Medicare Medicaid Financial Alignment Initiative Frequently Asked Questions

What is the Medicare Medicaid Financial Alignment Initiative?

The Medicare Medicaid Financial Alignment Initiative (MMAI) is a new **managed care program** for dual eligibles (people who have full Medicare and Medicaid) that will change the way they receive and access their healthcare benefits. Instead of traditional fee-for-service Medicare and Medicaid, the state will pay managed care organizations (MCOs) **capitated payments**, and the MCOs will pay their members' healthcare providers for services.

Who will MMAI affect?

To be eligible for the Medicare Medicaid Financial 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) waiver programs
- 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?

Managed care organizations will be responsible for covering individuals' medical and hospital care, prescription drugs (members will no longer receive prescriptions through a Medicare Part D plan), mental health and behavioral health services, and **Long Term Care Services and Supports (LTSS)**. The managed care organizations must cover the same services that Medicare and Medicaid currently cover, but the plans have the option of covering additional services. MMAI MCO health plans may not charge higher cost-sharing than traditional fee-for-service Medicaid.

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Instead of needing to use their Medicare card, Medicaid card, and Medicare Part D prescription drug plan card to access their services, MMAI enrollees will receive all of these services through the managed care plan and use that plan's card. However, members should not throw away their Medicare card or their Medicaid card.

Once enrolled in MMAI, an individual must use providers and services within the health plan's network, and they will be assigned a Primary Care Provider (PCP) and a **medical home**. Members can change their PCP at any time of the year, with changes being effective within 30 days. The MCO health plans will only cover out-of-network care in emergency situations.

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. For information on Care Coordinator caseloads, training/education requirements, and how often Care Coordinators must contact their clients, see the MMAI three-way contract here (pages 42-48 and Appendix K): http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/IllinoisContract.pdf

For individuals receiving long term services and supports (LTSS), the MMAI plan will provide coverage for those services, in addition to covering medical, behavioral health, and pharmaceutical benefits. LTSS services include care provided in a long term care facility, as well as care provided through a home and community-based (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. Assessments for these waiver services will continue to be conducted by the same agencies that currently conduct those assessments. Once an individual is deemed eligible for HCBS waiver services, his/her MMAI plan will be responsible for working with the individual to develop a care plan and provide care coordination for LTSS services.

When can beneficiaries enroll in MMAI?

Enrollment for Individuals NOT Receiving LTSS

Voluntary enrollment began March 1, 2014 for individuals who are not receiving LTSS. After this date, individuals eligible for MMAI can voluntarily enroll in an MCO health plan if they choose. They will receive a letter from the **Client Enrollment Broker** about 30 days before voluntary enrollment begins, explaining their enrollment and health plan options. The individual can respond to the letter by calling the Client Enrollment Broker to choose an MCO health plan of their choice or by opting out of the program. If an

individual opts out of the program, s/he will continue to use fee-for-service Medicare and Medicaid for medical benefits.

MMAI **passive enrollment** is being rolled out in phases over several months beginning June 1, 2014 for those who did not make a choice during voluntary enrollment. It is estimated that about 5,000 individuals per month will be automatically enrolled into an MCO health plan in the Chicago area, and 3,000 individuals per month will be automatically enrolled in Central Illinois. These individuals will receive a letter from the Client Enrollment Broker notifying them of their automatic enrollment into an MCO health plan about 60 days before their plan will be effective. They will also receive a reminder letter about 30 days prior to being enrolled. The letters will explain the program and list the plan that the individual will be enrolled in. If an individual is satisfied with the plan listed in these letters, s/he does not need to do anything – s/he will be automatically enrolled into this plan. If the individual does not want to be enrolled in the MCO health plan listed, s/he will need to respond to the letter by choosing an MCO health plan of their choice or opting out of the program entirely to keep their current coverage under traditional fee-for-service Medicare and Medicaid.

Enrollment for Individuals Receiving LTSS

Initial enrollment letters are being sent to individuals receiving LTSS in batches beginning in September, 2014. Once an individual receives an MMAI enrollment letter, s/he will have 60 days to respond by enrolling in an MMAI plan or opting out of the program. If s/he does nothing, s/he will be automatically enrolled into the plan designated in the letter.

Individuals receiving LTSS can opt out of the program or switch plans any time of the year. However, if individuals who are receiving LTSS opt out of the program, they will receive a letter with information about the Managed Long Term Care Services and Supports (MLTSS) program around winter of 2015. The letter will inform them that they must choose an MLTSS plan to cover their LTSS, but they can continue to receive their medical services through fee-for-service Medicare and Medicaid. Individuals will be locked in to their MLTSS plan choice for one year from date of enrollment, but will always have the option to enroll into an MMAI plan to cover all of their services at any time of the year.

MMW has created a one-page timeline of these MMAI enrollment periods. You can view that timeline on our website here, in the Medicaid Managed Care Toolkit section: http://www.ageoptions.org/services-and-programs_MMW-MedicaidandManagedCare.html

How can beneficiaries enroll into MMAI?

Clients can call the Illinois Client Enrollment Services at 1-877-912-8880 (TTY: 1-866-565-8576) to talk to the Client Enrollment Broker or go to enrollhfs.illinois.gov and complete an application. You can also compare MMAI plans (listed as “Medicare-

Medicaid plans") on the Client Enrollment Services website:
http://enrollhfs.illinois.gov/node/13

What information should the Client Enrollment Broker have?

