

**ADDENDUM to
State of Illinois
Illinois Department of Healthcare and Family Services
Capitated Financial Alignment Demonstration Proposal**

As discussed in the July 8, 2011 State Medicaid Director (SMD) letter, CMS is evaluating State demonstration proposals against a list of standards and conditions that CMS is requiring all States to meet to participate in the demonstration. After reviewing Illinois' demonstration proposal, CMS has several clarifying questions to help us determine whether the proposal adequately meets the standards and conditions.

Please note, given that many of the policies related to the implementation of the Medicare-Medicaid Alignment Initiative (MMAI) overlap with Phase II of the Integrated Care Program (ICP), there are several questions asking Illinois to address or discuss both programs and any differences between the two.

Service Area Updates

The Illinois Department of Healthcare and Family Services (HFS) provided the following update on the Capitated financial alignment demonstration.

After further discussion with the CMS, the department does not expect a Year 2 expansion of the geographic areas. The department's interest shall remain in the Year 1 geographic areas, where Plans can propose to serve one or both of the following service areas:

Greater Chicago Counties:

- Cook
- DuPage
- Kane
- Lake
- Kankakee
- Will

Central Illinois Counties:

- Champaign
- Christian
- DeWitt
- Ford
- Knox
- Logan
- Macon
- McLean
- Menard
- Peoria
- Piatt
- Sangamon
- Stark
- Tazewell
- Vermilion

Integration of Benefits

1. Please discuss your plan for incorporating the four HCBS waivers into the demo.

Response: In both the Medicare-Medicaid Alignment Initiative (MMAI) and ICP, the transition of HCBS waiver services into managed care requires a clear process for allocating the responsibilities associated with providing, coordinating and oversight of HCBS waiver services. The goal of transitioning HCBS waiver services into managed care is to improve the delivery of care through coordination of all Enrollees' needs and to improve monitoring and oversight of HCBS waiver services.

- a. **Service delivery**—Service delivery will remain as today the responsibility of the HCBS providers. We expect there to be very little change in providers.
- b. **Care Coordination**—Care coordination will ultimately be the responsibility of the Plans. Plans bring resources to the programs that will greatly enhance care coordination beyond that available to waiver Enrollees today. They will have greater staff resources, both in quantity and qualifications, to devote to hands on care coordination and greater IT resources to connect and share information from the many providers that serve clients. These resources will result in greater oversight and monitoring of the provision of services and greater assurances that needs are being met. We expect that in some instances the Plans will contract with existing agencies that provide care coordination to waiver Enrollees. This is particularly true in the Aging and AIDS waivers. In such cases, the contracted waiver agency Care Coordinators will be incorporated into a larger care coordination structure. Many waiver agencies are invaluable resources for connecting Enrollees to local community services not covered by Medicaid and outside the service package that the Plans or the waivers are required to cover. However, these agencies lack the expertise and knowledge to coordinate clinical healthcare or the IT resources to efficiently collect, use, and share information on Enrollees. Therefore, the most robust coordination models to meet Enrollee needs and sustain people in the community will incorporate the waiver agencies into larger systems.

In instances where the Plans do not contract with the existing agencies that provide care coordination, the Plans will be required to provide the full range of care coordination including HCBS waiver service planning and connecting Enrollees with local community services. The State will monitor the Plans' performance throughout the operation of the demonstration and will require Plans have the capacity to perform the full range of care coordination prior to implementation.

- c. **Service Plan Development**—Responsibilities regarding service plan development may differ depending on whether a demonstration Enrollee is already receiving HCBS waiver services at the time of enrollment in the demonstration (*"existing HCBS eligible"*) or 2) a demonstration

Enrollee is determined newly eligible for HCBS waiver services after enrollment in the demonstration (“*newly HCBS eligible*”). In all aspects of service planning, the Enrollee will be a key member of the team.

- For those *newly HCBS eligible* Enrollees, the Plan will be involved in service plan development from the moment the Enrollee is determined eligible for services. The Plans will be responsible for actual HCBS waiver service planning, including the development, implementation, and monitoring of the service plan, and updating the plan when an Enrollee’s needs change. The Plan Care Coordinator will lead HCBS waiver service planning.

