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

Responses for Round 2 Q&A (Rev. 2)

April 28, 2017

1. Question: Will we have the opportunity to decline a "renewal" after the initial contract term has ended. Additionally, outside of losing the security bond, are there legal implications around withdrawal of a bid or furthermore, declining award if selected?

Answer: Yes. The Contractor will have the opportunity to decline a renewal after the initial contract term has ended.

The Department will not provide legal advice to Offerors.

---

2. Question: When will the contractor be required to prove network adequacy?

Answer: At the time of readiness review for a given population and geographic service area.

---

3. Question: When does HFS anticipate readiness reviews to occur?

Answer: A date has not yet been determined.

---

4. Question: Section 5.8.1.1.4 requires pediatric dental access. Are Oral Surgeons equally included in 5.8.1.1.6 as "other specialist providers?

Answer: Yes.

---

5. Question: 5.10.6.3 Provider Directory If a provider is listed at multiple location in the directory, but has not submitted a claim from a specific address in the 6-month period, should the provider be deleted from that location in the directory?

Answer: The Department has no clarifications on this topic at this time.

---

6. Question: What is meant by the "maximum percentage of the goods or services" that may be subcontracted is 20%?

How does HFS calculate 20% of goods or services? Is it 20% of a particular dollar amount (cost/spend/premium)?

Or is it 20% of goods or services categories, and if so, how would the categories be defined? Please clarify.

Answer: The 20% subcontracting percentage on Page 60 of the RFP is calculated as a percentage of the total contract value, defined as the total capitation payments made to the Contractor.

---

7. Question: What is the policy or intent behind the restriction of subcontracting goods or services to a maximum of 20%? What is the issue that HFS is trying to address by limiting subcontracts to a maximum percentage?

Answer: Any additional subcontracting that the Vendor would want to utilize must have prior approval by the Department.

---

8. Question: Are subcontracts with an Offeror's subsidiaries or affiliates subject to the 20% maximum percentage of goods or services that can be subcontracted?

Answer: No.

---

9. Question: As acknowledged by section 1.12.9 of the RFP, the solicitation and the resulting contract are related to the purchase of care and therefore exempt from the Illinois Procurement Code (30 ILCS 500/1-10(b)(3)) and Standard Procurement Rules (44 Ill. Admin. Code 1.10(a)(3)). The Procurement Code requirement that entities register with the State Board of Election (30 ILCS 500/20-160) would not therefore apply to Offerors. However, section 3.4.6.1 of the RFP indicates that if the Offeror does not submit its State Board of Elections Registration Certificate its proposal will be disqualified. Tab 4, RFP Forms for Submission (page 58 of the RFP), also indicates the State Board of Elections Registration Certificate should be enclosed.

Could you please confirm that an Offeror may provide a certification that it is exempt from registration with the State Board of Elections in lieu of providing a State Board of Elections Registration Certificate for purposes of section 3.4.6.1 and Tab 4 of the RFP?

Answer: No. Per the RFP, a State Board of Elections Registration Certificate is a required component of an Offeror's Proposal.

---

10. Question: The Division of Specialized Care for Children (DSCC) is a division of the University of Illinois. DSCC provides care coordination and both medical and non-medical supports and services to eligible children under Title V of the Social Security Act. DSCC, thus, acts as both a care coordinator and provider of medical and non-medical support and services. In reaching out to potential bidders of the above referenced RFP for purposes of engaging in discussions regarding inclusion in proposed MCO networks, a potential MCO bidder stated that Section 1.2 (highlighted below) and definition 1.1.188 (highlighted below) forbad discussions with DSCC. Can HFS please issue a written clarification stating that DSCC is a provider and not a "State officer or employee" within the meaning of Sections 1.2 and Definition 1.1.188?

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 potential providers of medical or other services regarding contracting for services.

---

11. Question: Can HFS please clarify that DSCC is not considered an employee or Contractor of the Department as contemplated in Section 1.4.? DSCC is concerned that Section 1.4 may be misconstrued as well.

Answer: As indicated, restrictions on communication do not apply to potential Offerors' discussions with potential providers of medical or other services regarding contracting for services.

---

12. Question: It appears that the transition assumptions (for DA-SPII and MLTSS 65+) described in Attachment II may not have been applied appropriately at the high end of the rate range for the "new" populations in the appendices provided. Can you please review and make corrections if necessary?

Answer: The high end of the rate range for DA SP II and MLTSS 65+ were applied incorrectly in Appendix VII for the FFS experienced data book. The Department will provide an updated data book with the correct rebalancing applied. Note, this will have no effect on DA SP II for regions 3, 4, or 5.

---

13. Question: The rate development for the new populations have been trended to a midpoint of July 1, 2018, which is consistent with the narrative provided. The narrative also indicates that these populations will not be phased-in to managed care until 4/1/2018, which would imply that these rates should be projected to a midpoint of 8/15/2018. Please review.

Answer: The Department can confirm that the rate ranges for both the existing and new managed care populations were trended to July 1, 2018. Based on HFS' final enrollment transition schedule, the Department's actuary will adjust the trend midpoint for the new populations accordingly.

---

14. Question: Will you please provide more clarity around whether a 1/1/2018 or 4/1/2018 effective date was assumed for the MLTSS population? If a 4/1/2018 effective date was assumed, are the MLTSS rates developed in Attachment II intended to cover current MCO enrollees in the existing MLTSS population (in Greater Chicago region) during 1Q2018?

Answer: A 4/1/2018 effective date was reflected in the original data book. The revised data book reflects the Greater Chicago MLTSS having a 1/1/2018 effective date.

---

15. Question: It is our understanding that 15 counties (DeKalb, Lee, Henderson, Warren, Woodford, Adams, Brown, Pike, Scott, Livingston, Washington, Randolph, Perry, Jackson, and Williamson) were previously voluntary managed care during CY2015 due to having only a single MCO available to enrollees. However, Attachment 3 to Appendix VII indicates that only MCO experience was used in the rate development, which would exclude critical FFS experience. We request that Milliman comment on whether (or not) all appropriate experience for these counties, including FFS experience, was reflected in the development of rates, and adjust the rate development accordingly.

Answer: The Department can confirm that FFS experience for counties that were voluntary managed care during CY 2015 is not included in the development of CY 2018 capitation rates for the RFP data book. For the final certified CY 2018 capitation rates, the Department's actuary will review CY 2016 experience. To the extent FFS experience in previously voluntary managed care counties differs significantly from the MCO experience data, the Department may make an adjustment to reflect the differences in acuity.

---

16. Question: Based on the [OptionB_CookCounty] worksheet within the Financial Proposal Template (2018-24-001_RFP_Form_VI.xlsx) provided on 3/29/2017, which includes a space for Option B Offerors to bid on DCFS Youth, are Option B bidders allowed to bid on the DCFS Youth population?

Answer: Option B (Cook County Only) bidders are not allowed to bid on the DCFS Youth population. The Department has removed the DCFS Youth population from Option B.

---

17. Question: Milliman stated at the Offeror Conference (Round 2) on 4/4/2017 that the DCFS Youth contract would be awarded to the "highest overall score." Please confirm whether (or not) this will be the sole criteria used to determine the winner of the statewide DCFS Youth contract.

Answer: Yes. The DCFS Youth population will be awarded to the Offeror with the highest overall score.

---

18. Question: Does the 20% Office Visit managed care efficiency consider the different mixtures of FQHCs and government-owned providers between managed care and FFS enrollees?

Answer: The office visit managed care efficiency assumption was developed from and applied to primary care provider (PCP) visits only. The Department recognizes the different reimbursement structure and mixture of FQHCs and government-owned providers and has only applied this adjustment to the per visit cost for PCPs other than FQHCs and government-owned providers.

---

19. Question: Will HFS allocate membership from the plans that do not win the reprocurement to the winning plans in approximately equal shares OR such that the winning plans all have approximately equal market shares after reassignment?

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

---

20. Question: Round 1 Q&A indicated in several places that the Model Contract would be amended to reflect HFS responses to the Q&A. When will the amended Model Contract be published?

Answer: The Department will publish amendments to the Model Contract at the time that it posts to answers to Round 2 Q&A. The Department will not make any further amendments between the time Round 2 answers are posted and the deadline for submission of Proposals.

---

21. Question: We understand that the 2018 rate ranges were developed from the 2017 rate methodology. At the April 4th bidders conference it was stated that the 2018 midpoint rate will be revised with 2016 data. Please confirm that this process will be consistent with Section 6.6 of the RFP titled, "Adjustments and resetting". Will the State please list which rate setting assumptions will be re-visited and re-analyzed as part of the revised rate range development?

Answer: The Department's actuary will review all available experience from CY 2016 dates of service to determine the scope of potential adjustments. HFS has not committed to specific adjustments to revisit or not revisit at this time.

---

22. Question: At the April 4th bidders conference it was stated that the 2018 midpoint rate will be revised with 2016 data. Will the State please provide the timeline to complete the revisited midpoint rate?

Answer: The Department's actuary will perform a review of available CY 2016 experience during the third calendar quarter of 2017. HFS anticipates finalizing the CY 2018 offered rates prior to 90 days before the beginning of the rating period.

---

23. Question: At the April 4th bidders conference it was stated that the 2018 midpoint rate will be revised with 2016 data. Will the MCOs have the opportunity to re-evaluate the midpoint rate developed, and if necessary, re-submit bids?

Answer: No.

---

24. Question: Will the State consider delaying the cost bid submission until the 2018 midpoint rate has been revised with 2016 data? If not, please explain.

Answer: No.

---

25. Question: Section 3.5.8.1 states that The Department will evaluate the Financial Proposals separately and after Oral Presentations are complete. Does this provide for additional time to complete the final rate ranges with 2016 data?

Answer: No.

---

26. Question: Other states with competitive bids has allowed for region level bidding to allow MCOs to better align operational efficiencies that vary geographically across the state. Will the State consider allowing region level bids?

Answer: No.

---

27. Question: Will the State please provide the analysis that supports the reduced administrative expense load? Specifically, what percent of expenses does the State assume to be fixed and what is the expected average membership growth rate for each MCO that wins relative to current averages? Will the State consider that the membership for the winning MCOs will likely vary? Will the State please share the anticipated membership by winning MCO by region and program under multiple scenarios that capture one, two or three incumbents remain?

Answer: The anticipated membership base of successful Offerors will vary based on the number of successful Offerors for each of Option A and Option B. The State is developing an auto-assignment algorithm that may influence the total number of members enrolled with each individual MCO. Regardless of the precise number of successful Offerors, the number of enrolled members for any MCO during CY 2018, whether new or incumbent, will increase significantly from CY 2017 levels due to the expansion of mandatory managed care in all counties, the inclusion of new populations under managed care, and the reduction in total number of MCOs from current (12 in CY 2017).

---

28. Question: Will the State please confirm that maternity costs will now be included in the capitation rate and not as a case rate? Removing maternity case rates and adding the costs to the capitation rates explicitly puts the MCO at risk for the Medicaid population pregnancy rates and places operational burden on the plans to manage this risk. Will the State consider increasing the administrative load to capture the costs for this significant change in rate policy?

Answer: Yes. The capitation rates for adolescent and adult females will include maternity-related costs. Administrative costs include in the maternity case rate have been moved into the respective female rate cells.

---

29. Question: Removing maternity case rates and adding the costs to the capitation rates puts the MCO at risk for the Medicaid population pregnancy rates and places operational burden on the plans to manage that risk. Will the State please explain how this rate setting change improves the effectiveness of the rates to align risk and reimbursement? How will risk adjustment be changed to address this added MCO risk?

Answer: The Department's actuary does not anticipate changes in the number of deliveries per eligible female. In a review of historical deliveries per eligible female member month, material differences did not exist between MCOs. The Department's actuary does not believe the change in reimbursement structure changes the inherent incentive for high quality pre-natal, delivery, or post-partum care. Risk adjustment changes will be documented with the final 2018 rate range.

---

30. Question: Given that the maternity costs vary significantly by age, has the State considered creating additional female Non-Disabled Children and Adults rate cells with 5 year age bands?

Answer: No. The Department's actuary believes actuarially sound rates can be developed under the current rating structure.

