Request for Qualifications (RFQ) for Care Coordination and Support Organizations (CCSOs) Frequently Asked Questions (FAQ)

Originally Posted: September 15, 2021
Updated: October 22, 2021

The questions below were submitted to HFS between September 1, 2021 and October 15, 2021, by email and during Conferences for Interested Applicants held on September 7, September 8, and October 15. Questions related to the RFQ process or contents are included. All other questions regarding the Pathways to Success program and CCSOs are included in the FAQ document maintained on the Pathways to Success website and can be found here: https://www2.illinois.gov/hfs/MedicalProviders/behavioral/pathways/Pages/resources.aspx.

***October 22 Update**: This FAQ has been updated to reflect new questions received in relation to the posted Supplemental RFQ. Questions strictly related to the initial RFQ posted on September 1, 2021, have been removed to prevent any confusion with Supplemental RFQ requirements.*

RFQ Application Requirements

1. **Why is the Department issuing a supplemental RFQ? (new 10/22/21)**

   A. The supplemental RFQ is being posted to solicit interest in providing coverage for those handful of DSAs for which HFS did not receive an application that met the criteria for eligible applicants.

2. **Will selected CCSOs be required to establish a physical site in the Designated Service Area (DSA)? (new 10/22/21)**

   A. CCSOs selected through the supplemental RFQ must have or establish a physical location within at least one of the counties in which the DSA operates by the target implementation date of 5/1/22. The physical location that is established must be Medicaid certified and enrolled as a Community Mental Health Center (CMHC) or Behavioral Health Clinic (BHC) with a Crisis Services Program Approval.

3. **What will be the new timelines for Mobile Crisis Response (MCR)? (new 10/22/21)**

   A. HFS will evaluate the feasibility of maintaining a 2/1/22 statewide transition of MCR responsibilities in conjunction with selected CCSOs and current designated MCR providers following notification of CCSO selection. Ensuring the stability of the crisis network and safety of customers in need of crisis services will be a top priority and consideration.

4. **For organizations that submitted applications in response to the original RFQ, would you recommend updating the application for the Supplemental RFQ? If so, what sections should be adjusted? (new 10/22/21)**

   A. This is up to the applicant, and may vary depending on how the applicant structured their application. An applicant could resubmit the same application in response to the Supplemental RFQ as they did in response to the original, but they may want to consider reading back through their application to determine if the application would be strengthened by making any changes to accommodate the DSAs they are applying for. For example, the organization may want to consider whether any strategies for community engagement, staffing plans, or other plans for service delivery need to be updated or tweaked to account for any differences in DSAs.

5. **Do you need an application for each DSA? Or, if applying for multiple DSAs, one narrative but multiple Appendix B?**

   A. Applicants applying to cover two or more DSAs must submit one unique RFQ Application Cover Sheet (please see Appendix B) for each DSA the applicant is applying to cover. The applicant has discretion in how they would like to handle the required written proposal – one written proposal is allowed and will be accepted for multiple DSAs. Alternatively, the applicant may choose to submit a separate written proposal for each DSA they are applying to cover. Applicants must also submit two unique Letters of Support for each DSA they are applying to cover and must be sure to include a copy of the Medicaid certification letter for the physical site identified on Appendix B for each DSA the applicant wants to cover.

6. **Section 9, Application Content and Requirements – if an applicant wants to include a table in the proposal, does the table also need to be double spaced or can it be single spaced?**

   A. Tables included within the written proposal may be single spaced.

7. **Section 9, Application Content and Requirements – are there formatting requirements for attachments (e.g., font size/type, spacing)?**

   A. There are no formatting requirements for the required attachments.

8. **Section 9, Application Content and Requirements – are there any page limit for attachments?**

   A. There are no page limits for the required attachments.

9. **Can providers collaborate in the application process to identify a CCSO collaboration for DSA coverage?**

   A. No. Responding applicants must assume full responsibility of CCSO requirements, as outlined in the RFQ, for the full DSA. Applicants may only propose partnerships with other provider organizations for the fulfillment of MCR responsibilities.