The Plan Care Coordinator will be the interdisciplinary care team member to primarily have direct contact with the Enrollee. The Plan Care Coordinator will coordinate HCBS waiver service planning and updating the care plan through coordination with the Enrollee and interdisciplinary care team.

- For *existing HCBS eligible* Enrollees, the Plans will inherit a service plan and that plan will remain in place for at least a 180-day transition period unless changed with the consent and input of the Enrollee and only after completion of a comprehensive needs assessment. These service plans will be transmitted to MCOs prior to the effective date of enrollment.

d. Eligibility Determinations— Initial and ongoing waiver eligibility determinations under the demonstration will be conducted by the currently designated operating agency. Because waiver eligibility will be a determining factor in the rate paid to a Plan, Plans will not have any control of this function.

e. Health Safety and Welfare Roles and Responsibilities—The health, safety, and welfare of the waiver Enrollees will also be the responsibility of the Plan. This will include monitoring to assure Enrollee needs are being met, assuring providers are qualified, and reporting and following up on critical incidents. HFS will oversee Plans to assure compliance with federal and HCBS waiver requirements and ensure Enrollees’ needs are being met.

f. Participant Direction—Participant direction is a cornerstone of the demonstration. The State will require that Plans allow all Enrollees to participate in their own care plan development, including the selection of providers and services to receive or not receive. Furthermore, participant direction is a component of the HCBS waivers operated by the Division of Rehabilitation Services under the State’s Home Services Program. The three waivers that have participant direction are: the persons with disabilities waiver; the persons with HIV or AIDS waiver; and the persons with brain injury waiver. The State will monitor Plans to ensure effective implementation of self-direction including through the use of consumer satisfaction surveys and other mechanisms.

- g. Quality Improvement Systems**—Currently, each of the HCBS waivers are operated under Quality Improvement (QI) Systems that contain performance measures for each of the federal waiver assurances. Currently many of the assurances are delegated to the waiver operating agencies and HFS oversees the overall QI system as the single state Medicaid authority. The operating agencies conduct program monitoring and report findings and remediation to HFS. HFS conducts validation reviews through a Quality Improvement Organization (QIO). HFS and the operating agencies meet at least quarterly to review findings and discuss trends and patterns, and the need for systemic change.

Under the demonstration, the QI system will be reviewed and modified to assure that the Plans are complying with the federal assurances and performance measures that fall under their level of responsibility. For example, the Plans will primarily be responsible for service planning and health, safety, and welfare; therefore, HFS will assure that the Plans are complying with the waiver assurances in these areas. See question # 17 for more detail on monitoring of waiver services under the MMAI and ICP.

2. *In response to #1 above, the State indicates that initial and ongoing waiver eligibility determinations under the demonstration will be conducted by the currently designated operating agency. How will potentially eligible Enrollees be connected to the currently designated operating agency?*

Response: The Plans, specifically the Care Coordinators, will be responsible for connecting potentially eligible Enrollees to the currently designated operating agencies for waiver eligibility determinations.

Network

3. *Please describe the specific network adequacy requirements for long term services and supports. Please detail the similarities or differences with the ICP. Will the State require the health plans to meet a minimum number of waiver providers by service type? If so, how did the State determine those standards? If not, how will the State ensure adequate access for these services? Please detail the similarities or differences with the ICP.*

Response: Plans will be initially required to offer contracts to any willing provider that meets quality and credentialing standards. After the initial contracting period, Plans will be allowed to impose a known quality standard and to terminate contracts with underperforming providers, while ensuring transition of any Enrollees to better performing providers.

In addition to the any willing provider standard described above, Plans must continually meet the following network adequacy requirements throughout the term of their contracts.

Nursing Facilities: Plans must offer contract to all nursing facilities and supportive living facilities on a county-by-county basis that currently provide services to MMAI or ICP Enrollees unless HFS approves an exception.