The Client Enrollment Broker will be available to help educate enrollees, provide unbiased information about their health plan choices, and assist with enrollment into a health plan. The enrollment broker will have access to the following information:

- Provider and hospital networks of MMAI health plans
- Provider ID numbers
- All health insurance plans' benefits

What information do clients/patients need to have when enrolling?

- Social Security Number
- A chosen primary care provider and the provider's ID number (Call doctor or HFS at 877-912-8880 to get this number)
- Name of primary care physician or specialists they wish to continue seeing (so they can ask if those providers are in network).
- Medication list. (So clients/patients can ask if medications are covered)
- Preferred hospitals and clinics. (So clients/patients can ask if their hospital is in network for the plans)

Can a beneficiary disenroll from MMAI?

Disenrollment options for individuals not receiving LTSS:
Once an individual who is not receiving LTSS is enrolled into an MCO health plan, they are able change plans on a monthly basis throughout year. They will not be "locked" into a plan.

These Individuals also have the option to disenroll from the program at any time of the year to receive traditional fee-for-service Medicare and Medicaid (regardless of whether they were voluntarily or passively enrolled). If the individual disenrolls from their MCO to use fee-for-service Medicare and Medicaid for their medical benefits, they will be able to enroll into a Medicare Part D prescription drug plan at any time of the year. Individuals can disenroll from MMAI by contacting the Client Enrollment Broker or by calling 1-800-Medicare. Disenrollment will be effective the first day of the month following the request.

Disenrollment options for individuals receiving LTSS:
Individuals receiving LTSS (including home and community-based waiver services) must receive their LTSS services from an MCO. Therefore, if an individual with LTSS chooses to opt out of MMAI, s/he will be enrolled into a separate "Managed LTSS" (MLTSS) program. Individuals who opt out of MMAI and end up in MLTSS as a result

will receive their medical services through fee-for-service Medicare and Medicaid, but they will receive LTSS services through an MCO. (They will have the same choices of MCO plans as in MMAI.) Once an individual chooses (or is passively enrolled into) an MLTSS MCO, s/he will be "locked" into that health plan for one year (after a 90 day initial election period), and will not be able to switch MCO health plans throughout the year. Individuals enrolled in the MLTSS program will have an open enrollment period every year in which that individual can switch MCO plans.

If an individual receiving LTSS opts in to MMAI, s/he will receive all medical and LTSS services through that plan, and s/he will be allowed to change his/her MMAI plan at any time during the year. S/he will also be able to opt out of MMAI at any time during the year. If an individual opts out of MMAI, s/he will be enrolled into the MLTSS program instead (see paragraph above).

Individuals can disenroll from MMAI by contacting the Client Enrollment Broker or by calling 1-800-Medicare. Disenrollment will be effective the first day of the month following the request.

If an individual disenrolls from MMAI, s/he should re-enroll in a Medicare Part D prescription drug plan. (This will not happen automatically.) If the individual does not enroll in a Part D plan, s/he can use the LINET program at the pharmacy to get his/her drugs covered. If an individual uses LINET, s/he 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

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 continue to cover services provided by the out-of-network provider. (The 180 day transition period applies to both medical and LTSS providers.) The 180 day transition period will provide time for the provider to join the plan's network, or for the patient to find a different provider within the health plan's network. The MCO will not cover services provided by the out-of-network provider after the 180 day transition period.

What MMAI plans can a beneficiary choose from?

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Beneficiaries can enroll by calling the Client Enrollment Broker or through the Client Enrollment Broker website. MMAI MCO health plan options are as follows:

Chicago area (Chicago and surrounding suburbs):
Aetna Better Health
IlliniCare (Centene)
Meridian Health Plan of Illinois

HealthSpring
Humana
Blue Cross/Blue Shield of Illinois

Central Illinois:
Molina Healthcare
Health Alliance

(Please note: The plans listed above may not be operating in every county within the designated area. You can see the plans available in a specific county by visiting http://enrollhfs.illinois.gov/ and clicking on "Compare Plans," then choosing your county and clicking on "Medicare-Medicaid Plans.")

Where can I go for more information?

For more information about the Medicare Medicaid Financial Alignment Initiative, please visit the Illinois Client Enrollment Broker website:
http://enrollhfs.illinois.gov/program-materials

Or the Illinois Department of Healthcare and Family Services website:
http://www2.illinois.gov/hfs/PublicInvolvement/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/individual) 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 of individuals) 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.

Client Enrollment Broker – an entity that facilitates enrollment into insurance plans. An Enrollment Broker may assist consumers in finding a plan that will work for them by helping them analyze the available plans' networks or other relevant factors.

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: http://www2.illinois.gov/hfs/MedicalPrograms/HCBS/Pages/default.aspx

Managed Care – a method of financing and delivering health care that uses a variety of techniques improve to reduce 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), utilization review (such as 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).

Medical Home – A healthcare provider/site who provides evidence based primary care services, family-centered health promotion, wellness programs, acute illness care, and chronic health condition management. In a managed care model, a person receives most of their care at their medical home, and the medical home will provide referals for patients to receive services outside of the medical home when needed. A medical home will coordinate a patient's care throughout the healthcare system including coordination between physical and behavior health services. As part of a care team, medical homes will provide discharge planning, medication management, assuring integration of specialty care, and referrals for behavioral health and community based resources.

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.

Voluntary Enrollment – a model in which individuals only enroll in a plan or project if they choose to enroll.