---

31. Question: Has the State considered other states' experience in reimbursing maternity costs as a part of the capitation rate? If so, have they (does "they" refer to the other states? or the State"? This should be clarified) been successful at aligning risk adjusted capitation rates with expenses to mitigate delivery prevalence risk between MCOs?

Answer: Yes. The Department is aware of potential issues related to the prevalence risk between MCOs.

---

32. Question: Will the State consider any risk mitigation programs that will recognize this significant rate policy change and additional risk placed on the MCOs? Such as, the maternity component of the rate could be retrospectively adjusted for the change in delivery rates reflected in the base period experience to the actual rates in payment period.

Answer: Prior to the final 2018 rate range development, contracted MCOs will have the opportunity to opine on the proposed risk adjustment process for CY 2018.

---

33. Question: Will the State please confirm that the high rate range reflects 2017 managed care savings assumptions with one change – the office visit unit cost adjustment was significantly reduced? Will the State please explain what this change is driven by (e.g. unit cost or service mix)?

Answer: Based on review of additional information, the office visit unit cost efficiency adjustment has been removed from the MCO-experienced capitation rate range development. The updated Data Book reflects this change.

---

34. Question: We understand that the high rate range reflects 2017 managed care savings assumptions with one change – the office visit unit cost adjustment was significantly reduced. To the extent MCOs achieve these savings through provider contracting, has the state considered the potential negative impact to downstream operations (e.g. member access or managed care savings)? If so, how did the state reflect changes to downstream operations resulting from the significant decrease to provider reimbursement in the rate setting process?

Answer: Based on review of additional information, the office visit unit cost efficiency adjustment has been removed from the MCO-experienced capitation rate range development. The updated Data Book reflects this change.

---

35. Question: Will the State please confirm that the basis of the additional managed care savings is based on current MCO variances after acuity adjustments?

Answer: Yes. The additional managed care savings for the low end of the rate range for MCO-experienced data book reflect variances for existing managed care counties and populations after all applicable acuity adjustments.

---

36. Question: Has the State observed MCOs succeed in lowering costs by the magnitude reflected in the rates in one year? If so, in which states? Did these states have managed care penetration similar to IL?

Answer: The Department notes the managed care efficiencies reflected in the CY 2018 MCO-experienced rates reflect expected savings over the course of a three year period (CY 2015 base data period to CY 2018 rating period). Further, it is noted that the only change on the high rate range for the MCO data book from CY 2017 is the per visit savings applied to office visits.

---

37. Question: Will the State please confirm that the retrospective acuity adjustment reflects removing members that now qualify for a new eligibility category? If so, are the acuity adjustments based on claim cost or risk score differences? If the former, will the State please

provide the resulting change in risk score by region and program to help MCOs understand the change to the average?

Answer: Yes. The retrospective acuity adjustments reflect removing members that now qualify for a new eligibility category. The adjustments were developed based on claims cost.

---

38. Question: The MCO needs information and analysis to evaluate the ability to achieve the managed care savings with the restricted Preferred Drug List (PDL). Will the State please provide the therapeutic class data and assumptions used to develop the pharmacy trends?

Answer: The CY 2018 RFP rate range does not reflect the restricted PDL. The impact of this policy change will be reflected in the final CY 2018 rate range.

---

39. Question: The continuation of 2017 rating trends and managed care assumptions results in both negative inpatient trends for three years and lowered costs due to managed care savings. Will the State please provide additional data and analysis that ensures the potential for savings is not double counted?

Answer: It is confirmed that it is not the intent to double count any savings due to achieved managed care efficiencies and changes otherwise observed in utilization and cost per day changes due to trend. The Department notes the trend rates illustrated in the data books reflect the projected trend from CY 2015 to CY 2018 and not the historical trend rates from CY 2015 and prior.

---

40. Question: Will the State please confirm that the capitation rates for all programs and regions will be risk adjusted in 2018?

Answer: Yes, with the exception of the DCFS Youth population that will be awarded to a single MCO.

---

41. Question: To evaluate the data book experience relative to historical MCO experience by region, program and population type (existing and new), Will the State please provide the risk scores under both models that are needed that align with the experience utilized for rate setting?

Answer: No further information in response to this question is available at this time.

---

42. Question: On page 20 of Attachment 1 CY 2018 Illinois Medicaid Managed Care Data Book Existing Counties.pdf, it states that the low end of the rate range was developed by comparing acuity adjusted claim costs between MCOs. Given the high scenario rates are inclusive of

managed care savings, how did the State adjust for the interaction between assumed managed care savings already contained and the high scenario rates and the analysis to develop the additional managed care savings?

Answer: The base experience includes data from MCOs that are operating at a varying degree of managed care efficiency and provider contracting levels. The low rate range is reflective of MCO experience that is associated with a well performing plan.

---

43. Question: The rate range spread varies by program between 3% and 6% (most are at 5% or 6%). Has the State evaluated the size of the spread relative to other states to understand if this spread is achievable? Has the State observed in other states this level of variance in acuity adjusted claim costs between MCOs as a benchmark for whether this spread is achievable? For example, in Minnesota, the rate range spread for the 2016 procurement was 5%. In 2017, a plan that bid at the low end of the range exited the market completely due to the inadequacy of the rates.

Answer: The Department anticipates responsible and responsive Offerors will submit bids based on their individual assessment of ability to meet the stated requirements of the RFP. The rate range reflects greater care coordination expenditures at the low end for health plans that achieve greater efficiencies, and lower care coordination expenditures at the high end of the rate range for health plans that do not achieve as significant efficiencies. The Department anticipates actual health plan experience will vary based on individual health plans' ability to perform at the level commensurate with the submitted offer.

---

44. Question: Will the State please explain the use of 2017 rate setting assumptions to develop the high scenario of the rate range? From our actuarial perspective, the 2017 rates reflect a best average or midpoint rate development scenario and not the high range. Will the State please provide further clarification regarding the appropriateness of the 2017 assumptions to set the high rate scenario of the published range?

Answer: The CY 2017 rates reflect a best estimate for the CY 2017 rating period. In the absence of a rate range for CY 2018, we would anticipate the CY 2018 best estimate would reflect greater efficiencies relative to CY 2017 due to economies of scale, new managed care counties and populations, and improvements in quality outcomes as compared to the existing MCOs. Based on the quality metrics of existing MCOs, we believe further managed care efficiencies should ultimately be realized beyond those reflected in the CY 2017 rates.

---

45. Question: Has the State sought approval from CMS for the current rate range spreads? To the extent that the current rate range spreads are not accepted by CMS and will be revised, how will plan bids be adjusted?

Answer: We have not sought CMS input for the rate range spreads.

---

46. Question: The assumed shift from nursing home to other waiver status for the new MLTSS population are considerably higher than the existing DA SPII population assumptions. Will the State please explain and provide an analysis on how these shift assumptions developed?

Answer: As presented during the Round 2 Offeror's conference held on April 4, the historical mix of nursing home vs. waiver population for the MLTSS eligible population is weighted much more significantly to nursing home members as compared to the DA population. Based on a review of regional variation, a significant shift from institutional to community settings appears possible.

---

47. Question: Has the State considered additional risk that plans are accepting on the new population when setting risk margin in the New Managed Care Counties and Population rate range development? The current rates reflect the same assumption as the existing population.

Answer: HFS does not view the risk for new managed care counties for existing populations to be significantly different from that of existing managed care counties. To the extent members in new counties have higher or lower acuity than existing counties, the risk margin on a PMPM basis varies commensurate with the expected medical costs. For the new DC and DCFS populations, the Department's actuary has assumed a higher risk margin relative to the Non-Disabled Children population to reflect higher relative risk for these members.

---

48. Question: In Section 8(a) of the Existing Managed Care Counties and Populations, the State adjusted rates downwards by 0.5% for TPL and Fraud, Waste and Abuse (FWA). Were those included in the rates that that State set for improving managed care practices?

Answer: This assumption was developed consistent with the TPL & FWA assumption in the CY 2017 rate development. As documented in the MCO-experienced data book and presented to existing MCOs during the CY 2017 rate development, several MCOs indicated they did not have robust TPL or FWA procedures in place during the base period thus recognized little to no medical cost reductions accordingly. Other MCOs indicated the expenditures were reported gross of TPL & FWA and it was thus appropriate to reduce benefit expense by the reported amounts.

---

49. Question: Given that there are extensive delays in the review and approval process for custodial nursing home benefits. How are the costs associated with the eventual retrospective approval and payment accounted for in the rates?

Answer: The base experience included in the data book is from CY 2015 experience with significant claims runout. For MCOs, we have reflected all reported nursing home expenditures including reasonable accruals for incurred but not reported claims.

---

50. Question: Has the state analyzed redetermination patterns emerging since the 2015 experience period? If so, has the state included any adjustments to reflect redetermination?

Answer: The Department is not aware of any changes in redetermination patterns.

---

51. Question: The 2017 rates included adjustments for redetermination. Will the State please provide an analysis on the accuracy of these assumptions?

Answer: The 2017 rates did not include adjustments for redetermination. Adjustments were made for the re-assignment of certain ACA beneficiaries to the ICP population.

---

52. Question: Hepatitis C Fibrosis Score Change: Effective October 1, 2016, the state expanded state plan coverage for hepatitis C drug treatment to include fibrosis scores of F3 and F4, compared to previously covering only F4 scored members. The state communicated that it would review the impact of this policy change relative to current MCO policy as disclosed in the 2015 MCO Survey. Has the state re-reviewed emerging experience for this change? If so, what are the results and have they been incorporated into the rate setting process?

Answer: The Department will review 4th quarter 2016 experience when it is available to evaluate the impact of the policy change. This evaluation will occur for the final CY 2018 rate range.

---

53. Question: Will the State please clarify if the payment of sub-capitation during the run-out months should be included in the MLR calculation if those payments relate to the coverage year?

Answer: Yes. This understanding is correct.

---

54. Question: How will MLRs be scored, since MLRs cannot be compared across state Medicaid programs due to the fact that each state has different MLR requirements and sets capitation rates differently?

Will offers be negatively impacted because a state sets a capitation rate high which causes a low MLR?

Answer: MLRs provided in response to RFP Section 4 Proposal Requirements will not be scored as part of the Technical Proposal or Financial Proposal. The scoring, evaluation criteria and process have been fully elaborated in sections 3, 4, 5 and 6 of the RFP.

---

55. Question: Net underwriting gain or loss for Medicaid line of business by state of operation – Will the State please indicate how many years of data is required to be submitted? (for example, 4.1.1.5 specifically requests data for the most recent 2 years)

Answer: For the most recent 2 years.

---

56. Question: Will the State please clarify in detail, how the prohibition of MCO pharmaceutical rebates is factored in the rate development methodology?

Answer: The CY 2018 RFP rate range does not reflect the restricted PDL. The impact of this policy change will be reflect in the final CY 2018 rate range.

---

57. Question: Will the State please clarify, as stated at the Offeror Conference Round 2, will the DCFS contract be awarded to the highest scored Offeror?

Answer: Yes. The DCFS Youth population will be awarded to the Offeror with the highest overall score.

---

58. Question: Will the State please confirm the Care Coordination fee is included in the DCFS Youth rates and it is the requirement of the one selected MCO to continue making payment to the coordinating agencies?

Answer: The capitation rates developed for DCFS Youth are intended to include all covered Services and activities described in the Model Contract.

---

59. Question: Should the State's actuarial firm adjust the published rate range values after proposal submission due to factors that impact the underlying costs, will a new Data Book be published to accompany the new rate range values?

Answer: Yes. An updated and final rate range will be published reflecting the final rate range and certified offered rates for CY 2018. To the extent revisions or adjustments are made to the rate range subsequent to the RFP data book, the updated data book will be provided to successful Offeror's including documentation of applicable changes, as well as an in-person presentation with subsequent opportunity for Q&A. The Department and the Department's actuary believe in

providing information to MCOs in a transparent manner to facilitate an effective and collaborative partnership among stakeholders.

---

60. Question: Is there a mitigation plan if MCO's who are no longer participating is no longer submitting encounter data that would be used to set future rates?

Answer: MCOs are contractually obligated to submit encounter data through the end of their contract regardless of CY 2018 contracting status.

---

61. Question: Will the State please confirm that each MCO with a successful bid will be paid different capitation rates based on where their actual bid amount falls within the range provided by the state and that the MCOs will not all be paid the same capitation rates? For example, the amount resulting from averaging their respective bid amounts.