HCBS waiver providers: For each of the following HCBS waiver services, Plans' must contract, on a county-by-county basis, with a network of providers that provided at least 80% of the fee-for-service services during CY 2012. In counties where there is more than one service provider, Plans must contract with at least two providers, even if one provider serves more than 80% of current clients. In counties where there is no current service provider, Plans must contract with the providers in other counties who, in the aggregate, currently provide at least 80% of the services to clients in that county.

- Adult Day Care
- Homemaker
- Day Habilitation (BI waiver)
- Supported Employment (BI waiver)
- Home Delivered Meals
- Home Health Aides
- Nursing Services
- Occupational Therapy
- Speech Therapy
- Physical Therapy

The State determined the network adequacy requirements based on an analysis of the number of providers in each county and the percentage of current beneficiaries receiving services from each provider. The State determined that an 80% standard will require Plans to contract with the majority of providers in a region and ensures a network with more than adequate capacity to serve 100% of Plan Enrollees.

The following requirements apply for the remaining HCBS waiver services:

- Environmental Modifications: Plans will be monitored to ensure that necessary modifications are made in a timely fashion.
- Personal Assistants: The State is not dictating a network adequacy requirement, as personal assistants are hired at the discretion and choice of the beneficiary. However, Plans are required to assist Enrollees in locating potential personal assistants as necessary.
- Personal Emergency Response System: Plans must contract with at least two providers in the region.

4. *As there are any specific network capacity requirements for personal assistants? Please describe the State's expectations on the MCOs related to this service.*

Response: MCOs are expected to fully inform consumers of the concept of self-direction and co-employer relationship with personal assistants and have resources available to help consumers find trained personal assistants if the consumer has no one they would like to employ.

5. *How does this program coordinate with the existing ADRC, AAA, and CCU networks in Illinois? How would their roles change? How would the demonstration leverage their expertise? Please detail the similarities or differences with the ICP.*

Response: The MMAI demonstration and ICP will coordinate with existing Aging and Disability Resource Networks (ADRN), AAA, and CCU networks in IL. Currently, CCUs provide assessment and

case coordination services in Illinois. As discussed above, CCUs will continue to provide assessment services to determine an individual's level of need. Whether they continue to play an ongoing role in care coordination depends on whether they are contracted with an MMAI plan to do so. In Illinois, ADRNs serve as a point-of-entry to the options counseling program, ensuring that beneficiaries are informed of their health care options. Under this Demonstration, the State will provide ADRNs with information about Demonstration Plans so that the ADRNs can inform beneficiaries about all of their enrollment options. The AAA will continue to serve as a planning source for services and programs for the elderly. In Illinois, AAAs operate care transition programs that ensure appropriate discharge planning and follow up from hospitals. AAAs are also involved in the Make Medicare Work Coalition and Benefits Eligibility Check-up, efforts to increase consumer awareness and access to public benefits. Illinois encourages MCOs to consider working with the AAAs to leverage their experience in direct service and the program structure in place to advance consumer education.

Care Model

- 6. In today's Medicare Advantage program, beneficiaries with ESRD can stay in an MA plan in which they are already enrolled, but cannot otherwise join an MA plan. Do you intend to follow this type of enrollment policy? If not, would passive enrollment processes apply to beneficiaries with ESRD? If so, what types of special approaches are you proposing to meet the unique needs of the population?*

Response: Yes, passive enrollment processes will apply to beneficiaries with ESRD. To meet the unique needs of the population, the State will work with CMS during readiness reviews to ensure Plan networks have the capacity to serve beneficiaries with ESRD and to consider modifying the auto-assignment algorithm to ensure beneficiaries are aligned with networks best capable of meeting their needs and maintain current provider relationships to the greatest extent possible.

- 7. While the proposal discusses roles for the Care Coordinator, it is unclear what the responsibilities of the medical home are and how it differs from the Care Coordinators. Please clarify and detail the similarities or differences with the ICP.*

Response: Each Enrollee will be required to have a medical home that houses, at a minimum, their PCP. PCPs will provide evidence-based primary care services, acute illness care, chronic health condition management, and referrals for specialty care. The medical home ensures continuity of care with a comprehensive view of an Enrollee's entire health needs. Plans will be required to have policies that create an incentive for medical homes to move towards accreditation.