10. **Should any partnerships for MCR be outlined in the RFQ, or just providing a 30-day proposal to HFS for approval? (updated 10/22/21)**

    A. Any partnerships for MCR responsibilities the applicant anticipate having in place for initial MCR implementation should be outlined to the extent possible in the RFQ. This is critical to ensure a smooth transition of crisis accountability. Selected CCSOs are not prohibited from establishing MCR partnerships after the RFQ process is completed, so long as the appropriate 30-day notice and approval of the partnership from HFS is obtained.

11. **Section 9, Application Content and Requirements – can you amplify on the desired content of Attachment IV (Attachment III in the Supplemental RFQ), Statement on Legal Relationship with Hospital? Are integrated health systems precluded from applying? (updated 10/22/21)**

    A. This attachment requires the applicant to disclose whether its organization, or any of its proposed MCR partner organizations, has a legal relationship with a hospital. If the applicant's organization does have a legal relationship with a hospital, it is required that the organization maintain separation between its hospital functions and community service delivery functions. This separation needs to be explained and described as part of the attachment. Integrated

health systems with multiple lines of business (e.g., hospital, outpatient, crisis) are not precluded from applying to become a CCSO but are required to meet the conflict of interest standards, as outlined in the RFQ.

12. **Do Letters of Support need to be submitted for a proposed MCR partner or just the applicant?**

    A. Letter of Support are only required for the applicant. Letters of Support do not need to be submitted for organizations the applicant is proposing as partners in fulfilling the MCR responsibilities.

13. **Is Attachment II, Proposed Staffing Plan, also known as the Personnel Matrix (RFQ, p23, item 2.1)?**

    A. Yes.

RFQ Process

14. **What is the date that CCSOs will be notified of selection? (updated 10/22/21)**

    A. Applicants who responded to the initial RFQ posting will be notified of the outcome of the RFQ process by no later than November 15, 2021. Applicants who respond to the Supplemental RFQ posting will be notified of the outcome of the RFQ process by no later than November 30, 2021.

15. **Is it possible for more than one CCSO to be selected in a given DSA? Can you elaborate a bit more on the selection details of multiple applicants for a specific DSA?**

    A. Yes, it is possible for more than one applicant to be selected as a CCSO for a given DSA if multiple applicants are determined to be equally qualified.

16. **If multiple CCSOs are selected for a DSA, how will that impact applicant's staffing plans? How will youth be divvied up amongst multiple CCSOs in a DSA?**

    A. HFS will work with selected CCSOs to come to consensus on the handling of referrals and responsibilities within a single DSA, if multiple CCSOs are selected. Customer choice will serve as the primary driver of which CCSO in a DSA would serve a youth.

17. **Is there a scoring matrix for the written proposal? If yes, can you make it available?**

    A. The scoring tool that will be utilized by RFQ reviewers is not a public document at this time.

Enrollment Estimates

18. **Can someone remain enrolled in Pathways if they aren't receiving Care Coordination and Support (CCS)? In what scenario would that happen?**

    A. Yes, a youth and family may decline the service of Care Coordination and Support (CCS) and remain enrolled in the Pathways program. Pathways provides access the seven (7) new home and community-based services for eligible youth and their families. Youth and families have the right to choose to receive any mix of medically necessary services for which they are eligible.

19. **Is it HFS's expectation that each CCSO will be staffed and capable of serving the estimated 250 youth on the go live date in 2022? Or is it some other proportion of the estimated enrollment numbers listed in Appendix E?**

A. No, HFS does not expect that CCSOs be staffed and capable of serving 250 youth as of the CCS implementation date for their DSA. HFS expects each CCSO will establish capacity during the initial months of CCS implementation that would allow them to serve Pathways Youth as follows:

   i. Implementation Month 1: 70 Pathways Youth
   ii. Implementation Month 2: 125 Pathways Youth
   iii. Implementation Month 3: 175 Pathways Youth
   iv. Implementation Month 4: 250 Pathways Youth

   HFS will maintain close communication with selected CCSOs regarding staffing capacity and challenges, as well as any updates to Pathways enrollment estimates.

