April 2013

Illinois MOU Summary

On February 22, the Centers for Medicare and Medicaid Services (CMS) entered into a Memorandum of Understanding with the State of Illinois approving the Illinois Medicare-Medicaid Alignment Initiative.[1] Illinois is the fourth state to execute a MOU under the demonstration and the third state to employ a risk-based capitated model.[2]

Illinois will enroll as many as 135,000 dual eligibles in the Greater Chicago and Central Illinois region into capitated health plans[3] (Demonstration Plans) beginning on January 1, 2014. The plans will be responsible for delivering all covered Medicare and Medicaid services to plan enrollees. Illinois already has selected plans to participate in the demonstration.[4]

In contrast with previous state MOUs, this MOU:

- Establishes a plan for a phased passive enrollment that includes monthly caps on enrollment;
- Requires savings targets in the second and third year that are higher than any previous agreement; and
- Does not require plans to provide any new supplemental services for beneficiaries.

This summary of the Illinois MOU emphasizes elements related to beneficiary protections. As this is the third MOU approving a capitated program, the Illinois agreement offers some insight into how state demonstrations will vary, and the overall direction of the Financial Alignment demonstration.

---

[1] Memorandum of Understanding between CMS and the State of Illinois (IL MOU), available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/ILMOU.pdf.

[2] The other three states with approved MOUs are Massachusetts and Ohio (risk-based capitated model) and Washington (managed fee for service model). See http://dualsdemoadvocacy.org/state-profiles for summaries of these three MOUs.

[3] In November, Illinois selected the eight plans that will serve the dual eligible individuals under the Medicare-Medicaid Alignment Initiative. See http://www3.illinois.gov/PressReleases/ShowPressRelease.cfm?SubjectID=2&RecNum=10692.

[4] Illinois issued a Request for Proposals in May 2012 and selected plans in November 2012. See http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/default.aspx.

Enrollment

Illinois will use an initial voluntary enrollment period and will then passively enroll beneficiaries as plans demonstrate their capacity for new members.

Timing: Demonstration Plans will begin to offer coverage October 1, 2013.[5] For the first three months, from October to January, eligible beneficiaries will be able to voluntarily enroll in a demonstration plan. CMS and the State will use this three-month window to monitor each Demonstration Plan's ability to manage enrollment.[6] Beginning on January 1, 2014, the State may begin to enroll beneficiaries passively into Demonstration Plans that have the capacity for new enrollees.[7]

Under the passive enrollment mechanism, beneficiaries will be automatically assigned to plans by the State unless they affirmatively opt out of the demonstration.[8] The passive enrollment will be phased. The MOU sets numerical limits on the rate of plan enrollment. In the Greater Chicago region, the State will passively enroll a maximum of 5,000 beneficiaries per month per the Demonstration Plan over a six-month period. In the Central Illinois region, the State will passively enroll no more than 3,000 beneficiaries per month per plan.[9] The State will only enroll beneficiaries into a plan after the State and CMS determine the Demonstration Plan has the capacity to take on new beneficiaries.

The State will develop an "intelligent assignment" algorithm for passive enrollment. The algorithm will consider the beneficiaries' previous managed care enrollment and historic provider utilization.[10]

Counseling and enrollment entities: Independent enrollment and options counseling assistance will be offered by the State's Independent Client Enrollment Services.[11] The MOU also designates the Aging and Disability Resource Networks (ADRNs)[12] as the entity to provide additional enrollment options counseling to beneficiaries. It is unclear how the state or CMS will fund this assistance.

[5] IL MOU at 9: No earlier than 90 days prior to October 1, 2013, eligible individuals will have the opportunity to elect to enroll into the Demonstration to begin receiving services on October 1, 2013.
[6] IL MOU at 57.
[7] IL MOU at 57. A Demonstration Plan's capacity will be determined by its ability to manage the voluntary enrollments and the prior month's passive enrollments (once applicable).
[8] IL MOU at 58. The State will provide notice of passive enrollment at least 60 days and no more than 90 days prior to the passive enrollment effective date, and will accept opt-out request before the enrollment date.
[9] IL MOU at 58.
[10] IL MOU at 59.
[11] IL MOU at 12.
[12] IL MOU at 12.

