

Discussion Items for Stakeholder Input on the Dual Alignment Initiative

1. Federal CMS does not allow dual enrollees in a Medicare Advantage HMO to be locked-in to the HMO for Medicare services. They have stated the State may choose to lock-in an enrollee in the health plan for Medicaid services. What are the pros and cons of requiring an enrollee to remain enrolled in the health plan of their choice for 12 months for Medicaid services only, allowing for opt out only during the first 90 days of enrollment and annually thereafter.
2. Currently persons with developmental disabilities are required to enroll in the pilot Integrated Care Program (ICP) in suburban Cook and the collar counties; however, their DD waiver services and long term care institutional services are excluded from the ICP program at this time. Should the Dual Alignment Initiative include persons with disabilities and their waiver and long term care institutional services so that all of their needs are the responsibility of one entity, or should the individuals receiving these services be excluded from the Dual capitation program altogether.
3. Should MCCN's be allowed to participate on a more limited geographical basis in the Dual Alignment Initiative than what is required for HMOs?
4. Discussion of questions the following questions received to date on the Dual Alignment Initiative:

- On page 15 of the proposal in the section entitled "Context within Current State Initiatives" the proposal states: "The State recently released a solicitation requesting proposals for...Seniors and Adults with Disabilities including those dually eligible for Medicare and Medicaid." On page 8 of the proposal in the section discussing the enrollment process the proposal states:
 - i. "The State will implement a unified, passive enrollment process..."
 - ii. Beneficiaries will be provided a choice
 - iii. If a beneficiary does not exercise an affirmative choice, they will be auto-assigned to a Plan

Will CCE's and MCCN's participating in the Seniors and Adults with Disabilities Innovations project serving dually eligible beneficiaries under the managed fee-for-service option be included in the passive enrollment process along-side the Plans participating in the "Dual Capitation Initiative?" More specifically, will managed fee-for-service CCE's and MCCN's serving dually eligible participants receive auto-assigned members equally with the capitated Plans?

- In the 4th paragraph of page 9, the proposal states: "Plans must be licensed according to State Licensure and solvency requirements." If allowed to participate, please provide the State Licensure and solvency requirement for CCE's and MCCN's operating in the "Dual Capitation Initiative?" Said differently, how do these requirements apply to MCCN's and CCE's? Will a Plan, Managed Care Entity, or Managed Care Organization referenced in the proposal have to be licensed and regulated by the Illinois Department of Insurance as an HMO or Health Insurance Company to participate in the "Dual Capitation Initiative"?
- The proposal states that enrollment will be capped for Plans based on Provider Network Capacity. Will the State allow, or impose, limits on Plans based on

operational or financial reserve capacity? Please let me explain the basis for this question. Total capitation contemplated under this initiative could well exceed \$5 Billion. Alternative models being formed in response to the HFS Innovations Project may have more limited operational and financial reserve capacity when compared to traditional Medicare Advantage Plans, many of whom are national, for profit HMOs. Enrollment limits based on operational and financial capacity will make it feasible (and even encourage) alternative models to participate. If HFS allows enrollment caps, at what minimum level? For example, Plans may limit enrollment to not less than 5,000 members.

- As is the case with the “Seniors and Adults with Disabilities” solicitation, will the State allow Plans to propose risk corridors and stop loss? Will there be a minimum MLR?
- Over what time period will you phase in enrollment of the 172,000 eligible beneficiaries? In other words, how many beneficiaries per month do you anticipate enrolling starting January 1st, 2013?
- What risk adjusted premium system or methodology will be used? Will you use the federal program’s hierarchical condition code (HCC) based risk adjusted premium system, the Chronic Illness & Disability Payment System (CDPS) or both?
- Approximately 78% (or 118,000) of the eligible beneficiaries reside in Cook County. Would you consider allowing plans to solely concentrate on Cook County and not the remaining 5 collar counties? In short, do proposals have to include the collar counties to be considered?
- Several of the federally mandated timelines for Medicare Advantage plan submissions have passed (e.g., Notice of Intent due in late 2011, 1st bid submission due in late February, etc.). That being the case, will the State be granted different timelines and processes for setting up Medicare Advantage or Medicare Advantage-like health plans for this solicitation?
- As stated in the proposal, approximately 40% of the dual eligible population also receives long-term supports and services (LTSS) in either a community or institutional setting (i.e., nursing homes). Will offering and coordinating LTSS be a requirement for all bidders? When will the transition of LTSS to awardees take place? At enrollment or auto-assignment?
- How will the State handle the room and board portion of institutional care? Will chosen awardees simply pass the same rates on to participating nursing homes or will they be required to negotiate separate contracts with each entity? What will the state do to ensure that each participating nursing home remains in the program? For instance, the TennCare Choices LTC program in Tennessee mandated that all nursing homes have 3-year contracts with each awardee and that their rates would simply be administrated (but not changed) by the chosen managed care companies.
- Who will be responsible for the initial and re-determination of a beneficiaries’ eligibility to receive LTSS? The State, awardees, Area Agencies on Aging, etc?

- How do you envision the rating for LTSS to be constructed? Different rates cells for specific populations in the community versus institutional setting? Blended rates between community and institutional settings?