MMAI April 18, 2013
Stakeholders Meeting
Questions and Answers

		Type	Question	Answer
1	Yicklun, Mo yicklun_mo@caslservice.org	Enrollment	Will the state broker be able to assist limited English speaking individuals to choose and enroll in a plan?	Yes, the Illinois Client Enrollment Services (ICES) offers individuals interpretive services for any language, in order to provide assistance with education and enrollment activities. In addition, the ICES Call Center is staffed with both English and Spanish-speaking individuals.
2	Yicklun, Mo yicklun_mo@caslservice.org	Enrollment	Will enrollment package be in languages other than English?	Enrollment information from the ICES will be available in English and Spanish. The Department uses the standard where there is a prevalent single-language minority within the low income households in the relevant DHS local office area (which for purposes of this program shall exist when five percent (5%) or more such households speak a language other than English, as determined by the Department according to published Census Bureau data), the written materials provided to potential enrollees, prospective enrollees or enrollees must be available in that language as well as in English. Enrollment assistance in any language is available through the Illinois Client Enrollment Services interpretive services line.
3	South-East Asia Center seac5120@yahoo.com	Enrollment	What is Maximus' language capacity?	See response to #1.
4	South-East Asia Center seac5120@yahoo.com	Enrollment	Will clients receive notification letters in their native languages?	See response to #2.
5	Rebecca Zuber rfzuber@gmail.com	Enrollment	Why can't a beneficiary opt out of auto assignment during the voluntary enrollment process? As currently conceived, you will assign folks and then they will have to opt out. Why not let them opt out to begin with?	A beneficiary will have the opportunity to opt out before they become effective in a health plan. They will receive an enrollment notification from the ICES 60 days before their enrollment becomes effective and can choose to opt out during that time.

		Type	Question	Answer
6	Lorrie George-Baskin lgeorge-baskin@nicasa.org	Enrollment	How will the enrollment process comply with HIPAA regulations?	Please clarify which HIPAA regulations are being referred to here.
7	kshelton@sirmanagement.com	Enrollment	If enrollment doesn't start until October for this program, why are some residents of nursing facilities receiving enrollment forms from DHS now to enroll by end of May, 2013?	There are no enrollment forms for MMAI in distribution at this time.
8	Kristen Pavle KPavle@hmprg.org	Enrollment	Can Illinois commit to a full 3 months of voluntary enrollment for MMAI? In the event that the start time gets pushed back (which I would anticipate is entirely possible), it's important to keep the 3 month voluntary enrollment time to give beneficiaries a chance to choose and understand their options. It's my understanding that the ICP expansion in Rockford has decreased the 3-months amount of time for voluntary enrollment due to delays, if we could avoid that in MMAI that would be ideal. It would be ideal to ensure the ICP expansion also has a 3 month voluntary enrollment period too.	The plan is that voluntary enrollment will now begin in January 2014. Passive enrollment will begin in April 2014 but will be phased in over several months.

		Type	Question	Answer
9	Hadley Ravencroft hadley@pacecil.org	Enrollment	The enrollment brokers from MAXIMUS have what kind of qualifications? Are they nurses? Social workers? People familiar with working with older adults, people with disabilities, have cultural sensitivity, people who may have lower income?	The role of the ICES, Maximus, is to ensure that all Potential Enrollees and Enrollees receive unbiased education and information about their health plan choices, and to assist with enrollment into a health plan. The ICES is not responsible for obtaining any services or proving any care, therefore their staff are not medical professionals or social workers. However all Maximus staff go through extensive training on the health plans and Department programs and cultural aspects and sensitivities. Maximus has experience with transitions to new programs and addressing concerns of clients and try to hire individuals that have backgrounds or experience with current programs in order to further assist Potential Enrollees and Enrollees.
10	Chicago Health Project chicagohealthproject@gmail.com	Enrollment	Many of the health plans have experience with Medicare and Medicaid populations already. Will you make available historical HEDIS and other quality measurements for each of the health plans to help enrollees choose a health plan?	See response to #38 below.
11	ATyree@wellspringresources.co	Enrollment	When will enrollment be expanded to the Metro-East area in Southwestern Illinois? We are a large population center?	The MMAI demonstration is approved only for the greater Chicago and Central Illinois region. The demonstration will not be expanded to other areas of the State. The Integrated Care Program (ICP) for non-dual seniors and people with disabilities currently operating in suburban Cook county and the collar counties will be expanded to include the Rockford region, the Quad Cities region, central Illinois and the Metro-East region in 2013 and the city of Chicago in 2014.

		Type	Question	Answer
12	Amanda Moswin AMoswin@tpoint.org	Enrollment	Given what you just said about patients being able switch plans monthly, is the state looking into developing a faster system of verifying patient eligibility? Perhaps having cards that can be scanned and having current coverage information linked to the card? This has been one of our agency's biggest difficulties with the ICPs thus far.	Current eligibility information is available through a variety of means. It is imperative that providers verify eligibility for each date of service they provide. Eligibility can be verified through any of the following • Medical Electronic Data Interchange (MEDI) Internet Site • Recipient Eligibility Verification (REV) System • Automated Voice Response System (AVRS) 1-800-842-1461 • Health Benefits Provider line at 1-800-226-0768 (press option 6) or 217-557-6544
13	rrubin.icarehc@gmail.com	General	You mentioned that Illinois is only the 4th state to get the approval for this MMAI program. Which are the other states and do they have the same deadline as Illinois or are they further ahead?	The other states with Memorandum of Understandings (MOU) with CMS are Massachusetts, Ohio, California, and Washington All of these states are on about the same schedule, Massachusetts is slightly ahead, everyone else is targeting about the same time period. The Illinois MOU can be found on the CMS website at: http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4547
14	Regas, Peggy A Peggy-Regas@RiversideHealthCare.net	General	Is HealthSpring a separate contract from CIGNA?	HealthSpring, Inc. (HealthSpring) and its subsidiaries are wholly-owned by Cigna Corporation (Cigna), a publicly-traded global health service company. The MMAI contract will be with the subsidiary, HealthSpring.