Enrollment mechanics: CMS and the State will use an independent, third party entity to facilitate enrollment into the demonstration plans.[13] All enrollment and disenrollment transactions, including transfers between plans, will be processed through the Illinois Client Enrollment Services (CES), the state's Medicaid enrollment broker. The State contracted with Maximus to operate CES, and CES is conducting enrollment for the State's entire Integrated Care program. [14] The State or Maximus will submit enrollment transactions to the CMS MARx enrollment system directly or via a third party CMS designates to receive the transactions.[15] Over-the-phone enrollment through the CES is the primary method of enrollment.[16]

Written materials: CMS and the State will develop uniform enrollment and disenrollment letters and forms.[17] Also, all enrollee materials must be integrated, and will be required to be accessible and understandable to the enrollee, the prospective enrollee and their caregivers. This includes individuals with disabilities, individuals with cognitive limitations, individuals with functional limitations, and those with limited English proficiency.[18] If the Medicare and Medicaid standards differ, the standard providing the greatest access to individuals with limited English proficiency will apply.[19] The proposal addendum provides more detail on language access requirements. For example, when there is a prevalent[20] single-language minority within the service area,[21] the Demonstration Plan's written materials must be available in that language as well as English.

The State or its vendor will provide notices, as approved by CMS, to ensure information is provided in concert with other Medicare communications. CMS may also send notices to beneficiaries and will coordinate notices with the State.[22]

Eligibility for enrollment: Most full benefit dual eligible individuals over age 21 in the Greater Chicago and Central Illinois region will be eligible for the demonstration. Exceptions are limited to the spend down Medicaid population, individuals receiving developmental disability institutional services, or those who participate in an HCBS waiver for Adults with Developmental Disabilities, individuals in the Illinois Medicaid Breast and Cervical Cancer

[13] IL MOU at 9.
[14] Illinois Integrated Care Program Information, available at http://www2.illinois.gov/hfs/managedcare/pages/integratedcareprograminformation.aspx.
[15] IL MOU at 56.
[16] IL MOU at 56.
[17] IL MOU at 56.
[18] IL MOU at 13.
[19] IL MOU at 13.
[20] IL Proposal Addendum at 13, available at: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/IL_Proposal_Addendum.pdf.
[21] The service area is described as the Department of Human Services local area. IL Addendum at 13.
[22] IL MOU at 60.

program, and individuals who have comprehensive third party insurance.[23] All other full benefit dual eligibles, including those with End Stage Renal Disease (ESRD)[24] and those in waiver programs for the elderly, persons with disabilities, HIV/AIDS, brain injury and supportive living are eligible.

Beneficiaries in Medicare fee-for-service and those enrolled in Medicare Advantage plans operated by the same parent organization that operates a Demonstration Plan will be eligible for passive enrollment, unless they opt out. Beneficiaries currently enrolled in a Medicare Advantage plan operated by a parent organization offering a Demonstration Plan will be passively enrolled into that parent organization's Demonstration Plan.

Total enrollment cap: The State originally proposed to enroll 172,000 dual eligibles into the demonstration, while the MOU approves enrollment for 135,000 individuals. The demonstration is a component of Illinois' Medicaid Reform, which requires that 50% of all Medicaid clients will be enrolled in managed care by 2015.[25]

Demonstration Authority

Illinois must seek additional waiver authority from the Centers for Medicaid and CHIP Services before implementing the demonstration.

The authority for the Medicare changes that are part of the demonstration comes from 1115A of the Social Security Act, codified at 42 U.S.C. 1315a, which authorizes the Center for Medicare and Medicaid Innovation to test new Medicare and Medicaid payment and delivery models. The State must also submit Section 1915(c) waiver amendments and State Plan amendments before the demonstration may begin.

The State is also proposing to enroll dual eligibles mandatorily into Medicaid managed care plans for all Medicaid services, including long-term services and supports.[26] Enrollment in Medicaid managed care would be required even of dual eligibles that opt-out of the demonstration. The MOU does not address that proposal, which will require separate Medicaid approval.

[23] IL MOU at 8.
[24] IL Proposal Addendum, at 6. The addendum explains that the State will work with CMS during readiness reviews to ensure that Plan networks have the capacity to serve beneficiaries with ESRD. Plans will also consider modifying the passive enrollment algorithm to ensure beneficiaries are aligned with networks best capable of meeting their needs.
[25] Illinois Care Coordination, available at, http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/default.aspx.
[26] IL MOU at 39.

