An Independent Evaluation of the Integrated Care Program

Findings from the Baseline through Year Two (FY13)

Tamar Heller, Randall Owen, Dale Mitchell, Chris Keys, Judah Viola, Yochai Eisenberg, Anne Bowers, Hailee Gibbons, Kiyoshi Yamaki and Coady Wing

Institute on Disability and Human Development

University of Illinois at Chicago

May 2014

Funded by the Illinois Department of Public Health

Submitted by the Department of Disability and Human Development, University of Illinois at Chicago to the Illinois Departments of Public Health and the Illinois Department of Healthcare and Family Services.

[page intentionally blank]

Table of Contents

Table of Figures and Tables

Executive Summary

Over the past several years, the State of Illinois has been implementing and planning several programs to move Medicaid and Medicare recipients into systems of care coordination. The original, mandatory Medicaid managed care program in Illinois is known as the Integrated Care Program (ICP) and serves seniors and people with disabilities who are Medicaid-only eligible residing in the suburbs of Cook County (not including the City of Chicago) or the five collar counties (DuPage, Kane, Kankakee, Lake, and Will counties). This program began on May 1, 2011 with the goal of improving the quality of care and services that the Medicaid population receives, along with saving the State money on Medicaid expenditures (estimated at $200 million over the first 5 years).

Originally, ICP only covered acute healthcare services (Service Package 1), but beginning in February 2013 the Managed Care Organizations (MCOs) also became responsible for long-term services and supports (LTSS) (Service Package 2) for all of their members except for people on the developmental disability waiver. There was a six-month transition period until August 2013 for LTSS, so this report does not include LTSS to the extent it will next year.

The State of Illinois (through the Department of Public Health) contracted with the University of Illinois at Chicago (UIC) to conduct an independent evaluation of ICP. This report presents results from the second full year (FY13) that the program has been in operation. Although the results focus on FY13, there are a few instances where they relate to a different time period. When this occurs, it is noted accordingly. The results in this report are based on both qualitative and quantitative data, including focus groups conducted with stakeholders; a consumer satisfaction survey; and analysis of Medicaid encounter data, MCO data, and reports the MCOs submit to the Department of Healthcare and Family Services (HFS). The direction of the evaluation has been developed through consultation with an active advisory board and participation in various stakeholder, MCO, and HFS meetings.

This report is primarily based around four general questions with specific analytical areas within each question. The major findings are summarized below.

A. How well has the Integrated Care Program been implemented?

The transition to managed care involves several new processes for members to navigate. While some of these are similar to what exists within the general Medicaid program, the way they are implemented and used can differ. Within this section, the analysis focuses on these processes and their outcomes. This includes enrollment and the development of provider networks, which are essential to the functioning of MCOs, along with processes of prior authorization, grievances and appeals, and payment of providers. This section also provides an analysis of the care coordinators and care plans that the MCOs use.

- *Enrollment was steady*. Monthly enrollment for each MCO was relatively steady, with each MCO having just shy of 18,000 members per month. Approximately 60% of people made an active choice regarding which plan they enrolled in. The rate of auto enrollment was about 40%, which is an improvement from the 60-70% in the first year of ICP. About 2.1% of each MCO's members left the plan each month, and of those, only about one out of every nine moved to the other plan. Many of

those who left an MCO likely did so because they gained Medicare eligibility, which made them ineligible for ICP.

- *There were improvements in the adequacy of provider networks.* UIC worked along with HFS and HSAG (Health Services Advisory Group, the external quality reviewer HFS hired to help monitor the MCOs) to identify the number of "available" and "active" providers in each network. UIC also calculated various provider (e.g. primary care physicians, dentists, community mental health centers, home health providers, and pharmacies) densities per persons served for the six counties of the ICP. For the most part, the networks included similar or more primary care providers per 1,000 members than were available pre-ICP. For instance, in FY11, prior to the beginning of ICP, 150 primary care physicians were available per 1,000 ICP-eligible members, but as of January 2014, Aetna reported 190.4 PCPs and IlliniCare reported 174.7 PCPs per 1,000 members. The focus group participants agreed that the networks were improving, but pointed out that there was room for improvement in the number of specialists in some areas.
- *MCO websites are useful sources of information for potential members and providers*. Each website provides an array of information that is often essential to a member making a choice to join one plan over the other. Individual members look for different information, and it is difficult to conclude that one website is more effective than the other. However, from the pages that the UIC team analyzed, the IlliniCare website was consistently written in an easier to understand format. On the other hand. Aetna's search tool was more easily accessible from the home page (requiring one click) while it took three clicks from IlliniCare's home page to get to its provider search tool.
- *MCOs are making efforts to track the accessibility of provider offices.* While the traditional fee-for-service (FFS) Medicaid program does not check the accessibility of provider offices, each MCO asks providers if they are accessible during the credentialing process. Nearly 80% of each plan's provider offices identified as accessible in FY13. However, this is based on a self-assessment of the office's accessibility. Both MCOs have plans to improve this by checking some provider offices in person and by implementing on-site accessibility assessments.
- *There are few differences between the MCOs in terms of paying provider claims.* IlliniCare pays more of their claims to in network providers than does Aetna, and pays more of their claims within the 21 (electronic) or 30 (paper) day standards. Over 60% of IlliniCare's claims are from in network providers compared to almost 55% of Aetna's. Aetna has noted that it has a liberal policy of allowing out of network providers to provide services, which may account for the gap of claims from network providers between the MCOs. IlliniCare resolves nearly 97% of paper claims within 30 days and 99% of electronic claims within 21 days; Aetna resolves about 97% and 95% of each type of claim, respectively.
- *While each MCO varies in terms of number and types of care coordinators and the amount of staff turnover, both MCOs are growing their workforce of care coordinators.* Aetna began FY13 with 27 care coordinators, and ended with 64. However, 13 (48%) of the 27 care coordinators that worked there during the year left the position (including promotions) before the year's end. IlliniCare began the year with 42 care coordinators and ended with 70. Only 6 (14%) left the position during the year.

- *Both plans have room for improvement regarding the completion of screenings, assessments, and care plans.* IlliniCare has completed more initial screenings than Aetna (57.9% to 35.0%). Of those completed, IlliniCare is completing them faster on average (31.4 days to 55.9 days). More of Aetna's members need an in-depth assessment than IlliniCare's members (32.7% to 24.6%) and Aetna completes a higher percentage of them within 60 days (74.0% to 60.3%). About 15% of the members receiving an in-depth assessment is determined to need care plans, and each MCO completes a much higher percent of them within 90 days than they did during the first year of ICP.
- *The MCOs vary in the number and types of prior authorization requests received and approved.* Overall, ICP receives 130.2 requests for prior authorization per 1,000 member months. Aetna receives more inpatient requests (49.9 to 1.0 per 1,000 member months), while IlliniCare receives more outpatient requests (96.3 to 59.7) and pharmacy requests (31.8 to 21.6). Each MCO has its own prior authorization requirements, which explains much of the differences in rates of requests. Requests may be standard (i.e., the MCOs have 10 days to respond) or expedited (i.e., the MCOs have 3 days to respond). For standard inpatient requests, 89.5% for Aetna are approved, compared to 40% for IlliniCare. For expedited inpatient requests, IlliniCare approves almost 97%. Aetna did not report any expedited requests. Each MCO approves over 95% of standard outpatient requests. IlliniCare also approves 98% of expedited outpatient requests.
- *Transportation continues to be most common reason for a grievance.* Aetna received almost twice as many total grievances as IlliniCare (1.93 to 1.06 per 1,000 member months). Over half of the grievances that each plan received regarded transportation. In regard to outcomes IlliniCare substantiated (i.e., investigated and corroborated) over half of its grievances, and could not substantiate 17.4%. Only 30.4% had unknown outcomes. Similarly, Aetna substantiated 53.2% of its grievances, could not substantiate 23.8%, and 23.0% had unknown outcomes.
- *The MCOs receive appeals for different reasons.* In FY13, IlliniCare received more appeals than Aetna (160 to 92). Most of Aetna's appeals regarded medical necessity (85.9%) or access to care (13%), while IlliniCare's were for pharmacy (63.8%) and medical necessity (33.8%). IlliniCare overturned 64% of its appeals, and Aetna overturned 37%.

B. What impact has ICP had on healthcare and long-term services and supports utilization outcomes?

This section provides an analysis of the services that the MCOs provide. Within research on managed care, rates of emergency room (ER) and hospital usage are key areas for analysis as their reduction can lead to improved cost effectiveness. Special analysis is presented on high-cost users from the baseline to determine what impact ICP has had on those members who were the most costly to begin with. The analysis presented in this report extends the focus on ER and hospital use by also analyzing the use of preventive care, radiology, and pharmacy services. The use of transportation and dental services is also included in this section. Finally, analysis is presented on member movement from setting to setting (i.e. institutional settings to community), as rebalancing from institutional to community settings is an important area of focus in Illinois.

- *Providing transportation services is an area where the MCOs have made some useful additions compared to FFS Medicaid, although there are still concerns with the quality of transportation services.* For instance, unlike FFS, the MCOs allow for trips to the pharmacy to pick up prescriptions after a medical visit. From FY11 (prior to ICP) to FY13, the percentage of enrollees who utilized non-emergency medical transportation increased slightly from 14.6% to 16.1%. However, transportation is the leading reason for grievances for both MCOs and was a frequent area of concern in the stakeholder focus groups, both from members and MCO care coordinators. A large percentage of pre-ICP transportation users did not use transportation in the ICP period, and the transportation general contractors had difficulties in coordinating the network of transportation providers, resulting in greater use of Taxi services.
- *Dental services are an area of "value added" for the ICP as compared to FFS Medicaid.* The enactment of the Saving Medicaid and Resources Together (SMART) Act dramatically cut access to dental services for most of the FFS Medicaid population. The SMART Act resulted in a significant decrease in cost for non-emergency dental services for FFS Medicaid, with an 88% decrease in costs from FY11 to FY13. ICP also decreased costs from FY11 to FY13, but only by 16%, because each MCO continued to follow the pre-SMART Act guidelines in offering dental services. Still, the number of ICP enrollees that utilized dental services decreased 21.8% from FY11 to FY13 (7,521 to 5,879). On the other hand, the number of ICP enrollees who received preventive dental services in FY13 was 668% higher than at the baseline (2,091 compared to 313). According to the survey data collected following the second year of ICP, a significantly higher percentage (60.1%) of people in FFS had unmet needs for dental compared to 49.3% in ICP.
- *Cost for emergency room (ER) utilization in ICP significantly decreased in FY13 as compared to the baseline and to FFS.* In FY13, the MCOs paid just over $337 per FTE member for ER services, compared to almost $390 in FY11 at baseline. For people in FFS the ER costs increased from $457 to $579 per FTE member. Results of the propensity analysis that matched ICP members with the FFS comparison group and controlled for differences indicated a marginally significant decrease in ER costs for ICP compared to FFS.
- *Cost for hospital admissions decreased for both ICP and FFS from the baseline to FY13.* The ICP group decreased in hospital admissions costs from $4,700 in FY11 to almost $3,200 in FY13. The FFS comparison group also decreased in hospital costs from $5,700 in FY11 to just over $4,500 in FY13. Results of the propensity analysis showed that ICP hospital costs decreased significantly less for the ICP group versus the FFS comparison group.
- *The use of preventive services increased from FY11 to FY13 for both ICP and FFS.* Among ICP-eligible members, the use of preventive services increased from 7.5 to 8.7 claims per 1,000 member months (the cost also increased per 1,000 member months from almost $560 to over $835). Claims per 1,000 member months also increased for the FFS group (3.3 to 4.5 claims per 1,000 member months; cost increased from $233 to $362 per 1,000 member months). Among the survey respondents following the second year of ICP, there were no significant differences between ICP and FFS for the number of preventive counseling services received.

- *The use of radiology services increased for the ICP population from FY11 through FY13.* In FY11, there were 60.3 claims per 1,000 member months (just over $5,500 per 1,000 member months) while in FY13 there were 80.0 claims (costing more than $16,000 per 1,000 member months). IlliniCare had more claims (87.7 versus 73.3) and higher costs (over $21,000 versus over $11,000) per 1,000 member months than Aetna. Much of the increased utilization was due to increased use of CT scans. For the FFS group, claims and costs per 1,000 member months decreased slightly.
- *The MCOs have increased the number of prescriptions and decreased the costs per 1,000 member months, though the decrease in costs was not statistically significant over the change in FFS.* In FY11, the ICP-eligible population had 3,783.3 prescriptions at a cost of $277,259 per 1,000 member months, which increased to 4,308.9 prescriptions at a cost of $263,111 per 1,000 member months in FY13. Each MCO had similar numbers on these measures and also used about the same percent of generic prescriptions (86.5%). The FFS comparison group decreased the number of prescriptions from 3,899.5 to 2,836.4 prescriptions per 1,000 member months (cost also decreased from $282,321 to $200,668 per 1,000 member months). When adjusting for differences between the ICP and FFS groups, propensity analysis did not show any significant differences between the ICP and FFS group in changes in cost of pharmacy services.
- *Rebalancing long-term services and supports from long-term settings to the community has not yet occurred.* Based on capitation payments for FY13, 163 people have moved from long term care settings into the community and another 32 have moved from long term care settings into a waiver category. Another260 people have moved from the community into long term care settings and 528 people have moved from the community to waiver services. The MCOs only transitioned to managing long-term services and supports in February 2013, so it is difficult to make conclusions about their impact on rebalancing without more data and a longer timeframe to observe.
- *Age adjusted mortality rates for the ICP group decreased and the Chicago FFS group and a downstate FFS group slightly increased from the two years prior to ICP to the two years period following ICP implementation.* The UIC team did not yet have the information to conduct a propensity matching analysis.

C. What are the consumer experiences with ICP?

To better understand enrollee experiences, this evaluation uses consumer surveys and focus groups. Findings related to the consumer experience are integrated throughout this report.

- *ICP enrollees report a decline in satisfaction with health care services from baseline to after the first year of ICP, but there are no statistically significant differences between ICP enrollees and people receiving FFS in Chicago following the second year of the program.* Longitudinally, satisfaction declined in the first year among the overall ICP sample regarding satisfaction with their primary care physician and with medical services. There were differential effects for different disability groups; people with physical disabilities declined in satisfaction with overall services and medical services, while people with mental health disabilities were less satisfied with primary care physicians. Following the second year of ICP, ICP enrollees reported significantly higher health services appraisal than people receiving FFS, except for people with physical disabilities who had a significantly higher

appraisal of FFS than ICP. Higher levels of healthcare appraisal were associated with receiving more preventive counseling services and having fewer unmet needs.

- *Consumer reports do not show significant changes in overall access to services longitudinally or differences between ICP and FFS.* Longitudinally, various measures of access to services and the number of unmet needs did not change significantly from the baseline through the first year of ICP. However, people did note that they had to travel less time to get to their specialist after enrolling in ICP. Following the second year of ICP, there were no statistically significant differences between ICP and FFS with regard to the number of unmet needs that a person had. The number of unmet needs was higher for people with specific disabilities.
- *Focus group participants of consumers and providers cited examples of some members' struggles to get the medication they needed, having to change from medications that were working and a lack of communication with pharmacies covered by MCOs.*

D. What impact has ICP had on costs to the State?

One of the primary reasons that many states move towards managed care is that managed care has the potential to reduce Medicaid expenditures. Also, it allows the state to more accurately predict expenditures due to the use of capitated payments. This section of the report focuses on the cost of ICP in terms of Medicaid spending.

While cost analysis is difficult under typical circumstances, the implementation of the SMART Act nearly one year after the beginning of ICP further complicates possible answers to this question. In addition, there were other forces at work, such as the economic conditions in the state, the rollout of the ACA, and changing Medicaid eligibility requirements, that may have influenced how health costs changed and to what degree. Trying to account for the impact of these systemic factors is outside the scope of this study.

- *Cost savings were projected to be approximately $40 million per year under the ICP and the state is projecting the ICP will meet that goal in the third year of the program.* Prior to implementation of the ICP, the state estimated savings of $200 million over the first five years of the program. In fall 2013, HFS made the prediction that they would save $40 million for Service Packages 1 and 2 in FY14 for the entire ICP population ($20 million in the pilot areas that this report focuses on). This approach assumes that capitation rates for Service Package 1 services have been maintained at a level at least 4% below what the likely corresponding FFS costs would have been (and 2% below similar costs for Service Package 2 services).
- *In April of 2013, 8 months after the implementation of the SMART Act, the state reduced capitation rates for Service Package 1 services by an overall average of 8.4%.* This adjustment was made to reflect several factors, including the impact of the SMART Act, updated utilization data, revised claim experience, and other policy and program changes in the Medicaid program.
- *The MCOs have spent an average of 82% of their revenues on member "benefits" for the first two years of the ICP compared to a minimum medical loss ratio requirement of 88%.* This has resulted in

a refund of almost $38 million back to the state from the MCOs for the first two years of the ICP ($11.6 million in CY11 and $26.3 million in CY12).

- *Any analysis of cost effectiveness needs to take into account the balance between cutting costs and improving quality. The SMART Act was primarily a cost cutting measure.* The ICP on the other hand has two primary goals: to cut costs and to improve quality of care for its members. To ensure there would be a balance between the two goals, the state put in place over 60 outcome measures related to quality. Throughout this report, the UIC research team has tried to provide the best data available on both the costs and the quality outcome measures to compare the performance of the MCOs on these measures to the same measures in the FFS system.

E. How has ICP fared on quality assurance outcome measures?

- *This section focuses on issues of quality assurance within Illinois.* The State has required extensive use of quality indicators and implemented pay for performance standards for the MCOs, and this section reviews those standards and how that MCOs have measured.
- *In 2013, the Health Services Advisory Group (HSAG) evaluated both MCOs for their performance on outcome measures associated with Service Package 1.* Of the 11 pay-for-performance measures (P4P), Aetna improved above the state baseline on 10 of the measures and met the P4P goal on 5 of them, while IlliniCare improved over the state baseline on 4 of the measures and met the P4P goal on 3 of them. Aetna earned approximately $5.3 million in incentives for P4P measures; IlliniCare did not earn any incentives for P4P for 2012.
- *With regard to non-P4P measures, of the 21 applicable measures for Aetna, they improved over the baseline for 17 and declined for 4 measures. Of the 20 applicable measures for IlliniCare, they improved for 13 and declined for 7 of the measures.*

F. Recommendations

Goal 1: Ensure adequacy of the health and LTSS provider network of the expanded ICP state-wide prior to "going live."

- The State should develop standards for what an adequate network looks like, including standards for "adequate" numbers or provider "coverage" for select key provider types across counties.
- The State should continue to work with HSAG to ensure that networks are maintained.
- The State and the MCOs should develop plans for ensuring accessibility of provider offices which would minimally include criteria of what "accessibility" means, especially in regards to exam tables and diagnostic equipment, and also would include some pro-active audits of providers by the MCOs.
- HFS should work with other state agencies to ensure that procedures are in place that minimize the need for providers to enter duplicate billing and service information into electronic databases.
- The State should hold at least annual meetings with providers to solicit feedback regarding their experience with submitting claims and being paid by the MCOs.

- The MCOs should expand the number of specialists available in the suburbs further away from Chicago.

Goal 2: Improve consumer access to services.

- MCOs should make medications more readily available to people with mental illness. Aetna and IlliniCare have programs in place to facilitate this. However, this was a concern for focus group participants, who may not know how to take advantage of them. This implies that member and provider education may help ease the concern over access to medication.
- MCOs should work to improve transportation access to reduce complaints and help members get to and from appointments.
- The State should establish procedures that ensure that MCO care coordinators are aware of and make necessary referrals to providers for the provision of non-Medicaid services that members might need.

Goal 3: Improve the information available to the public about the program.

- The State should provide clearer information regarding enrollment procedures because some members still had difficulty enrolling, either because they were assured they were being transitioned from Medicaid to ICP or they could not access adequate information to make an informed choice.
- The MCOs should provide clearer information regarding what services and benefits are covered as ICP members and others expressed confusion as to whether the provisions of the SMART Act applied to them.
- MCOs should consistently update information provided on their programs' websites, including accurate information regarding providers who are actually available.
- The State should create a task force of MCO staff, Medicaid members, and public stakeholders to develop some minimum criteria regarding information that will be available on MCO web sites and establish general guidelines for navigation of the sites.

Goal 4: Continue and improve training related to ICP.

Both Aetna and IlliniCare have used a number of strategies and partnerships to train members and staff about ICP. However, because of the importance of training, the UIC team has a number of recommendations for training related to ICP, especially as ICP expands to include additional MCOs.

- Although the State has improved the process of tracking the training that care coordinators receive, better information on the amount and type of training received by care coordinators would be useful.
- HFS should continue to work with other state agencies to ensure that ICP care coordinators receive training on waiver services as those services change in the state system (this will be especially important as the 1115 waiver is introduced).
- Other areas of continued training needed for MCO staff include person-centered approaches, family support, cultural competence, and health promotion strategies for people with disabilities.

- MCOs should continue to work with consumer organizations and provider agencies to develop peer training (including people with disabilities and family community health workers) within their organization.

Goal 5: Improve consistency and usefulness of data reporting.

- The State should work closely with the MCOs to develop a specific and common set of data elements to ensure that encounter data for ICP members can be entered into a database maintained by the State until the time the State is able to maintain this encounter data in the current Medicaid claims database.
- The State and the MCOs should continue to work to standardize data reporting formats for monthly and quarterly reports (e.g., resolutions of grievances).
- The State should establish a regular process of reporting those waiver members that move into and out of the ICP (e.g., reason for movement and state agency notified).
- The State should create a structure that will more easily track the number of deaths within the ICP so they can be compared to risk-adjusted rates in the rest of the Medicaid population.

Introduction

Like many states nationally, Illinois is rapidly implementing various forms of managed care for its Medicare and Medicaid populations. In 2011, the Medicaid reform law, Public Act 96-1501, was passed by the Illinois General Assembly, requiring HFS to move at least 50 percent of Medicaid members to a "risk-based care coordination program" by January 1, 2015. To meet this goal, HFS has announced that this care coordination will be provided by three types of "managed care entities" for the Medicaid populations of SPD/ABD (seniors and people with disabilities/aged, blind or disabled) people:

1) Traditional insurance-based Health Maintenance Organizations (HMO) accepting full-risk capitated payments;
2) Managed Care Community Networks (MCCN), which are provider-organized entities accepting full-risk capitated payments; and
3) Care Coordination Entities (CCE) which are provider-organized networks providing care coordination, for risk- and performance-based fees, but with medical and other services paid on a fee-for-service basis.

The state is also working on the implementation of the "Medicare-Medicaid Alignment Initiative," a federal demonstration project that will provide care coordination to people dually eligible for both Medicare and Medicaid.

By 2010, 47 states and DC had implemented some form of managed care that covered 71% of their Medicaid enrollees (National Association of State United for Aging and Disability, 2013). Although many of these states initially covered just health care services and excluded long term supports, states have begun integrating both health and long term services and supports into their managed care initiatives. As of 2011, there were 21 states that had included long term services in their managed care programs; by 2014 this is projected to increase to at least 25 states.

In February 2010, HFS issued a Request for Proposals (RFP) seeking two health maintenance organizations to provide adults with disabilities and older adults in the Medicaid program the full spectrum of Medicaid covered services through an integrated care delivery system. HFS received proposals from five vendors in June 2010 and awarded contracts to Aetna and Centene-IlliniCare to run the Integrated Care Program (ICP) pilot.

The ICP pilot was targeted towards approximately 40,000 Medicaid members not eligible for Medicare and living in suburban Cook, DuPage, Kane, Kankakee, Lake and Will Counties. The ICP was projected to save the state $200 million in the first five years of the program. A main goal of this program is to improve the quality of care and services that consumers receive and to do so in an efficient and cost-effective manner.

The state announced that it was "committed to an independent evaluation of the program" and contracted with the University of Illinois at Chicago (UIC), to conduct this evaluation and "determine the extent that these goals have been met." The state also announced "this evaluation will ensure an efficient way of monitoring the implementation of the integrated care program and inform future expansions and/or changes to the program design. The evaluation will also serve as a mechanism for

ensuring that consumers receive quality services from their medical providers and achieve their personal health goals."

The first report released by UIC (March 2013) primarily covered Service Package 1 (acute healthcare). Service Package 2 (long term services and supports for everyone except those on the developmental disability waiver) began to be covered by the MCO's in February 2013, although the transition period lasted until August 2013. Because the data included in this report primarily covers FY13 (July 1, 2012 through June 30, 2013), it does not fully capture the experience of long term services and supports (LTSS) through the MCOs. However, the report does include some aspects of the transition to the new Service Package covered by the MCOs. A more detailed analysis of the long term services and supports outcomes will be included in the report UIC prepares one year from now.

Evaluation Design and Methods

A. Evaluation Components

The evaluation contract that UIC has with the Illinois Department of Public Health specifies three components: process evaluation, outcome evaluation, and economic impact evaluation. These are briefly described below.

1. Process Evaluation

Process variables for this evaluation include MCO organizational structure, formal policies and procedures, resource allocation, and effectiveness of the MCOs in carrying out consumer "readiness" activities (awareness and knowledge of the program). This evaluation component is primarily addressed in Section 1 (see page 23).

A key aspect underpinning the process evaluation is the capacity building framework. The capacity building process is facilitated when institutional factors such as strong leadership, resources and supports for program implementation are present along with strong individual factors such as consumer readiness (awareness and motivation) and competence (knowledge about the program), and when attention is given to contextual and cultural factors. As part of the capacity building process, the UIC team uses a logic model approach to evaluate the attainment of project goals and outcomes of ICP.

2. Outcome Evaluation

In addition to assessing the implementation of ICP, this evaluation is examining the health care utilization, consumer satisfaction, and outcomes for participants. To isolate the effects of external factors on the outcomes being measured, the research team has used a comparison sample and, to the extent possible, statistically controlled for differences in the populations. This outcome evaluation component is primarily addressed in Section 2 (see page 23) and Appendices B and C.

Specifically, this part of the evaluation examines outcome measures related to six overarching questions.

1) Did consumers gain increased access to needed services through the reduction of existing physical and other barriers, the increase in available services from existing providers, and an increase in existing services?
2) Did an increase in prevention services and care coordination improve health and decrease costs through a decrease of admissions to hospitals and nursing homes and trips to hospital emergency rooms?
3) Did enrollment in the managed plan result in improved health outcomes as measured by standard HEDIS measures?
4) Did consumer satisfaction increase as a result of enrollment in the program as measured by standard CAHPS measures and other survey and focus group measures?
5) Did ICP (service package 2) result in rebalancing in LTSS?
6) Did ICP (service package 2) impact consumer choice and quality of life?

3. Economic Impact Evaluation

An essential component of an evaluation of a new program is an analysis of the costs of care. The evaluation team has access to Medicaid encounter data for the ICP population at baseline (FFS Medicaid) and has received capitation payment information from HFS for FY13 and encounter-like data sets from each MCO. Using this data, Section 3 (see page 73) details the findings in this area. The research team is employing a propensity score matching scheme to control for demographic differences in the ICP and comparison group areas. This method allows us to more accurately attribute changes in the costs to ICP and not to other policy trends.

B. Data Collection Processes

In conducting the overall evaluation, the UIC evaluation team is collecting both quantitative and qualitative data and solicits input from concerned stakeholders, including the Illinois Department of Healthcare and Family Services, the Illinois Department of Human Services, the Illinois Department of Public Health, the Illinois Department on Aging, providers, MCOs, advocacy groups, and consumers themselves. An evaluation advisory group consisting of various stakeholders has met throughout providing advice and review in the development and execution of the evaluation. The data collected includes consumer surveys, focus groups, and secondary quantitative data provided to the evaluation team. The methods the research team used for these processes are described below.

1. Consumer Survey

The research team has developed and disseminated a consumer satisfaction survey at the baseline and following the first two years of ICP. The survey includes measures of unmet needs, satisfaction, access to services, self-rated health status, and questions related to respondents' experiences within ICP. The survey was developed in consultation with the ICP Advisory Board, IDPH, and groups of people with disabilities.

This survey is primarily a mailed survey, although a few respondents choose to do it over the phone. 4,700 surveys were sent to each of samples of ICP enrollees and a comparison group of people receiving FFS Medicaid who live in Chicago and would be ICP eligible if they lived in the pilot area. The samples are chosen at random, stratified by waiver status, except that people who answered the survey in the previous year are automatically included in the sample in order to have a longitudinal cohort to follow. This report includes analysis of both longitudinal (n=208) responses from the baseline to after the first year of ICP and cross-sectional analysis comparing ICP and the comparison fee-for-service group. The cross-sectional analysis includes 790 respondents from ICP and 720 from fee-for-service. Overall, the response rate is about 25%. More detail on the responses to this survey is included in Appendix B.

For each survey distributed, follow-up efforts are made to each person in the sample to encourage them to complete the survey. Many surveys are returned with invalid addresses and many people cannot be reached by phone. Approximately 35% of the phone numbers provided to the research team were either disconnected or wrong numbers. See Appendix B for additional detail on the participant demographics.

2. Focus Groups

The research team conducted a series of focus groups (17 in 2012 and 15 in 2013) and interviews (2 in 2012 and 4 in 2013) with interested stakeholders. ICP members and caregivers were recruited by disseminating a flier though local disability advocacy and service organizations and through direct phone calls using the contact information provided by IDPH. Given the mobility and low income of Medicaid recipients, a significant proportion of the phone numbers received from existing records were either disconnected or incorrect. Members and caregivers were also recruited based on interest expressed during the previous year's focus group participation. Finally, the survey offered participants the option to indicate their interest in a focus group; several participants were recruited in this way. Participants were recruited for particular groups based on geographical location. Service providers, managed care employees and leadership, and state employees were recruited through community organizations, hospitals and clinics, and direct contact.

During the second year of ICP, the research team conducted 15 focus groups and 4 individual interviews with 30 consumers and 3 caregivers residing in 6 counties (suburban Cook, Kankakee, Will, Kane, DuPage, & Lake), 17 providers, 46 managed care employees, and 7 state employees. See Table 155 in Appendix C for an overview of focus group participants.

Each focus group was conducted at a public, accessible location (e.g., Centers for Independent Living, University offices, HFS offices, Community Agencies, etc.). At each focus group, members of the research team explained the purpose of the focus group and obtained informed consent. An experienced, trained facilitator using a semi-structured focus group interview guide conducted the focus groups. The development of the guide was informed by input and feedback from the Evaluation Advisory Board and health care and focus groups experts. The resulting guide was reviewed and approved by the Illinois Department of Public Health and the UIC Institutional Review Board. The focus groups were recorded digitally and transcribed verbatim to create a transcript for analysis. Additional research team members took notes at the focus groups to capture additional contextual information. Each focus group lasted between 70 minutes and 180 minutes. Following the focus groups/interviews, participants (excluding MCO leadership and governmental employees) received $50 as compensation for their time.

The research team used qualitative analysis/coding software (Atlas.ti) to assist with a mixed approach (grounded theory and a priori codes) to qualitative analysis. In general, the research team examined the data for themes that emerged during the analysis. In addition the researchers looked for themes on the pre-identified topics of transition, communication, network adequacy, quality of care, prevention, and coordination of care. Use of multiple coders and analysts ensured consistency and agreement on general themes. These themes are illustrated by descriptive quotes. A combination of inductive and deductive coding enabled the researchers to narrow themes into subthemes for each type of participant, allowing subthemes to emerge organically while also using the existing framework guiding the focus groups. The quotes in the report are just a small portion of exemplary comments in order for a set of comments to be considered a "theme" multiple stakeholders must have raised the concerns across groups. Thus, each quote represents one individual's perspective or experience and is indicative of similar comments made by other participants.

3. Quantitative Data Sources

The majority of the findings presented in this report are based on various quantitative data sources. This subsection describes the datasets to which the UIC evaluation team had access.

Fee-for-service (FFS) claims data provided by HFS to UIC

There were two (2) different FFS claims datasets received from HFS. The first was a dataset of all Medicaid claims for approximately 41,000 ICP eligible members just prior to the start of ICP, for the nine-month period of July 1, 2010 through March 31, 2011.

The second dataset was for all claims for a comparison group of FFS members who lived in Chicago and were eligible for ICP except for living in Chicago. This dataset covered three fiscal years, from July 1, 2010 through June 30, 2013. There were between 65,000 and 70,000 ICP-eligible members in this dataset for each year.

The two datasets contained all FFS Medicaid costs incurred by the state for these members, including pharmacy and non-pharmacy costs.

Contractual reports submitted by MCOs to HFS

The contracts between the MCOs and the state list certain regular reports (or deliverables) that the MCOs must submit to the state reporting on various topics and outcome measures. The UIC research team made note of these reports and developed a list of which reports were important for the project. The team began receiving these MCO reports in December of 2011 and has continued to receive these reports as requested.

While these reports have provided helpful information, they present challenges in reliably comparing the performance of the two MCOs on specific outcome measures. Although most of the reports have improved considerably in terms of reliability and comparability since Year 1, most of the improvement came near the end of FY13. For that reason, the reports were again used primarily this year for confirming data received from other sources within HFS or the MCOs.

During the summer of 2013, HFS made several important changes in how the plans submit the regular reports and in how the reports are reviewed by HFS. The improvements made by HFS in the reporting process include:

1) Development of standard templates that all MCOs use submitting data;
2) Key changes in the submission and storage of the reports; and
3) Increased involvement of HFS in the submission and review of the reports.

Examples of changes made by HFS in the area of provider network reporting are detailed in Tables 80-83 in Appendix A.

ICP claims dataset provided by HFS to UIC

Illinois is not alone in having difficulties in producing a complete and reliable encounter dataset for a capitated Medicaid program. Many states have found it difficult to produce complete and reliable data because of the way the payment process works in a capitated system. Unlike the FFS program, the managed care plans are not paid for each service delivered; rather, they receive a capitated payment

from the state for each member covered for a month. In turn, they can set their own standards on how providers are paid by them, which might be less stringent in terms of reported information than the regular Medicaid FFS system.

"Official" encounter dataset. In the Year 1 report, some of the problems that HFS and the MCOs had in producing a reliable post-ICP encounter dataset were described. Briefly described below are some of the additional challenges that remain in Year 2 and the steps that HFS took to obtain a substitute claims dataset that permitted the UIC research team to complete its work.

The HFS Medicaid claims warehouse is set up to handle thirteen different billing forms. The overall claim processing protocol has more than 600 different "edits" or checks it could apply, depending on the specific claim form being processed. Most of the claim documents have to pass more than 100 individual checks during the Medicaid claim process.

Each MCO has a slightly different process for paying claims submitted to them by their own providers. In working with HFS to create an encounter dataset, the MCO then submits encounter data for that claim to HFS to process through the Medicaid warehouse as a non-paying encounter. Based on the type of document submitted by the MCO and the subsequent edit checks, the encounter is either "passed" or "rejected." Table 1 lists the results of the encounters the MCOs have submitted since the ICP began through August of 2013.

Table 1 indicates that in FY12, almost three quarters (73.7%) of Aetna's claims passed all checks while nearly 90% of IlliniCare's submissions passed. In FY13, both of these rates increased to 87.1% and 92.4%, respectively. Despite this improvement, as of the fall of 2013, HFS had not been able to produce a complete and reliable encounter dataset that could pass the checks in their production system. It should be noted while IllilniCare generally had a higher "pass" rate than Aetna, the number of encounters that Aetna processed through the HFS system was more than twice as many as IlliniCare did.

Table 1: Submitted Encounters (May 2011 thru August 2013)

Year	Aetna		IlliniCare	
	Submitted	% Pass	Submitted	% Pass
FY11	22,810	59.0%	4,646	93.7%
FY12	1,947,204	73.7%	1,026,766	87.8%
FY13	1,814,230	87.1%	591,400	92.4%
FY14	142,574	95.5%	4,310	93.0%
TOTAL	**3,926,818**	**80.6%**	**1,627,122**	**89.5%**

Data Source: MCO Special Datasets

Alternative encounter dataset. In the fall of 2013, when it became apparent that a full and reliable encounter dataset would not be available for analysis, HFS and UIC devised an alternative option. HFS requested a full claim dataset from each MCO for FY13 consisting of all claims the MCO had paid to providers. There was no attempt to process these claims through the official HFS claim warehouse (as discussed above) as it was hoped that the raw claims would contain adequate information to be

comparable to the FFS claim datasets already obtained. In conjunction with the previous FFS datasets and a series of "special" datasets from the MCOs (discussed below), the research team was able to make cost comparisons and other analyses between the FFS pre-ICP period and Year 2 of the ICP.

Special datasets submitted by MCOs to UIC

As previously discussed, the research team was limited in its work due to the lack of any "official" post-ICP encounter data. To meet the needs of the research analysis, the team was able to obtain and use a an alternative encounter dataset (described above) of raw claims that the MCOs had paid their own providers but had not necessarily been processed through the official HFS Medicaid warehouse. For some of the team's work, this alternative encounter dataset was sufficient; however, for some areas, the claim dataset was not adequate. In those instances the UIC team was able to work with the two plans to obtain "special" datasets focusing in on specific areas not adequately covered by the claims dataset. These special datasets from the MCOs included ER visits, hospital admissions, drug usage, risk stratification, care plans, prior approval requests, grievances, appeals, enrollment, and radiology services.

Capitated payment dataset provided by HFS to UIC

UIC also obtained a dataset of all capitated payments HFS made to the MCOs for ICP members for the first two years of the program. This data included the rate cell, amount paid, month, member, and MCO. Besides being used to calculate the costs of the ICP to the state, it also allowed for tracking member movement from rate cell to rate cell and to track member enrollment in the plans. In addition to the capitated payments, UIC obtained the FFS claims that HFS continued to process for Service Packages 2 and 3 services for ICP members.

Provider network dataset provided by HSAG to UIC

As discussed in another section of this report (see Adequacy of Provider Networks, page 26), HFS expanded the responsibilities of the external reviewer, Health Services Advisory Group (HSAG), to include the on-going monitoring of the development and maintenance of the MCO provider networks. HSAG worked with HFS and the MCOs to standardize the format that the MCOs would use to report the providers in their networks.

HSAG created standardized provider categories for the MCOs to use in reporting their providers, instituted an active protocol to detect and minimize duplications of providers, and expanded reporting to include counts of providers by counties within the ICP. As a result, the UIC research team was able to obtain extensive provider network data for both MCOs from HSAG.

Medical Loss Ratio reconciliation dataset provided by HFS to UIC

The contract between the MCOs and the state specifies that each MCO spend at least 88% of the revenues it collects each year on member "benefit expenses." If they fail to do so, they have to refund the difference to the state. The UIC research team requested and obtained the MCO cost dataset from HFS that it had used to calculate the official medical loss ratio (MLR) for calendar years 2011 and 2012.

HEDIS/State outcome measures dataset provided by HSAG to UIC

In 2013, the Health Services Advisory Group (HSAG) evaluated both MCOs for their performance on two sets of the three quality indicators. The two sets of indicators evaluated by HSAG were the P4P measures and the non-P4P HEDIS measures for Service Package 1. HSAG did not evaluate the Service Package 2 quality measures but will do so in 2014. These 2 datasets from HFS detailing the outcomes for these two sets of measures were received and used for analysis by the research team.

4. Propensity Scores and Difference in Differences Design

Some of the fundamental questions underlying the efforts to evaluate the ICP pilot program concern counterfactual quantities. Data on the capitation payments and service utilization levels associated with the ICP members indicates what actually happened in the ICP pilot. Those descriptive patterns are often of considerable interest because they help clarify how the MCOs are operating and whether they seem to be doing the things described in contracts and planning documents. But data on what actually happened does not show what would have happened in the absence of the ICP pilot. These kind of counterfactual "what if" questions are central in most branches of science and they are a major part of any serious attempt to evaluate public policies and social programs such as the ICP pilot.

Research Design

To pursue these questions a quasi-experimental approach is taken to construct a comparison group of ICP eligible disabled Medicaid recipients who were not enrolled in the ICP pilot. In essence, two groups were followed for three years. The ICP group consists of ICP-eligible Medicaid enrollees who lived in the ICP pilot area. The Chicago group is made up of people who would be ICP-eligible except that they lived in Chicago proper, outside of the pilot area. FFS Medicaid covered both groups in 2011. But in 2012 the ICP group switched from the FFS Medicaid program to the ICP pilot, while the Chicago group continued with FFS Medicaid. The Chicago group represents a potential comparison group that can help shed light on what key measures of cost and utilization would have looked like in the ICP group if they had not switched to the managed care program.

Threats to Validity

Although the Chicago Group is a useful starting point for evaluation, it is important to note that simple comparisons between the Suburban and Chicago groups are problematic for several reasons. First, people are not randomly assigned to live in the suburbs or the city. Disabled people in particular might make residential choices that reflect their health care and service needs. These non-random choices could mean that the Chicago and ICP groups had pre-existing differences with respect to racial composition, age structure, future health risks, current health status and clinical morbidities, and past health care expenditure and utilization history. These pre-existing differences between the two groups could mean that simple comparisons between the groups provide a misleading perspective on the effects of the ICP pilot. Put differently: is the difference between the groups due to ICP and not to pre-existing differences?

Second, geography of health care markets may mean that the cost and availability of some health services differs between the city and the suburbs. For some health services, this may be a minor issue because people probably drive between the city and the suburbs to receive care so that there is a

common regional market. But more basic services might be consumed locally or not at all. One concern is that market level differences could generate differences in cost and utilization between Chicago and the ICP pilot areas for reasons that have nothing to do with the ICP pilot.

A third issue is that health care cost and utilization patterns may change over time in ways that are unrelated to the ICP pilot. Rising health care costs, changes in the demand for physician and hospital services, prevailing economic conditions, and changes in the structure of the state Medicaid program can all affect the cost of Medicaid insurance coverage and the level of utilization in the Medicaid population.

A minor issue that also is related to time trends is that the data we from the pre-ICP era covers a period of 9 months, while the post-ICP data analyzed in the report covers a 12 month period. In the absence of adjustment, the difference in the number of months in the two periods of the research design could generate a mechanical trend between the periods in both the ICP and the Chicago group. The analysis is standardized throughout the results to account for this difference between the two periods.

Econometric Methods

To mitigate or avoid the threats to validity described above, a careful quasi-experimental research design was employed which revolved around two important stages of analysis. In the first stage, a concern was that the raw Chicago group was simply too different from the ICP group to allow for a meaningful comparison of post-ICP outcomes. A statistical technique called inverse propensity score weighting was implemented to construct an analytic Chicago comparison group that closely resembled the ICP group at baseline. The goal was to ensure that later analysis of post-ICP outcomes were based on "apples to apples" comparisons and not "apples to oranges" comparisons. The procedure used to construct the analytic comparison group was designed to match the two groups with respect to:

1) Age Structure; Gender; Race and Ethnicity (Asian, Black, White, Other, Hispanic)
2) FY11 Utilization (Any Physician Utilization, Any Dental Utilization, Any Pharmacy Utilization)
3) Medicaid Waiver Categories (Physical Disability, Community Resident, Nursing Home, Developmental Disability, Aging, Brain Injury, ICFMR, HIV/AIDS, Technology Dependent, Supported Living)
4) FY11 Expenditures (16 Discrete Expenditure Categories, and Linear Total Expenditures)
5) Health Status (The team used HCUP's Clinical Classification Software (CCS) to convert ICD9 codes from FY11 Medicaid claims to construct a set of variables indicating whether a person suffered from a particular health condition. The matching procedure adjusted for a set of 260 different CCS categories.)

In the second stage of our analysis, treatment effects in the matched analytic sample were estimated using a technique called "difference-in-differences" analysis. This second stage estimation procedure was designed to adjust for secular time trends, and for any remaining compositional or market differences between the ICP and Chicago groups that may have escaped the first step matching procedure. The easiest way to understand this approach is with a simple before and after table presented in Table 2. In practice, the outcomes are measures of average costs or average utilization levels, but the table simply considers a generic outcome of interest and refers to group and period

average outcomes using capital letters. The first row in the table refers to outcomes in the ICP group. In the Pre-ICP column, the average outcome consists of simply the average baseline outcome in the ICP group. In the Post-ICP column, the average outcome in the ICP group is comprised of the original baseline, plus a secular trend, plus the effect of the ICP intervention. The Change column shows that the before after difference in the ICP group consists of a Trend factor and an ICP Effect factor. Disentangling these two factors to isolate the effect of the ICP pilot is the goal of the analysis. The second row shows the results from the (matched) Chicago group. In the Pre-ICP column the average outcome is referred to as the Chicago Baseline, which might differ from the ICP Baseline due to market differences in prices and access to services and any remaining differences between the two groups. In the Post-ICP column, the average outcome consists of the Chicago Baseline plus the secular trend factor. There is no ICP effect because ICP was not available in Chicago during the study. The change column shows that the before after difference in Chicago reveals the secular trend. The final row in the table shows the "difference-in-differences" effect, which is simply the difference in the two change scores. The key idea is that the Trend factor cancels in the difference-in-difference calculation so that all that remains is the ICP effect. This is the sense in which the DID analysis reveals the treatment effect of the ICP pilot.

Table 2: Example Table Showing Matched Sample Pre and Post Difference in Differences

Group	Pre-ICP	Post-ICP	Change
ICP group	A = ICP Baseline	B = ICP Baseline + Trend + ICP Effect	B – A = Trend + ICP Effect
Chicago Group	C = Chicago Baseline	D = Chicago Baseline + Trend	D – C = Trend
Difference in Differences			(B – A) – (D – C) = ICP Effect

Tables using the format of Table 2 can be found throughout the report to show the impact of ICP on service utilization for the matched groups.

Strengths and Weaknesses of Methodology

Although it falls short of the gold standard set by a randomized experimental design, the quasi-experimental research design used here meets a very high methodological standard. It depends on clear assumptions that are plausible in the specific context of the study. The design strategy aligns well with a growing consensus from the statistical and econometric literatures concerned with the performance of non-experimental methods in terms of reproducing the estimates from a benchmark set by a randomized experiment. Covariate matching strategies such as the one pursued in the first stage of analysis are most successful at reproducing experimental benchmarks when they are able to (i) adjust for a rich set of theoretically relevant covariates along with pretreatment measures of the outcome variables of interest, (ii) form matches from treatment and control units drawn from common geographical areas, (iii) apply longitudinal and difference-in-difference methods to adjust for trends and between group differences that survive the matching procedure, and (iv) use common measurement schemes for the treatment and comparison units.

This study does well along most of these dimensions. This design is able to adjust for a large set of characteristics that should well capture the expected health care cost and utilization risks of the

individuals in the sample. The Suburban and Chicago samples are drawn from a common "Chicagoland" regional market and this should minimize gross differences in the availability of health services across geographical areas. The matched sample is combined with subsequent longitudinal "difference-in-difference" analysis that accounts for time trends and market differences that are not captured by the covariate adjustment procedure. At the study baseline, data from Medicaid administrative records are utilized for the entirety of the analysis. After the introduction of the ICP in the suburbs, Medicaid administrative records are also used for the analysis of the Chicago Group. However, data from Medicaid records and records from the MCOs that operate the ICP pilot for the ICP group are combined. This could create a small but unavoidable change in the measurement schemes used for the treatment and comparison groups in the analysis. The research team will continue to study and rectify any measurement differences between the two samples over the course of our evaluation and it is not believed to create systematic bias in the analysis.

5. SMART Act

The evaluation faced a unique challenge in that the FFS Medicaid program (and the comparison group) was drastically altered during FY13 by the SMART Act.

Background

In the spring of 2012, the Governor's Office stated that "the Medicaid system is on the brink of collapse...we must save our Medicaid program in order to continue providing services that millions of Illinois residents depend upon. The status quo is not an option. Every day without action to stabilize Medicaid only makes the problem worse and will lead to additional service reductions."

The Governor's Office and HFS stated 4 primary reasons for the crisis:

1) Deferral of Medicaid bills to future years for payment. This budgeting practice had dated at least 20 years. Often the Illinois budget has been chronically underfunded and bills pushed off to next year, resulting in the state ending each fiscal year with billions in dollars of unpaid bills to providers. At end of FY12, the estimate was $1.7 billion in unpaid bills; in FY13, it was predicted by the Governor's Office this amount could rise to $4.7 billion.
2) The one time Federal stimulus that created about $1.2 billion in Federal funds for the state for the period of 10/2008 through 6/2012 disappeared all at once at end of FY12.
3) Continued reliance of the state on an "inefficient and wasteful" FFS system.
4) Significant enrollment growth in Medicaid during the national recession.

Options considered

To assist the General Assembly in developing a budget and legislation to deal with the crisis, HFS in February of 2012 published a "menu of possible options" for program eliminations and spending reductions. These possible changes included:

1) Changes in Medicaid eligibility, where not otherwise prohibited by federal law.
2) Elimination of optional services or imposition of utilization controls to better manage use of services.
3) Cost sharing by members.

4) Rate reductions for providers.
5) Redesign of service delivery (from FFS to coordinated care).