		Type	Question	Answer
15	John Plowman johnp@srhhs.com	General	Regarding the study results, what is the rate of hospital readmissions within 48 hours of discharge?	UIC did not report on hospital readmissions in their first year evaluation of ICP. In ICP we are using calendar year 2010 as the base year and comparing it to calendar year 2012, the first year of total implementation since 2011 was an implementation year. The measure for ICP for hospital readmission is the 30 day re-admission rate for both acute inpatient facility and inpatient mental hospital. In the MMAI demonstration- Demo Year 2 and 3 withhold measure is the percent of members discharged from a hospital stay who were readmitted to a hospital within 30 days, either from the same condition as their recent hospital stay or for a different reason.
16	Haller, Barb BHaller@ihastaff.org	General	Have dates or approximate time frames been set for the Plans' readiness reviews? Will this be a public process?	Each health plan has received a date for their Readiness Review from HFS for the ICP Readiness Review. CMS and the State will also perform separate readiness reviews for the MMAI program, which will build off of and, to the extent possible, not duplicate the ICP review. With the shift in the implementation date, CMS and the State are revisiting the dates of the MMAI readiness reviews, but plans will likely receive site visits late summer/early fall. The Readiness Reviews are not a public process.
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		Type	Question	Answer
18	Hall, Claude claude.hall@sinai.org	General	Will Aging or other programs be applying for funds from CMS to provide objective information about the Marketplace and other managed care through MMAI or Medicaid?	Yes, CMS has released a Funding Opportunity for States that would provide financial assistance to Senior Health Insurance Program (SHIP) sites and/or Aging and Disability Resource Centers (ADRCs) to provide options counseling to Medicare-Medicaid Individuals. This is only available for States with MOUs for the Medicare/ Medicaid Alignment Initiative. The Department on Aging is taking the lead in applying for this opportunity and officially submitted their application to CMS on 6/5/13. They should hear in August if they were awarded the funding.
19	Intentionally Left Blank			
20	Ruth Mammen-CIR-A lccoamammen@gmail.com	General	I am a SHIP Coordinator. In the phone conference someone had said that the navigators in Illinois needed to have a license. Is that true? And if so what kind of license are we talking about?	According to the Illinois Department of Insurance, Navigators are not required to have a license but will be trained and certified. For more information, visit http://insurance.illinois.gov/hiric/ .
21	Danise Habun dhabun@msn.com	General	Could the Department make more information available to providers and interested parties?	Yes. Information will be shared on our website as it becomes available, and the Department will be hosting regular meetings for continued dissemination of information and stakeholder input.
22	CCDI Outreach outreach@ccdionline.org	General	To whom should I address questions or concerns about the health and quality of life measures as they are posted on the HFS site? Are these metrics for dual-eligible, or only for ICP? The date on the document is 24 January; is this the most recent?	The measures posted are the most recent measures on which the Department is seeking input. These are posted under the Integrated Care Program; the Department has received many comments and is in the process of evaluating the comments and requests. While these were originally posted for input on the ICP, the Department hopes to use these same measures for all care coordination programs serving seniors and persons with disabilities.
23	Ann Hilton Fisher ann@aidslegal.com	General	Are any of the participating plans non-profit?	Yes, Healthcare Service Company (Blue Cross/ Blue Shield) is non-profit.

		Type	Question	Answer
24	Ann Hilton Fisher ann@aidslegal.com	General	Is the full ICP one year study available on-line somewhere?	Yes, the Department has a link to it under the May 18th, 2013 Stakeholder's Meeting heading at : http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/default.aspx
25	Sarah Follmer SarahFollmer@juf.org	General	What is the state agency role in the contracting relationship as provider agencies move from contracting with state agencies to directly contracting with MCOs? Is HFS involved in the approval process for MCO provider sub-contracts? Has HFS considered the development of a standardized template for use by the MCO so that subcontractors have a level playing field in relationship to each other as well as across MCOs?	HFS does not approve provider sub-contracts nor is there a standardized template HFS has developed for providers to use in subcontracting. The health plans, through the Medicaid Managed Care Association, are trying to streamline as many systems as possible, especially their billing practices, but provider contracting has not yet been addressed. The Department does have some requirements for subcontracts but is not involved in negotiations or terms, that is a private contractual relationship.
26	Sarah Follmer SarahFollmer@juf.org	General	What steps has HFS taken with MCOs in order to ensure that smaller providers (those with smaller geographical reach and/or capacity) will be included in networks and will receive referrals?	Adequacy standards for network providers were devised to ensure most of the current providers will participate in MMAI. CMS has very detailed and specific network adequacy requirements for specialists on a county by county basis. Please see the Memorandum of Understanding Appendix 7 Section IV(i).

		Type	Question	Answer
27	Yicklun, Mo yicklun_mo@caslservice.org	Marketing	What are the marketing rules?	All marketing activities must comply with the requirements in 42 C.F.R. Section 438.104. General marketing activities by mail, mass media, advertising and community-oriented marketing directed at Potential Enrollees throughout an entire geographic area will be allowed subject to the Department's prior approval. Each Health Plan shall be responsible for the costs of such outreach efforts, including labor costs. Face-to-face marketing by a Health Plan directed at a Potential Enrollee, including direct or indirect door-to-door contact, telephone contact, or other cold-call activities, is strictly prohibited.
28	Yicklun, Mo yicklun_mo@caslservice.org	Outreach/ Education	What is the outreach plan to limited English speaking population?	As discussed in response to Question 18, the Department on Aging is taking the lead in applying for a funding opportunity to provide financial assistance to SHIPs and/or ADRCs to provide options counseling to Medicare-Medicaid Individuals. This is only available for States with MOUs for the Medicare/ Medicaid Alignment Initiative. Special consideration will go into working with those ADRC and SHIP sites that reach the limited English speaking population, including making sure outreach materials are provided in the appropriate languages. In addition, education and enrollment efforts offered by the ICES will provide for interpretive services, the ICES Call Center is staffed with both English and Spanish-speaking customer service representatives.