Enrollees will also be assigned a care team with a Care Coordinator. The Care Coordinator is designed to provide Plan level coordination of all covered services. This Care Coordinator will be responsible for ensuring completion of the health risk and behavioral health risk assessments and care plans; monitoring Enrollee compliance with the care plan; updating the care plan; assuring appointments are kept; and coordinating communication of clinical and other information among the Enrollee's providers and care team. An Enrollee's PCP must be part of the care team and work with the Care Coordinator to assist in coordinating an Enrollee's care including providing clinical care updates and referrals to specialty care. The Care Coordinator ensures access to needed services and facilitates communication and sharing of information between all providers and the Enrollee.

The State expects the primary difference in operation between the ICP and MMAI is that, in ICP, Enrollees stratified to high or moderate-risk will have a care team and care plan. Enrollees stratified to low-risk will generally not have a care team or care plan. In MMAI, consistent with Medicare Advantage requirements, all Enrollees regardless of risk-stratification will have access to a care team and will have a care plan.

8. *Please clarify whether individuals will be re-evaluated for 1915(c) waiver services upon transition to managed care. If so, please describe that process, including responsible parties and timeframes. Please clarify and detail the similarities or differences with the ICP.*

Response: Enrollees receiving HCBS waiver services prior to enrollment in the demonstration (*existing HCBS eligible*) will remain eligible for these services until the time of the Enrollee's redetermination. There is no re-evaluation for eligibility for services and care plans stay in place for at least 180 days unless the Enrollee agrees to a change. Plans are expected to assess that the Enrollees' needs are being met.

The State expects similar operation in both the MMAI and the ICP.

9. *Will individuals continue to have a case manager and an individual team as described in the current 1915(c) waiver programs or will those services and teams be eliminated and replaced by the network Care Coordinator and multi-disciplinary team? Please clarify and detail the similarities or differences with the ICP*

Response: MMAI and ICP Enrollees who receive HCBS waiver services will have a Care Coordinator and care team provided by the Plan. In some cases, however, the existing HCBS case manager may be part of the care team. For example, if the Plan contracted with the existing HCBS case management organization, the existing HCBS waiver case manager will be a care team member to assist with finding HCBS waiver providers and other community resources.

The State expects similar operation in both the MMAI and the ICP.

10. *Please provide additional information on the health home SPA; the proposed timing of implementation; and how it will interact with this demonstration (page 20).*

Response: Illinois will propose that the Plans operate as the health homes as the organization ultimately responsible for providing care coordination services. The exact timing of submitting a Health Homes SPA is not determined. It cannot be submitted until Illinois has Health Homes available to all categorical groups that are covered by its Medicaid program, and these are not all in place.

11. *For the financial alignment demonstration, how will the State assess the appropriateness of each plan's proposed caseload for Care Coordinators?*

Response: The MCO submitted the proposed caseload ratios and procedures for determining those ratios to the State for review prior to contract execution. Illinois assessed each Plan's proposed Care Coordinator caseloads based on several criteria including: how caseload size varies based on risk level; proposed qualifications of Care Coordinators and how they vary based on risk level; and cultural, linguistic, and disability competence of Care Coordinators based on the population to be served. After reviewing the proposed caseloads of all the plans, the State developed a standardized maximum number of Enrollees for each stratification level to ensure for consistency and fairness between the plans.

- *Qualifications:* Plans may propose varying qualification requirements depending on whether Care Coordinators serve low, moderate, or high-risk Enrollees. Care Coordinators for low risk/low need individuals need not have clinical backgrounds. Higher-level case managers must have backgrounds as registered nurses, medical social workers, rehabilitation specialists or other relevant clinical backgrounds. Higher-level care managers must also include staff with community-based experience on aging, disabilities, including potentially persons with developmental disabilities, and person-centered planning approaches. Plans proposed ratios must include a sufficient number of Care Coordinators, based on an analysis of the population to be served, with the background and training to serve moderate and high-risk Enrollees.
- *Cultural, linguistic, and disability competence:* Plans must demonstrate that the number of Care Coordinators to serve each risk-level is adequate to meet the cultural and linguistic needs of the populations to be served. Plans must demonstrate an adequate number of Care Coordinators, as appropriate to the population mix in the demonstration, with training working with individuals with disabilities.
- *Duties:* The assignment of various duties to staff other than the Care Coordinator will also impact what the acceptable caseload will be.
- *Requirement for face-to-face contact:* The State will establish a contractual requirement that Plans must meet face-to-face with Enrollees stratified to high-risk at least every 90 days or as often as required by the HCBS waiver, if applicable. Proposed caseloads must be reasonable enough to allow Care Coordinators to complete all face-to-face contracts in a timely manner while allowing for completion of the Care Coordinator's other assigned duties.

