Appendix 5: State of Illinois Additional Requirements

1. Illinois Medicare-Medicaid Alignment Initiative (MMAI) Eligibility Requirements for Enrollment in MMPs – *This section supplements and clarifies the requirements of §10.5 of the MMP Enrollment and Disenrollment Guidance.*

In addition to the criteria in Section 10, an individual must meet all of the following criteria in order to be eligible to enroll:

- age 21 and older at the time of enrollment;
- entitled to or enrolled in Medicare Part A, enrolled in Part B, and eligible to enroll in a Part D plan as of the effective date of coverage under the MMP;
- enrolled in the Medicaid Aid to the Aged, Blind, and Disabled (AABD) category of assistance.

Eligible populations include:

- beneficiaries who meet all other Demonstration criteria and are in the following Medicaid 1915(c) waivers:
    - Persons who are Elderly;
    - Persons with Disabilities;
    - Persons with HIV/AIDS;
    - Persons with Brain Injury and
    - Persons residing in Supportive Living Facilities.
- individuals with End State Renal Disease (ESRD) at the time of enrollment.

Individuals are not eligible to enroll if

- they are under the age of 21;
- they are receiving developmental disability institutional services or participate in the HCBS waiver for Adults with Developmental Disabilities;
- they are within the Medicaid Spend-down population;
- they are in the Illinois Medicaid Breast and Cervical Cancer program;
- they are enrolled in partial benefit programs; and
- they have Comprehensive Third Party Insurance.

2. Elections and Effective Dates - *This section supplements and clarifies the requirements of §20 of the MMP Enrollment and Disenrollment Guidance.*

In order for an enrollment to be effective the first day of the following month, Illinois' cut-off date for accepting voluntary enrollments (which includes transfers between MMPs) is the 18th of each month. Enrollment requests received after the 18th of the month will be effective the first day of the second month following the month in which the request was initially received.

In addition to the options listed in the guidance, on an ongoing (i.e., month to month) basis, individuals who meet the criteria for enrollment in MMPs may:

- Disenroll from an MMP by enrolling in a Medicare health or drug plan (Medicare Advantage or Part D plan);
- Disenroll from an MMP to Medicaid fee-for-service, so long as the individual is **not** living in the Greater Chicago Region and in a nursing facility or receiving services from a Home and Community-based Services (HCBS) Waiver program;
- Disenroll from an MMP to a Managed Long Term Services and Supports (MLTSS) plan, so long as the individual is living in the Greater Chicago Region in a nursing facility or receiving services from a HCBS Waiver program;
- Disenroll from one MMP by enrolling in another MMP; or
- Disenroll from an MMP by enrolling in a PACE organization.

Mandatory Managed Long Term Services and Supports

If the individual disenrolling from an MMP does not choose to enroll into another MMP and meets the following eligibility under the 1915(b) waiver, the individual will be required to receive Medicaid covered services from a Managed Long Term Services and Supports (MLTSS) plan. The individual, meets eligibility under the 1915(b) waiver if the individual lives in the Greater Chicago Region, is eligible for full Medicaid and Medicare benefits and:

- Resides in a nursing facility; or
- Participates in the following 1915 (c) waivers:
  - Persons who are Elderly;
  - Persons with Disabilities;
  - Persons with HIV/AIDS;
  - Persons with Brain Injury and
  - Persons residing in Supportive Living Facilities.

An individual enrolling into an MLTSS plan has an initial 90day period to change his or her MLTSS plan enrollment following the coverage effective date. This MLTSS policy will have no impact on the individual's right to change Medicare Part C or D coverage, including the right to enroll into an MMP at any time, with MMP coverage effectuated based on the 18th of the month cut-off schedule.

For MLTSS coverage, after the initial enrollment period, once each twelve (12) months thereafter, each individual shall have a 60-day period in which to change the MLTSS plan in which the individual is enrolled. The 60-day period for each Enrollee shall begin ninety (90) calendar days prior to such Enrollee's Anniversary Date. If the Enrollee selects a different

MLTSS plan, enrollment in the new MLTSS plan will be effective on the Enrollee's Anniversary Date. The MLTSS health plan must issue a new Member ID card and new member materials within 5-days of enrollment into the MLTSS plan.