		Type	Question	Answer
29	Cynthia Worsley cfyworsley@hotmail.com	Outreach/ Education	Many Community Care Plan clients experience mild to more progressed forms of dementia and may not be able to understand information received from MCO's regarding the MMAI plan. They will be frightened and at worst discard the materials; at best give them a caregiver. How do you plan to work with these people to prevent automated enrollment?	The outreach discussed above, especially that to be provided through the ADRC and SHIP sites, will be especially helpful to providing education in special circumstances. In addition all of the involved state agencies will be providing information to their grantees on changes to programs. The ICES is committed to ensuring it is respectful of any individual that contacts them for education and enrollment assistance.
30	Pamela Cairns Pam@leadinghealthyfutures.com	Outreach/ Education	What is the recommended method for a current grantee of Dept on Aging and Dept of Human Services to find out which (if any) of our current grants will be affected by MMAI?	For home services, there will be very little impact but grantees should be open to contracting with MCOs to continue to provide services to their clients that will be in MMAI. The Agency currently working with the grantee for the provision of waiver services will be able to provide more detail to each provider type. The Department on Aging is developing policy for our grantees and provider network pertinent to MMAI. This information will be shared with our network well in advance of the MMAI roll-out which is targeted for implementation in January of 2014. In the interim, grantees and providers are encouraged to contact the Department on Aging with specific questions at 1-800-252-8966.
31	South-East Asia Center seac5120@yahoo.com	Outreach/ Education	Are there resources to outreach to populations who are limited in English?	See response to questions #1, #2 and #28.

		Type	Question	Answer
32	Yicklun, Mo yicklun_mo@caslservice.org	Outreach/ Education	Can we invite MCOs to speak about their plans directly to our clients?	Organizations and community groups may invite MCOs to speak to clients about their health plans. If organizations do invite plans to speak to their members, the Department encourages the groups and organizations to include all MCOs operating in a specific area to participate in these events in order to ensure clients have an opportunity to hear from all health plans. Organizations and plans, however, should be aware that plans may not market prior to the time that their three-way contracts are signed and they have passed their readiness reviews, although they may participate in educational events. As provided in Appendix 1 of the Medicare Marketing Guidelines, educational events are designed to inform beneficiaries about programs (e.g., Medicare Advantage, Prescription Drug, or other Medicare programs such as the demonstration) and do not include any marketing (e.g., the event sponsor does not steer, or attempt to steer, potential enrollees toward a specific plan or limited number of plans). In other words, no plan-specific information (including information about benefits) should be provided until after a plan may market, and the information provided must generally describe the demonstration program only. Until such time as a plan's participation in the demonstration program is certain, community organizations should be cautious about inviting specific plans to participate in educational events. Provision of information about the demonstration by another entity (e.g., SHIP, the State enrollment broker, etc.) may be more appropriate.

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33	South-East Asia Center seac5120@yahoo.com	Outreach/ Education	How does the State plan to outreach to limited-English-speaking and non-Spanish speaking elderly and disabled?	See response to questions #1, #2 and #28.
34	South-East Asia Center seac5120@yahoo.com	Outreach/ Education	Which department is in charge of outreach, education and enrollment?	This is a statewide responsibility. The Governor's office, the Department on Aging, DHS and HFS are all concerned and working together to outreach through as many venues as possible.
35	South-East Asia Center seac5120@yahoo.com	Outreach/ Education	What's the time frame for notifying concerned clients?	Clients eligible for the MMAI Program will receive notification and information of their options in December 2013 (30-days before the voluntary period). Those who do not make a selection and who are eligible for passive enrollment will receive a notification and information from the Illinois Client Enrollment Services on their choices 60 days prior to being enrolled in a health plan, and then again at 30 days prior to being enrolled (unless they opt-out beforehand). However, the State is very interested in your ideas and suggestions on how to communicate this information to clients in advance so that this mailing is not the first they hear of it.
36	Katherine Pyde kpyde@ilshealth.com	Outreach/ Education	Many providers have asked for additional information to share with patients since they are the front line. If general meetings or site meetings are established, perhaps notifying the providers to inform their patients would be an easy way of informing those who are not usually responsive to mailers.	Education and enrollment materials developed by the Department, CMS and the Illinois Client Enrollment Services (ICES) will be made available on-line for providers and others to use to educate and inform clients of the program.
37	Katherine Pyde kpyde@ilshealth.com	Outreach/ Education	Can provider be included in the mailing of benefit information as they are the front line to help their patient select the best plan?	Education and enrollment materials developed by the Department, CMS and the Illinois Client Enrollment Services (ICES) will be made available on-line for providers and others to use to educate and inform clients of the program.