Ombudsman

Illinois will support an independent Ombudsman office, with CMS support for ombudsman training.

The State plans to support an Ombudsman office that will be independent of the State Medicaid agency.[27] Its role will be to advocate and investigate on behalf of demonstration enrollees, including recipients of long term services and supports, and to serve as an early and consistent means of identifying systemic problems with the demonstration.[28] The Ombudsman will support individual advocacy and independent systemic oversight for the Demonstration, with a focus on compliance and principles of community integration, independent living, and person-centered care in the home and community-based care context.[29] The Ombudsman will be responsible for gathering and reporting data on Ombudsman activities to the State and CMS via the Contract Management Team, and provide input about timeliness of responses to beneficiary enrollment requests.[30]

CMS and the State will provide ongoing technical assistance to the Ombudsman. The MOU is silent on how ombudsman activities will be funded. It also does not state where the ombudsman function will reside.

Americans with Disabilities Act (ADA) and Civil Rights Act of 1964

The Illinois MOU includes general requirements for State and plan ADA and Olmstead compliance.

The MOU requires all plans and providers to demonstrate a commitment and ability to accommodate an individual's physical needs, including providing flexible scheduling. They must also commit to providing interpreters for those who are deaf or hard of hearing or who do not speak English and accommodations for beneficiaries with cognitive limitations.[31] The State and CMS agreed to work with stakeholders and beneficiaries to develop further learning opportunities, monitoring mechanisms, and quality measures to promote ADA compliance by the plans and providers.

The Illinois MOU is silent on additional protections that were included in previous state MOUs.

[27] IL MOU at 12. Illinois is the second state to include a plan for ombuds in the MOU. Ohio also included an ombudsman provision in its MOU. Massachusetts did not; however, the Commonwealth plans to develop an ombuds oversight office for the demonstration.
[28] IL MOU at 12.
[29] IL MOU at 12.
[30] IL MOU at 56.
[31] IL MOU at 13.

For example, the Ohio MOU included provisions that ongoing surveys, readiness and implementation reviews would address *Olmstead* compliance; that demonstration plan training would include ADA and *Olmstead* requirements; and that plans would be required to provide all medically necessary services in compliance with the ADA, as specified by the *Olmstead* decision. Those protections are not spelled out explicitly in the Illinois MOU, though there is a general commitment to "continue to work with stakeholders on these issues."[32]

Baseline Spending and Plan Payments

Illinois' savings of 1%, 3%, and 5% are higher than all previous state MOUs.

In February 2013, CMS updated its guidance to states on the rate setting process for plan payments under the demonstration.[33] Illinois will follow this guidance with Medicare and Medicaid each contributing to a total capitation payment. The contribution each program makes will be determined by following a series of steps.

Setting baseline rates: Spending contributions will be set for Medicare and Medicaid. CMS will determine the Medicare baseline spending amount based on what Medicare would have spent on Part A and B services for beneficiaries in the absence of the demonstration.[34] Illinois' Medicaid agency will set the Medicaid baseline based on historical State data and spending for Medicaid services provided to dual eligible beneficiaries. CMS contractors and staff will validate the state baseline.[35] Payment for Part D services will follow existing Part D rules.

Risk adjustment: The Medicare and Medicaid rates will each be risk adjusted. CMS will use the existing CMS-HCC risk adjustment methodology for the Medicare rate. For Medicaid, the rate will be stratified by age,[36] geographic service area,[37] and setting-of-care.[38] Plans will be paid differently depending on how many enrollees are in each of four settings-of-care: nursing facility (NF), Waiver, Waiver Plus and Community. The Community rate is for individuals who do not meet nursing facility level of care.[39] The Waiver rate is for individuals qualifying for the HCBS waiver. The Waiver Plus rate is provided for the first three months after an individual has

[32] IL MOU at 13.
[33] CMS Memo, "Joint Rate-Setting Process Under the Capitated Financial Alignment Initiative," available at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/JointRateSettingProcess.pdf.
[34] IL MOU at 41. This rate will be based on a blend of the Medicare Advantage projected payment rates and the Medicare FFS standardized county rates for each year. It will be weighted by the duals population who meet the criteria and who are expected to transition into the demonstration.
[35] IL MOU at 42.
[36] IL MOU at 43. Two age categories: 21-64 and 65 and up.
[37] IL MOU at 43. Two geographic categories: Greater Chicago and Central Illinois.
[38] IL MOU at 43.
[39] IL MOU at 43.

transitioned from a NF to a Waiver category. The rate cell for NF will be paid for individuals residing in an NF. For individuals that transition from the Waiver category to a NF, the plan will continue to be paid at the Waiver rate for 3 months.

