Medicare Medicaid Financial Alignment Initiative (MMAI) Frequently Asked Questions

What is the Medicare Medicaid Alignment Initiative?

The Medicare Medicaid Alignment Initiative (MMAI) is an Illinois managed care program for dual eligibles (people who have full Medicare and Medicaid). Through MMAI, the state pays managed care organizations (MCO’s) capitated payments to provide health coverage, and the MCO pays the health care providers who provide services to their plan members. MMAI is currently operating in select geographic areas of Illinois.

Who will MMAI affect?

To be eligible for the Medicare Medicaid Alignment Initiative, an individual must:

- Be receiving full Medicare (Medicare Parts A & B or a Medicare Advantage plan) and full Medicaid benefits (without a spenddown)
- Be age 21 and over
- NOT have high-level private third party insurance (such as retiree or employer coverage)
- NOT be enrolled in the Developmental Disabilities (DD) Medicaid waiver program
- Live in one of the following project counties: Cook, Lake, Kane, DuPage, Will, Kankakee, Knox, Peoria, Tazewell, McLean, Logan, DeWitt, Sangamon, Macon, Christian, Piatt, Champaign, Vermilion, Ford, Menard, Stark

What services are provided under MMAI?

In MMAI, managed care organizations (MCO’s) are responsible for covering individuals' medical and hospital care, prescription drugs (MMAI members receive drug coverage through their MMAI plan instead of through a Medicare Part D plan), mental health and behavioral health services, and Long Term Care Services and Supports (LTSS). MMAI MCO’s must cover the same services that Medicare and Medicaid currently cover, but the plans have the option of covering additional services if they wish. MMAI MCO’s may not charge higher cost-sharing than traditional fee-for-service Medicaid.
Once enrolled in MMAI, an individual must use providers and services within the health plan’s network, and choose a **Primary Care Provider (PCP)**. Members can change their PCP at any time of the year (changes become effective within 30 days).

Managed care organizations will also provide **care coordination** to help their members better organize and streamline their care. Each person enrolled in MMAI will be assigned a Care Coordinator who will assess the individual’s level of “health risk” and work with the individual to coordinate necessary care.


Individuals receiving long term services and supports (LTSS) receive coverage for those services from their MMAI plan, as well. LTSS services include care provided in a long term care facility, as well as care provided through a **home and community-based service (HCBS) waiver program**, such as the Community Care Program, the Persons with Disabilities Waiver Program, the Persons with HIV or AIDS Waiver Program, the Persons with Brain Injury Waiver Program, and the Supportive Living Facility Waiver Program. Eligibility assessments for HCBS Waiver services continue to be conducted by the same agencies that conducted those assessments prior to the existence of MMAI. Once an individual is deemed eligible for HCBS waiver services, the MMAI plan will be responsible for working with the individual to develop a care plan and provide care coordination for LTSS services.

Instead of needing to use their Medicare card, Medicaid card, and Medicare Part D prescription drug plan card to access health care services, MMAI enrollees will receive all of their health care services through their MMAI plan and use that plan’s card. However, members should not throw away their Medicare card or their Medicaid card; they should keep them in a safe place for future reference.

### What if a health care provider is not in an MMAI plan’s network?

Individuals seeing a doctor outside of their MCO health plan network will receive a 180 day transition period in which the MCO will cover services provided by the out-of-network provider (as long as the provider is willing to bill the MCO for those services). The 180 day transition period applies to both medical and LTSS providers. This transition period provides time for the provider to join the plan’s network or for the client...
to find a different provider within the health plan’s network. MMAI MCO’s are not required to cover services provided by out-of-network providers after the 180 day transition period (except for emergency services).

**How can beneficiaries enroll into MMAI?**

When an individual first becomes eligible for MMAI, they should receive an enrollment letter in the mail from Client Enrollment Services explaining the program and their coverage options. MMAI is not mandatory, so an individual who is eligible for MMAI is not required to enroll. However, in most cases, individuals who do not take action upon receiving their initial enrollment letter are automatically enrolled into MMAI plans (otherwise known as **passive enrollment**). These individuals have to actively opt out of the MMAI program by calling Client Enrollment Services at the number below.

To enroll in an MMAI plan, disenroll/opt out, or change plans, consumers should call Client Enrollment Services at 1-877-912-8880 (TTY: 1-866-565-8576). To view and compare MMAI plans (listed as “Medicare-Medicaid plans”), visit the Client Enrollment Services website at enrollhfs.illinois.gov.

Client Enrollment Service representatives are available (at the telephone number listed above) to help educate enrollees, provide unbiased information about their health plan choices, and assist with enrollment into a health plan. Client Enrollment Services representatives are able to provide network information for each of the MMAI plans, so they can help clients determine which MMAI plans provide coverage for their desired doctors/health care providers. However, we recommend that clients also contact their health care providers before enrolling in a plan to verify that those providers will accept the person’s desired MMAI plan.