		Type	Question	Answer
38	John Peller JPeller@aidschicago.org	Outreach/ Education	We have two requests related to education and enrollment: 1) Release a one-page fact sheet targeted to beneficiaries that providers can distribute to duals between now and October. It would be helpful if it alerted people that they are going to have a choice, that they should actively choose their plan, etc. 2) Include plan quality info in the initial mailing sent to beneficiaries. Even if the quality info is not available for the Illinois plan (not likely because it's new), it sounds like there's information from other states or the national NCQA star system. The Medicare Advantage plan rating would also be helpful to include.	Thank you for these requests, the Department appreciates the input. Regarding the first question, the Department agrees this would be helpful to educate clients prior to the implementation of MMAI and will develop such educational material and work with stakeholders on the best way to distribute the information. The Department will take your second suggestion under consideration if a fair way to represent often conflicting information can be developed. Not all MMAI plans have a Medicare Advantage product in Illinois but we could make a link to the Medicare Advantage rating system available.
39	Jan Grimes JanGrimes@frontline-online.net	Outreach/ Education	Home health care providers would like all managed care organizations to understand our issues – such as the importance of timely authorization of visits and front-loading services. Could education and dialogue such as this be facilitated through the new Assn of Medicaid Health Plans? If so, who is the key contact for this?	Yes. The contact for the Association of Medicaid Health Plans is: Matthew S. Collins, COO HealthSpring of Illinois 9701 W. Higgins Road #360 Rosemont, IL 60018 Office - 847-993-1913 E-mail - matthew.collins@healthspring.com

		Type	Question	Answer
40	Hadley Ravencroft hadley@pacecil.org	Outreach/ Education	Advertising could be: Through collaborating agency e-newsletters, print newsletters, Billboards, Senior Centers, Facebook, Centers for Independent Living (who are already working with you as Stakeholders---and invite those who have not, through Ann Ford, at INCIL, Division of Rehab Services letters to customers, Association of Community Living (DOA) letters to consumers, Home Health Care providers, SNAP, etc.	Thank you very much for the input, these suggestions are appreciated and are exactly the type of input the Department is seeking.
41	Sonya Holmes sholmes@associationhouse.org	Outreach/ Education	What consumer or patient education plan is in place in regards to these changes, the option to opt out, etc?	At this time, the Department is in the process of developing processes for enrollment and disenrollment activities. The Department will provide more information about these processes soon.
42	Philippe Largent plargent@lgs-il.com	Outreach/ Education	Relative to the ADRCs and SHIP sites, are these entities private, nonprofit organizations? Is there a listing of sites, location on the DoA website?	Most ADRC and SHIP sites are nonprofit organizations with a few exceptions. For example, some hospitals serve as SHIP sites. There is a list of organizations posted on the Department on Aging website at http://www.state.il.us/aging/ To access a list of the Centers for Independent Living (CILs) in Illinois, please visit the Illinois Network of Centers for Independent Living website at www.incil.org
43	South-East Asia Center seac5120@yahoo.com	Pharmacy	How do Medicare Part D drug plans and MCO's work?	The MCOs participating in MMAI will also be responsible for providing Part D drugs.
44	rrubin.icarehc@gmail.com	Pharmacy	How will the pharmacy MED-D Prescription Drug Plan system work with MMAI?	Medicare Part D policies will remain intact, and will be administered by the MMAI plan that is responsible for all of the Enrollees Medicare and Medicaid services.

		Type	Question	Answer
45	Garth Reynolds goprph@gmail.com	Pharmacy	You mentioned that for pharmacy and prescription services this program will be utilizing the Medicare Part D backbone. Does this also include the Medication Therapy Management (MTM) services?	Yes.
46	Garth Reynolds goprph@gmail.com	Pharmacy	Also, you have mentioned this program as a HMO. Is this an open panel HMO? Meaning will any pharmacy be able to participate in the network and that will allow the beneficiary to stay with their pharmacist provider.	Under the Demonstration, plans must contract with any willing pharmacy; meaning, if a pharmacy is willing to accept the terms and conditions of the plan, the plan must contract with them. There may be instances when a beneficiary's pharmacy decided not to contract with a plan. Under these circumstances, a beneficiary will need to find a new pharmacy provider.
47	Sarah Follmer SarahFollmer@juf.org	Program Structure	There appears to be no recognition on the part of the MCOs, HFS, or State Agencies of the impending stress on the resources of social service providers to educate the public about options and the enrollment process. Social service providers should be compensated for the key role they will play in the enrollment process. As past experience with the implementation of Medicare Part D has shown, human service providers will be relied on to provide consumer education and one on one counseling to guide clients through the enrollment process as the state transitions a huge percentage of the Medicaid and Dual Eligible population to managed care.	State agencies recognize that the roll-out of MMAI may put additional pressure on social service providers to assist their clients. We understand that resources are limited and some organizations may view this support as an additional burden. As mentioned in previously, the Department on Aging will be applying for a federal funding opportunity for Aging and Disability Resource Centers (ADRCs) and Senior Health Insurance Program (SHIP) sites to provide beneficiary support, education and outreach. Thank you very much for the input, these suggestions are appreciated and are exactly the type of input the Department is seeking.

		Type	Question	Answer
48	Sarah Follmer SarahFollmer@juf.org	Program Structure	What steps has HFS taken to develop a process that affords Consumer and Provider protection in their relationship with the MCOs? Is there an appeals process in place so that perceived errors with respect to care plan decisions or payment can be addressed?	Each MCO must have a system in place for enrollees that include a grievance process, an appeals process, and access to the State's Fair Hearing system. MCOs are required to educate Enrollees about their Grievance and Appeals processes through their Member Handbooks. This subject has received major attention and focus both with CMS and State. There is some additional information in the MCO and the 3-way contract under development will contain more detail. It is important to note that no one will lose access to the appeals process, they will actually gain access. The MOU also requires an Ombudsman responsible for taking concerns and complaints on the program statewide. The Department is currently working on the development of the Ombudsman program.
49	Sarah Follmer SarahFollmer@juf.org	Program Structure	MCOs are being guaranteed prompt payment by the state and in return they are guaranteeing prompt payment to their providers. The concern is that this will delay even further payment to providers for services for non-Medicaid eligible clients. What guarantees of prompt payment will be afforded to the non-Medicaid contracts?	The Department is making every attempt to pay the MCOs in a prompt fashion and recognizes the concern with non-MCO payments. The Department is not in a position to give assurances of prompt payment from the state as part of the MMAI stakeholder process.