Answer: Yes. This understanding is correct.

---

62. Question: On page 11 of Attachment 1 CY 2018 Illinois Medicaid Managed Care Data Book Existing Counties.pdf mentions that the direct usage of MCO encounter data was not possible and then describes several steps that were taken to improve the quality of the EUM expenditure data. What has been done to improve the quality of encounter data since The State determined it was not usable? Does The State anticipate being able to use 2016 encounter data in revising the 2018 rate ranges? Has the encounter data been used to set rates in the past? If so what changed recently to make this data unusable? Will the State be sharing the results of the analysis done at the end of the EUM reconciliation process and/or the reasons for the remaining disparities?

Answer: 2016 encounter data will be evaluated in revising the 2018 rate ranges. The Department has ongoing calls with the MCOs concerning reported encounter data. Specific encounter data issues at the MCO-level are discussed between the Department and the respective MCO.

---

63. Question: How did The State build in sub capitated costs? Were the shadow prices from the MCO's used to convert the sub capitation costs into claims costs? If so did The State do any analysis to verify the reasonability of those shadow prices?

Answer: Yes. The Department asked each MCO to complete a survey outlining shadow priced claims, delegated administrative expenses, and total sub-capitated costs for each subcapitated arrangement.

---

64. Question: On page 24 of Attachment 1 CY 2018 Illinois Medicaid Managed Care Data Book Existing Counties.pdf, under the maternity section, it states that "No adjustments were made to the total number of deliveries". Will the State please explain how this statement relates to the Managed Care Adjustments - Utilization Adjustment as shown in columns O & V in CY 2018 Existing Appendix 4 Prosp Models.xlsx for the following service lines: Inpatient Maternity Delivery - Normal - Non-Govt, Inpatient Maternity Delivery - Normal - Govt, Inpatient Maternity Delivery - Cesarean - Non-Govt & Inpatient Maternity Delivery - Cesarean - Govt. For example, in Region 1, NDCA - 21-44 Years Female Rate Cell, rows 483:486 of the Region 1 tab in 2018 Existing Appendix 4 Prosp Models.xlsx, the four inpatient maternity delivery service categories each have the same managed care adjustment - utilization adjustment: 0.9458 for Low and 0.9958. We observed that all existing NDCA 19-44 female rate cells include a managed care utilization adjustment for these four service categories. Our interpretation of this adjustment is that serves to reduce to the expected number of total deliveries in the rating period due to managed care savings, and therefore, contradicts the statement that no adjustments were made to total number of deliveries. Please provide further explanation on how the utilization adjustments are consistent with the documentation provided. Based on our understanding of the documentation, the total estimated of admits between low and high rates will be the same with only the mix between normal and cesarean being different, which will cause a change in the total unit cost due to mix.

Answer: The maternity delivery managed care efficiency adjustments reflect a shift in deliveries from Caesarean to vaginal. The factors were illustrated and applied on a composite basis to both the Normal and Caesarean lines. This reflects lower average days per delivery and lower average cost per day related to this transition. The Department's actuary has assumed no change in the number of deliveries.

---

65. Question: On page 19 of Attachment 2 CY 2018 Illinois Medicaid Managed Care Data Book New Counties and Populations.pdf, under the maternity section, it states that "Managed care savings were estimated by evaluating the cost per delivery difference between cesarean and vaginal deliveries. No adjustments were made to the total number of deliveries". Please help us understand how this statement relates to the Managed Care Adjustments - Utilization Adjustment and cost adjustment as shown in columns O, P, V & W in CY 2018 New Appendix 4 Prosp Models.xlsx for the following service lines: Inpatient Maternity Delivery - Normal - Non-Govt, Inpatient Maternity Delivery - Normal - Govt, Inpatient Maternity Delivery - Cesarean - Non-Govt & Inpatient Maternity Delivery - Cesarean - Govt. For example, in Region 1, NDCA - 21-44 Years Female Rate Cell, rows 483:486 of the Region 1 tab in 2018 CY 2018 New Appendix 4 Prosp Models.xlsx, the four inpatient maternity delivery service categories have a similar pattern for utilization adjustments: normal deliveries are greater than one and cesarean deliveries are less than one. This is consistent with our interpretation that the intent is to remix the service categories to hit target normal delivery rates (70% for low rate scenario). We are confused at why a cost adjustment is required in addition to the utilization adjustment. Our interpretation of this adjustment is that serves to "double-count" the impact of the shift in utilization between cesarean and normal deliveries. By shifting the deliveries, the total unit cost will change

consistent with the delivery rate target, and therefore, and additional unit cost adjustment is unnecessary. Please provide further clarification on the interaction of managed care adjustments - utilization and cost relative to the documented target normal delivery rates included in Attachment 2 CY 2018 Illinois Medicaid Managed Care Data Book New Counties and Populations.pdf.

Answer: The maternity delivery managed care efficiency adjustments reflect a shift in deliveries from Caesarean to vaginal. The factors were illustrated and applied on a composite basis to both the Normal and Caesarean lines. This reflects lower average days per delivery and lower average cost per day related to this transition. The Department's actuary has assumed no change in the number of deliveries.

---

66. Question: On page 19 of Attachment 2 CY 2018 Illinois Medicaid Managed Care Data Book New Counties and Populations.pdf, under the trends section, it states that "Generally, we did not deviate our trend assumptions from the CY2017 capitation rate development". Does this statement apply to the CY2018 Existing Rate Development in that trend assumptions are similar between the two populations? We note that a negative trend was applied to the following four service categories: Inpatient Maternity Delivery - Normal - Non-Govt, Inpatient Maternity Delivery - Normal - Govt, Inpatient Maternity Delivery - Cesarean - Non-Govt & Inpatient Maternity Delivery - Cesarean - Govt. First, this is a deviation from the Existing Rate Development, which has a zero trend rate. Please provide justification from this deviation. Second, please provide justification as to how the delivery rate is expected to decrease in the FFS population underlying the New Rate Development.

Answer: The annualized trend rates assumed between the MCO- and FFS-experienced data books are generally similar. Regarding trend assumptions for delivery inpatient and professional services, the Department's actuary noted that the non-delivery trend rates have been illustrated in Appendix 4 of the respective data books. The intended trend rate for delivery services is 0%. The data books will be updated to reflect this change.

---

67. Question: The 2018 rate ranges were developed from the 2017 rate methodology. Our understanding of the April 4th bidders conference is the 2018 midpoint rate will be revised with 2016 data. Will the state have a similar process for MCOs to evaluate the updated data book? Specifically, will there be an opportunity to submit questions to be answered by the state. If not, what forum will exist to ask questions?

Answer: The state will provide an updated data book for the final CY 2018 rate range to reflect subsequent revisions and adjustments including any applicable policy and program changes. Successful Offerors will be presented with documentation and an on-site presentation to walk through changes from the RFP rate range data books. MCOs will have an opportunity to submit questions and feedback relative to development of the final rate range.

---

68. Question: As MCOs have previously discussed, observed Rx trends have historically been higher than rate development assumptions. When the databook and CY2018 rates are developed, will The State revisit this specific trend assumption using 2016 experience? Will The state evaluate the cost impact of new blockbuster treatments (e.g. Spinraza was FDA approved in Dec 2016)?

Answer: Yes. The Department's actuary will review 2016 pharmacy utilization, as well as high costs drugs scheduled for release during the CY 2018 rating period.

---

69. Question: Will the CY2018 Disabled Adults Service Package II risk adjustment be consistent from prior rating years? If not, will the State please explain any changes. For the New MLTSS rate cells, will the risk adjustment methodology be consistent with Disabled Adults Service Package II? If not, please explain any deviations.

Answer: At this time, the Department's actuary does not anticipate any changes from the current Service Package II risk adjustment methodology for the Disabled Adults. Risk adjustment for the MLTSS rate cells will follow a similar methodology.

---

70. Question: The State is building significant reductions into the initial 2018 capitation rates to account for anticipated improvements in managed care savings generated by the MCOs. The initial 2018 rates are primarily based on 2015 experience, whereas the final 2018 rates will reflect 2016 experience. Since a portion of potentially improved managed care savings will be represented in the 2016 experience, any additional improvement in managed care savings built into the final 2018 rate adjustment should be reduced from the amount built into the initial 2018 rates. Confirm that you intend to reduce the assumed managed care savings assumptions when moving from the initial 2018 rates (based on 2015 experience) to the final 2018 rates (based on 2016 experience).

Answer: For the CY 2018 rate range, the Department's actuary will re-evaluate the level of managed care efficiency observed in the CY 2016 base experience data relative to 2015. To the extent there was an increase in managed care efficiency observed in CY 2016, there would be a reduction in incremental managed care savings assumed in the development of the final 2018 rate range.

---

71. Question: In October 2016 the State of IL filed a Waiver under section 1115 of the Social Security Act, but that as of the preparation of this RFP, and approval for that waiver is still pending. How will approval or potential disapproval of this waiver impact the bid process, 2018 capitation rates, or other aspects of administration of the IL Medicaid program in 2018?

Answer: The Department does not anticipate any impact of the potential approval or disapproval of the section 1115 waiver on the current bid process. Negotiations with CMS on the 1115 Waiver are ongoing; further detail will be made available at the appropriate time.

---

72. Question: If the MCOs achieve the office visit unit cost savings through provider contracting, has the State considered the potential unintended negative impact to provider access?

Answer: Based on review of additional information, the office visit unit cost efficiency adjustment has been removed from the MCO-experienced capitation rate range development. The updated Data Book reflects this change.

---

73. Question: In light of the significant changes in the Managed care savings and the lack of complete encounter information from the incumbent MCOs, would the State consider implementing risk corridors for the first two years?

Answer: No.

---

74. Question: Will the initial list provided to the MCO communicate preferred drugs on the PDL and any other drugs using NDCs, GPIs, GSN, or another descriptor?

Answer: The initial list will use NDC as a universal product descriptor.

---

75. Question: Are diabetic test strips an example of non-drug items that the PBM/MCO can negotiate rebates on?

Answer: The restriction on rebate negotiation applies to both prescription and over-the-counter drugs, but does not apply to non-drug items such as blood glucose test strips. The Department does have a preferred test strip that we receive rebate on, but according to the Model Contract, MCOs would not have to use it.

---

76. Question: The CMS list of rebatable manufacturers presents drugs by NDCs. Is it the State's expectation that only NDCs found on this list could be adjudicated by the MCO or does the State expect that any manufacturer (first 5 digits of NDC: labeler) found on the list be eligible for adjudication regardless if a specific NDC is found on the list?

The CMS rebatable list is updated quarterly, thus NDCs approved by the FDA between quarterly updates will not be found on the rebatable list. Does the State reference the CMS rebatable list to ensure PDL NDC additions are found on the list prior to making updates to the PDL?

Answer: The federally rebatebale requirement applies only to covered outpatient drugs. A labeler on the CMS list may also manufacture prescribed drugs that are not subject to the rebate requirement and that are reimbursable by the Department. CMS produces a quarterly drug product data file. They also maintain a New and Terminated Labeler list that is updated daily. The state uses the optional effective date for coverage determination.

---

77. Question: Will the PDL files be provided to us by NDC or GPI level on an excel spreadsheet?

Answer: The initial list will use NDC as a universal product descriptor.

---

78. Question: Will the PDL files also include status of each drug (non-preferred vs. preferred) by NDC or GPI?

Answer: The Department's PDL can also be found at: https://www.illinois.gov/hfs/MedicalProviders/Pharmacy/preferred/Pages/default.aspx

---

79. Question: Will the PDL file include utilization management (PA, QL, AL, ST) for each drug by NDC or GPI?

Answer: Yes.

---

80. Question: How often will the state provide us with PDL files?

Answer: Quarterly.

---

81. Question: What is the expected turn around time for implementation of any updates to the PDL file?

Answer: The changes become effective at the beginning of the quarter.

---

82. Question: Can we receive the full list of covered drugs in excel prior to bid submission?

Answer: The Department's PDL can also be found at: https://www.illinois.gov/hfs/MedicalProviders/Pharmacy/preferred/Pages/default.aspx

---

83. Question: For the final CY 2018 rate ranges, will the width of the rate range change?

Answer: The Department does not anticipate significant changes from RFP rate range width.