12. *Please provide an example of an arrangement of the co-location of physical and behavioral health, and how you might enforce this requirement (page 11).*

Response: Co-location of physical and behavioral health is accomplished through providers working together in the same practice setting to provide a team-based approach to care delivery and immediate referral when necessary. Co-location may be accomplished through the placement of a behavioral health clinician in a primary care setting or the placement of a primary care clinician in a behavioral health practice.

The State plans to enforce this requirement by: 1) including the Plan's approved approach to integration of physical and behavioral health in its three-way contract with the State and CMS; and 2) ensuring the Plan has the necessary contractual agreements in place between providers to integrate these services during readiness review.

13. *In transitioning the waiver services into the proposed demonstration, will any beneficiary be at risk for losing his or her ability to self-direct care, or reducing the extent of self-direction? Please detail the similarities or differences with the ICP.*

Response: No beneficiary will lose his or her ability to self-direct care as a result of enrolling in the MMAI demonstration. In order to maintain the ability to self-direct care that beneficiaries currently have, Plans will be contractually required to:

- Provide assurances of consumer-direction throughout their care plans and service delivery model. Enrollees must be allowed to participate in their own care plan development, including the selection of providers and services to receive or not receive. Plans must receive Enrollee signatures on service plans.
- Preserve and protect the right of Enrollees to select their own personal assistants and institute quality and integrity controls over personal assistants. Enrollees will be the co-employer of Personal Assistants.

Furthermore, as background, self-direction is a component of the HCBS waivers operated by the Division of Rehabilitation Services under the State's Home Services Program. The three waivers that have participant direction and are included in the demonstration and ICP are: the persons with disabilities waiver; the persons with HIV or AIDS waiver; and the persons with brain injury waiver. Personal assistant services are the most common service under these waivers, accounting for 85 percent of the total services. The State currently serves as the fiscal intermediary for these programs and operates a payroll system for personal assistants.

The State expects similar operation in both the MMAI and the ICP. See response to question #18 for more information on monitoring of self-direction.

14. *As referenced in response above, who will serve as the fiscal intermediary and operate the payroll system for self-directed Personal Assistants (a responsibility currently maintained by the State)?*

Response: The State will continue to act as the fiscal intermediary for Personal Assistants.

15. *Please advise whether HCBS waiver services will only be allowed for those beneficiaries who currently qualify for waiver services, or whether the plans may provide services to any enrolled beneficiary based on need.*

Response: Plans may provide waiver services to individuals not eligible for a waiver based on need. Under the demonstration, Plans will be required to provide HCBS waiver services to any Enrollee that is determined eligible for a HCBS waiver under current assessment procedures. A key goal of the demonstration is to increase utilization of HCBS waiver services, when appropriate, to help Enrollees live independent lives in the community and to decrease the use of institutional long term services by demonstration Enrollees. Plans will be encouraged to improve utilization of these services, when appropriate, through methods such as rate setting and the ability to offer services outside of the covered service package. Further, in order to prevent institutionalization of individuals, Plans will be free to provide waiver services to individuals not eligible for the waiver based on need.

Note: initial and ongoing waiver eligibility determination criteria will not change under the demonstration and will be conducted by the currently designated operating agency.

16. *Please describe any modifications that you anticipate to the care model to accommodate the different special populations served by the demonstration (e.g., people with HIV/AIDS, people with serious and persistent mental illness).*

Response: The care model, as developed, is designed to meet the specific needs and goals of each Enrollee. Plans will be required to assign care teams and develop care plans that are specific to the needs and goals of each Enrollee. For example, Plans have the option of designating specialty providers, as appropriate to the Enrollee's health condition, to act as the PCP in instances where the specialist provides the majority of the care.