		Type	Question	Answer
50	Sarah Follmer SarahFollmer@juf.org	Program Structure	Reimbursement rates: MCO's are not all proposing to pay Medicaid and/or Medicare rates for services provided. In addition in the skilled care area we are concerned that we have been told by one MCO that for residents on Medicaid days for which pharmacy and therapy services are not included in the rate, the Pharmacy or Rehabilitation provider will be the one contracted to the MCO not the facility. If this is the policy for all MCO's it would eliminate the ability of the facility to maintain its favorable pricing for those services for Medicare services when the facility must pay. Please respond.	The intent of the MMAI Demonstration is to promote the idea of an integrated benefit package and to move away from the traditional Medicare/Medicaid divide, given that the plans are receiving one rate that should encompass Medicare, Medicaid, and Part D. The contractual terms for how these services are reimbursed are at the discretion of the health plans and the facilities to negotiate. However, it appears what is proposed by the MCO is no different than the Medicaid system today because if a dual eligible is in a NF on a Medicaid day, any drugs are reimbursed through the Medicare Part D provider. We will be working with nursing facility representatives on a monthly basis to discuss operational issues of the demo and reduce administrative burdens wherever possible.
51	rrubin.icarehc@gmail.com	Program Structure	Will all services require "Pre-Authorization" under the MMAI plans?	All services will not require prior authorization; however, each MMAI plan will have their own prior authorization policies and procedures.
52	Paul Selden pbselden@gmail.com	Program Structure	Will supportive housing service providers for dual eligibles be paid through HMO?	No. The services put into the HMO contracts are those Medicare and Medicaid reimbursable services, which supportive housing is not. The plans do have an obligation to help their enrollees find those services, and all social services that will help them live a healthy and as independent of a life as possible for their situation.
53	kshelton@sirmanagement.com	Program Structure	Can a resident of nursing home still be able to use their Medicare benefits following a hospitalization? If not, at what rate will the HMO reimburse the nursing facility?	All Medicare and Medicaid benefits remain intact, they will all be provided through the client's HMO. Rates between the plan and the nursing facility will be a contractually negotiated rate between the two parties.

		Type	Question	Answer
54	Dotty Lagesse dotty@hkvcares.org	Program Structure	Formerly if Medicare managed care patients enrolled in hospice, the billing reverted to usual Medicare. So, with this MMAI that will not happen now; the hospices will bill whichever managed care insurance they are with, correct?	As in Medicare Advantage, if an Enrollee elects to receive the Medicare hospice benefit, the Enrollee will remain in the Demonstration Plan, but will obtain the hospice service through the Medicare FFS benefit and the Demonstration Plan would no longer receive Medicare Part C payment for that Enrollee. Medicare hospice services and hospice drugs and all other Original Medicare services would be paid for under Medicare fee-for-service. Demonstration Plans, and providers of hospice services would be required to coordinate these services with the rest of the Enrollee's care, including with Medicaid and Part D benefits and any additional benefits offered under the Demonstration Plans. Demonstration Plans would continue to receive Medicare Part D payment for all non-hospice covered drugs.
55	Dotty Lagesse dotty@hkvcares.org	Program Structure	Dual eligible hospice patients' room and board, rather than being billed from the facility to Illinois Medicaid, is a pass through the hospice who receives 95% from Illinois Medicaid despite paying the nursing homes 100%. How will the new models affect that room and board pass through?	The Medicaid payment to the hospice provider for the "room and board" component (95% of the Nursing Home rate) will be the responsibility of the MCO.
56	Amanda Moswin AMoswin@tpoint.org	Program Structure	Will reimbursement rates for Medicare and Medicaid (specifically, Rule 132 Behavioral Health service) remain the same?	Providers must enter into contracts with the HMOs participating in the MMAI demonstration. Provider reimbursement rates will be set in those contracts and are negotiable.

		Type	Question	Answer
57	WYROSTEK, JOHN JOHN.WYROSTEK@presencehealth.org	Program Structure	I have a benefit coordination question. Under MMAI is the providers allowed to collect coinsurance and copayments from the patient or does that fall to COB which under Medicaid would be zero? EXAMPLE-A bill for $100 with 80% from Medicare /20% patient what would we end up with - 80% Medicare and $0 from the patient or 80% + 20%?	Even in the example, there would be no financial obligation for a Medicare-Medicaid beneficiary: providers are not allowed to balance bill such individuals. Current prohibitions on balance billing will carry over into the MMAI. The MMAI demonstration is not going to look like FFS Medicare where there is 80/20 split. Except for Part D services, plans/providers are not allowed to charge co-pays to beneficiaries for Medicare services and plans have elected to waive nominal Medicaid copayments.
58	ranjana khipple rkhipple@aol.com	Program Structure	Are providers able to collect "bad debt" from CMS?	Provider payments associated with Medicare bad debt are included in the standardized FFS county rates and Medicare Advantage capitation rates used to determine the Medicare baseline estimates for the demonstration capitation rates. As a result, providers will not bill Medicare separately for bad debt under the demonstration. This is consistent with current CMS policy under which Medicare FFS does not reimburse facilities for bad debts associated with Medicare Advantage plan enrollees as the plan payment constitutes payment in full; providers' cost reports detailing bad debt can only include those debts from FFS enrollees.
59	South-East Asia Center seac5120@yahoo.com	Program Structure	Please explain again about clients who receive long term care or waiver services. Did you mean it's mandatory for these clients to join MMAI?	See response to #61 and #62.
60	Mandrelle, Rajnish RMandrelle@the-association.org	Program Structure	Can Persons with DD voluntarily enroll in MMAI for their health care services only?	Persons receiving developmental disability institutional services or who participate in the HCBS waiver for Adults with Developmental Disabilities will be excluded from the demonstration. They may not voluntarily enroll.

