

## **Medicare-Medicaid Alignment Integrated Care Initiative Demonstration (MMAI Demonstration)**

This contract was re-executed on September 14<sup>th</sup>, 2016 in order to:

- Add a two-year extension to the contract, for a new demonstration end date of December 31, 2019, as agreed upon by CMS and HFS. The contract also includes the policies applicable to the two-year extension throughout the contract in relevant sections, including savings percentages for demonstration years 4 and 5 (see 4.1.2), and applicable quality withhold measures (see 4.4.4.7).
- Perform general clean-up and make technical changes to streamline provisions across all three-way contracts for the capitated model demonstrations under the Medicare-Medicaid Financial Alignment Initiative. These changes include:
  - Adding policies and procedures related to discretionary involuntary disenrollments, such as clarifying when an MMP may disenroll an enrollee due to disruptive behavior, and adding procedures that MMPs must complete before effectuating the disenrollment (see 2.3.2.6);
  - Adding requirements related to model of care submissions (see 2.5.8);
  - Clarifying out-of-network reimbursement rules, including clarifying reimbursement for emergent or urgent care (see 2.6.10.5.1) and policies regarding when plans may not pay for items or services (see 2.7.1.19).
- Add the encounter data process measure as a quality withhold for demonstration years 2, 3, 4, and 5 (see Figure 4.2), and penalties for failing to submit complete and accurate encounter data (see 2.17.3, and 5.3.14.1.12).
- Add the new managed care policy regulation requirement that continuation of benefits pending an appeal must include benefits in cases where the authorization for such disputed covered services expires or authorization limits for such covered services are met (see 2.12.4.3).
- Add updates to align with other Illinois Medicaid program requirements. For example:
  - Remove requirements related to web-based access to the care management system for enrollees and providers (in alignment with other state Medicaid managed care contracts) (see 2.5.2.8.2).
  - Provide greater specificity to MMPs on data that must be included in predictive modeling and health risk stratification, and clarify the plans' obligations related to performing immediate care management (see 2.5.2.8.3).
  - Clarify requirements for health risk assessments and care plans, for example, clarifying care plan and continuity of care rules for nursing facility (NF) residents transferring to MMAI from the fee-for-service system, or moving from the community to a NF (see 2.6.10.10).
  - Add details related to how the Money Follows the Person program aligns with demonstration policies, and require incentive payments to community-based providers in specified circumstances when enrollees transition to the community (see 1.101 and 2.5.3.6).
- Incorporate elements of the March 2015 contract amendment.

- Update rate cell stratification, deleting Medicaid rate cell components specifically related to the HCBS Waiver Plus, Community Plus, and nursing home admission rates (see 4.2 and 4.5.1).
- Update marketing requirements to align with national Medicare Marketing Guidelines, Medicare-Medicaid marketing guidance, and state-specific marketing guidance (see 2.10.2.1, 2.10.6, 2.14.4 and 2.14.5).