20. **Appendix E lists enrollment numbers at full participation. Is this accurate that it is a monthly number?**

    A. Appendix E provides an estimate of the monthly average number of youth enrolled in Pathways in each DSA at full implementation, which is not anticipated to be achieved until at least year two or three of implementation.

21. **Appendix E - Do you have estimates for number served annually?**

    A. HFS does not have annual estimates for the unique number of youth to be served in each DSA at this time.

22. **What assumptions has HFS made about the proportion of eligible youth for Pathways due to their IM+CANS scores who are then engaged and enroll in the program?**

    A. HFS anticipates that a significant portion of eligible youth will engage and consent to participate in Pathways, particularly after the program has been in operation for a period of time.

General Infrastructure and Service Requirements

23. **Section 4, item 1.4 – can you provide more information on what you believe to be "negotiating in good faith" with the MCOs? Are the MCOs required to pay CCSOs the state rates?**

    A. CCSOs are required to enter into a contract with all MCOs. HFS expects that MCOs and selected CCSOs deal honestly and fairly with one another, that each side makes sincere attempts to reach agreement on contract terms, and that neither side holds up the contracting process in pursuit of unreasonable requests. MCOs are not required to pay the State established rates for services; however, MCOs generally do not pay below the State rate.

24. **Section 4, item 1.5 – what is an All Kids Application Agent?**

    A. All Kids Application Agents (AKAAs) help families apply for medical assistance programs. AKAAs can receive reports on results of applications submitted and ongoing updates on the application process. More information about AKAAs can be found on the HFS website: https://www2.illinois.gov/hfs/MedicalPrograms/AllKids/akaa/Pages/become.aspx.

25. **Section 4, item 1.9 – If the CCSO enters into an agreement with another agency to provide MCR services for parts of the DSA would an MOU be sufficient between the two entities? Will HFS be providing the template or does the applicant have to develop these agreements? (new 10/22/21)**

    A. It is up each of the organizations entering into an agreement or partnership with one another. HFS will not provide a template and does not intend to dictate the format of the agreement to organizations.

26. **Will HFS still have a contract in place with existing MCR providers even if the CCSO also has an agreement in place with the MCR provider? (new 10/22/21)**

    A. MCR providers will need to remain certified and enrolled with HFS as a CMHC or BHC with a Crisis Services Program Approval. The Provider Enrollment Terms and Conditions serve as HFS' contract with enrolled providers. CCSOs and all MCR providers must also enter into and maintain Network Agreements for participation in each of the MCO's provider networks.

27. **Section 4, item 1.10.2 – can you please say more about the requirements to use ADT and WrapStat?**

    A. ADT is a statewide data exchange platform currently in its initial phase of implementation, which allows for admission, discharge, and transfer alerts to be shared with providers whose customers visit a hospital or emergency department. CCSOs will be required to subscribe to receive ADT notifications for their Medicaid customers to promote care coordination and quality of care. WrapStat is a web-based data collection, management, and feedback system designed to evaluate the fidelity of Wraparound services. CCSOs will be required to input relevant data regarding Care Coordinators and their assigned Pathways Youth receiving CCS to assist in the Wraparound fidelity monitoring process.

28. **Section 4, item 1.11.1 – can you give us a description of a firewall between the CCSO and the home and community-based services if the agency is the only provider in certain counties of the DSA? (new 10/22/21)**

    A. If a CCSO is identified as the only entity willing and qualified to provide the other Pathways home and community-based services, the CCSO will be required to have sufficient organizational separations and independence between operations (management structures, standard operating procedures, and separation of job functions) to prevent any possible conflict of interest. Specifically, the provider will be required to administratively separate the function of assessment and person-centered service planning from direct service provision functions. In such instances, HFS would provide specific technical assistance to the CCSO to ensure these requirements are met prior to implementation of new services.