		Type	Question	Answer
61	Yicklun, Mo yicklun_mo@caslservice.org	Program Structure	How often a participant can switch to another health plan?	In the demonstration clients can switch MMAI plans or opt of the MMAI program at any time, on a monthly basis. Those clients receiving Long Term Supports and Services (LTSS) may choose to opt-out or disenroll from the Medicare side of MMAI, but will be required to remain enrolled in a managed care health plan for their Medicaid services and will be locked in for one year following an initial 90 day change period. Clients will have an open enrollment period each year.
62	South-East Asia Center seac5120@yahoo.com	Program Structure	Do dual eligible clients who receive CCP services have an option to opt out?	Those dual individuals receiving LTSS will be required to be in managed care for their Medicaid services. They will have the option to opt-out on the Medicare side. The State believes that the benefits of integration are worth the client remaining in both and will stress that in the educational materials and information provided to the enrollee.
63	rrubin.icarehc@gmail.com	Program Structure	Can D/E switch plans whenever they want (Like MEDD plans) or will be subject to wait for the open enrollment period?	See responses to #61 and #62.
64	rrubin.icarehc@gmail.com	Program Structure	Will there be a penalty if you opt out and choose to enroll at a later date? (like Medicare D)	No.
65	rrubin.icarehc@gmail.com	Program Structure	Does passive enrollment mean mandatory enrollment?	No. Clients are not mandatorily enrolled into the MMAI program. In the MMAI program, clients will be enrolled in a plan if they don't make a choice, but they can opt out of the MMAI program or change plans at any time. If a client is receiving LTSS, he or she will need to receive their Medicaid services from an MCO. See above responses.
66	rrubin.icarehc@gmail.com	Program Structure	As with the Med D plan, if a beneficiary "Opts Out" of the Medicare portion, will they be assessed a penalty as the Medicare beneficiaries are if they choose to sign up at a later date?	No. If a beneficiary opts out of passive enrollment, there is no impact on their enrollment in Part B, and assuming they remain dually eligible, there will be no gap in Part D coverage as Medicare will auto-enroll them into a Part D plan.

		Type	Question	Answer
67	Roth, Joel [BSD] - MED jroth@medicine.bsd.uchicago.edu	Program Structure	What does it mean to 'opt out' on the Medicare side but remain 'in' on the Medicaid side?	See response to #61 and #62.
68	Regas, Peggy A Peggy-Regas@RiversideHealthCare.net	Program Structure	A patient who is Medicare Part A and Part B eligible, will they have a choice not to elect in a MMAI plan?	See responses to #5, #61 and #62.
69	Patty Ward pattiward@phoenixhomecarellc.com	Program Structure	If a client opts out of this program, do they lose their Medicaid benefits?	No, no one loses Medicaid benefits by opting out or joining an MMAI health plan.
70	mosactionphotography@gmail.com	Program Structure	Please clarify the opt out for Med A services for residents in long term care facilities.	See responses to #61 and #62.
71	lynne Schweppe lschweppe@whitesidehealth.org	Program Structure	Will these patients be assigned to providers in the designated counties? What if their medical home is outside the targeted areas?	Plan networks are not limited to the geographic boundaries of the demonstration. The geographic boundaries only define the clients that will be eligible to enroll in the program. This is particularly true in areas of the state where the normal process is for clients to go outside of their county or state for care. These providers can be enrolled in the MCO networks. The Department encourages the MCOs to include providers outside of the geographic boundaries in their networks in order to ensure access for clients. The Department has provided the health plans with data on where clients are receiving their services currently so they can focus on building their networks to include those providers.
72	kshelton@sirmanagement.com	Program Structure	Can residents of nursing facilities opt out of the Managed Care process who are dual eligible?	See responses to #61 and #62.

		Type	Question	Answer
73	Kim Czyzowicz kac@lambsfarm.org	Program Structure	You state that folks with Developmental Disabilities receiving services in facilities will be excluded...but will they be excluded always, or will they be included at a later time?	There is no plan under this MMAI demonstration to include individuals receiving developmental disability institutional services or who participate in the HCBS waiver for Adults with Developmental Disabilities. See response to #60.
74	Eakle, Nell nell@ectc1.com	Program Structure	I saw that individuals with Developmental Disabilities living in Long Term Care institutions are excluded from the MMAI (this was on one of the first slides in the Power Point). Is that true? I cannot find that information in writing, or get any verification anywhere on your website, to share with my administrator or our management company. Could you please send me a web-link to that exclusion?	Per page 8 of the Memorandum of Understanding between the State of Illinois and CMS, *"The following populations will be excluded from enrollment: …Individuals receiving developmental disability institutional services or who participate in the HCBS waiver for Adults with Developmental Disabilities;"* The MOU can be found at: http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4547
75	Bruce Fitzpatrick bfitzpatrick@mchsi.com	Program Structure	I have heard that individuals living in Intermediate Care Facilities for the Developmentally Disabled (ICFDD) and Community Integrated Living Arrangements (CILAs) are carved out from the MMAI. Would you please confirm or address this during the Webinar.	There are no plans in MMAI to include these individuals in the demonstration.
76	Anna Hintz ahintz@legacyhc.com	Program Structure	Is an individual with Medicare, Supplemental insurance and Medicaid excluded from this program?	No. Supplemental insurance does not count as high level TPL.
77	South-East Asia Center seac5120@yahoo.com	Program Structure	With 6 MCOs involved, will there be some kind of standardized bureaucratic system; e.g., billings, forms, etc. to ensure a smooth transition for CCP providers?	The health plans, through the Medicaid Managed Care Association, are trying to streamline as many systems as possible, especially their billing practices and are planning to develop a unified handbook.