For example, an assigned care team for an Enrollee with HIV/AIDS may include designating a provider who specializes in treatment of HIV/AIDS as the PCP; and, if the individual is on various medications for the maintenance of his or her condition, the care plan goals may focus on medication management. Alternatively, an assigned care team for an individual with ESRD may include a nephrologist as the designated PCP and a dietician; and the care plan goals may be nutrition and diet-focused.

The qualifications for Care Coordinators will also change for different subpopulations. An Enrollee with a primary diagnosis of serious mental illness may have a Care Coordinator who is a LCSW, while one whose primary diagnosis is a physical illness may have an RN as a Care Coordinator.

Illinois feels that it developed a care model for the demonstration that is person-centered and provides Plans with the appropriate flexibility to tailor its care coordination efforts to assure that each Enrollee's individual care needs are met.

Monitoring

17. *Please provide additional detail specifically on the staff that will be responsible for monitoring the demonstration and the staff that will monitor the 1915(c) waiver services implemented through the demonstration. Please address this question for the ICP as well as the financial alignment demonstration.*

Response: The Deputy Administrator for Operations of the Department of Healthcare and Family Services will oversee Illinois' move to managed care on a daily basis. The Bureau of Managed Care, with a staff of approximately 30, has primary responsibility for program implementation and oversight. Their monitoring efforts to ensure appropriate access to various services will be assisted by the following Bureaus and Divisions and Agencies:

- Bureau of Interagency Coordination—This Bureau within HFS has primary responsibility for waiver monitoring in Illinois and will continue in this role;
- DHS Division of Rehabilitation Services—This is the operating agency for the Persons with Disabilities Waiver, the Traumatic Brain Injury Waiver and the Persons with HIV/AIDS waiver. It will continue to play a role in overseeing waiver services delivered within the MCO setting. It will also lend its subject matter experts to implementation planning, readiness reviews, quality measure development and analysis;
- Department on Aging—The operating agency for the Elderly waiver will continue to play a role in oversight of the waiver, and lend expertise on quality monitoring;
- Bureau of Long Term Care—This Bureau within HFS oversees institutional long-term services and the Supportive Living Facilities waiver. It will assist in monitoring access to nursing facility services and the quality of those services as well as efforts at rebalancing within the long-term care delivery system.
- DHS Division of Mental Health—This Division has been central in reviewing mental health service taxonomy within the MCOs, developing and reviewing quality measures related to mental health and facilitating ongoing billing assistance between the MCOs and mental health providers.
- Office of Data Analytics and Research—This office in HFS, headed by an actuary, is responsible for providing data analysis for program bureaus for monitoring and quality assurance as well as assisting and reviewing the work of the state's contracted actuaries.

- The University of Illinois at Chicago—UIC has a contract to evaluate ongoing operations of the ICP and MMAI MCOs and assist in continuous quality improvement. It has assembled a multi-disciplinary team of Ph.D. level experts to lead this effort. It conducts consumer satisfaction surveys and focus groups that touch on all aspects of care delivery, access and quality of life as well as analysis of encounter data and other reports and data from the MCOs.

In addition, the state has engaged Navigant consulting to review and suggest improvements in the state's monitoring activities and organizational structures as well as to assist in monitoring during the initial critical months of implementation for ICP Service Package II and MMAI.

18. How will the State monitor plans to ensure effective implementation of self-direction? Please address this question for the ICP as well as the financial alignment demo.

Plans will be required to assure implementation of self-direction through ensuring Enrollees are integral to the care planning process including the selection of providers and which services to receive or not to receive. Enrollees must sign off on service plans. In addition, Enrollees will serve as co-employer of personal assistants and Plans will be responsible for supporting Enrollees in this venture. Plans must assure that Care Coordinators are properly trained and have the skills and resources to be able to train Enrollees in employing their own personal assistants.

