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State/Territory Name: IL

State Plan Amendment (SPA) #: 19-0020

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form
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TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTER FOR MEDICARE AND MEDICAID SERVICES <input type="checkbox"/> REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	1. TRANSMITTAL NUMBER 19-0020	2. STATE: ILLINOIS
	3. PROGRAM IDENTIFICATION: Title XIX of the <i>Social Security Act</i> (Medicaid)	

4. PROPOSED EFFECTIVE DATE
January 1, 2020

5. TYPE OF PLAN MATERIAL (Check One)


NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION: Section 1902 of the <i>Social Security Act</i>	7. FEDERAL BUDGET IMPACT a. FFY 2020 \$155,625,000 b. FFY 2021 \$207,550,000
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-F, Page 45-46	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 3.1-F, Page 45-46

10. SUBJECT OF AMENDMENT:
Medicare-Medicaid Alignment Initiative Demonstration Extension

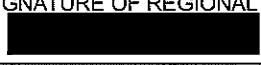
11. GOVERNOR'S REVIEW (Check One)
 GOVERNOR'S OFFICE REPORTED NO COMMENT
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
 OTHER, AS SPECIFIED: Not submitted for review by prior approval.

12. SIGNATURE OF AGENCY OFFICIAL: 	16. RETURN TO: Department of Healthcare and Family Services Bureau of Program and Reimbursement Analysis Attn: Mary Doran 201 South Grand Avenue East Springfield, IL 62763-0001
13. TYPED NAME: Theresa Eagleson	
14. TITLE: Director of Healthcare and Family Services	
15. DATE SUBMITTED 12-31-19	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 12/31/2019	18. DATE APPROVED: 01/31/2020
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PLAN APPROVED—ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 01/01/2020	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME James G. Scott	22. TITLE: Director, Division of Program Operations

23. REMARKS:

State: Illinois

V MCO-Medicare Medicaid Alignment Initiative (MMAI)

1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act.

The Centers for Medicare & Medicaid Services (CMS) and State of Illinois will establish a Federal-State partnership to implement the Medicare-Medicaid Alignment Initiative (Demonstration) to better serve individuals eligible for both Medicare and Medicaid (Medicare-Medicaid Enrollees). The Federal-State partnership will include a Three-way Contract with Demonstration Plans that will provide integrated benefits to Medicare-Medicaid Enrollees in the targeted geographic areas. The Demonstration will begin on February 1, 2014 and will continue until December 31, ~~2019~~2022. The initiative is testing an innovative payment and service delivery model to alleviate the fragmentation and improve coordination of services for Medicare-Medicaid Enrollees, enhance quality of care, and reduce costs for both the State and the Federal government. The Demonstration will be voluntary with passive enrollment of those Medicare-Medicaid Enrollees that do not select a health plan. Participants can opt out of the demonstration at any time. Passive enrollment will be in compliance with the requirements of 42 CFR 438.50 (f), "enrollment by default" - for recipients who do not choose an MCO during their enrollment period, the State must have a default enrollment process for assigning those recipients to contracting MCOs.

B. General Description of the Program and Public Process.

For B.1 and B.2, place a check mark on any or all that apply.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(1)

1. The State will contract with an
- i. MCO
 - ii. PCCM (including capitated PCCMs that qualify as PAHPs)
 - iii. Both

42 CFR 438.50(b)(2)
42 CFR 438.50(b)(3)

2. The payment method to the contracting entity will be:
- i. fee for service;
 - ii. capitation;
 - iii. a case management fee;
 - iv. a bonus/incentive payment;
 - v. a supplemental payment; or
 - vi. other. (Please provide a description below).

Bonus/Incentive Payment- Quality Withhold:

Both CMS and the Department will withhold a percentage of their respective components of the Capitation Rate, with the exception of the Part D Component amounts. The quality withhold will be 1% of the capitation in the first year of the demonstration. This amount will

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increase to 2% in the 2nd year and 3% in the 3rd year and will remain at 3% through calendar year 2022. The withheld amounts will be repaid subject to the Contractor's performance consistent with established quality thresholds. Additional details, including technical specifications, withhold methodology and required benchmarks, are to be provided in subsequent demonstration guidance.

1905(t) 3.
42 CFR 440.168
42 CFR 438.6(c)(5)(iii)(iv)

For states that pay a PCCM on a fee for service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met.

If applicable to this state plan, place a check mark to affirm the state has met *all* of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).

- i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered.
- ii. Incentives will be based upon specific activities and targets.
- iii. Incentives will be based upon a fixed period of time.
- iv. Incentives will not be renewed automatically.
- v. Incentives will be made available to both public and private PCCMs.
- vi. Incentives will not be conditioned on intergovernmental transfer agreements.
- vii. Not applicable to this 1932 state plan amendment.

CFR 438.50(b)(4) 4.

Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. (*Example: public meeting, advisory groups.*)

The State began stakeholder engagement in the planning of managed care programs for the Seniors and Persons with Disabilities (SPD) populations in April 2010. Since then, the State held 16 planning meetings with stakeholders specific to managed care development and engaged stakeholders in topics pertinent to the development of a managed care program including consumer direction, quality outcomes and measurement, care management, enrollment, and provider networks. Examples of stakeholder feedback and lessons learned that