded from the definition of "Subcontractor" in Appendix II, Definitions, Abbreviations, & Acronyms, Section 1.1.192, p. 24. Similarly, the definition of Network Provider in Appendix II, Section 1.1.135 states that "[a] Network Provider is not a Subcontractor..."

Consistent with these definitions and DHFS' prior approach, please confirm that Network Providers are not considered "subcontractors" for purposes of the Section "III. Subcontractor Disclosures" and that their services do not count toward the 20% subcontracted services limitation in that section.

**Answer:** *Confirmed.*

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**308. Question:** Page 60 of the RFP, Part III (Subcontractor disclosures) states that "[t]he maximum percentage of the goods or services....that may be subcontracted is 20% unless otherwise approved by the Department." Please confirm that only the services of third party subcontractors that are not affiliated, or under common ownership, with the Offeror count toward the 20% subcontracted service threshold and that services performed by an affiliate under common ownership with the Offeror do not count toward the 20% threshold.

**Answer:** *Confirmed.*

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**309. Question:** Page 60 of the RFP, Part III (Subcontractor disclosures) sets a 20% maximum on the percentage of goods or services that may be subcontracted and defines "subcontractor" as "a person or entity that enters into a contractual agreement with a total value of \$50,000 or more with a person or entity...pursuant to which the person or entity provides some or all of the...services...that are the subject of the primary State contract."

Appendix II, section 1.1.192, defines "Subcontractor" as "an entity, other than a Network Provider, with which the Contractor has entered into a written agreement for the purpose of delegating responsibilities applicable to the Contractor under this Contract..." Consistent with the definition of "Subcontractor" in Appendix II, please confirm that only entities performing delegated administrative functions (e.g., delegated administrative services performed by

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pharmacy, dental, or vision managers) count toward the 20% subcontracted services limitation on page 60 of the RFP, Part III (Subcontractor disclosures) and that ancillary administrative functions such as printing or mailing, for example, do not.

**Answer:** *All Subcontractors, as defined in Appendix II Section 1.1.194 (Per Rev 2 posted with Addendum 1 on 3/7/2017), with an annual contract value of greater than the amount specified in RFP Form for Submission III, shall be reported to the Department using RFP Form for Submission III, Subcontractor disclosures. The purchase of goods or services by the Contractor from organizations that do not meet the definition of Subcontractor need not be reported.*

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**310. Question:** Offeror is completing its registration in the Illinois Procurement Gateway. The registration requires the registering Vendor to provide Financial Disclosures and Conflicts of Interests disclosures are also required by Form B. Step 1 of the Financial Disclosures and Conflicts of Interests, both in the Illinois Procurement Gateway and in Form B asks provides six options under which Offerors can categorize their company. Which category applies to an LLC owned by a public company?

**Answer:** *The Department will not provide legal advice to Offerors.*

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