Savings: After establishing the rates, the rate estimate will be reduced by a predetermined savings amount, guaranteeing state and federal savings.

For the first year, both the Medicare and Medicaid baseline rates will be reduced by 1%. For the second and third year, that amount is 3% and 5%, respectively. The second and third year savings are higher than any previous state MOU. The two previous MOUs (Massachusetts and Ohio) reduced spending by 2% and 4% for the second and third year, respectively.[40] The Illinois MOU does not provide a detailed explanation of why significantly greater savings are expected in Illinois. Although it states that Illinois has one of the highest rates of potentially avoidable hospital admissions among dual eligibles, the MOU does not explain why its savings rate should be greater than that of Ohio, which has an even higher rate of avoidable hospital admissions[41] and also a similar rate of institutional placement.

Quality withholds: Both Medicare and Medicaid will withhold a portion of their contribution to the rate, and this amount will be paid at the end of each year subject to the Demonstration Plan's meeting certain quality requirements. Consistent with other state MOUs, the quality withholds in year 1, 2 and 3 will be 1%, 2%, and 3% respectively.

The measures on which quality payments are based change from the first year to the second and third year. The first year measures include seven measures, most of which are process measures (e.g., timely comprehensive risk assessments, establishment of an advisory board).[42] For the second and third year, nine different measures are used, including outcome measures (e.g., members moved out of institutions, hospital readmissions).[43]

Medical Loss Ratio: Consistent with the Ohio MOU, Illinois Demonstration Plans will be required to meet a Medical Loss Ratio of at least 85%.[44] In Illinois, the MLR begins in 2014, when Demonstration Plans will be required to meet a Target MLR of 85%. Demonstration Plans will be required to remit money back to the Medicare and Medicaid program if their MLR is below the target. Further information will be included in the three-way contracts.

[40] IL MOU, 47-49.
[41] Center for Strategic Planning, Policy and Data Analysis Group Policy Insight Report: Dual Eligibles and Potentially Avoidable Hospitalizations, p.5, Table 5, available at http://www.cms.gov/reports/downloads/Segal_Policy_Insight_Report_Duals_PAH_June_2011.pdf.
[42] IL MOU, 47-49.
[43] IL MOU, 49-51.
[44] IL MOU at 52.

Care Teams and Assessments

The plans will assess each enrollee and build a care plan based on the enrollee's level-of-care needs.

The Demonstration Plans will assess the medical, behavioral health, long-term services and supports, and social needs of their members, and use this assessment to place the member into a care team.[45] All enrollees will be assigned a care coordinator and a care team.[46] Led by the care coordinator, the care team will provide care management, assure appropriate and efficient care transitions, provide medication management, assist with referrals, and assist in the development, implementation and monitoring of the care plan.[47]

The Demonstration Plans will conduct an assessment to determine if a member is low, moderate or high risk. [48]

The plan will administer a health screening within 60 days after enrollment. It is unclear if this assessment is conducted based on existing data or with direct in-person or telephonic contact with the beneficiary. Enrollees will be stratified into three levels: low-, moderate-, and high-risk. Those enrolees stratified to moderate-or high-risk levels will receive a further comprehensive enrollment within 90 days after enrolment.[49] The plan will use predictive modelling and surveillance data for this assessment. It is unclear what the comprehensive assessment involves, and it is also unclear if the comprehensive assessment will be comparable across Demonstration Plans.

The Illinois MOU is the first to set specific caseload and stratification requirements. The plans will use the risk categories to determine care management services, care coordinator case loads and care management services:[50] For low risk individuals, the care coordinator caseload must be no more than 1,600; for moderate risk, 1:150, and for high risk, 1:75. [51]

Demonstration Plans will use the assessment to stratify no less than 5% of enrollees as high-risk. Demonstration Plans will be required to stratify no less than 20% of enrollees to

[45] CMS Fact Sheet, CMS and Illinois Partner to Coordinate Care for Medicare-Medicaid Enrollees, available at http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4547&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date.
[46] IL MOU at 62.
[47] IL MOU at 63.
[48] IL MOU at 61.
[49] IL MOU at 61.
[50] IL MOU at 62.
[51] IL MOU at 64.

moderate-and high-risk levels combined.[52]

Network Adequacy Standards

Plans will be required to enter into and maintain contracts with HCBS providers who provided 80% of fee-for-service services in 2012.