During the spring of 2012, the political process worked through the problem and on May 24, 2012, the SMART Act passed the General Assembly, to be effective on July 1, 2012. At the time of passage of the law, HFS published a document listing 62 possible changes authorized by the SMART Act and a listing of possible savings for each proposed change. The total "gross savings" amounted to $1.6 billion. These changes were grouped into seven (7) major categories:

1) Tighten and verify client eligibility;
2) Reducing and/or eliminating optional Medicaid services;
3) Increasing utilization controls on other mandatory Medicaid services;
4) Imposing increased cost sharing on members and third parties;
5) Adjusting provider rates;
6) Expansion of "care coordination" practices to reduce inefficiencies in the FFS system; and
7) Other changes not elsewhere listed.

For a complete listing of proposed changes, a description of each, the original cost savings for each proposed change, and the current estimate of the cost savings for the change, see http://www2.illinois.gov/hfs/SiteCollectionDocuments/SMARTActReport.pdf.

Since the initial passage of the SMART Act, HFS has revised some of the original cost savings projections associated with the legislation. In February of 2014, in a report to the General Assembly, HFS stated that it was revising the estimated total savings downward from $1.6 billion downward to $1.1 billion. Some of this reduction was based on difficulty in achieving some previous goals to tighten eligibility standards to ensure only properly qualified persons received Medicaid services and due to the federal government disallowing or slowing some of the proposed service changes.

In a presentation to the Illinois House Human Services Appropriations Committee in April of 2014, HFS presented data that indicated that "Illinois base Medicaid costs" grew at an annual rate of 6.3% per year from FY2007 to FY2011, stayed "relatively flat" in FY12, and declined approximately 6% in FY13, primarily due to the SMART Act.

Tables 70 and 71 in Appendix A describe changes under the SMART Act and detail which parts of the SMART Act the MCOs implemented; each MCO made its own decision on most parts of the SMART Act, and each often chose not to reduce services. Notably, each MCO maintained dental services, while the SMART Act eliminated most dental services from FFS Medicaid.

Section 1: How well has the Integrated Care Program been implemented?

A. Enrollment

This section discusses the enrollment for each of the MCOs involved in ICP during FY13. Based on capitation payments from the state, Table 3 shows an enrollment summary for each MCO. The enrollment is similar per month for Aetna and IlliniCare, and the average numbers of members who added and dropped each plan each month are fairly even. Data on the reasons for departure from an MCO or ICP were not available, but it is likely that a large proportion of those who left did so because they gained Medicare-eligibility, therefore losing eligibility for ICP. The UIC team found that 47% of people who disenrolled from waiver services did so because they became Medicare-eligible.

Table 3: ICP Enrollment Summary (FY13)

Measure	Aetna	IlliniCare	ICP – Total
Total Members (Average per Month)	17,737.23	17,632.8	35,370.0
New Members			
New Members (Average per Month)	312.8	374.5	687.3
% New Members (of Total Members)	1.8%	2.1%	1.9%
% Auto-Enrolled (of New Members)	36.8%	47.7%	43.0
Departing Members			
Departing Members (Average per Month)	373.4	380.6	754.0
% Departing Members (of Total Members)	2.1%	2.2%	2.1%
% Switched Plans (of Departing Members)	11.0%	11.8%	11.4%
Tenure			
Average Tenure (Months)	**10.0**	**9.8**	**10.1**

Based on FY13 Capitation Payments

New Members

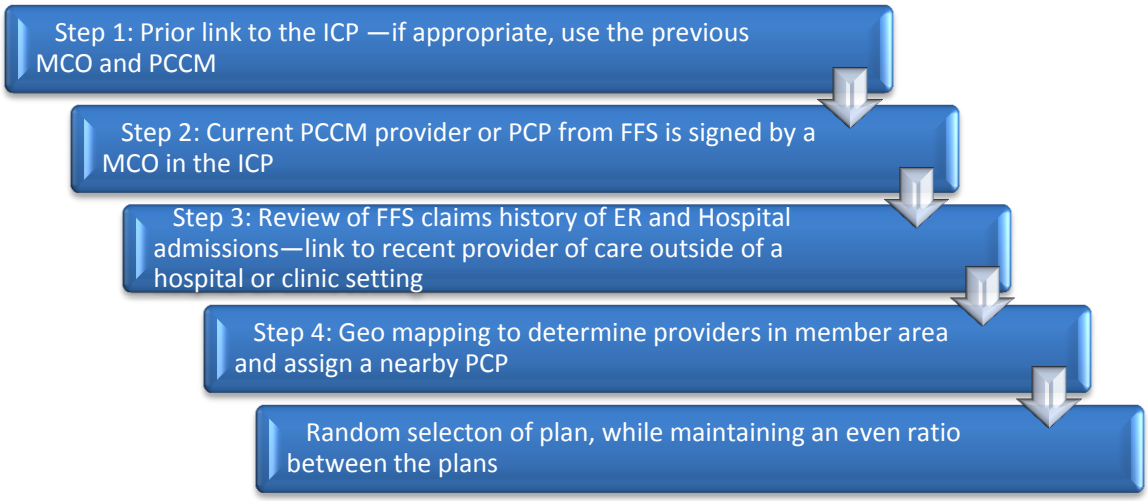
New members must choose between two MCOs for the ICP: IlliniCare and Aetna. When a member becomes eligible for ICP, they are sent information in the mail, followed by two rounds of reminder letters before HFS automatically enrolls them with one of the plans. The enrollment process is summarized in Table 4 (see Table 74 in Appendix A for more detail). During the initial enrollment process, members are encouraged to compare the plans and make an active choice (in Appendix A, Figure 11 shows some of the questions that HFS recommends that members attempt to answer during enrollment, and Figure 12 details the help and information available to members).

For members who do not actively choose which MCO to enroll with after determination of ICP-eligibility, HFS uses a smart enrollment process to assign members to one of the MCOs. In order of importance, the factors that smart enrollment process considers are shown in Figure 1. Prior to randomly assigning a member to a plan, HFS uses a 4 step “smart” process to determine the member’s “best fit” plan. Only after those steps are exhausted, would a random assignment occur.

Table 4: Enrollment Process (Summary)

Item	Description
How can a member enroll in the ICP (mail, online)?	A member may enroll in ICP by contacting the Illinois Client Enrollment Broker (ICEB) call center or by going online to enroll via the ICEB Program Web site.
What type of assistance is the member given regarding the various plans?	Members can: (1) read information about their Plan choices in the enrollment packet they receive in the mail, which includes a comparison chart, (2) received unbiased education from ICEB Customer Service Reps, (3) check the ICEB Program Website for information about each Plan, and (4) contact Aetna or IlliniCare directly to learn more about their plan.
How long does the member have to make a decision of which plan they will choose?	A member has 60 days to select a Plan and PCP. If a member does not make a voluntary choice, the ICEB will auto-assign the member to a Plan and PCP based on an auto-assignment algorithm that takes into consideration a members current PCP, claims data and location.
Is the member given information regarding providers in the area?	Members can: (1) use the ICEB Program Website to search for providers on their plan and in their area, (2) contact the ICEB call center for assistance, and (3) contact their Plan's service call center for assistance.
Can others (family, friends, advocates) help the member during the enrollment process?	Yes, if a member has provided the necessary authorizations, a family member, friend, or other representative may assist the member with the enrollment process via the ICEB Call Center or ICEB Program Web Site.
When can a member switch plans under normal circumstances?	During the first 90 days of enrollment and during the members Open Enrollment Period.
Are there any other circumstances, other than the open enrollment period, under which a member can switch plans?	Yes, during the first 90 days of enrollment and during their lock-in period for cause.
How is the member aware of the open enrollment period and the choice he/she has?	The ICEB will mail the member an Open Enrollment Packet notifying them that they are in their Open Enrollment Period and may switch Plans. If the member does not switch, they will stay enrolled with their current Plan for another 12 month period.

Figure 1: Smart Enrollment Process



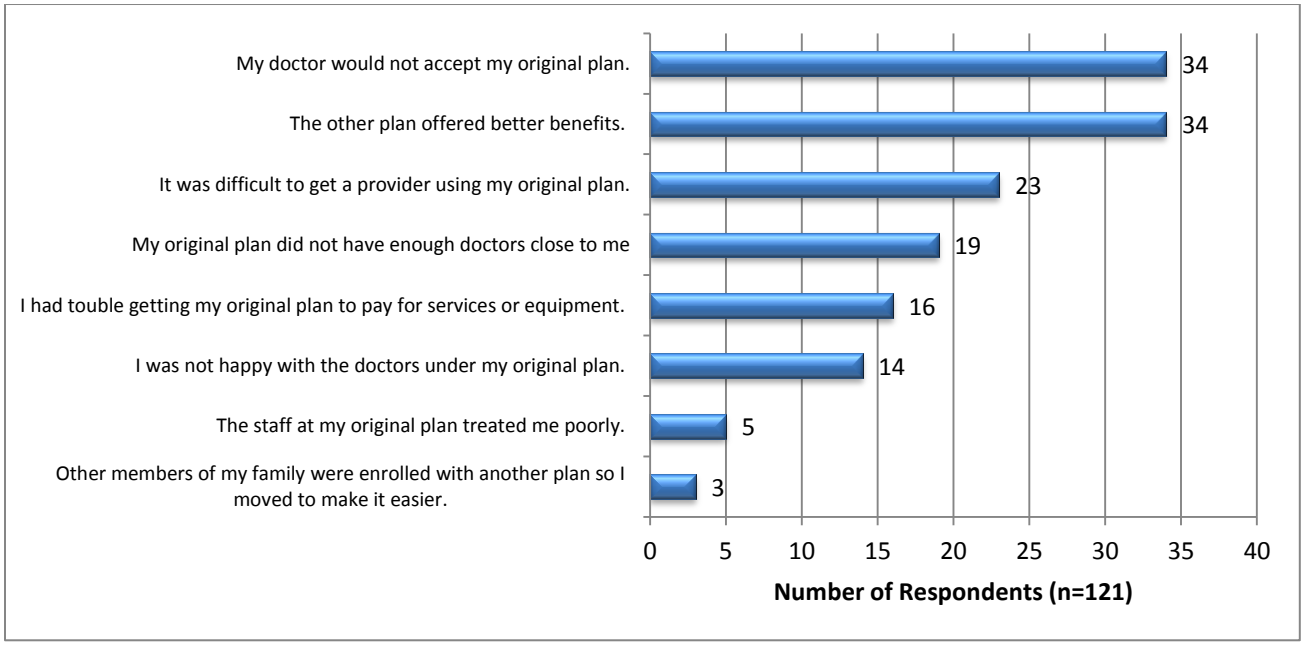
If a member regains eligibility within 60 days, the ICEB will assign that member back with their original plan as long as the member's eligibility status and geographic residence remains valid for participation in the previous program. If the member regains eligibility after 60 days, the ICEB (Illinois Client Enrollment Broker) will mail an enrollment packet letting the member know they have 60 days to select a plan and PCP. If no choice is made during their 60-day choice period, the ICEB will auto-assign the member to a plan and PCP.

In the first year of ICP, auto enrollment decreased slowly but steadily from 70.6% in August 2011 to 62.4% in April 2012. During FY13, the rate of auto enrollment was closer to 40% for each MCO. In February 2013 the state hired a new enrollment broker and the enrollment process restarted for people waiting to be enrolled, thus, there was no auto enrollment between February and April 2013. People who were in the initial enrollment process had their "clocks" reset to 0 and given 60 days to make an active choice from the start of the new enrollment broker. When the auto enrollment process restarted, 1,306 people were auto enrolled with IlliniCare. These trends are shown in the Table 75 in Appendix A.

Departing Members

People who enroll with one of the MCOs can switch plans at any point within the first 90 days, and then have an open enrollment period after a year of being in ICP. According to the consumer survey results that were received following the second year of the ICP, of the 790 people who responded, 121 (15.3%) reported switching plans, 2 of them multiple times (note: this percentage is slightly higher than 11.4% switching per the capitation data, although this is not a significant difference). Figure 2 displays the reasons that survey respondents reported switching plans. Of the 121 who switched, the most frequent reasons for switching was that the other plan had better benefits or that their doctor would not accept the plan they were originally enrolled with; 34 people (28.1%) gave each of these as a reason for switching plans.

Figure 2: Reasons Members Switched Plans (FY13)



In summary, this section discussed enrollment of members into ICP, steps in the enrollment process, and details surrounding the movement of individuals within or leaving ICP. Each MCO had about the same average numbers of members enrolled per month, about 18,000. The number of members departing ICP was also similar for both MCOs. Auto-enrollment decreased from over 70% in August 2011 to nearly 40% in FY13. According to the survey, 15% of enrollees reported switching plans during the year, with doctors not accepting an enrollee's original plan and that the other plan offered better benefits as the most cited reasons for departure. Others likely left after gaining Medicare eligibility (thus losing eligibility for ICP), although this data was not available.

B. Adequacy of Provider Networks

Measuring and reporting on the adequacy of the provider networks that the two plans have developed has been an important priority for this evaluation. During the first round of formal focus groups that the UIC team conducted, the issue of the adequacy of the new provider networks was raised by virtually all stakeholders who reported problems related to the provider network. These problems included consumers needing to switch primary and specialty providers, long wait times to see providers, extensive travel time, and inaccessibility of specialty services for consumers. The second round of focus groups shows that most stakeholders feel that the situation has improved from the first year, although there are still some areas that lack enough specialists.

Federal Medicaid regulations (CFR 438.207) do not articulate minimum criteria for provider networks of Medicaid managed care programs. The federal regulations require states to ensure that networks are "sufficient to provide adequate access to all covered services" and require the state to monitor the network and take into account the "expected utilization" of services based on "the characteristics and health care needs of specific Medicaid populations represented in the particular MCO."

This section summarizes findings of the first year of our evaluation, discusses the changes that the state has made in monitoring the provider networks in the second and third years of ICP, and summarizes the available and active providers found in ICP in FY13.

1. Review of FY12 Findings

This section briefly summarizes the process the UIC team used in FY12 to evaluate the adequacy of the provider networks and the recommendations that were made in the first report. These findings will then be compared to what the team found for FY13.

Description of Process

During Year 1, the UIC team worked with the MCOs and HFS to calculate a count of the number of providers in each of the two networks. The calculations started with the official monthly files of signed providers by the plans to HFS and were supplemented with data from both of the MCOs and HFS as needed.

The HFS Medicaid claims database tracks 77 different provider types. The Year 1 report focused on 28 provider types to track and report on. At the end of Year 1, the two plans reported a total of 28,373 individual practitioners and 1,975 group providers between them. Despite efforts to minimize

duplications for each plan, the overall count of providers was duplicated because some providers were enrolled in both networks.

Lessons learned

The research team's work on the Year 1 report provided several lessons regarding data challenges in determining provider adequacy

1) Obtaining a count of providers that can be used for reliable comparisons among the MCOs is a challenging and complex task;
2) MCOs typically use different categories to classify and report their providers making it difficult to compare different provider types among the MCOs;
3) Even in the event that a reliable and comparable count of providers can be obtained, it serves as an inadequate proxy for the "capacity" of a provider network (e.g. not all "available" providers can or will equally serve Medicaid members);
4) The MCOs differed considerably in the geo-mapping process they used to evaluate the adequacy of their provider networks in terms of proximity of their providers to members;
5) Maintaining an accurate, complete, and up-to-date provider directory for use by the members is a complex and challenging task for the MCOs;
6) It is difficult to evaluate the accessibility of the network in terms of the physical accessibility of provider sites.

Recommendations made by UIC

Because of these lessons, the final report for Year 1 included several specific recommendations related to provider networks and suggested steps that HFS could take:

1) Clarify what specific responsibilities each plan should have in terms of signing local providers that have existing relationships with members.
2) Clarify and have consistency in what provider types and specialties will be included in the Geo-mapping process conducted by the MCOs.
3) Consider specifying minimum provider ratios for some categories of providers in addition to geographic access standards.
4) Consider better defining the information that it requires the plans to report in their affiliated provider reports.
5) Consider instituting regular reviews of the provider files to ensure accuracy of the network listings.
6) Establish a regular process to publicly update stakeholder groups on the progress of provider network development.

Changes made by HFS

During Year 1 of ICP (FY12), HFS staff carried out most of the activities associated with monitoring the adequacy of the provider networks. During Year 2 (FY13), ICP expanded beyond the original 6 county area and more MCOs entered the program. As a result, HFS expanded the responsibilities of the

external reviewer, Health Services Advisory Group (HSAG), to include the ongoing monitoring of the development and maintenance of the provider networks.

HSAG worked with HFS and the MCOs to standardize the format that the MCOs would use to report the providers in their networks. HSAG created standardized provider categories to use, instituted an active protocol to detect and minimize duplications of providers, and expanded reporting to include counts of providers by counties within ICP. As a result, HSAG developed standard templates that they required the MCOs to begin using to report the providers in their networks.

2. Results for FY13

This subsection summarizes the number and type of providers reported for ICP FY13, and, where appropriate, compares these numbers to previous years. The section highlights the difference between "available" and "active" providers. The data presented here is a combination of data collected by UIC and data collected by HSAG and summarized by UIC.

Available Providers

UIC has tracked the number of available providers for ICP for three years, from FY11 (the year before the implementation of ICP) through the first two years of ICP. "Available" providers are defined as:

1) Available providers in the FFS system – any provider that was registered with Medicaid and listed in the official state-wide Medicaid provider table with an address located within either the 6 county ICP area or within the city of Chicago.
2) Available providers in ICP – any provider signed to a contract by at least one of the MCOs and included in either the monthly "provider affiliation" file each MCO submitted to HFS or the regular provider updates provided to HSAG.

Table 5 lists the number of available providers in FY11 (before the roll-out of ICP) for 7 specific provider types and tracks this number for the first 2 years of ICP. For example, prior to the start of ICP, there were more than 22,000 physicians registered as Medicaid providers within the ICP area. By the end of Year 1, Aetna had signed 4,500 physicians to their network while IlliniCare had signed over 3,800. By the end of Year 2, these numbers had increased to about 10,000 physicians for each MCO.

Table 5: Count of "Available" Providers by Year

Provider Type	FY11 (FFS)[1]	FY12 (ICP)[2]		FY13 (ICP)[3]	
		Aetna	IlliniCare	Aetna	IlliniCare
Community Mental Health Centers	132	16	29	47	54
Dentists	2,087	398	131	550	387
General Hospitals	122	68	66	71	79
Home Health Agencies	335	33	28	89	123
Nurse Practitioners	2,550	220	131	664	642
Pharmacies	1,408	1,813	22	1,482	1,103
Physicians	22,258	4,503	3,827	9,806	10,137

[1]Providers on the state-wide list of Medicaid providers that had billing addresses within the six county ICP area, including Chicago
[2]Signed providers listed in MCO 7/2012 monthly Provider Affiliation file submitted to HFS
[3]Signed providers listed in provider summary by HSAG for January 2014

Density of Available Providers by County for FY14

During the first two years of ICP, staff from HFS carried out most of the activities of tracking the development of provider networks within ICP. In the fall of 2013, HSAG took over the task of tracking the provider networks and made three key changes:

1) Tracked and counted providers by counties;
2) Standardized the provider categories the MCOs reported for their network; and
3) Included Waiver providers in the count.

HSAG reported provider counts for individual counties for January 2014 and, using HFS enrollment data as of the same date, UIC was able to calculate provider ratios for certain provider types by county. Table 6 lists data for physicians who were serving as PCPs as of January 2014. For more information about other provider types by county, see Tables 84-95 in Appendix A.

Table 6: Physician PCPs per 1,000 members in January 2014

County	Aetna	IlliniCare	FFS (FY11)
Cook	252.1	221.0	165.7
DuPage	177.8	160.7	231.0
Kane	97.0	97.8	83.7
Kankakee	77.3	20.9	59.2
Lake	127.6	189.9	108.7
Will	50.3	54.7	81.1
Total	**190.4**	**174.7**	**150.0**

Data Source: HSAG provider data and HFS enrollment data for January 2014

Prior to the start of ICP, in the FFS system, there was an overall ratio of 150 PCPs per 1,000 members, with the ratio ranging from 59.2 in Kankakee to 231 in DuPage. By January 2014, the MCO networks had an overall ratio that exceeded the pre-ICP ratio. It must be noted that Table 6 does not reflect all physicians but only those physicians who are primary care physicians (i.e. family practice, general practice, geriatrics, internal medicine, and obstetrics and gynecology). In addition, since providers can be "available" in multiple counties, the UIC team calculated the Total average listed in Table 6 by eliminating duplicates across counties and it is a ratio of the unduplicated number of providers for the entire ICP area to the entire membership of the area.

MCO leaders felt that there were major improvements in expanding the network of primary care providers. One said, *"Well from the perspective of members, clearly we have been able to meet longstanding requests to have new providers come in, providers that they had relationships with"* (Aetna Leadership). Additionally, they spoke of efforts to reconnect members with former PCPs once those PCPs came into the network:

> *"There was a little bit of disruption initially and this pre-dates I think most of us in the room where some of these centers were not [in network], with [university] being a big example. So we had to […] reassign those members to other PCPs. Now that they are in the network, if they have a history of having seen [members] in the past two years, members [will] be able to see their previous providers." (Aetna Leadership)*

Table 7 lists the results for dentists. Prior to the start of ICP, in the FFS system, there was an overall ratio of almost 50 dentists per 1,000 members, with the ratio ranging from 14.4 dentists per 1,000 members in Kankakee to 61.0 in Cook. By 2014, Aetna reported almost 28 dentists per 1,000 members

for their network and IlliniCare was reporting 8.2 dentists per 1,000 members. Similar tables for pharmacies, CMHCs and Home Health Agencies are included in Appendix A (Tables 77-79).

Table 7: Dentists per 1,000 members as of January 2014

County	Aetna	IlliniCare	FFS (FY11)
Cook	33.7	9.7	61.0
DuPage	20.8	12.3	33.4
Kane	22.0	7.3	33.8
Kankakee	9.4	4.2	14.4
Lake	28.6	3.4	36.9
Will	16.6	2.8	33.0
Total	**27.9**	**8.2**	**49.5**

Data Source: HSAG provider data and HFS enrollment data for January 2014

Available Waiver Providers for FY14

Approximately halfway through FY13, on February 1, 2013, the MCOs became responsible for Service Package 2 services, which include all waiver services except for the DD waiver members. Table 8 lists the number of unduplicated Waiver providers for each MCO (providers are unique for each MCO but may be duplicated across MCOs). Aetna reported 533 Waiver providers, of which approximately two-thirds are individual practitioners. IlliniCare reported 482 Waiver providers, all of which are group providers. IlliniCare explained the fact that they did not report any "individual" waiver providers to HSAG:

> *"IlliniCare contracts and managed provider relationships for waiver providers at the group level based on their unique services. i.e.contract at a group level with environmental home modification service providers, but they employ downstream multiple individual providers. We feel this is the best way for us to be able to work through these waiver entities to coordinate care for our members with our ICT team. Same logic applies to Home Health. It would be challenging to maintain a provider database of individual practitioners that each perform home health under their parent entity/group."*

Table 8: Waiver Providers as of January 2014

Provider Type	Aetna	IlliniCare
Group Provider	172	482
Individual Practitioners	361	0
Total	**533**	**482**

Data Source: HSAG (January 2014)

Appendix A provides more detail and summarizes data provided by the MCOs to HSAG regarding coverage of waiver providers by county. Since Service Package 2 will be fully implemented in another year, UIC's next report will be able to focus more on the network of waiver providers.

Active Providers

Just because a provider is signed with a network does not necessarily mean that members will have ready access to that provider. A more accurate picture of how many providers actually were actively participating in the network can be obtained by analyzing claims data for FY11 and FY13 for ICP members. The FY11 claims data was FFS claims for the 9-month period immediately prior to the start of ICP and the FY13 data was the claims that the MCOs paid their providers in FY13.

Table 9 lists 7 types of providers and the number who submitted 1 or more claims for ICP members. For example, in FY11, before ICP began, 12,656 physicians submitted at least 1 claim. In FY13, 5,241 physicians in Aetna's network had submitted at least 1 claim, while IlliniCare reported 9,670 physicians

who had submitted a claim. It should be noted that the number of providers in Table 9 (active providers) may exceed the number of providers in Table 5 (available providers) since the providers in Table 5 include only those signed to the network while Table 9 includes providers both in and out of network that submitted claims.

Table 9: Count of Active Providers

Type of Provider	Aetna (FY13)	IlliniCare (FY13)	FFS (FY11)
Community Mental Health Centers	45	51	59
Dentists	296	290	855
General Hospitals	69	96	88
Home Health Agencies	46	73	83
Nurse Practitioners	140	306	428
Pharmacies	2,842	1,976	1,231
Physicians	5,241	9,670	12,656

[1] # of providers who submitted claim in FY11 under FFS program
[2] # of providers who submitted claim in FY13 under ICP

In summary, this section has detailed the development of the MCO provider networks over time within the ICP. Both MCOs have increased the number of available providers from FY12 to FY13. The ratio of PCP providers per 1,000 members for key provider types have also increased during the FY13 year to reach pre-ICP levels for most provider types for both MCOs, and this increase was echoed in focus group feedback.

C. MCO websites

Access to information and educational resources regarding the provider network is essential for Medicaid enrollees to obtain appropriate health care services in their area. The websites of the MCOs are a critical tool utilized by both enrollees and network providers to find information and resources to navigate the health care plan, including selecting and comparing physicians and specialists in the network. For this reason, it is important for MCOs to design sites that all users can navigate and access resources with ease. This section presents analysis of each website based on content; navigation ease; accessibility; and other pertinent factors for members, providers and potential members or providers. Each MCO website has been reviewed and approved by HFS as meeting contract standards, and this section does not suggest that one, or both, of the websites is not up to contract standards.

Members and Potential Members

Tables 96 through 100 in Appendix A display the findings for analyses in several content areas of the websites from the perspective of a Medicaid managed care enrollee in each of the organizations, including using the provider search engines, finding information on how to file a grievance, obtaining a summary of plan benefits, and accessing frequently asked questions. These tables include only content areas which do not require web portal registration to access. It is important for member content areas to maintain an appropriate reading level and ease score, as well as be fully functionally accessible for members with disabilities navigating the website. The strengths and weaknesses of both MCOs are illustrated in the tables in terms of appropriate reading level, reading ease scores, accessibility, and content area features.

For the most part, the websites are very comparable. Notable differences include that it only takes one click from the home page to get to Aetna's provider search engine, while it take three clicks from

IlliniCare's. Aetna's website content is written at a higher reading level (more complex to understand) than IlliniCare's content for each of the four sections analyzed.

The provider search engine is the online tool that members use to search and compare physicians, specialists, dentists, eye care services, pharmacies, DME suppliers, and other health care entities in each MCO network. Fully developed search and filter features of a search engine help to facilitate member choice when selecting providers or health care services. Table 10 details the provider search engine feature on both of the MCO websites. While IlliniCare's search filters were limited compared to those offered by Aetna, evaluation of the websites demonstrated IlliniCare's superior navigation accessibility for visitors with disabilities in terms of text equivalents and styling for this part of the website. Aetna includes a filter to search for accessible office locations, while IlliniCare requires a separate PDF list. Table 96 detailing all differences between MCO provider search engines can be found in Appendix A.

Table 10: Provider Search Engine (FY13)

Measure	Aetna[1]	IlliniCare[2]
Search		
Search by location?	Yes	Yes (MUST use Zip or County)
Search with # of miles of location?	Yes	No
Map feature?	No	Yes
Filter		
Can filter by: Physician Type?	Yes - 170 options	Yes - 4 options
Can filter by: Specialty type?	Yes	Yes
Can filter by: Gender?	Yes	Yes
Can filter by: Accepting New Patients?	Yes	Yes
Can filter by: Ages Served?	Yes	No
Can filter by: Language?	Yes	Yes
Can filter by: Board Certification?	Yes	No
Can filter by: Accessible offices?	Yes	No – need a separate list PDF
Ease of Use		
Flesch-Kincaid (English) Reading Level	12.5	4.4
Flesch-Kincaid (English) Reading Ease Score	39.6	77.1
Accessibility: Navigation and Orientation	77% Pass	74% Pass

[1] http://www.aetnabetterhealth.com/illinois/find-provider
[2] http://apps.illinicare.com/findadoc/changeNetwork?prodId=324

Providers and Potential Providers

Tables 101 through 103 in Appendix A display the findings for the website analysis from the perspective of a Medicaid managed care provider in each of the organizations. These tables include only content areas that do not require web portal registration to access. Limitations in available content, resources, and website accessibility may shape or affect a provider's ability to compare MCO features when determining whether to join a network to serve Medicaid enrollees. This, in turn, may affect the growth of a MCO's network and ability to attract new providers.

Some MCO website features are restricted and made available only to registered providers with the MCO. Table 97 (in Appendix A) outlines the web portal features for registered users as described by

each MCO's provider handbook. Based on the handbook information, the web portals appear to offer different features for each MCO and may affect the capability of potential providers to navigate select content areas and compare MCO features when determining whether to join a network.

In summary, this section outlined the MCO websites in terms of content, access, readability, and navigation ease for members and providers. Overall the websites of the two MCOs are fairly comparable though one is easier to navigate and the other has a more friendly readability level. Website development is important to educate current members and providers about the health care plan and attract potential new members and providers to the MCO network.

D. Accessibility of Provider Offices

Accessible provider offices are essential to meeting the needs of members with disabilities. According to the MCO's final contract, "All Provider locations where Enrollees receive services shall comply with the requirements of the Americans with Disabilities Act (ADA). Contractor's network shall have Provider locations that are able to accommodate the unique needs of Enrollees" (section 2.8, p. 25).

The MCOs track whether provider offices are accessible for their members; however this is done through a provider self-assessment. Specifically, when contracting with providers, each MCO asks the applicant to complete a self-assessment form, and one of the questions (or a short series of questions) inquires whether the office is accessible. MCO Care Coordinators may inquire about the accessibility of an office when scheduling appointments for members, or the MCO may respond to member complaints about inaccessibility, but there are no current formal processes for evaluating and confirming accessibility. Both Aetna and IlliniCare have long term plans to conduct on-site assessments involving site visits and questionnaires.

Table 11, below, describes the number of offices meeting accessibility requirements and compares Aetna and IlliniCare. Nearly 80% of each MCO's provider offices are reported as accessible. The FFS Medicaid program does not track or monitor accessibility of provider offices. Monitoring of provider office accessibility is a "value added" area of ICP.

Table 11: Number of Offices Meeting Accessibility Requirements (FY13)

Measure	Aetna	IlliniCare	FFS Medicaid[1]
Total Unique Providers	9,870	4,151	N/A
Total Unique Office Locations	3,251	1,683	N/A
Self-Assessment by Providers			
Accessible (self-assessment) Office Locations	2,574	1,322	N/A
Percentage of Office Locations that are Accessible (self-assessment)	79.2%	78.6%	N/A
On-site Assessment by MCOs			
# and % of offices that meet accessibility requirements as measured by On-site Assessment	No On-site Assessment	No On-site Assessment	No On-site Assessment

[1] HFS reported that they do not have a process to evaluate the accessibility of providers.
Data Sources: Special Datasets from MCOs – MCO Data is based on Self-Assessment

Table 12, below, describes the number of Primary Care Provider (PCP) office locations that self-identify as accessible within the MCO's provider network. PCPs include Family Practice, General Practice, Internal Medicine, Obstetrics/Gynecology, and Geriatrics, as defined by HSAG. More of IlliniCare's PCPs (94.8% to 73.4%) and Board Certified PCPs (98% to 85%) self-reported being accessible compared to Aetna's. The MCOs plan to begin on-site assessments in the near future. IlliniCare explained that they plan to do onsite assessments every year using a random sample of providers or as needed based on any member complaints regarding Physical Accessibility. IlliniCare's survey covers, parking, routes, entry, restrooms, exam rooms, equipment and accommodations. The survey has measurements that would allow for reliable and detailed evaluation of ADA accessibility. Aetna's provider site-visit form has 3 questions on accessibility that simply ask if the (1) building, (2) parking and (3) restrooms are accessible. In future years, the research team will report on the data collected by MCO on-site assessments.

Table 12: Number of PCPs[1] Self-Reporting as Accessible (FY13)

Measure	Aetna	IlliniCare	FFS Medicaid[2]
Total PCP Office Locations	1,159	692	N/A
Accessible (self-assessment) PCP Office Locations	851	656	N/A
Percentage of PCPs Office Locations that Self-Reported as Accessible	73.4%	94.8%	N/A
Total Board Certified PCP Office Locations	585	445	N/A
Board Certified PCP Office Locations that Self-Reported as Accessible	497	436	N/A
Percentage of Board Certified PCP Office Locations that Self-Reported as Accessible	85.0%	98.0%	N/A

[1]PCPs include family practice, general medicine, internal medicine, obstetrics/gynecology, and geriatrics.
[2]HFS reported that they do not have a process to evaluate the accessibility of providers.
Data Sources: Special Datasets from MCOs – MCO Data is based on Self-Assessment

Stakeholders did not mention accessibility issues in the second round of focus groups. Only a small percent of survey respondents following the second year of ICP reported encountering barriers at their PCP office: 6.5% in ICP and 5.6% in FFS. However, other questions asked about specific barriers, including how often a person was able to use the restroom or get on the examination table at the PCP office show that respondents did encounter barriers.

Only about half of members in both ICP and FFS were able to always get on the examination table at their provider's office, and only about three-quarters of members were always able to use and move

Table 13: Responses to Survey Questions on PCP Office Accessibility (FY13)

	How often were you able to use and move around the restroom?		How often were you able to get on the examination table?	
Responses	ICP (n=630)	FFS (n=585)	ICP (n=630)	FFS (n=585)
Never	6.8%	10.3%	12.1%	13.7%
Sometimes	6.1%	6.5%	19.1%	14.3%
Usually	12.0%	13.3%	19.5%	15.4%
Always	75.2%	69.9%	54.1%	51.8%

around the restroom (see Table 13). There were no significant differences between the ICP and FFS groups. Therefore, accessibility continues to be a challenge for some members. This also highlights the limitations of the self-assessments of accessibility. Future work by the MCOs to conduct on-site assessments will aid in identifying barriers and provide a more accurate account of accessibility.

In summary, approximately 80% of each MCO's provider offices were reported as accessible. However, about only about half of survey respondents reported being able to always get on the examination table and only about three-quarters of respondents reported always being able to use the restroom, indicating that accessibility remains a challenge for some members. FFS Medicaid does not track data on accessibility, so comparisons between FFS and ICP were not possible. Since the current assessments rely on self-reporting, both MCOs have plans to implement on-site accessibility assessments in the future.

E. Payment of Providers

This section describes the payments that each MCO makes to providers for claims they submit and timeliness of those payments by the MCO. According to Section 5.25 of the MCO contract, "Contractor must pay 90 percent (90%) of all Clean Claims from Providers for Covered Services within thirty (30) days following receipt. Contractor must pay 99 percent (99%) of all Clean Claims from Providers for Covered Services within ninety (90) days following receipt."

Each MCO is required to submit monthly "Adjudicated Claims" reports to HFS summarizing the non-pharmacy claims that have been resolved for the month and summary information for those claims, including length of time it takes to "resolve" submitted claims. This section is based on those reports.

Although the target set in the MCO contract is to pay 90% of claims within 30 days and 99% within 90 days, the state has encouraged the MCOs to pay claims more quickly if they are submitted electronically. Both MCOs received about 75% of their non-pharmacy claims electronically and about 25% remain paper.

Table 14 lists the resolution status for both MCOs and further detail about the "aging" of the claims. More than 90% of the claims for both MCOs are resolved within 30 days. In fact, Table 14 indicates that about 66% of the claims for Aetna and 85% for IlliniCare are resolved within the first 10 days.

The figures in Table 14 for MCO payments to providers show faster payment responses than the payment times publicly quoted by many providers for the regular FFS system in Illinois. A published report in 2009 cited an average payment period of 103.4 days for Medicaid claims in Illinois. The research team asked HFS for the current payment time for FFS providers and was told that as part of the SMART Act, HFS is now

Table 14: Non-pharmacy Paid Claims (FY13)

Resolution Status	Aetna	IlliniCare
% Paper resolved in 30 days	96.4%	96.9%
% Electronic resolved in 21 days	95.4%	99.0%
Age of Claim		
0 to 10 days	66.0%	85.6%
11 to 20 days	26.4%	12.1%
21 to 30 days	5.4%	1.4%
31 to 60 days	2.1%	0.8%
61 to 90 days	0.1%	0.1%
More than 90 days	0.1%	0.0%
TOTAL	**100.0%**	**100.0%**

Data Source: MCO monthly report "Adjudicated Claims"

required to be more timely in payments to providers. HFS data received in April of 2014 indicated that of the 58 provider types paid by Medicaid, only 8 provider types were averaging more than 90 days in payment times, with the average payment time at slightly less than 45 days for all providers for FY14 (through 3/21/14).

There are two cautions about the data in Table 14 that should be noted:

1) The reports that this table is based on do not include any pharmacy claims (however, pharmacy claims are usually paid very quickly);
2) The reports that this table is based on only consider "clean claims" – if a provider has a claim rejected by the MCO's clearinghouse, the clock does not start on the aging process of that claim until the provider successfully submits a clean claim through to the MCO; and
3) Conversations with the MCOs showed that they use a slightly different definition of which claims to include on their monthly report. One MCO only includes new claims while the other MCO includes the same claim on subsequent reports if there is an adjustment to the claim.

Despite these cautions, the overall results indicate that most providers receive timely payments, especially when compared to the traditional FFS system.

Table 15 describes how many paid claims were made for in network providers versus out of network providers in FY13 and indicates that IlliniCare paid slightly more of their non-pharmacy claims to network providers than Aetna did (60.4% to 54.6%).

Table 15: Payment of Providers Paid Claims by Network Status (FY13)

Network Status	Aetna		IlliniCare	
	#	%	#	%
In Network	617,095	54.6%	398,608	60.4%
Out of Network	531,639	45.4%	261,560	39.6%
TOTAL	**1,130,734**	**100.0%**	**660,168**	**100.0%**

Data Source: MCO monthly report "Adjudicated Claims"

In summary, there are few small differences between the MCOs regarding the timely payment of providers. Both MCOs pay more than 95% of their providers within 30 days of receiving a clean claim and both MCOs still pay a substantial number of providers who have not yet joined the formal network.

F. Care Coordinators

Prior to implementation of Service Package 2, Care coordinators for the MCOs coordinated services primarily for members designated as being at either high or medium risk. With the rollout of Service Package 2 in February of 2013, the care coordination responsibilities of the MCOs expanded as their staff became responsible for members on HCBS waivers.

This section presents findings related to the number of care coordinators employed by the MCOs, their qualifications and training, the caseloads they assume, and the amount and level of contact they are expected to have with members on their caseload.

Number of Care Coordinators

Table 16, below, displays the number of care coordinators for each MCO. IlliniCare started FY13 with 42 coordinators, compared to 27 for Aetna. Both ended the year with approximately the same number of coordinators, although turnover for care coordinators who started the year was much higher for Aetna (13 of 27; 48%) than for IlliniCare (6 of 42; 14%). These turnover figures include staff who left a position as a care coordinator for a promotion within the MCO. Although this is still turnover from the standpoint of the member, the experience of a care coordinator that remains with the MCO in another position could still benefit the plan's members overall. For IlliniCare, 2 of the 6 members who left during FY13 were promoted within the MCO. Comparable figures for Aetna were not available.

Table 16: Number of Care Coordinators (FY13)

Coordinator Type	Aetna			
	# Began Year	# Left during Year	# Added during	# Ended Year
Full	23	12	48	59
Associate	4	1	2	5
TOTAL	**27**	**13**	**50**	**64**

Coordinator Type	IlliniCare			
	# Began Year	# Left during Year	# Added during	# Ended Year
Behavioral Case Manager	8	1	2	9
Case Manager II	11	3	7	15
Program Coordinator	9	1	2	10
Program Coordinator II	7	0	0	7
Program Spec I (Social Worker)	3	1	19	21
Program Spec II (Social Worker)	4	0	4	8
TOTAL	**42**	**6**	**34**	**70**

Qualifications

According to Section 5.11.2.1 of the MCO contracts, "Care Coordinators who serve Enrollees within the DoA Persons who are Elderly HCBS Waiver, DHS-DRS Persons with a Brain Injury HCBS Waiver, DHS-DRS Persons with HIV/AIDS HCBS Waiver, or DHS-DRS Persons with Disabilities HCBS Waiver must meet the applicable qualifications set forth in Attachment XVI." The qualifications include standards for both education and work experience.

The state permits a broad array of educational qualifications in terms of who can serve as care coordinators for waiver members. The most common is Registered Nurse (4 waivers), bachelor's level-unspecified (3 waivers), LPN (2 waivers), and licensed counselor (2 waivers). For a more detailed listing of permissible qualifications, see Tables 105 and 107 in Appendix A.

Training

According to Section 5.11.2.2 of the MCO contracts, care coordinators who serve members on waivers must meet the applicable training requirements that are listed in a separate attachment in the contract.

These training guidelines require each Care Coordinator to receive at least 20 hours of training per year, prorated to 1.5 hours per month. For more detail on specific training requirements, see Table 106 in Appendix A.

Although the language in the contract specifies 20 hours of training per year and training on special issues depending on the waiver, there are still many aspects not covered in the contract. Several questions presented themselves to the UIC team: If a care coordinator covers more than 1 waiver (some can cover up to 4 waivers), are there additional training requirements? If a coordinator does not complete their annual training, are they pulled out from their duties until it is completed? How is it decided on the specific training to be provided and who provides it (MCO vs. external party)?

The MCOs are required to track and quarterly report the training of their coordinators to the state. The report format requires the MCOs to report how many coordinators they employ and how many have met the training requirement. However, in talking with the MCOs, it became clear that the two plans had different interpretations of how the report was to be completed. One plan believed they were to only report on the initial training of new coordinators while the other plan believed the report was for tracking ongoing training of existing coordinators. In addition, there was confusion as to whether quarterly "compliance" meant total compliance of 20 hours for the entire year or merely compliance with 1.5 hours per month for the year to date.

Table 108 in Appendix A summarizes data received from the MCOs, HFS, IDoA, and IDHS on trainings they offered for care coordinators. However, sometimes enrollment was not taken at these trainings and it was impossible to calculate how many staff participated in the training and for how long.

Caseloads

According to Section 5.12.1 of the MCO contract, "Caseloads of Care Coordinators shall not exceed the following standards on average during the calendar year:"

- High Risk Enrollees: 75
- Moderate Risk Enrollees: 150
- Low Risk Enrollees: 600
- For Enrollees in the Persons with Brain Injury Waiver or the Persons with HIV/AIDS Waiver: 30

The above language applies to coordinators who have members from only one risk level or waiver type.

In most cases, care coordinators have members at different risk levels on their caseload. To cover these situations, the MCO contract defines different caseload maximums for these blended instances, specifying "caseload weights."

According to Section 5.12, "Care Coordinators responsible for Enrollees with varying risk levels shall have their overall caseload weighted and a blended overall caseload limit set, taking into account the location of the Enrollee. The maximum weighted caseload for a Care Coordinator is 600 with low risk weighted as one (1), moderate risk weighted as four (4), and high risk weighted as eight (8)."

The above case load standards technically went into effect in the middle of FY13, on February 1, 2013. However, for existing waiver members, there was a 180 day transition period for them to be fully

implemented. For this reason, the current report does not provide results on caseload compliance for FY13--the next UIC report will include compliance with caseload requirements.

Contact with members

At the time of the rollout of Service Package 2 on February 2013, new standards went into effect specifying the amount of face to face and other contact that care coordinators must have with waiver and other high risk members. Table 17 summarizes these new minimum contact standards.

Table 17: Minimum Contact Standards with Members for Care Coordinators (FY13)

Member Type	Face to Face	Total Contact
High Risk members	N/A	1 x every 90 days
Elderly waiver	1 x every 90 days	1 x every 90 days
Brain injury waiver	1 x every month	1 x every month
HIV/Aids waiver	1 x every 2 months	1 x every month
Disabilities waiver	1 x every 90 days	1 x every 90 days
SLF waiver	N/A	1 x every year

Data source: MCO contract with state of Illinois

Similar to the discussion on caseloads, and due to the fact that there was a 180 day transition period from February through August 2013, contact data for FY13 cannot be reported. However, this will be an important part of next year's evaluation report, especially concerning how contacts are defined and how member cancellations or "no-shows" are counted by HFS and the MCOs.

Stakeholder Feedback

Figure 3 illustrates responses (following the second year of ICP) to survey questions asked to members about how often one's care coordinator demonstrated knowledge of the patient's medical history and the input the patient had in the development of their personal care plan. Over half (61.6%) of ICP members who received case coordination reported that their care coordinator usually or always demonstrated knowledge of their medical history. Nearly one out of five (17.3 %) of the ICP participants said that their care coordinator never demonstrated knowledge of their medical history.

Figure 3. How often did your care coordinator demonstrate knowledge of your medical history? (FY13)

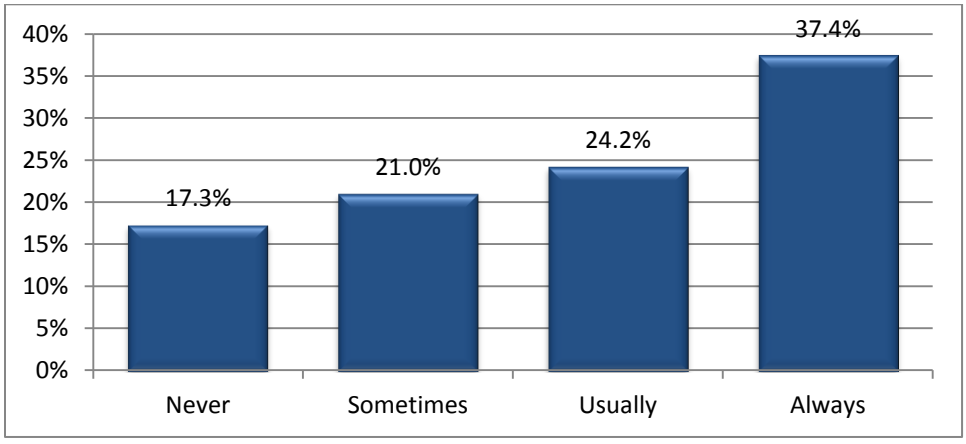
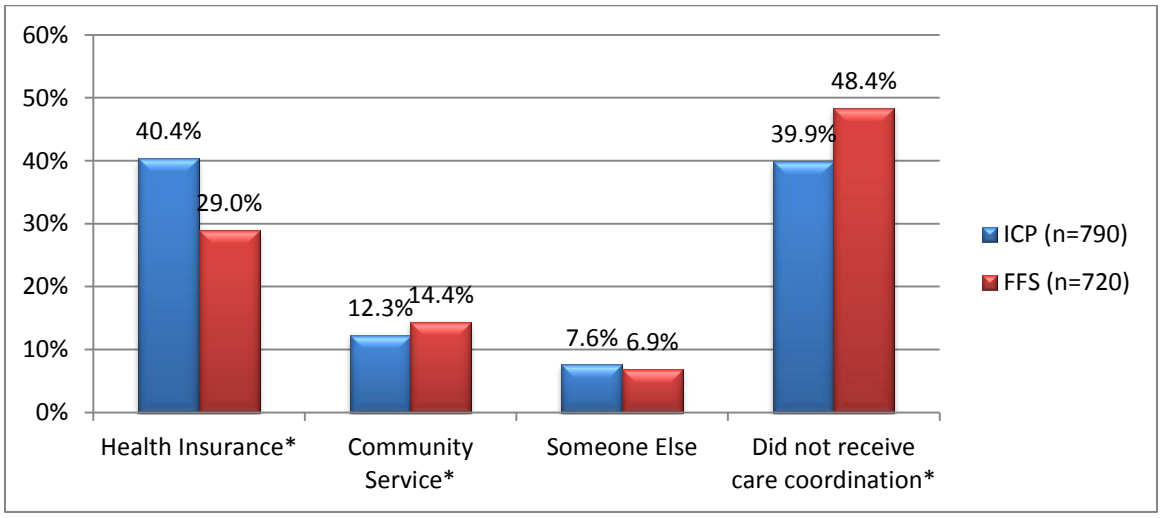


Figure 4 illustrates the sources of care coordination received by enrollees in ICP as well as FFS Medicaid. Within FFS, health insurance was reported as the most utilized care coordination source for enrollees (29%). Within ICP, most enrollees also received care coordination from their health insurance program (40.4%). The results reveal some confusion about care coordination and who provides it. Almost one third of FFS respondents reported that they received care coordination from insurance; they likely meant the Medicaid system. Still, the fact that the MCOs are providing care coordination is apparent to respondents, as a significantly higher percentage of people in ICP reported receiving care coordination from insurance than people in FFS.

The survey results show that compared to people in FFS, after controlling for demographic differences (using logistic regression, see Table Table 18) people in ICP are significantly more likely to report that they received care coordination from their health insurance, less likely to report they received it from a community service and less likely to not receive care coordination at all. Other significant differences are for people with specific disabilities versus people without them, including that people with mental health disabilities and people with I/DD are more likely to receive care coordination from a community service and people without, people with physical disabilities were more likely to receive care coordination through their health insurance than people without physical disabilities, people with I/DD were more likely to receive the care coordination from someone else than people without I/DD, and people with mental health disabilities and I/DD are less likely not to receive care coordination than people without those disabilities.

