1. Is there a similar evaluation of the Partnership Program as there has been for Family Care?
   Not yet, but we have one in process. Partnership organizations are working with the same independent entity that did our Family Care assessment. They are working toward having an assessment of the Partnership organizations that is comparable to the Family Care assessment. We hope to see results from this assessment by the end of year.

2. Do you have any special rate cells for particular conditions, for example, Alzheimer's? Are those part of -- just part of the usual rate cells?
   Our rate setting methodology does not have particular cells. Actually, we set a rate for each and every individual using a fairly sophisticated analysis of their individualized needs and the usual costs associated with those needs -- and make that calculation for each person enrolled in the MCO -- and then we roll it all up and created an average rate. The needs of every enrollee in a particular managed care organization are captured by this once-a-year snapshot. We don't simply average costs based on a few indicators such as an Alzheimer's diagnosis.

3. This is a clarifying question about the 20-plus medications per person. Are those separate prescriptions or does that 20 include refills?
   No, those are separate drugs.

4. Is your RFP available on your website? If so, what is the URL?
   http://dhfs.wisconsin.gov/ManagedLTC/rfpmco/index.htm

5. Do Family Care plans offer consumers the option of managing (hiring & firing workers) their own care?
   Yes. There's a very strong self-directed supports option within Family Care, and the care management organizations that we use need to be prepared to support consumers. Within that option, people can choose to self-direct one service, two, or as many as they want. This is an example of the flexibility offered by Family Care. A managed care organization in Family Care could, for example, provide all services but personal care and then the individual can self-direct his or her personal care. Consumers have the opportunity to fashion a great deal of how their care is delivered, especially the hands-on care, where it's so important.

6. If you don't yet have an HMO license, where do you need to be in the process on July 13, 2007?
   Since an HMO license is not necessary for providing Family Care, this answer assumes you are proposing a program other than Family Care.

7. What role does the state play, if any, in helping consumers make the choice of plans or the choice to participate?
   Alongside the creation of managed care organizations, the Family Care Initiative has included the creation of Aging and Disability Resource Centers. That ADRC idea really originated here, and we're also taking that statewide. Those resource centers are really the front end to the managed care process; we'll need them in order to go statewide. They are prepared to do very robust options counseling with people who are seeking long-term care in both the private world -- if you have your own resources -- but if you need public support. ADRCs are prepared to help consumers choose among managed care organizations, choose between Partnership and Family Care, eventually consider Family Care Plus, maybe choose to stay in our SSI managed care program until your needs change. We have no doubt that a very robust options counseling piece is essential so consumers have the help they need to make wise choices.

8. What is the difference in enrollment criteria between Family Care and Partnership? (in terms of qualifying for programs or populations served?)
   Actually, we have a long-term care functional screening tool that's automated, and it's there that we capture the information necessary, and the resource centers do this. We're using that in our home and community-based waiver program already, as well. Staff at the ADRC assist the individual complete that functional screen assessment, and that automated tool makes the judgment that a person is at the nursing home level of care. Then the ADRC completes the enrollment process, and the applicant chooses a managed care organization and enrolls. The managed care organization must accept that enrollment and begin working with the consumer. After enrollment the consumer receives a full assessment and our detailed care planning process occurs.
9. How has the county/local organizations worked out the taking on risk requirements?
   Our experience there is what prompted us to say, as we go into statewide expansion, we’re not going to go one county at a
   time. We’ve asked our counties to come together and do this planning process. Some of them are opting to leave the
   waiver business, if you will, and allow private organizations to come into their areas, but in others, multiple counties are
   coming together to form new public entities. We believe that an MCO really need to have at least 1,500 people enrolled in
   the program to effectively manage financial risk over a large enough population. So going forward, we’re not expanding
   Family Care one county at a time, except potentially in Milwaukee, which is obviously a very large county. We’re
   encouraging counties to work with their neighboring counties to form new public entities or to work with private entities.
   Counties will continue to operate the Aging and Disability Resource Centers so they’ll still have a very consumer-focused
   role, but not necessarily operating managed care programs.

10. What are the biggest obstacles to taking these programs statewide?
    Well, it’s developing new managed care organizations. We’re still trying to create them. It’s a major challenge because there
    are parts of our state that don’t have a great deal of population and are not likely to, at least in the short run, attract new
    private managed care organizations with the right kind of mission-driven consumer-centered focus, and we really want to
    capitalize on our home and community-based waiver services and experience.

    Our waiver program is county-operated, so we do have people all over the state who know this population. They need to
    learn managed care, and that’s not a small learning curve. That’s going to be the work of the next several years, but we’ve
    got a huge amount of momentum, and as I said, we’ve got actually four major parts of this state are ready for this RFP and
    think they can begin enrolling in Family Care, and some in Partnership, as soon as next January.