---

84. Question: On Page 24 of the Existing Managed Care Counties Data Book, Generic Unit Cost Trends were expected to decrease by 2.8%. Please provide a list of generic drugs where you are expecting lower unit costs.

Answer: For development of the rate range, the Department's actuary identified generic drugs consistent with classification available in Medispan. The 2.8% reduction in unit cost reflects the aggregate per script savings across all generic drugs over all regions over all MCOs; expected savings will vary by individual generic drug and by MCO.

---

85. Question: Can Milliman provide the full PDL in Excel for the MCOs to be able to evaluate the impact of the 2018 State PDL Requirement?

Answer: The Department's PDL can also be found at:
https://www.illinois.gov/hfs/MedicalProviders/Pharmacy/preferred/Pages/default.aspx

---

86. Question: Can Milliman provide us with the expected change in pharmacy cost projections due to the Model Contract State PDL Requirement?

Answer: The Department's actuary has not reflected the PDL requirement in the RFP rate range development, nor has it performed an analysis at this time of the impact resulting from the policy change.

---

87. Question: How will the Managed Care Savings adjustments (including those for GDR change and unit cost adjustments) pertaining to pharmacy be modified when the State's New PDL is applied?

Answer: For the final CY 2018 rate range, the Department's actuary will perform an analysis to determine potential managed care efficiencies under the new preferred drug list in conjunction with CY 2016 pharmacy experience data. To the extent the results of the analysis vary materially from the assumptions illustrated in the RFP data book, a revision will be made to reflect this change.

---

88. Question: On Page 24 of the Existing Managed Care Counties Data Book, the GDR is projected to increase by 0.3%. Can you provide a comparison of MCO vs. FFS GDRs during the base period? Also, please advise what reduction was made to the expected rebate percentage due to the shifting from brand to generic.

Answer: The MCO generic dispensing rate (GDR) during CY 2015 was 88.3%. The FFS GDR during CY 2015 was 86.0%. The Department's actuary notes that actual experience GDR varied by population, rate cell, region, and MCO.

---

89. Question: The RFP indicates that the Plans will not be able to collect rebates due to the implementation of the new PDL. However, you indicated that the base data was lowered to include the impact of rebates in projecting pharmacy costs. How will you modify the rebate assumption to account for this new PDL requirement?

Answer: The Department's actuary has not reflected the PDL requirement in the RFP rate range development, nor has it done an analysis at this time of the impact resulting from the policy change. The impact of the new PDL requirement will be reflected in the final 2018 rate range.

---

90. Question: In your presentation, you indicated that only Managed Care Experience would be included in Cook County for the populations that are currently in Managed Care. Managed Care implementation of Cook County was not completed until the 2nd Quarter of 2015. Why was the 2015 FFS experience of those members who converted during 2015 not included in your base data?

Answer: FFS experience for counties that were existing managed care counties during CY 2015 is not included in the development of CY 2018 capitation rates for the RFP data book. The Department's actuary did not determine a significant acuity adjustment for these members. For the final certified CY 2018 capitation rates, CY 2016 experience will be reviewed. To the extent FFS experience in historically existing managed care counties differs significantly from the MCO experience data, the Department's actuary may make an adjustment to reflect the differences in acuity.

---

91. Question: You mentioned that there are some DC members who currently reside in the FHP (NDCA) population. Are there any DCFS members currently residing in the FHP rate cells?

Answer: As documented in the footnotes of Table 1 in Appendix VII, the FHP population has approximately 200 DCFS Youth currently enrolled in managed care.

---

92. Question: Will the final 2018 rates be presented as a range or a point estimate?

Answer: Range.

---

93. Question: How will rates be paid in 2018? Will the populations and counties that are currently mandatory be paid the "Existing Counties" rates while all other counties will be paid

the "New Counties" rates? If these populations are paid on a blended basis, how will the rates be blended?

Answer: Capitation rates will be paid on a regional basis by rate cell, using a blend of FFS- and MCO-experienced rate development as illustrated in Form VI. As indicated during the Round 2 Offeror conference, to the extent significant acceleration or delay occurs in the roll out of Medicaid managed care to new counties and populations, final or amended rates may be adjusted to reflect the updated timing.

---

94. Question: If the rates for the new counties and existing counties are blended, will the rate paid for January 2018 be an existing county only rate or a blend of the new and existing county rate using an estimated blend for the year?

Answer: Capitation rates will be paid on a regional basis by rate cell, using a blend of FFS- and MCO-experienced rate development as illustrated in Form VI. All else equal, the capitation rate paid on a regional and rate cell basis will be equivalent in all months. Actual payment rates will vary based on factors including P4P withholds, rate amendments, risk adjustment, and health insurance providers fee adjustments as applicable.

---

95. Question: Will the 2018 Risk Adjustment be altered to take into account maternity, now that the maternity kick payment is being eliminated?

Answer: Yes. The Department's actuary will evaluate this issue for the final 2018 rate range.

---

96. Question: Certain members participating in waiver programs currently reside within the FHP and ACA Expansion populations. Will those members all be moved into the DA or DC rate cells in 2018?

Answer: The Department does not anticipate any movement with the exception of the populations documented in the data books.

---

97. Question: The "IMD" rate cell which was a part of the 2017 rates is not being included in the 2018 Data Book. When will the 2018 "IMD" rates be provided?

Answer: The IMD rates will be provided in the final 2018 rate range data book. The Department's actuary does not anticipate deviating from the methodology used in developing the 2017 IMD capitation rates.

---

98. Question: The Membership Projections are materially different between the "landscape of IL Medicaid Eligible enrollees" on Page 17 of the RFP as compared to the membership provided in the Data Books. Please confirm that the projections in the 2018 Data Book are the best estimate to use.

Answer: The Department confirms the enrollment projections in Appendix VII (Data Book) reflect the best estimate of CY 2018 managed care enrollment. As indicated in the Data Book and Round 2 Offeror's conference, the FFS-experienced data book reflects 9 months of enrollment for new managed care counties and populations. The Dual-Eligible enrollment on page 17 of the RFP is overstated.

---

99. Question: Please explain the basis for negative IP Utilization Trends given that other utilization adjustments are already being captured in the Managed Care Efficiency assumptions.

Answer: Slightly negative IP utilization trends in the FFS delivery system have been observed.

---

100. Question: Please explain the basis for negative Outpatient ER Benefit Cost Trends.

Answer: Slightly negative OP ER trends in the FFS delivery system have been observed.

---

101. Question: Please explain the rationale for the Administrative Load being lower for the low rate range, given that not all activities leading to managed care efficiencies can be categorized as Quality or Care Coordination.

Answer: The administrative expense variation represents expected potential variation in administrative costs by potential Offerors. The quality expense variation is higher for the low rate range than for the high rate range, representing expected higher care coordination costs attributable to lower medical expenses. The administrative expense component is not explicitly related to care coordination.

---

102. Question: It appears that the rebalancing between HCBS and Nursing Facility members will be implemented for the full rate period. This means that the average rebalancing percentage will have to be at the targeted level on average so the true required rebalancing will be even greater than what is being assumed in the rates. For example, a 3% rebalancing means that 6% of the members would need to be moved by the end of the year assuming a constant rate of shifting throughout the year. Please confirm our understanding is correct.

Answer: Yes. This understanding is correct.

---

103. Question: There is a patient liability component in the MLTSS rate sheets that reduces the rates. Is this patient liability cost share? Who is responsible for collecting the patient liability?

Answer: Patient liability is collected by the nursing homes.

---

104. Question: On the MLTSS – Nursing Facility rate sheets the utilization per thousand is close to 300,000. We would expect this to be closer to 365,000 since these members are in a facility long term. Please explain.

Answer: Members eligible under the MLTSS Nursing Facility rate cell may have fewer than 365 Medicaid days per year due to: coordination of benefits with Medicare, population churn, or breaks in institutional setting of care. Additionally, hospice room and board charges are not covered under MLTSS and will result in a lower utilization rate as compared to other Medicaid covered LTSS-eligible populations.

---

105. Question: How will NF vs. HCBS mix variances by MCO be handled? If overall mix is used for all MCOs, there will be unintentional winners and losers. How will this mix be updated over time?

Answer: For the CY 2018 rating period, the mix of Nursing Facility and Other Waiver rate cells will be reflected in each MCO's blended and capitation rate. The methodology will be evaluated in subsequent rating periods based on the actual mix of enrollment by MCO.

---

106. Question: What was used to validate the average "LTC Gross Cost" per diem on the MLTSS – Nursing Facility rate sheets? They appear to be lower than expected.

Answer: The Department's actuary has reviewed historical monthly LTC per diem costs for reasonability and consistency.

---

107. Question: Targeted case management services (early intervention) - which are labeled as Category of Service 068 - are currently excluded from required services for Medicaid members. Will HFS reconsider making this a covered service as it is an effective tool for managing members and for the integration of Behavioral Health and Physical Health? In particular, we would like to see T1017 and T2023 incorporated into covered services.

Answer: This comment has been noted for future consideration. MCO-covered services will be documented in the final 2018 rate range, including any adjustments.

---

108. Question: What is the justification for the large physician unit cost reduction for office visits? Does the encounter data provide evidence that MCOs could contract with providers at 20-35% lower rates than their current reimbursement levels?

Answer: Based on review of additional information, the office visit unit cost efficiency adjustment has been removed from the MCO-experienced capitation rate range development. The updated Data Book reflects this change.

---

109. Question: The Managed Care Efficiency Adjustments appear to be more in line with a FFS population or at a minimum a brand new Managed Care Program. When the rates are updated with 2016 experience, will the managed care efficiency adjustments be updated to reflect a more mature program in the Existing Counties?

Answer: For the final CY 2018 rate range, the Department's actuary will review CY 2016 experience to determine changes to the rate development assumptions as appropriate.

---

110. Question: The main driver of the variance between the low rate range and the high rate range comes from the changes in managed care savings. The Existing Managed Care Counties and Populations Data Book includes some documentation behind how the managed care efficiency savings were derived. Can you please provide additional documentation on how the additional managed care efficiency savings will be attained?

Answer: The Department notes the most recent quality ratings of existing MCOs indicate significant opportunity for additional managed care efficiencies as compared to the current experience. The Department anticipates there is potential for variation in managed care efficiencies achievable by potential Offerors.

---

111. Question: According to the Data Book, the experience from the first three months of FFS eligibility was excluded from the base experience. How was this assumption checked for reasonability? Can you confirm that the claims removed are equivalent to the average amount of retro-eligibility back dating?

Answer: The Department's actuary excluded the first three months of FFS eligibility and claims as a proxy for retroactive eligibility. In review of historical FFS experience, it was observed that utilization of services by Medicaid beneficiaries varies more significantly in the first three months than in subsequent months. The Department believe this assumption is reasonable.

---

112. Question: Table 7 of the New Managed Care Counties and Populations Data Book appears to be labeled incorrectly. There are two exhibits for ACA Expansion Adults and none for the DCFS youth.

Answer: The second label 'ACA Expansion Adults' should read 'DCFS Youth'. The assumptions illustrated in this section correspond to the DCFS Youth.

---

113. Question: The New Managed Care Counties and Populations Data Book assume a large decrease in Outpatient Non-ER due to the shifting of some outpatient surgeries to a professional or ambulatory setting. There doesn't appear to be any resulting increase in the professional side of increased utilization of services, or increases in Cost Per Unit due to the fact that these surgeries would have higher relative utilizations of more expensive services. Will an adjustment be made for this?

Answer: The Department's actuary has made an upward adjust in office visit utilization in conjunction with the decrease in ER utilization. It has also made an upward adjustment in the ER cost per unit to reflect that remaining ER visits will have a higher cost on average once the potentially avoidable visits have been removed.

---

114. Question: Table 12 of the New Managed Care Counties and Populations Data Book appears to be labeled incorrectly. Should it say "New Managed Care Counties and Populations" instead of "Existing Managed Care Counties and Populations?"

Answer: Table 12 of the New Managed Care Counties should be labeled as "New Managed Care Counties and Populations". The assumptions illustrated are correct as pertaining to these populations.

---

115. Question: Why do most of the Other Data adjustments in the Existing Counties Retro Models result in reductions? According to Table 5, in the Data Book, the overall change appears to be positive along with most of the changes. Please provide some background around what else might be causing "Other Data Adjustment" decreases in the Existing Counties Retro Model.