Figure 4: Who Provides Care Coordination: FFS vs. ICP? (FY13)



*Differences are statistically significant (p<.05)

Many of the ICP providers and members participating in the second round of focus groups were not aware of the role played by care coordinators within the ICP. Providers expressed uncertainty about their own role in care coordination as well. *"And so the care coordination piece [of ICP], is that from the actual managed care to the patient directly or by the physician?"* Many ICP members participating in focus groups did not fully understand care coordination and the role of their care coordinator and in some cases if they were assigned a coordinator. *"I didn't find this out until yesterday afternoon [that I*

had a MCO case coordinator]." Members who were aware of their coordinators were often unclear about the distinct role the coordinator played. Yet, MCO care coordination staff consistently expressed that they had more time and focus in the past year than in the previous year to coordinate care as opposed to finding doctors who would see their members and "putting out fires." This is supported by the data in Table 16, which shows an increased number of case managers as the year progressed.

In summary, both MCOs have a growing workforce of care coordinators. Aetna had 27 care coordinators at the start of FY13, and ended with 64. IlliniCare had 40 care coordinators at the start of FY13, and ended with 70. IlliniCare experienced fewer turnovers than Aetna. Only 6% of IlliniCare's care coordinators left their position by the end of the year, whereas 48% of Aetna's care coordinators left.

Table 18: Logistic Regression Analysis for Who Provides Care Coordination (FY13)

	Health Insurance		Community Service		Someone Else		Did Not Receive	
	Odds-Ratio	95% C.I.	Odds-Ratio	95% C.I.	Odds-Ratio	95% C.I.	Odds-Ratio	95% C.I.
ICP v. FFS	1.869**	1.474-2.369	.689*	.493-.964	.910	.585-1.416	.682**	.539-.864
Age	.999	.992-1.007	1.000	.990-1.011	.997	.983-1.011	.997	.989-1.005
Female v. Male	.906	.724-1.132	1.069	.781-1.463	.885	.590-1.327	1.150	.920-1.438
Hispanic v. not Hispanic	1.055	.719-1.549	.875	.512-1.495	.665	.303-1.459	1.058	.725-1.545
White v. non-White	.809	.600-1.089	.920	.610-1.389	1.383	.807-2.369	1.241	.921-1.673
Black v. non-Black	1.187	.892-1.580	.763	.511-1.139	.932	.541-1.606	.938	.704-1.251
Mental Health v. no MH	1.137	.905-1.428	1.724**	1.267-2.345	1.342	.895-2.011	.672**	.534-.844
Physical Disability v. no PD	1.338**	1.071-1.673	.851	.616-1.175	1.385	.918-2.089	.811	.647-1.015
I/DD v. no I/DD	.799	.618-1.034	2.282**	1.630-3.196	2.019**	1.293-3.154	.684**	.528-.885

*p<.05; **p<.01

G. Care Plans

Care coordinators are instrumental in screening, assessing, and facilitating the creation of care plans for members on their caseload. According to Section 5.14.1.1 of the MCO contract, "Contractor shall have a Health Risk Screening, and make its best efforts to administer the Health Risk Screening and, if needed, a behavioral health risk assessment to all new Enrollees within sixty (60) days after enrollment, to collect information about the Enrollee's physical, psychological and social health. Contractor will use the results to guide the administration of more in-depth health assessments."

Table 19 reports how often the MCOs met the requirement of completing a health risk screening within 60 days of enrollment. Overall, IlliniCare completed more screenings for new enrollees than Aetna

(57.9% to 35.0%) and completed more within 60 days (48.4% to 27.2%). IlliniCare also took fewer days on average to complete screenings (31.4 days to 55.9 days).

Table 19 also presents results on the completion of an in-depth assessment for those members that the MCO determined needed one based on the results of the initial health screening. For the first two years of the ICP, the proportion of new enrollees needing a more in-depth assessment has stayed relatively constant, between 20% and 35%. Both of the MCOs have taken more than 60 days on average to complete assessments, but each has improved the average time it takes to complete a screening over their timeframes for the first year.

Table 19: Care Plans (Year 1 vs. Year 2)

Measure	Year 1		Year 2	
	Aetna	IlliniCare	Aetna	IlliniCare
Initial Screenings				
% Screening completed for new enrollments	50.9%	73.7%	35.0%	57.9%
Completed within 60 days (% is of new enrollments)	30.7%	33.5%	27.2%	48.4%
Ave days to complete (of screenings completed)	100.9	127.7	55.9	31.4
In-depth Assessment				
% of new enrollments needing In-depth assessment	27.7%	21.4%	32.7%	24.6%
% assessments completed within 60 days (of those completed)	33.0%	37.5%	74.0%	60.3%
Ave days to complete (of assessments completed)	244.0	153.5	63.3	94.0
Care Plans				
% of new enrollments needing care plan	12.4%	18.6%	14.0%	16.3%
% care plans completed within 90 days (of those completed)	1.7%	15.7%	45.9%	61.2%
Ave days to complete (of those completed)	435.4	322.9	137.8	96.3

Data Source: MCO Special Datasets

Following an in-depth assessment, each MCO completes a care plan for a few members, typically those classified as medium or high risk. According to Section 5.14.8 of the MCO contract, the MCO "will develop a comprehensive person-centered Enrollee Care Plan for Enrollees stratified as high or moderate risk and for Enrollees in a HCBS Waiver. The Enrollee Care Plan must be developed within ninety (90) days after enrollment."

The third section of Table 19 displays results for the completion of these care plans. In year two, each MCO required that about 15% each MCO's new Enrollees needed a care plan (14.0% for Aetna and 16.3% for IlliniCare). IlliniCare completed more of their care plans within 90 days (61.2% to 45.9%) and their average number of days to completion also was lower than Aetna's (96.3 days to 137.8 days).

One of the outcomes of the screening and assessment process is that members are assigned a risk level. In general, members assigned to the "low" risk category do not have to have active care coordinators, while members in the medium and high risk categories are automatically assigned care coordinators. Table 20 shows the risk stratification of members for ICP members at the close of FY13, on June 30, 2013. A higher proportion of IlliniCare members were assigned to the high risk category as compared to Aetna (11.2% vs. 8.5%).

During focus groups, the care planning process was frequently mentioned. The following quote from an MCO leader stressed the value the MCOs place on engaging with members as soon as possible following enrollment, in order to effectively begin the care planning process. "*By sticking to a primary model, when reach that person that first time, [we] do the assessment, identify certain needs, engage the person in case management, and initiate the beginning of a care plan to catch that member with a higher degree of success*" (MCO leadership).

Table 20: Risk Stratification of Members (FY13)

Risk Level	Aetna		IlliniCare	
	Number	% of Total	Number	% of Total
Low	14,243	80.5%	13,753	77.8%
Medium	1,924	11.0%	1,947	11.0%
High	1,519	8.5%	1,987	11.2%
Total	**17,686**	**100.0%**	**17,687**	**100.0%**

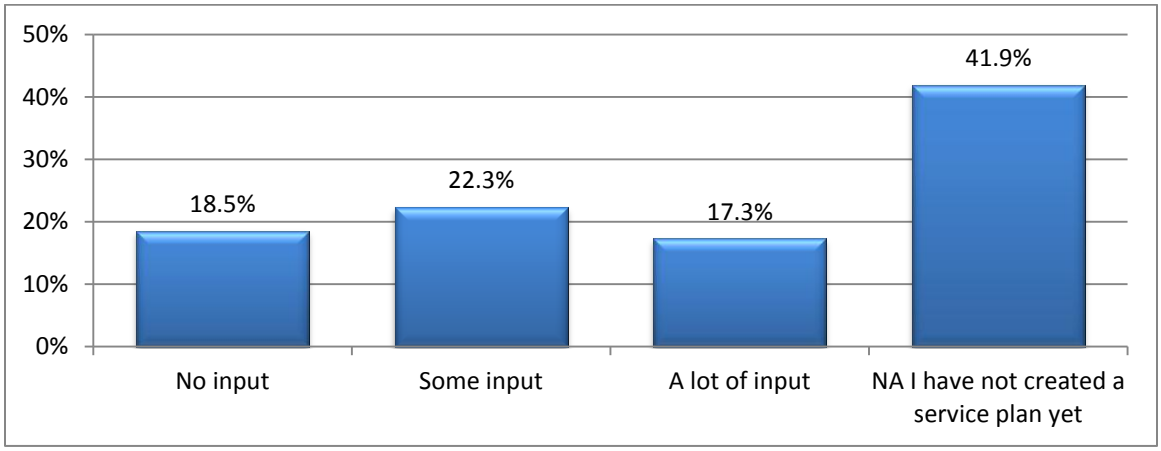
Data Source: Monthly Report MCOs Submit to HFS called "CM.DM Summary"

Care coordinators commented on promoting choice in healthcare by involving members in care planning. *"…I want to empower them because I am thinking so many [members are] used to people doing [everything] for them that they lay back and they don't [follow through and take charge of their health]. So my main thing is empowerment and freedom of choice."*

UIC's consumer survey also gathered information regarding care plans. One of the questions in the survey following the second year of ICP concerned how much input the individual or his/her family had in creating the service plan. 41.9% of those who responded said they had not created a service plan (see Figure 5). More people reported that they had no input than who reported having a lot of input (18.5% versus 17.3%), with another 22.3% reporting having some input. This implies that there is still work for care coordinators to do to obtain input from members and their families.

It should be noted that the consumer uses the language of "service plans," which in reality are only for people who receive LTSS. A service plan is a subset of a care plan, which more people will have. Thus, many of the respondents who answered this question likely do not have or need a service plan. This question is perhaps best interpreted as a general measure of engagement with an MCO regarding services.

Figure 5: How much input did you have in creating your care plan? (FY13)



In summary, each MCO has room to improve the timeliness and completion rate of screenings, assessments, and care plans. From Year 1 to Year 2 of ICP, IlliniCare completed a smaller percentage of initial screenings, in-depth assessments, and care plans. Aetna also completed a smaller percentage of initial screenings, but completed a greater percentage of in-depth assessments and care plans. Both MCOs increased their completion rate for screenings, in-depth assessments, and care plans from Year 1 to Year 2.

H. Prior Authorizations

The traditional FFS Medicaid program requires prior authorization for several inpatient services. These are largely based on diagnoses and procedures codes. A list of services subject to prior authorization is available at http://www2.illinois.gov/hfs/SiteCollectionDocuments/DRGCodes040114.pdf. The FFS Medicaid program could not provide data on the number of prior authorization requests received, approved, and the timeframe for making that decision.

In the ICP, authorization is typically required for certain procedures and pharmaceuticals. Prior authorizations for the ICP are divided into six categories: standard inpatient, expedited inpatient, standard outpatient, expedited outpatient, standard pharmacy, and expedited pharmacy.

According to the MCO contracts, requests for prior authorization are to be reviewed and decided within ten days after receiving the request for authorization from a Provider, with a possible extension of up to ten additional days. Expedited requests will be decided within three days. This timeline is much shorter than FFS Medicaid, which requires that decisions be made within 30 days. Aetna and IlliniCare use different definitions for determining inpatient and outpatient requests. In discussions with the two MCOs, the UIC team has determined that Aetna more frequently classifies requests as inpatient than IlliniCare does.

Prior authorization is a major area of concern for members, care coordinators, and providers. In the focus groups, all stakeholders expressed that they found the process of prior authorization challenging and frustrating at times. For example, one member shared a story about getting out of the hospital after hip surgery and having difficulty getting assistance from his PCP:

Table 21: All Prior Authorization Requests (FY13)

Measure	Total ICP	Aetna	IlliniCare
Inpatient Requests	10,921	10,706	215
Outpatient Requests	33,255	12,812	20,443
Pharmacy Requests	11,371	4,624	6,747
Total Requests	**55,547**	**28,142**	**27,405**
Inpatient Requests per 1,000 MM	25.7	50.3	1.0
Outpatient Requests per 1,000 MM	78.4	60.2	96.6
Pharmacy Requests per 1,000 MM	26.8	21.7	31.9
Total Requests per 1,000 MM	**130.9**	**132.2**	**129.5**

Data Source: MCO Special Datasets

> *"I called the [hospital] and I talked with this [nurse] for half an hour and she said you have got to get a referral. My [primary care physician] won't refer me to [another kind of specialist]. He said I am not going to get involved in that. You have to get that from the guy [surgeon] that did your hip."*

Table 21 summarizes the total prior authorization requests across the ICP program. Overall, the MCOs received over 55,000 prior authorization requests in FY13. Aetna had more inpatient requests, while IlliniCare had more outpatient and pharmacy requests. Aetna had 50.3 inpatient requests per 1,000 member months, whereas IlliniCare had only 1 inpatient request per 1,000 member months. Aetna had 60.2 outpatient requests per 1,000 member months, and IlliniCare had 96.6 outpatient requests per 1,000 member months. Aetna had 21.7 pharmacy requests per 1,000 member months, and IlliniCare had 31.9 pharmacy requests per 1,000 member months. Overall, Aetna and IlliniCare had about the same number of total requests per 1,000 member months. Each MCO has different prior authorization requirements, which explains much of the variation between the MCOs with regard to the rates of prior authorization requests.

Inpatient Requests

Tables 22 lists additional information for the inpatient requests reported by the MCOs (for additional detail, see Table 113 in Appendix A). Table 22 breaks down the number of standard and expedited requests, the percent approved, and timeline for approving inpatient requests. IlliniCare considers only requests for services not yet provided as prior authorizations. Most inpatient services are not requested prior to the member being admitted, thus are not considered prior authorizations, but notification of inpatient services. This explains much of why IlliniCare has less inpatient requests and more prior authorization requests for outpatient services (next section).

It should be noted that Aetna does not consider any of their inpatient (or outpatient) prior authorization requests to be expedited. They label some requests as "urgent", but informed the UIC team that these “urgent” requests are not considered to be to be “expedited” as defined by the MCO contracts.

The MCOs submit monthly reports to HFS about their requests for prior authorization and the types of those requests according to 8 categories. Aetna had substantially more standard requests than IlliniCare (10,706 to 215), and nearly one-third of their requests were for durable medical equipment. The rest of their requests were split between behavioral health and skilled nursing facilities. On the other hand, all of IlliniCare’s standard inpatient requests were for behavioral health services. Aetna did not have any expedited requests for inpatient services. IlliniCare’s requests were classified as other (37.6%), rehabilitation (32.9%), and skilled

Table 22: Inpatient Requests (FY13)

Measure	Total ICP	Aetna	IlliniCare
# of total requests	10,921	10,706	215
Member months	424,440	212,846	211,594
Standard	10,711	10,706	5
Expedited	210	0	210
Standard Requests			
Standard Inpatient per 1,000 MM	25.71	50.3	0.0
% Approved	89.5%	89.5%	40.0%
Mean number of days to decision	0.4	0.4	0.4
% decided within 10 days	99.7%	99.7%	100.0%
Expedited Requests			
Expedited Inpatient per 1,000 MM	0.5	-	1.0
% Approved	96.7%	-	96.7%
Mean number of days to decision	2.6	-	2.6
% decided within 1 day	78.1%	-	78.1%

Data Source: MCO Special Datasets

nursing facilities (27.6%); 1.9% were for behavioral health.

Outpatient Requests

Table 23 presents data on the number of outpatient requests. IlliniCare had over 20,000 outpatient requests, almost 8% of which were expedited. Aetna had almost 13,000 outpatient requests for prior authorization, none of which were expedited. Aetna approved 95.4% of requests, while IlliniCare approved 98% of both standard and expedited requests.

Table 23: Outpatient Requests (FY13)

Measure	Total ICP	Aetna	IlliniCare
# of total requests	33,255	12,812	20,443
% Standard	94.9%	100.0%	91.7%
% Expedited	5.1%	0.0%	8.3%
Standard Requests			
% Approved	96.9%	95.4%	98.0%
Mean number of days to decision	4.3	2.8	5.3
% decided within 10 days	99.2	99.3%	99.2%
Expedited Requests			
% Approved	96.9%	N/A	98.0%
Mean number of days to decision	1.8	N/A	1.8
% decided within 3 days	82.2%	N/A	82.2%

Data Source: MCO Special Datasets

During a meeting with Aetna, the UIC team asked Aetna staff if they wished to comment on the substantially lower number of outpatient requests that Aetna had as compared to IlliniCare. Aetna provided the UIC team this narrative to explain the difference:

"Aetna Better Health originally had Rule 132 prior authorization requirements similar to the HFS prior authorization requirements (i.e., requiring prior authorization when a certain number of service units were reached for particular services). On May 18, 2012, Aetna Better Health removed all prior authorization requirements for Rule 132 services delivered by network providers. This reduced barriers for members seeking Rule 132 services at network providers, as no services needed to be delayed while waiting for the prior authorization to be completed. This also reduced Rule 132 network provider administrative time spent on prior authorization requests. Non-network Rule 132 providers are few, so there are significantly fewer prior authorization requests for Rule 132 services for Aetna staff to process.

Additionally, Aetna Better Health never had a prior authorization requirement for the Rule 132 Mental Health Assessment done by network providers. This allowed network providers to remain adherent to the Rule 132 requirement to conduct a Mental Health Assessment update annually for each member, without a delay of prior authorization. The Level of Care Utilization System service, billed as case management –LOCUS, also never had a prior authorization requirement for network providers; this allowed adherence to Rule 132 requirements for LOCUS services to occur at particular treatment points for members served by network providers."

Each plan approved over 99% of requests within 10 days, although IlliniCare took nearly twice as long to make a decision on average for standard requests (5.3 days versus 2.8 days).

Table 24 shows the type of requests for outpatient services. Across ICP, the largest groups are "other" (37.9% standard and 35.5% expedited) and therapies (31% standard and 29.9% expedited). Again, Aetna did not have any expedited outpatient requests.

Table 24: Types of Outpatient Requests (%) (FY13)

Type	Total ICP		Aetna		IlliniCare	
	Stand.	Exp.	Stand.	Exp.	Stand.	Exp.
Behavioral Health	3.0%	0.2%	3.0%		3.0%	0.2%
DME	14.0%	9.2%	18.2%		11.2%	9.2%
Medical Inpatient	0.1%	0.0%	0.0%		0.1%	0.0%
Medical Outpatient	13.8%	25.1%	7.6%		18.0%	25.1%
Therapies	31.0%	29.9%	30.0%		31.8%	29.9%
SNF	0.0%	0.0%	0.0%		0.0%	0.0%
Rehab	0.1%	0.1%	0.1%		0.2%	0.1%
Other	37.9%	35.5%	41.1%		35.7%	35.5%
Total	**100.0%**	**100.0%**	**100.0%**		**100.0%**	**100.0%**

Data Source: MCO Special Datasets

Pharmacy Requests

See Pharmacy section, page 70 for detail on the number and types of prior requests for pharmacy services.

In summary, the MCOs differ in the number and type of prior authorization requests they receive and approve. Although Aetna and IlliniCare receive approximately the same number of total requests, Aetna receives more inpatient requests than IlliniCare and IlliniCare receives more outpatient and pharmacy requests than Aetna. Overall, Aetna approved about 90% of inpatient requests, about 95% of outpatient requests, and about 57% of pharmacy requests. IlliniCare approved about 95% of inpatient requests, about 98% of outpatient requests, and about 56% of pharmacy requests.

I. Grievances and Appeals

A grievance is an expression of dissatisfaction by a member or authorized representative. Grievances include complaints and requests for disenrollment, or any other matter that is not classified as an appeal. A complaint is a "phone call, letter, or personal contact from a Participant, Enrollee, family member, Enrollee representative, or any other interested individual expressing a concern related to the health, safety, or well-being of an enrollee" (MCO Contact, Section 1.29).

An appeal is a request for review of a decision made by the MCO with respect to:

1) denial or limitation of authorization or a requested service
2) reduction, suspension, or termination of a previously authorized service
3) denial of payment for a service
4) failure to provide services in a timely manner
5) failure to respond to an appeal in a timely manner, or

6) denial of an Enrollee's request to obtain services outside of the Contracting Area if they live in a rural community (MCO Contract, Sections 1.18 and 1.8).

One of the core differences between a grievance and an appeal is that an appeal asks for a decision to be reconsidered, whereas a grievance does not (MCO Contract, Section 1.64).

Grievances not resolved to the member's satisfaction can be escalated to a Grievance Committee for further review, then to HFS. Appeals that are not resolved to the member's satisfaction can be escalated to external review, fair hearing process, or both (MCO Contact, Section 1.64).

Table 114 in Appendix A outlines the differences between complaint, grievance, and appeal in the MCOs contracts. Table 115 in Appendix A compares the complaint process between FFS Medicaid, Aetna, and IlliniCare. Table 116 in Appendix A illustrates the responsibilities of the MCOs according to the contract with the state, in handling grievances and appeal processes.

1. Grievances

Table 25 illustrates the number and type of grievances in ICP by MCO. The types were derived from quarterly reports to HFS. IlliniCare received about half as many grievances as Aetna. For both MCOs, the majority of grievances were related to transportation (about 80% for Aetna and 51% for IlliniCare) and quality of care (about 20% for Aetna and 25% for IlliniCare). During the October-December 2013 quarter, HFS recorded 1264 grievances for all HFS programs in the state (including some managed care and Medicare). The largest number of complaints had to do with the DHS local offices; less than one percent (0.6%) had to do with transportation. See Table 118 in Appendix A.

Table 25: Number and Type of Grievances (FY13)

	Total ICP	Aetna	IlliniCare
Total Grievances	**631**	**408**	**224**
Medical Necessity	0.0%	0.0%	0.0%
Access to Care	3.0%	1.2%	6.3%
Quality of Care	20.0%	17.4%	25.0%
Transportation	69.9%	80.1%	51.3%
Pharmacy	0.2%	0.0%	0.4%
LTSS Services	0.0%	0.0%	0.0%
Other	7.0%	1.2%	17.0%
TOTAL	100%	100%	100%
Grievances per 1,000 MM	**1.49**	**1.92**	**1.06**

Data Source: MCO Special Datasets

Table 26 compares the different outcomes of grievances between MCOs. IlliniCare reported substantiating about 50% of grievances and not substantiating about 20%; the rest are unknown. Aetna closes grievances after a member has been notified. They were able to provide reasons for closing a grievance involving transportation.

Table 26: Grievance Outcomes (FY13)

Measure	Aetna		IlliniCare	
	#	%	#	%
Outcome Unknown	94	23.0%	68	30.4%
Grievance Not Substantiated	97	23.8%	39	17.4%
Grievance Substantiated	217	53.2%	117	52.2%
Total	**408**	**100%**	**224**	**100%**

Data Source: MCO Special Datasets

Transportation grievances are either valid (53.2% of total grievances) or invalid (23.8% of total grievances), which are equivalent to IlliniCare's substantiated and substantiated, respectively. Ten transportation grievances and all of the other grievances besides transportation are unknown.

The timeline for responding to a grievance is within 90 days of receipt. Table 117 in the Appendix specifies the timelines for grievances and appeals. Table 27 shows how well each MCO adheres to the timelines for resolving grievances. Aetna took an average of approximately 25 days to resolve a grievance, while IlliniCare took an average of approximately 12 days. For both MCOs, nearly 100% of grievances were resolved within 90 days.

Table 27: Timeline Compliance with Grievance Resolution (FY13)

	Aetna	IlliniCare	FFS Medicaid
Mean Days to Grievance Resolution	24.9	12.4	Unknown
Percent of Grievances Resolved within 90 Days	99.3%	99.5%	Unknown

Data Source: MCO Special Datasets

2. Appeals

Table 28 describes the types of appeals reported by each MCO in ICP. The types were derived from quarterly reports to HFS. The majority of Aetna's appeals (about 86%) were related to medical necessity, whereas the majority of IlliniCare's appeals (about 64%) were related to pharmacy. Transportation was the leading reason for a grievance, no appeals involved transportation in ICP. Although people did not have to make an appeal in order to receive transportation services, there were complaints when transportation was received (although very infrequent relative to the number of trips). Within FFS, 467 grievances were received for the entire State (HFS did not supply the number of member months this covers), with most regarding medical necessity (56.3%) or pharmacy (40.9%). Some additional appeals are also conducted at Fair Hearings, although data was not available on that process.

Table 28: Number and Type of Appeals (FY13)

Measure	Total ICP	Aetna	IlliniCare	FFS
Total	**252**	**92**	**160**	**467**
Medical Necessity	52.8%	85.9%	33.8%	56.3%
Access to Care	4.8%	13.0%	0.0%	0%
Quality of Care	0.0%	0.0%	0.0%	0%
Transportation	0.0%	0.0%	0.0%	2.7%
Pharmacy	40.5%	0.0%	63.8%	40.9%
LTSS Services	0.0%	0.0%	0.0%	0%
Other	2.0%	1.1%	2.5%	0%
Member Months	424,440	212,846	211,594	
Appeals per 1,000 MM	**0.59**	**0.43**	**0.76**	

Data Source: MCO Special Datasets, HFS calculations for FFS

Table 29 shows the outcomes of appeals for each MCO. Almost two-thirds of appeals were overturned by IlliniCare (64.4%), compared to 37% for Aetna and 1% for FFS.

Table 29: Appeals Resolutions (FY13)

Measure	Aetna		IlliniCare		FFS Medicaid	
	#	%	#	%	#	%
Overturned (in favor of member)	34	37.0%	103	64.4%	5	1.1%
Upheld	44	47.8%	57	35.6%	65	13.9%
Partial	1	1.1%	0	0.0%	2	0.4%
Unknown	13	14.1%	0	0.0%	395	85.5%
Total	**92**	**100%**	**160**	**100%**	**467**	**100%**

Data Source: MCO Special Datasets

The timeline for responding to an appeal is within 45 days of receipt. If an appeal is expedited, a decision must be made within 3 working days of receipt. Table 117 in the Appendix specifies the timelines for grievances and appeals. Table 30 shows how well each MCO adheres to the timelines for resolving appeals. Aetna took an average of about 14 days to resolve an appeal, and IlliniCare took an average of about 10 days. For both MCOs, nearly 100% of appeals were resolved within 90 days. FFS Medicaid averaged 473 days to resolve an appeal, with 0% being resolved within 90 days.

Table 30: Timeline Compliance with Appeal Resolution (FY13)

	Aetna	IlliniCare	FFS Medicaid
Mean Days to Appeals Resolution	13.7	10.5	473
Percent of Appeals Resolved within 90 Days	100.0%	99.4%	0%

In summary, the primary type of grievance for both MCOs was related to transportation. The majority of the remaining grievances involved quality of care, access to care, and “other.” IlliniCare substantiated about half of their grievances. The remaining resolutions were either withdrawn by the member or the outcome is unknown. Aetna classified the majority of their grievance outcomes as outcome unknown. For appeals, the majority of Aetna’s were related to medical necessity, whereas the majority of IlliniCare’s were related to pharmacy. Aetna overturned 37% of appeals and upheld 48%, whereas IlliniCare overturned 64% of appeals and upheld 36%.

Section 2: What impact has ICP had on healthcare and long-term services and supports utilization outcomes?

A. Transportation

Transportation is an important service area that removes barriers to accessing health care. Each MCO had a contract with a transportation vendor in FY13 (Aetna with MTM and IlliniCare with First Transit [note: IlliniCare switched vendors to FirstTransit at the end of December 2013]) to provide transportation services to their enrollees to get to doctor appointments and pharmacies. Tables 119 and 120 in Appendix A describe the transportation policies and procedures used by each MCO and the data collected by each call center. One service that the MCOs have added is to allow for stops at a pharmacy to pick-up prescriptions after a medical appointment, which is not allowed under FFS.

Transportation utilization

Table 31, below, shows a similar percentage of members utilized non-emergency medical transportation (NEMT) in FY13 compared to the baseline (FY11). Details on each MCO also show that a similar number of members in each MCO utilized non-emergency medical transportation, 16.5% for Aetna and 14.8% for IlliniCare. The number of travel days was fairly similar across time periods as well. A travel day represents a day when a member utilized a transportation service. A travel day may have several trips and each trip may include several claims submitted by a transportation provider.

Table 31: Non-Emergency Medical Transportation Utilization

Measure	ICP		ICP FY13 Detail	
	FY11	FY13	Aetna	IlliniCare
% of members utilizing NEMT*	14.6%	16.1%	16.5%	14.8%
Travel days per utilizing member per year**	18.7	17.2	19.4	15.4

*Adjusted for member months; had enrollment data
**The data presented is for travel days because FFS data for FY11 is not available in terms of individual trips.
Data Source: MCO Special Datasets, HFS Baseline Encounter Data

Trip Completion

Although Table 31 indicates that only about 16% of enrollees used transportation services through an MCO, most of the participants in the focus groups had comments to share about transportation. One of the more common themes concerned transportation "no shows" and lateness. While data on timeliness of transportation was not available, Table 32 displays data for FY13, including the number of trips scheduled, completed, and the reasons that trips were not completed.

Table 32: Trip Completion (FY13)

Measure	Aetna	IlliniCare	FFS Medicaid
Total Trips Scheduled	131,738	Missing data	N/A
% of Completed Trips	87.6%		N/A
% of trips with member no show	3.7%		N/A
% of trips canceled by members	8.1%		N/A
% of trips of 'No Show' by provider	0.6%		N/A

Data Source: MCO Special Datasets, HFS Baseline Encounter Data

Aetna's members scheduled 131,728 trips and 87.6% were completed. Less than 1% (0.6%) were provider "no shows" and 3.7% of the trips were no shows by members. One of the limitations of the data is that it does not show whether members cancelled or did not show up because they were forced to find other means of transportation as a result of providers being late. IlliniCare's transportation vendor did not collect this information and FFS Medicaid did not provide data on trip completion as of the writing of this report.

Although Table 32 indicates that "no shows" by a transportation provider is a relatively rare occurrence, the great majority of grievances that each MCO received concerned transportation (see page 48). Some focus group participants also talked about negative health outcomes associated with challenges securing transportation:

> *"One time I did go without [an appointment for] a while because I couldn't get transportation. It was a big mess. And I went without my meds for a month and ended up like a total 'wound up clock' the whole month. Because I didn't have it one month, it must have been withdrawal." (member)*

The consumer survey also includes a measure of timeliness of transportation arranged through one of the MCOs. On a scale from 1 to 4 (1-never arrived on time, 2-sometimes, 3-usually, and 4-always), the average score for ICP was 3.19, which indicates transportation provided by MCOs usually arrived on time. Controlling for demographic differences (age, gender, race and disability type), a regression on this variable does not show any significant differences between ICP and people in FFS. Hence, ICP enrollment did not seem to affect timeliness of transportation.

Changes in NEMT Utilization

Table 33 describes the change in nonemergency medical transportation utilization of ICP enrollees from FY11 to FY13. Approximately half of the members who received transportation services in FY11 didn't receive them in FY13, although it is not possible to determine if the others needed them or not. The bottom portion of Table 33 focuses on members who were among the top 25% of transportation users at the baseline. The table shows that travel days for these individuals decreased from FY11 to FY13 for each of the MCOs from a rate of 87.0 to 61.4 travel days per member in FY13.

Table 33: NEMT Utilization among ICP Members Enrolled in FY11 and FY13

Measure	ICP		ICP FY13 Detail	
	FY11	FY13	Aetna	IlliniCare
Baseline utilizers enrolled in FY13		4,061	2,230	1,968
Members enrolled in baseline and in FY13 utilizing NEMT[1]		1,902	1,004	928
% of baseline utilizing members who didn't receive transportation benefit in FY13		51%	52%	49%
High baseline utilizing members[2]	474	474	275	208
Travel days for high baseline utilizing members	31,168	27,312	17,270	10,042
Travel days per utilizing member per year[2]	87.0	61.4	68.1	52.6

[1] Had enrollment data
[2] top 25%
Data Source: MCO Special Datasets, HFS Baseline Encounter Data

Type of Transportation

Table 34 describes the type of vehicles being used to provide non-emergency transportation and the percentage of travel days for each category of transport used by a member. From baseline to FY13, the use of a few categories increased (notably taxis and private transportation) and others decreased (Medicar and bus/paratransit). Aetna was more likely to make use of taxis in FY13 than IlliniCare. The MCOs noted that they used taxi services only when other transportation providers were not available.

Table 34: Travel by Categories of Service (% of Travel Days)

Category	ICP		ICP FY13 Detail	
	FY11	FY13	Aetna	IlliniCare
Non-emergency Ambulance	4.1%	2.6%	1.8%	3.7%
Medicar	19.5%	7.7%	5.9%	10.4%
Taxi	2.5%	11.9%	18.1%	3.2%
Service car	69.1%	73.1%	67.1%	81.6%
Private transportation	2.0%	2.5%	4.3%	0.0%
Bus or paratransit (other)	2.9%	2.1%	2.8%	1.0%

Data Source: MCO Special Datasets, HFS Baseline Encounter Data
The data presented here is for travel days because FFS data for FY11 is not available in terms of trips.

Tables 122 and 123 in Appendix A provide additional detail on which types of categories of service were provided.

Stakeholder Feedback

One of the MCO care coordinators expressed concerns in the focus groups that sometimes transportation *"might show up in an inappropriate vehicle, might show up and the vehicle is full of smoke and the member has COPD."* This is a serious concern for people with disabilities and is related to physical accessibility of their vehicles, as well. This is another question asked in the consumer survey: how often are you able to get into the vehicle provided by your MCO? On a scale from 1 to 4 (1-never, 2-sometimes, 3-usually, and 4-always), the average score for ICP was 3.32, which indicates that transportation usually, but not always, was appropriate for members' use. Again, controlling for demographic differences (age, gender, race and disability type), a regression on this variable does not show any significant differences between ICP and people in FFS. That is, the likelihood of a person being able to get into the vehicle is about the same for ICP members and those receiving FFS.

The survey also asks people how often they received transportation help from an MCO when they needed it. A regression analysis found the only significant difference for the frequency of receiving transportation is Hispanic origin, with people from Hispanic origins receiving the transportation assistance they needed less frequently (see Table 125 in Appendix A). There was no significant difference between the frequencies of receiving transportation for people in ICP versus FFS.

In the second round of focus groups, various stakeholders, including, MCO leadership and care coordinators, providers, and ICP members talked about the positives of this system. As one provider said, "*We have had success with that [ICP-provided transit] as well. It is a pretty easy system for them [ICP members] to access to call for the transportation. That has been a good resource".*

Overall, several aspects of transportation improved with the ICP, including the ability to make a pharmacy stop and the ease of getting transportation. However, transportation still is a major source of complaints for both the ICP and FFS groups.

Overall, several aspects of transportation improved with the ICP, including the ability to make a pharmacy stop and the ease of getting transportation. However, transportation still is a major source of complaints for both the ICP and FFS groups.

B. Dental

The following section summarizes the changes that the SMART Act made in dental benefits for the traditional FFS Medicaid program, what benefits the MCOs continued to offer in the ICP, and a comparison of actual services that were provided to members in the ICP as compared to services provided to FFS members in FY13.

SMART Act

The Save Medicaid Access and Resources Together (SMART) Act limited dental services available to adult Medicaid members to emergencies, "a situation deemed medically necessary to treat pain, infection, swelling, uncontrolled bleeding, or traumatic injury that can be treated by extraction only. Although, dental services for the Medicaid population in Illinois have been restricted by the Act, each MCO continued to pay for dental services for ICP members in FY13.

Dental Benefits provided by the MCOs

Both Aetna and IlliniCare delegate the management of dental care services to DentaQuest. DentaQuest handles benefit management, provider network development and maintenance, credentialing and recredentialing, utilization management, and claims processing. The MCO websites list the dental benefits they offer on their websites. Figure 6 presents the dental benefits each MCO provides.

Figure 6: MCO Dental Benefits (as listed on websites)

Aetna

- Exams (1 per year for members under age 21 and limited to first visit per dentist for members over age 21)
- Cleanings (2 per year, per member)
- X-rays, Fillings and Extractions (pulling)
- Fluoride treatments (1 per year for members under age 21)
- Sealants (for members under age 21)
- Crowns (caps) (for members under age 21)
- Root canals (for members under age 21)
- Dentures (for members under age 21)
- "Practice" visits for members to become more comfortable with the dentist's office
- Mobile dental services for members in intermediate care facilities and nursing homes

IlliniCare

- Annual dental cleaning for those 21 years and older
- Semi-annual (two times a year) cleanings for those 20 years and younger
- Simple extractions and oral surgery if medically needed
- Bitewing x-rays
- Fillings
- "Practice" visits for members to become more comfortable with the dentist's office

MCO leadership conveyed that they chose not to reduce dental services covered to ICP members in line with the SMART act: "*I think our sense is that restricting services is not the most cost effective way to manage people. So getting them the right things, and chose to keep the dental benefit…*" (IlliniCare leadership).

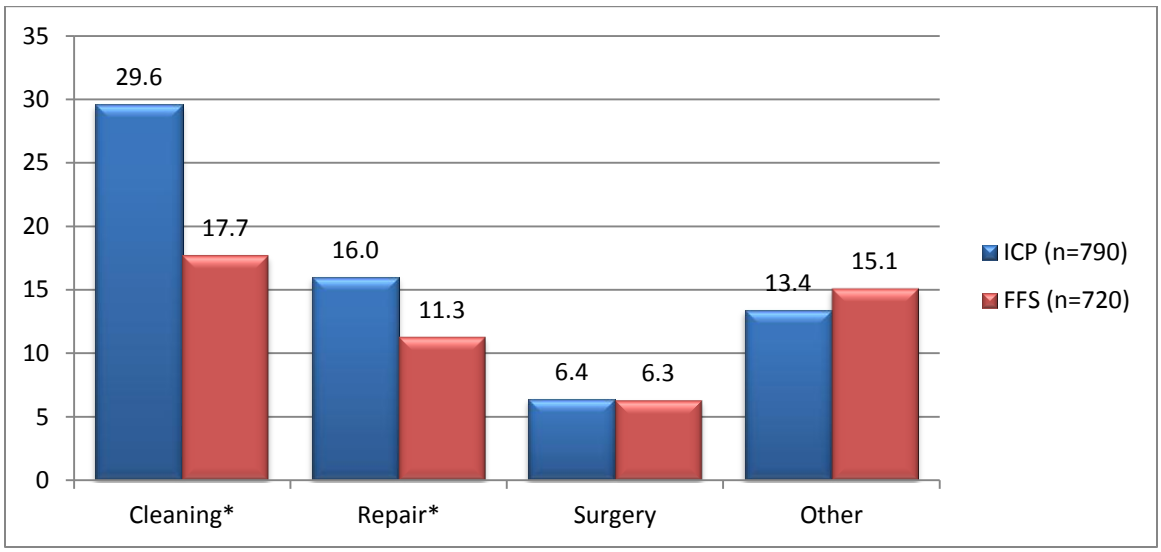
The importance of dental services was mentioned in both MCO annual reports. According to Aetna, "Educational articles about the importance of preventative health care are published in the member newsletters" (Aetna Annual Report, 2013, p. 7). Dental health was among the preventative care topics covered.

IlliniCare "encouraged members to go to the dentist annually through a postcard mailing…reminding them that an annual dental visit is part of their benefits with IlliniCare, and that neglecting proper dental care could cause future health issues. This postcard was sent to non-compliant members." Additionally, IlliniCare "discussed the importance of dental health in [a] newsletter. The article explained the need to brush twice a day, eat right and see your dentist once per year. This newsletter was sent to [all members]" (IlliniCare Annual Report, 2013, p. 10).

Stakeholder Feedback

In the second round of focus group, participants made it clear that dental was very important to them. A family caregiver said, *"One of the reasons I chose [MCO] over [MCO] was because it did give two visits a year versus [MCO]'s one."* According to the survey data collected following the second year of ICP, 60.1% of people in FFS had unmet needs for dental compared to 49.3% in ICP. This is a statistically significant (p=.001) difference. Of the total ICP respondents, 222 (29.6%) received dental cleaning, 120 (16.0%) received dental repair, 48 (6.4%) received dental surgery and 100 (13.4%) received other dental services. Results were statistically significant between ICP and FFS with regard to dental cleaning and dental repair, with people in ICP receiving them more frequently (as expected given SMART Act changes for people receiving FFS). These are shown in comparison with people in FFS in Figure 7.

Figure 7: Dental Services Received (percent of survey respondents) (FY13)



*Differences are statistically significant (p<.05)

Overall service utilization

Table 35 summarizes data for dental visits during the baseline period immediately prior to the ICP start-up and Year 2 of the ICP. A dental "visit" is defined as all the claims billed for a member on a single day. The total number of visits decreased along with the average number of visits per 1,000 member months from baseline to FY13. Aetna and IlliniCare had similar numbers of dental visits per 1,000 member months (25.9 and 25.4, respectively), although the cost per visit for IlliniCare was higher ($149.48 to $101.76). A summary of the total number of visits is shown in Table 126 in Appendix A. Appendix A also contains Tables 127-129, which break down the visits by the procedure type: emergency procedures, non-emergency procedures, and visits including both.

Table 35: Dental Visits (Pre and Post ICP)

Measure	ICP		ICP FY13 Detail	
	FY11	FY13	Aetna	IlliniCare
Cost per visit	$88.88	$125.28	$101.76	$149.48
Visits per 1,000 MM	40.4	25.8	25.9	25.4
Cost per 1,000 MM	$3,593.63	$3,227.71	$2,651.08	$3,807.74

Table 36 shows the difference in utilization of dental services after matching the ICP and FFS groups (for more information on this method, see page 18). After matching the samples, utilization of dental services (standardized in terms of dollars per person per month) decreased significantly more per member per year in FFS than in ICP.

Table 36: Matched Pre and Post Differences in Utilization of Dental Services

	Pre	Post	Change
Chicago FFS	$3.73	$0.39	-$3.34***
ICP	$3.61	$1.42	-$2.19
Treatment Effect			$1.15***

*** p<0.001

Emergency Dental Services

Table 37 shows the change in emergency dental claims in ICP and the FFS comparison group from FY11 to FY13. In July of 2012, HFS implemented the SMART Act provisions which limited adult dental services to "emergencies." These were basically defined as "a situation deemed medically necessary to treat pain, infection, swelling, uncontrolled bleeding, or traumatic injury that can be treated by extraction only." HFS provided specific dental procedure codes that would be permitted after July 1, 2012. See http://www.hfs.illinois.gov/html/061312n.html for the memo HFS distributed regarding this change.

In second year of the ICP, the number of claims per 1,000 member months increased from 16.1 to 19.1, while they decrease in FFS (21.4 to 18.6). Similarly, cost per 1,000 member months increased for ICP ($456.90 to $589.43) and decreased for FFS ($613.22 to $443.45). IlliniCare had more claims per 1,000 member months (26 to 12) and higher cost per 1,000 member months ($826.53 to $353.73) than Aetna in FY13.

Table 37: Dental Claims (Emergency Only)

ICP-Baseline vs. ICP-Year 2	ICP		ICP FY13 Detail	
	FY11	FY13	Aetna	IlliniCare
Cost per claim	$28.30	$30.94	$29.35	$31.67
Claims per 1,000 MM	16.1	19.1	12.1	26.1
Cost per 1,000 MM	$456.90	$589.43	$353.73	$826.53

ICP vs. FFS Comparison	ICP		FFS Comparison	
	FY11-FFS	FY13-MCO	FY11-FFS	FY13-MCO
Cost per claim	$28.30	$30.94	$28.63	$23.79
Claims per 1,000 MM	16.1	19.1	21.4	18.6
Cost per 1,000 MM	$456.90	$589.43	$613.22	$443.45

Non-Emergency Dental Services

Table 38 summarizes the figures for non-emergency dental claims and shows a pronounced decrease in the rate of non-emergency claims per 1,000 member months for Chicago comparison group members (66.8 to 6.3) compared to a much milder decrease (79.0 to 58.4) for the ICP group.

This decrease is apparently due to the SMART Act. Claims per 1,000 member months (66.8 to 6.3) and cost per 1,000 member months ($2886.96 to $337.16) also decreased substantially for the FFS comparison group, by 88% from FY11 to FY13. These rates are also decreased for the ICP population, although much less drastically (by 16%). IlliniCare had higher numbers of the claims per 1000 member months (67.9 versus 48.8) and higher costs per 1000 member months ($2981.22 versus $2297.35) than Aetna in FY13.

Table 38: Dental Claims (Non-Emergency Only)

ICP-Baseline vs. ICP-Year 2	ICP		ICP FY13 Detail	
	FY11	FY13	Aetna	IlliniCare
Cost per claim	$39.72	$45.20	$47.03	$43.88
Claims per 1,000 MM	79.0	58.4	48.8	67.9
Cost per 1,000 MM	$3,136.73	$2,638.28	$2,297.35	$2,981.22

ICP vs. FFS Comparison Measure	ICP		FFS Comparison	
	FY11-FFS	FY13-MCO	FY11	FY13
Cost per claim	$39.72	$45.20	$43.23	$53.63
Claims per 1,000 MM	79.0	58.4	66.8	6.3
Cost per 1,000 MM	$3,136.73	$2,638.28	$2,886.96	$337.16

In summary, one advantage for the ICP enrollees was that the MCOs continued to cover preventive and non-emergency dental services, while the FFS group saw major decreases in these services after enactment of the SMART Act. However, dental services continue to be an area of high unmet need for both groups.

C. Emergency Department Visits

One of the primary ways that managed care hopes to save money is by reducing hospitalizations and emergency room (ER) usage, especially avoidable or unnecessary visits. Both Aetna and IlliniCare have noted this in their annual reports and have set goals to educate members on proper ER utilization.

Average costs per member have decreased under the ICP when compared to the average costs for the same members in FY11 before the ICP began. Average costs per member was almost $390 per member under the FFS system in FY11—by FY13, this average had decreased to less than $340 per member (see Table 39).

Table 39: Emergency Department Events

ICP - Baseline vs. Year 2 Measure	ICP		ICP FY13 Detail	
	FY11-FFS	FY13-MCO	Aetna	IlliniCare
Cost per FTE member	$389.98	$338.83	$241.70	$436.52
ICP vs. FFS Comparison Measure	**ICP**		**FFS Comparison**	
	FY11-FFS	**FY13-MCO**	**FY11**	**FY13**
Cost per FTE member	$389.98	$338.83	$457.24	$579.20

Table 39 also indicates that average costs for the FFS group showed the opposite trend, increasing from $457 per member in FY11 to $579 in FY13.

Table 40 shows the difference in ER utilization after matching the ICP and FFS groups (for more information on this method, see page 18). After matching the samples, utilization of ER services (standardized in terms of dollars per person per month) decreased by $2.81 per member per year more in ICP than FFS. This difference is marginally statistically significant, but fairly small.

Table 40: Matched Pre and Post Differences in Utilization of ER Admissions

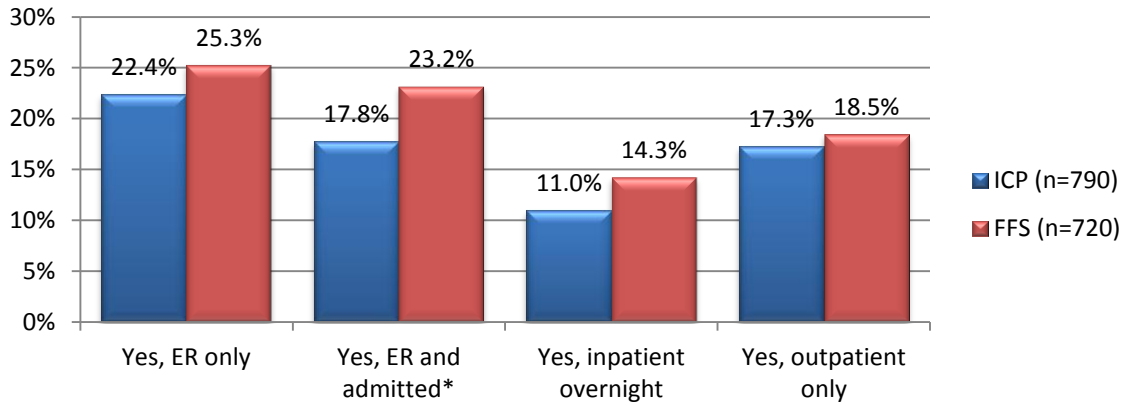
	Pre	Post	Change
Chicago FFS	$33.00	$24.30	-$8.71
ICP	$30.09	$18.58	-$11.51
Treatment Effect			-$2.81*

* p<0.10

The survey following the second year of ICP showed that about a quarter of people in ICP and FFS said that they went to the ER only at some point in the last year, and about 20% said that they went to the ER and were admitted in the last year (see Figure 8). Using logistic regressions to control for demographic differences between ICP and FFS, there were no significant differences for how likely people in ICP were to receive a service versus people in FFS. However, there were other significant differences, including that people with physical disabilities were more likely to receive any one of these

services than people without physical disabilities, females were more likely to go to the ER than males, older people were more likely to go to the ER and be admitted than younger people, Blacks are more likely to go to the ER and go to the ER and be admitted than non-Blacks (see Table 41).