		Type	Question	Answer
78	Semetrius Stubbs peerless.realty@att.net	Program Structure	Will this new system involve a new billing system/format from MEDI system we are currently using?	See above response. This streamlined process will not be the same as billing the Department.
79	Ryan Kilgore ryan.kilgore@mosaicinfo.org	Program Structure	How soon will these changes go into effect?	The MMAI program will begin on a voluntary enrollment basis in January 2014. The passive enrollment will begin in April 2014.
80	rrubin.icarehc@gmail.com	Program Structure	Will this ever become a mandatory program?	The MMAI Demonstration is a 3-year demonstration. No determinations of the continuation of the demonstration can be made until it is has been fully evaluated by the Department, CMS and other stakeholders. We will try to continue the best practices and successes.

		Type	Question	Answer
81	Rebecca Zuber rfzuber@gmail.com	Program Structure	How will DHFS maintain oversight to insure that the needed services are being provided since the MCOs have potentially conflicting incentives--e.g. performance vs. financial?	The risk based nature of the MMAI is the first thing that is going to promote the MCOs providing services, particularly the community waiver and preventive services primary care. When those services are not provided the end result is admissions acute episodic hospitalizations and nursing facility admissions, that the MCO is responsible for paying for. The structure incentivizes the provision of service. Additionally, MLR requires 85% of funds we pay MCO must be spent on direct services to clients or they pay it back to the state. The additional 15% is not profit, it is administrative overhead- systems development, care management systems, payroll, office space, etc. The program will also include P4P. CMS and the State will also withhold some of payments and the MCO can only earn them back by meeting quality standards set by the contract. CMS and the State carefully considered what those metrics are and which ones incent better care and outcomes. Furthermore, HFS, along with CMS will oversee each plan under the demonstration. We will receive encounter data and will use them to monitor utilization and develop a robust set of monitoring measures. . CMS and HFS take holding the MCOs accountable very seriously; HFS is also in the process of increasing staffing to be able to monitor plans.
82	Rebecca Zuber rfzuber@gmail.com	Program Structure	Not all out of state services beneficiaries need will be emergency in nature. What about snow birds?	Similar to current Medicare Advantage policy, the MMAI plans will only have to cover urgent/emergent care out of the service area. They have the option of offering coverage to members out of the service area as an added benefit.

		Type	Question	Answer
83	Pamela Cairns Pam@leadinghealthyfutures.com	Program Structure	Please describe the future state of expected financial relationships for organizations who are currently providing behavioral health and waiver services only, and currently billing to Medicaid on FFS basis? Are they expected to contract with the MCOs?	Yes. Anyone providing Medicare or Medicaid services today to dual eligibles, will need to contract with the MCOs to continue to provide those services.
84	Nina Allen nallen@thrivecc.org	Program Structure	It seems very difficult for smaller organizations to align with the MMAI project. I have contacted everyone I know to contact, spoken to different people involved in the care coordination project, attended meetings, etc. Do you have suggestions?	There is contact information on our website for network development contacts at each plan. If you are not getting responses from contacting these individuals the Department would appreciate knowing that. The web link is: http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/MMAIProviderNetworkContact.aspx
85	familycounselingin@comcast.net	Program Structure	How do we become a provider for MMAI?	See above response.
86	Mark Mroz MMroz@madomanagement.com	Program Structure	Besides for being involved as a provider agency I have an adult son who has a TBI with multiple deficits and disabilities. We live in Central Illinois and have a good primary physician locally but as it should his physiatrist (rehab doctor) is in Chicago and the specialty physician providers when needed are in Chicago. Will Molina and Health Care Alliance include these providers from Chicago in their networks or will I lose the Doctors who have the necessary specialties and experience with him.	The provider network of the MCOs is not limited to a specific geographic region. The MCOs may contract with providers outside of the region of the demonstration, and for specialists and subspecialists it is expected this will occur. Each health plan will have its own network of providers. The Department cannot guarantee your son's providers will choose to participate in the program, but there is nothing in the structure of MMAI that would prohibit them from doing so. The MCOs are required to provide access to covered services, and as such will work with enrollees to make sure they have access to providers with the necessary specialties and experience. MCOs are willing to enter into single case agreements with a provider if necessary.
87	Mandrelle, Rajnish RMandrelle@the-association.org	Program Structure	As a Behavioral Health provider, do we have to negotiate with each of the MMAI or do we bill the current Medicaid rates for Rule 132 Services?	You must enter into a provider agreement with each of the MMAI health plans.

		Type	Question	Answer
88	kshelton@sirmanagement.com	Program Structure	Is the negotiated rate between the HMO and the nursing facility done for each individual or is it done for the facility as a whole?	The HMO will contract with the nursing facility as a provider in their network. The payment arrangement between the nursing facility and the HMO is between those two parties and subject to negotiation.
89	Kristen Pavle KPavle@hmprg.org	Program Structure	Where will the ombudsman office be located: within which department? Also, worth reiterating that this is different than a long-term care ombudsman. So perhaps, a definition of what the Managed Care ombudsman will do would be helpful: could you share the 'job description'? This level of transparency would be useful to advocates.	The managed care ombudsman is under development. All of the requested information will be made available to the stakeholders as plans are further refined.
90	Kathy Weiman kweiman@4olderadults.org	Program Structure	What is the State of Illinois' plan for the role of the current care coordination units throughout the state as this moves forward?	The State has determined that CCUs may subcontract with MCOs to provide care coordination services. Also CCUs will continue to be reimbursed directly by the state for Determination of Need assessments.
91	John Scatena joscatena@maxhealth.com	Program Structure	How will the MMAI affect a provider that's only licensed for Medicaid and not Medicare? Will the provider be able to work with MMAI participants in this case? Will the provider have to get licensed for both Medicare, and Medicaid?	In MMAI, a provider that provides Medicare services will have to be enrolled in the Medicare program to participate, and those that provide Medicaid covered services will have to be enrolled with Medicaid.
92	Santila Terry specialtherapycare@yahoo.com	Program Structure	How will the MMAI impact private medical clinics that accept Medicaid clients?	All providers must enter into provider agreements with the MCOs to continue to serve clients enrolled in MMAI.
93	dbrown@djnellum.org	Program Structure	Will there be a MMAI launch at some point during this process for clients in who are under the age of 21? If so, when is that launch scheduled to occur?	No. There are not plans for MMAI to include those under age of 21.