Answer: In addition to the adjustments listed in Table 5, the Other Data Adjustments columns also reflect the adjustments listed in Table 8, Exclusions of Payments or Services.

---

116. Question: Why do some of the Government Provider Program and Policy Cost Adjustments in the Existing Counties Prospective Models appear as large reductions?

Answer: The inpatient prospective government provider program changes reflect the change from per diem to APR-DRG reimbursement effective January 1, 2016. While this reimbursement change was budget neutral as of January 1, 2016, the impact varied by region and rate cell.

---

117. Question: Why are managed care efficiency utilization reductions projected in the Inpatient Maternity Delivery service category? Please explain the basis for that assumption.

Answer: The maternity delivery managed care efficiency adjustments reflect a shift in deliveries from Caesarean to vaginal. The factors were illustrated and applied on a composite basis to both the Normal and Caesarean lines. This reflects lower average days per delivery and lower average cost per day related to this transition. The Department's actuary has assumed no change in the number of deliveries.

---

118. Question: How will the 2018 rates take into account the impact of Mental Health Parity?

Answer: This will be documented in the final 2018 rate range. No adjustments have been made for Mental Health Parity in the RFP rate range.

---

119. Question: There doesn't appear to be any mention of the 1% Withhold in the Data Book. How will this be incorporated into the projected rate ranges, and will we get a revised Data Book which includes this information?

Answer: The Data Book is gross of any withhold percentages. The final CY 2018 rate certifications will document the withhold percentage; however, all materials will continue to reported gross of the withhold.

---

120. Question: Will the final Administrative Loads be adjusted to take into consideration the number of MCOs to which the State awards contracts as well as more updated MCO administrative expenses trended forward?

Answer: The Department reserves the right to review the administrative expense assumptions in the final CY 2018 rates. Any changes in administrative loads will be documented, and successful Offerors will be provided an opportunity to ask questions subsequently.

---

121. Question: Effective 1/1/2018, MCOs will be responsible for payment of the Health Insurer Fee (HIF). How will the cost of this be included into the rates for CY 2018?

Answer: To the extent MCOs are responsible for the health insurance providers' fee (HIF), MCOs will subsequently be reimbursed by the State for appropriate fees. As the HIF payment is payable from health plans to the IRS in arrears, specific amounts will be documented in an amendment to the original rate certification.

---

122. Question: Please further explain what the percentages in Table 13 represent. For example, does 1% mean that 1% of the NF population will shift to HCBS or there will be a 1% shift in total NF+HCBS to HCBS?

Answer: The percentages indicate there will be a 1% shift in the penetration of HCBS. For example, a 1% shift would occur if the percentage of beneficiaries receiving HCBS increased from 50% to 51%.

---

123. Question: Under the current contract health plans were able to achieve savings through more flexibility on our formularies. Both High and Low rate ranges seem to assume additional savings beyond those we have achieved without the same flexibility. How was the PDL requirement considered in developing the rate ranges, where there is an expectation of lowering costs from the existing managed care contract?

Answer: The CY 2018 RFP rate range does not reflect the restricted PDL. The impact of this policy change will be reflect in the final CY 2018 rate range.

---

124. Question: Section 5.3.4 of the model contract states that the Contractor cannot collect rebates on any drugs that the Department has on its PDL or has a State supplemental rebate program. This restriction will decrease the amount of rebates MCOs can collect compared to the existing managed care contract. How was the change in rebates considered in the development of the rate ranges?

Answer: The CY 2018 RFP rate range does not reflect the restricted PDL. The impact of this policy change will be reflect in the final CY 2018 rate range.

---

125. Question: Section 5.3.5 of the model contract states that the Contract or the Department's PDL prohibit utilization controls. Can you specify which drugs are prohibited from utilization controls since this could have a material impact on the pharmacy utilization?

Answer: There are situations where either statutorily or contractually (via State Supplemental Rebate Agreements) utilization controls are prohibited for drugs or classes of drugs and the MCOs would be rerquired to comply with those statutory and/or contractual prohibitions. The Department would identify where these prohibitions exist. The Department's PDL can also be found at: https://www.illinois.gov/hfs/MedicalProviders/Pharmacy/preferred/Pages/default.aspx

---

126. Question: There are high levels of managed care savings assumed on unit costs for office visits for the existing managed care population. The rate ranges assume 20% cost savings for the high end of range and 36% for the low end of the range. Please specify if the higher reimbursement in managed care was driven by a specific MCO, region, or provider type?

Answer: Based on review of additional information, the office visit unit cost efficiency adjustment has been removed from the MCO-experienced capitation rate range development. The updated Data Book reflects this change.

---

127. Question: The risk mitigation section refers to risk adjustment for the composite rate in the disabled adult (DA) population. In other states this has taken a significant time to implement. What risk adjustment methodology will be used to adjust the service package II (SP II) rates for the disabled adult (DA) population and would it be applied immediately or at a later date?

Answer: The Department's actuary has historically performed risk adjustment for the Disabled Adults service package I on a composite basis and anticipate continuing this practice. For service package II, the Department's actuary will be implementing risk adjustment using RUGs scores during CY 2017 and anticipate continuing this practice.

---

128. Question: The managed care savings assumptions for the existing population was developed by comparing experience among MCOs after adjusting for acuity. How were risk scores, or any other method of adjusting for acuity, used in the development of the managed care efficiency adjustment for the new population? If available, would the risk scores for the FFS populaton be provided to assist the Offerors in developing their financial proposals?

Answer: No further information in response to this question is available at this time.

---

129. Question: Will we have the opportunity to decline a “renewal” after the initial contract term has ended?

Answer: Yes. The Contractor will have the opportunity to decline a renewal after the initial contract term has ended.

---

130. Question: When does HFS anticipate readiness reviews to occur?

Answer: A date has not yet been determined.

---

131. Question: Will HFS grant awardees the ability to retain the data book? If so, will HFS reconsider the destruction date to be extended to the award date? If yes, please provide revised data sharing agreement.

Answer: No. The data sharing agreement was specifically for this RFP and the submission of proposals. A new data sharing agreement may be initated with the successful Offerors at the time of contract negotiations.

---

132. Question: Please expand on the rationale for the regional adjustments in the retrospective models and provide an example of the development of these regional adjustments, including confirmation of their neutrality within each rate cell.

Answer: The EUM medical expenditures included in the base data was reported on a statewide rather than a regional basis. The regional spend from MCO survey responses was used to develop and apply regional adjustment factors to reflect relative differences on a regional basis.

---

133. Question: Using a single year of experience (CY2015) as the base may not be credible for all rate cells. Please describe how variability for these smaller rate cells was considered and accounted for in the rate ranges.

Answer: For rates developed from FFS data, a smoothing adjustment was made to claimants incurring more than $250,000 in expenditures during the calendar year. We believe will mitigate the volatility in rate changes for rate cells / regions with limited enrollment.

---

134. Question: Please explain how the managed care utilization assumptions in the low range of the new regions account for the shift of costs when care management initiatives are achieved. For example, Inpatient Mental Health/Substance Abuse utilization is decreased in some cases by as much as 30%, but there is no associated increase in Outpatient Behavioral Health where these services would transfer in an efficient system. Similarly, Inpatient non-MH/SA utilization decreases without any apparent offsetting increase to Outpatient non-BH. Please explain how the assumed reductions in Inpatient are reflected in the change in mix of services elsewhere in the cost models

Answer: Adjustments were made to the 'MH / SA Physician' service category. For example, for the Region 3 Disabled Adults Community rate cell, inpatient mental health / substance abuse days were reduced by 107 days per 1,000. The assumed MH / SA Physician utilization was increased by 218 units per 1,000.

---

135. Question: When developing the managed care assumptions for the Low range, how were differences in acuity mix for the MCOs that were selected as the benchmark relative to the other MCOs accounted for?

Answer: The development of managed care efficiency assumptions controls for any potential differences in acuity amongst enrollees by limiting the analysis to potentially avoidable costs.

---

136. Question: The margin load included in the capitation rate development is at the low end of what we have observed nationally, and what has been illustrated in a recent SOA paper, "Medicaid Managed Care Organizations: Considerations for Calculating Margin in Rate Setting". Please describe how risk-based capital contributions/cost of capital, the risk of new populations, and the risk that the final CY2018 capitation rates will be updated in an unknown way, contribute to the determination of the margin used in the rate ranges.

Answer: The referenced paper indicates that RBC requirements for MCOs range between 0.3% and 1.0% of revenue. Given the anticipated size of the successful Offerors, and the convexity of the RBC formula, the risk margin built into the capitation rate range is reasonable and adequate to support minimum RBC requirements.

---

137. Question: When CY2016 experience is incorporated to revise the rate ranges, how will the various assumptions such as trend and managed care be revised in addition to the base data? To the extent that CY2016 experience develops unfavorably outside of the rate ranges offered, how would that be adjusted/reconciled?

Answer: The CY 2016 experience will be reviewed to determine if adjustments are warranted. Adjustments may be made to any assumption based on emerging and actual experience. These adjustments will be fully documented and communicated to successful Offerors as part of the CY 2018 final rate development.

---

138. Question: When updated CY2016 data is available, will the CY2015 base data be fully replaced or will both CY2015 and CY2016 be used?

Answer: The Department's actuary will determine whether to apply experience and revised assumptions to the existing data books or to rebase to CY 2016 data upon receipt and review of all available information related to CY 2016 dates of service.

---

139. Question: Please clarify why participants enrolled in an HMO were excluded in the NDCA and DA base experience development (see pages 5 and 6 of the Existing populations databook).

Answer: Morbidity adjustments were made to the MCO-experienced data book for participants enrolled in an MCO during CY 2015 who are considered eligible for the Disabled Children or DCFS Youth populations in CY 2018. The acuity of these members is not consistent with the expected acuity of NDCA enrollees in CY 2018.

---

140. Question: Why were Capitation services (COS 081) excluded from the base?

Answer: This is consistent with the HFS list of covered services maintained by the State.

---

141. Question: Please demonstrate how efficiencies of scale and enrollment growth were incorporated into the non-benefit expense assumption development.

Answer: The Department's review of administrative expenses takes into consideration additional, non-public sources that detail costs by population type (e.g., Non-Disabled Children and Adults, Disabled Adults, etc.). The Department's actuary reviewed historical administrative expense levels relative to public and non-public sources to determine reasonable and attainable levels. Further, it is anticipated that economies of scale can be achieved pertaining to fixed or tiered cost structures (e.g., corporate overhead) as these costs will be allocated across a significant membership base.

---

142. Question: Please provide more detail on how trend rates were determined by population and region specifically for non-pharmacy

Answer: The Department's actuary reviewed historical monthly costs by service category, normalized for completion, program, and policy adjustments. Various regression and forecasting techniques were applied to project normalized utilization and PMPM rates to the rating period. Following this review, trend assumptions were made by population consistent with the review of the historical and prospective trend analyses.

---

143. Question: Risk Adjustment: Will the risk adjustment methodology use the CDPS+Rx algorithm for acute medical, similar to current contracts? If so, will the algorithm be updated to keep certain NDC codes up to date?

Answer: The risk adjustment methodology will be communicated to successful Offerors and documented in the final CY 2018 rate certification. The risk model used will reflect the most recently available list of NDC and/or diagnosis codes as applicable.

---

144. Question: Risk Adjustment: Will the risk adjustment be applied by region and rate group, similar to current risk adjustment methodology? Will the rate groups be similar to current risk adjustment methodology?

Answer: The Department anticipates the implementation of risk adjustment factors will be made on a regional and rate group basis similar to the methodology currently in place. Final details will be communicated to successful Offerors as part of the final CY 2018 rate development.

---

145. Question: Risk Adjustment: Please describe the mechanism for applying the risk adjustment in an environment where each MCO may be paid different base capitation rates.

Also, is the intent for the risk adjustment process to be budget neutral, and if so, how will this mechanism work to ensure that?

Answer: The risk adjustment methodology will be budget neutral to the State at a rate cell level on a projected basis. An illustrative example of the application of risk adjustment will be provided to successful Offerors during the CY 2018 rate development.

---

146. Question: Risk Adjustment: Will the entire capitation be risk adjusted as in current methodology, or just the claims expense portion?