Figure 8: Did you go to the ER or Hospital? (Percent Yes) (FY13)



* Difference is statistically significant (p<.05)

Table 41: Logistic Regression Analysis for Going to ER (FY13)

	Going to ER only		Going to ER and Admitted		Inpatient Hospital		Outpatient Hospital	
	Odds-Ratio	95% C.I.	Odds-Ratio	95% C.I.	Odds-Ratio	95% C.I.	Odds-Ratio	95% C.I.
ICP v. FFS	1.026	.789-1.334	.777	.589-1.025	.736	.524-1.035	.997	.746-1.334
Age	.999	.990-1.008	1.011*	1.002-1.021	1.003	.991-1.015	1.005	.995-1.015
Female v. Male	1.413**	1.095-1.824	1.000	.768-1.301	1.268	.912-1.762	1.017	.771-1.342
Hispanic v. not Hispanic	1.124	.729-1.735	1.094	.692-1.729	1.025	.592-1.774	.832	.503-1.377
White v. non-White	.940	.665-1.330	1.492**	1.035-2.150	1.728*	1.115-2.678	1.246	.853-1.819
Black v. non-Black	1.600**	1.159-2.209	1.723*	1.217-2.437	1.393	.911-2.130	1.391	.971-1.992
Mental Health v. no MH	1.316*	1.020-1.697	1.011	.770-1.327	1.098	.788-1.529	.906	.679-1.208
Physical Disability v. no PD	1.531**	1.195-1.962	1.399*	1.079-1.814	1.638**	1.193-2.248	1.473**	1.121-1.936
I/DD v. no I/DD	.780	.583-1.045	.773	.566-1.055	.482**	.319-.730	.843	.609-1.167

*p<.05; **p<.01

MCO Care Coordinators in the focus groups described a reduction in ER usage and attributed it to building relationships with members so that they could advise them. One Care Coordinator explained,

"[We] help our members try to stay more healthy and we try to encourage when we go out to the home to say, 'If you have a pain in your big toe, please don't go running to the emergency room. If it is something you can deal with, deal with it and go to your doctor tomorrow or call your doctor.'"

In summary, the ICP did result in a decrease in ER use. As discussed previously, MCO care coordinators attribute this reduction to "building relationships" with members.

D. Hospital Admissions

In their annual reports, Aetna and IlliniCare set goals to improve patient care and reduce hospital utilization and admissions. Similar to the trend noted for emergency room events, the average costs per member for hospital admissions also decreased under the ICP when compared to the baseline levels. Average costs per member for hospital admissions decreased from $4,705 under the FFS system in FY11 to slightly more than $3,200 by FY13 under the ICP (see Table 42). The FFS Chicago comparison group also decreased, from $5,730 in FY11 to just over $4,500 in FY13.

Table 42: Hospital Admissions

ICP-Baseline vs. ICP-Year 2	ICP		ICP FY13 Detail	
	FY11-FFS	FY13-MCO	Aetna	IlliniCare
Cost per FTE member	$4,705.12	$3,209.68	$3,422.94	$2,995.14
ICP vs. FFS Comparison	**ICP**		**FFS Comparison**	
	FY11-FFS	FY13-MCO	FY11	FY13
Cost per FTE member	$4,705.12	$3,209.68	$5,730.00	$4,532.20

Data Source: MCO Special Datasets, HFS Baseline Encounter Data

Table 43 shows the difference in hospital utilization after matching the ICP and FFS groups (for more information on this method, see page 18). After matching the samples, hospital utilization (standardized in terms of dollars per person per month) was reduced significantly more per member per year in FFS than ICP. The treatment effect estimate implies that the FFS group decreased $89 more for utilization of hospital services than the ICP group.

Table 43: Matched Pre and Post Differences in Utilization of Hospital Admissions

	Pre	Post	Change
Chicago FFS	$504.88	$218.99	-$285.89
ICP	$385.50	$188.26	-$197.24
Treatment Effect			$88.65***

** p<0.01

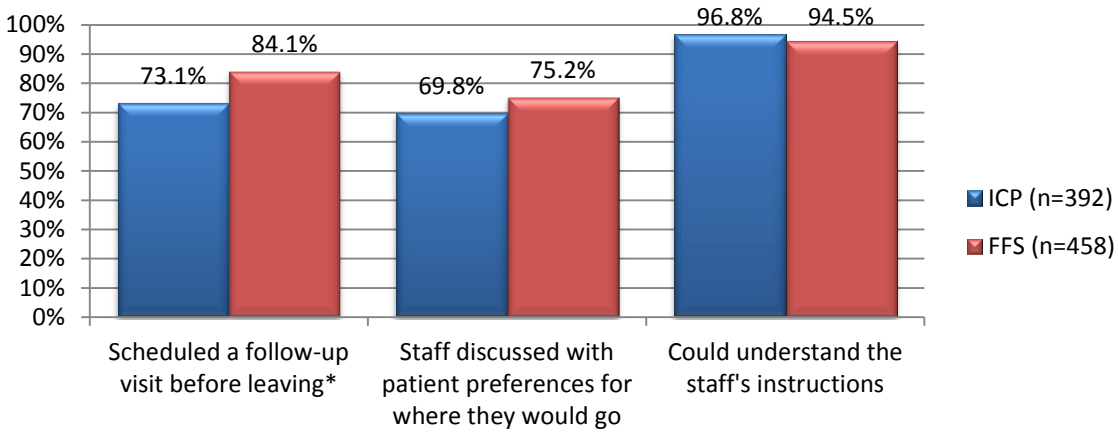
In the second round of focus groups, the issue of hospitalization was not often discussed. However, the consumer survey did cover a number of aspects related to hospital utilization. Most notably, there was

no significant difference in satisfaction with hospitals after controlling for demographic differences between people in ICP and people receiving services through FFS.

The survey also includes a question asking whether each person went to the emergency room or hospital and which service they received (multiple answers allowed) (see Figure 8, in the Emergency Department Visits section). Less than 15% received inpatient services overnight, and less than 20% received outpatient services. Using logistic regressions to control for demographic differences between ICP and FFS, there were no significant differences for how likely people in ICP were to receive a service versus people in FFS. However, white people were significantly more likely to have an inpatient hospitalization than non-whites, people with physical disabilities were more likely to receive any one of these services than people without physical disabilities, and people with I/DD are less likely to have an inpatient hospitalization than people without I/DD (see Table Table 41).

Other questions ask whether a follow-up appointment was scheduled upon discharge, whether the staff discussed a person's preference for where they will go upon discharge, and whether the person could understand the instructions given to them. Using logistic regression to control for demographic differences, versus people in FFS, people in ICP were significantly less likely to have hospital staff to schedule a follow-up appointment and significantly more likely to understand the hospital instructions after discharge. The only other significant difference was that people with I/DD were significantly less likely to understand hospital instruction after discharge than people without I/DD.

Figure 9: Experiences with the Hospital (Percent Yes) (FY13)



* Difference is statistically significant (p<.05)

Table 44: Logistic Regression Analysis for Likelihood of "Yes" Response to Hospital Experiences (FY13)

	Hospital staff helped schedule a follow-up		Hospital staff talked to patient about where they would go		Patient could understand hospital instructions	
	Odds-Ratio	95% C.I.	Odds-Ratio	95% C.I.	Odds-Ratio	95% C.I.
ICP v. FFS	.544**	.372-.796	.773	.546-1.093	2.822*	1.251-6.365
Age	1.007	.994-1.021	1.009	.996-1.021	.987	.961-1.013
Female v. Male	1.114	.772-1.608	.942	.673-1.317	.839	.411-1.715
Hispanic v. not Hispanic	.593	.336-1.049	.975	.558-1.702	2.421	.530-11.058
White v. non-White	1.026	.630-1.669	.988	.626-1.558	.362	.129-1.014
Black v. non-Black	1.296	.814-2.063	1.009	.662-1.536	.647	.247-1.692
Mental Health v. no MH	1.051	.723-1.527	.779	.558-1.089	.600	.297-1.215
Physical Disability v. no PD	1.106	.770-1.589	1.197	.862-1.663	1.239	.611-2.512
I/DD v. no I/DD	.723	.479-1.091	1.165	.785-1.727	.300**	.140-.641

*p<.05; **p<.01

Generally, there were few significant differences between the ICP and FFS groups regarding hospital utilization. However, analyses did not indicate any differences in hospital costs for the ICP group versus the FFS group over the two years.

E. Prevention

One of the ways that managed care initiatives can be successful in decreasing costs, in theory, is by increasing access to preventive services, thereby reducing future medical care and costs. Use of preventive services offers members an opportunity to avoid or delay onset of new disease, respond to disease in its earlier stage, and to maintain health and function.

"Standard" Preventative Services

The traditional FFS Medicaid system in Illinois does not pay for all prevention services. The preventive services Medicaid reimburses for in Illinois are "standard preventive evaluation and management (E/M) for adults" which include:

1) a family and social history and physical examination,

2) anticipatory guidance, risk factor reduction interventions and counseling,

3) ordering of immunizations and lab/diagnostic procedures, and

4) management of insignificant problems.

HFS will reimburse for a few other preventive services, but they are population specific and do not necessarily correspond to ICP. Therefore, they are not included in the analyses contained in this section.

Table 45 summarizes the prevention services the FFS system paid for in FY11 and compares this to claims paid by the MCOs in FY13. The cost per claim, claims per 1,000 member months, and cost per 1,000 member months all increased from FY11 to FY13 (see Table 45). Aetna and IlliniCare had similar rates of preventive service claims per 1,000 member months, although IlliniCare paid 15.7% more per claim than Aetna ($102.93 to $88.97).

Table 45: Preventive Service[1] Claims

ICP-Baseline vs. ICP-Year 2				
	ICP		ICP FY13 Detail	
Measure	FY11*	FY13	Aetna	IlliniCare
Cost per claim	$74.20	$96.02	$88.97	$102.93
Claims per 1,000 MM	7.5	8.7	8.6	8.8
Cost per 1,000 MM	$559.70	$835.88	$765.42	$906.76

ICP vs. FFS Comparison				
	ICP Group		FFS Comparison group	
Measure	FY11-FFS	FY13-MCO	FY11	FY13
Cost per claim	$74.20	$96.02	$71.08	$81.29
Claims per 1,000 MM	7.5	8.7	3.3	4.5
Cost per 1,000 MM	$559.70	$831.44	$232.99	$362.06

Data Source: MCO Special Datasets, *HFS Baseline Encounter Data (covers July 2010-Mar 2011)
1 CPT codes: 99385, 99386, 99387, 99395, 99396, and 99397

Other Prevention Services

In their contracts with the state, there were six (6) prevention outcome measures that the MCOs were responsible for:

1. Care Coordination Influenza Immunization Rate (CCI);
2. Colorectal Cancer Screening (COL);
3. Breast Cancer Screening (BCS);
4. Cervical Cancer Screening (CCS);
5. Adult BMI Assessment (ABA); and
6. Glaucoma Screening (GSO).

HSAG reviewed two of these measures (CCI and CCS) as part of their review of the ICP quality review for 2013. For CCI (influenza immunization), the baseline rate was 9.92% (percentage of members 19 years and older who received at least one influenza immunization). During 2013, Aetna's rate was 13.08%, while IlliniCare's rate was 10.72%. For cervical cancer screening (CCS), the baseline rate was 40.81% (percentage of women 21-64 years of age who received one or more Pap tests to screen for cervical cancer). Rates for both Aetna and IlliniCare declined as compared to the baseline rate. Aetna's 2013 rate was 31.87% and IlliniCare's 2013 rate was 37.55%.

According to HFS, the other 4 prevention outcome measures "all require continuous enrollment for the measure year and the year prior with no more than one gap during each year. No members met this

requirement for the first year (2013) of reporting on CY2012 data." It is expected that results for these other prevention measures will be reported in the future as appropriate.

Consumer Experiences

Preventive services can also be as simple as having conversations with a physician and being weighed. The consumer survey also includes a series of six questions, including:

1) whether a person and their doctor discussed healthy eating,
2) whether a person and their doctor discussed exercise or physical activity,
3) whether a person and their doctor discussed emotional or behavioral health,
4) whether a person and their doctor discussed birth control or family planning,
5) whether a person and their doctor discussed prevention of sexually transmitted diseases (STDs), and
6) whether the patient was weighed by the physician's office.

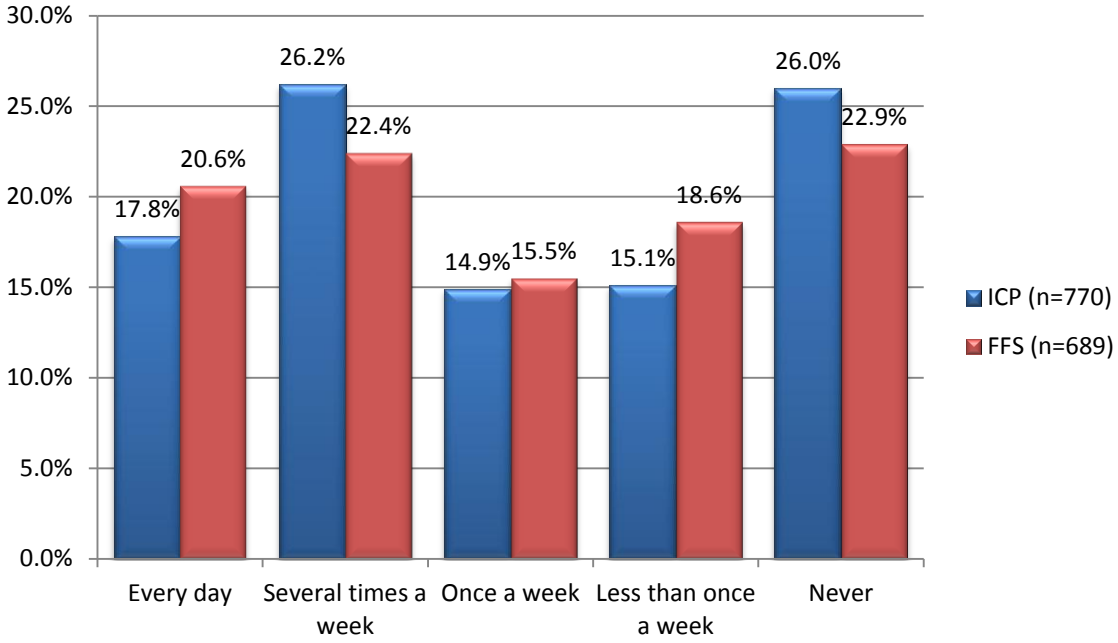
Together, these are known as preventive counseling services and Appendix B provides more detailed analysis of that variable. Regression analysis showed that for people who completed the survey after the second year of ICP, there were no statistically significant differences between people in ICP and those receiving FFS for the number of preventive counseling services received. However, in both ICP and FFS, people with mental health disabilities received significantly more preventive services than people without (p=.003; 3.06 to 2.68).

People of Hispanic origin also reported receiving more preventive counseling services than people who were not of Hispanic origin (p=.042; 3.03 to 2.77). It should be noted that the average number of preventive counseling services received was only 2.77 out of a possible 6, so most people did not receive half of those services.

In the second round of focus groups, Care Coordinators for the MCO's noted that prevention was important to them. They encouraged members to exercise and give them information on improving their diet. The consumer survey asked people about the frequency of their exercise (Figure 10). Regression analyses did not show any significant differences between ICP and FFS for the frequency of exercising after controlling for demographic variables. The responses are fairly evenly distributed across the range of possible answers.

In summary, the MCOs increased spending for "standard preventive evaluation and management (E/M) for adults" as compared to the FFS period prior to the ICP. For two special prevention outcome measures, the MCOs showed improvement for one of the measures and decline for the other prevention measure. In the consumer surveys, members did not report an increase in preventive counseling.

Figure 10: How often do you exercise? (FY13)



F. Radiology

Utilization of advanced technology and high-cost diagnostic imaging has increased substantially over the past decades. This growth can be attributed to various factors such as aging populations, advances in imaging technology, that radiology is required to help identify a clinical condition, availability of the technology and the increasing number of radiologists. If used to pro-actively identify and treat expensive conditions in their early stages, these tests could save money. However, the increased use of these imaging technologies could have the opposite effect and contribute to increasing health care cost. This section reports the use of three types of high cost imaging (i.e., MRI, PET, and CT) before and after ICP implementation.

Table 46 displays radiology claim data for ICP in FY11 and FY13, as well as detailed radiology claim data for the two ICP MCOs in FY13. The number of radiology claims per 1,000 MM, costs per 1,000 MM, and costs per radiology claim all increased in the ICP from FY11 to FY13. IlliniCare's figures for these measures are all higher than Aetna's, including the cost per 1,000 member months, ($21,270.23 for Aetna versus $11,265.77 for IlliniCare).

In the comparison group of people receiving FFS Medicaid in Chicago, there was a slight decrease in in the number of claims per 1,000 member months (51.0 versus 49.3) and cost per 1,000 member months ($4812.27 versus $4708.17).

Table 47 describes the number of radiology services per 1,000 member months for MRI, PET, and CT services, which are the most common radiology services. Again, the rate of each service per 1,000

member months increased from FY11 to FY13. Aetna used MRI and PET more frequently than IlliniCare, while IlliniCare used more CT scans.

Table 46: Radiology Claims

ICP-Baseline vs. ICP-Year 2				
	ICP		ICP FY13 Detail	
Measure	FY11*	FY13	Aetna	IlliniCare
Cost per claim	$91.33	$201.98	$153.69	$242.60
Claims per 1,000 MM	60.3	80.5	73.3	87.7
Cost per 1,000 MM	$5,504.42	$16,253.24	$11,265.77	$21,270.23

ICP vs. FFS Comparison				
	ICP Group		FFS Comparison group	
Measure	FY11-FFS	FY13-MCO	FY11	FY13
Cost per claim	$91.33	$201.98	$94.28	$95.46
Claims per 1,000 MM	60.3	80.5	51.0	49.3
Cost per 1,000 MM	$5,504.42	$16,253.24	$4,812.27	$4,708.17

Data Source: MCO Special Datasets, *HFS Baseline Encounter Data (covers July 2010-Mar 2011)

Table 47: Types of Radiology Used

	ICP		ICP FY13 Detail	
Measure	FY11*	FY13	Aetna	IlliniCare
MRI per 1,000 MM	12.86	15.11	15.73	14.49
PET per 1,000 MM	0.74	0.99	1.06	.92
CT per 1,000 MM	46.67	64.36	56.51	72.27
Total Radiology per 1,000 MM	**60.27**	**80.47**	**73.30**	**87.68**

Data Source: MCO Special Datasets, *HFS Baseline Encounter Data (covers July 2010-Mar 2011)

In summary, the rate of radiology use increased over the two years for both the ICP and FFS groups. However, the costs of radiology services increased in the ICP program but not in FFS.

G. Pharmacy

In order to track changes in pharmacy utilization, the UIC research team requested a special dataset from each MCO listing all pharmacy claims for FY13. This dataset permitted the team to track the number of scripts and amount of medications (days supply), cost, drug formulary interactions, and prior authorization outcomes for all claims.

Supply of Medications

Table 48 indicates that the proportion of members who generated pharmacy claims (of all members) increased from 77.7% of the members in FY11 (prior to the ICP beginning) to 79.8% by Year 2 of the ICP. The number of scripts per 1,000 member months increased by almost 14%, from 3,783.3 in FY11 to 4,332 in FY13.

While the average days' supply per script only increased slightly (from 25.8 days to 25.9 days), the overall days' supply per 1,000 member months increased by slightly more than 14%, largely due to higher number of utilizing members and scripts per 1,000 member months. The measures between the MCO's are very similar, although a slightly higher percent of IlliniCare's members utilize pharmacy services. However, Aetna had more scripts per 1,000 member months, days' supply per script, and days' supply per 1,000 member months.

The bottom portion of Table 48 compares the change in the ICP group for the two years with the change in the FFS comparison group during the period of FY11 to FY13 for the same two years. Similar to the ICP group, the comparison group's proportion of members that utilized pharmacy services also increased from FY11 to FY13 (79.3% to 80.2%). But unlike the ICP group, the number of scripts per 1,000 member months decreased by 27% for the comparison group (compared to a 14% increase for the ICP group). Overall, the days' supply of medications per 1,000 member months fell by about 23% while the ICP group saw an increase of 14%. Part of this may be due to restrictions placed on FFS members through the SMART Act.

Table 48: Supply of Medications

ICP-Baseline vs. ICP-Year 2				
	ICP		ICP FY13 Detail	
Measure	FY11-FFS	FY13-MCO	Aetna	IlliniCare
% Utilizing members	77.7%	79.8%	76.6%	78.3%
Scripts per 1,000 MM	3,783.3	4,332.0	4,438.7	4,224.6
Days' supply per script	25.8	25.9	26.7	25.1
Days' supply per 1,000 MM	97,752.1	112,220.9	118,377.4	106,0287.1

ICP vs. FFS Comparison				
	ICP		FFS Comparison	
Measure	FY11-FFS	FY13-MCO	FY11	FY13
% Utilizing members	77.7%	79.8%	79.3%	80.2%
Scripts per 1,000 MM	3,783.3	4,332.0	3,899.5	2,836.4
Days' supply per script	25.7	25.9	25.7	27.1
Days' supply per 1,000 MM	97,752.1	112,220.9	100,022.1	76,831.1

Data Source: MCO Special Datasets, HFS Baseline Encounter Data

Costs

Table 49 shows the costs of the pharmacy claims and that the average cost per script for the ICP group declined by 18% from the baseline to Year 2 ($73.29 to $61.06) while the cost per 1,000 member months decreased by about 5% ($277,259 to $264,516).

Similar to the ICP group, the average cost per script for the FFS group (bottom portion of Table 49) but by a much smaller percentage than for the ICP group (2.2% decrease for the FFS group vs. about 18% decrease for the ICP group). The average cost per 1,000 member months for the comparison group

decreased by almost 29%, which is substantially greater than the 5% decrease reported for the ICP group for the same two-year period. Much of this larger decrease can be attributed to the decrease in days' supply for the comparison group as compared to the ICP group, as discussed above.

Table 49: Cost of Medication

ICP-Baseline vs. ICP-Year 2				
	ICP		ICP FY13 Detail	
Measure	FY11-FFS	FY13-MCO	Aetna	IlliniCare
Cost per script	$73.29	$61.06	$60.78	$61.36
Cost per 1,000 MM	$277,259	$264,516	$267,783	$259,218

ICP vs. FFS Comparison				
	ICP		FFS Comparison	
Measure	FY11-FFS	FY13-MCO	FY11	FY13
Cost per script	$73.29	$61.06	$72.40	$70.75
Cost per 1,000 MM	$277,259	$264,516	$282,321	$200,668

Data Source: MCO Special Datasets, HFS Baseline Encounter Data

Table 50 shows the difference in utilization of pharmacy services after matching the ICP and FFS groups (for more information on this method, see page 18). After matching the samples, utilization of pharmacy services (standardized in terms of dollars per person per month) did not significantly change between the ICP and FFS groups. The ICP program appears to have had little effect on utilization of pharmacy services.

Table 50: Matched Pre and Post Differences in Utilization of Pharmacy Services

	Pre	Post	Change
Chicago FFS	$421.95	$194.98	-$226.97
ICP	$278.16	$65.15	-$213.02
Treatment Effect			-$13.95

Difference is not significant

Drug Formularies

HFS maintains a preferred drug list (PDL) that groups drugs by major drug classifications and then splits specific drugs in those groups between "preferred" and "non-preferred" drugs. For drugs not on the PDL, there is a "drug search engine" that a provider can use to determine if the drug is a "preferred" one or not. HFS maintains a website to permit providers to obtain the latest of status of drugs.

According to the HFS website related to the PDL, HFS uses a process to maintain and update the PDL that "ensures that HFS's PDL is developed based on safety, effectiveness, and clinical outcomes. If these factors indicate no therapeutic advantage among the drugs being considered in the same drug class,

then HFS considers the net economic impact of such drugs when recommending drugs for inclusion in the PDL...HFS contracts with the University of Illinois at Chicago (UIC) College of Pharmacy to perform a clinical review of products within the classes being reviewed."

The HFS website further explains that "upon receipt of the clinical recommendations, the department, in consultation with pharmacologists, pharmacists, and physicians, develops its PDL recommendations taking into account both clinical and cost factors. Those recommendations are then presented to the Illinois State Medical Society Committee on Drugs and Therapeutics D and T Committee, a committee comprised of practicing physicians representing various specialties who actively participate in the Medicaid Program. The D and T Committee's review and recommendations are based on evidence-based clinical information, not cost."

Both MCOs maintain preferred drug listings online for their members. This listing lists the drug's reference name, common brand name, and any requirements or limits. Members or providers can also search through the listing or download it for further use.

Overall, 97.3% of the scripts written in second year of the ICP were for medications on the formularies of the MCOs (see Table 51). Of all scripts written, 86.5% were for generic versions of the medication, which is an increase from the rate (80.0%) reported for the FFS claims for the baseline period. Data on the number of medications on the drug formulary was not available for any of the FFS groups: ICP baseline or Chicago comparison.

In terms of prior authorization, only 2.4% of the scripts written against the MCO's formulary needed a prior authorization while 86.5% of the medications prescribed that weren't on the approved formulary needed prior approval.

Table 51: Formulary

Drug Formulary	ICP		ICP FY13 Detail	
	FY11	FY13	Aetna	IlliniCare
% of scripts on formulary		97.3%	96.8%	97.8%
Prior Authorization (PA)				
Scripts on drug formulary needing PA		2.4%	1.3%	3.5%
Scripts NOT on drug formulary needing PA		86.0%	83.2%	89.8%
Generic vs. Brand name				
% of all scripts that were generic	80.0%	86.5%	86.0%	87.0%

Data Source: MCO Special Datasets, HFS Baseline Encounter Data

Prior Authorization

As of July 22, 2013 through the SMART Act, prior authorization requests are required for members who want to fill more than 4 prescriptions in a 30-day period. (The former policy required prior authorization for more than 5 prescriptions.) According to HFS, "The purpose of the four prescription policy is to have providers review their patients' entire medication regimen and where possible and clinically

appropriate, reduce duplication, unnecessary medications, polypharmacy, etc. The four prescription policy was developed as a result of budget negotiations, but best-practices call for an annual review of the full regimen of prescriptions for any patients." The MCOs did not implement the four prescription policy for ICP members but instead used their own prior approval process.

Drug Prior Approval requests may be submitted via:

1) Fax to the Drug Prior Approval Hotline
2) Call to the Drug Prior Approval Hotline
3) Entering Data into the Drug Prior Approval/Refill Too Soon Entry System through HFS' Medical-Electronic Data Interchange (MEDI) System

According to the HFS Drug Utilization Board, over 30,000 prior approval requests are processed each month in FFS Medicaid. FFS Medicaid and reported that they received 475,000 requests for prior authorization of pharmacy services in FY13. Of those, approximately 60% were approved. FFS Medicaid did not provide data on how many of those requests were expedited, how long it took to make decisions, and the number of member months (which is needed to compare request rates.

The contracts between the MCOs and the state define two different types of prior authorization requests, standard and expedited. A member or provider may request that the request be marked as "expedited" in order to receive a decision quicker. Slightly less than 20% of the requests to the MCOs were marked as "expedited" (see Table 52).

Table 52: Pharmacy Requests (FY13)

Measure	Total ICP	Aetna	IlliniCare
# of total requests	11,371	4,624	6,747
% Standard	81.2%	73.6%	86.4%
% Expedited	18.8%	26.4%	13.6%
Standard Requests			
% Approved	55.0%	56.2%	54.4%
Mean number of days to decision	1.3	2.6	0.57
% decided within 10 days	99.4%	99.9%	99.0%
Expedited Requests			
% Approved	62.3%	57.5%	68.8%
Mean number of days to decision	.85	1.0	0.64
% decided within 1 day	92.0%	93.7%	89.8%

Data Source: MCO Special Datasets

Nearly twice as many of Aetna's pharmacy requests were expedited as compared to IlliniCare's (26.4% to 13.6%). 55% of standard requests were approved and over 62% of expedited requests were approved. These rates are similar to the approval rate for the FFS system discussed previously. MCO's have 10 days to decide whether to approve a standard request and one day to approve or deny an expedited request. Aetna made a decision on standard requests in an average of 2.6 days and 1.0 days

for expedited requests; IlliniCare was slightly faster at 0.57 and 0.64 days, respectively. This data was not available for the ICP baseline or for the Chicago comparison group in FY13.

In summary, the MCOs decreased pharmacy costs despite an increased number of prescriptions. FFS Medicaid decreased the number of prescriptions and decreased pharmacy costs.

H. Movement from setting to setting

One of the quality of life performance measures listed in the contracts between the state and the MCOs requires the MCOs to track and report on members who move between various living settings. Specifically, the measure entitled "Movement of members between Community, Waiver and LTC Services (MWS)" stipulates that the MCO will "report number of members moving from: institutional care to waiver services, community to waiver services community to institutional care and waiver services to institutional care. (Exclude institutional stays < 90 days)." It is not specified in the contract how often and in what manner the MCOs will report these movements. HFS did not provide any data related to this measure.

However, it was possible to track members as they moved from one capitation cell to another. Table 53 lists the number of members in each cell at the beginning of FY13 (July 2012) and the number at the end of the year (June 2013). The number of members in the three long term care cells decreased during the year. The number of people in the DD waiver also decreased while the "Waiver-Other" and "community" cells increased.

Another reason for/type of movement is it a member loses eligibility for ICP. This could happen for a number of reasons, including gaining eligibility for Medicare, no longer meeting income requirements, or death.

Table 53: Snapshot of Capitation Cells for FY13

Description	Begin (July 2012)	End (June 2013)	Net Change	% Change
Community ICF/MR (W7035)	423	397	-26	-6.1%
State ICF/MR (W7036)	258	246	-12	-4.7%
Nursing Home (W7037)	2,734	2,535	-199	-7.3%
DD Waiver (7038)	1,723	1,715	-8	-0.5%
Non DD Waiver (7039)	2,848	2,909	61	2.1%
Community residents (W7040)	27,191	27,640	449	1.7%
TOTAL members	**35,177**	**35,442**	**0.8%**	**0.8%**

Data Source: Capitation Payments Dataset from HFS

In addition, the data in Table 53 and 54 have a number of cautions that accompany it:

- the data is based on payment of capitation cells, and payments sometimes lag behind member movements;
- the criteria for cell whole movement is not always identical to setting movement;
- the cells are broadly defined and can include several different kinds of settings.

Table 54: Summary of Cell Movements (FY13)

From	To	#
Long Term Care Setting	Waiver	32
	Community	163
	Other LTC Setting	5
	Total	200
Waiver	Community	220
	LTC Setting	67
	Other Waiver	6
	Total	293
Community	LTC Setting	260
	Waiver	528
	TOTAL	788

Data Source: MCO Special Datasets

Table 54 lists the number of movements from the three main types of rate cells: 1-Long term care settings (community ICF/MR, state ICF/MR, and nursing homes); 2-Waiver (DD and other); and 3-Community residents. For example, in FY13 there were 200 rate cell movements out of long term care settings. Of those, 80% (163) were into the "community" cell group.

In summary, more people moved from the community into long-term care settings than moved from long-term care settings into the community. Therefore, rebalancing services and supports from long-term care settings to the community has not yet occurred.

I. Mortality

As part of this evaluation, UIC obtained data regarding member deaths for both the baseline period prior to the start of the program and during the first two years of the program. While raw data on mortality rates (i.e. date of death, cause of death, assigned plan) was not available for analysis by UIC, HFS provided summary statistics on the number of deaths for the ICP group as well as the Chicago comparison group and FFS members living in downstate Illinois. Table 55 compares the mortality rates of members who died in the 2 years prior to July 1, 2011 and those who died in the 2 years after.

Table 55: Mortality Rates per 1000 Before and After the ICP

Geography	2009 - 2011	2011 - 2013	Rate Change
ICP	47.4	46.4	-1.0
Chicago	43.5	45.6	2.1
Downstate	52.4	53.3	0.9

Data Source: Historical enrollment and deaths as known to the HFS enterprise data warehouse on 4/25/2014
*Age standardized to the July 1, 2011 statewide ICP-eligible population

The figures vary slightly by geographic groups in the mortality rates of members who died before the ICP and those who died once the program was underway for any of the three groups. Table 134 in Appendix A provides more detailed information on the number of deaths by specific age groups in the two time periods.

Section 3: What Impact has ICP had on costs to the State?

A. Questions about ICP and Costs

As the ICP was being developed, the state made certain assumptions about cost savings that the ICP would generate when compared to the traditional fee for service (FFS) system. The state encountered many unknowns that needed to be estimated in order to establish capitation rates. Estimates were made using historical claims experience and trends, anticipated changes in policy and other program parameters, and actuarial experience. In the following section, the research team reports the "estimates" made by the state made and potential limitations associated with them. Specifically, this section considers ten questions:

1) Prior to the ICP, what information did the state have regarding how FFS costs would change in the future?
2) Prior to the implementation of the ICP, what projections did the state make regarding cost savings that would be generated by the ICP?
3) How were the initial capitation rates for the ICP calculated?
4) How have capitation rates changed since the start of the ICP?
5) What are the estimated changes in FFS costs for non-ICP members in the regular Medicaid program during the first two years of the ICP?
6) Since the implementation of the ICP, what subsequent attempts has the state made in estimating cost savings associated with the ICP?
7) What were the estimates of what the likely FFS costs for Service Package 1 would have been for the ICP members if the ICP had not been implemented?
8) To what extent have the MCOs met the contractual requirement to spend at least 88% of their revenue on member benefits and services?
9) To what extent have the MCOs earned any of the payments they are eligible to receive for meeting the "pay for performance" quality measures?
10) Is it possible to reliably determine whether the ICP has thus far generated cost savings for the state?

This section summarizes UIC's findings, focusing on Service Package 1 services, since this was the only one of the three service packages that was fully implemented in fiscal year 2013. In those cases where attention is devoted to the other service packages, it is noted.

1. Prior to the ICP, what information did the state have regarding how FFS costs would change in the future?

Prior to the start of the ICP, the state hired Milliman, Inc. to analyze actual FFS costs for ICP eligible members and to calculate capitation rates to be used for the ICP. In November of 2010, Milliman published the data supporting the original capitation rates for the ICP. As part of this process, Milliman used a "trend factor" to adjust the rates for what the past claim history had been for this group. Milliman used claim history for the period of FY07 through FY09 and projected that overall costs for Service Package 1 services would likely increase by about 11.1% for the period from July 1, 2008 to April 1, 2012. This calculates to an approximate annual increase of 3.4% per year.

2. Prior to the implementation of the ICP, what projections did the state make regarding cost savings that would be generated by the ICP?

In a press statement prior to the implementation of the ICP, the state predicted savings of about $200 million for the first 5 years of the program. Table 56 summarizes information regarding anticipated cost savings publicized by the state prior to implementation of the ICP.

Table 56: Initial Cost Projections made by the State

Item	Description
Projected savings	The savings/cost avoidance estimates over the five-year contract were estimated at nearly $200 million
Capitation rates	Capitation rates were to be set for the plans at 3.9% below what was otherwise estimated would have been spent on care for the members
Projected first year of program	Scheduled for October 2010 through September 2011; start delayed to May 2011
Projected initial enrollment in ICP	413,676 member months (equal to 34,473 full time members)

3. How were the initial capitation rates for the ICP calculated?

The state hired Milliman, Inc. to develop capitated rates that the state would pay to the MCOs to provide necessary services and care for members in the ICP. Essentially, Milliman used a 5-step process to calculate the original 6 rate cells for the ICP. These steps were:

1) Utilize historical experience for the target population to establish historical utilization, cost per service, and per member per month values by capitation rate category
2) Develop and apply anticipated medical trend rates by category of service to calculate estimated future expenditures
3) Develop and apply policy and program adjustment factors to reflect changes either implemented or to be implemented
4) Develop and apply estimated changes in utilization and cost per service due to management of health care services
5) Include an administration and risk load for the health plan to perform managed care services.

4. How have capitation rates changed since the start of the ICP?

Capitation rates for the ICP rate "cells" are typically recalculated on an annual basis. At the end of Year 1, starting on May 1, 2012, the rates for all capitation cells increased slightly from Year 1, but due to different projected utilization for the cells for the upcoming year, the overall composite rate for Service Package 1 increased by less than $1. The capitation rates were adjusted for a second time, effective 3/1/2013, the first change in rates since the SMART Act took effect on 7/1/2012. Table 57 summarizes the initial rates for the ICP and the two subsequent rate changes.

Table 57: Changes in Capitation Rates (Service Package 1 Only)

Rate Cell	Changes in Capitation Rates[1]		
	Rate #1 (Effective 5/1/2011)	Rate #2 (Effective 5/1/2012)	Rate #3 (Effective 3/1/2013)
Community	$971.35	$985.35	$890.59
DD Waiver	$741.85	$753.06	$655.70
ICF/MR	$875.54	$891.55	$832.52
Nursing Facility	$2,126.65	$2,146.33	$1,773.44
Other Waiver	$1,704.16	$1,726.74	$1,786.59
State Operated	$269.13	$269.71	$117.66

[1] SMART Act Effective 7/1/2012

Table 58 provides more detail on the rate changes that took place effective 3/1/2013. These changes took into account several factors including changes made by the SMART Act, updated claims data that the state had received, utilization changes , and other Medicaid policy and program changes. Even though the SMART Act took effect for the FFS program on 7/1/12, it did not take effect until 4/1/13 for the ICP. In addition, the MCOs were given some flexibility in terms of what SMART Act changes they were required to implement and when (for more detail on the SMART Act, see page 21.

Table 58: SMART Policy and Program Changes Effective April 1, 2013[1] (Service Package 1 only)

Rate Cell	Projected 2013 Member Months	Current Capitation Rate[2]	Proposed Capitation Rate[3]	% Change	$ Change
Community	281,631	$985.35	$890.59	-9.6%	($26,680,000)
DD Waiver	17,730	$753.06	$655.70	-12.9%	($1,720,000)
ICFMR	2,893	$891.55	$832.52	-6.6%	($170,000)
Nursing Facility	9,174	$2,146.33	$1,773.44	-17.4%	($3,420,000)
Other Waiver	29,158	$1,726.74	$1,786.59	3.5%	($1,740,000)
State Operated	1,477	$269.71	$117.66	-56.4%	($230,000)
Composite	**342,064**	**$1,063.76**	**$974.65**	**-8.4%**	**($30,480,000)**

[1] This table is extracted from Enclosure 1 in Milliman's document entitled "March 1, 2013 Service Package 1 Capitation Rates-Integrated Care Program-V2", dated March 18, 2013. It covers original 6 county ICP area ("collar counties") and includes only Service Package 1.
[2] Rate effective from 5/1/2012 through 2/28/2013
[3] Rate effective 3/1/2013

Table 58 indicates that all but one of the individual rate cells decreased from the previous rate. In fact, for all of the capitation cells except for the “Waiver-Other” cell, the rates for the new rate cells are lower than the rate cells were for the start of the ICP two years earlier. Overall, the composite rate for Service Package 1 that took effective in March of 2013 was 8.4% lower than the composite rate for the previous rates.

Table 58 also indicates that if the enrollment within each of the capitation cells stayed constant, the new rates implemented on 3/1 would result in a reduction of $30.5 million in payments from the state to the MCOs for the 10 months remaining on the current contract (3/1/13 through 12/31/13). According to Milliman, about half of this rate decrease can probably be attributed to the effect of the SMART Act, which went into effect on July 1, 2012, 8 months earlier.

5. What are the estimated changes in FFS costs for non-ICP members in the regular Medicaid program during the first two years of the ICP?

The ICP started on May 1, 2011. A little more than one year later, on July 1, 2012, legislation called "Save Medicaid and Resources Together (SMART)" was implemented. The SMART Act generally reduced provider rates and placed limitations or restrictions on many Medicaid services. Even prior to the SMART Act, costs for Service Package 1 seemed to be declining for the ICP population immediately prior to implementation of the ICP. For example, Milliman had calculated the average costs of claims for Service Package 1 for ICP members for the years of FY08 through FY11 in their two databooks of 2010 and 2013. The composite PMPM cost in FY08 for Service Package 1 services had been calculated to be $1,026.75; by FY11 it had dropped to $974.75, an annual decrease of almost 1.7% over 3 years.

To determine how the SMART Act and other state actions had impacted FFS claims for ICP-eligible members during the first two years of the ICP, UIC received a FFS claims dataset for the 3 years of FY11 through FY13 for Medicaid members living in Chicago who met the criteria for the ICP but remained under the FFS system because they lived in Chicago.

Initial results indicated that FFS costs for Service Package 1 for the Chicago group had decreased by about 13% from FY11 to FY13. However, in consulting with Milliman, the research team became aware that there were two major adjustments that needed to be made. Due to substantial changes in enrollment of members with varying levels of disability across the 3 years, normalization of the member enrollment within specific rate cell groups was necessary to minimize cost differences due to different mixes of members between FY11 and FY13. Results indicated that this adjustment added approximately $25 per member per month to the FY13 PMPM.

A second needed adjustment for the FFS comparison group was to account for any lagging claims that were not yet in the dataset as these claims would further increase costs for FY13 when they are eventually submitted for payment. Although the claim dataset for the comparison group was run approximately 9 months after the end of FY13, the team was informed by HFS that it was likely that there were still some claims not yet included in the dataset. In reviewing lag times for the other FFS claims for FY11 and FY12, the team roughly estimated the number and amount of likely claims still outstanding and made the adjustments to the FY13 rate for the comparison group. This adjustment added approximately another $20 to the FY13 PMPM.

Making these two rough adjustments caused the drop in average member costs for Service Package 1 services from FY11 to FY13 for people in the FFS comparison group to be about 9% (compared to the unadjusted figure of about 13%). This estimated decrease of 9% in the costs for the FFS comparison group from FY11 to FY13 is still only a rough estimate of the "real" change given the limitations of the available data at this time.

6. Since the implementation of the ICP, what subsequent attempts has the state made in estimating cost savings associated with the ICP?

HFS completed an informal projection of cost savings for the ICP in FY14. While state officials considered several approaches in estimating "likely" costs that would have been incurred under the FFS in the absence of the ICP, they finally settled on what can be termed the "premium discount" approach (see Table 59). This approach assumes that capitation rates for Service Package 1 services have been maintained at a level at least 4% below what the likely corresponding FFS costs would have been (similarly 2% below similar costs for Service Package 2 services).

Overall, in FY14, for the entire ICP, the state projected that it will make payments of about $1.14 billion to the MCOs for 478,995 months of coverage of services for Service Packages 1 and 2. This is compared to $1.18 billion in "likely" FFS costs that HFS estimated it would have incurred in the traditional FFS system if the ICP would not have been implemented. If these assumptions are correct, the state will realize a savings of about $40 million for Service Packages 1 and 2 in FY14 for the entire ICP area.

Since the HFS projection was for the entire expanded ICP, the UIC team pulled data specifically for the original ICP demonstration area to develop an estimate of the savings which will be achieved for the original 6 county ICP area, using the original HFS assumptions. Table 59 indicates that in FY14, using the same HFS assumptions, the ICP will save the state slightly more than $20 million for Service Package 1 services for the original ICP 6 county area.

Table 59: HFS Projection of Savings By ICP for FY14

Description	Projected Capitated Payments	Estimated FFS Costs [1]	Estimated Savings
Entire ICP (6 county & expansion) and Service Packages 1 & 2	$1,140,841,458	$1,181,353,959	$40,512,501
Original 6 county and Service Package 1 only [2]	$483,209,386	$503,343,110	$20,133,724

[1] HFS assumed that capitated rates for SP1 would be 4% lower than what corresponding FFS rates would have been (rate for SP2 was assumed to be 2% below FFS costs)
[2] UIC used HFS data and scaled it to the original ICP area and SP1 only.

7. What were the estimates of what the likely FFS costs for Service Package 1 would have been for the ICP members if the ICP had not been implemented?

In question 5 the research team reviewed and estimated changes in costs for Service Package 1 services for the FFS control group during the period of FY11 to FY13. Another important question that the team considered is what the estimates of likely costs for Service Package 1 would have been for the actual ICP members in the absence of the ICP.

Table 60 summarizes 2 scenarios that were used to estimate the likely costs of Service Package 1 services for the ICP group in FY13 in the absence of the ICP. The two scenarios are based on assumptions and trends known prior to the implementation of the ICP.

Table 60: Possible Scenarios to Estimate Likely FFS Costs (FY13)
(Service Package 1 services in the absence of the ICP)

#	Scenario Name	Description	Calculation of "likely" FFS costs	FFS PMPM Estimate
1	HFS Premium Discount trend	Assumes that capitation rates would have been maintained at a level that was 4% less than corresponding FFS costs.	FFS costs = Composite Capitation Rate For FY13 ($1,068.16) divided by .96	$1,112.67
2	Pre-ICP Milliman 39 month trend rate	Assumes that FFS costs would have increased at the same annual rate (3.4%) as Milliman had projected costs would increase for the period of July 2008 to October 2011	FFS costs =FY11 Rate ($974.75) trended forward by the annual pre-ICP rate of 3.4% for the 2 year period	$1,042.16

A. Prior to the implementation of ICP, what estimates of <u>likely FFS costs</u> could have been made for the ICP population?

Table 60 summarizes two scenarios the team considered for calculating likely costs that HFS would have incurred for the ICP members in the absence of the ICP. The first scenario is based on the previously discussed method that HFS used to estimate cost savings for the ICP in FY14 and assumes that capitation rates in effect for Service Package 1 services in FY13 would have been 4% lower than what corresponding FFS costs would have been for the same members (see previous sub-section).

Scenario #2 uses the pre-ICP trend rate that Milliman used to develop the initial ICP capitation rates for Service Package 1. Milliman used historical FFS data from the period of July 2006 through June 2009 and projected that costs would increase by 11.1% for the 39-month period of July 2008 to October 2011 (the projected midpoint of the first year of the ICP). The 11.1% increase for this period calculates to an approximate annual rate of increase of 3.4% and is used for Scenario #2 in Table 60. Table 61 estimates the total costs associated with each of these scenarios.

Table 61: Likely FFS Cost Estimates Prior to ICP (FY13)
(Service Package 1 services in the absence of the ICP)

Possible Scenarios for "likely" FFS Service Package 1 costs in absence of ICP	Likely FFS PMPM	Enrollment Months	SP1 Costs
1-HFS Premium Discount	$1,112.67	424,440	$472,261,655
2-FY07-09 pre-ICP Trend	$1,042.16	424,440	$442,334,390

The estimate of costs for Service Package 1 services for the first two scenarios range from $442.3 million to $472.3 million (see Table 61).

8. To what extent have the MCOs met the contractual requirement to spend at least 88% of their revenue on member benefits and services?

The contract between the MCOs and the state specifies that each MCO will spend at least 88% of the revenues it collects each year on member "benefit expenses." If the MCO fails to do so, it has to refund the difference to the state.

The state and the MCOs have calculated the MLR for calendar year (CY) 2011 and 2012 and determined the amount of refunds due to the state (see Table 62). In CY11, the MCOs refunded the state a total of over $11.5 million while the amount refunded in CY12 was almost $26.3 million. For more detail on expenses paid by the MCOs in both years, see Tables 136-137 in Appendix A.

Table 62: Medical Loss Ratio (first 2 calendar years of ICP)

Item	CY11	CY12	TOTAL
Member Months	159,692	422,795	582,487
Total Revenue for MCOs	$165,908,245	$462,774,051	$628,682,296
Total Expenses for MCOs	$134,331,859	$380,943,381	$515,275,240
Medical Loss Ratio	81.0%	82.3%	82.0%
Refund due to State	**$11,574,848**	**$26,297,784**	**$37,872,632**

The UIC team obtained additional cost detail from HFS that was used to calculate the Medical Loss Ratio (MLR) for CY12 which is summarized in Table 63. For example, the state made total capitated payments in CY12 of $462.8 million to the 2 MCOs but received approximately $26.3 million in refunds back from the MCOs for failure to meet the MLR minimum. As a result of the MLR refunds by the MCOs back to the state, the net cost of the ICP in CY12 to the state was about $436.5 million (this figure does not account for any refunds that the MCOs made to the state for P4P measures that were not met).

Table 63 indicates that MCOs paid out about $348.7 million in claims to regular providers, made $23.7 million to capitated providers for other member benefits (i.e. transportation, behavioral health, dental, nursing home), spent $8.4 million for care coordination, and $55.5 million for general plan administration.

Table 63: Spending for ICP (total $) (January thru December 2012)

Item	Aetna	IlliniCare	TOTAL
Member Months	213,916	208,879	422,795
Capitated Payments by State			
Payments made to MCOs	$238,772,518	$224,001,533	$462,774,051
Refund from MCOs for MLR	-$13,749,179	-$12,548,605	-$26,297,784
Net Cost to State [1]	$225,023,339	$211,452,928	$436,476,267
Spending by MCOs			
Total claims [2]	$184,602,609	$164,122,497	$348,725,106
Other member benefits [3]	$7,606,985	$16,114,852	$23,721,837
Care Coordination	$4,161,042	$4,335,394	$8,496,436
Plan administration	$28,652,702	$26,880,184	$55,532,886
Net Spending by MCOs	$225,023,339	$211,452,927	$436,476,266

[1] Does not include adjustment for any refund made by MCOs for P4P
[2] Includes incurred but not yet paid claims
[3] This category includes primarily payments made by MCOs to capitated providers to provide services to members

Table 64 converts the total dollar figures in Table 63 to monthly costs per member. For example, both MCOs spent about $20 per member per month on care coordination services.