29. **Section 4, item 1.11.3 - can you clarify the legal relationship with a hospital? In other words if we have partnerships/contracts for other services not related to the CCSO? (new 10/22/21)**

    A. This item refers to an agency that, at the organizational level, also has an ownership stake in an entity that operates as a hospital. An applicant that has entered into a contract with a hospital for the provision of services would not be required to establish firewalls or conflict of interest protections for the purposes of this item 1.11.3.

30. **Section 4, item 1.11.5 – requires CCSOs to establish processes to clearly outline how customers can request a different Care Coordinator or Case Manager at any time. Are Care Coordinator and Case Manager interchangeable?**

    A. Generally speaking, HFS uses the term Care Coordinator to refer to the role staff play when delivering Care Coordination and Support (CCS) to Pathways Youth. The term Case Manager is generally used to refer to staff who are providing more traditional case management services, such as case management for Screening, Assessment and Support Services (SASS), Family Support Program (FSP), or Specialized Family Support Program (SFSP) eligible youth.

31. **Section 4, item 1.12, Community stakeholder council - given the requirement to include community stakeholders and Pathways consumers, is there a timeframe for when CCSO must begin holding these meetings?**

    A. CCSOs will be required to begin holding Community Stakeholder Council meetings within six (6) months of when the CCSO begins providing CCS services.

32. **Section 4, item 1.12, Community stakeholder council - does the co-chair of council need to be a current Pathways youth or family?**

    A. It is strongly preferred that the co-chair be a youth or family currently receiving services from the CCSO, but it is not required. HFS recognizes some families may not be ready or have the capacity to take on the responsibilities of a co-chair while simultaneously engaging in intensive services.

33. **Section 4, item 1.14 references a Readiness Review. Is there a tool or rubric that applicants can review to self-assess readiness?**

    A. Additional information regarding the requirements of the Readiness Review will be provided to selected CCSOs as part of implementation preparation.

<u>CCS Requirements</u>

34. **Section 4, item 2.1 – Multifaceted approach to locate, engage, and communicate including text and email. This is not HIPAA-compliant communication which our legal states requires client/family consent prior to utilizing these communication modalities. Will that consent be obtained prior to sending the information to the CCSO for engagement and outreach?**

    A. Section 4, item 2.1 is a requirement for CCSOs to use multiple methods for engaging youth and families in services, both during initial outreach and as part of its ongoing engagement efforts. Nothing in this item requires CCSOs to use all the listed methods before consent is obtained. HFS will continue to explore methods for enhanced data sharing between the Department and selected CCSOs.

35. **Section 4, item 2.7.3.2 – the requirement for an Emergency Child and Family Team (CFT) meeting within 48 hours. Is this for all MCR events or only Pathways enrolled youth who are subsequently screened?**

    A. The requirement to hold an emergency CFT within 48 hours of an MCR event is only applicable to Pathways enrolled youth engaged in CCS services who have experienced an MCR event.

36. **Section 4, item 2.9 – The requirement is for one (1) successful contact a week. What service or activity would count as a successful contact? Can this be any of the Pathways services/providers including psychiatric services? Would consultation with MCO Care Coordinators count?**

    A. The RFQ defines a Successful Contact as "An oral communication (telephonic, video, or in-person) between the CCSO and a Pathways Youth and/or their parent/guardian for purposes of conducting CCS activities. Written communication (emails, texting) is not considered a Successful Contact." Contact or consultation with another service provider or the MCO Care Coordinator is not considered a Successful Contact.

MCR Requirements

37. **Section 4, item 1.3 – Can you explain the requirement to respond to "customers presenting in crisis in a contiguous county to Illinois for which the CCSO is responsible." Does that mean if a IL eligible youth has crossed the state boundary for a visit or a hospital stay?**

    A. Correct. If an eligible Illinois customer is presenting in crisis in a county contiguous to Illinois and an MCR referral for that customer is received by the CCSO, the CCSO must respond.

