Selected Highlights of Illinois' Memorandum of Understanding (MOU) with CMS for the Illinois Medicare-Medicaid Alignment Initiative

Geographic Scope and Eligible Populations

- Two areas of the state will be included: the Greater Chicago Region, with 118,050 potential enrollees; and the Central Illinois Region, with 17,775 potential enrollees.
- Eligible participants include individuals age 21 and older entitled to benefits under Medicare Part A, enrolled under Medicare Parts B and D, and receiving full Medicaid benefits. Beneficiaries in the following Medicaid 1915(c) waivers are included:

  - Persons who are elderly
  - Persons with disabilities
  - Persons with HIV/AIDS
  - Persons with Brain Injury and
  - Persons residing in Supportive Living Facilities

- Also eligible are individuals with End Stage Renal Disease (ERSD) at the time of enrollment who meet the above Medicare and Medicaid eligibility criteria.

Excluded Populations

- Individuals under age 21, individuals receiving DD institutional or waiver services, Medicaid spend-down population, persons enrolled in the Illinois Medicaid Breast and Cervical Cancer program, individuals enrolled in the partial benefit program, and individuals enrolled in both Medicare and Medicaid who have Comprehensive Third Party Insurance.

Contracting and Rates

- CMS and the State, through a joint selection and procurement process, selected entities that are eligible to enter into Demonstration Plan contracts.
- Medicaid actuarial soundness will apply to payments to health plans and will include consideration of both Medicare and Medicaid contributions and the opportunity for efficiencies unique to an integrated program.
- Rates for each demonstration year will incorporate projected savings as follows: Year 1, 1%; Year 2, 3%; Year 3, 5%.
- The Medicaid rate component will include payments incentives for moving individual out of nursing homes and keeping them in home and community-based settings.
- A majority of new Demonstration Plan enrollees will come from Medicare FFS, so CMS plans to phase in the use of the Medicare Advantage coding intensity adjustment factor.

Enrollment

- Demonstration Plans will be required to accept opt-in enrollments no earlier than 90 days prior to the initial effective implementation date of October 1, 2013, when they must begin providing services.
- The earliest effective date for passive enrollment is January 1, 2014 and passive enrollment will be phased in on a monthly basis, with new enrollment in the Greater Chicago area not to exceed 5,000 per month and new enrollment in Central Illinois not to exceed 3,000 beneficiaries per month.
- Beneficiaries who move into a new Medicare Prescription Drug Plan effective January 1 of a given year will be eligible for passive enrollment into a Demonstration Plan only in the following year.

- Beneficiaries will receive two written notifications prior to passive enrollment in a Demonstration Plan, and may also receive a call from the Illinois Client Enrollment Services (CES).
- Eligible beneficiaries enrolled in a Medicare Advantage (MA) plan that is not operated by the same organization sponsoring a Demonstration Plan may only enroll in the Demonstration Plan after disenrollment from their current MA plan.

Care Model and Assessments

- Demonstration Plans are required to implement an evidenced-based model of care (MOC) having explicit components consistent with the Special Needs Plan (SNP) Model of Care and must meet a minimum standard score of 70% based on NCQA scoring methodology. A plan with an MOC score of 85% or higher will receive a three-year approval. A score between 75%-84% will result in a two year approval. A score of 70%-74% will result in a one-year approval.
- A Care Coordinator will responsible for coordination of all benefits and services for an enrollee and will lead an interdisciplinary care team.
- A health risk questionnaire will be administered to all enrollees within 60 days of enrollment.
- Plans will supplement the initial health screening with predictive modeling and surveillance data to stratify enrollees to the appropriate level of intervention.
- Demonstration plans will be required to stratify no less than 5% of enrollees as high-risk and will stratify no less than 20% of enrollees to moderate- and high-risk levels combined. Such enrollees will have their care plans reviewed at least every 90 and 30 days, respectively, and reassessments will be conducted as necessary based upon these reviews.
- Care management services will vary on the basis of risk. Persons considered high risk will have intensive care management, while care management for persons considered moderate-risk will be focused on problem-solving interventions. Persons designated low-risk will receive prevention and wellness messaging and condition-specific education materials.

Consumer Protections

- Demonstration plan enrollees will receive a single notice developed by the State and CMS for of applicable Demonstration, Medicare, and Medicaid appeal and State Fair Hearing rights.
- Demonstration Plans will not be allowed to market directly to individual potential enrollees.
- Demonstration Plans will be required to establish a toll-free telephone number for access by beneficiaries 24/7 to medical professionals and call centers must have interpreter services available, as well as TTY or comparable services for people who are deaf or hard of hearing.
- Eligibility for HCBS waiver services will be determined outside the Demonstration Plans.
- Care coordinators will have prescribed caseload caps based on the level of risk of enrollees.

Continuity of Care

- For existing HCBS-eligible enrollees, the Demonstration Plan will maintain the existing waiver service plan for 180 days unless a change is made with the consent of and input from an enrollee.
- For a set of 10 specified HCBS waiver services, Demonstration Plans must enter into contracts in each county of the service area with a set of providers that provided at least 80% of the FFS services delivered in CY 2012. For counties where there is more than one provider of these covered services, Demonstration Plans must contract with at least two providers.

Evaluation and Monitoring

- CMS has contracted with an independent evaluator to measure, monitor, and evaluate Financial Alignment Demonstrations, including the Illinois Demonstration. Key issues that will be targeted for evaluation include: 1) beneficiary health status and outcomes; 2) quality of care provided across care settings; 3) beneficiary access to and utilization of care across care settings; 4) beneficiary satisfaction and experience; 5) administrative and systems changes and efficiencies; and 6) overall costs or savings for Medicare and Medicaid.