Table 64: Spending for ICP (PMPM) (January thru December 2012)

Item	Aetna	IlliniCare	TOTAL
Member Months	213,916	208,879	422,795
Capitated Payments by State			
Payments made to MCOs	$1,116.20	$1,072.40	$1,094.56
Refund from MCOs for MLR	-$64.27	-$60.08	-$62.20
Net Cost to State[1]	**$1,051.92**	**$1,012.32**	**$1,032.36**
Spending by MCOs			
Total claims[2]	$862.97	$785.73	$824.81
Other member benefits[3]	$35.56	$77.15	$56.11
Care Coordination	$19.45	$20.76	$20.10
Plan administration	$133.94	$128.69	$131.35
Net Spending by MCOs	**$1,051.92**	**$1,012.32**	**$1,032.36**

[1] Does not include adjustment for any refund made by MCOs for P4P
[2] Includes incurred but not yet paid claims
[3] This category includes primarily payments made by MCOs to capitated providers to provide services to members

9. To what extent have the MCOs earned any of the payments they are eligible to receive for meeting the "Pay for Performance" (P4P) quality measures?

The state withholds 1% of the capitated payments from the MCOs and puts the funds in a "pool" for the P4P quality measures. In addition, the state supplements the pool with additional funding that is equal to 4% of capitation payments. Each year, the MCOs are evaluated as to whether they met the targets set for the quality measures. Thus if the MCOs fail to meet the targets, there could be a refund to the state from the MCOs.

Of the 11 measures, compared to the state's baseline at the start of 2012, Aetna improved on 10 of the 11 measures and IlliniCare improved on 4 of the measures. In terms of P4P results, Aetna "met" the P4P goal on 5 of the measures and IlliniCare met the P4P goal on 3 of the 11 measures. The state informed the UIC research team that Aetna will be receiving a P4P payment of $5.3 million for calendar year 2012. IlliniCare did not qualify for any P4P funds for 2012. For more specific details on performance measures and results for P4P, see page 85.

10. Is it possible to reliably determine whether the ICP has thus far generated cost savings for the state?

This section addresses the primary question on the minds of many people, "Has the ICP generated cost savings for the state?" The complications that the SMART Act introduces towards answering this question are discussed and then the findings are briefly summarized.

SMART Act greatly complicates the issue

Under typical situations, states have found it difficult to determine whether managed care initiatives have actually saved them money. The enactment of the SMART Act in Illinois approximately one year after the roll-out of the ICP makes the task even more complex, perhaps impossible. It is very challenging to untangle the savings the SMART Act has generated from the savings that the ICP has produced on its own.

Currently, the Illinois Medicaid system is undergoing a dramatic transformation. By 2015, at least half of `Medicaid members in Illinois are required to be in a "coordinated care" system of care. It is useful to review and compare the basic goals and infrastructure of the ICP and the SMART Act FFS systems (see Table 65).

Table 65: Comparison of Medicaid Systems

Component	SMART Act FFS System	Integrated Care Program (ICP)
Primary Goal(s)	Cut costs	Cuts costs and improve quality
Provider network	Uncoordinated array of providers	Coordinated network of providers
Quality assurances	Few outcome measures related to quality	Over 60 quality measures, some linked to monetary rewards
Impact on Costs	Costs for Service Package 1 FFS services have decreased by 12.9% for the comparison group.	Capitation rates for Service Package 1 services have decreased by 8.4%

The two systems are quite different. The primary goal of the SMART Act was to cut costs at a time when there was fear among some public officials that the entire Medicaid system might fail. During passage of the SMART Act, there was little focus on establishing quality assurance mechanisms in the legislation. Its primary goal was to cut costs and if the results of the comparison group are representative, the SMART Act has been successful in cutting FFS costs.

The ICP on the other hand has two primary goals: to cut costs and to improve quality of care for its members. To ensure there would be a balance between the two goals, the state put in place over 60

outcome measures related to quality. Cutting costs and improving quality at the same time is difficult and these goals can be competitive with each other.

At the time the ICP was being developed, the FFS typically was experiencing annual cost increases. The ICP was constructed in part to respond to and reverse these annual incremental increases. However, the enactment of the SMART Act, which was a cost cutting instrument, resulted in substantial cuts in costs and services. There is a question as to whether cost savings should be put in the context of the pre-SMART Act system or the current SMART Act FFS system. This will be a future area of focus for the research team.

Summary

1) In 2010, at the time that the state was developing the original capitation rates for the ICP, actuaries calculating the rates were projecting that average costs for Service Package 1 services would increase by an annual rate of about 3.4% during the 39-month period between July 2008 and October 2011.
2) Prior to the implementation of the ICP, the state predicted savings of about $200 million for the first 5 years of the program.
3) In December of 2013, the state projected that it would save $40.5 million for Service Package 1 and 2 services in the entire ICP (original and expanded regions) during FY14 (scaling this scenario to the original ICP counties and to Service Package 1 generated $20.1 million in savings).
4) It appears that costs decreased from FY11 to FY13 for Service Package 1 services for Medicaid members living in Chicago who met the criteria for the ICP but remained under the FFS system. It is not possible at this time to identify the specific amount of the decrease but it is likely the decrease was about 9% for the two year period.
5) Approximately 8 months after the SMART Act was enacted, capitation rates for Service Package 1 were reduced by an overall average of 8.4%--however, this reduction is not necessarily related to the previously noted decrease on FFS costs for the FY11-13 period.
6) The MCOs have spent an average of 82% of their revenues on member “benefits” for the first two years of the ICP compared to a minimum medical loss ratio requirement of 88%. This has resulted in a refund of almost $38 million back to the state from the MCOs for the first two years of the ICP ($11.6 million in CY11 and $26.3 million in CY12).
7) For the first year of the “Pay For Performance” (P4P) program (calendar year 2012), Aetna earned approximately $5.3 million in payments while IlliniCare did not earn any of the P4P payments.

Section 4: How does ICP handle critical incidents and ensure quality?

A. Critical Incidents

A critical incident is a report or observation of neglect, abuse, exploitation, or other issue such as death, potential fraud, violence, or threat of violence. A critical incident is typically reported in one of two ways: a provider may report a critical incident to the MCO, or a care coordinator may observe an issue that requires reporting to law enforcement, OIG, or Adult Protective Services. Examples of critical incidents include, but are not limited to, a personal assistant claiming more hours than s/he worked, evidence of neglect or abuse, or a member reporting to the MCO that he or she is being abused. Table 135, in Appendix A, displays the definition of a critical incident and also describes the process of how each MCO handles a critical incident. Aetna and the of the best Medicaid program did not provide information on the process used to report critical incidents.

Because Service Package 2 only began in February 2013 and the transition period lasted until August, each MCO reported that they had changed the process of reporting critical incidents. Prior to Service Package 2, each MCO tracked critical incidents internally. Neither MCO detailed the critical incident process that it uses after the transition.

HFS requires the MCOs to submit a quarterly report on critical incidents reported and referred. The quarterly report for Quarter 4 of FY13 shows that only six critical incidents are reported for IlliniCare, all of which were referred. Data has not yet been received from Aetna. Critical incidents will be a large part of the evaluation report UIC release next year for the first full year of ICP covering Service Package 2.

B. Coordination of MCOs with Other State Agencies

Experiences in other states have revealed challenges in the coordination between the state Medicaid agency and other state agencies providing Medicaid services. Due to this, the research team met with two major state agencies involved with ICP waiver members, including two meetings each with the Illinois Department on Aging (IDoA) and the Illinois Department of Human Services (IDHS) staff along with numerous phone and email conversations. Some of the observations that IDoA staff related to the UIC research team related to the ICP include:

1) Difficulty obtaining data from HFS regarding enrollment changes of IDoA clients-IDoA staff receive a weekly data extract file with enrollment changes. Staff stated that it was difficult to track enrollment status for their members in the absence of a real-time data system.
2) Need for more training of MCO care coordinators-IDoA staff expressed concern regarding the amount and type of training care coordinators received. According to DoA staff, there is some inconsistency across plans in terms of their understanding of and application of policies and procedures established by IDoA and HFS.
3) Need for MCOs to develop a "preferred" list of providers with IDoA-IDoA has communicated to the MCOs that Aging staff should be involved with the MCOs in developing and reviewing criteria the MCOs might use in developing a preferred list of providers and/or excluding any IDoA certified providers from serving waiver members.

4) Lack of reporting of Critical Incidents-At the time of their meeting with UIC, IDoA staff had not received any "critical incidents" reports from the MCOs. IDoA wants to ensure that MCOs are reporting this information through the processes that have been established by IDoA/HFS.
5) Need for tracking of Waiver Performance Measures-IDoA staff want to ensure that Waiver performance measures are tracked and reported, especially regarding the requirement for face-to-face contact with waiver members.
6) Questions about how case management interfaces between MCO care coordinators and existing waiver care coordinators-IDoA staff expressed concerns about the method and extent that MCO staff would maintain referral networks with community resources. They also wanted more information regarding the format and content of the new care and service plans that would be developed by the MCO staff and how MCO staff would obtain non-waiver services for their members.
7) Duplication of effort for some providers-IDoA staff noted billing duplication due to confusion experienced by providers when timely information about client transfers to MCOs is not obtained or completed. Providers have entered vendor requests for payment into IDoA's system when payment actually needed to be made by the MCO for the service month(s). This error creates the need for labor-intensive billing reconciliation and/or recoupment.

IDoA is exploring the ability to internally prevent duplicate billing in its system once notification is obtained that the client transferred to an MCO, as opposed to waiting until the required case authorization transaction ordinarily completed by the client's Care Coordination Unit in the field is done. Additionally, IDoA staff informed the research team that HFS and IDoA are working to finalize arrangements regarding how the number of Aging waiver members enrolled in ICP are captured in reports to federal CMS.

The importance of having in place a good reporting system between the ICP and the state agencies who are responsible for the various waivers is illustrated by the amount of movement of waiver members off of the ICP. Table 66 summarizes the number of "original" waiver ICP members who have dis-enrolled from ICP during the first 13 months of ICP's implementation of Service Package 2.

Table 66: Disenrollment of Waiver Members

Status	#	%
Waiver Clients as of 2/1/13	2,906	100%
Left program by 3/1/14	561	19.3%
Original waiver clients still in ICP	2,345	80.7%
Reason left ICP	**#**	**%**
Medicare enrollment	268	47.8%
Lost Medicaid eligibility	202	36.0%
Other (TPL, spend-down, moved)	91	16.2%
Total left	561	100.0%

On February 1, 2013, when Service Package 2 was rolled out, there were 2,906 wavier members enrolled in the ICP. During the next 13 months, almost 20% (19.3%, 561 members) left the ICP for various reasons. Almost half of them left the ICP due to enrolling in the Medicare program while another third of the waiver members lost their Medicaid eligibility. The remaining members left for other reasons, including moving out of the ICP area, obtaining third party insurance, and having to enter the "spend down" process.

C. Quality Assurance

One of the most important but challenging responsibilities of the state Medicaid agency is to put in place a quality assurance system that will ensure that not only are costs being constrained but that quality services are being delivered to members as they need them. Developing and tracking relevant quality outcome measures is not a one-time process; the process needs continual attention and fine-tuning. Although ideas and measures can be borrowed from other states, care must be taken that the unique characteristics of the Illinois Medicaid program is taken into account.

HFS has taken many steps to provide quality assurance for the ICP program. The following section focuses on the outcome measures that HFS established to evaluate the performance of the MCOs, the incentive process it developed to pay the MCOs additional funds for some of these measures, a summary of the first formal review of the quality measures, and a short discussion of plans HFS has for improving quality assurance efforts in the future.

1. Description of how the list of Quality Indicators were developed

The original request published by HFS in 2010 for ICP proposals included a listing of 31 quality measures that the state developed after consulting with other states, working with stakeholders from Illinois, and soliciting input from other state agencies. Between the time of the posting of the original RFP and the development of the second contract with the rollout of Service Package 2, the quality outcome measures underwent further revision.

Table 67 summarizes the quality measures at each of 3 "checkpoints" (original RFP, years 1-3 contracts) and shows an evolution that is common in most states as their managed care initiatives mature. States often typically rely heavily on either standard or modified HEDIS standards because they have been tested and outcomes can often be benchmarked against national results. For more detail on how the actual quality measures evolved during this 3-year period, see Appendix A, page 143.

Table 67: Evolution of ICP Quality Measures

Document	Type of Measure			Source of Measure			
	P4P	Other	Total Measures	HEDIS	Modified HEDIS	State Defined	Other
Original RFP	--	--	31	13	--	16	2
Contract 1	13	15	28	12	3	11	2
Contract 2	13	16	29	12	3	12	2
Contract 3	13	22	35	13	9	10	3

2. Pay for Performance (P4P)

For the Pay for Performance (P4P) quality measures, HFS established an "incentive pool" from which each MCO "may earn payments based on its performance" on the P4P measures. The amount in the pool each year is equal to 5% of the overall capitation amount paid to the MCOs. To fund the pool, HFS uses two types of revenue, the first being a 1% of funds withheld from the MCO capitated payments

each month and the second being additional funds that HFS will deposit in the pool. Generally, with some exceptions, each P4P measure will have equal weight in paying from the pool.

In 2013, the Health Services Advisory Group (HSAG) evaluated both MCOs for their performance on 25 outcome measures associated with Service Package 1. HSAG did not evaluate the Service Package 2 quality measures but will do so in 2014.

Table 68 lists the eleven (11) P4P measures and the performance of the MCOs on each for calendar year 2012. Of the 11 measures, compared to the state's baseline at the start of 2012, Aetna improved on 10 of the 11 measures and IlliniCare improved on 4 of the measures. In terms of P4P results, Aetna "met" the P4P goal on 5 of the measures and IlliniCare met the P4P goal on 3 of the 11 measures.

Table 68: Pay for Performance (2012 Calendar Year)

Measure	Aetna		IlliniCare	
	Progress Related to Baseline	P4P Result	Progress Related to Baseline	P4P Result
Follow-up After Hospitalization for Mental Illness (FUH) - 30 day follow-up	Declined	Not Met	Declined	Not Met
Annual Dental Visit (ADV) Total - DD Population	Improved	Not Met	Declined	Not Met
Comprehensive Diabetes Care (CDC)	Improved	Not Met	Mixed	Not Met
Congestive Heart Failure (CHF)	Improved	Met	Improved	Met
Coronary Artery Disease (CAD)	Improved	Not Met	Mixed	Not Met
Pharmacotherapy Management of COPD Exacerbation (PCE)	Improved	Met	Improved	Met
Ambulatory Care Follow- up with a Provider within 14 Days of Emergency Department Visit	Improved	Not Met	Declined	Not Met
Ambulatory Care Follow-up with a Provider within 14 Days of Inpatient Discharge (FPID)	Improved	Met	Improved	Not Met
Antidepressant Medication Management (AMM) Effective Acute Phase Treatment	Improved	Not Met	Declined	Not Met
Antidepressant Medication Management (AMM) Effective Continuation Phase Treatment	Improved	Met	Declined	Not Met
Ambulatory Care - ED Visits per 1,000 Member Months	Improved	Met	Improved	Met
Total	**Improved 10/11**	**Met 5 of 11**	**Improved 4/11**	**Met 3 of 11**

3. Other Quality Measures

Table 69 lists the other 25 quality measures the MCOs were evaluated on for 2012. The measures are grouped into in 8 major areas, with the MCO improving or declining from the state baseline. Two (2) of the measures for Aetna and three (3) of the measures for IlliniCare were not applicable for calendar year 2012. Of the 21 applicable measures for Aetna, it improved over the baseline for 17 and declined for 4 of the measures. Of the 20 applicable measures for IlliniCare, it improved for 13 and "declined" for 7 of the measures.

As mentioned previously, the outcome measures associated with Service Package 2 have not yet been evaluated and will be reviewed by HSAG for calendar year 2013 in the summer of 2014. For more detail on all three sets of these measures, see Appendix A.

Table 69: ICP – Other Quality Indicators (Calendar Year 2012)

Measure	Aetna		IlliniCare	
	Improved	Declined	Improved	Declined
Access to Care (3 measures)	2	1	0	3
Preventive Care (2 measures)	1	1	1	1
Appropriate Care (6 measures)	6	0	5	1
Behavioral Health (3 measures)	1	2	1	2
Utilization Per 1,000 Member Months (2 measures)[1]	2	0	1	0
Inpatient Utilization Per 1,000 Member Months (3 measures)	3	0	3	0
Mental Health Utilization Inpatient and Outpatient (4 measures)[2]	0	0	0	0
Long Term Care Per 1,000 Member Months (2 measures)	2	0	2	0
Total	**17**	**4**	**13**	**7**

[1] One of measures was not applicable for IlliniCare
[2] All four measures was not applicable for Aetna and IlliniCare

4. Future Plans of HFS related to Quality Assurance

Due to the state mandate to have half of the Medicaid population in "coordinated care" by 2015, HFS recognized that it would need to increase its infrastructure within the agency to meet the increased demand for developing and monitoring quality of care. As a result, HFS created the new Bureau of Quality Management (BQM) in May 2013. The intent was to organize, streamline, consolidate, and standardize as much as possible the QA activities and responsibilities of the HFS related to the health reforms occurring in the state (i.e. Medicaid expansion, transition to managed care delivery platforms).

As of the fall of 2013, BQM consisted of approximately 20 professional staff. The majority of these staff were re-assigned from existing HFS bureaus, while a few staff were hired from the private sector. Early on, the BQM staff adopted a mission statement that would guide their future activities:

> *"The mission of the BQM is to serve as the focal point within HFS Division of Medical Programs to define, measure and evaluate the quality of healthcare services provided to enrollees and to use data analytics and evidence-based practices to drive continuous quality improvement within HFS and through the efforts of our partners."*

HFS staff have worked to develop and standardize quality measures that can be applied to all entities in the state Medicaid program, whether the FFS or the managed care sector. HFS is also monitoring current trends in quality assessment, input from stakeholders, plan performance and new initiatives and best practices for future measure updates/improvements.

To improve efficiency, HFS is also attempting to develop other data sources to use in the evaluation process of quality measures. Currently HFS relies primarily on enrollment and claims data, which can

cause problems in the quality assurance process because this type of data is not always timely, since the adjudication of claims can take weeks or months. Overall, HFS's goal is to develop data sources that are easy to access and interpret, are integrated, and permit comparisons of the MCOs on the measures.

Recommendations

Goal 1: Ensure adequacy of the health and LTSS provider network of the expanded ICP state-wide prior to "going live."

- The State should develop standards for what an adequate network looks like, including standards for "adequate" numbers or provider "coverage" for select key provider types across counties.
- The State should continue to work with HSAG to ensure that networks are maintained.
- The State and the MCOs should develop plans for ensuring accessibility of provider offices which would minimally include criteria of what "accessibility" means, especially in regards to exam tables and diagnostic equipment, and also would include some pro-active audits of providers by the MCOs.
- HFS should work with other state agencies to ensure that procedures are in place that minimize the need for providers to enter duplicate billing and service information into electronic databases.
- The State should hold at least annual meetings with providers to solicit feedback regarding their experience with submitting claims and being paid by the MCOs.
- The MCOs should expand the number of specialists available in the suburbs further away from Chicago.

Goal 2: Improve consumer access to services.

- MCOs should make medications more readily available to people with mental illness. Aetna and IlliniCare have programs in place to facilitate this. However, this was a concern for focus group participants, who may not know how to take advantage of them. This implies that member and provider education may help ease the concern over access to medication.
- MCOs should work to improve transportation access to reduce complaints and help members get to and from appointments.
- The State should establish procedures that ensure that MCO care coordinators are aware of and make necessary referrals to providers for the provision of non-Medicaid services that members might need.

Goal 3: Improve the information available to the public about the program.

- The State should provide clearer information regarding enrollment procedures because some members still had difficulty enrolling, either because they were assured they were being transitioned from Medicaid to ICP or they could not access adequate information to make an informed choice.
- The MCOs should provide clearer information regarding what services and benefits are covered as ICP members and others expressed confusion as to whether the provisions of the SMART Act applied to them.
- MCOs should consistently update information provided on their programs' websites, including accurate information regarding providers who are actually available.

- The State should create a task force of MCO staff, Medicaid members, and public stakeholders to develop some minimum criteria regarding information that will be available on MCO web sites and establish general guidelines for navigation of the sites.

Goal 4: Continue and improve training related to ICP.

Both Aetna and IlliniCare have used a number of strategies and partnerships to train members and staff about ICP. However, because of the importance of training, the UIC team has a number of recommendations for training related to ICP, especially as ICP expands to include additional MCOs.

- Although the State has improved the process of tracking the training that care coordinators receive, better information on the amount and type of training received by care coordinators would be useful.
- HFS should continue to work with other state agencies to ensure that ICP care coordinators receive training on waiver services as those services change in the state system (this will be especially important as the 1115 waiver is introduced).
- Other areas of continued training needed for MCO staff include person-centered approaches, family support, cultural competence, and health promotion strategies for people with disabilities.
- MCOs should continue to work with consumer organizations and provider agencies to develop peer training (including people with disabilities and family community health workers) within their organization.

Goal 5: Improve consistency and usefulness of data reporting.

- The State should work closely with the MCOs to develop a specific and common set of data elements to ensure that encounter data for ICP members can be entered into a database maintained by the State until the time the State is able to maintain this encounter data in the current Medicaid claims database.
- The State and the MCOs should continue to work to standardize data reporting formats for monthly and quarterly reports (e.g., resolutions of grievances).
- The State should establish a regular process of reporting those waiver members that move into and out of the ICP (e.g., reason for movement and state agency notified).
- The State should create a structure that will more easily track the number of deaths within the ICP so they can be compared to risk-adjusted rates in the rest of the Medicaid population.

Appendix A: Extra Tables

A. SMART Act Tables

- Table 70: SMART Act Changes
- Table 71:MCO SMART Act Implementation

Table 70 details the major Medicaid changes included in the SMART Act

Table 70: SMART Act Changes

Number/Category	Benefit	HFS Change
6: Optional Service	Dental care for adults	Services eliminated for adults except for emergency care which includes critical extraction services.
7: Optional Service	Adult Chiropractic	Benefit eliminated for adults.
8: Optional Service	Adult Podiatry	Service limited to care for individuals with diabetes.
9: Optional Service	Adult eyeglasses	Limit is one pair of glasses every two years.
10: Optional Service	Group psychotherapy for nursing home residents	Service is eliminated.
12: Optional Service	Adult speech, hearing and language therapy services	Annual limit is a maximum of 20 services per year.
13: Optional Service	Adult occupational therapy services	Annual limit is a maximum of 20 services per year.
14: Optional Service	Adult physical therapy services	Annual limit is a maximum of 20 services per year.
19: Utilization Controls	Baby deliveries	Only pay normal vaginal delivery rate for C-sections, unless medically necessary.
20: Utilization Controls	Hospitals: provider preventable conditions	Reduce payment for the hospital stay if provider preventable condition occurs during that period.
22: Utilization Controls	Bariatric (weight-loss) surgery	Adopt Medicare standard with patient responsibility; six-month medically supervised weight loss program under primary care physician
26: Utilization Controls	Ambulance services	Change law requiring ambulance transportation between 24-hour medically monitored institutions (i.e. hospitals/nursing homes)
28: Utilization Controls	Pharmaceuticals: prescriptions in Long Term Care settings	Require pharmacies to dispense brand name drugs in no more than seven days' supply for recipients in long-term care settings.
37: Utilization Controls	Incontinence supplies	Quantity limit of 200 per month.
40: Cost Sharing	Copays	$3.65 copayment for medical services, including doctor and clinic visits.
46: Rate Adjustment	Nursing Home bed holds	Eliminate bed hold for adults age 21 and over in nursing homes.
48: Rate Adjustment	Power wheelchair rates	Reimburse for power wheelchairs at actual purchase price rather than current practice of Medicare rate minus 6%
49: Rate Adjustment	Pharmacy copays	$2.00: generic $3.90: brand name prescription (revised price as of 4/1/13).
62: Rate Reductions	General medical provider rate reductions	Reduce most medical provider reimbursement rates by 2.7% effective July 1, 2012, with exceptions.

Data Sources: SMART Act Provider Notification Letter (IlliniCare), SMART Act Report

Table 71 shows whether each MCO implemented provisions of the SMART Act

Table 71: MCO SMART Act Implementation

Benefit	Aetna	IlliniCare (change as of 4/1/13)
Dental care for adults	No, most dental is covered still with the exception of sealants, crowns, root canals, and dentures for members over 21	No, remains a value added benefit
Adult Chiropractic		No, remains a benefit with 12 annual visits/member without PA
Adult Podiatry	No, continues to be a covered benefit.	No, also offered to persons with circulatory conditions
Adult eyeglasses	No, but changing benefit of new pair of glasses to once every 2 years (rather than 1 year)	Yes, but with added value benefits like annual exam
Group psychotherapy for nursing home residents (and related transportation)		Yes, adopting SMART Act changes
Adult speech, hearing and language therapy services	Yes, adopting SMART Act changes	Yes, adopting SMART Act changes
Adult occupational therapy services	Yes, adopting SMART Act changes	Yes, adopting SMART Act changes
Adult physical therapy services	Yes, adopting SMART Act changes	Yes, adopting SMART Act changes
Baby deliveries		Yes, adopting SMART Act changes
Hospital provider-preventable conditions		Yes, adopting SMART Act changes
Bariatric (weight-loss) surgery		Yes, adopting SMART Act changes
Ambulance services		Yes, adopting SMART Act changes
Pharmaceuticals: prescriptions in Long Term Care settings		Yes, adopting SMART Act changes
Incontinence supplies		Yes, adopting SMART Act changes
Copays		No, will not charge copays for medical visits
Nursing Home bed holds		Yes, adopting SMART Act changes
Power wheelchair rates		Yes, adopting SMART Act changes
Pharmacy copays		Yes, with exceptions such as meds dispensed at LTC facilities
General medical provider rate reductions		Yes, adopting SMART Act changes
Hospice	Yes, limited to Medicare coverage and benefit limitations	

Data Sources: SMART Act Provider Notification Letter (IlliniCare), Aetna Member Benefit Change Notification (March 1, 2014)

B. Methodology Tables

- Table 72: Comparability of the ICP and Chicago Samples Before and After Matching

Table 72 illustrates the comparability of the ICP and Chicago samples before matching and after matching.

Table 72: Comparability of the ICP and Chicago Samples Before and After Matching

Variable	ICP	Raw Chicago	Matched Chicago
Demographics			
Hispanic	0.135	0.157	0.137
Asian	0.084	0.026	0.082
Black	0.342	0.664	0.344
White	0.415	0.159	0.413
Female	0.538	0.515	0.541
Age Distribution			
Age	49.245	48.246	49.672
Age 20-30	0.172	0.137	0.165
Age 30-40	0.104	0.115	0.104
Age 40-50	0.159	0.198	0.161
Age 40-60	0.241	0.32	0.243
Age 60-70	0.164	0.156	0.164
Age 70-80	0.084	0.03	0.089
Age 90-90	0.03	0.011	0.031
Age 90+	0.003	0.001	0.003
Waiver Composition			
Physical Disability Waiver	0.044	0.041	0.044
Community Resident Waiver	0.752	0.822	0.743
Nursing Home Waiver	0.089	0.068	0.099
Developmental Disability Waiver	0.061	0.021	0.055
Aging Waiver	0.029	0.028	0.031
Brain Injury Waiver	0.009	0.011	0.01
ICFMR Waiver	0.012	0.004	0.015
HIV/AIDS Waiver	0.002	0.006	0.002
Technology Dependent Waiver	0.001	0.000	0.000
Supportive Living Waiver	0.000	0.000	0.000
Baseline Expenditures			
Total Medicaid Expenditures FY 2011	$15,151	$13,125	$16,722
Total Non Pharmacy Medicaid Expenditures FY 2011	$12,647	$7,279	$7,429
Total Pharmacy Medicaid Expenditures FY 2011	$2,503	$2,549	$3,798
Total Dental Medicaid Expenditures FY 2011	$32	$32	$34
Total Hospital Admissions Medicaid Expenditures FY 2011	$3,469	$4,290	$4,544
Total ER Admissions Medicaid Expenditures FY 2011	$271	$344	$297

C. Enrollment: Extra Tables

- Table 73: MCO Enrollment Month-by-Month
- Table 74: Initial Enrollment Process
- Figure 11: Questions HFS Recommends Members Answer when Deciding on a Plan

- Figure 12: Help and Information Available to Members
- Table 75: Rates of Active Choice and Auto Enrollment
- Table 76: Summary of Member Tenure

Table 73 displays MCO enrollment for each month from July 2012 to June 2013 based on capitation payments to the MCOs.

Table 73: MCO Enrollment Month-by-Month*

Month	Aetna				IlliniCare			
	Begin Month [1]	Adds [2]	Drops [3]	End Month [4]	Begin Month [1]	Adds [2]	Drops [3]	End Month [4]
2012-07	17,809	443	515	17,737	17,399	557	516	17,440
2012-08	17,737	440	419	17,758	17,440	577	425	17,592
2012-09	17,758	568	464	17,862	17,592	519	491	17,620
2012-10	17,862	442	502	17,802	17,620	344	448	17,516
2012-11	17,802	358	349	17,811	17,516	491	367	17,640
2012-12	17,811	334	398	17,747	17,640	475	390	17,725
2013-01	17,747	328	334	17,741	17,725	356	406	17,675
2013-02	17,741	362	328	17,775	17,675	461	356	17,780
2013-03	17,775	380	330	17,825	17,780	293	364	17,709
2013-04	17,825	87	291	17,621	17,709	103	280	17,532
2013-05	17,621	201	277	17,545	17,532	271	258	17,545
2013-06	17,545	351	274	17,622	17,545	541	266	17,820
Total	**213,033**	**4,294**	**4,481**	**212,846**	**211,173**	**4,988**	**4,567**	**211,594**

*Based on FY13 Capitation Payments to MCOs

Table 74 below describes the initial process for enrollment in the Integrated Care Program. Included are descriptions detailing ways members can enroll, the types of assistance available, program information access, and information about switching plans.

Table 74: Initial Enrollment Process

Item	Description
How can a member enroll in the ICP (mail, phone, online, fax)?	A member may enroll in ICP by contacting the Illinois Client Enrollment Broker (ICEB) call center or by going online to enroll via the ICEB Program Web site.
What type of assistance is the member given regarding the various plans?	The ICEB mails enrollment packets that provide a member with information about their Plan choices, including a comparison chart that identifies the extra benefits each Plan may offer. The ICEB Customer Service Reps are available through the ICEB Call Center to provide unbiased education about each Plan and enrollment assistance. In addition, the ICEB Program Web site includes information about a members Plan choices and information on how to select a Plan. A member may also contact the individual Plans to discuss their Plan before making a choice. All enrollments must be processed by the ICEB.
How long does the member have to make a decision of which plan they will choose?	A member has 60 days to select a Plan and PCP. If a member does not make a voluntary choice, the ICEB will auto-assign the member to a Plan and PCP based on an auto-assignment algorithm that takes into consideration a members current PCP, claims data and location.
Is the member given information regarding providers in the area?	The ICEB Program Website is one tool a member may use to search for providers that participate in specific areas by Plan. A member may contact the ICEB call center for assistance in identifying providers in their area of service, by Plan. In addition, a member may contact a Plan's member service call center and Plan Web site for information on providers participating in their network.
Can others (family, friends, advocates) help the member during the enrollment process?	Yes, if a member has provided the necessary authorizations, a family member, friend, or other representative may assist the member with the enrollment process via the ICEB Call Center or ICEB Program Web Site.
When can a member switch plans under normal circumstances?	Members who are required to enroll in a Health Plan with a lock in provision have an initial change period of 90 calendar days from the effective date of the enrollment whether the Enrollee made an active choice or was auto-assigned. During the initial change period, the member may choose to enroll in another available Health Plan. In ICP, if a member changes Plans during their initial 90 day change period, a second 90 calendar day change period shall begin. During this second 90 day change period, the Member may change Plans again. Upon conclusion of the members second 90 day change period, the member is locked into the Plan for a period of 12 consecutive months and may not change Plans until the members' open enrollment period. Members enrolled in Plans with lock-in provisions will be given an annual 60 calendar day period in which to change the Plan in which the member is enrolled. The open enrollment period shall begin no later than 95 calendar days prior to the Member's Anniversary Date. The ICEB shall mail a notice to the member informing him or her of the open enrollment period, the opportunity to voluntarily change Plans, and the 60 calendar day timeframe for making changes in enrollment. If the Member chooses to enroll in a different Plan during the open enrollment period, the enrollment in the new Plan will be effective on the member's Anniversary Date. The member will have a 90 calendar day period from this effective date to switch back to the previous Plan. If the member switches back to the previous Plan during the 90 calendar day period, the member's Anniversary Date will be adjusted to the effective date of the new enrollment in the Plan. If no change is made during the 60 calendar day open enrollment period, the member will remain enrolled with the current Plan for the next consecutive 12 month period beginning on the Member's Anniversary Date.
How is the member aware of the open enrollment period and the choice he/she has?	The ICEB mails the member an Open Enrollment Packet notifying them that they are in their Open Enrollment Period and may switch Plans. If the member does not switch, they will stay with their current Plan for another 12 months.

Figure 11 displays the guiding questions HFS recommends members answer when making a decision regarding a health care plan. The figure also includes questions relating to selecting a primary care provider and finding a new doctor.

Figure 11: Questions HFS Recommends Members Answer when Deciding on a Plan (FY13)

The HFS Website provides the following guiding questions to help members make a decision regarding a health care plan:

- Do you want to keep your current doctor or clinic, or do you want a new doctor or clinic?
- Does the health care plan have the doctors, hospitals, and specialists you use?
- Does anyone in your family have special health care needs?
- What extra services does the health care plan have?

The HFS Website provides the following guiding questions to help members choose a primary care provider:

- Is there a doctor you already like?
- If so, what plan(s) is this doctor in?
- How far are you willing to travel to see a doctor?
- Do you need a doctor that speaks a certain language?

If a member is looking for a new doctor, the HFS Website suggests:

- Ask people you trust to recommend doctors and then search to see what health plans those doctors are in.
- Search for providers near you, using the HFS Website.

Figure 12 below displays help and information sources available to members including enrollment brokers, direct mailings, and website information. The figure also shows the ways each information source can assist a member with managing their health care plan.

Figure 12: Help and Information Available to Members (FY13)

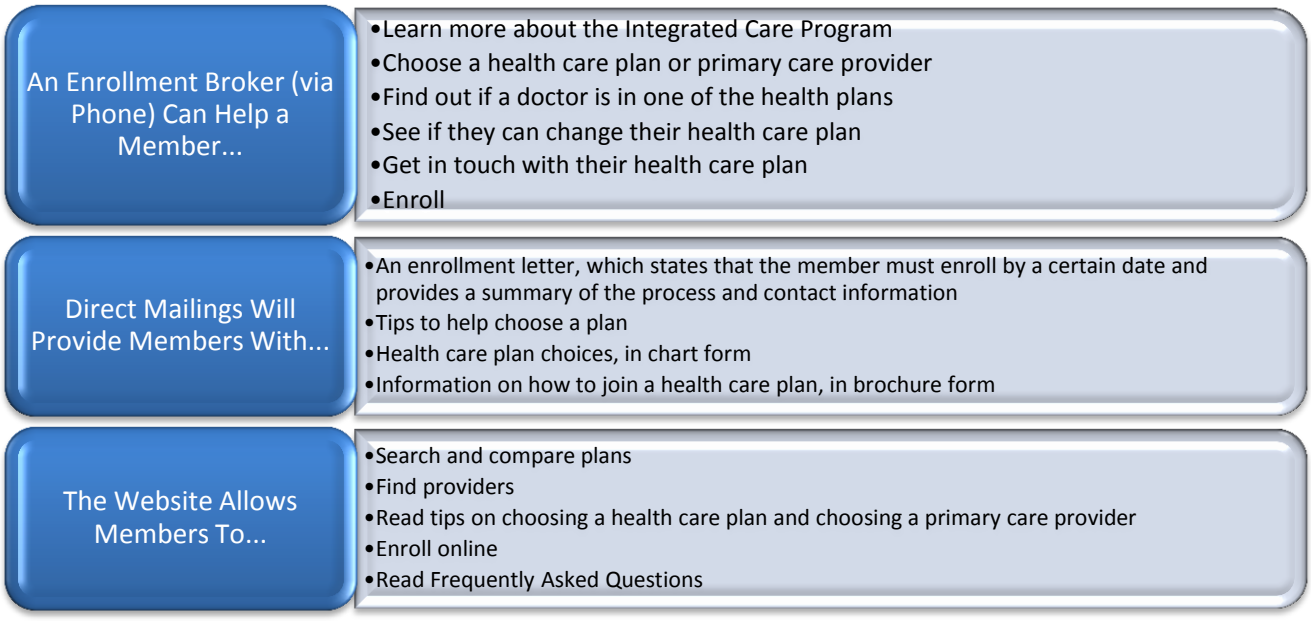


Table 75 displays the rates of active choice and auto enrollment for each MCO during each month of the 2013 fiscal year. For both plans, some months showed 100% active choice enrollment and some months showed 0% active choice. Aetna's highest rate of auto enrollment was 48.8% while IlliniCare's highest rate of auto enrollment was 56.4%.

Table 75: Rates of Active Choice and Auto Enrollment (FY13)

Month	Aetna			IlliniCare		
	% Active Choice	% Auto Enrolled	Total	% Active Choice	% Auto Enrolled	Total
2012-07	60.9%	39.1%	1,071	54.0%	46.0%	1,228
2012-08	51.2%	48.8%	1,170	43.6%	56.4%	1,393
2012-09	54.9%	45.1%	1,153	53.0%	47.0%	1,027
2012-10	52.5%	47.5%	946	60.9%	39.1%	717
2012-11	63.3%	36.7%	673	55.3%	44.7%	787
2012-12	68.5%	31.5%	530	60.0%	40.0%	667
2013-01	56.0%	44.0%	504	49.8%	50.2%	538
2013-02	0.0%	0.0%	0	0.0%	0.0%	0
2013-03	100.0%	0.0%	76	100.0%	0.0%	108
2013-04	100.0%	0.0%	297	99.8%	0.2%	441
2013-05	100.0%	0.0%	324	25.7%	74.3%	1757
2013-06	95.9%	4.1%	344	84.5%	15.5%	549

Table 76 is a summary of the member tenure for each MCO based on capitation payments from the 2013 fiscal year. Included in the table are members, months, and average months of enrollment in a single plan, both plans, and total enrollment. For each kind of enrollment, the average months of enrollment were determined to be about the same at around 10 months.

Table 76: Summary of Member Tenure (FY13)

MCO	Enrolled in a Single Plan		
	Members	Months	Average Months
Aetna	20,483	208,080	10.2
IlliniCare	20,765	207,013	10.0
Total	**41,248**	**415,093**	**10.1**
Enrolled in BOTH Plans			
Aetna	896	4,766	5.3
IlliniCare	896	4,581	5.1
Total	**896**	**9,347**	**10.4**
TOTAL Enrollment			
Aetna	21,379	212,846	10.0
IlliniCare	21,661	211,594	9.8
Total	**42,144**	**424,440**	**10.1**

Based on FY13 Capitation Payments

Total Members for ICP is not the sum of total members for individual MCOs since some members were in both plans.

D. Adequacy of Provider Networks: Extra Tables

- Table 77: Pharmacies per 1,000 members as of January 2014
- Table 78: CMHCs per 1,000 members as of 2014
- Table 79: Home Health per 1,000 members as of 2014
- Table 80: Provider Network Issues from UIC's 2013 Report: Counting of Providers
- Table 81: Provider Network Issues from UIC's 2013 Report: Quantifying Network Capacity
- Table 82: Identification of Provider Network Issues from UIC's 2013 Report: Qualifications and Experience of Providers
- Table 83: Identification of Provider Network Issues from UIC's 2013 Report: Members' Knowledge and Public Awareness of Network
- Table 84: Primary Care Providers (PCPs) – Totals by County
- Table 85: Physician Extenders – Totals by County
- Table 86: Behavioral Health Providers – Totals by County
- Table 87: Medical Specialists – Totals by County (1 of 2)
- Table 88: Medical Specialists – Totals by County (2 of 2)
- Table 89: Other Providers – Totals by County (1 of 2)
- Table 90: Other Providers – Totals by County (2 of 2)
- Table 91: Waiver Providers – Totals by County (1 of 2)
- Table 92: Waiver Providers – Totals by County (2 of 2)
- Table 93: Facilities – Totals by County (1 of 2)
- Table 94: Facilities – Totals by County (1 of 2)
- Table 95: Hospitals – Totals by County

Table 77 displays the number of pharmacies per 1,000 members as recorded for January of 2014.

Table 77: Pharmacies per 1,000 members as of January 2014

County	Aetna	IlliniCare	FFS (FY11)
Cook	97.5	69.1	40.4
DuPage	98.8	71.0	43.6
Kane	60.3	48.9	24.4
Kankakee	23.0	17.8	16.6
Lake	66.4	50.3	32.7
Will	60.8	45.3	32.7
Total	**84.1**	**60.8**	**37.2**

Data Source: HSAG provider data and HFS enrollment data for January 2014

Table 78 displays the number of community mental health centers per 1,000 members as recorded for January of 2014.

Table 78: CMHCs per 1,000 members as of January 2014

County	Aetna	IlliniCare	FFS (FY11)
Cook	12.0	12.8	18.0
DuPage	14.4	3.7	10.0
Kane	9.0	12.2	11.0
Kankakee	5.2	8.4	10.1
Lake	1.7	1.1	12.6
Will	6.1	7.2	7.3
Total	10.0	9.8	14.9

Data Source: HSAG provider data and HFS enrollment data for January 2014

Table 79 displays the number of home health care agencies per 1,000 members as recorded for January of 2014.

Table 79: Home Health Agencies per 1,000 members as of January 2014

County	Aetna	IlliniCare	FFS (FY11)
Cook	11.8	10.5	11.4
DuPage	8.5	14.9	12.9
Kane	4.1	4.1	2.0
Kankakee	6.3	3.1	2.2
Lake	5.1	2.9	4.2
Will	6.1	5.5	4.8
Total	**9.4**	**8.9**	**9.3**

Data Source: HSAG provider data and HFS enrollment data for January 2014

Table 80 explains issues that UIC identified in an earlier report with counting providers and how HFS responded.

.

Table 80: Provider Network Issues from UIC's 2013 Report: Counting of Providers

General Area	Description of Problem	Current Status
Problem of duplicates caused by minor address differences	The provider lists were not checked to ensure that duplicates due to minor name or address differences caused the same provider to be counted more than once.	Corrected-HSAG instituted a protocol to minimize the possibility of a provider being counted more than once. In some instances, the same provider may be counted more than once if they offer the same service at two or more sites or two or more services at the same site. HSAG does not consider the provider a duplicate if they provide services in more than one county. The MCO must complete the county column to verify that they provide services in more than one county. HFS requires HSAG to provide unduplicated counts by provider type for the MCOs.
Providers at same location serving different group providers and counted twice	The provider lists were not checked to ensure that individual practitioners working for different group providers were not counted twice.	Corrected-HSAG specifically checks for this occurrence
Lack of standardization of provider types and specialties	Each MCO was permitted to develop and maintain their own provider types and specialties; making comparison between the MCOs difficult for all types and impossible for some provider types.	Substantial progress made-HSAG has fully implemented a process where all MCOs are required to use the same service lines or provider listings when reporting their provider data. HSAG includes all provider types in the network analysis including SPII providers. HSAG reports these providers on the HCBS pivots and summary tables and ensures that all contract required SPII providers are included in the analysis of the HCBS network.
Hospital service lines may cause over-counting	The same hospital may have multiple Medicaid Provider IDs, making counting and comparing signed hospitals among the MCO networks difficult.	Corrected-HSAG does not currently use a provider ID for Hospitals. HSAG only counts the hospital once for each type of service by county. HSAG includes in-patient behavioral health. LTAC, and Rehabilitative/Specialty inpatient services if they are included as a service through the acute inpatient contracted hospital.
Not all available providers had Medicaid Provider ID or NPI	Some individual practitioners do not have a Medicaid Provider ID or NPI. They work for a group Medicaid provider who does the billing, making counting these individual providers a challenge.	No change made
Confusion over availability of the provider to serve members arose during the credentialing process	There was no specific tracking mechanism as to when a provider was fully credentialed and available to provide services to members.	Corrected-HSAG has put an extensive tracking mechanism as to when a provider is fully credentialed and available to provide services to members. They are not "counted" as a signed provider until fully through the process. This process is checked and validated each time HSAG conducts an MCO network analysis.

Table 81 explains issues that UIC identified in an earlier report concerning the difficulty of quantifying network capacity and how HFS has responded.

Table 81: Provider Network Issues from UIC's 2013 Report: Quantifying Network Capacity

General Area	Description of Problem	Current Status
Available hours of providers for appointments	Providers were not required to report how many hours they were available at a certain location, making providers available one day a week equal to providers available five days a week in terms of "capacity" of the providers.	Future changes under consideration-This item is under discussion for inclusion in 2014 Access and Availability review that will be conducted by HSAG.
Willingness or restrictions on taking Medicaid members	Providers were required to check "Yes" or "No" whether they were willing to take new Medicaid members but not to indicate the number of new Medicaid members they could take on their caseload. For PCPs, there was some restriction on their total "panel size" of overall patients they would have but nothing specific about ICP members they would be willing to take. As a proxy for "capacity" or "willingness" of providers to serve ICP members, UIC reviewed and published Medicaid claims processed by providers during the baseline period.	Future changes under consideration-This item is under discussion for inclusion in 2014 Access and Availability review that will be conducted by HSAG.
Billing versus service addresses	There was no requirement for providers to list their service locations. In some cases, addresses were actually billing addresses and were not always within the ICP catchment area.	Substantial progress made-HSAG works with the MCOs during each submission to ensure that providers are not duplicated and are required to remove billing addresses if the provider is not providing services at that location.
Distance of providers from members	The formal state contract between the state and the plans requires each plan to conduct geographic analysis of the provider network on a quarterly basis to identify any gaps in terms of provider distance from members. However, each MCO was permitted to use their own outcome measures and provider types/specialties to include in these reports, making them very difficult to compare.	No change made
Wait time for appointment	There was no data collect on this measure.	Future changes under consideration-This item is under discussion for inclusion in 2014 Access and Availability review that will be conducted by HSAG.

Table 82 explains issues that UIC identified in an earlier report concerning the difficulty of accurately assessing the qualifications and experiences of network providers and how HFS has responded.

Table 82: Identification of Provider Network Issues from UIC's 2013 Report: Qualifications and Experience of Providers

General Area	Description of Problem	Current Status
Experience with disabled or aged population	Providers were required to answer "Yes" or "No" as to whether they could serve certain populations but there were no expectations to guide providers on what was expected.	No change made
Physical accessibility of location, facilities, and equipment	Providers were required to answer "Yes" or "No" as to whether they could serve certain populations but there were no expectations to guide providers on what was expected.	No change made

Table 83 explains issues that UIC identified in an earlier report concerning publicizing network providers and how HFS has responded.

Table 83: Identification of Provider Network "Issues" from UIC's 2013 Report: Members' Knowledge and Public Awareness of Network

General Area	Description of Problem	Current Status
Listing of provider directories on MCO websites	There were many initial complaints that the on-line provider directories maintained by the MCOs were out of date, inaccurate, and not easy to search providers by.	Future changes under consideration-This item is under discussion for inclusion in 2014 Access and Availability review that will be conducted by HSAG.
Updating of stakeholder groups regarding network status	HFS held three meetings during the first year of the ICP to update the public on the number of PCPs, specialists, and hospitals in each of the two provider networks but there have been complaints about lack of these meetings after the initial roll-out.	No change made
No minimum provider ratios for most provider types	HFS set a minimum provider-to-member ratio for only one provider type, Primary Care physicians. There were no stated targets for other provider types	No change made

Table 84 details the number of primary care providers available in each county by MCO.

Table 84: Primary Care Providers (PCPs) – Totals by County (FY13)

Provider Type	Cook		DuPage		Kane	
	Aetna	IlliniCare	Aetna	IlliniCare	Aetna	IlliniCare
Family Practice	762	715	140	134	49	50
General Practice	25	36	1	2	1	2
Geriatrics	20	32	1	0	0	0
Internal Medicine	1,348	930	154	123	34	44
Obstetrics & Gynecology	340	474	37	42	35	24
Total	**2,495**	**2,187**	**333**	**301**	**119**	**120**
Provider Type	**Kankakee**		**Lake**		**Will**	
	Aetna	**IlliniCare**	**Aetna**	**IlliniCare**	**Aetna**	**IlliniCare**
Family Practice	17	13	113	126	32	41
General Practice	1	0	2	6	0	2
Geriatrics	1	0	0	0	1	0
Internal Medicine	51	7	84	97	52	47
Obstetrics & Gynecology	4	0	24	103	6	9
Total	**74**	**20**	**223**	**332**	**91**	**99**

Data Source :Summarized Information from MCO Data Submitted to HSAG in January 2014

Table 85 details the number of physician extenders available in each county by MCO.