**Individuals eligible for MMAI can enroll in, disenroll from, or change MMAI plans at any time.** They are never locked in to a particular plan. If someone has opted out of MMAI, that person will not receive any additional letters about MMAI in the future. But they can always voluntarily enroll in the program by calling Client Enrollment Services.

**What information should clients have available when enrolling?**

- Social Security Number
- A chosen primary care provider and the provider’s ID number (Call doctor or Client Enrollment Services at 877-912-8880 to get this ID number)
- Name of primary care physician, specialists, hospitals/clinics or other health care providers they wish to continue seeing (so they can ask if those providers are in the plan(s)’ network(s))
- Medication list (so they can ask if their medications are covered by the plan(s))
What Happens if Someone Disenrolls from MMAI?

MMAI members can disenroll from the program at any time. Beginning July 1, 2016, what happens when a person disenrolls from MMAI depends on whether or not that person is receiving Long Term Services and Supports (LTSS).

LTSS services are services that help people perform activities of daily living, such as eating, cooking, cleaning, bathing, getting dressed, etc. LTSS services can be provided in a long term care facility or through a home and community-based service (HCBS) waiver program, such as the Community Care Program, the Persons with Disabilities Waiver Program, the Persons with HIV or AIDS Waiver Program, the Persons with Brain Injury Waiver Program, and the Supportive Living Facility Waiver Program.

If an individual is not receiving any LTSS services and disenrolls from MMAI, they will return to traditional fee-for-service Medicare and Medicaid coverage. They will need to enroll in a Medicare Part D prescription drug plan or Medicare Advantage plan to cover their drugs. This will not happen automatically. (Note that dual eligibles are allowed to enroll into or change a Medicare Part D plan or Medicare Advantage plan at any time of the year.) If they do not enroll in a Part D or Medicare Advantage plan, they can use the LINET program at the pharmacy. If an individual uses LINET, they will eventually be automatically enrolled into a Part D plan. For more information about LINET, see our fact sheet here:
http://www.ageoptions.org/documents/LimitedIncomeNetProgram.pdf

If an individual is receiving LTSS services and chooses to opt out of or disenroll from the MMAI program, what happens next depends on where they live:

Dual eligibles receiving LTSS services who live in the Central Illinois MMAI counties will return to traditional fee-for-service Medicare and Medicaid coverage, and everything described above (for people who are not receiving LTSS) applies to them, as well.

Dual eligibles receiving LTSS services who live in the greater Chicago area will have a different experience. Beginning July 1, 2016, if these individuals disenroll from or opt out of MMAI, they will be required to enroll in a different program. That program is called “Managed Long Term Services and Supports” (MLTSS). In the MLTSS program, dual eligibles who receive Medicaid-covered LTSS services are required to enroll into a Managed Care Organization (MCO) to cover those services (as well as Medicaid-covered transportation services, and certain mental/behavioral health services that are only covered by Medicaid, not by Medicare).

When someone is enrolled in MLTSS, they will receive their LTSS services, transportation services, and certain mental/behavioral health services (that are covered by Medicaid only) from a managed care organization (MCO). They will receive their medical services (including mental/behavioral health services that are covered by both Medicare and Medicaid) through fee-for-service Medicare (or a Medicare Advantage
plan, if they choose) and fee-for-service Medicaid. They will receive prescription drug coverage from a Medicare Part D plan (or a Medicare Advantage plan if they choose).

When someone enrolls in an MLTSS plan, they will have 90 days to switch to a different plan if they wish. After that, they will be locked into their MLTSS plan for 12 months. However, it is important to note that anyone in MLTSS is still eligible for MMAI, so they can also choose to enroll into MMAI at any time and receive all of their services from an MMAI plan.

**Options for Dual Eligibles with LTSS**

- Medical services and Long Term Services and Supports (LTSS) covered by Managed Care Organization (MCO)
- Can change plan or opt out at any time, HOWEVER...

**MMAI**

If someone opts out of MMAI and receives LTSS, they **MUST** enroll in...