For the purpose of determining the appropriate enrollment effective date, an enrollment request is considered "received" on the date it is initially received by Illinois Client Enrollment Services (CES). CES will process enrollment requests during normal business hours, Monday – Friday, 8:00 am – 7:00 pm.

3. Effective Date of Voluntary Enrollments - *This section supplements and clarifies the requirements of §20.1 of the MMP Enrollment and Disenrollment Guidance.*

Voluntary enrollments are effective the first day of the month following a beneficiary's request to enroll, so long as the request is received by the 18th of the month. Enrollment requests received after the 18th of the month will be effectuated the first day of the second month following the month in which the initial request was received.

4. Effective Date of Voluntary Disenrollment - *This section supplements and clarifies the requirements of §20.2 of the MMP Enrollment and Disenrollment Guidance.*

Individuals have until the last day of the month to request disenrollment. Individuals will be directed to call Illinois' Client Enrollment Services vendor to request disenrollment, but may request disenrollment directly from 1-800-MEDICARE, or by enrolling directly in a new Medicare Advantage, Medicare prescription drug, or MLTSS plan (if eligible). The effective date for all voluntary disenrollments is the first day of the month following the State's receipt of the disenrollment request. The State has a reconciliation process to address any retroactive enrollment changes.

5. Enrollment Procedures - *This section supplements and clarifies the requirements of §30 of the MMP Enrollment and Disenrollment Guidance.*

MMPs may not accept enrollment, disenrollment, and opt-out requests directly from individuals and process such requests themselves, but instead, must refer individuals to Illinois' Client Enrollment Services.

While the State will not defer enrollment activities to the MMP, the State is delegating the following Exhibits to the MMPs:

- Exhibit 4: Model Notice to Acknowledge Receipt of Completed Enrollment Request and to Confirm Enrollment
- Exhibit 5a: MMP Welcome Letter for Passively Enrolled Individuals
- Exhibit 16: Model Notice to Confirm Voluntary Disenrollment Following Receipt of Transaction Reply Report (TRR)

- Exhibit 17: Model Notice for Denial of Disenrollment
- Exhibit 27: Model Acknowledgement of Reinstatement
- Exhibit 29: Model Notice for Enrollment Status Update
- Exhibit 30: Model Notice to Research Potential Out of Area Status – Address Verification Form included

6. Format of Enrollment Requests - *This section supplements and clarifies the requirements of §30.1 of the MMP Enrollment and Disenrollment Guidance.*

The primary mechanism for a potential enrollee to submit a voluntary enrollment request is to call Illinois' Client Enrollment Services (CES), who will process the enrollment over the phone. Potential enrollees may call the CES to request a paper enrollment form. However, Potential enrollees are strongly encouraged to enroll over the phone in order to ensure they are properly educated about all of their health plan choices and avoid potential delays in processing their enrollment due to missing information on a paper enrollment form.

7. Enrollment via the Internet - *This section supplements and clarifies the requirements of §30.1.2 of the MMP Enrollment and Disenrollment Guidance.*

Enrollment via the internet is prohibited in Illinois.

8. Passive Enrollment - *This section supplements and clarifies the requirements of* ***§30.1.4 of the MMP Enrollment and Disenrollment Guidance****.*

A. Individuals Subject to Passive Enrollment

In addition to the listed eligibility criteria for passive enrollment, an individual must meet all State eligibility criteria for the Demonstration, as described in this Appendix, and in Section 10.5 of the national guidance.

The State will not passively enroll individuals currently enrolled in a Medicare Advantage plan **unless** that Medicare Advantage Plan's parent organization is also operating an MMP in the same service area. Where the Medicare Advantage Plan's parent organization also operates an MMP, beneficiaries will be passively enrolled from the parent organization's Medicare Advantage plan into the corresponding MMP.