Table 85: Physician Extenders – Totals by County (FY13)

Provider Type	Cook		DuPage		Kane	
	Aetna	IlliniCare	Aetna	IlliniCare	Aetna	IlliniCare
Midwifery	39	48	0	5	2	0
Nurse Anesthetist	0	0	0	0	0	0
Nurse Practitioner	309	182	33	48	32	24
Physician Assistant	8	0	0	0	0	0
Total	**356**	**230**	**33**	**53**	**34**	**24**
Provider Type	**Kankakee**		**Lake**		**Will**	
	Aetna	**IlliniCare**	**Aetna**	**IlliniCare**	**Aetna**	**IlliniCare**
Midwifery	0	0	9	4	0	0
Nurse Anesthetist	0	0	0	0	0	0
Nurse Practitioner	4	2	16	8	12	25
Physician Assistant	0	0	0	0	0	0
Total	**4**	**2**	**25**	**12**	**12**	**25**

Data Source :Summarized Information from MCO Data Submitted to HSAG in January 2014

Table 86 details the number of behavioral health providers available in each county by MCO.

Table 86: Behavioral Health Providers – Totals by County (FY13)

Provider Type	Cook		DuPage		Kane	
	Aetna	IlliniCare	Aetna	IlliniCare	Aetna	IlliniCare
Counselor	59	168	4	13	12	30
Psychiatrist	270	78	50	13	20	8
Psychologist	114	26	4	3	1	2
Social Worker	60	90	8	3	6	12
Total	**503**	**362**	**66**	**32**	**39**	**52**
Provider Type	**Kankakee**		**Lake**		**Will**	
	Aetna	**IlliniCare**	**Aetna**	**IlliniCare**	**Aetna**	**IlliniCare**
Counselor	0	5	88	25	7	12
Psychiatrist	10	1	26	11	10	2
Psychologist	0	0	4	2	3	1
Social Worker	1	1	21	9	2	3
Total	**11**	**7**	**139**	**47**	**22**	**18**

Data Source :Summarized Information from MCO Data Submitted to HSAG in January 2014

Tables 87 and 88 details the number of medical specialists available in each county by MCO.

Table 87: Medical Specialists – Totals by County (1 of 2) (FY13)

Provider Type	Cook		DuPage		Kane	
	Aetna	IlliniCare	Aetna	IlliniCare	Aetna	IlliniCare
Allergy and Immunology	28	37	3	5	1	0
Cardiology	345	449	104	67	32	24
Cardiothoracic Surgery	89	85	11	29	2	3
Chiropractor	6	5	6	3	4	1
Dentists	334	96	39	23	27	9
Dermatology	71	70	9	12	2	0
Endocrinology	83	70	9	6	4	8
ENT/Otolaryngology	59	61	11	4	1	0
Gastroenterology	185	162	24	21	14	17
General Surgery	174	233	22	23	3	2
Infectious Diseases	132	160	23	23	2	1
Nephrology	183	202	46	26	11	4
Neurology	151	169	26	19	1	1
Neurosurgery	57	61	5	12	0	0
Oncology-Medical, Surgical	219	171	26	31	4	4
Oncology-Radiation, Radiation Oncology	67	88	12	6	9	18
Ophthalmology	253	243	56	28	3	2
Oral Surgeons	5	3	0	0	0	0
Orthopedic Surgery	117	137	103	40	0	0
Physiatry, Rehabilitative Medicine	153	142	44	12	4	0
Plastic Surgery	34	38	6	1	0	1
Podiatry	158	135	20	10	5	5
Psychiatry	270	78	50	13	20	8
Pulmonology	121	178	17	23	0	3
Rheumatology	66	80	10	6	1	3
Urology	98	80	6	3	0	0
Vascular Surgery	36	42	4	6	1	0
Total	**3,494**	**3,275**	**692**	**452**	**151**	**114**

Data Source :Summarized Information from MCO Data Submitted to HSAG in January 2014

Table 88: Medical Specialists – Totals by County (2 of 2) (FY13)

Provider Type	Kankakee		Lake		Will	
	Aetna	IlliniCare	Aetna	IlliniCare	Aetna	IlliniCare
Allergy and Immunology	1	1	5	7	2	2
Cardiology	8	5	27	61	32	115
Cardiothoracic Surgery	3	0	9	21	0	5
Chiropractor	0	1	0	0	4	0
Dentists	9	4	50	6	30	5
Dermatology	0	0	0	3	11	2
Endocrinology	1	1	1	4	2	3
ENT/Otolaryngology	2	1	4	10	0	0
Gastroenterology	7	0	39	27	5	3
General Surgery	7	3	10	38	3	6
Infectious Diseases	1	3	7	11	7	3
Nephrology	6	4	11	14	22	17
Neurology	4	0	6	23	4	10
Neurosurgery	2	0	4	11	1	6
Oncology-Medical, Surgical	2	0	6	7	32	26
Oncology-Radiation, Radiation Oncology	6	0	4	5	6	14
Ophthalmology	9	2	13	24	13	6
Oral Surgeons	0	0	0	0	0	0
Orthopedic Surgery	11	1	2	13	1	3
Physiatry, Rehabilitative Medicine	6	0	1	9	6	0
Plastic Surgery	0	0	0	0	4	0
Podiatry	6	2	21	26	8	5
Psychiatry	10	1	26	11	10	2
Pulmonology	3	5	5	17	1	5
Rheumatology	2	0	1	4	0	0
Urology	3	2	2	5	12	14
Vascular Surgery	1	0	0	6	0	2
Total	**110**	**36**	**254**	**363**	**216**	**254**

Data Source: Summarized Information from MCO Data Submitted to HSAG in January 2014

Tables 89 and 90 details the number of ”Other providers” available in each county by MCO.

Table 89: Other Providers – Totals by County (1 of 2) (FY13)

Provider Type	Cook		DuPage		Kane	
	Aetna	IlliniCare	Aetna	IlliniCare	Aetna	IlliniCare
Audiology	6	16	4	4	3	1
Chiropractic	6	5	6	3	4	1
Critical Care Medicine	58	460	3	33	0	5
Dietitian	0	0	0	0	0	0
Emergency Medicine	395	400	12	10	4	4
Home Health	118	108	16	29	5	5
Hospice	21	14	9	0	2	0
Hospitalist	70	4	34	0	0	0
Maternal Fetal Medicine	43	0	6	0	0	0
Occupational Therapy	46	8	8	1	4	0
Optometry	250	302	29	47	18	25
Pain Management	18	15	0	0	0	0
Pathology	179	187	13	4	4	0
Physical Medicine & Rehabilitation	153	142	44	12	4	0
Physical Therapy	48	13	8	0	4	0
Plastic Surgery	34	38	6	1	0	1
Podiatry	158	135	20	10	5	5
Radiology	315	56	33	6	32	2
Speech Therapy	46	6	4	0	4	0
Toxicology	0	2	0	0	0	0
Urgent Care Facility	8	0	0	0	0	0
Wound Care	0	0	0	0	0	0
TOTAL	**1,972**	**1,911**	**255**	**160**	**93**	**49**

Data Source :Summarized Information from MCO Data Submitted to HSAG in January 2014

Table 90: Other Providers – Totals by County (2 of 2) (FY13)

Provider Type	Kankakee		Lake		Will	
	Aetna	IlliniCare	Aetna	IlliniCare	Aetna	IlliniCare
Audiology	2	1	1	2	0	0
Chiropractic	0	1	0	0	4	0
Critical Care Medicine	0	2	4	36	0	4
Dietitian	0	0	0	0	0	0
Emergency Medicine	0	3	5	41	1	2
Home Health	6	3	9	5	11	10
Hospice	3	0	1	0	3	0
Hospitalist	0	1	10	0	0	0
Maternal Fetal Medicine	0	0	0	0	2	0
Occupational Therapy	2	0	6	0	3	1
Optometry	8	6	15	24	20	30
Pain Management	1	0	1	1	2	0
Pathology	0	0	17	24	0	0
Physical Medicine & Rehabilitation	6	0	1	9	6	0
Physical Therapy	3	0	5	0	3	1
Plastic Surgery	0	0	0	0	4	0
Podiatry	6	2	21	26	8	5
Radiology	0	0	36	2	12	0
Speech Therapy	2	0	6	0	3	0
Toxicology	0	0	0	0	0	0
Urgent Care Facility	0	0	0	0	0	1
Wound Care	0	0	0	0	0	0
TOTAL	**39**	**19**	**138**	**170**	**82**	**54**

Data Source :Summarized Information from MCO Data Submitted to HSAG in January 2014

Tables 91 and 92 details the number of waiver providers available in each county by MCO.

Table 91: Waiver Providers – Totals by County (1 of 2) (FY13)

Provider Type	Cook		DuPage		Kane	
	Aetna	IlliniCare	Aetna	IlliniCare	Aetna	IlliniCare
Adult Day Services	28	59	9	9	5	6
Adult Day Services Transportation	20	17	8	3	5	5
Behavioral Health Services	232	76	15	12	18	11
Day Habilitation	6	24	3	3	1	1
Environmental Accessibility	8	32	7	33	6	28
Home Delivered Meals	7	16	6	3	3	2
Home Health Aide	71	104	37	28	26	5
Homemaker Services	80	123	35	29	28	19
Nursing Intermittent	12	99	5	28	5	5
Nursing Skilled	47	100	26	28	17	6
Occupational Therapy	49	72	28	24	17	15
Personal Emergency Response System	8	4	7	2	7	3
Physical Therapy	51	74	29	26	18	14
Pre-vocational Svcs	3	23	1	1	1	2
Respite Care Services	30	55	11	14	11	13
Specialized Medical Equipment	5	44	3	5	3	5
Speech Therapy	47	68	27	23	18	15
TOTAL	**704**	**990**	**257**	**271**	**189**	**155**

Data Source :Summarized Information from MCO Data Submitted to HSAG in January 2014

Table 92: Waiver Providers – Totals by County (2 of 2) (FY13)

Provider Type	Kankakee		Lake		Will	
	Aetna	IlliniCare	Aetna	IlliniCare	Aetna	IlliniCare
Adult Day Services	1	2	6	9	12	9
Adult Day Services Transportation	2	1	6	6	11	3
Behavioral Health Services	1	3	103	15	12	12
Day Habilitation	1	0	1	2	1	3
Environmental Accessibility	3	29	3	30	8	29
Home Delivered Meals	1	2	3	2	4	1
Home Health Aide	21	3	29	5	42	10
Homemaker Services	15	10	34	21	38	24
Nursing Intermittent	4	3	4	6	10	10
Nursing Skilled	12	3	19	7	30	10
Occupational Therapy	15	6	19	16	33	19
Personal Emergency Response System	6	2	5	2	8	2
Physical Therapy	15	6	20	16	35	20
Pre-vocational Svcs	2	1	1	3	1	2
Respite Care Services	6	7	11	12	15	16
Specialized Medical Equipment	3	1	4	4	4	5
Speech Therapy	14	5	17	15	33	17
TOTAL	**122**	**84**	**285**	**171**	**297**	**192**

Data Source :Summarized Information from MCO Data Submitted to HSAG in January 2014

Tables 93 and 94 details the number of ”Facilities” available in each county by MCO.

Table 93: Facilities – Totals by County (1 of 2) (FY13)

Provider Type	Cook		DuPage		Kane	
	Aetna	IlliniCare	Aetna	IlliniCare	Aetna	IlliniCare
Acute Inpatient Hospitals	47	49	3	8	4	4
Cardiac Catheterization Services	24	16	3	2	3	2
Cardiac Surgery Program	24	14	3	1	3	1
CMHC	119	127	27	7	11	15
Critical Care Services – Intensive Care Units (ICU)	44	30	4	2	4	2
Diagnostic Radiology	58	19	6	2	4	2
Durable Medical Equipment	138	165	45	42	10	3
FQHC	67	95	0	2	6	7
Heart Transplant Program	4	2	4	2	4	2
Heart/Lung Transplant Program	1	2	1	2	1	2
Home Health	117	104	16	28	5	5
Inpatient Psychiatric Facility Services	25	18	2	1	0	2
Kidney Transplant Program	4	2	3	2	3	2
Laboratories	103	12	19	5	11	0
Liver Transplant Program	3	2	3	2	3	2
Lung Transplant Program	1	2	1	2	1	2
Mammography	43	19	4	2	4	2
Occupational Therapy	46	22	8	2	4	2
Orthotics and Prosthetics	16	15	3	4	0	2
Outpatient Dialysis	132	58	17	9	7	2
Outpatient Infusion/Chemotherapy	37	14	4	2	3	2
Pancreas Transplant Program	3	1	2	1	2	1
Pharmacies	965	684	185	133	74	60
Physical Therapy	48	23	8	2	4	2
Skilled Nursing Facilities	102	22	18	7	7	4
Speech Therapy	46	21	4	2	4	2
Surgical Services (Outpatient or ASC)	46	18	5	2	4	2
TOTAL	**2,263**	**1,556**	**398**	**276**	**186**	**134**

Data Source :Summarized Information from MCO Data Submitted to HSAG in January 2014

Table 94: Facilities – Totals by County (2 of 2) (FY13)

Provider Type	Kankakee		Lake		Will	
	Aetna	IlliniCare	Aetna	IlliniCare	Aetna	IlliniCare
Acute Inpatient Hospitals	2	1	5	4	3	5
Cardiac Catheterization Services	1	0	2	1	0	2
Cardiac Surgery Program	1	0	2	0	0	1
CMHC	5	8	3	2	11	13
Critical Care Services – Intensive Care Units (ICU)	2	1	4	3	3	3
Diagnostic Radiology	2	1	5	3	5	3
Durable Medical Equipment	13	4	17	10	18	14
FQHC	1	1	0	7	0	0
Heart Transplant Program	4	2	4	2	4	2
Heart/Lung Transplant Program	1	2	1	2	1	2
Home Health	6	3	9	5	11	10
Inpatient Psychiatric Facility Services	1	0	3	3	1	1
Kidney Transplant Program	3	2	3	2	3	2
Laboratories	4	0	14	0	7	0
Liver Transplant Program	3	2	3	2	3	2
Lung Transplant Program	1	2	1	2	1	2
Mammography	2	1	5	3	3	3
Occupational Therapy	2	1	6	3	3	3
Orthotics and Prosthetics	0	2	3	3	0	2
Outpatient Dialysis	5	0	17	8	13	6
Outpatient Infusion/Chemotherapy	2	1	4	1	6	3
Pancreas Transplant Program	2	1	2	1	2	1
Pharmacies	22	17	116	88	110	82
Physical Therapy	3	1	5	3	3	3
Skilled Nursing Facilities	4	1	15	4	9	3
Speech Therapy	2	1	6	3	3	3
Surgical Services (Outpatient or ASC)	2	1	6	3	3	3
TOTAL	**96**	**56**	**261**	**168**	**226**	**174**

Data Source :Summarized Information from MCO Data Submitted to HSAG in January 2014

Table 95 details the number of hospitals available in each county by MCO.

Table 95: Hospitals – Totals by County (FY13)

Provider Type	Cook		DuPage		Kane	
	Aetna	IlliniCare	Aetna	IlliniCare	Aetna	IlliniCare
Acute In-Patient	47	49	3	8	4	4
Behavioral Health	27	18	2	1	2	2
Long Term-Acute Care (LTAC)	23	1	1	0	0	0
Rehabilitative/Specialty	19	47	1	5	3	4
TOTAL	**116**	**115**	**7**	**14**	**9**	**10**
Provider Type	**Kankakee**		**Lake**		**Will**	
	Aetna	**IlliniCare**	**Aetna**	**IlliniCare**	**Aetna**	**IlliniCare**
Acute In-Patient	2	1	5	4	3	5
Behavioral Health	1	0	4	3	2	1
Long Term-Acute Care (LTAC)	0	0	2	0	0	0
Rehabilitative/Specialty	1	1	2	3	2	4
TOTAL	**4**	**2**	**13**	**10**	**7**	**10**

Data Source :Summarized Information from MCO Data Submitted to HSAG in January 2014

E. MCO websites: Extra Tables

- Table 96: Provider Search Engine Detail (Full)
- Table 97: Web Portal Features for Registered Providers
- Table 97: Member Website Comparison: Provider Search Engine
- Table 98: Member Website Comparison: How to File a Grievance
- Table 99: Member Website Comparison: Summary of Benefits Information
- Table 100: Member Website Comparison: Frequently Asked Questions (FAQ)
- Table 101: Provider Website Comparison: Pharmacy Prior Authorization Forms
- Table 102: Provider Website Comparison: Prior Authorization Information
- Table 103 : Provider Website Comparison: Claims and Billing Information

In these tables, reading level and reading ease score were determined using Microsoft Word tools analyzing introductory or explanatory text available on the individual web pages. The Flesch-Kincaid Grade level indicates the grade a person needs to have reached to be able to understand the text. The Flesch-Kincaid Reading Ease score indicates how easy a text is to read (a higher ease score implies an easier text to read). The accessibility of each site for visitors with disabilities was assessed using the Functional Accessibility Evaluator 1.1 developed at the University of Illinois at Urbana-Champaign.

Table 96 fully details the provider search engine available on each MCO website. The table includes search options, filter options, and accessibility options. While IlliniCare does not have as many filter options as Aetna's search engine, IlliniCare surpasses Aetna in accessibility for persons with disabilities regarding text equivalents, scripting, and styling.

Table 96: Provider Search Engine Detail (Full) (FY13)

Measure	Aetna[1]	IlliniCare[2]
Search Options		
Search by location?	Yes	Yes (**MUST provide Zip or County to use search engine)
Search with # of miles of location? (within 5, 10, 25, 50, 75, 100 miles from your location)	Yes	No
Pharmacy Search on page?	Yes, link to another page	Yes, in search engine
Map feature?	No	Yes
Filter Options		
Can filter by: Physician Type?	Yes - 170 options	Yes - 4 options
Can filter by: Provider Name?	Yes	Yes
Can filter by: Office Name/Group Name/Hospital Name?	Yes	Yes
Can filter by: Specialty type?	Yes	Yes
Can filter by: Gender?	Yes	Yes
Can filter by: Accepting New Patients?	Yes	Yes
Can filter by: Ages Served?	Yes	No
Can filter by: Hospital Affiliation?	Yes	Yes
Can filter by: Language?	Yes	Yes
Can filter by: Board Certification?	Yes	No
Can filter by: Accessible offices?	Yes	No – need a separate list PDF
Accessibility Options		
Flesch-Kincaid (English) Reading Level	12.5	4.4
Flesch-Kincaid (English) Reading Ease Score	39.6	77.1
Accessibility: Navigation and Orientation	77% Pass	74% Pass
Accessibility: Text Equivalents	50% Pass	100% Pass
Accessibility: Scripting	100% Pass	100% Pass
Accessibility: Styling	83% Pass	100% Pass
Accessibility: HTML Standards	50% Pass	50% Pass

[1] http://www.aetnabetterhealth.com/illinois/find-provider
[2] http://apps.illinicare.com/findadoc/changeNetwork?prodId=324

Table 97 displays the web portal features offered to registered users of the MCO websites according to the MCO provider handbooks. While some features are mentioned in both MCO handbooks, IlliniCare does not mention several education options available through Aetna's portal, and Aetna's portal lacks some features available within IlliniCare's portal including viewing patient history and submitting claim adjustments.

Table 97: Web Portal Features for Registered Providers (FY13)

Measure	Aetna	IlliniCare
Prior Authorization Submission	Yes	Yes
PA Status Inquiry	Yes	Yes
Claim Status Inquiry	Yes	Yes
Eligibility Status Inquiry	Yes	Yes
Member Education	Yes	
Provider Education	Yes	
Outreach Materials	Yes	
PCP panel (patient list)		Yes
Submit Claims Adjustment		Yes
View Patient History		Yes
Member gaps in care		Yes
Quality scorecard		Yes
Contact confidentially		Yes

Data Sources: MCO Provider Handbooks

Table 98 displays a comparison of MCO member websites regarding the content area of filing a grievance. The information was not contained in a single location on IlliniCare's website. Aetna's information regarding grievances had a higher reading level than IlliniCare's information.

Table 98: Member Website Comparison: How to File a Grievance (FY13)

Measure	Aetna[1]	IlliniCare[2]
Clicks from homepage	4 clicks	3 clicks; 3 clicks
Location on site	Found in Resources section	Information located in Member Handbook Information in FAQ section
Detailed instructions for filing?	Yes	Yes
Grievance committee review timeline included?	No	Yes
Accessibility		
Flesch-Kincaid (English) Reading Level	8	5.8 (Link 1 only)
Flesch-Kincaid (English) Reading Ease Score	61.5	60 (Link 1 only)
Accessibility: Navigation and Orientation	81% Pass	88% Pass (Link 2 only)
Accessibility: Text Equivalents	50% Pass	75% Pass (Link 2 only)
Accessibility: Scripting	100% Pass	100% Pass (Link 2 only)
Accessibility: Styling	83% Pass	83% Pass (Link 2 only)
Accessibility: HTML Standards	50% Pass	0% Pass (Link 2 only)

[1] http://www.aetnabetterhealth.com/illinois/members/icp/resources
[2] http://www.illinicare.com/files/2011/10/IlliniCare-Member-Handbook_Draft_3-29-11-final.pdf and http://www.illinicare.com/for-members/frequently-asked-questions/faqs-about-illinicare/

Table 99 displays a comparison of MCO member websites regarding the content area of benefits information. IlliniCare's site did not include a definition of medical necessity, nor did it include a list of services that were explicitly not covered in the plan. Aetna's information regarding benefit information had a slightly higher reading level and a slightly lower reading ease score than IlliniCare's information.

Table 99: Member Website Comparison: Summary of Benefits Information (FY13)

Measure	Aetna[1]	IlliniCare[2]
Clicks from homepage	3 clicks	2 clicks
Website Options		
Location on site	Link from Drop Down Menu	Side Menu Item
Benefit chart included?	Yes	Yes
Definition of medical necessity?	Yes	No
Non-covered service list included?	Yes	No
Accessibility		
Flesch-Kincaid (English) Reading Level	8.8	8
Flesch-Kincaid (English) Reading Ease Score	53	57
Accessibility: Navigation and Orientation	74% Pass	85% Pass
Accessibility: Text Equivalents	50% Pass	75% Pass
Accessibility: Scripting	100% Pass	100% Pass
Accessibility: Styling	83% Pass	83% Pass
Accessibility: HTML Standards	50% Pass	0% Pass

[1] http://www.aetnabetterhealth.com/illinois/members/icp/benefit-summary
[2] http://www.illinicare.com/for-members/benefit-information/

Table 100 displays a comparison of MCO member websites regarding the content area of frequently asked questions (FAQ). Many of the topics covered in Illinicare's FAQ section were not covered by Aetna. Aetna's content had a higher reading level than IlliniCare as well as a lower reading ease score.

Table 100: Member Website Comparison: Frequently Asked Questions (FAQ) (FY13)

Measure	Aetna[1]	IlliniCare[2]
Clicks from homepage	3 clicks	3 clicks
Location on site	Link from Drop Down Menu	Side Menu Item
Accessibility		
Flesch-Kincaid (English) Reading Level	10.4	8.3
Flesch-Kincaid (English) Reading Ease Score	51.2	58.4
Accessibility: Navigation and Orientation	85% Pass	85% Pass
Accessibility: Text Equivalents	50% Pass	75% Pass
Accessibility: Scripting	100% Pass	100% Pass
Accessibility: Styling	83% Pass	83% Pass
Accessibility: HTML Standards	50% Pass	0% Pass
Questions		
Topic of Questions	ID Card (2)	ID Card (2)
	Contacting ABH (1)	Contacting IC (2)
	PCP (3)	PCP (4)
	Specialists (2)	
	Emergency Care (2)	Emergency Care (2)
	Vision/Dental (1)	Vision/Dental (2)
	Prescription (1)	Prescription (1)
	Transportation (1)	Transportation (1)
	Accessible Resources (1)	
	Integrated Care Program (7)	Integrated Care Program (6)
	Medical Home (2)	Medical Home (1)
	Care Manager (1)	Care Coordinator (1)
		IlliniCare Organization Information (2)
		Benefit Coverage (1)
		Network Coverage (1)
		Filing a Grievance (1)
		Health Risk Screening (1)
		Preventive Health Services (1)

[1] http://www.aetnabetterhealth.com/illinois/members/icp/faqs
[2] http://www.illinicare.com/for-members/frequently-asked-questions/faqs-about-the-integrated-care-program/

Table 101 displays a comparison of MCO provider websites regarding the content area of pharmacy prior authorization forms. IlliniCare's site could not be scored for reading level or reading ease because it was a list format without any explanatory text. However, IlliniCare's pharmacy PA forms were conveniently linked from the general forms section, unlike Aetna.

Table 101: Provider Website Comparison: Pharmacy Prior Authorization Forms (FY13)

Measure	Aetna[1]	IlliniCare[2]
Clicks from homepage	3 clicks	4 clicks
Location on site	Link from Drop Down Menu	Link from Drop Down Menu
Flesch-Kincaid (English) Reading Level	12.0	N/A
Flesch-Kincaid (English) Reading Ease Score	39.3	N/A
Accessibility: Navigation and Orientation	77% Pass	81% Pass
Accessibility: Text Equivalents	50% Pass	50% Pass
Accessibility: Scripting	100% Pass	100% Pass
Accessibility: Styling	83% Pass	66% Pass
Accessibility: HTML Standards	50% Pass	0% Pass
Notes	Pharmacy PA forms found separately from general forms, located in Pharmacy section	Found linked in Resources section, linked to general forms

Data Sources: The Flesch-Kincaid Grade level retrieved using Microsoft Word tools.
The Flesch-Kincaid Reading Ease score retrieved using Microsoft Word tools.
Accessibility of Navigation and Orientation, Text Equivalents, Scripting, Styling, and HTML Standards retrieved using the Functional Accessibility Evaluator 1.1 (developed at University of Illinois at Urbana-Champaign) from http://fae.cita.illinois.edu/
[1] http://www.aetnabetterhealth.com/illinois/providers/icp/pharmacy
[2] http://www.illinicare.com/forproviders/resources/specialty-drug-pa-forms/

Table 102 displays a comparison of MCO provider websites regarding the content area of prior authorization information. Aetna's website had a much higher reading level and much lower reading ease score than IlliniCare. Aetna's website would also not clearly provide a list of services requiring PA to unregistered users.

Table 102: Provider Website Comparison: Prior Authorization Information (FY13)

Measure	Aetna[1]	IlliniCare[2]
Clicks from homepage	2 clicks	3 clicks
Prior Authorization Access		
Location on site	Link from Drop Down Menu	Side Menu Item
Provides instructions for submission?	Yes	Yes
Can you submit a claim here?	No, must be a registered user to submit	No, must be a registered user to submit
PA Services List?	No, list services requiring PA only available to registered users	Yes, includes list of services that require PA
Accessibility		
Flesch-Kincaid (English) Reading Level	15.7	10.9
Flesch-Kincaid (English) Reading Ease Score	13.6	34.6
Accessibility: Navigation and Orientation	81% Pass	77% Pass
Accessibility: Text Equivalents	50% Pass	100% Pass
Accessibility: Scripting	100% Pass	100% Pass
Accessibility: Styling	83% Pass	83% Pass
Accessibility: HTML Standards	50% Pass	0% Pass

Data Sources: The Flesch-Kincaid Grade level retrieved using Microsoft Word tools.
The Flesch-Kincaid Reading Ease score retrieved using Microsoft Word tools.
Accessibility of Navigation and Orientation, Text Equivalents, Scripting, Styling, and HTML Standards retrieved using the Functional Accessibility Evaluator 1.1 (developed at University of Illinois at Urbana-Champaign) from http://fae.cita.illinois.edu/
[1] http://www.aetnabetterhealth.com/illinois/providers/resources/priorauth
[2] http://www.illinicare.com/for-providers/auths/

Table 103 displays a comparison of MCO provider websites regarding the content area of claims and billing information. Aetna's website had a higher reading level and a lower reading ease score than IlliniCare. Aetna's website would also not clearly provide detailed instructions for claim submission to providers or informational links to third party affiliates for claim submission and billing.

Table 103: Provider Website Comparison: Claims and Billing Information (FY13)

Measure	Aetna[1]	IlliniCare[2]
Clicks from homepage	3 clicks	3 clicks; 2 clicks; 3 clicks
Claims and Billing Access		
Location on site	Link from Drop Down Menu	Side Menu Item
Instructions for claim submission?	No	Yes (1)
Information about third party affiliates?	Yes, but no link.	Yes, with links (2&3)
Accessibility		
Flesch-Kincaid (English) Reading Level	14.0	11.7 (Link 1 only)
Flesch-Kincaid (English) Reading Ease Score	26.0	37.9 (Link 1 only)
Accessibility: Navigation and Orientation	81% Pass	81% Pass (Links 2 & 3)
Accessibility: Text Equivalents	50% Pass	50% Pass (Links 2 & 3)
Accessibility: Scripting	100% Pass	100% Pass (Links 2 & 3)
Accessibility: Styling	83% Pass	66% Pass (Links 2 & 3)
Accessibility: HTML Standards	50% Pass	0% Pass (Links 2 & 3)
Notes	Contacting Provider Services is suggested by Aetna in this content area.	Site provides detailed instructions for filing a claim.

Data Sources: The Flesch-Kincaid Grade level retrieved using Microsoft Word tools.
The Flesch-Kincaid Reading Ease score retrieved using Microsoft Word tools.
Accessibility of Navigation and Orientation, Text Equivalents, Scripting, Styling, and HTML Standards retrieved using the Functional Accessibility Evaluator 1.1 (developed at University of Illinois at Urbana-Champaign) from http://fae.cita.illinois.edu/
[1] http://www.aetnabetterhealth.com/illinois/providers/resources/claims
[2] http://www.illinicare.com/files/2011/10/IlliniCare-Provider-BILLING-Manual-_04-2011.pdfwithcover.pdf and http://www.illinicare.com/for-providers/electronic-transactions/payformance/ and http://www.illinicare.com/for-providers/electronic-transactions/

F. Accessibility of Provider Offices

- Table 104: Accessibility Definitions and Verification Procedures

Table 104 outlines the accessibilities definitions and verifications procedures for each MCO as compared to FFS Medicaid. This information was obtained through phone interviews with representatives from the MCOs. No content was provided for this area by FFS Medicaid.

Table 104: Accessibility Definitions and Verification Procedures

Measure	Aetna	IlliniCare
1. Is there a definition of what constitutes "physical access"?	Aetna's self-assessment form of ADA requirements. This gets simplified into basic categories of "Handicap Accessible" yes or no.	Modified ADA self-assessment form is simplified into basic categories of "Handicap Accessible," yes or no. Offices are marked as not accessible if any one of their answers are marked not accessible.
2. How did you confirm whether "accessibility to provider office locations" is adequate?	Each provider site has to fill out the self-assessment form.	Provider completes paper form upon credentialing.
3. How many on-site assessments of an offices' accessibility were completed?	None. When provider relation staff visit a site, they may informally note an issue but no data is collected currently. An onsite assessment form is being planned.	None. However, onsite verification of the form is planned with random sampling of offices.
4. In addition to self assessments, is there another method for confirming the accessibility of a doctor's office?	Informally, case coordinators reach out to providers to ask about accessibility of offices when scheduling appointments for a member with a disability.	Informally, case coordinators reach out to providers to ask about accessibility of offices when scheduling appointments a member with a disability.
5. Is there any language in your contracts with providers regarding accessibility of provider sites?	No. It is simply part of the credentialing process for any provider.	No. It is simply part of the credentialing process for any provider.
6. Does the language require providers to submit any proof (documentation) of accessibility?	No. They just have to fill out paper form.	No. They just have to fill out paper form.
7. When does the confirmation of the provider's accessibility occur? During credentialing? After credentialing? Other?	During credentialing.	During credentialing and after 3 years for re-credentialing.
8. For group providers that have multiple sites, do you require all sites be physically accessible, or only some of the sites?	Assessment form done for each location for group providers with multiple sites.	Assessment form done for each location for group providers with multiple sites.
9.. How did you ensure that "All provider locations where Enrollees receive services comply with the requirements of ADA"? (Section 2.8 of Contract)	Use assessment form.	Start with the assessment form and then if issues arise, take corrective action or terminate contract.
10. How do you determine what languages the provider is proficient in, including American Sign Language?	The language benefit for Aetna provides services for ASL and other languages. It is prescheduled through language services. An interpreter for any language can be provided.	IlliniCare provides interpreter services. Member asks for sign language interpreter. Every provider orientation includes cultural competency and this includes disability awareness training.
11. Is information on accessibility used for scheduling persons with disabilities for different locations or providers?	Data from self-assessment forms are entered into a database. When a provider is pulled up on the website they are marked as accessible.	Data from self-assessment forms are entered into a database and into categories. The scheduler can see which providers are accessible.

Data Sources: Phone Interviews with Representatives from each MCO

G. Care Coordinators: Extra Tables

- Table 105: Care Coordinators Allowed Qualifications for Waivers
- Table 106: Care Coordinators – Required Training
- Table 107: Care Coordinators Required Qualifications for Waivers
- Table 108: Training for MCO Care Coordinators

Table 105, below, illustrates the required qualifications for Care Coordinators to work with waiver services.

Table 105: Care Coordinators Allowed Qualifications for Waivers (FY13)

Qualification	Waiver Type			
	Elderly	TBI	HIV	DRS
Registered Nurse	X	X	X	X
LPN	X			X
Doctorate Level				
MSW			X	
Other Masters				X
Licensed Professional Counselor		X		X
Bachelor Level	X		X	X
Vocational Specialist		X		
Commensurate Work Experience	X			
Licensed Social Worker		X		
Certified Case Manager		X		
Unlicensed Social Worker		X		
Licensed Clinical Professional Counselor		X		X
Licensed Clinical Social Worker				X
Licensed Marriage and Family Therapist				X
PsyD				X

Table 106 shows the required training of care coordinators. The table details the training under all waivers, and additional focused training for each individual waiver category.

Table 106: Care Coordinators – Required Training (FY13)

FFS Medicaid Waiver	Required Training
ALL Waivers	Care Coordinators for HCBS Waiver Enrollees shall receive a minimum of 20 hours in-service training initially and annually. For partial years of employment, training shall be prorated to equal one-and–a-half (1.5) hours for each full month of employment.
Elderly Waiver	Training must include Aging related subjects.
TBI Waiver	Training must include training relevant to the provision of services to persons with brain injuries.
HIV/AIDS Waiver	Training must include training relevant to the provision of services to persons with AIDS (e.g., infectious disease control procedures, sensitivity training, and updates on information relating to treatment procedures).
DRS Disability Waiver	No special topics specified
Supported Living Waiver	Training on the following subjects: resident rights; prevention and notification of Abuse, Neglect, and exploitation; behavioral intervention, techniques for working with the elderly and persons with disabilities; and, disability sensitivity training is required.

Data Source: MCO Contract with State of Illinois

Table 107 outlines the required qualifications for care coordinators for each FFS Medicaid waiver as mandated in the MCO contracts. Qualifications are detailed by minimum education and job experience.

Table 107: Care Coordinators Required Qualifications for Waivers (FY13)

FFS Medicaid Waiver	Education	Job Experience
Elderly Waiver (must meet at least 1 of the 4 Education or Experience requirements)	-Registered Nurse (RN) Licensed in Illinois -Bachelor's Degree in Nursing, Social Sciences, Social Work, or Related Field	-LPN with one (1) year experience in conducting comprehensive assessments and provision of formal service for the elderly -One (1) year of satisfactory program experience may replace one year of college education, at least four (4) years of experience replacing baccalaureate degree
TBI Waiver (must meet at least 1 of the 7 Education or Experience requirements)	-Registered Nurse (RN) Licensed in Illinois -Certified or Licensed Social Worker -Unlicensed Social Worker: Minimum of Bachelor's Degree in Social Work, Social Sciences, or Counseling -Licensed Clinical Professional Counselor (LCPC) -Licensed Professional Counselor (LPC) -Certified Case Manager (CCM)	-Vocational specialist: certified rehabilitation counselor or at least three (3) years' experience working with people with disabilities
HIV (must meet at least 1 of the 3 Education or Experience requirements)	-A Registered Nurse (RN) licensed in Illinois and a Bachelor's degree in nursing, social work, social sciences or counseling or four (4) years of case management experience. -A Social worker with a bachelor's degree in either social work, social sciences or counseling (A Bachelor's of social work or a Masters of social work from a school accredited by any organization nationally recognized for the accreditation of schools of social work is preferred).	-Individual with a bachelor's degree in a human services field with a minimum of five (5) years of case management experience.
DRS Disability (must meet at least 1 of the 9 Education or Experience requirements)	-Registered Nurse (RN) -Licensed Clinical Social Worker (LCSW) -Licensed Marriage and Family Therapist (LMFT) -Licensed Clinical Professional Counselor (LCPC) -Licensed Professional Counselor (LPC) -PhD -Doctorate in Psychology (PsyD) -Bachelor or Master's Degrees in Human Services Related Fields -Licensed Practical Nurse (LPN)	
SLF	None Specified	None Specified

Data Sources: MCO Contracts

Table 108 displays training sessions available to MCO Care Coordinators during the year.

Table 108: Training for MCO Care Coordinators (FY13)

Date of Training	General Topic	Presenter	Attendance
Oct 31 2012 – Dec 10 2013 (varies from 3 to 9 days of training)	Onboarding Training - 20hrs (IlliniCare employees only)	IlliniCare	59 Total Trainees Oct 31 – Nov 8 2012 (10 trainees) Nov 23 – Nov 30 2012 (9 trainees) Dec 6 – Dec 11 2012 (3 trainees) Mar 20 – Mar 28 2013 (11 trainees) Sept 30 – Oct 4 2013 (4 trainees) July 22 – July 26 2013 (5 trainees) Aug 19 – Aug 23 2013 (6 trainees) Nov 5 – Nov 8 2013 (4 trainees) Dec 5 – Dec 10 2013 (7 trainees)
June 5 & 6, 2013	Department of Aging Training	Department of Aging	40 Total Trainees Aetna = 1 trainee IlliniCare = 0 trainees
September 6	How to Report Critical Incidents	Division of Rehabilitation Services, Department of Aging and SLF staff combined	
November 1	DON Training	Department of Aging	
November 13	All day onsite meeting in Chicago to explain services, policies, IT, etc.	Division of Rehabilitation Services	
November 14 & 15	DON and Service Plan Training	Division of Rehabilitation Services	
November 26 & 27	Two-day onsite meeting in Springfield to explain their waiver, their services, their policies	Department of Aging	
December 3	Home Modifications	Division of Rehabilitation Services	
December 3	Assistive Technology	Division of Rehabilitation Services	
January 7	Fraud within the Home Services Program	Division of Rehabilitation Services, HFS' OIG	
January 9	Customer and Provider Packets	Division of Rehabilitation Services	
December 5	Customer and Provider Packets	Service Employees International Union	
March 8	Housing Services	Housing Coordinators	Only some MCO staff (such as IlliniCare's Colbert team) receives this training. This training is a component of an employee's Colbert contract but not typically covered in ICP training.

H. Care Plans: Extra Tables

- Table 109: Initial Health Risk Screening
- Table 110: Completion of "In-Depth Assessment"
- Table 111: Development of Care Plans
- Table 112: Risk Stratification of Special Groups

Table 109 displays the new enrollments and completed initial health risk screenings for each MCO in Year 1 and Year 2 of the ICP.

Table 109: Initial Health Risk Screening (FY13)

Measure	Year 1		Year 2	
	Aetna	IlliniCare	Aetna	IlliniCare
Total enrollments for year in dataset		14,528		3,278
Disallowed due to date problems		-2		-23
Total new enrollments	21,672	14,526	3,435	3,255
Screenings completed	11,029	10,708	1,202	1,886
# completed in 60 days	6,658	4,866	935	1,576
Total days for completions	1,112,600	1,367,336	67,244	59,242
% screenings completed	50.9%	73.7%	35.0%	57.9%
% completed in 60 days	30.7%	33.5%	27.2%	48.4%
Ave days to complete	100.9	127.7	55.9	31.4

Data Source: MCO Special Datasets

Table 110 displays the new enrollments and completed "in-depth" assessments for each MCO in Year 1 and Year 2 of the ICP.

Table 110: Completion of "In-Depth Assessment" (FY13)

Measure	Year 1		Year 2	
	Aetna	IlliniCare	Aetna	IlliniCare
Total enrollments for year in dataset		14,528		
Disallowed due to date problems		-2		
Total new enrollments	21,672	14,526	3,435	3,754
Needing assessment	6,007	3,106	1,123	923
# completed in 60 days	1,980	1,166	831	557
Total days for completions	1,465,730	476,661	71,115	86,762
% Needing assessment	27.7%	21.4%	32.7%	24.6%
% completed in 60 days	33.0%	37.5%	74.0%	60.3%
Ave days to complete	244.0	153.5	63.3	94.0

Data Source: MCO Special Datasets

Table 111 displays the new enrollments and completed care plans for each MCO in Year 1 and Year 2 of the ICP.

Table 111: Development of Care Plans (FY13)

Measure	Year 1		Year 2	
	Aetna	IlliniCare	Aetna	IlliniCare
Total enrollments for year in dataset		14,528		3,278
Disallowed due to date problems		-2		-23
Total new enrollments	21,672	14,526	3,435	3,255
Needing care plans	2,698	2,696	482	531
# completed in 90 days	45	422	221	325
Total days for completions	1,174,651	870,645	66,408	51,117
% Needing care plans	12.4%	18.6%	14.0%	16.3%
% completed in 90 days	1.7%	15.7%	45.9%	61.2%
Ave days to complete	435.4	322.9	137.8	96.3

Data Source: MCO Special Datasets

Table 112 displays the risk stratification of waiver groups in each MCO as submitted to HFS by the MCOs. Groups are stratified by low, medium, and high risk levels.

Table 112: Risk Stratification of Special Groups (FY13)

Group	High Risk		Medium Risk		Low Risk	
	Aetna	IlliniCare	Aetna	IlliniCare	Aetna	IlliniCare
Waiver – DD	9	21	44	49	76	309
Long Term Care	21	115	1,283	126	0	1,118
Behavioral Health	131	654	2,356	216	677	1,236
Waiver-Persons with Disability	9	183	545	294	0	1,153
Waiver-Brain Injury	8	17	112	32	0	111
Waiver-HIV	6	10	28	10	0	15
Waiver-Elderly	4	65	592	137	0	626
Waiver-SLF	0	1	11	12	0	47
Percent of Total Enrollees	3.2%	16.3%	84.1%	13.4%	12.7%	70.4%

Data Source: Monthly Report MCOs submit to HFS called "CM.DM Summary"

I. Prior Authorizations: Extra Tables

- Table 113: Outpatient Requests

Table 113 illustrates the outpatient requests for each MCO and the total ICP as reported in the MCO special data sets. The table outlines both the standard and expedited requests. IlliniCare reported more total requests than Aetna for both standard and expedited requests.

Table 113: Outpatient Requests (FY13)

Measure	Total ICP	Aetna	IlliniCare
# of total requests	33,255	12,812	20,443
Member Months	424,440	212,846	211,594
Standard	31,558	12,812	18,746
Expedited	1,697	0	1,697
Standard Requests			
Standard Outpatient per 1,000 MM	74.0	59.7	88.3
% Approved	96.9%	95.4%	98.0%
Mean number of days to decision	4.3	2.8	5.3
% decided within 10 days	99.2%	97.5%	85.0%
Expedited Requests			
Expedited Outpatient per 1,000 MM	4.0	0.0	8.0
% Approved	98.8%	-	98.8%
Mean number of days to decision	1.8	-	1.8
% decided within 1 day	82.2%	-	82.2%

Data Source: MCO Special Datasets

J. Grievances and Appeals: Extra Tables

- Table 114: Difference between “Complaint,” “Grievance,” and “Appeals”
- Table 115: Overview of Complaint Process
- Table 116: Responsibilities of the Plans
- Table 117: Timelines for “Complaint,” “Grievance,” and “Appeals”
- Table 118: HFS Grievances (Oct-Dec 2013)

Table 114 illustrates the difference between a complaint, a grievance, and an appeal. These definitions are stated in the MCO contracts.

Table 114: Difference between "Complaint," "Grievance," and "Appeals"

Contact Section	Question	Contract Language
1.29	What is a complaint?	Complaint means a phone call, letter or personal contact from a Participant, Enrollee, family member, Enrollee representative or any other interested individual expressing a concern related to the health, safety or well-being of an Enrollee.
1.18	What is an appeal?	Appeal means a request for review of a decision made by Contractor with respect to an Action.
1.8	From the definition of appeal above, what kind of "action" is section 1.18 referring to?	Action means (i) the denial or limitation of authorization of a requested service; (ii) the reduction, suspension, or termination of a previously authorized service; (iii) the denial of payment for a service; (iv) the failure to provide services in a timely manner; (v) the failure to respond to an Appeal in a timely manner, or (vi) solely with respect to an MCO that is the only contractor serving a rural area, the denial of an Enrollee's request to obtain services outside of the Contracting Area.
1.64	What is a grievance?	Grievance means an expression of dissatisfaction by an Enrollee, including Complaints and requests for disenrollment, about any matter other than a matter that is properly the subject of an Appeal. IlliniCare: "A Grievance is an expression of dissatisfaction from a member (or authorized representative) while an appeal is a request to reconsider a decision to limit, terminate or deny a service or item such as a DME. Grievances not resolved to the member's satisfaction can be escalated to Grievance Committee for further review, then to the Department. Appeals can be escalated to external review, fair hearing process, or both."

Data Sources: MCO Contracts

Table 115 displays an overview of the complaint process for each MCO and FFS Medicaid. The table details the process in terms of ways to submit a grievance, initial response time, and 2nd level action.

Table 115: Overview of Complaint Process (FY13)

Item	Aetna	IlliniCare	FSS Medcaid
1. How to Submit Grievance	Mail-Yes; Fax-Yes; Phone-Yes; Online-No	Mail-Yes; Fax-Yes; Phone-Yes; Online-No	Mail-Yes; Fax-No; Phone-Yes; Online-No
2. Initial Response Timeline	Member/Provider files "grievance" with plan--plan has 30 days to respond but may ask for an additional 14 days.	Member/Provider files "grievance" with plan--plan has 30 days to respond but may ask for an additional 14 days.	Member/Provider files "complaint" with Illinois Health Connect--which has 30 days to respond.
3. 2nd Level	If member/provider not satisfied, he/she may file "appeal" with HFS thru the "Fair Hearing" process. Providers do not have right to Fair Hearing unless they have received written authorization from the member.	If member/provider not satisfied, he/she may file "appeal" with HFS thru the "Fair Hearing" process.	If member/provider not satisfied, he/she may file "appeal" with HFS thru the "Fair Hearing" process.

Data Sources: MCO and FFS Handbooks and Narratives

Table 116 displays the responsibilities of the plans when handling grievances and appeals from members as mandated in the MCO contracts. The table details information MCOs need to track, meeting and committee parameters, and information about the appeals process.

Table 116: Responsibilities of the Plans (FY13)

Contract Section	Question	Contract Language
Attachment XIII	What information does the plan need to track for grievances and appeals?	Contractor shall submit a detailed report on Grievances and Appeals providing Enrollee Medicaid number, Enrollee name, description of Grievance, date received, incident date, date resolved, source of Grievance, status (open or closed), reason closed, incident summary and resolution summary, grouped by incident type.
5.26.2, 5.26.1.3	Does a formal meeting have to be held for a grievance or appeal?	A formally structured Grievance Committee that is available for Enrollees whose Grievances cannot be handled informally; Contractor must have a committee in place for reviewing Appeals made by its Enrollees.
5.26.1	What action does the plan have to take in response to a grievance or an appeal?	Contractor's procedures must: (I) be submitted to the Department in writing and approved in writing by the Department; (ii) provide for prompt resolution, and (iii) assure the participation of individuals with authority to require corrective action.
5.26.1	Can a grievance be appealed?	All Grievances shall be registered initially with Contractor and may later be appealed to the Department.
5.26.1.4	Can a member appeal to an external party?	Final decisions under the Managed Care Reform and Patient Rights Act procedures and those of the Grievance Committee may be appealed by the Enrollee to the Department under its Fair Hearings system.

Data Sources: MCO Contracts

Table 117 outlines the timelines for complaints, grievances, and appeals as mandated in the MCO contracts. The table details MCO response times as well as information regarding expedited grievances and appeals.

Table 117: Timelines for "Complaint," "Grievance," and "Appeals" (FY13)

Code of Federal Regulations Section	Question	Contract Language
	What is the timeline for responding to a complaint?	Not specified
438.408 (b) (1)	What is the timeline for responding to a grievance?	Within 90 days of receiving grievance
438.408 (b) (3)	What is the timeline for responding to an appeal?	Within 45 days of receiving appeal
5.26.1.2	Can a grievance be expedited?	The plan must have procedures "to ensure expedited decision making when an Enrollee's health so necessitates."
438.408 (b) (2)	What is the timeline for expedited appeal?	Within 3 working days of plan receiving appeal

Data Sources: MCO Contracts

Table 118 illustrates HFS grievances, including the type of issue, number, and corresponding percentage.