38. **Section 4, item 3.2.5 – refers to "in the event the customer is not enrolled in one of full benefit Medical Assistance Programs." Does this section refer to the current process of temporary eligibility and need for the family to apply for Medicaid?**

    A. Section 4, item 3.2.5 is referring to any time a customer is identified by CARES as not having full medical assistance benefits. In these instances, the CCSO is responsible for educating and notifying the family of the limited benefit coverage made available through the HFS Social Services special eligibility period and the potential costs associated with receiving benefits not covered by the HFS Social Services segment. CCSOs should be working with these families to apply for full medical assistance benefits.

39. **Section 4, item 3.2.6 – will MCR partners have access to the Crisis Reporting System (CRS) for data entry? (new 10/22/21)**

    A. HFS is exploring making CRS access available to identified MCR partners.

40. **Section 4, item 3.2.7.2 – is the CCSO responsible for providing Rule 140 Crisis Stabilization services if there are no other providers willing or able to do so?**

    A. Yes, the CCSO must ensure access to Crisis Stabilization services, either through partnerships with other providers delivering Crisis Stabilization or by delivering Crisis Stabilization itself.

41. **Section 4, item 3.2.9 – Seems to allow ability to contact CCSO directly in lieu of CARES for current clients. Will this be consistent across all MCOs?**

    A. Yes. This is currently a requirement of both the fee-for-service and the managed care Mobile Crisis Response service delivery systems.

42. **Section 4, item 3.3 – Services during Inpatient Hospitalization: For Pathways CCSO engaged youth, are these provided by the MCR staff or the Care Coordinator?**

    A. For Pathways Youth receiving CCS services, the Care Coordinator should be taking lead on coordinating while the youth is receiving inpatient hospital services. The CCSO's MCR team is expected to provide support to the Care Coordinator and CFT during the time a Pathways Youth is receiving crisis services, including participating in the emergency CFT meeting that occurs pursuant to RFQ Section 4, item 2.7.3.2.

43. **Section 4, item 3.6 – notes "SASS Program." Is the current system where HFS Social Services equals 90 days and MCOs have different or no timeframes continuing?**

    A. Children eligible for the SASS program will continue to be issued an initial 90-day HFS Social Services segment by the CARES line. MCO contractual requirements for children who access Mobile Crisis Response services can be found in the HealthChoice Illinois model contract and any subsequent amendments.

44. **Under Section 4, item 3.6 – In current state we serve as the DSA SASS agency and provide all services under that program. In future state, do all follow-up SASS responsibilities fall to the DSA CCSO?**

    A. As outlined in the RFQ, all MCR requirements for SASS eligible youth residing in a DSA are the responsibility of the CCSO covering that DSA, or the CCSO's designated MCR partner. This includes coordinating care for SASS eligible youth, including linking the youth and family to necessary services, for the duration of the youth's HFS Social Services special eligibility period.

45. **To be clear, if an established client is in another county, will the assigned CCSO be responsible for getting the client crisis care?**

    A. The CCSO serving the DSA in which the customer is experiencing a crisis will be contacted by CARES to respond and complete the MCR screening event. If the CCSO responding to the crisis is not the customer's home CCSO, then the responding CCSO is responsible for collaboration with the home CCSO and ensuring the case is appropriately transferred following the crisis event.

46. **Crisis Safety Plan is referenced multiple times - does HFS anticipate releasing a standard template for this document?**

    A. Yes.

Family Support Program / Specialized Family Support Program Requirements

47. **Section 4, item 4.3 – "The CCSO shall complete and maintain the IM+CANS for all FSP Youth whose home address is within the provider's DSA, incorporating the youth, family, and other treatment provider, as applicable, in the service planning process." Does this make CCSO's responsible for the IM+CANS for youth in residential treatment outside of the CCSO's DSA, if their home is within? Currently that responsibility is with the residential treatment center.**

A. The CCSO is responsible for maintaining the IM+CANS for all Pathways Youth and FSP Youth that reside in the CCSO's DSA. HFS will work with selected CCSOs and FSP residential treatment providers to provide additional guidance regarding IM+CANS responsibilities and coordination for youth who receive residential treatment services.