B. Excluding Individuals with Employer or Union Coverage from Passive Enrollment

Individuals with other comprehensive employer or union coverage who otherwise meet the eligibility criteria for the Demonstration may enroll in an MMP if they disenroll from their existing programs.

9. ESRD and Enrollment (applicable to States for which an individual's ESRD status is an enrollment eligibility criterion) - *This section supplements and clarifies the requirements of §30.2.4 of the MMP Enrollment and Disenrollment Guidance.*

Individuals with ESRD may enroll in MMAI. Furthermore, they will not be excluded from passive enrollment on the basis of their ESRD status.

10. Prior to the Effective Date of Coverage - *This section supplements and clarifies the requirements of §30.4.1 of the MMP Enrollment and Disenrollment Guidance.*

For MMPs that have requested and obtained CMS approval to do so, a Health Risk Screening (HRS) and/or Health Risk Assessment (HRA) may be completed up to 20 days prior to the individual's coverage effective date for individuals who are passively enrolled. Early HRS/HRA outreach for opt-in members is permitted for all participating MMPs. This provision does not waive the requirement that MMPs send a welcome letter 30 days prior to a beneficiary's effective date.

11. Individuals with Employer/Union Coverage – Other Sources - *This section supplements and clarifies the requirements of §30.2.6 of the MMP Enrollment and Disenrollment Guidance.*

Individuals with other comprehensive employer or union coverage who otherwise meet the eligibility criteria for the Demonstration may enroll in an MMP if they disenroll from their existing programs.

12. Voluntary Disenrollment by Member - *This section supplements and clarifies the requirements of §40.1 of the MMP Enrollment and Disenrollment Guidance.*

Note that the State enrollment broker is MAXIMUS, Inc, who assumes the role of the Illinois' Client Enrollment Services (CES).

Written disenrollment/opt out requests received by the MMP that are complete should be faxed to CES at (312) 596-0281. The MMP must write the client's first name, last name, and Medicaid Recipient ID Number in the upper right hand corner of the disenrollment request. The request must be clear regarding the client's request to disenroll or opt out. General written requests such as "what is this plan" or "why did I receive this notice" must be addressed by the MMP's Member Services staff and should not be sent to CES.

For written disenrollment/opt out requests received by the MMP that are NOT complete, the MMP should send the enrollee Exhibit 17, "Model Notice for Denial of Disenrollment."

13. Required Involuntary Disenrollment - *This section supplements and clarifies the requirements of §40.2 of the MMP Enrollment and Disenrollment Guidance.*

The Department shall disenroll an Enrollee when an Enrollee no longer permanently resides in the plan's service area, except for an Enrollee living in the plan's service area who is admitted to a Nursing Facility outside the plan's service area and placement is not based on the family or

social situation of the Enrollee. If an Enrollee is to be disenrolled at the request of the MMP under the provisions of this Section, the MMP must first provide documentation satisfactory to the Department that the Enrollee no longer resides in the plan's service area. Disenrollment shall take effect at 11:59 p.m. on the last day of the month in which the Department determines that the Enrollee no longer resides in the plan's service area. Disenrollment for this reason is always prospective, unless the Enrollee requests a retroactive effective date based on the month the Enrollee moved from the plan's service area.

The Department and CMS shall disenroll an Enrollee when the Department or CMS determines that an Enrollee has other significant insurance coverage, is placed in Spend-down status or becomes ineligible for any other reason. The Department shall notify the MMP of such disenrollment on the 834 Daily File. This notification shall include the effective date of termination.

14. Loss of Medicaid Eligibility - *This section supplements and clarifies the requirements of §40.2.3 of the MMP Enrollment and Disenrollment Guidance.*

Note that an individual cannot remain a member in an MMP if he/she no longer meets eligibility criteria as outlined in this document and *§10.5 of the MMP Enrollment and Disenrollment Guidance.* Please also note that in Illinois, MMP are **excluded** from offering the "Optional Period of Deemed Continued Eligibility Due to Loss of Medicaid Eligibility" as may be available in other states.