Answer: The Department anticipates the entire capitation portion will be risk adjusted as in the current methodology. The final methodology will be communicated to successful Offerors during the CY 2018 rate development.

---

147. Question: Risk Adjustment: Will the DA SPII nursing facility rates be adjusted based on composite RUG score, or will some other risk adjustment methodology be used? If so, please describe the expected methodology and data inputs.

Answer: The Department anticipates the DA SPII rates will be risk adjusted based on RUGs scores. The final methodology will be communicated to successful Offerors during the CY 2018 rate development.

---

148. Question: Rates reflect current coverage and exclude additional services in Attachment IV that are in the pending 1115 Waiver and State Plan amendments. How material are the additional services?

Answer: The Department's actuary has not evaluated the impact to the capitation rates in the pending 1115 Waiver or pending state plan amendments. Approved changes in covered eligibility and services will be reflected in the final CY 2018 rate range.

---

149. Question: Please confirm that the government risk pool is to be structured the same as that discussed during CY2017 rate setting, and to the extent that it differs, please describe those changes.

Answer: The structure of the government risk pool in CY 2018 has not been finalized. This information will be communicated to successful Offerors during the final CY 2018 rate development.

---

150. Question: The bid for DA and MLTSS are based on program-wide membership distributions for SPII/long term services and supports. Please confirm that actual SPII/long term services and supports rates paid to an MCO will be based on the MCOs bid percentage applied to the rate range by rate cell, rebalanced using an MCOs own membership distribution as a starting point, rather than the program-wide membership.

Answer: Yes. The Department can confirm the DA SP II and MLTSS rates will be blended based on each MCO's own mix of membership by setting of care.

---

151. Question: How does the base data and/or the adjustments account for providers that have the leverage to contract above 100% in the new to managed care counties?

Answer: The capitation rates developed based on managed care experience were not adjusted from CY 2015 inherent provider reimbursement levels, with the exception of government provider reimbursement and office visits. Explicit adjustments were not made to FFS experience for provider reimbursement levels.

---

152. Question: What implementation costs are included in the non-benefit expenses assumptions for the new to managed care populations?

Answer: The non-benefit expenses reflect costs anticipated to be incurred by successful Offerors during the rate period.

---

153. Question: For what period of time will plans be held to the offeror bid percentiles?

Answer: MCOs are required to maintain or lower offeror bid percentiles through the course of the contract.

---

154. Question: At what withhold percentage will winning bidders that are current contractors be held in 2018 for existing populations? What about new populations and/or regions?

Answer: The withhold percentages in section 7.9 will apply to all Contractors, regardless of whether they currently hold a contract with the Department. Section 7.9.4 defines the first measurement year.

---

155. Question: Please confirm that the projected member months in DA and MLTSS for CY 2018 as presented in the databook are reflective of 2016/2017 initiatives to move membership from facilities to a community setting.

Answer: The Department confirms the DA and MLTSS projected CY 2018 enrollment reflects initiatives during CY 2016 and CY 2017 to transition setting of care for eligible members.

---

156. Question: In the new region blend and rebalance workbook, the high end rate range for DA SPII and MLTSS 65+ show rebalancing targets, but an unadjusted rebalanced PMPM. Please explain why the rebalanced PMPM does not differ from the original blended PMPM when the rebalancing target is non zero.

Answer: The high end of the rate range for DA SP II and MLTSS 65+ were applied incorrectly in Appendix VII for the FFS experienced data book. An updated data book will be provided with the correct rebalancing applied. Note, this will have no effect on DA SP II for regions 3, 4, or 5.

---

157. Question: Please describe how MCO-reported provider incentives are incorporated into the existing population data and please quantify those amounts.

Answer: The amount of provider incentives included in the CY 2015 base experience was $36 million.

---

158. Question: Please describe how care coordination fees (both MCO reported and FFS) are incorporated into the rate ranges and please quantify those amounts. If they are embedded in the QI non-benefit expense assumptions, please identify and quantify the other items included.

Answer: The quality improvement portion of the non-benefit expenses are inclusive of care management, care coordination, and quality improvement expenditures. The Department's actuary has not explicitly attributed the amounts within these costs to line item care and quality activities as we anticipate allocations will vary by MCO.

---

159. Question: The new “white space” counties are considered rural. Building an administrative model of care management support in rural counties costs more due to travel and geography coverage. At a minimum, we do not anticipate the administrative savings of additional members to be the same in the rural versus urban areas, especially where the MCO has existing administrative staff (i.e. Chicago area). How is the difference between urban and rural geography factored into the administrative assumptions?

Answer: The Department believes the administrative assumptions are appropriate for the populations covered, number of enrollees, and anticipated number of contracted MCOs. The Department's actuary has not developed separate administrative cost assumptions urban vs. rural counties.

---

160. Question: The reduction in administrative load is greatly influenced by the ultimate number of MCO's selected to operate state-wide. Please provide the administrative saving assumptions based on 5 state-wide winners and then separately for 3 state-wide winners. Our estimate is the membership difference between 1/3rd and 1/5th could be as much as 65% higher

Answer: No further information in response to this question is available at this time.

---

161. Question: The material administrative cost reductions in the proposed rates appears counterintuitive to requirements for MCOs to expand to all products and all geographies which requires investment on behalf of the bidding MCOs. In addition, increased administrative costs will be required with limited membership potential in the new population and geographies if the majority of large MCOs remain and membership is not reassigned equally. Please provide clarification on the proposed administrative cost reductions in light of the required expansion and membership opportunities.

Answer: The MLTSS administrative costs were increased significantly from assumptions used for the July 1, 2016 through December 31, 2017 rating period. For all populations, the Department believes the administrative costs are consistent with other Medicaid managed care programs of similar size, number of plans, and populations.

---

162. Question: The assumption is that administrative cost will be reduced with greater scale per MCO which can be achieved only with considerable membership movement and disruption. Please clarify how managed care assumptions and efficiency factors were adjusted downward to reflect the result of member movement between current and new MCOs which will disrupt the managed care interactions for members new to the MCOs without prior clinical claims history and established member relationships. Assuming the benefit in administrative savings from members shift and disruption, but not assuming lag in managed care effect does not appear actuarially sound. Please explain.

Answer: MCOs will receive 24 months of claims and diagnosis history for each new enrollee. MCOs should use this information to help establish a clinical and provider profile of each beneficiary.

---

163. Question: Please clarify how administrative savings from the scale are possible for populations that have LTSS benefits and are highly regulated by staffing and care management requirements with very limited additional potential to generate savings from the scale of any given MCO.

Answer: The MLTSS administrative costs were increased significantly from assumptions used for the July 1, 2016 through December 31, 2017 rating period. The high rate range administrative

costs for the Disabled Adults Service Package II population were decreased approximately 0.5% from the CY 2017 rate setting assumptions.

---

164. Question: Since it is Milliman's intent to use the CY2016 data to develop the CY2018 capitation rates, how will the MLTSS program rates be developed since the MLTSS program started in July 2016 and is therefore partially managed by MCOs during the CY 2016 period in the counties that were included in the initial launch of that program?

Answer: The Department's actuary will review all available MLTSS experience from CY 2016 including both FFS and MCO experience in development of the final MLTSS CY 2018 rate range.

---

165. Question: The "attainability" of the Pay For Quality (P4Q) withhold dollars is critical to the overall rate adequacy. The State has consistently raised the performance targets and has not reported out to the public the overall attainment of previous rate withholds. We would respectfully request that the 2018 performance targets be clearly stated and the estimate of withhold payments (approximately 2% of premium) assumed in the rate adequacy model be provided to bidders.

Answer: There are no withholds for 2018.

---

166. Question: Please provide examples and specifics relative to the "large claim smoothing" that was done to the New Managed Care Counties and Populations FFS data.

Answer: The Department's actuary reviewed member-level claims experience during CY 2015. Members with annual claims exceeding $250,000 were considered "outliers" and these expenditures were reallocated over a larger population basis to mitigate potential volatility in the capitation rates due to large claimants. The smoothing was performed on a budget neutral basis.

---

167. Question: Please provide an explanation for why there was no "large claim smoothing" to the MCO data?

Answer: Due to the availability and quality of MCO encounter data, the Department's actuary relied primarily on encounter utilization monitoring (EUM) reported data. Given this data source and the concerns with the quality of available encounter data, the appropriateness of applicable large claim smoothing adjustments could not be determined.

---

168. Question: The requirement of a single formulary removes some level of rebate from the current MCO operating model. How was this assumed to be budget neutral?

Answer: The CY 2018 RFP rate range does not reflect the restricted PDL. The impact of this policy change will be reflect in the final CY 2018 rate range.

---

169. Question: Please clarify how the new CMS Mega Rule requirement to explicitly and separately account for RBC requirement was incorporated in the development of the rates.

Answer: The Mega Rule does not indicate an actuarial certification must "explicitly and separately account" for RBC requirements. It does indicate the non-benefit components of the rate must include expenses related to cost of capital. This cost in assumed in the margin assumptions that have been included in the rate development.

---

170. Question: Please specify what RBC level was targeted that corresponds to the RBC margin component that was built into the capitation rates.

Answer: The Department did not target a specific RBC margin.

---

171. Question: How will an MCO be compensated if their membership is skewed toward previously managed vs. unmanaged (or vice versa) in a region? Will the point in the rate range be used or will their rate reflect the mix of previously managed vs. unmanaged members?

Answer: The Department does not anticipate any adjustments for membership mix differences between managed and unmanaged populations. Risk adjustment will mitigate potential cost variances resulting from enrollment variances between MCOs.

---

172. Question: How will risk adjustment be applied? To the respective MCO rate or to the same rate for each MCO?

Answer: The risk adjustment methodology will be budget neutral to the State at a rate cell level on a projected basis. An illustrative example of the application of risk adjustment will be provided to successful Offerors during the CY 2018 rate development.

---

173. Question: The Existing Managed Care CY18 rate ranges include an adjustment to the physician reimbursement based on a conclusion that the MCOs are reimbursing the providers at 30% to 80% higher than the state's Medicaid Fee Schedule. It does not seem logical that the MCOs would reimburse that much higher than the state Medicaid Fee Schedule. Were reimbursements compared at the CPT/HCPC level for the same providers or were the average unit costs simply compared between the two (2) data sources?

Answer: Reimbursement levels were compared between FFS and MCO experience on a CPT/HCPCS level.

---

174. Question: FFS claim payments have been delayed by the State's budget crisis. The comptroller's office reports regular payments have increased to be at least 7 months in arrears, substantially different than the historical claim payments likely causing actuarial lag models to under-report the outstanding claim liabilities. Existing providers have confirmed in published Accounts Receivable reports that the State of Illinois is one of the highest debtors. How are the completion factors adjusted for the CY15 FFS data to reflect this?

Answer: The Department's actuary specifically reviewed FFS claims payments patterns over time for dates of service from January 2012 through December 2016. The base FFS experience includes 13 months of claims payment runout. Both of these factors were taken into consideration when developing claims completion adjustment factors.

---

175. Question: Does the model contract dictate that no-risk enrollees must be assigend to a care coordinator at no more than 600:1? today, not every low or no risk member is assigned a care manager. If MCO's are required to staff for 100% assignment, there will be a significant increase in adminstrative expenses.

References from Model Contract:

5.13.1.4 indicates "Contractor shall

stratify all Enrollees to determine the appropriate level of intervention by its Care Management program." Level 1 = low or no risk enrollees.

5.17.2 indicates that Caseload Standards of Level 1 at 600:1

Answer: The case load standards for a care coordinator apply to all Enrollees who require or request Care Management as described in Section 5.12.

---

176. Question: The financial bid is valid for 180 days and section 6.1.1 of the Financial Proposal requirements indicates that the bidder's proposed reimbursement rate is for the one (1) year period beginning January 1, 2018. Is our proposed reimbursement rate only in affect for one year and if so, how will the proposed rates be updated in the following years of the initial term?

Answer: The process for updating Offeror rates for the following years (as well as rate amendments) is described in the RFP.

---

177. Question: It is stated that the MCO survey data was completed in July 2016 and that the MCOs provided information related to subcapitated arrangements, affiliated party contracts, non-benefit expense costs, reimbursement and utilization of government providers during CY2015 and other information.

Answer: The MCO data collection process spanned from July 2016 to January 2017 including collection of subcapitated arrangements, provider contracting, non-benefit expenses, medical reimbursement levels, and various other information.