The MOU does not detail specific time, geographic, and number of provider standards in explaining the network requirements for demonstration plans. Instead, the MOU's network adequacy appears to be built on three principles: maintain the existing LTSS network in the first year, include at least 80% of the current HCBS network, and adhere to Medicare network adequacy requirements.

For the first year, plans are required to contract with all willing nursing facilities (NF), supportive living facilities (SLF), and LTSS providers in the service area.[53] After the first year, Demonstration Plans have 90 days to establish quality standards and contract only with the providers who meet those standards. The State must approve the quality standards; however, it is not clear what criteria the State will use to evaluate the Demonstration Plan specific standards.

If the Demonstration Plan terminates contracts, it must have a plan to transition beneficiaries prior to terminating the contracts. For NF and SLF, the plans must maintain the adequacy of its provider networks in each county served. For services provided under the HCBS waiver, the Demonstration Plan must maintain contracts with providers who provided at least 80% of the fee-for-service services during 2012.

If Medicare requirements are stricter than described above, the Medicare requirements must be followed.

Medical Necessity Determinations

The MOU does not explain which standard will be used for services provided by both Medicare and Medicaid.

The MOU uses existing State and CMS definitions for medically necessary services for Medicaid and Medicare, respectively. The MOU diverges from the previous capitated MOUs by not affirming that when there is overlap between Medicare and Medicaid coverage for a service, the definition most favorable to the beneficiary will be used.[54] Instead, the MOU indicates that

[52] IL MOU at 61.
[53] IL MOU at 68.
[54] IL MOU at 71.

the three-way contract will determine which standard will be used.

Benefits

The MOU does not require supplemental services. It does include care continuity provisions.

Scope of benefits: Plans will be required to provide all Medicare services and all State Plan Medicaid services and services under 1915(c) waivers.[55] Plans have discretion to offer flexible benefits.

Plans will not be responsible for eligibility determinations for 1915(c) waivers but will be responsible for HCBS service planning and implementation.[56] In an addendum to its proposal, the State clarifies that Demonstration Plans will be required to provide HCBS waiver services to any enrollee determined eligible for an HCBS waiver under current waiver procedures.[57]

The MOU does not require that plans provide any new supplemental services. The MOU states that plans will have discretion to use the capitated payment to offer flexible benefits appropriate to address the enrollee's needs, but does not require them to do so and does not establish any right for beneficiaries to receive services other than those currently available to them.[58] This lack of required supplemental services contrasts with the significant lists of such services found in the Massachusetts and Ohio MOUs.

Care continuity: Plans must offer 180 day transition period in which enrollees may maintain a current course of treatment with an out-of-network provider. The care continuity protection covers all providers, including behavioral health and LTSS providers. Out-of-network PCPs and specialists providing ongoing course of treatment must be offered single case management agreements to continue to care for enrollees beyond the 180 days if they remain outside the network.[59]

[55] IL MOU at 10
[56] IL MOU at 66
[57] IL Proposal Addendum at 10, available at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/IL_Proposal_Addendum.pdf.
[58] IL MOU at 71. In comparison, the Ohio MOU explains that plans will provide all current waiver services, along with services not previously provided under the state plan, including: adult day health, personal care, homemaker, emergency response system service, home delivered meals, home modification, maintenance and repair, out-of-home respite, home care attendant services, chore services, community transition service, enhanced community living, independent living assistance, nutritional consultation, home care attendant service, alternative meals service, pest control, assisted living service. Services that are currently offered under the state plan, but will be expanded under the waiver, include: transportation, nursing service, home medical equipment and supplemental adaptive device services, and social work counseling.[58]
[59] IL MOU at 72.

Existing HCBS service plans cannot be changed for the first 180 days of plan membership without the consent of the enrollee and a comprehensive assessment.[60] Transitions to a new Primary Care Provider before the end of the 180-day period can only take place if the enrollee consents and if the individual has already been assigned a medical home, appropriate screenings have been completed, the Demonstration Plan had determined that the medical home is accessible, competent and appropriate and a transition care plan is in place.[61]

Appeals

The MOU does not change the Medicare Part D appeals process but it does make significant changes to Medicare A and B and Medicaid appeals.