Table 118: HFS Grievances (Oct-Dec 2013)

Issue	#	%
All Kids/County Code 180	44	3.5%
Billing	227	18.0%
DentaQuest	33	2.6%
DHS Local Office	422	33.4%
DME	23	1.8%
Illinois Health Connect	27	2.1%
Illinois Health Women	1	0.1%
Long Term Care	4	0.3%
MCO	49	3.9%
MediCare	143	11.3%
Optical	148	11.7%
Transportation	8	0.6%
Other	135	10.7%
Total	**1264**	**100.0%**

K. Transportation: Extra Tables

- Table 119: Transportation Policies and Procedures
- Table 120: Call Centers
- Table 121: Other Modes of NEMT Travel
- Table 122: Travel & Cost by Categories of Service
- Table 123: Non-Emergency Medical Transportation Utilization
- Table 124: Travel Days by Categories of Service

Table 119 details the transportation policies and procedures for each MCO as well as FFS Medicaid. The table details eligibility criteria for members to receive transportation services, tracking procedures, and trip allowances and approvals.

Table 119: Transportation Policies and Procedures (FY13)

Measure	Aetna	IlliniCare	FFS Medicaid
1. What are the eligibility criteria for transportation service? Or can any member use the program as long as the other conditions of the trip are met?	Any member is eligible for transportation benefit. However, the general contractor screens each member to determine the category of service that will be provided. MTM may recommend a member use personal transportation, the bus or para-transit service.	Any member is eligible for transportation benefit. However, the general contractor screens each member to determine the category of service that will be provided. First Transit may recommend a member or if a member use their own personal transportation, the bus or para-transit service.	The Recipient must be transported to a Medicaid covered medical service. Additionally, the trip request must be to the closest appropriate and available medical provider in the least expensive mode of transportation. Both Recipient and transportation provider must be eligible for transportation services.
2. How is the number of "provider no shows" tracked?	By MTM	Through a trip booking software.	First Transit posts a denial of transportation services.
3. How is information on transportation complaints tracked?	Becomes a grievance. Aetna works with MTM to follow-up with providers	Becomes a grievance. Illinicare works with First Transit to follow-up with providers.	Through First Transit's prior approval system.
4. How are cancellations tracked?	By MTM call center	By First Transit through a trip booking software.	Through First Transit's prior approval system.
5. Are 'Missed Appointments' due to transportation being late tracked?	No, they find out after-the-fact and it becomes grievance if member complains.	Missed trips due to transportation being late would be included as a category of cancellation.	Not tracked
6. Are trips to pharmacy allowed after a doctor's appointment?	It is a policy that transportation providers allow members to stop by pharmacy.	It is a policy that transportation providers allow members to stop by pharmacy.	Trips to the pharmacy are not covered by Illinois Medicaid under NETSPAP.
7. How are the credentials of the transportation providers verified?	Credentials are verified when providers apply to MTM and must prove proper insurance, maintenance and working condition of vehicles.	Credentials are verified when providers apply to First Transit. First Transit employs a Transportation Manager for credentialing transportation providers, who performs on site vehicle inspections, verifies insurance and ensures that criminal background checks and drug screen policies and procedures are in place and being followed.	Provider credentialing is not a responsibility under NETSPAP.

Data Sources: Phone Interviews with Representatives from each MCO

Table 120 presents information regarding call centers for transportation services. The table details information for both MCOs as well as FFS Medicaid. This table illustrates the number of call centers for each entity, information collected during calls, and how the collected information is kept at the call centers.

Table 120: Call Centers (FY13)

Measure	Aetna	IlliniCare	FFS Medicaid
1. How many call centers are there for the Medicaid population or the ICP program?	One dedicated call center with MTM	One dedicated call center with First Transit	One dedicated call center with First Transit
2. What information is collected at the call center?	Member name, ID#, address, phone, date and of appointment, appointment reason (type of service), doctor/facility name, address, phone, special needs (wheelchair, crutches, pregnancy), additional passengers/attendants.	Name, Member number, pickup and drop off addresses, phone number, reason for the request, date and time of service, category of service, mileage, transportation provider, Provider ID, NPI (if applicable), cost of trip, license plate and exact pickup and drop off times.	All trip related data, Recipient eligibility, provider file, historical data, phone recording.
3. How is data from call centers kept?	Trip information is stored in our AS400 scheduling system. Call Center Information is stored in our Cisco Server	Call center data is kept in a SQL database.	In the vendor's prior authorization software program (SQL).

Data Sources: Phone Interviews with Representatives from each MCO

Table 121 shows other modes of NEMT travel for each MCO and FFS Medicaid. The table details information regarding credential providers, Pace paratransit service, types of vehicles, and reimbursement.

Table 121: Other Modes of NEMT Travel (FY13)

Measure	Aetna	IlliniCare	FFS Medicaid
1. What Non-NEMT credentialed providers were paid for transportation services?	Para-transit, fixed route and Taxi	Para-transit, fixed route and Taxi	Para-transit, fixed route and Taxi
2. Is Pace- Paratransit service utilized for medical appointments? If so, how?	Yes. Those individuals who are registered for para-transit through the RTA are sent tickets to use on para-transit.	Yes. Those individuals who are registered for para-transit through the RTA are sent tickets to use on para-transit.	Yes, when a Recipient is registered for ADA Paratransit, tickets are purchased and mailed to the Recipient to accommodate their transportation requests.
3. Did the type of vehicle used for transport change over time or remain the same as year 1?	Yes, seen in table 34	Yes, seen in table 34	The most predominate mode of transportation continues to be via service car.
4. Is transportation reimbursed if using private vehicle, public transportation or did not schedule a ride?	Members can get reimbursed for private vehicle mileage but most do not submit this claim.	Members can get reimbursed for private vehicle mileage but most do not submit this claim. Transportation is reimbursed for public transportation as long as notice is in advance of transport. Transportation is not reimbursed if the ride was not scheduled. All transportation must have prior approval.	Yes, but all transports must follow the prior approval process.

Data Sources: Phone Interviews with Representatives from each MCO

Table 122 displays the travel and cost of transportation services by category for each MCO and across time.

Table 122: Travel & Cost by Categories of Service

Measure	ICP		ICP FY13 Detail	
	FY11	FY13	Aetna	IlliniCare
Member Travel Days				
Nonemergency Ambulance	3,419	2,610	1,067	1,543
Medicar	16,290	7,662	3,389	4,273
Taxi	2,101	11,795	10,455	1,340
Service car	57,791	72,428	38,781	33,647
Private transportation	1,635	2,479	2,476	3
Bus or paratransit (other)	2,446	2,048	1,618	430
Total	**83,682**	**99,022**	**57,786**	**41,236**
% of Total Member Travel Days				
Nonemergency Ambulance	4.1%	2.6%	1.8%	3.7%
Medicar	19.5%	7.7%	5.9%	10.4%
Taxi	2.5%	11.9%	18.1%	3.2%
Service car	69.1%	73.1%	67.1%	81.6%
Private transportation	2.0%	2.5%	4.3%	0.0%
Bus or paratransit (other)	2.9%	2.1%	2.8%	1.0%
Total Costs				
Nonemergency Ambulance	$416,512.89	$564,218.19	$231,207.27	$333,010.92
Medicar	$341,186.85	$442,147.72	$239,728.38	$202,419.34
Taxi	$35,021.32	$734,204.70	$655,985.22	$78,219.48
Service car	$997,109.62	$2,843,378.03	$1,722,961.69	$1,120,416.34
Private transportation	$27,679.79	$24,437.46	$24,357.22	$80.24
Bus or paratransit (other)	$60,143.96	$11,785.67	$9,239.06	$2,546.61
Cost per Member travel day				
Nonemergency Ambulance	$121.82	$216.25	$216.69	$215.82
Medicar	$20.94	$59.05	$70.74	$47.37
Taxi	$16.67	$60.56	$62.74	$58.37
Service car	$17.25	$38.86	$44.43	$33.30
Private transportation	$16.93	$18.29	$9.83	$26.75
Bus or paratransit (other)	$24.59	$5.82	$5.71	$5.92

Data Source: MCO Special Datasets, HFS Baseline Encounter Data

Table 117 displays non-emergency medical transportation utilization over time and for each MCO.

Table 123: Non-Emergency Medical Transportation Utilization (FY13)

Measure	ICP		ICP FY13 Detail	
	FY11	FY13	Aetna	IlliniCare
Total members enrolled	41,094	43,667	21,810	21,857
Total Travel Days	81,833	98,269	57,523	40,369
Members utilizing NEMT	5,878	6,420	3,396	3,024

*Adjusted for member months; had enrollment data
Data Source: MCO Special Datasets, HFS Baseline Encounter Data

Table 124 displays the member travel days by categories of service over time and for each MCO.

Table 124: Travel Days by Categories of Service

Travel Type	ICP		ICP FY13 Detail	
	FY11	FY13	Aetna	IlliniCare
Non-emergency Ambulance	3,419	2,610	1,067	1,543
Medicar	16,290	7,662	3,389	4,273
Taxi	2,101	11,795	10,455	1,340
Service car	57,791	72,428	38,781	33,647
Private transportation	1,635	2,479	2,476	3
Bus or paratransit (other)	2,446	2,048	1,618	430
Total	83,682.00	99,022.00	57,786.00	41,236.00

Data Source: MCO Special Datasets, HFS Baseline Encounter Data

Table 125 shows the results of regression analysis for the frequency of receiving transportation.

Table 125: Regression Analysis for Frequency of Receiving Transportation (Year 2)

	Unstandardized Coefficients		Standardized Coefficients		
	B	Std. Error	Beta	t	Sig.
(Constant)	2.819	.385		7.330	.000
Age	.002	.005	.029	.470	.639
Gender	.038	.131	.018	.290	.772
Hispanic Origin	-.553	.254	-.131	-2.182	.030
White	-.003	.173	-.001	-.016	.987
Black	.161	.159	.076	1.015	.311
Intellectual/Developmental Disability	.068	.141	.030	.480	.631
Mental Health	-.201	.128	-.094	-1.573	.117
Physical Disability	-.038	.126	-.018	-.306	.760
ICP	.160	.129	.076	1.238	.217

R square = .041
**p<.01

L. Dental: Extra Tables

- Table 126: Dental Visits
- Table 127: Emergency Dental Visits
- Table 128: Non-Emergency Dental Visits
- Table 129: "Mixed" Visits (Visit Included Both Emergency and Non-Emergency Services)
- Table 130: Preventive Services

Table 126 outlines the number of dental visits over time in the ICP and for each MCO.

Table 126: Dental Visits

Measure	ICP		ICP FY13 Detail	
	FY11	FY13	Aetna	IlliniCare
Utilizing members	7,521	5,879	2,801	3,078
# of visits	14,483	10,935	5,545	5,390
# of claims				
Total costs	$1,287,222	$1,369,967	$564,272	$805,695
Total member months (MM)	358,195	424,440	212,846	211,594

Data Source: MCO Special Datasets, HFS Baseline Encounter Data

Table 127 displays the emergency dental visits over time in the ICP and for each MCO.

Table 127: Emergency Dental Visits

Measure	ICP		ICP FY13 Detail	
	FY11	FY13	Aetna	IlliniCare
Utilizing members	1,297	1,212	611	601
# of visits	1,729	1,575	833	742
# of claims				
Total costs	$101,892	$158,635	$55,508	$103,127
Total member months (MM)	358,195	424,440	212,846	211,594

Data Source: MCO Special Datasets, HFS Baseline Encounter Data

Table 128 displays the non-emergency dental visits over time in the ICP and for each MCO.

Table 128: Non-Emergency Dental Visits

Measure	ICP		ICP FY13 Detail	
	FY11	FY13	Aetna	IlliniCare
Utilizing members	6,754	5,125	2,475	2,650
# of visits	11,499	8,592	4,404	4,188
# of claims				
Total costs	$1,029,078	$1,020,136	$456,588	$563,548
Total member months (MM)	358,195	424,440	212,846	211,594

Data Source: MCO Special Datasets, HFS Baseline Encounter Data

Table 129 displays the mixed dental visits (visits that included both emergency and non-emergency procedures) over time in the ICP and for each MCO.

Table 129: "Mixed" Visits (Visit Included Both Emergency and Non-Emergency Services)

Measure	ICP		ICP FY13 Detail	
	FY11	FY13	Aetna	IlliniCare
Utilizing members	1,115	736	292	444
# of visits	1,255	768	308	460
# of claims				
Total costs	$156,252	$191,196	$52,176	$139,021
Total member months (MM)	358,195	424,440	212,946	211,594

Data Source: MCO Special Datasets, HFS Baseline Encounter Data

Table 130 shows dental preventative services over time in the ICP and for each MCO.

Table 130: Dental Preventive Services

Measure	ICP		ICP FY13 Detail	
	FY11	FY13	Aetna	IlliniCare
Utilizing members	313	2,091	1,161	930
# of claims	535	2,324	1,343	981
# of visits where preventative received	337	2,269	1,326	943
Total costs	$12,353	$92,876	$54,064	$38,812
Total member months (MM)	358,195	424,440	212,946	211,594
Visits per 1,000 MM	1.5	6.19	6.3	4.6
Cost per visit	$23.09	$39.96	$40.26	$39.56
Cost per 1,000 MM	$34.49	$217.66	$252.07	$182.88

Data Source: MCO Special Datasets, HFS Baseline Encounter Data

M. Emergency Department Visits: Extra Tables

- Table 131: All Emergency and Non-Emergency Claims

Table 131 displays all emergency and non-emergency claims over time in the ICP and for each MCO.

Table 131: All Emergency and Non-Emergency Claims

Measure	ICP		ICP FY13 Detail	
	FY11	FY13	Aetna	IlliniCare
Utilizing members	14,516	14,737	7,513	7,224
# of Events	39,186	43,048	21,560	21,488
# of Claims	123,483	146,438	74,891	71,547
Total costs	$11,640,831.00	$11,984,272	$4,287,129	$7,697,143
Total member months (MM)	358,195	424,440	212,846	211,594

Data Source: MCO data is from Paid Bills reported by MCO

N. Prevention: Extra Tables

- Table 132: Preventive Service Claims

Table 132 displays the claims for preventive services in the ICP over time and for each MCO in FY13.

Table 132: Preventive Service[1] Claims

Measure	ICP		ICP FY13 Detail	
	FY11*	FY13	Aetna	IlliniCare
Utilizing members	2,521	3,433	1,657	1,776
# of claims	2,702	3,695	1,831	1,864
Total costs	$200,483.41	$354,781.22	$162,916.21	$191,865.01
Total member months (MM)	358,195	424,440	212,846	211,594

Data Source: MCO Special Datasets, *HFS Baseline Encounter Data (covers July 2010-Mar 2011)
[1] CPT codes: 99385, 99386, 99387, 99395, 99396, and 99397

O. Radiology: Extra Tables

- Table 133: Radiology Claims

Table 133 displays the radiology claims for the ICP over time and for each MCO during FY13.

Table 133: Radiology Claims

Measure	ICP		ICP FY13 Detail	
	FY11*	FY13	Aetna	IlliniCare
Utilizing members	9,140	9,703	4,840	4,863
# of claims	21,588	34,154	15,602	18,552
Total costs	$1,971,657	$6,898,527	$2,397,874	$4,500,653
Total member months (MM)	358,195	424,440	212,846	211,594

Data Source: MCO Special Datasets, *HFS Baseline Encounter Data (covers July 2010-Mar 2011)

P. Mortality

- Table 134: Mortality FY12-13 and FY10-11 in Chicago, ICP, and Downstate

Table 134 shows mortality rates by age band for Chicago, Downstate and the ICP area.

Table 134: Mortality FY12-13 and FY10-11 in Chicago, ICP, and Downstate

	July 1, 2009-June 30, 2011			July 1, 2011-June 30, 2013		
Age Band	**Recipients**	**Deaths**	**Mortality %**	**Recipients**	**Deaths**	**Mortality %**
CHICAGO						
19-44	22,966	380	1.7%	23,003	425	1.8%
45-54	18,168	871	4.8%	17,636	858	4.9%
55-64	18,879	1,158	6.1%	20,759	1,431	6.9%
65-69	2,868	205	7.1%	2,762	167	6.0%
70-74	1,350	88	6.5%	1,324	68	5.1%
75-79	936	62	6.6%	1,022	62	6.1%
80-84	542	50	9.2%	633	56	8.8%
85+	365	62	17.0%	451	76	16.9%
Total	**66,074**	**2,876**	**4.4%**	**67,590**	**3,143**	**4.7%**
Age Standardized			**4.4%**			**4.6%**
DOWNSTATE						
19-44	18,039	335	1.9%	18,536	330	1.8%
45-54	11,407	597	5.2%	11,866	655	5.5%
55-64	10,227	774	7.6%	11,566	943	8.2%
65-69	940	86	9.1%	924	75	8.1%
70-74	358	23	6.4%	389	23	5.9%
75-79	210	22	10.5%	249	16	6.4%
80-84	131	18	13.7%	134	20	14.9%
85+	83	23	27.7%	108	30	27.8%
Total	**41,395**	**1,878**	**4.5%**	**43,772**	**2,092**	**4.8%**
Age Standardized			**5.2%**			**5.3%**
ICP						
19-44	12,847	256	2.0%	13,707	252	1.8%
45-54	7,752	413	5.3%	8,034	433	5.4%
55-64	9,059	659	7.3%	10,181	732	7.2%
65-69	2,303	111	4.8%	2,366	119	5.0%
70-74	1,958	68	3.5%	2,145	68	3.2%
75-79	1,437	87	6.1%	1,714	80	4.7%
80-84	841	82	9.8%	1,030	76	7.4%
85+	541	85	15.7%	721	127	17.6%
Total	**36,738**	**1,761**	**4.8%**	**39,898**	**1,887**	**4.7%**
Age Standardized			**4.7%**			**4.6%**

Q. Critical Incidents

- Table 135: Critical Incidents Process Table

Table 135 displays the critical incidents process for each MCO. The table includes information regarding what a critical incident is, how it is reported, appropriate MCO response, and which incidents must be reported to the state.

Table 135: Critical Incidents Process Table

Measure	Aetna	IlliniCare
What is a critical incident?	Information Not Yet Received	A critical incident is a report or observation of neglect, domestic violence, abuse, exploitation, death, potential fraud, violence or threat of violence, or other.
How does a critical incident get reported?	Information Not Yet Received	A critical incident can be reported to the MCO in a number of ways: by a provider; the care coordinator may observe an issue that requires reporting to law enforcement, OIG or Adult Protective Services. Examples of reportable incidents include, but are not limited to, a personal assistant padding hours, evidence of neglect or abuse; a member could report to the MCO that s/he is being abused. When a care coordinator receives such a report or observes a reportable issue such as neglect or abuse, that person is required to notify his/her IlliniCare manager within 4 hours; additional reporting to the appropriate agency is also required.
Who reports a critical incident?	Information Not Yet Received	For issues not involving potential fraud, the care coordinator is responsible for reporting the issue to the appropriate agency. For potential fraud, IlliniCare Compliance reports to the OIG and HFS for SFY 2014 and forward.
How does a MCO follow up on a critical incident?	Information Not Yet Received	Care coordinators continue to monitor members for whom a critical incident is reported. In some situations, changes need to be facilitated to protect the member such as removing a personal assistant. If the situation warrants, additional critical incidents will be reported. If reported to a law enforcement agency, the MCO may not receive official follow-ups from that agency. We will follow up with the member directly, but may not have any access to official follow-ups by other agencies.
What critical incidents have to be reported to the state?	Information Not Yet Received	All critical incidents are reported to the state via monthly and quarterly reports. Critical incidents are reported to appropriate state and local or law enforcement agencies as soon as possible for investigation and resolution. Critical incidents involving potential fraud are reported directly to OIG and HFS for investigation and resolution.

Data Sources: Phone Interviews with Representatives from each MCO

R. Quality Assurance

As state Medicaid programs move more of their senior members and members with disabilities into managed care, there is increasing attention paid to the development and monitoring of quality outcome measures for these populations, especially for long term supports and services. At the present time, most states are experimenting with what measures to adapt from the private commercial health care sector and what measures need to be newly developed.

States face several challenges in developing appropriate quality measures for seniors and members with disabilities. These challenges include complex methodological issues around appropriate comparison groups and time periods, how to collect the reliable data to measure the outcomes, and the lack of established quality measures that are relevant for this population. Few standardized and validated measures are available for some of the most critical areas associated with Medicaid members needing long term supports and services.

The Affordable Care Act requires that the federal Health and Human Services (HHS) identify and publish "a recommended initial core set of health quality measures for Medicaid-eligible adults." The Affordable Care Act also requires that HHS establish an Adult Medicaid Quality Measurement Program that would fund "development, testing, and validation of emerging and innovative evidence-based measures." The use of these measures would be voluntary for the states to use in their Medicaid programs.

HHS worked with the states and the Agency for Healthcare Research and Quality's (AHRQ) Subcommittee to the National Advisory Council for Healthcare Research and Quality. In 2010 and 2011, several subcommittees met and reviewed 51 recommended draft measures that were later reduced to 26 measures. In January of 2013, HHS published the 26 voluntary measures.

The following section focuses on the outcome measures that HFS established to evaluate the performance of the MCOs in the ICP. It discusses the method that HFS used in determining which quality measures to include in the ICP, the payment system it developed to pay the MCOs additional funds for some of these measures, a description of the annual review and reporting of results for these measures, and future plans HFS has for quality assurance in general.

1. Description of how the list of Quality Indicators were developed

Original Request for Proposal (RFP) in 2010

The original request published by HFS in 2010 for proposals for the ICP included a listing of 31 quality measures that the state developed after consulting with other states, working with stakeholders from Illinois, and soliciting input from other state agencies. In addition, HFS staff consulted with HFS's Disease Management program (Your Healthcare Plus) and with the state's External Quality Review Organization (Health Services Associates Group).

HFS held a public stakeholders meeting to review the initial draft of quality measures and asked for comments. HFS staff reviewed all the comments and did further research/development of measures, including contacting the state's Division of Mental Health, HSAG and UIC's Department of Pharmacy to develop a draft that could be part of the RFP.

First contract between the state and the MCOs-2011

Between the time between the posting of the original RFP and the development of the first contract with the two selected plans, the list of quality measures underwent further revision. The first formal contracts between the state and the MCOs included 30 measures, mostly modifications of the measures from the RFP.

Half of the 30 measures in the first contract were classified as "pay for performance" measures. These would pay the MCOs additional money in addition to the capitation payments if they met certain pre-defined benchmarks. Of the 30 measures, 13 were HEDIS measures, 2 were HEDIS measures that had been modified by the state for the ICP, 13 of the measures were specifically developed by the state for the program, and 2 measures were borrowed from other sources.

Contract Amendments for Service Package 2-2013

In February of 2013, Service Package 2 was implemented and the existing measures for Service Package 1 were updated and a new set of measures were added for Service Package 2.

2. Types of Indicators

As mentioned in the section above, HFS used a variety of sources to draw from in developing the quality measures. For many of the measures, HFS adopted existing national Healthcare Effectiveness Data and Information Set (HEDIS) measures without change. HEDIS is a set of standardized performance measures designed to ensure that the public and health officials have the information it needs to reliably compare the performance of managed health care plans.

The National Committee for Quality Assurance (NCQA) maintains and updates the HEDIS standards. NCQA first released HEDIS measures in 1993–since then the measures have become an accepted national standard for comparing performance of health plans, both in the private market and in the Medicaid program.

Although the state used HEDIS measures without change for many of the quality measures in the ICP, in a few instances it used slightly modified HEDIS (or "HEDIS like") measures. In addition, due to the fact that standard HEDIS rates may not adequately reflect the experiences of for seniors and people with disabilities in the Medicaid program, HFS created some "home-grown" measures. These state defined measures were often based on either existing measures used by other Illinois state agencies or were Medicaid measures in use by other states. The next several pages contain a table compiled by HFS showing the health and quality of life performance measures they are using.

Health and Quality of Life (HQOL) Performance Measures: Seniors and People with Disabilities – Reporting Years 2013-2015

Count of Measures				Acronym	Category	Performance Measure	Specification Source	Quality Monitoring	P4P Measures		
RFP	Yr1	Yr2	Yr3						2013	2014	2015
Access/Utilization of Care											
Hold 29	Hold 1	1	1	SAAP	**Access to Member's Assigned PCP**	Percentage of members who had an ambulatory or preventive care visit with the members assigned PCP during the measurement year. Exclude LTC population.	State Modified HEDIS®	X	Hold	Yes	Yes
12	2	2	2	AMB	**Ambulatory Care**		HEDIS®	X			
					1) Total - All	Emergency Department visits per 1,000 Member Months			Yes	Yes	Yes
			DD		2) Total - DD Waiver population only (Retire for 2015 reporting on 2014 data)						Retired
			2		3) Outpatient	Outpatient visits per 1,000 Member months					
13	3	3	3	IAPE	**Ambulatory Care Follow-up with a Provider within 14 Days of Emergency Department (ED) Visit**	Follow-up with any Provider within 14 days following Emergency Department visit. Exclude ED visits with a principal diagnosis of mental health or chemical dependency.	Illinois	X	Yes	Yes	Yes
6	4			IADV	**Dental Utilization**	Enrollees who receive an annual dental visit (Retire for 2014 reporting on 2013 data)	Illinois	X		Retired	
					1) Annual Dental Visit – All						
					2) Annual Dental Visit – DD waiver population only				Yes		
7	5	4		IDER	**Dental ER Utilization**	Emergency room visits for Enrollees with dental primary diagnoses (Retire for 2015 reporting on 2014 data)	Illinois	X			Retired
14	6	5	4	IPU	**Inpatient Utilization General Hospital/Acute Care**	Utilization of acute inpatient care and services, per 1,000 Enrollees - exclude discharges with a principal diagnosis of mental health or chemical dependency.	HEDIS®	X			
					1)Total Inpatient Discharges						
					2) Total Medical Discharges						
					3) Total Surgery Discharges						
16	7	6	5	IAPI	**Ambulatory Care Follow-up with a Provider within 14 Days of Inpatient Discharge**	Ambulatory care follow-up visit within 14 days of having an inpatient hospital stay. Exclude discharges for deliveries (births) and discharges with a principal diagnosis of mental health or chemical dependency.	Illinois	X	Yes	Yes	Yes
17 a-b	8	7	6	IIHR	**Inpatient Hospital 30-day Re-Admission Rate**	Inpatient Hospital readmission for the same discharge diagnosis (to 3rd digit) within 30 days after having an initial inpatient hospital stay	Illinois	X			
					1) Non-Behavioral Health Primary Diagnosis						
					2) Behavioral Health Primary Diagnosis						
Prevention/Screening Services											
5	9	8		ICCI	**Care Coordination – Influenza Immunization Rate**	Enrollees who received at least one influenza immunization annually (Retire for 2015 reporting on 2014 data)	Illinois	X			Retired
25	10	9	7	SCOL	**Colorectal Cancer Screening**	Percentage of members 50-75 years of age who had appropriate screening for colorectal cancer – apply to Medicaid product line.	State Modified HEDIS®	X			
26	11	10	8	BCS	**Breast Cancer Screening**		HEDIS® - Adult Core	X			
27	12	11	9	CCS	**Cervical Cancer Screening**		HEDIS® - Adult Core	X			

Health and Quality of Life (HQOL) Performance Measures: Seniors and People with Disabilities – Reporting Years 2013-2015

Count of Measures				Acronym	Category	Performance Measure	Specification Source	Quality Monitoring	P4P Measures		
RFP	Yr1	Yr2	Yr3						2013	2014	2015
28	13	12	10	ABA	**Adult BMI Assessment**		HEDIS® - Adult Core	X			
			11	SGSO	**Glaucoma Screening**	Percentage of members who received a glaucoma eye exam by an eye care professional for early identification of glaucomatous conditions. Medicaid product line	State Modified HEDIS®	X	N/A	N/A	
					1) Age 40-59						
					2) Age 60-64						
					3) Age 65 and older						
					4) Total - All						
						Appropriate Care					
8 a-e	14	13	12	MCDC	**Diabetes Care**		Mixed	X	Yes	Yes	Yes
					1) HbA1c testing 1x per year	Increased utilization of disease specific therapies. **(P4P must meet 2 of rates 1- 3 and 1 of rates 4-5)**	HEDIS® - Adult Core				
					2) Microalbuminuria testing 1 X per year						
					3) Cholesterol testing 1X per year						
					4) Statin Therapy 80% of the time – CDC Eligibles		State Modified HEDIS®				
					5) ACE/ARB 80% of the time – CDC Eligibles						
					6) DD Waiver Population only	HbA1c testing 1x per year (Retire for 2015 reporting on 2014 data)					Retired
			13	PQI08	**Heart Failure Admission Rate**	Number of discharges for heart failure per 100,000 members age 18 and older – (Start reporting in 2015 on 2014 data)	AHRQ - Adult Core	X	N/A	N/A	
9 a-c	15	14		ICHF	**Congestive Heart Failure**	Increased utilization of disease specific therapies **(P4P must meet 2 of 3 rates)** (Retire for 2015 reporting on 2014 data)	Illinois	X	Yes	Yes	Retired
					1) ACE/ARB 80% of the time						
					2) Beta Blocker 80% of the time						
					3) Diuretic 80% of the time						
10 a-d	16	15	14	MCVC	**Coronary Artery Disease**	Increased utilization of disease specific therapies **(P4P must meet 2 of 4 rates)**	Mixed	X	Yes	Yes	Yes
					1) Cholesterol testing 1X per year		Illinois				
					2) Statin Therapy 80% of the time						
					3) ACE/ARB 80% of the time						
					4) Persistence of Beta-Blocker Treatment After a Heart Attack **(PBH)**		HEDIS®				

Health and Quality of Life (HQOL) Performance Measures: Seniors and People with Disabilities – Reporting Years 2013-2015

Count of Measures				Acronym	Category	Performance Measure	Specification Source	Quality Monitoring	P4P Measures		
RFP	Yr1	Yr2	Yr3						2013	2014	2015
11 a-c	17	16	15	**MCOP**	**Chronic Obstructive Pulmonary Disease**	Increased utilization of disease specific therapies (**P4P must meet 2 of 3 rates)**	HEDIS®	X	Yes	Yes	Yes
					1) Acute COPD Exacerbation w/corticosteroid (**PCE**)						
					2) COPD hospitalizations with bronchodilator medications (PCE)						
					3) Use of Spirometry testing in the Assessment and Diagnosis of COPD (1 time in last three years) (**SPR**)						
21	18	17	16	**MPM**	**Annual monitoring for Patients on persistent medications**	Members who received at least 180 treatment days of ambulatory medication therapy and at least one therapeutic monitoring event during the measurement year	HEDIS® Adult Core	X			
					1) ACE Inhibitors pr ARBs						
					2) Digoxin						
					3) Diuretics						
					4) Anti-convulsants						
					5) Total						
	19	18	17	**SDAE**	**Use of High-Risk Medications in the Elderly**	Percentage of member's age ≥60 who received at least one drug to be avoided in the elderly and the percentage of members who received at least two different drugs to be avoided in the elderly. Medicaid product line.	State modified HEDIS	X			
					Long Term Care						
18	20	19	18	**IUTI**	**Long Term Care Residents – Urinary Tract Infection Hospital Admission**	Hospital Admissions due to urinary tract infections for LTC Residents	Illinois	X			
19	21	20	19	**IBPR**	**Long Term Care Residents – Bacterial Pneumonia Hospital Admission**	Hospital Admission due to bacterial pneumonia for LTC Residents	Illinois	X			
Hold 20		21	20	**IPPU**	**Long Term Care Residents – Prevalence of Hospital Acquired Pressure Ulcers**	LTC Residents that have category / stage II or greater pressure ulcers acquired during an inpatient hospital stay (**Start reporting in 2014 on 2013 data** - start P4P with 2015 reporting on 2014 data)	Illinois	X	N/A		Yes

Health and Quality of Life (HQOL) Performance Measures: Seniors and People with Disabilities – Reporting Years 2013-2015

Count of Measures				Acronym	Category	Performance Measure	Specification Source	Quality Monitoring	P4P Measures		
RFP	Yr1	Yr2	Yr3						2013	2014	2015
					Behavioral Health						
22 & 23	22	22	21	AMM	**Antidepressant Medication Management**	Members diagnosis of major depression and treated with antidepressant medication	HEDIS®- Adult Core	X	Each rate is a separate P4P		
					1) Effective Acute Phase Treatment. Members who remained on antidepressant medication for at least 84 days (12 weeks)				Yes	Yes	Yes
					2) Effective Continuation Phase Treatment. Members who remained on an antidepressant medication for at least 180 days (6 months)				Yes	Yes	Yes
	23	23	22	SAA	**Adherence to Antipsychotic Medications for Individuals With Schizophrenia**	Percentage of members with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period (Start reporting in 2014 on 2013 data)	HEDIS®- Adult Core	X			
24	Replaced by SAA			IMMS	**Medication Monitoring for Patients with Schizophrenia** 1) 6 months 2) 12 months	Percentage of members age 19-64 years wutg schizophrenia who were dispensed and remained on an antipsychotic medication for indicated period of time. (Replaced by HEDIS® SAA for reporting)	Illinois	X	Replaced by SAA		
			23	IMMP	**Medication Monitoring for Patients with Psychotic Disorders**	Percentage of members diagnosed with specified psychotic disorders in the prior year that remained on appropriate medication for 6-months and 12-months during the measurement year. (Start reporting in 2015 on 2014 data)	Illinois	X	N/A	N/A	
			24	SSD	**Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications**	Percentage of members with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening (HbA1c) during the measurement year. (Start reporting in 2015 on 2014 data)	HEDIS®	X	N/A	N/A	
2	24	24	25	IET	**Initiation and Engagement of Alcohol and other Drug Dependence Treatment**	Enrollees with new episode of alcohol or other drug (AOD) dependence who received initiation and engagement of AOD treatment	HEDIS®- Adult Core	X			
					1) Initiation of AOD Treatment						
					2) Engagement of AOD Treatment						
Hold 3	Hold 25	Hold 25	26	IFUP	**Follow-up With a Provider Within 30 Days After an Initial Behavioral Health Diagnosis** Measure on HOLD pending further development	Appropriate follow-up with any Provider within 30 days after initial BH diagnosis	Illinois	X	Hold	Hold	Yes
4	26	26	27	FUH	**Follow-up after hospitalization for Mental Illness**		HEDIS®- Adult Core	X			
					1) Follow-up in 7 days						
					2) Follow-up in 30 days				Yes	Yes	Yes

Health and Quality of Life (HQOL) Performance Measures: Seniors and People with Disabilities – Reporting Years 2013-2015

Count of Measures																
RFP	Yr1	Yr2	Yr3	Acronym	Category	Performance Measure	Specification Source	Quality Monitoring	P4P Measures		
										2013	2014	2015
					Mental Health Utilization							
15	27	27	28	MPT	1) Any Services	Mental Health services utilization per 1,000 Enrollees	HEDIS®	X				
					2) Inpatient							
					3) Intensive Outpatient/Partial Hospitalization							
					4) Outpatient							
					Behavioral Health Risk Assessment and Follow-up							
1	28	28	29	IBHR	1) Behavioral Screening/ Assessment within 60 days of enrollment	New Enrollees who completed a behavioral health assessment (BHRA) within 60 days of enrollment, also measures percent of Enrollees with a positive finding on BHRA who receive follow-up with MH provider within 30 days of assessment	Illinois	X				
					2) Behavior Health follow-up within 30 days of screening							
						Member Movement						
30 & 31	[redacted]	29	30	IMWS	**Movement of Members Between Community, Waiver and LTC Services**	Member's location (community, waiver or long-term care) on January 1 and the same member's location of December 31 of the measurement year. (Exclude LTC stays ≤90 days) (Start reporting in 2014 on 2013 data - P4P are movement into and out of LTC facilities only)	Illinois	X	N/A	Yes	Yes
						Surveys						
			31	SCPA	**CAHPS – Consumer Assessment of Health Plan Survey**	CAHPS, Adult Version as approved by HFS. Provides information on the experiences of members with the organization and gives a general indication of how well the organization meets member's expectations. (Start reporting in 2015 on 2014 data) The following questions must be added for the waiver populations only. Do you receive additional care through IlliniCare's waiver service? □Yes…skip to xx □No…Thank you for completing the survey □I do not know if I qualify for waiver services…Thank you for completing the survey Did you receive the services you need when you needed them? □Yes □No Did you receive all the services listed in your plan of care? □Yes □No Were you treated well by your direct support staff? □Yes □No	State modified HEDIS - Adult Core	X	N/A	N/A	

Health and Quality of Life (HQOL) Performance Measures: Seniors and People with Disabilities – Reporting Years 2013-2015

Count of Measures															
RFP	Yr1	Yr2	Yr3	Acronym	Category		Performance Measure	Specification Source	Quality Monitoring	P4P Measures		
										2013	2014	2015
			32	SFSA	Flu Shots for Adults Ages 18 and Older							
					1) Flu Vaccinations for Adults Ages 18-64 (FVA)		Percentage of members 18 and older who received an influenza vaccination between July 1 of the measurement year and the date when the CAHPS 5.0H adult survey was completed.	State modified HEDIS - Adult Core	X	N/A	N/A	
					2) Flu Vaccinations for Adults Ages 65 and Older (FVO							
			33	SFRM	Fall Risk Management		*Discussing Fall Risk:* The percentage of member's ≥60 years of age who in the past 6 months had balance or walking problems or a fall who were seen by a practitioner and discussed fall risk *Managing Fall Risk* Percentage of members ≥60 years of age who in the past 6 months had a fall or balance or walking problems who were seen by a practitioner and received fall risk intervention from their current practitioner. Medicaid product line. Add questions to CAHPS. (Start reporting in 2015 on 2014 data) A fall is when your body goes to the ground without being pushed. In the **past 6 months**, did you talk with your doctor or other health provider about falling or problems with balance or walking? □Yes □No □I had no visits in the past 6 months Did you fall in the **past 6 months?** □Yes □No In the **past 6 months,** have you had a problem with balance or walking? □Yes □No Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking? Some things they might do include: ▪ Suggest that you use a cane or walker. ▪ Check your blood pressure lying or standing. ▪ Suggest that you do an exercise or physical therapy program. ▪ Suggest a vision or hearing testing. □Yes □No □I had no visits in the past 6 months	State modified HEDIS	X	N/A	N/A	

Health and Quality of Life (HQOL) Performance Measures: Seniors and People with Disabilities – Reporting Years 2013-2015

Count of Measures				Acronym	Category	Performance Measure	Specification Source	Quality Monitoring	P4P Measures		
RFP	Yr1	Yr2	Yr3						2013	2014	2015
			34	SMUI	Management of Urinary Incontinence in Older Adults	*Discussing:* Members who reported having a problem with urine leakage in the past six months and who discussed their urine leakage problem with their current practitioner. *Receiving Treatment:* Members who reported having a urine leakage problem in the past six months and who received treatment for their current urine leakage problem. Medicaid product line. Add questions to CAHPS. (Start reporting in 2015 on 2014 data) Many people experience problems with urinary incontinence, the leakage of urine. In the past 6 months, have you accidentally leaked urine? □Yes □No How much of a problem, if any, was the urine leakage for you? □A big problem □A small problem □Not a problem Have you talked with your current doctor or other health provider about your urine leakage problem? □Yes □No There are many ways to treat urinary incontinence including bladder training, exercises, medication and surgery. Have you received these or any other treatments for your current urine leakage problem? □Yes □No	State modified HEDIS	X	N/A	N/A	
			35	SPAO	Physical Activity in Older Adults	*Discussing Physical Activity:* Members who had a doctor's visit in the past **6** months and who spoke with a doctor or other health provider about their level of exercise or physical activity. *Advising Physical Activity:* Members who had a doctor's visit in the past **6** months and who received advice to start, increase or maintain their level exercise or physical activity. Medicaid product line. Add questions to CAHPS. (Start reporting in 2015 on 2014 data) In the **past 6 months,** did you talk with a doctor or other health provider about your level of exercise or physical activity? For example, a doctor or other health provider may ask if you exercise regularly or take part in physical exercise. □Yes □No □I had no visits in the past 6 months In the **past 6 months,** did a doctor or other health provider advise you to start, increase or maintain your level of exercise or physical activity? For example, in order to improve your health, your doctor or other health provider may advise you to start taking the stairs, increase walking from 10 to 20 minutes every day or to maintain your current exercise program. □Yes □No	State modified HEDIS	X	N/A	N/A	
29	28	29	35			**Total Counts**			12	12	13

3. Bonus Payments

For the P4P quality measures, HFS established an "incentive pool" from which each MCO "may earn payments based on its performance" on the P4P measures. The amount in the pool each year is equal to 5% of the overall capitation amount paid to the MCOs. To fund the pool, HFS uses two types of revenue, the first being a portion of funds withheld from the MCO capitated payments each month and the second being additional funds that HFS will deposit in the pool to ensure it equals 5% of capitated payments.

Specifically, in terms of funding the incentive pool, the contracts states that, "the withheld amount will be one percent (1%) in the first measurement year, one and a half percent (1.5%) in the second measurement year and two percent (2%) in the third measurement year. Subsequent withheld amounts will be negotiated and agreed to by the Parties. The withheld amount will be combined with an additional bonus amount funded by the Department so that total funding of the incentive pool shall be equal to five percent (5%) of the Capitation rate."

Generally, with some exceptions, each P4P measure will have equal weight in paying from the pool. If the MCO reaches the target (QISMC Goal-see below), then it is eligible to earn the percentage of the incentive pool that was assigned to that measure, contingent on whether the MCO has met the overall "minimum performance standard" as outlined in the next paragraph below.

According to the contract, each MCO must meet an overall "minimum Performance Standard" before it can earn any payments from the pool, even if it has met the target of some of the P4P measures. Specifically, the contract states that the "contractor will not be eligible to receive any Incentive Pool payments if it fails to meet a minimum performance standard. The minimum performance standard will require Contractor's measurement year performance to be no lower than one percent (1%) below that year's baseline on all P4P measures, except that Contractor may regress more than one percent (1%) in three (3) P4P quality metrics in the first measurement year."

4. Annual Review of Results

Baseline Rates

According to the state's contract with the MCOs, for purposes of measuring P4P measures, calendar year 2010 was the first baseline used for the bonus payments. In subsequent years, the previous year's performance average for all of the plans will serve as the baseline for the next year. In the case where the overall performance rate for any specific measure is below the baseline rate for the year, the baseline will remain the same.

QISMC Goals

HFS has adopted the federal Quality Improvement System for Managed Care (QISMC) methodology for setting targets linked to the P4P measures. This methodology was developed by the Centers for Medicare and Medicaid Services (CMS), for setting targets for health plans to meet on quality measures. Briefly, this process uses a "reduction of the difference" procedure to achieve a ten percent (10%) increase each year over the previous rate.

For example, the baseline rate for the first measure in the P4P table, "Follow-up After Hospitalization for Mental Illness (FUH) - 30 day follow-up" was 55.42%. The QISMC goal for this measure is set higher than the baseline rate, at 59.88%. To calculate this goal, the following steps were taken:

a. the difference between the goal of 100% compliance and current rate is 44.58% (100% minus 55.42%);
b. 10% of the difference of the figure derived in "a" above is 4.458% (10% of 44.58%).
c. Adding the figure in "b" above (4.458%) to the current baseline rate of 55.42% gives a QISMC goal of 59.878%, which rounds to 59.88%.

5. Future Plans of HFS related to Quality Assurance

Due to the state mandate to have half of the Medicaid population in "coordinated care" by 2015, HFS recognized that it would need to increase its infrastructure within the agency to meet the increased demand for developing and monitoring quality of care. As a result, HFS created the new Bureau of Quality Management (BQM) in May 2013. The intent was to organize, streamline, consolidate, and standardize as much as possible the QA activities and responsibilities of the HFS related to the health reforms occurring in the state (i.e. Medicaid expansion, transition to managed care delivery platforms).

As of the fall of 2013, BQM consisted of approximately 20 professional staff. the majority of these staff were re-assigned from existing HFS bureaus, while a few staff were hired from the private sector. Early on, the BQM staff adopted a mission statement that would guide their future activities:

"The mission of the BQM is to serve as the focal point within HFS Division of Medical Programs to define, measure and evaluate the quality of healthcare services provided to enrollees and to use data analytics and evidence-based practices to drive continuous quality improvement within HFS and through the efforts of our partners."

The Bureau of Quality Management, in terms of quality assurance, is responsible for the following areas:

- Administration of the contract with the federally-certified Quality Improvement Organization (QIO - eQH Solutions) responsible for utilization review and quality of care for a wide range of hospital stays (acute short stay, acute long term, and psychiatric) and some medical necessity and prior authorization reviews for select services (primarily surgeries).
- Quality assurance monitoring of the Home & Community Based Services Waiver programs (now LTSS) of HFS, maintaining liaison with sister operating agencies (e.g., IDoA, DHS, DSCC), and reporting to federal CMS on activities and outcomes; administration of the contract with the external Quality Improvement Organization/EQRO responsible for QA monitoring of most of the nine HCBS waiver program services.
- Business and administrative oversight, in cooperation with other bureaus, for the EHR Medicaid Incentive Payment Program (eMIPP), which adjudicates applications and provides incentive payments to eligible hospitals and providers for adopting-implementing-upgrading and meaningful use of electronic health records; work with OHIT, OIS, ILHIE and others on use of Meaningful Use Clinical Quality Measures (CQMs) for QA purposes.
- Oversight of quality measures development and reporting on all services provided to children and pregnant women regardless of service delivery mechanism (FFS or managed care);

- Research and publish the legislatively-mandated Perinatal Quality Report biennially; Administration of the CHIPRA Quality Demonstration Project and annual reporting to federal CMS on the Core Set of Health Care Quality Measures for Children in Medicaid and CHIP;
- Administration of the Illinois Healthy Women Program (1115 family planning waiver program); and
- Development of a mechanism to annually report, as requested by CMS, on the newly released Core Set of Health Care Quality Measures for Medicaid-Eligible Adults.
- Implementation of SMART Act initiatives, including improved utilizations controls for institutional care and working with sister agencies to improve birth outcomes among Medicaid-covered women.

HFS staff have worked to develop and standardize quality measures that can be applied to all entities in the state Medicaid program, whether the FFS or the managed care sector. HFS is also monitoring current trends in quality assessment, input from stakeholders, plan performance and new initiatives and best practices for future measure updates/improvements.

HFS is also attempting to develop other data sources to use in the evaluation process of quality measures. Currently HFS relies primarily on enrollment and claims data. But this type of data is not timely, since claims data do not come in immediately and adjudication of claims can take weeks or months.

HFS's goal is to develop data sources that are easy to access and interpret, integrated, summarized, and actionable. For example, the Intensive Prenatal Case Management Program in cooperation with DHS, is targeting high-risk pregnant women, with goal to reduce adverse pregnancy outcomes, as well as costs.

S. Cost: Extra Tables

- Table 136: Medical Loss Ratio (CY 2011)
- Table 137: Medical Loss Ratio (CY 2012)

Table 136 below shows the medical loss ratio for Aetna and IlliniCare from May 2011 to December 2011.

Table 136: Medical Loss Ratio (CY 2011)

	Aetna	IlliniCare
Members	**81,661**	**78,031**
Revenue	**$85,618,262.00**	**$80,289,983.00**
Paid Claims (A)		
Community Mental Health Services	$2,071,377.00	
Inpatient Hospital	$24,416,828.00	$18,922,230.00
Nursing Facility	$614,305.00	$597,421.00
Other Ancillaries	$4,814,503.00	$4,283,587.00
Outpatient Hospital	$7,491,864.00	$4,446,743.00
Pharmacy	$21,876,937.00	$21,155,717.00
Professional	$5,182,012.00	$5,979,104.00
Total Paid Claims	**$66,467,785.00**	**$55,384,803.00**
Incurred but Not Paid Claims (B)	**$461,189.00**	**$289,628.00**
Provider Incentive Payments	**$8,135.00**	**$0.00**
Total Care Coordination Expense	**$1,953,770.65**	**$2,564,031.00**
Other Benefit Expense (Specify)		
Behavioral Health		$3,023,241.00
Capitated Physician Expense (Various PMPM)		$319,096.00
Dental	$433,168.00	
Health Management		$348,018.00
Nurse Triage Capitation		$234,093.00
Nursing Home Capitation	$105,470.00	
Other Medical Expenses (D)		$249,174.00
Radiology		$745,173.00
Reinsurance	$106,246.00	-$5,416.00
Transportation	$363,719.00	$753,779.00
Vision	$136,030.00	$66,387.00
All Other (See Detail Tab)	$422,658.00	
Disallowed Expenses		-$98,319.00
Total Other Benefit Expense	**$1,567,291.00**	**$5,635,225.00**
Total Benefit Expense	**$70,458,171.00**	**$63,873,688.00**
Calculated Medical Loss Ratio	**82.30%**	**79.60%**
Target Medical Loss Ratio	**88%**	**88%**
Difference (Refund)/No Refund	**-5.70%**	**-8.40%**
Refund Due to Department	**-4,793,351.00**	**-6,781,497.04**

CY 2011 (May 2011-December 2011)

Table 137 below shows the medical loss ratio for Aetna and IlliniCare from January 2012 to December 2012.