		Type	Question	Answer
94	Cory Baxter corybaxter@dewittcountyhrc.org	Program Structure	Will the HMO's have their own care coordinators / teams in the community, or will they be exploring the available resources existing in communities that may already provide care coordination (or similar) services?	Both – the MCOs will have own care coordinators, but they understand value of contracting with groups that have existing relationships with their enrollees, such as CILs, CCUs and other agencies. Every plan will have employed coordinators but will also have relationships with these groups.
95	CCDI Outreach outreach@ccdionline.org	Program Structure	The presentation referred to aligning incentives, improving outcomes, and aligning metrics: what are these criteria, please?	One purpose of this demonstration is to align incentives to produce better health outcomes. One problem with a fragmented system operated by two different payers is that the incentives may not be aligned for best outcomes because they are siloed by the different payers. With this demonstration, a single entity responsible for providing and paying for all services, helps to align that their incentive is to provide the needed services in least restrictive environment that allows for the best quality of life, and reduces acute episodes with bad health and life outcomes. Quality metrics – we have asked for input and published a list of quality metrics. You can also see the metrics in the current ICP contracts on-line. All of entities servicing the SPD will be held to these metrics. Health and quality life measures are posted under the Integrated Care Program and we are putting finishing touches on comments received to develop a final product.
96	ATyree@wellspringresources.co	Program Structure	What about behavioral health services? What is the schedule of benefits? What about parity for behavioral health services?	The benefits included in MMAI are the entire package of Medicare and Medicaid benefits, combined. The services covered under each of these programs will not change.

		Type	Question	Answer
97	Amanda Moswin AMoswin@tpoint.org	Program Structure	Will the MMAIs have uniform Utilization Management requirements and procedures?	The health plans are looking into making as many administrative functions uniform as possible, such as billing and credentialing requirements. They have formed an association to help with this endeavor. However, utilization management is one component that would be difficult to make uniform, it is unique to how they run their business, and could vary depending on their plan criteria, network and philosophy. In addition, they must be cognizant of anti-trust issues, which would limit the ability for them all to look exactly the same.
98	Ryan Kilgore ryan.kilgore@mosaicinfo.org	Program Structure	How will these changes affect clients who live in CILA homes?	See response to #75.
99	Philippe Largent plargent@lgs-il.com	Program Structure	Please repeat your comments regarding MMAI and CILAs…your original comments did not come through clearly… Also, what education is DHS offering to CILAs and DD providers on managed care contracting?	See response to #75.
100	rrubin.icarehc@gmail.com	Program Structure	Dual Eligible beneficiary is admitted to long term care facility. He/she has regular Medicare A/B and is enrolled in Illinicare. Admitted under a Medicare Stay. Medicare A will pay 100% for first 20 days and 80% for remaining 80 days. No preauthorization required for Medicare stay. Does the Dual Eligible require pre-authorization for the portion of the stay that will be paid by MEDICAID?	For a LTC admission to be processed the recipient still has to meet the Medicaid eligibility and screening requirements before caseworker can process the admission. A pre authorization should be necessary as Medicaid becomes payer on day 100 or when Medicare ends their coverage which may be before the 100 days is up. Medicaid is also responsible to pay the co payment amounts during days 22 -100, but the amount if any would be the Medicaid charges over and above Medicare's payment amount.

		Type	Question	Answer
101	rrubin.icarehc@gmail.com	Program Structure	Long term care. Admission and Service People w/ Managed Care Medicare vs. People with Regular Medicare. Will the admission guidelines vary from one to the other (hospital stay before admission, Benefit Periods, Readmissions, etc..)	The question appears to focus on the Medicare SNF benefit. The Medicare SNF benefit is covered under MMAI, so for MMAI enrollees SNF services will be covered through a health plan. The plans are required to cover the full Medicare Part A SNF entitlement (as with all covered services). However, the admission guidelines may indeed vary from Medicare FFS. For example, we expect that some health plans will choose to waive the three-day hospitalization requirement prior to authorizing the SNF benefit (many Medicare Advantage plans already use such flexibility)
102	rrubin.icarehc@gmail.com	Program Structure	If a dual eligible signs up, what happens when they travel out of state and need medical care? Now, if they have MEDA/B, they can go to any physician, any state. If they sign up for Illinicare, for example, will they be faced with network/out of network issues, preauthorizations, etc...at well when traveling out of state?	Plans are required to provide emergency services outside of their coverage area.
103	MYRTA REYES mreyes@itexcompany.com	Program Structure	Will LTC facility still work with a DHS case worker? Does LTC facility collect income due?	LTC facilities will continue to work with their respective DHS Local Offices in regards to admission, discharge, income collection, etc. Resident income will continue to be reported as it is today. Providers must electronically submit changes in recipient income using the HFS Web based MEDI system or through their contracted REV vendor. Providers can also view and update the patient credit through this electronic interchange.