Plan enrollees will be notified of all Medicare and Medicaid appeals rights in a single, integrated notice.[62]

Beneficiaries must initially file all appeals with the Demonstration Plan. This requirement is consistent with the Ohio MOU but different from the Massachusetts MOU, which permits the enrollee to go directly to a state fair hearing for Medicaid services. If the plan does not resolve the issue in favor of the beneficiary, for services covered by Medicare, appeals will be automatically forwarded, by the plan, to the Independent Review Entity (IRE). For services covered by Medicaid, it is up to the enrollee to request a State Fair Hearing (SFH).

Aid Paid Pending (APP): The MOU seems to indicate that during the initial, plan-level of appeal, the plan must provide benefits pending appeal if the benefits are Medicare Part A or B benefits as long as the beneficiary files the appeal within the 60 day appeal timeframe. For the beneficiary to receive aid paid pending during an appeal about Medicaid-only and Medicare-Medicaid overlap services, however, the appeal must be filed within 10 calendar days of the Notice of Action.[63]

The Illinois MOU differs from the Massachusetts and Ohio MOUs, in that the Illinois MOU sets different standards for APP at the plan level depending on whether the service being appealed is covered by Medicare or Medicaid.

At the next level of appeal, the beneficiary is entitled to aid paid pending for Medicaid services pending the resolution of a SFH. When an appeal is filed with the IRE, aid paid pending will be provided if the service is one that could be covered by Medicare or Medicaid, but not if it is a

[60] IL MOU at 66.
[61] IL MOU at 72
[62] IL MOU at 77.
[63] IL MOU at 77.

service only covered by Medicare.[64]

Oversight

The State and CMS will form a Contract Management Team that will be responsible for day-to-day monitoring of each demonstration plan. The team's responsibilities will include regular meetings with each demonstration plan, coordinating review of grievance and appeals data, and reviewing reports and responses from the Ombudsman.[65] Neither the state nor CMS will take a unilateral enforcement action related to day-to-day oversight without notifying the other party in advance.[66] It is unclear who will serve on the Contract Management Team for the State. The CMS members of the team will include the state lead from the Medicare-Medicaid Coordination Office, the Regional Office Lead from the Consortium for Medicare and Children's Health Operations, and an account manager from the Consortium for Health Plan Operations.

The State recently hired additional staff charged with analyzing current policies and procedures to develop enhanced monitoring for the demonstration.[67]

Quality Measures

As mentioned in previous state MOUs, the State and CMS are still working on quality measures. The MOU includes a list of potential quality measures that will be refined and specified in the three-way contracts. The LTSS measures appear to be a work in progress, and are all determined by the State. They include measures of: medication adherence, transitions between community, waiver and long-term care services, and an Illinois-specific measure of the Participant Outcomes and Status Measure (POSM) Quality of Life Survey.[68]

Stakeholder Engagement

The MOU provides an overview of an ongoing stakeholder engagement process, with few specific requirements for the State. The State is required to establish a plan for gathering and incorporating stakeholder feedback on an ongoing basis during the demonstration.[69] Demonstration Plans are required to develop an independent beneficiary advisory committee that reflects the diversity of the demonstration population. The MOU also requires the State to

[64] IL MOU at 77. If the service is only covered by Medicaid, the appeal would need to be filed with the SFH, not the IRE.
[65] IL MOU at 82.
[66] IL MOU at 81.
[67] IL MOU at 55.
[68] IL MOU at 98.
[69] IL MOU at 29.

maintain a website to provide updates on the demonstration progress.[70]

Conclusion

Between now and October 1, when Demonstration Plans will begin to offer coverage, a tremendous amount of work must be completed by CMS, the State, the Demonstration Plans and community organizations. The State must complete readiness reviews, distribute notices to affected beneficiaries, train and hire staff, prepare enrollment brokers, conduct outreach to beneficiaries, providers, and community organizations, establish oversight and monitoring structures, develop the ombuds program, prepare the ADRNs to assist with enrollment counseling, and more.

For more information on the progress of the demonstration, and information on other state MOUs, visit www.dualsdemoadvocacy.org.

[70] IL MOU at 14.