Prior to implementation the State will conduct a readiness review, which will include an assessment of the Plan's ability to assure self-direction. In addition to reviewing each Plan's Care Coordinator training materials, Enrollee handbook on employing personal assistants, and other necessary documents, the State will conduct a review of the Plan's on-the-ground management and care coordination processes. This review will include an assessment of intake visits – activities such as Enrollee education on Plan benefits and care coordination services, health risk and behavioral health risk assessments, care plan development, and training on Enrollee roles and responsibilities as a co-employer of their personal assistant.

Plans will be required to perform test case visits with either Illinois staff or EQRO staff. Plans will be given feedback regarding strengths and necessary areas of improvement and will be required to showcase an ability to provide appropriate training to Enrollees on employing personal assistants and to assure self-direction in terms of Enrollee and family/caregiver involvement in developing the care plan and selecting services to receive or not to receive.

In addition, as the Enrollees will be the co-employer of personal assistants, they will receive support from the state or a fiscal vendor for assistance with timekeeping and payroll.

Throughout the operation of the demonstration, the State will continue to monitor self-direction through various methods including Enrollee satisfaction surveys, occasional Illinois staff observations of intake visits, and other monitoring activities. The other monitoring activities will include reviews of Enrollee care plans, service authorizations, and services received to ensure that Plans are providing services agreed to by the Enrollee in the plan of care and critical incident

reports. In addition, the State review of care plans will include a determination of the percentage of care plans with Enrollee signatures confirming agreement with the plan of care.

The State expects similar operation in both the MMAI and the ICP.

Beneficiary protections

19. *Please confirm that the 180-day transition period also includes HCBS waiver providers (page 8). Please detail the similarities or difference with the ICP.*

Response: The 180-day period in which Enrollees may maintain a current course of treatment with an out-of-network provider also includes HCBS waiver providers. This will be true in ICP and MMAI.

20. *Will plans be held responsible for translation standards, in addition to the noted standards for interpretation services (page 25)?*

Response: Yes, Plans will be held responsible for translation standards, which include providing translated materials in, at a minimum, English and Spanish. Plans must also make materials accessible, at a minimum, for those who are visually and hearing impaired. See below for sample contract language to which Plans will be required to adhere:

Translated written materials and scripts for translated key oral contacts require prior approval and must be accompanied by the Plan's certification that the translation is accurate and complete, and that the translation is easily understood by individuals with a sixth grade reading level. The Plan shall make all written materials distributed to English speaking Potential Enrollees, Prospective Enrollees and Enrollees, as appropriate, available in Spanish and other prevalent languages, as determined by HFS. Where there is a prevalent single-language minority within the low income households in the relevant Department of Human Services local office area (which for purposes of this Contract shall exist when five percent (5%) or more such families speak a language other than English, as determined by the Department according to published Census Bureau data), the Plan's written materials provided to Potential Enrollees, Prospective Enrollees or Enrollees must be available in that language as well as in English.

The Plan shall make key oral contacts and written materials available in alternative formats, such as Braille, sign language interpreters in accordance with the Interpreters for the Deaf Act (225 ILCS 442), CART reporters, Video Relay Interpretation or Video Relay Services and in a manner that takes into consideration the special needs of those who are visually impaired, hearing-impaired or have limited reading proficiency. Plans shall inform Potential Enrollees, Prospective Enrollees and Enrollees, as appropriate, that information is available in alternative formats and how to access those formats. The Plan must provide TDD/TTY service upon request for communicating with Prospective Enrollees and Enrollees who are deaf or hearing impaired.

Data Standards

21. *Please provide written confirmation that the State will provide to CMS a description of any changes to the State Plan that would affect Medicare-Medicaid Enrollees during this three year period (e.g., payment rate changes, benefit design, addition or expiration of waivers, etc.).*

Response: During the operation of the MMAI, the State will provide to CMS a description of any changes to the State Plan that would affect Medicare-Medicaid Enrollees.

22. *Please provide written confirmation that the State will provide to CMS data on State supplemental payments to providers (e.g., DSH, UPL) during the three year period.*

Response: During the operation of the MMAI, the State will provide to CMS data on State supplemental payments to providers.