48. **Section 4, item 5.6 – requires CCSOs to complete or arrange for completion of IM+CANS for SFSP youth within 5 days of CARES referral. Please clarify this requirement.**

    A. Unless the family declines enrollment in SFSP, CCSOs will be required to either complete or arrange for the completion of an IM+CANS assessment for each SFSP Youth within five (5) days after the CCSO receives the referral from the CARES line. Additional information regarding SFSP requirements and processes can be found here.

Staffing and Training Requirements

49. **In terms of Care Coordination staff planning, what is HFS's best assumption of the ratio of Pathways enrolled youth who will receive High Fidelity Wraparound vs. Intensive Care Coordination?**

    A. It is anticipated the 35% of eligible Pathways Youth will receive High Fidelity Wraparound and that 65% of eligible Pathways Youth will receive Intensive Care Coordination.

50. **Is it accurate that at minimum per DSA there would need to be dedicated clinical manager, clinical supervisor and two (2) Care Coordinators at start?**

    A. Please refer to question 16 above. Each CCSO is required to have a dedicated Clinical Manager and the necessary number of CCS Supervisors and Care Coordinators to meet estimated enrollment numbers.

51. **When is training for identified staff expected to begin?**

    A. CCSOs should anticipate training for care coordination staff to begin approximately six (6) weeks prior to their DSA's CCS implementation date.

52. **How will the new timeframes outlined in the Supplemental RFQ impact trainings? (new 10/22/21)**

    A. HFS does not anticipate that the start of trainings for new services, including Care Coordination and Support, will change, but will likely need to be extended to accommodate the later start date of some DSAs.

53. **When does HFS assume CCSOs will hire new staff for this program?**

    A. HFS expects CCSOs to hire staff in sufficient time for staff to be trained and onboarded in preparation for the service implementation dates outlined in the RFQ.

54. **What will be the expectation/procedure if referrals exceed a CCSO's staffing availability and the CCSO is unable to maintain the required ratio? Will there be a grace period where we can be over-ratio?**

    A. HFS and the MCOs will have frequent communication with CCSOs, particularly during the implementation phase, regarding staffing and capacity and will collaborate closely with CCSOs to address any staff shortages.

55. **Section 5, item 1.2 – Can the dedicated LPHA Clinical Manager supervise a portion of MCR staff or supervisors who supervise MCR staff? Can they directly supervise a portion of the Care Coordinators when a team is large enough for 1 supervisor but not quite large enough for 2?**

    A. The Clinical Manager outlined in Section 5, item 1.2 is not intended to oversee the MCR team or MCR staff, but rather is intended to be designated to overseeing CCS services. On a case-by-case basis, HFS would consider allowing the Clinical Manager to directly supervise some Care Coordinators on a temporary basis while the CCSO works to hire additional needed CCS Supervisors.

56. **Section 5, item 2 - it's my understanding that new crisis staff (for MCR) will have to complete the PATH training for crisis. Will current crisis staff be required to retake the PATH training as well? Is it supposed to be an annual training? (new 10/22/21)**

    A. All MCR staff are required to obtain and maintain annual certification in either the IM+CANS or the IM-CAT, as well as attend PATH trainings on Crisis Safety Planning and crisis de-escalation on an annual basis.

57. **Section 5, item 2.2 – will the other trainings for care coordinators within PATH be an annual training? Or one time? (new 10/22/21)**

    A. New Care Coordinators will be required to attend the 2-day Wraparound training through PATH and then quarterly booster sessions thereafter. The topics identified in Section 5, item 2.4 are required trainings upon hire and annually thereafter for all CCSO staff. These training requirements may be met through attending relevant trainings through PATH.

Reimbursement and Fiscal Responsibilities

58. **Section 4, item 2.8.7 – regarding the CCSO's responsibility to complete and maintain the IM+CANS for each Pathways Youth. Is the IM+CANS a billable service or is that part of the expectation to be included in monthly rate?**

    A. The completion and maintenance of the IM+CANS for Pathways Youth receiving CCS services is included in the monthly CCS case rate and is not separately billable by the CCSO for those youth. The CCSO may bill Integrated Assessment and Treatment Planning (IATP) services, consistent with 89 Ill. Admin. Code 140.453, for the completion and maintenance of the IM+CANS for any youth not receiving CCS services.