Karen Kalaijian, Director of Program Implementation, Office of Managed Care, NY Department of Health

11. Does the state assist the plans in identifying potential subscribers in their area?
    When a Medicaid managed care enrollee “ages into” Medicare eligibility, the automated notice he or she receives regarding
    disenrollment from his/her mainstream Medicaid managed care plan suggests that he/she consider enrolling in Medicare and
    Medicaid Advantage products available in the area. The notice refers beneficiaries to contact the local district or
    enrollment broker for more information on available plans.

    Plans that participate in the mainstream Medicaid managed care program and Medicaid Advantage generally are aware of
    when members “age into” Medicare eligibility and can encourage these enrollees to transfer from their mainstream
    Medicaid product to their Medicare and Medicaid Advantage products.

    Also, when we first created the Medicaid Advantage program, we did do a mass mailing to duals eligible for enrollment
    including a brochure that describes the Medicaid Advantage program and a list of Medicaid Advantage health plans and
    plan contact numbers. Most plans later indicated that they didn’t see any significant increase in interest in the program as a
    result of that mailing.

12. Does the state provide a customer service/enrollment broker function for the Medicaid Advantage or Medicaid
    Advantage Plus programs?
    The State does have an enrollment broker that processes Medicaid Advantage enrollments in New York City and in
    selected other counties of the state. In other areas, Medicaid Advantage and Medicaid Advantage Plus enrollments are
    processed by the local social services departments.

    Health plans generally market their Medicare and Medicaid Advantage products at the same time and process enrollments
    in Medicare Advantage through CMS and enrollments in the complementary Medicaid Advantage products through the
    enrollment broker or the local social services district.

13. Can the nurse who assesses nursing home eligibility actually complete the Medicare enrollment process? (Rather than a
    licensed insurance broker, which is CMS's requirement for Medicare Advantage)?
    In the Medicaid Advantage Plus program, a health plan’s nurse can assess eligibility for nursing home placement. The
    completed assessment tool along with the Medicaid Advantage Plus enrollment form is sent to the local social services
    district for processing.
14. Beyond PACE, do any of the other health plan enrollment options provide fully integrated care for the dually eligible (as opposed to just integrated financing)?
   No, however, we believe our Medicaid Advantage models permit the integration of Medicare and Medicaid service delivery and financing at the plan level within the constraints of existing federal and state regulations, and without additional waivers.

15. How are substance abuse and mental health benefits provided?
   Medicare covered substance abuse and mental health benefits are covered by the uniform Medicare Advantage benefit package associated with our Medicaid Advantage products. Specialty mental health services are also available to plan enrollees on a FFS basis.

16. Who was the consultant who developed the assessment tool?
   The tool used to assess eligibility and continued eligibility for Medicaid Advantage Plus is based on the federal OASIS tool, as adapted by the Department of Health with the assistance of the Island Peer Review Organization and the University of Colorado.

17. For marketing materials, is the state DOH reviewing and approving materials within the same 45 day timeframe as CMS?
   The CMS/State joint review of marketing materials follows CMS timelines.

18. In our state, through our marketing activities, we have encountered a large number of SSI duals, with Parts B and D but not A. As a Medicare Part a buy in state, does DOH plan to audit to auto enroll in Part A to allow for wider participation?
   For individuals who are SSI, we systematically identify those who do not have Medicare Part A and we accrete such individuals to the Part A buy-in. For non-SSI individuals, local social service districts are instructed to identify individuals that would qualify for the Part A buy-in and add them to the Part A buy-in file.

   Were there time differences in terms of dual enrollment — i.e., Medicare enrollment can happen up to the end of the month for an effective date of the first of next month, where Medicaid enrollment ends on the 20th for the first of the next month. Any enrollment after the 20th becomes effective the first of the second month following enrollment. We adjusted the enrollment broker and local social district’s enrollment processes to permit Medicaid Advantage enrollments to become effective first of the next month as long as they are received before the second to the last business day of the month. As a result, enrollments are generally effective first of the next month for both Medicare and Medicaid Advantage.

19. What is the overall impetus for your program? Helping people stay in the community for as long as possible? Integrating Medicare and Medicaid for dual eligibles?
   Integrating Medicare and Medicaid for dual eligibles is the primary goal of our Medicaid Advantage program models. However, another important goal for the Medicaid Advantage Plus Program is to help people stay in the community for as long as possible.

20. There are obviously gaps in service in every community. Can you identify one or more systemic gaps that just don't exist at this time but would make a difference to have a successful managed care model?
   No

21. Do you have any comments regarding chronic cardiovascular services?
   No

22. Do you encourage clients with more serious chronic conditions to the Medicaid Advantage Plus program?
   No

23. In the Medicaid Advantage-Plus Program, is the Medicare program, in effect, subsidizing the Medicaid program? and what has CMS's position been on this issue?
   Medicare is the primary insurer for dual eligibles. Medicaid is the secondary insurer. Our Medicaid Advantage program models are designed to take advantage of Medicare dollars to cover some services that might normally be covered by Medicaid. On the other hand, the utilization of Medicaid services to keep enrollees in the community for as long as possible reduces the use of some acute care services for which Medicare is the primary payor.