---

178. Question: It is noted in Section (2) (A) (i) (a) Types of data, that the CountyCare data has been excluded from the development of the CY 2018 rate range because it would have required a "significant degree of adjustment". It was also noted that the membership for this population was not excluded. If the claims are excluded but the membership is still included, wouldn't the resulting PMPMs be understated? The CMS Policy, 42 CFR 438.7 (b)(4)(ii) requires the actuaries to provide the cost impact of the material adjustment and the aggregate cost impact of the non-material adjustments. Please provide the appropriate detail.

Answer: CountyCare projected enrollment has been included in the CY 2018 member month totals. The CY 2015 base experience in the retrospective actuarial models wholly excludes CountyCare experience.

---

179. Question: The LTSS rebalancing ranges that are included in the Section (6)(C) seem arbitrary. The CMS Policy, 42 CFR 438.7 (b)(4)(i) require the actuaries to document "how each material adjustment was developed and the reasonableness of the material adjustment for the enrolled population". We believe this information is also important and necessary to provide to the MCOs. There was no detail provided as to why there are different expectations for the different populations and the different regions.

Answer: The Round 2 Offeror's conference includes information illustrating the percentage of members in a home- or community-based setting by region and population. The information presented is indicative of the variation in assumed CY 2018 transitions. Please refer to the presentation materials for specific details.

---

180. Question: Please comment on the availability of the waivers in relation the LTSS rebalancing expectation.

Answer: There are no current waiting lists for waivers covered under the Service Package II rates.

---

181. Question: How was continuity of care taken into consideration in the calculation of the LTSS rebalancing targets?

Answer: The LTSS experience data of existing Medicaid beneficiaries inherently reflects transitional costs related to change in setting of care as these covered populations experience regular churn. The Department's actuary did not apply additional transitional adjustments factors to utilization rates or service cost mix related to the LTSS rebalancing.

---

182. Question: It was noted that the CY15 non benefit expenses were adjusted for assumed economies of scale. Please comment on what sources were reviewed that would demonstrate the level of economies of scale. In addition, a Milliman is citing an analysis of administrative costs. This study analyzes the administrative costs in total for the MCOs. We would suggest that these costs need to be analyzed by the different complex populations as well as the different staffing requirements for each state before being compared.

Answer: The Department's review of administrative expenses takes into consideration additional, non-public sources that detail costs by population type (e.g., Non-Disabled Children and Adults, Disabled Adults, etc.). The Department's actuary reviewed historical administrative expense levels relative to public and non-public sources to determine reasonable and attainable levels. Further, it is anticipated that economies of scale can be achieved pertaining to fixed or tiered cost structures (e.g., corporate overhead) as these costs will be allocated across a significant membership base.

---

183. Question: It is our understanding that the current MCO's are being paid 6 months in arrears. Please describe how this will be accounted for in the margin build.

Answer: MCOs are receiving interest payments for the late payments. No adjustments have been made to the margin build for this reason.

---

184. Question: In Section 2.3.1.1 covered populations include both “Families and children eligible for Medicaid through Title XIX and Title XXI.” Please explain the rationale to combine TANF and CHIP children in the same NDCA rate cells.

Answer: The covered populations and services for the NDCA, DA, ACA, and MLTSS are consistent with the covered populations and services under the existing managed care program (excluding expansion to new counties).

---

185. Question: Can the State clarify how section 7.9.1 of the model contract will work in 2018? It states that a new entrant with no existing membership will not have a withhold in year one; please confirm.

Answer: There are no withholds for 2018 for any MCO.

---

186. Question: What services are included in the "Other Ancillaries" rate cell?

Answer: The EUM logic has been provided.

---

187. Question: Can dental be split out separately from the Other Ancillaries rate cell? If not, can you provide the cost distribution between the services included in that rate cell?

Answer: Dental services will be separately identified for the final rate range.

---

188. Question: CMS Final Rule on Medicaid Managed Care states capitation rates must be specific to each rate cell and states must certify a specific rate, rather than a rate range for contracts beginning on or after July 1, 2018. With a bidder's rate range percentage applied to future contract years, please describe how these rates will be developed to be in compliance with the new rules regarding rate ranges. Specifically how will Milliman certify rates lower than their actuarially sound best estimate?

Answer: The Department's actuary is developing a rate range within which we believe successful Offerors may operate. In the final CY 2018 rates, each MCOs' certification will reflect the successful Offeror's bid submission within the developed rate range. The Department will rely on the Offeror's Actuary in the submission of a proposed bid to certify that the specific rates are reasonable and attainable for the given Offeror within the rate range based on that Offeror's submitted proposal.

---

189. Question: Please explain the rationale for removing the maternity kick payments as a separate revenue stream and form of better matching payment to risk. Will deliveries now be considered in the risk adjustment calculation?

Answer: The issuance of separate maternity kick payments had significant administrative complexities. The Department's actuary will consider adjustments for deliveries in our risk adjustment calculations for 2018.

---

190. Question: Milliman applies negative adjustments ranging from 0.7 – 1.3% for copayments not collected by MCOs. Can Milliman confirm that copayments for federally exempt vulnerable groups, such as children and pregnant women, were not included in the calculation? Additionally, studies have shown that waiving copayments for Medicaid recipients results in a reduction of higher cost services with an ultimate net savings. Can Milliman describe how these avoided high cost services were considered in the copayment adjustment?

Answer: Copayment adjustments were not applied to federally exempt groups. Pursuant to CMS policy on 42 CFR 447.56(d), the rate range development included all cost sharing irrespective of whether MCOs imposed the cost sharing or were able to collect the full amounts of copays.

---

191. Question: Please describe the expectations regarding the negotiations of provider contracts with UIC and CCHS with regards to the fee schedule, the non-direct MCO revenue payments, and the established risk pool.

Answer: Per RFP Appendix VII, Attachment 1 (Existing Counties), section 7.B (page 33), the State intends to include a risk pool for utilizaton of CCHS and U of I facilities in CY 2018. While the details of this risk pool have not been finalized, the Department will share the details of the risk pool that was established for CY 2017 with Offerors who request it and who have submitted the Department's data sharing agreement.

---

192. Question: Milliman states they "have assumed new populations and expansion counties will enroll beneficiaries in managed care in April 2018." Do the estimated member months for these beneficiaries reflect a full 9 months of enrollment or is there an assumed phase in of new beneficiaries starting in April 2018 and continuing into additional months?

Answer: For the purposes of the RFP rate range, we have assumed 9 months of enrollment for each new population / expansion county enrollee. As stated previously, the Department's actuary will re-evaluate estimated enrollment for the final 2018 rate range.

---

193. Question: The trend assumptions applied to the new to managed care populations are fairly consistent with the trend assumptions applied to the existing managed care populations. Considering the new to managed care populations will not be managed for the majority of the trend period in the rates, can Milliman describe how FFS versus mitigated trend assumptions were developed? Additionally, considering the new populations and counties are not expected to begin enrollment into managed care until April 1, 2018, will Milliman be updating the midpoint of the rate period to August 15th instead of the stated July 1, 2018?

Answer: Trend rates were developed independent of managed care adjustments, resulting in similar trends between the FFS and managed care delivery systems. The Department's actuary will adjust the midpoint of the rate period for new populations / expansion counties based on the final enrollment timeline.

---

194. Question: Milliman states historical healthcare quality initiative (HQI) expenses were reviewed. Can Milliman specify the HQI requirements in IL that are considered in the Non-Benefit Quality adjustment?

Answer: HQI data was collected from our managed care survey provided to the plans in July 2016. The Department believes MCOs reported HQI consistent with NAIC definitions of quality improvement expenses; however, no audit or review of each plan's reported expenses has been conducted.

---

195. Question: As HCBS and Nursing Facility mix can vary by MCO, will rebalancing and mix assumptions be made specific to each MCO in a manner budget neutral to the State as a form of risk adjustment on the blended MLTSS and DA SP II rates?

Answer: Yes. The blended rate will be developed separately for each MCO.

---

196. Question: It appears there is an error in the Excel document provided where the High End Rate Range should have the Rebalancing Targets applied when the Target assumption is greater than 0%. Please confirm and provide updated exhibits if necessary.

Answer: The high end of the rate range for DA SP II and MLTSS 65+ were applied incorrectly in Appendix VII for the FFS experienced data book. The Department will provide an updated data book with the correct rebalancing applied. Note, this will have no effect on DA SP II for regions 3, 4, or 5.

---

197. Question: How was the range for Service Package II developed for Cook County? The effective rates in the data book are significantly lower than the effective rate for 2017.

Answer: The methodology and actuarial models for the DA SP II Cook County capitation rates are documented in the MCO-experienced data book. The Department notes the CY 2018 and CY 2017 blended rates will vary due to differences in the baseline projected enrollment mix of Nursing Home and Other Waiver rate cells. In addition, the CY 2018 SP II low end rate range includes a component for rebalancing setting of care, whereas the CY 2017 rates do not.

---

198. Question: Why is the Quality PMPM component for the High End Rate Range lower than the PMPM for the Low End Rate Range for all products?

Answer: The Department's actuary has assumed a greater investment in quality improvement activities will result in lower claims expenses.

---

199. Question: For smaller health plans that are looking to grow and investing into resources and infrastructure, it would be helpful to have an estimation of expected membership growth, as this will affect the plan’s bids. Can the Department provide an estimate of membership growth?

Answer: Based on RFP information and other publicly available HFS managed care enrollment data, the Department believes MCOs can develop reasonable estimates of enrollment growth.

---

200. Question: How soon would risk adjustments be calculated based on the new members received for health plans that win contracts?

Answer: The Department has not made a determination on the risk adjustment timeline.

---

201. Question: Will there be any new add-on or pass through payments associated with members from these new populations? For example, the Cook County $10 pass-through access fee for Stroger and UIC?

Answer: No further information in response to this question is available at this time.

---

202. Question: How often will the State adjust and reset rates to the extent of emerging data, policy or program changes, legislative changes or other factors impacting the cost of the population? Once a year, once a quarter? Each occurrence?

Answer: The Department will evaluate the materiality of the impact of programmatic or legislative changes on a case by base basis.

---

203. Question: Although Service Package III is not in scope for the contract initially, if the health plan must assume responsibility for Service Package III with 180 days advance notice, what would be the timeframe for receiving the rates for Service Package III?

Answer: The Department would strive to provide rates for Service Package III at least 90 days prior to the initial coverage date.

---

204. Question: Is it possible to get a hardcopy of the deck used in the meeting on 4/4?

Answer: It will be posted to the State's website.

---

205. Question: Please explain/demonstrate how encounter data was stratified and formed into triangles and used to develop completion factors when it had been deemed by Milliman to be unreliable and non-credible for the base rate calculation.

Answer: For encounter data that was submitted, incurred and adjudicated dates were available.

---

206. Question: In the discussion of the completion adjustment, Milliman referred to “historical patterns” to assist with the calculation. What were the historical patterns based on and could they have been used to develop completion factors all on their own (without reference to non-credible encounter data, etc.)?

Answer: The methodology for completion factor development is outlined in the paragraph following the citation of "historical patterns".

---

207. Question: Could we see the supporting calculations that led to the development of the completion adjustments for the following:

• DASA, LTC (1.01)

• Non-delivery (1.015)

• Delivery (1.02)

Answer: No additional information will be provided.

---

208. Question: In the development of the low rate-range for the existing populations, the following description is given:

For the low rate range, we assumed approximately 5% to 10% additional aggregate savings from managed care efficiency improvement. These ranges were established based on variation in MCO expenditures on a population basis relative to average costs in CY 2015, after normalizing for member acuity differences. Note: the low rate range was established based on experience from the higher-performing MCOs in a given rate cell. It is not indicative of an MCO having achieved this level of performance for all rate cells or populations.

What precisely does this mean? Does it mean that for every line in Table 9 (Attachment 1), there is an MCO that is currently operating on that level of cost and utilization? Or does it mean that for every line in Table 9 there is an MCO operating at the average MCO level multiplied by the Low/High ratio? In other words, would that MCO still need to achieve further efficiencies in the contract year to hit the low range again, despite the fact that they are the model of utilization and cost efficiency for a particular service and population? Or does it mean something else entirely? Would it be possible to share the calculation of the low range values and/or perhaps provide a numerical example of how this works?