59. **Just to clarify, a family can decline CCS services and remain eligible for IHB services. The CCSO would not receive a case rate but are still responsible for IM+CANS and would bill under fee-for-service?**

    A. Yes, a Pathways Youth may decline CCS services and still receive other Pathways services, such as Intensive Home-Based services. Pathways enrolled youth and their families have the right to choose which Pathways services they engage in, so long as the services are medically necessary. The CCSO is responsible for completing and maintaining the IM+CANS for all Pathways Youth, regardless of which services that youth is receiving. If a Pathways Youth is not engaged in CCS services, the CCSO may bill for time spent completing, updating, and reviewing the IM+CANS under the service of Integrated Assessment and Treatment Planning (IATP) pursuant to 89 Ill. Admin. Code 140.453.

60. **Section 6, item 5.2.2 – why is Crisis Intervention not a billable service unless after a MCR event?**

    A. Care Coordination and Support (CCS) services include an expectation that the CCSO provide a basic level of crisis support services to Pathways Youth in an effort to prevent a crisis situation from occurring. This expectation is built into the monthly CCS case rate. HFS recognizes that additional staff and supports may be required to help stabilize a crisis situation following an MCR event and is, therefore, billable separately as Crisis Intervention.

61. **Section 4, item 6.1 – "the CCSO shall participate in case staffings as requested by DCFS staff, including Administrative Case Reviews (ACRs) and court hearings." How is court time reimbursed?**

    A. For Pathways Youth receiving CCS services, participation in case staffings is a component of care coordination and is included in the monthly CCS case rate. For customers not receiving CCS services, participation in case staffings may be reimbursed under the service of Case Management – Client-Centered Consultation (89 Ill. Admin. Code 140.453).

62. **Section 6, item 1 – if a CCSO utilizes partners for MCR, does reimbursement go directly from HFS to the MCR Provider when billings are submitted for MCR services? Or do claims and reimbursement go through the CCSO? (new 10/22/21)**

    A. The MCR provider must prepare and submit claims directly to HFS or the appropriate MCO for service rendered. Reimbursement for services will be made to the billing provider listed on the claim.

63. **Section 6, item 4 – indicates that billing for CCS services is done at a monthly case rate and that the monthly case rate may be reimbursed "for each calendar month a Pathways Youth is enrolled in the Pathways Program." In Section 2 it indicates there are 60 days allowed for outreach and engagement activities. Is it correct to assume that outreach and engagement is not reimbursable if it doesn't lead to an enrollment or if those activities occurred in a calendar month prior to the youth's enrollment?**

    A. Correct.

64. **Section 6, item 3 – "CCSOs shall serve as the fiscal agent for the TSS and ISS for Pathways Youth, as well as the fiscal agent for FSP Alternative Community Services for FSP and SFSP Youth." Please clarify.**

    A. Please refer to the definitions of FSP Alternative Community Services, Therapeutic Support Services, and Individual Support Services in the Definition section of the RFQ. The CCSO's fiscal agent responsibilities for these services are outlined in Section 6, items 3.1-3.7 of the RFQ.

<u>Monitoring and Reporting</u>

65. **Section 8, item 2 – will the required data be accessed through CRS, or will providers need to duplicate reporting those data points on a separate spreadsheet?**

    A. HFS will work to streamline data reporting requirements for CCSOs to the extent possible to reduce duplication of efforts. CCSOs should be prepared to submit the required reporting, as outlined in the RFQ, to HFS in the manner defined by HFS.

66. **Section 8, item 2.4 – "CCSOs may be required to periodically provide ad hoc data to HFS and MCO." What types of data would be expected?**

    A. Ad hoc data requests could include customer-specific data requests or could include aggregated data requests similar to those data points required in monthly and annual CCSO reporting.