**MLTSS**

- LTSS, transportation, and some other services covered by MCO
- Medical services provided through fee-for-service Medicare/Medicaid
- Locked in for 1 year (after initial 60 day choice period and 90 day switch period)
- Can enroll in MMAI at any time

**Which MCO’s Offer MMAI Plans in Illinois?**

Individuals can review their specific MMAI plan options by calling the Client Enrollment Broker or through the Client Enrollment Broker website (enrollhfs.illinois.gov). **Not every MMAI plan is available in every county/area.** Here is a full list of MMAI health plans:

**Chicago Area**
- Aetna Better Health
- Blue Cross/Blue Shield of Illinois
- Cigna HealthSpring
- Humana
- IlliniCare
- Meridian Health Plan of Illinois

**Central Illinois**
- Molina Healthcare
Where can I go for more information?

For more information about the Medicare Medicaid Financial Alignment Initiative, please visit:

- Illinois Client Enrollment Broker website: [http://enrollhfs.illinois.gov/program-materials](http://enrollhfs.illinois.gov/program-materials)
- Illinois Department of Healthcare and Family Services website: [http://www.illinois.gov/hfs/MedicalProviders/cc/mmai/Pages/default.aspx](http://www.illinois.gov/hfs/MedicalProviders/cc/mmai/Pages/default.aspx)

Medicare Medicaid Financial Alignment Initiative Key Terms

**Capitated Payment** – a form of payment in which an entity is paid a flat amount (per member) to provide care or coverage, regardless of how many services those members actually use in a period of time. Capitated payment is the opposite of “fee for service,” in which providers receive individual payments for each specific service that is performed.

**Care Coordination** – a method of managing a patient’s health care in which an individual (or in some cases, a team) helps a patient organize and streamline their care. In a care coordination model, a “Care Manager” or “Care Coordinator” may communicate with the patient’s health care providers to ensure that the patient receives all of the information and care they need, and that the care being received from different providers is not duplicated or conflicting. The Care Manager/Care Coordinator may also provide ongoing follow-up with the patient to ensure that the patient understands what s/he needs to do to manage his/her health conditions.

**Home and Community Based Services (HCBS)** – Supportive services that are offered to individuals in their homes. The goal of providing HCBS services is generally to help enable individuals to continue living in the community and avoid moving into a long term care facility. (See definition of Long Term Services and Supports below.) For more information about the Home and Community Based Waiver programs in Illinois, visit the Department of Healthcare and Family Services website here: [https://www.illinois.gov/hfs/MedicalClients/HCBS/Pages/default.aspx](https://www.illinois.gov/hfs/MedicalClients/HCBS/Pages/default.aspx)
**Long Term Services and Supports (LTSS)** – Care that helps individuals perform activities of daily living (eating, cooking, bathing, getting dressed, cleaning, etc.) This care may be provided in a long term care facility or through home and community based services. In Illinois, many individuals receive home and community based LTSS services through Medicaid “Waiver” programs (such as the Community Care Program for older adults). These programs provide a variety of in-home supports to older adults, people with disabilities, and individuals with specific conditions, such as brain injuries or HIV/AIDS. For more information about the home and community based Waiver programs in Illinois, visit the Department of Healthcare and Family Services website here: https://www.illinois.gov/hfs/MedicalClients/HCBS/Pages/default.aspx

**Managed Care** – A method of financing and delivering health care that uses a variety of techniques to reduce the cost of care while improving quality of care. These techniques often include care coordination, the use of “integrated delivery systems” (systems in which patients must use specified networks of providers who coordinate services with each other), utilization review (e.g., limits on the use of certain services or requiring prior authorization before a service will be covered), or financial incentives to encourage members to use care efficiently. In a managed care system, individuals are enrolled in a **Managed Care Organization (MCO)** that is responsible for paying for and monitoring their care. MCO’s are traditionally run by insurance companies and use a variety of network models (for example, Health Maintenance Organizations (HMO’s), Preferred Provider Organizations (PPO’s), and Private Fee For Service (PFFS) plans).

**Managed Long Term Services and Supports (MLTSS)** – a program for dual eligibles in the greater Chicago area who are receiving long term services and supports (LTSS) and disenroll from or opt out of MMAI. Through MLTSS, these individuals must enroll into a managed care plan to cover their LTSS, transportation, and certain mental/behavioral health services that are covered by Medicaid only (not Medicare). They will receive the rest of their medical and mental/behavioral health services through fee-for-service Medicare and Medicaid, and their prescription drug coverage through a Medicare Part D or Medicare Advantage plan. (Note: Anyone enrolled in MLTSS may opt into MMAI at any time to receive all of these services through an MMAI plan.)

**Passive Enrollment** – a model in which individuals are automatically enrolled into plans by another entity. If a project is voluntary and individuals are passively enrolled, those individuals may still choose to change plans or opt out of the project after they have been automatically placed into a plan.

**Primary Care Provider (PCP)** – a specified doctor/provider/clinic that an individual chooses to use as their central point for accessing health care. In a managed care system, members must generally consult with their PCP before seeking care from other healthcare providers. Managed care systems utilize primary care providers as a method of streamlining care and improving care coordination.