Answer: The low rate range for the MCO-experienced data book reflects managed care efficiencies indicative of higher-performing MCOs in a given rate cell. This does not indicate that a single MCO achieved the low rate range managed care efficiencies for all rate cells. Rather, the variation in composite managed care efficiencies from low to high rate range reflects

the observed variation by health plans from average to low-end at a rate cell level. The spread of efficiency assumptions from low to high reflects the differentials observed from higher-performing plans to the historical MCO average; the differential in rate range does not reflect the observed differences from highest-performing to lowest-performing plans.

---

209. Question: For the high ranges for the existing groups, we have the following questions:

• Inpatient: Milliman is assuming a 20% reduction in same-DRG readmissions. What is the basis for Milliman believing that same-DRG readmissions are too high and that 20% is a reasonable and attainable target?

Answer: In reviewing historical MCO experience, significantly higher incidence of potentially avoidable costs in Illinois as compared to other states are observed. The Department's actuary believes this assumption is corroborated by NCQA results as well as performance metrics related to existing MCO contracts. Further, the 20% reduction reflects the aggregate reduction on a three-year basis from CY 2015 to CY 2018. It is believed that this is a reasonable goal that should be achievable for a health plan.

---

210. Question: For the high ranges for the existing groups, we have the following questions:

• Inpatient: Precisely how did the AHRQ PQIs lead Milliman to believe that there is a 10% reduction that is reasonable and attainable (in a single year) in avoidable inpatient admissions? Can Milliman point to other States that are functioning at this level?

Answer: In reviewing historical MCO experience, significantly higher incidence of potentially avoidable costs in Illinois as compared to other states are observed. The Department's actuary believes this assumption is corroborated by NCQA results as well as performance metrics related to existing MCO contracts. Further, the 10% reduction reflects the aggregate reduction on a three-year basis from CY 2015 to CY 2018. It is believed that this is a reasonable goal that should be achievable for a health plan.

---

211. Question: For the high ranges for the existing groups, we have the following questions:

• Inpatient: If readmissions and avoidable admissions are expected to decline, wouldn’t there be an increase (perhaps significant) in cost per unit for the remaining inpatient episodes (i.e. unnecessary inpatient stays should be cheaper than necessary ones)? Yet Table 10 in Attachment 1 shows inpatient costs per unit generally declining. Please explain.

Answer: Cost per unit adjustments were developed by removing readmissions and avoidable admissions from the base experience data.

---

212. Question: For the high ranges for the existing groups, we have the following questions:

• Emergency Room: The reductions in each type of classification appear to be significant, yet random. How were these specific amounts derived? What were the new targets based on? Is there any literature available to support this? Does Milliman truly consider these targets to be attainable in a single year? Did the NYU tool suggest these targets are achievable for this population? [Target reductions are 25% non-emergent, 15% emergent / PCP treatable, 12.5% emergency / preventable / avoidable]

Answer: The adjustments for existing populations were established based on 2015 experience for the 2018 rate period. This would allow MCOs 3 years to improve managed care efficiencies relative to the base experience year. Targets are established based on our review of other state Medicaid managed care programs with similar populations.

---

213. Question: For the high ranges for the existing groups, we have the following questions:

• Maternity: Milliman is assuming significant increases in vaginal deliveries in a single contract year. What are these targets based on? What benchmarks are available for comparison and where does Illinois Managed Medicaid rank in that comparison?

Answer: The adjustments for existing populations were established based on 2015 experience for the 2018 rate period. This would allow MCOs 3 years to improve managed care efficiencies relative to the base experience year. For the high rate range, the adjustments have not been modified from the 2017 rate setting process. For the low rate range, the Department's actuary developed slightly higher targets for vaginal delivery rates. Several of the MCOs already met these targets in 2015. A ranking of the Illinois Medicaid Managed Care program with respective to the vaginal delivery rate has not been undertaken.

---

214. Question: For the high ranges for the existing groups, we have the following questions:

• Prosthetics and DME Services: The 5% adjustment appears random. What is the assumption that “improved provider contracting as well as economies of scale” will lead to a 5% reduction in cost based on? Does Milliman have any research or documentation to support this assertion?

Answer: Please refer to Appendix 4 of the MCO-experienced data book, managed care efficiency columns for specific assumptions by rate cell. This assumption assumes a MCO's network development and reimbursement strategies will result in savings relative to a FFS delivery system.

---

215. Question: For the high ranges for the existing groups, we have the following questions:

• Office Visits: A 20% reduction in payment rates is substantial, especially to achieve it in a single year. Are there any concerns that the marketplace may be adversely affected? Has there been any consideration that utilization may increase as physicians try to recapture their lost revenue in alternate ways?

Answer: Based on review of additional information, the office visit unit cost efficiency adjustment has been removed from the MCO-experienced capitation rate range development. The updated Data Book reflects this change.

---

216. Question: For the high ranges for the new populations and groups, we have the following questions:

• Inpatient & OP Surgery: It appears that the efficiency factors are derived from the utilization differences between managed care and FFS. How much of this difference is assumed in year 1? 100%? 50%?

Answer: No. The professional component of surgery managed care efficiencies for the new managed care counties and populations was developed with FFS experience only. The Department's actuary reviewed potentially avoidable costs for inpatient visits in the FFS delivery system to develop these factors. In recognition of the transition from FFS to managed care for these populations, the impact of the full potentially avoidable cost during CY 2018 was dampened to reflect this transition.

---

217. Question: For the high ranges for the existing groups, we have the following questions:

• Emergency Room: The reductions in each type of classification appear to be significant, yet random. How were these specific amounts derived? What were the new targets based on? Is there any literature available to support this? Does Milliman truly consider these targets to be attainable in a single year? Did the NYU tool suggest these targets are achievable for this population? [reductions are 40% non-emergent, 25% emergent / PCP treatable, 15% emergency / preventable / avoidable]

Answer: The adjustments for existing populations were established based on 2015 experience for the 2018 rate period. This would allow MCOs 3 years to improve managed care efficiencies relative to the base experience year. Targets are established based on our review of other state Medicaid managed care programs with similar populations.

---

218. Question: For the high ranges for the existing groups, we have the following questions:

• Prosthetics and DME: What is the assumed reduction (i.e. 5%? 10%? Greater?) Attachment 2 does not specify. What is the assumption that “improved provider contracting as well as

economies of scale" will lead to a reduction in cost based on? Does Milliman have any research or documentation to support this assertion?

Answer: Please refer to Appendix 4 of the MCO-experienced data book, managed care efficiency columns for specific assumptions by rate cell. This assumption assumes a MCO's network development and reimbursement strategies will result in savings relative to a FFS delivery system.

---

219. Question: For the high ranges for the existing groups, we have the following questions:

• Office Visits: Attachment 2 references an increase in physician office visits due to "successfully diverting potential non-emergent emergency room utilization to an office setting, as well as increased efforts to provide care to Medicaid beneficiaries." We understand the logic behind this but why are the utilization adjustment for physicians (Table 7 in Attachment 2) downward? Wouldn't they be expected to go up as other services go down?

Answer: Table 7 illustrates a composite adjustment for high level service categories. As illustrated in Appendix 4, managed care adjustments varied at the service category level. For example, different assumptions were used for office visits vs. inpatient visits.

---

220. Question: Non-Pharmacy Trend

• The non-pharmacy trend ranges from 1% to 1.5%, depending on the population. These are low in our opinion. However, the following questions arises: If 1% is based on historical analysis, isn't there a portion of this rate due to MCOs meeting efficiency targets at the time? In other words, perhaps the 1% is the result of a real trend of 4% and an achieved efficiency of 3%. If so, then requiring a 1% trend along with the substantial managed care efficiency factors is double jeopardy, no? Has this been taken into account? The write-up in the Rate Book is insufficient to determine this.

• How did Milliman develop utilization and cost/unit trend from the NHE projections, considering those projections include growth and changing enrollment mix? Milliman claims it made adjustments for this. What were the adjustments?

Answer: Trend analysis was performed using historical data through CY 2015 dates of service. The projected trend rates reflect expected levels prior to application of potential managed care efficiencies. Based on review of MCOs' historical quality measures and managed care efficiencies achieved, the Department's actuary does not believe that the prospective trend rates are artificially low as a result of efficiencies achieved by MCOs. In the review of CY 2016 data for the final CY 2018 rate certification, the Department's actuary will review potentially avoidable costs and savings achieved by MCOs during CY 2016 when developing final trend and managed care assumptions. Regarding the NHE projections, these projections were referred to in the documentation as an external and independent source used in consideration for

reasonableness. The Department's actuary neither used NHE projections directly in the trend projection model, nor made explicit revisions to our assumptions to tie to specific NHE metrics.

---

221. Question: Non-Benefit Costs – This item generally runs between 7% and 11% (including Quality), depending on the population. Given the variation in size of the MCOs, wouldn't it reasonable to vary these percentages based on the MCO enrollment? It appears to us that the smaller MCOs are at a disadvantage due to the economies of scale enjoyed by the larger MCOs. Has the State considered this?

Answer: No adjustments will be made to the non-benefit expense assumptions for estimated MCO enrollment variances.

---

222. Question: In 2017 there was a 2% withhold. There is no mention of a withhold in the data book. Can you please confirm whether or not there will be a withhold for the 2018 rates?

Answer: There are no withholds for 2018.

---

223. Question: There are some overly aggressive managed care assumptions for office visits that was based on information that we believe is not accurate. For example, at the top of page 25 of the Data Book it says "MCOs have historically reimbursed physician office visits at a rate significantly higher than FFS, ranging from between 30% and 80% higher than FFS reimbursement levels." This was used as the basis for assuming office visit cost reductions of 20% to 36%. These savings are not realistic or achievable. We are not aware of any MCOs in the marketplace reimbursing at these levels. Is there a survey from the MCOs supporting the 30% to 80% higher FFS reimbursement levels and can you provide the survey?

Answer: Based on review of additional information, the office visit unit cost efficiency adjustment has been removed from the MCO-experienced capitation rate range development. The updated Data Book reflects this change.

---

224. Question: For many of the rate cells the pharmacy PMPMs from 2015 to 2018 results in only about 10-15% higher PMPMs over that 3 year period (so about 3-5% trend per year for low/high). This is partly due to managed care cost adjustments of 8-9% for low and 3-4% for high. Requiring MCOs to use the state's formulary will likely result in higher than average drug trends and should be factored into the rate build up. Requiring the state formulary to be used will prevent MCOs from actively managing their formulary which is critical for controlling costs. Is there any analysis that demonstrates drugs costs will go up less than average as a result of mandating the state's formulary and can you provide this analysis?

Answer: The single PDL is not reflected in the 2018 RFP rate range.

225. Question: There is a statement in the rate book: "For qualified government-owned entities submitting a financial proposal with an intergovernmental transfer agreement in place, the rate range will be adjusted by ta factor to be developed for the final certified rate." Will that adjusment factor be presented to such entitites prior to the deadline for submitting the financial proposal so that the entity can make an informed bid that enables it to meet the requirements of the contract?

Answer: *Any such adjustment factor will be documented in the final certified rate for such an Offeror.*

---

226. Question: The spreadsheet distributed shows a rate for "disabled children." The RFP describes a population as "Special Needs Children" or at times "High Needs Children." The RFP defines "Special Needs Children" as "enrollees under the age of 21 who are eligibile for Medicaid through Supplemental Security Income (SSI), Division of Specialized Care for Children (DSCC), or a disability category of eligibility." The definition of "High Needs Children" includes SSI and disability category children (but not specifically DSCC), but also includes other children stratified as high risk. Given these discrepencies, can you clarify who qualifies for the rate for "Disabled Children?"

Answer: *The Disabled Children covered populations are listed on page 6 of the "New Counties and Populations" attachment of the Data Book.*

---

227. Question: DSCC services children in the CORE pgoram as wella s those in the MFTD waiver. Does the rference to DSCC include children receiveing services through the CORE pgoram or just MFTD? Are CORE children "Disabled" for rate purposes?

Answer: *Yes, the reference to DSCC includes Medicaid-eligible children who are currently receiving care coordination services through DSCC, including the CORE program as well as the MFTD waiver. Medicaid-eligible children in the CORE program are also included in the "Disabled children" category for rate purposes.*