Table 137: Medical Loss Ratio (CY 2012)

	Aetna	IlliniCare
Members	**213,916**	**208,879**
Revenue	**$238,772,518.13**	**$224,001,533.06**
Paid Claims (A)		
Community Mental Health Services	$7,300,463.55	$0.00
Inpatient Hospital	$67,486,303.43	$55,413,378.63
Nursing Facility	$1,291,130.53	$3,035,313.25
Other Ancillaries	$4,451,793.35	$13,742,500.78
Outpatient Hospital	$21,982,030.67	$13,425,192.78
Pharmacy	$58,286,450.98	$58,920,121.68
Professional	$21,642,006.74	$16,973,829.84
Total Paid Claims	**$182,440,179.25**	**$161,510,336.96**
Incurred but Not Paid Claims (B)	**$2,162,429.89**	**$2,612,160.06**
Provider Incentive Payments	**$75,255.00**	**$0.00**
Total Care Coordination Expense	**$4,161,042.38**	**$4,335,393.77**
Other Benefit Expense (Specify)		
Behavioral Health		$9,144,023.00
Capitated Physician Expense (Various PMPM)		$834,060.00
Dental	$963,312.34	
Health Management	-$18,311.40	$931,600.00
Nurse Triage Capitation		$626,637.00
Nursing Home Capitation	$3,475,933.00	
Other Medical Expenses (D)		$442,072.00
Radiology		$975,657.00
Reinsurance	$115,545.74	-$1,441,857.00
SNFist Provider		$1,815,980.00
Transportation	$2,639,831.60	$2,431,352.00
Vision	$355,419.08	$355,328.00
All Other (See Detail Tab)		
Disallowed Expenses		
Total Other Benefit Expense	**$7,531,730.36**	**$16,114,853.00**
Total Benefit Expense	**$196,370,636.88**	**$184,572,743.77**
Calculated Medical Loss Ratio	**82.2%**	**82.4%**
Target Medical Loss Ratio	**88.0%**	**88.0%**
Difference (Refund)/No Refund	**-5.8%**	**-5.6%**
Refund Due to Department	**-$13,749,179.07**	**-$12,548,605.32**

CY 2012 (January 2012-December 2012)

Appendix B: Consumer Survey

A. Comparison of MCO CAHPS Surveys

All Medicaid healthcare provider plans are required to have an annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) conducted and reported as part of their compliance with HEDIS accreditation requirements. IlliniCare contracted with The Myers Group to complete their survey while Aetna used the Center for the Study of Services. Each survey was conducted using both mail and telephone outreach and data collection. The point of CAHPS is to use standard survey questions so that plans can be compared with one another. Table 138 includes demographics of the respondents to each CAHPS survey, along with the demographics of respondents who participated in UIC's consumer survey for each plan. In each case, their results correspond to the period of FY13. CAHPS surveys are meant for general Medicaid populations, and do not break down the number of respondents by disability type.

Table 138: Demographics of FY13 Survey Respondents

	Aetna		IlliniCare	
Demographic	**CAHPS**	**UIC**	**CAHPS**	**UIC**
Sample Size	1,350	N/A*	1,350	N/A*
Valid Responses	468	190	562	203
Response Rate	37.4%	N/A*	32.5%	N/A*
Gender				
- Female	55%	57.5%	60%	61.7%
- Male	45%	42.5%	40%	38.3%
Race				
- Black	29%	36.4%	31.8%	34.4%
- White	51%	51.4%	48.1%	47.2%
Hispanic Origin	18%	9.1%	16.9%	12.9%
Disability Type				
- Int/Dev Disability	N/A	28.9%	N/A	25.9%
- Mental Health	N/A	35.6%	N/A	40.4%
- Physical Disability	N/A	42.2%	N/A	42.5%

*2,000 surveys were sent to the entire ICP population, but it was not known which MCO each person was enrolled with. Therefore, a response rate cannot be calculated.

Table 139 presents results of both the UIC consumer survey and the CAHPS surveys. There were eight questions that were asked in each version of the survey. Each of these questions is listed in Table 139, along with the average of the score corresponding to that question. It is the convention of CAHPS surveys to present this data in scores standardized to a 3-point system, which varies according to question (described in the footnotes of the table). The responses that the UIC consumer survey tracks are directly translated into this same scoring system. For most questions, **the UIC consumer survey indicates similar scores**, although these are not directly comparable because it is possible that there are demographic differences in the sample used to calculate the scores (especially since the disability types that a respondent identified with for the CAHPS survey is unknown).

Table 139: 3-Point Survey Scores (FY13)

Question	UIC IlliniCare	IlliniCare CAHPS	UIC Aetna	Aetna CAHPS	UIC ICP Overall
How often did you get health care as soon as you needed it?[1]	2.33	2.32	2.33	2.30	2.33
How would you rate the quality of your health care? [2]	2.07	2.27	1.93	2.24	1.99
How often did your primary care provider seem informed and up to date about the care you received from specialists? [1]	2.29	2.38	2.18	2.36	2.18
In the last year, how often did your primary care provider take into account your wishes for your own care? [1]	2.28	2.48	2.12	2.39	2.13
Overall, how satisfied were you with your primary care provider over the last year? [3]	2.17	2.50	2.06	2.43	2.12
In the last year, how often was it easy to get an appointment with a specialist? [1]	2.16	2.17	2.18	2.18	2.17
How satisfied were you with the specialist you saw most during the last year? [3]	2.28	2.54	2.27	2.48	2.27
In general, would you say your overall health is: [4]	1.53	1.671	1.60	1.66	1.57

[1]Never/Sometimes – 1 Point, Usually – 2 Points, Always – 3 Points
[2]0 – 6 (Very Poor, Poor, Neither Poor Nor Good) – 1 Point, 7 – 8 (Good) – 2 Points, 9 – 10 (Very Good) – 3 Points
[3]0 – 6 (Very Dissatisfied, Dissatisfied, Somewhat Satisfied) – 1 Point, 7 – 8 (Satisfied) – 2 Points, 9 – 10 (Very Satisfied) – 3 Points
[4]Poor/Fair – 1 Point, Good – 2 Points, Very Good/Excellent – 3 Points

Table 140 presents a comparison of each MCO's CAHPS survey results. CAHPS are designed to make comparisons across plans nationwide, and this table presents the percentile ranking that each plan fell into for a variety of measures. Higher percentile ranks mean the plan performed better in relation to other plans nationally. **In general, the plans were in the middle or on the lower end of most percentile rankings.** A notable exception is the rating of a specialist for IlliniCare, which

Table 140: National Percentile Ranks of MCO's CAHPS Surveys

Item	Aetna 2013	IlliniCare 2013
Getting Needed Care (Composite)	25th	25th
Getting Care Quickly (Composite)	50th	50th
How Well Doctors Communicate (Composite)	75th	75th
Customer Service (Composite)	25th	75th
Rating of Health Care	25th	25th
Rating of Personal Doctor	50th	75th
Rating of Specialist	50th	90th
Rating of Health Plan	<25th	<25th

*Higher percentile ranks mean the plan performed better in relation to other plans nationally.

ranked in the 90th percentile nationally. It should be noted that CAHPS is for all plans nationally, so these scores pit the MCOs against plans serving all populations (i.e. not necessarily people with disabilities); expecting the MCOs to rank highly against other plans may not be feasible.

B. Findings from the UIC Enrollee Survey

As of Spring 2014, the UIC enrollee survey has been distributed three times to ICP enrollees: initially in summer 2011 to collect baseline data from ICP-eligible people, again in fall 2012 to collect data after the first year of ICP (although the average length of enrollment was about 7 months at that point), and in the fall of 2013 after the second year of ICP. In fall 2012, the research team began to survey a comparison group of people who would be eligible for ICP (i.e., they are Medicaid-only and ABD) but who live in Chicago. This group was surveyed in fall 2012 and fall 2013, and after controlling for demographic differences, the results can be used to make comparisons between ICP and fee-for-service Medicaid (FFS). The samples for each survey distribution were stratified random samples to ensure representation of each ICP Group (i.e., waiver status). However, respondents from the previous year were automatically included in each sample to allow for longitudinal analysis. The total sample, responses, complete surveys, and response rates for each round of the survey are found in Table 141.

Table 141: Survey Responses

	Baseline: Summer 2011		After Year 1: Fall 2012		After Year 2: Fall 20133	
	ICP	Comparison	ICP	Comparison	ICP	Comparison
Total Distribution	2195	N/A	2150	2000	5691	5688
Responses Received	418	N/A	562	422	790	720
Response Rate[1]	21.4%	N/A	29.0%	23.7%	24.0%	25.8%
Valid Surveys[2]	412	N/A	553	413	430	387

[1] The response rate reported is a conservative estimate as there are a large number of people in the sample we could not reach. This table only shows the number of surveys returned to us by the mail service as undeliverable; the true figure we cannot reach is likely much higher.
[2] The number of responses received and the number of valid surveys differ slightly because some of the respondents completed more than one survey or indicated that they used a private insurer through an employer and not Medicaid and/or ICP.
[3] This round of the survey is ongoing. These are the numbers that represent the survey to date.

Analysis of this data is presented in two ways in the following sections:

1) Longitudinal analysis of 208 ICP enrollees who completed the survey both at baseline and following the first year of ICP. These results show how ICP-implementation impacted enrollees during the first year of the program. We are following these individuals in future years, but fewer than 90 cases are currently available for the survey following the second year of ICP, which limits our ability to make statistical comparisons until we seek and receive additional responses.
2) Cross-sectional analysis of the 1510 survey responses we have received to date after the second year of ICP. More than half of these are from ICP enrollees and can be used to make comparisons with FFS recipients living in Chicago.

1. ICP Longitudinal Analysis: Baseline to Year 1 for ICP

The longitudinal analysis is based on 208 ICP enrollees who completed the survey both at baseline and following the first year of ICP. Of the 412 people with valid responses at baseline, 380 were still enrolled in ICP following the first year of the program, although we could not locate them all for survey distribution. The 208 responses are a 70% response rate from the people who completed the survey at baseline and with a valid mailing address. Demographic information on the respondents shows a higher percentage of females than males (Table 142). The disability groups have been constructed so that each respondent fits into one of the groups, which are then used for analysis. That is, each respondent is only in one group, and is not represented in another.

Table 142: Demographics of ICP Longitudinal Respondents

Demographic	n=208	%
Gender		
- Female	115	56.4
- Male	89	43.6
Race		
- Black	81	38.9
- White	98	47.1
Hispanic Origin	25	12
Disability Group		
- No Disability	19	9.1
- Int./Dev. Dis.	82	39.4
- Mental Health	46	22.1
- Physical Dis.	61	29.3
Age (After Year 1)	Mean=51.12; Range: 21-92	

Access to Services

Results of paired t-tests show few changes between the longitudinal respondents from baseline to a year after implementation of ICP regarding access to services. Table 3 shows the baseline and Year 1 mean scores on five variables that do not show any statistically significant differences: total unmet needs, total unmet specialist needs, number of preventive services received, frequency of timely care, travel time to primary care physicians. The lack of significant differences also held when we restricted the comparisons to groups of people with intellectual and developmental disabilities, physical disabilities, and mental health issues.

However, the sixth measure included in Table 143 does show a statistically significant difference. After the first year of ICP, **the participants reported shorter travel times to get to specialist offices**. When looking at this difference by population, people with physical disabilities and people with mental health issues did not show a statistically significant difference from the baseline to the first year of ICP. However, people with intellectual and developmental disabilities did show a statistically significant improvement. That is to say that while the overall longitudinal population showed this relationship, the difference can be attributed primarily to people with intellectual and developmental disabilities. Figure 13 shows these changes in a graphic.

Table 143: Longitudinal Measures of Access to Services (Full Sample n = 208)

Variable	Baseline	Year 1	t
Total Unmet Medical Needs[1]	1.06	0.95	0.78
Total Unmet Specialist Needs[2]	0.45	0.42	0.36
Preventive Services[3]	2.9	2.78	0.99
Frequency of Timely Care[4]	3.44	3.37	0.84
Travel Time to PCP[5]	1.86	1.785	1.51
Travel Time to Specialist[5]	2.31	2.12	2.43*

* p< .05; [1] measured 0-8, includes behavioral counseling, dental, dietician, home health, occupational therapy, personal assistance, physical therapy, and speech therapy services; [2] measured 0-7, includes allergist, cardiologist, psychiatrist, psychologist, physical rehabilitation, dermatologist, and surgeon; [3] measured 0-6 for provider talked to person about healthy eating, exercise, emotional health, birth control, and STDs and physically weighed the person; [4]scale 1-4, with higher meaning more frequent immediate access; [5]scale 1-4, with higher meaning more time.

Figure 13: Longitudinal Changes in Measures of Access

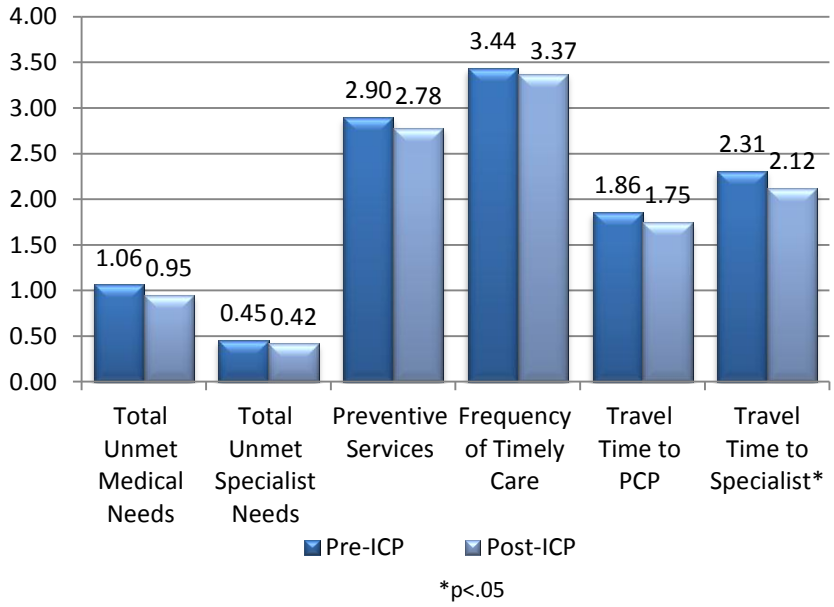


Table 144 includes the number of people in the longitudinal sample who reported having an unmet need for a specific service during the baseline and following the first year of ICP. Individually, the distributions of unmet needs for these specific services do not show statistically significant differences. By frequency of people reporting an unmet need for a service, **dental is the service with the highest number of unmet needs**. Table 144 also reports the percent of each unmet service out of the ICP longitudinal sample and by valid responses (i.e. only out of the number of people who answered the question; that is, they either said that they needed the service or they received it). Dietitian services, physical therapy, personal assistant services, and home health services were the other most frequent unmet needs. It bears noting that the frequency for each is relatively low, but the percent of people who needed the service is higher. The same services were highest at baseline and after the first year of ICP.

Table 144: Unmet Needs for Services

Service	Baseline			Year 1		
	Frequency Unmet	Percent of Longitudinal Sample (n=208)	Percent of People Needing the Service	Frequency Unmet	Percent of Longitudinal Sample (n=208)	Percent of People Needing the Service
Dental	66	31%	46%	74	35%	50%$
Dietician	18	8%	45%	27	12%	60%
PT	25	12%	40%	22	10%	42%
Personal Assistant	18	8%	33%	17	8%	28%
Home Health Services	22	100%	50%	15	7%	43%

In summary, the longitudinal survey respondents did not show many statistically significant differences in measures of access to services after moving to ICP from the FFS Medicaid program. The only thing that changed was that they reported a slight improvement in travel times to get to specialist services.

Satisfaction with Services

Although for the most part access to services did not change, it is also important to look at satisfaction with those services and with the ICP program in general. Table 145 includes measures of satisfaction with four aspects of ICP: overall satisfaction with the program, satisfaction with primary care providers, satisfaction with medical services, and satisfaction with specialist services. Each is measured on a scale of 1 to 5, with 5 indicating the highest level of satisfaction. Figure 14 shows these changes.

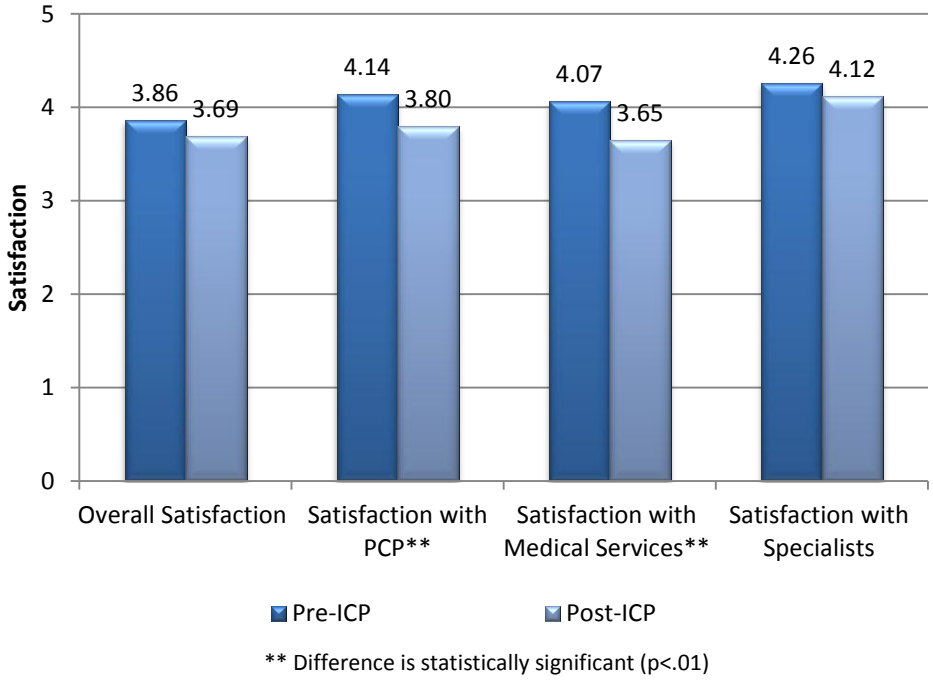
The results of these t-tests showed that for **overall satisfaction with ICP and for satisfaction with specialists, there was no significant difference for the longitudinal sample from the baseline to following the first year of ICP. However, satisfaction with primary care physicians and with the medical services received significantly decreased from the baseline to the first year of ICP.**

Table 145: Longitudinal Measures of Satisfaction (Full Sample n=208, Baseline to Year 1)

Variable	Baseline	Year 1	t
Overall Satisfaction	3.86	3.69	1.71
Satisfaction with PCP	4.14	3.8	2.99**
Satisfaction with Medical Services	4.07	3.65	3.30**
Satisfaction with Specialists	4.26	4.12	1.11

** p< .01; scales 1-5, with higher meaning more time.

Figure 14: Longitudinal Satisfaction



** Difference is statistically significant (p<.01)

Table 146 portrays the same measures of satisfaction by population type. It shows that people with intellectual and developmental disabilities did not have any significant differences in their level of satisfaction. People who identified as having mental health issues, did have a significant decrease in satisfaction with their primary care provider (4.22 to 3.66, p<.05) while the other measures of satisfaction did not change. People with physical disabilities reported a statistically significant decrease in their satisfaction with the overall program (3.98 to 3.58, p<.05) and with the medical services they were receiving (4.18 to 3.4, p<.01).

Table 146: Longitudinal Measures of Satisfaction

Variable	I/DD (n=82)			Mental Health (n=46)			Physical Disability (n=81)		
	Baseline	*Year 1*	*T*	*Baseline*	*Year 1*	*t*	*Baseline*	*Year 1*	*t*
Overall Satisfaction	3.94	3.77	1.12	3.52	3.6	-0.3	3.98	3.58	2.29*
Satisfaction with PCP	4.12	3.87	1.18	4.22	3.66	2.12*	4.06	3.76	1.72
Satisfaction with Medical Services	4.06	3.77	1.35	3.91	3.67	1.02	4.18	3.4	3.55**
Satisfaction with Specialists	4.13	4.04	0.36	4.35	4.14	1	4.3	4.03	1.16

* p< .05; **p<.01; scales 1-5, with higher meaning more satisfied

To determine factors that contribute to a person's overall satisfaction we conducted a regression analysis that included measures of continuity of care and perceptions of differences in quality. Figures 15 and 16 show the number of responses within the longitudinal sample to questions pertaining to these concepts. Figure 15 is specific to the question that asked whether a person can still see the same

doctors after enrollment in ICP. A little over one in three of the longitudinal responses (35%) could see all of the same doctors after enrollment. Thus, **the majority had to find new doctors, with nearly one-third (32.3%) having to see all new doctors.** The question in Figure 16 asks people to assess the quality of their care after the first year of ICP compared to the baseline. **More than half of the respondents thought that the quality of ICP was above similar to what it was before enrollment.** Slightly more people thought that the quality was better after enrollment with ICP (16.8%, and another 5.8% who said it was much better) than said it was worse (13.7%, and another 7.9% who said it was much worse).

Figure 15: After enrolling with ICP, can you see the same doctors? (n=192)

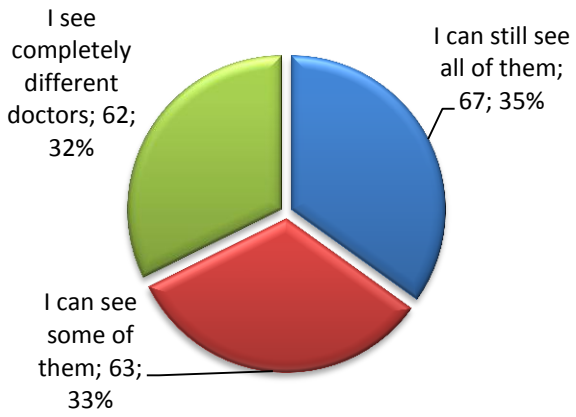
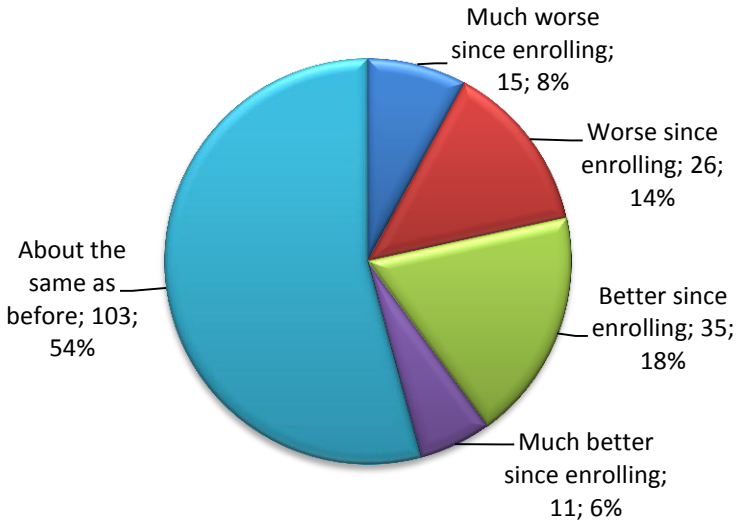


Figure 16: How would you rate the quality of your healthcare after enrolling with ICP? (n=190)



The regression analysis used overall satisfaction after enrollment as the dependent variable and continuity of care, quality of care, age, being white, being black, having Hispanic origin, and identifying as having a developmental or intellectual disability, physical disability, or mental health issues along with satisfaction with care before enrollment as independent variables. The results indicate that the demographic variables have little impact on satisfaction. Rather, **people who had to see fewer new doctors after enrollment** ($p<.01$; Figure 17), **people with a more favorable assessment of quality**

(p<.01; Figure 18)**, and people with a higher level of satisfaction** (p<.05) **before the enrollment have statistically significant higher levels of satisfaction after enrollment**. This regression is shown in Table 147.

Figure 17: The Impact of Changing Doctors on Satisfaction

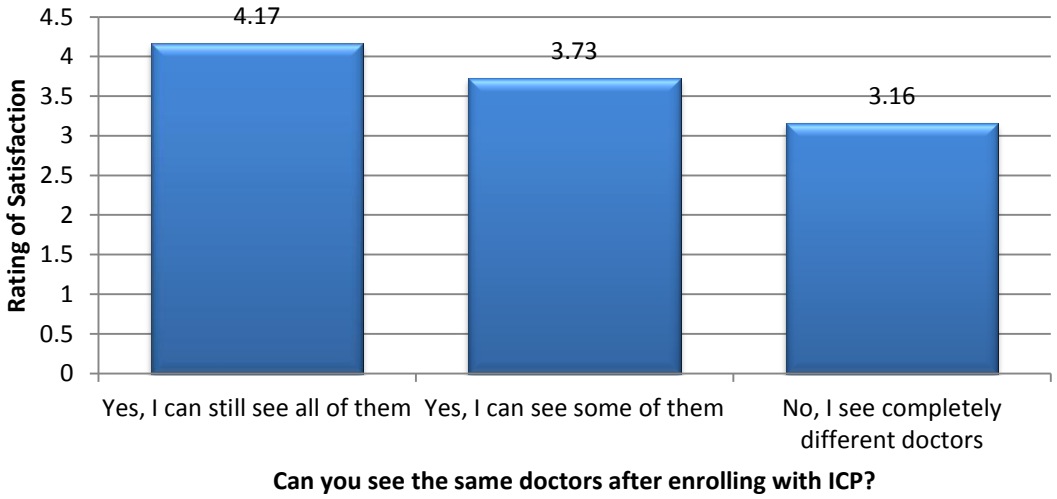
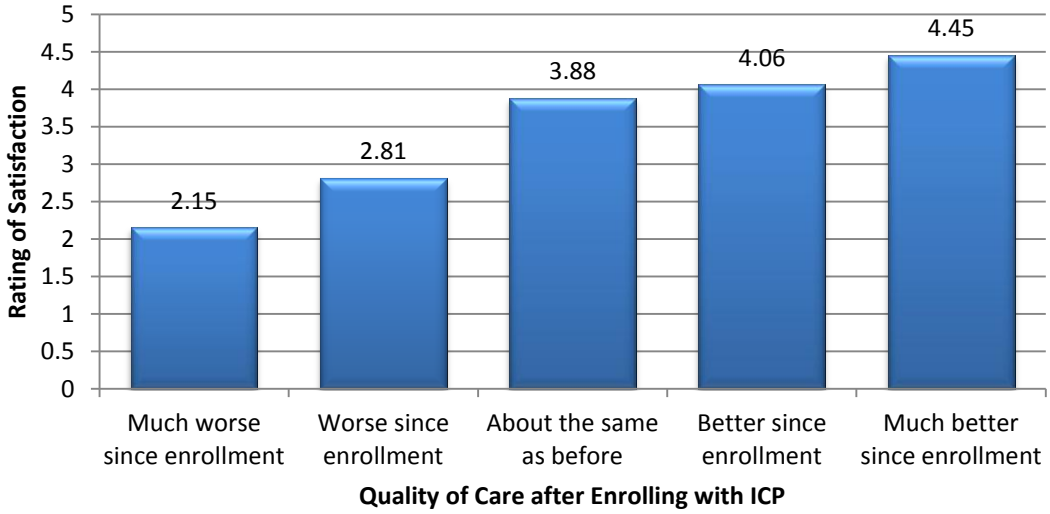


Figure 18: The Impact of Quality of Care on Satisfaction (After One Year)



The data that we have following the second year of ICP shows that this decline in satisfaction is not continuing; however the number of responses we have for this period does not allow us to make any statistically significant comparisons, yet. In the following section, we compared the level of satisfaction in ICP to the level of satisfaction in the FFS comparison group living in Chicago.

Table 147: Regression Analysis for Overall Satisfaction (FY13)

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	61.279a	10	6.128	6.897	0.000
Intercept	4.321	1	4.321	4.863	0.029
Baseline Satisfaction	4.42	1	4.42	4.975	0.027*
See Same Doctor	6.428	1	6.428	7.235	0.008**
ICP Quality	30.348	1	30.348	34.158	0.000**
Age	0.011	1	0.011	0.013	0.911
Hispanic Origin	0.131	1	0.131	0.148	0.701
White	0.002	1	0.002	0.002	0.967
Black	0.026	1	0.026	0.029	0.865
ID/DD	1.452	1	1.452	1.634	0.203
Mental Health	0.194	1	0.194	0.219	0.641
Physical Disability	0.164	1	0.164	0.185	0.668
Error	130.601	147	0.888		
Total	2241	158			
Corrected Total	191.88	157			

R Squared = .319 (Adjusted R Squared = .273)
* p<.05; ** p<.01

2. Cross-sectional Analysis: Year 2 ICP Compared with FFS Medicaid from Chicago

To date, 1,510 people completed the survey for the second year following implementation of ICP; 790 are enrolled in ICP, and 720 are receiving FFS Medicaid in Chicago. Table 148 describes the demographic characteristics of each sample.

Table 148: Cross-sectional (after Year 2) Demographics

Demographic	ICP		FFS Medicaid	
	n=790	%	n=720	%
Gender				
- Female	460	59.1%	401	57.2%
- Male	317	40.1	298	41.4
Race				
- Black	245	31.0%	435	60.4
- White	360	45.6%	108	15.0%
Hispanic Origin	65	8.2%	92	12.8%
Disability				
- Int/Dev Disability	313	39.6%	197	27.4%
- Mental Health	283	35.8%	244	33.9%
- Physical Disability	310	39.2%	311	43.2%
Age (mean)		50.67		53.55

The analyses presented in the next two subsections focus on access to services and general feelings towards their healthcare services for people enrolled in ICP and people receiving FFS Medicaid. Using regression analysis, we control for demographic differences and look at the impact of ICP on these constructs.

Access to Services

Similar to the analyses presented for comparisons of longitudinal ICP enrollees, one of the focal areas of analysis for the cross-sectional responses to the survey is to determine differences in access to services. To do this, we ran a series of regression analyses including the total number of unmet medical needs, total number of unmet specialist needs, total number of preventive services received, and total number of unmet needs for long term services and supports, and total number of unmet needs (encompassing the three previous measures) as dependent variables. The independent variables for these analyses included dummy variables for demographics (white; black; Hispanic origin; having a intellectual disability, developmental disability, mental health issues, or physical disability; age; and gender) and enrollment in ICP. The results of the regressions are presented in Tables 149-152.

Table 149 is the regression for total unmet medical needs. The results show that **people enrolled with ICP have significantly fewer unmet medical needs versus people receiving services through FFS Medicaid** (p=.009; 1.02 versus 1.3). Having an intellectual/developmental disability (p=.000) or physical disability (p=.003) was also significantly related. Irrespective of the other factors, **people with either intellectual/developmental or physical disabilities had a higher number of unmet medical needs** than people without those conditions, both in ICP and FFS. This implies that people in ICP have significantly less unmet medical needs than people in FFS Medicaid and that certain disability types are more likely to have unmet needs in both programs, making it important to ensure that people with specific disabilities access services. People who identified as white also had significantly fewer unmet medical needs than non-whites.

Table 149: Regression Analysis for Total Unmet Medical Needs (FY13)

	Unstandardized Coefficients		Standardized Coefficients		
	B	Std. Error	Beta	t	Sig.
(Constant)	.708	.241		2.941	.003
Age	.002	.003	.021	.744	.457
Gender	.134	.087	.040	1.533	.125
Hispanic Origin	-.206	.150	-.037	-1.373	.170
White	-.300	.117	-.083	-2.563	.010**
Black	-.149	.113	-.044	-1.318	.188
Intellectual/Dev. Disability	.211	.101	.060	2.101	.036
Mental Health	.445	.090	.126	4.928	.000**
Physical Disability	.511	.089	.150	5.767	.000**
ICP	-.244	.093	-.073	-2.630	.009**

R square .051; **p<.01

Table 150 is the regression for total unmet specialist needs. Results of the regression for unmet specialist needs mirror the results for unmet medical needs: **enrollment with ICP or receiving services through FFS Medicaid is not related to the number of unmet specialist needs. People with mental health** (p=.000) **and physical disabilities** (p=.001) **have a higher number of specialist needs than people without those conditions**. As with unmet medical needs, this implies that ICP is not statistically different from FFS Medicaid with regard to unmet specialist needs and that certain disability types are more likely to have unmet needs in both programs, making it important to pay particular attention to ensuring that people with specific disabilities access specialist services.

Table 150: Regression Analyses for Total Unmet Specialist Needs (FY13)

	Unstandardized Coefficients		Standardized Coefficients		
	B	Std. Error	Beta	t	Sig.
(Constant)	0.064	0.160		0.400	0.690
Age	0.001	0.002	0.011	0.373	0.709
Gender	0.081	0.058	0.036	1.397	0.163
Hispanic Origin	-0.044	0.099	-0.012	-0.439	0.661
White	-0.072	0.078	-0.030	-0.929	0.353
Black	-0.056	0.075	-0.025	-0.750	0.454
Intellectual/Dev. Disability	0.019	0.067	0.008	0.281	0.779
Mental Health	0.345	0.06	0.149	5.758	0.000**
Physical Disability	0.287	0.059	0.127	4.874	0.000**
ICP	0.045	0.062	0.02	0.724	0.469

R square .039; **p<.01

Table 151 is the regression for total unmet LTSS needs. The results of the regression for unmet LTSS needs are similar to the results for unmet specialist needs: **enrollment with ICP or receiving services through FFS Medicaid is not related to the number of unmet LTSS needs. People with intellectual/developmental (p=.022), mental health (p=.022), and physical disabilities (p=.014) have a higher number of unmet LTSS needs** than people without those conditions. As before, this implies that ICP is not statistically different from FFS Medicaid and that having IDD, mental health, or physical disabilities is related to more unmet LTSS needs in both programs, making it important to pay particular attention to ensuring that people with these characteristics are able to access LTSS.

Table 151: Regression Analysis for Total Number of Unmet Long Term Services and Supports Needs (FY13)

	Unstandardized Coefficients		Standardized Coefficients		
	B	Std. Error	Beta	t	Sig.
(Constant)	1.612	0.164		9.858	0.000
Age	0.003	0.002	0.046	1.531	0.126
Gender	0.000	0.059	0.000	0.006	0.995
Hispanic Origin	0.085	0.100	0.024	0.842	0.400
White	0.025	0.080	0.011	0.311	0.756
Black	0.043	0.077	0.020	0.558	0.577
Intellectual/Developmental Disability	-0.209	0.068	-0.092	-3.064	0.002**
Mental Health	-0.140	0.061	-0.062	-2.291	0.022**
Physical Disability	-0.148	0.060	-0.068	-2.469	0.014**
ICP	0.087	0.063	0.040	1.380	0.168

R square .021
*p<.05; **p<.01

The results displayed in Table 152 are for the total number of unmet needs, inclusive of the three preceding analyses. Once again, the regression shows that e**nrollment with ICP or receiving services through FFS does not have a statistically significant role in predicting the number of unmet needs. People with mental health (p=.000) and physical disabilities (p=.000). In each case, people with one of these conditions have a higher number of unmet needs** than people without those conditions. As before, this implies that ICP is not statistically different from FFS Medicaid and that having disabilities means more total unmet needs in both programs, making it important to pay particular attention to ensuring that people with disabilities are able to access services. People who identified as white also had significantly fewer unmet medical needs than non-whites in both ICP and FFS.

Finally, the regression analysis in Table 153 for the number of preventive counseling/services received tells a similar story. This measure includes whether a provider talked to the patient about sexually transmitted diseases, healthy eating, emotional health, exercise, reproduction, and whether the person was weighed. **People enrolled with ICP received significantly fewer preventive counseling services than people receiving services through FFS Medicaid (p=.003; 2.60 to 2.98).** Mental health (p=.000) was the only condition with a statistically significant difference, with **people who have mental health issues receiving more preventive services** than people without. Identifying as white was also significantly related (p=.010); **people who identified as white reported receiving more preventive counseling services than people who were non-white.**

Table 152: Regression Analysis for Total Unmet Needs (FY13)

	Unstandardized Coefficients		Standardized Coefficients		
	B	Std. Error	Beta	t	Sig.
(Constant)	2.329	0.373		6.240	0.000
Age	0.009	0.005	0.054	1.821	0.069
Gender	0.225	0.135	0.045	1.675	0.094
Hispanic Origin	-0.184	0.229	-0.023	-0.805	0.421
White	-0.462	0.181	-0.086	-2.545	0.011*
Black	-0.263	0.175	-0.053	-1.501	0.134
Int./Dev. Disability	0.021	0.156	0.004	0.136	0.892
Mental Health	0.669	0.139	0.128	4.811	0.000**
Physical Disability	0.653	0.137	0.129	4.774	0.000**
ICP	-0.135	0.143	-0.027	-0.944	0.345

R square .082; *p<.05; **p<.01

Table 153: Regression Analysis for Number of Preventive Counseling Services Received (FY13)

	Unstandardized Coefficients		Standardized Coefficients		
	B	Std. Error	Beta	T	Sig.
(Constant)	2.907	0.254		11.447	0.000
Age	-0.006	0.003	-0.050	-1.758	0.079
Gender	0.114	0.092	0.032	1.237	0.216
Hispanic Origin	0.304	0.158	0.053	1.923	0.055
White	-0.320	0.124	-0.084	-2.592	0.010*
Black	0.131	0.119	0.037	1.102	0.271
Intellectual/Developmental Disability	-0.162	0.106	-0.043	-1.521	0.128
Mental Health	0.515	0.095	0.139	5.410	0.000**
Physical Disability	0.120	0.094	0.033	1.286	0.199
ICP	-0.296	0.098	-0.083	-3.014	0.003**

R square .069; *p<.05; **p<.01

To conclude this section on unmet needs and preventive counseling services received, people enrolled in ICP have fewer unmet medical needs than people who receive FFS Medicaid, although they receive fewer preventive counseling services. The primary factor in differences with regard to the unmet meets and receiving preventive services is disability type, where people with a condition have more unmet needs and received fewer preventive services than people without that condition.

Feelings Toward Healthcare Services

In order to assess differences between ICP enrollees and people receiving FFS Medicaid, we created a scale to measure a person's overall feelings towards the healthcare services received, known as their Healthcare Services Appraisal. It is composed of six items that are strongly correlated with one another (α=.732 overall; and α>.7 for groups of people with intellectual and developmental disabilities, mental health issues, and physical disabilities): overall satisfaction with healthcare, satisfaction with their primary care physician, satisfaction with medical specialists, satisfaction with care coordination, satisfaction with the medical services received, and perception of the quality of care received. This scale allows us to use a single measure in analyses of feelings that a person has towards their overall healthcare program (e.g. FFS Medicaid or ICP).

Table 154 shows results of the regression analysis for Healthcare Services Appraisal. In addition to the demographic variables and whether a person was enrolled in ICP or received services through FFS, the analysis includes the number of preventive counseling services received and total number of unmet needs as independent variables. These two variables were statistically significant (p<.01); **regardless of whether they were enrolled in ICP or not, people who received more preventive services had higher scores for Healthcare Services Appraisal. Similarly, people with more total unmet needs rated their Healthcare Services Appraisal lower.**

The impact of being enrolled in ICP versus FFS was not significant, so the analysis also includes interaction effects for people with mental health, physical and intellectual/developmental disabilities who were enrolled in ICP. The interaction of ICP with physical disability was statistically significant (p=.002). **In FFS, people with and without physical disabilities rated the Healthcare Services Appraisal equally, while in ICP people with physical disabilities had significantly lower appraisals than people without physical disabilities (3.73 versus 3.91).**

Having a mental health disability was also significant (p=.006). In both ICP and FFS, people with mental health disabilities rated their appraisals lower than people without those disabilities (3.65 versus 3.86 in FFS; 3.77 versus 3.86 in ICP).

The implication of this analysis is that Healthcare Services Appraisal is not dependent on enrollment in ICP versus receiving FFS Medicaid. Regardless of how healthcare services are delivered Healthcare Services Appraisal is related to the number of unmet needs, and preventive counseling services received. However, when one examines the appraisal of health care by disability type and ICP group status there are significant differences for physical disability. People with physical disabilities report lower appraisals than people without physical disabilities within ICP.

Table 154: Regression Analysis for Healthcare Services Appraisal (FY13)

	Unstandardized Coefficients		Standardized Coefficients		
	B	Std. Error	Beta	T	Sig.
(Constant)	3.757	0.111		33.847	0.000
Age	0.001	0.001	0.027	0.984	0.325
Gender	-0.063	0.038	-0.040	-1.634	0.102
White	0.017	0.051	0.010	0.341	0.733
Black	0.032	0.047	0.021	0.697	0.486
Preventive Services	0.076	0.011	0.173	6.953	0.000**
Total Unmet Needs	-0.137	0.012	-0.297	-11.896	0.000**
Intellectual/Developmental Disability	0.019	0.044	0.012	0.427	0.669
Mental Health	-0.129	0.040	-0.079	-3.184	0.001
Physical Disability	0.054	0.056	0.034	0.967	0.333
ICP	0.134	0.052	0.086	2.587	0.010**
ICP x Physical Disability	-0.184	0.077	-0.096	-2.396	0.017*

R square .144
*p<.05; p<.01

Appendix C: Focus Groups

The focus group summary and analysis focuses on the thoughts and feelings of the major groups involved in the Integrated Care Program (ICP) in six counties in suburban Chicago. These groups are the program members who receive healthcare services, their family caregivers, the healthcare providers, the Managed Care Organizations' (MCO) care coordinators, the MCO leadership, and the staff of the Bureau of Managed Care in the Illinois' Department of Healthcare and Family Services. The focus group data provide an in-depth exploration of participants' perspectives on their experiences with the ICP, the highlights of which are presented here. These data complement other data collected and presented throughout this report including specific properties and processes of the ICP such numbers of hospital admissions and survey data from samples of the ICP members.

A. Focus Group Methodology

The research team conducted a series of focus groups (17 in 2012, also called year 1 in the focus group analysis, and 15 in 2013, also called year 2) and interviews (2 in 2012 and 4 in 2013-14) with interested stakeholders. ICP members and family caregivers were recruited by disseminating a flier though local disability advocacy and service organizations, listservs of support groups and direct phone calls using the contact information provided by the Illinois Department of Public Health (IDPH). Recruiting focus group participants was a labor-intensive process, particularly members, for example, requiring that 40 to 50 members be called to find one focus group participant. Given the mobility and low income of Medicaid recipients, a significant proportion of the phone numbers received from existing records were either disconnected or incorrect. Members and caregivers were also recruited based on interest expressed during the previous year's focus group participation. Finally, the ICP member survey offered participants the option to indicate their interest in taking part in a focus group; several ICP members were recruited in this way. Participants were recruited for particular groups based on geographical location. Furthermore, in some instances we tried to reach out to members in different suburbs than we used for the previous year in order to get a more representative sample. Service providers, managed care employees and leadership, and state employees were recruited through community organizations, hospitals and clinics, and their work organizations.

During 2013 and early 2014, the research team conducted 15 focus groups and 4 individual interviews with 30 members who were receiving services and 4 caregivers residing in 6 counties (suburban Cook, Kankakee, Will, Kane, DuPage, & Lake). These members indicated that their disabilities were related to physical disability, mental health, blindness or visual impairments, deafness or hard of hearing, substance abuse, and/or chronic illness. Focus groups were also conducted with 17 providers, 33 MCO care coordinators, 13 MCO leaders, and 10 state employees. See Table 155 for an overview of these 107 focus group and interview participants.

Each focus group and interview was conducted at a public, accessible location (e.g., Centers for Independent Living, university offices, HFS offices, community agencies, etc.). Three interviews were conducted by phone. At or prior to each focus group and interview, members of the research team explained the purpose of the focus group or interview and obtained informed consent. The focus groups and interviews were conducted by experienced, trained facilitators using a semi-structured focus group

Table 155: Focus Group Participant Demographics (Year 2)

Participant Type	# of Focus Groups/ Interviews	Gender	Age	Race/Ethnicity	Total
Member*	6/0	Female: 63.3% (19) Male: 33.3% (10)	Range: 30-88 Median: 56	White: 30% (9) Black: 70% (21)	30
Caregiver*	0/4	Female: 100% (3)	Range: 37-62 Median: 60	White: 66% (2) Other: 33% (1)	4
Provider	2/0	Female: 82% (14) Male: 18% (3)	Range: 24-63 Median: 55.5	White: 71% (12) Black: 6% (1) Other: 24% (4)	17
MCO Care Coordination Staff*	4/0	Female: 91% (30) Male: 9% (3)	Range: 25-66 Median: 38	White: 42% (14) Black: 46% (15) Other: 9% (3)	33
MCO*	2/0	Female: 54% (7) Male: 46% (6)	Range: 29-62 Median: 46	White: 46% (6) Black: 31% (4) Other: 15% (2)	13
State Employees	1/0	Female: 90 % (7) Male: 10% (1)	Range: 28-62 Median: 49.5	White: 90% (9) Other: 10% (1)	10
Total	**15/4**				**107**

* Missing data from one or more participants in one or more demographic categories.

interview guide. The development of the guide was informed by feedback from an Evaluation Advisory Board made up of disability advocates approved by the governor's office. The resulting guide was reviewed and approved by the Illinois Department of Public Health and the UIC Institutional Review Board. The focus groups and interviews were recorded digitally and transcribed verbatim to create a transcript for analysis. Additionally, research team members took notes during the focus groups to capture contextual information that may or may not be detected through transcription. Each focus group lasted between 70 and 180 minutes, and each interview lasted between 25 and 180 minutes. Following the focus groups and interviews, participants (excluding MCO leadership and governmental employees) received $50 as compensation for their time. The recording were professionally transcribed yielding 402 pages of focus group and interview data.

The research team used qualitative analysis/coding software (Atlas.ti) to assist with a mixed approach (grounded theory and a priori codes) to qualitative analysis. Research team members reviewed the recordings and transcripts for accuracy and made revisions as necessary. Subsequently, the research team examined the data for themes that emerged during the analysis, and looked for themes on the pre-identified topics of transition/enrollment, communication, network adequacy, dental, quality of care, medication, long-term supports and services, transportation, and coordination of care. The research team used multiple coders and analysts to ensure consistency and agreement on general themes. These themes are illustrated by descriptive quotes. The research team also used a combination of inductive and deductive coding to narrow themes into subthemes for each type of participant,

allowing subthemes to emerge organically while also using the existing framework that guided the development of the focus group protocol. Quotes appearing in this report represent a small portion of exemplary comments. In order for a set of comments to be considered a "theme", the concerns must have been raised by multiple stakeholders across groups. Thus, each quote represents one individual's perspective or experience and is indicative of similar comments made by other participants.

B. Focus Group Findings

The eleven major topical areas presented in this analysis are:

- Enrollment/Disenrollment
- Network Adequacy
- Care Coordination
- Access to Services: Prior Authorizations and Referrals
- Pharmacy/Medication
- Dental
- Long Term Services and Supports
- Transportation
- Quality of Care
- Accountability
- Billing and Payment

In order to protect confidentiality of MCO care coordination staff, this report does not identify the MCOs by name in quotes from care coordinators. However, given this report's evaluation purposes, MCO affiliation is named for MCO leadership.

1. Enrollments/Disenrollment

Enrollment/Disenrollment refers to members' voluntary or involuntary registration with either Aetna Better Health or IlliniCare, as well as MCO efforts to transition members into or out of plans. Enrollment issues were discussed in the second round of focus groups but with less frequency and urgency than in the first round of groups; the main themes revolved around the challenges of members' being able to make a well informed choice in selecting an MCO and the challenges the MCOs faced rolling out Service Package 2.

Challenges and Facilitators of Member Choice

Some members found it difficult to make an informed choice about which MCO to join. They were frustrated by the lack of information provided to them and describe the *"packet of papers like this [showing thick stack of paper] and you could hold them side by side and see. But you didn't really know what it [being in one of the MCOs] was going to be like by the sheets of paper. And they said, 'Here is a, list of doctors,' and I didn't know how, how are you supposed to pick a doctor by a list of names?"* (Member). Some family members discussed the usefulness of being able to compare MCOs before joining. One said, *"One of the reasons I chose [MCO A] over [MCO B] was because it did give two dentals a year versus [MCO B]'s one"* (Family Caregiver). Another noted, *"Two years ago when I had to make my choice, one of the things that I looked at [was] what hospitals are in the program."* (Family Caregiver).

Care coordination staff at the MCOs noted that choice is very important to them and they expressed concern that *"a lot of [members were] not given a choice. They said at the beginning … they felt like it [ICP] was forced on them."* Here members were not referring to selecting between healthcare programs offered by the MCOs, but rather about having to change to managed care from fee-for-service Medicaid coverage. That staff member continued on to note how much of what care coordinators do is centered on promoting choice: *"So what we do when we go out there and assess, then we find out they have a need, we give them provider lists for whatever they might need and let them determine who they want to go to."* (Care Coordinator).

Usefulness of State Agency Trainings and the Challenge of Service Package 2

Another issue closely related to enrollment is the rollout of Service Package 2 (SP2) services. Although members had been enrolled with the MCOs for Service Package 1 services, the transition to long-term services and supports (LTSS) presented challenges for the MCOs to work with their members. This process was complicated by the delays in the rollout of SP2. Various providers were unsure of how to handle the situation and noted that in many instances, members who were once a part of a CCP transferred to an MCO and soon came back to the CCP. Nursing homes were mentioned by the MCO staff as a particular challenge in regards to member enrollment, especially because of the paperwork and data involved in identifying and enrolling eligible members, as well as having to wait for other state agencies to catch up on providing data concerning transitioning ICP members to nursing homes. MCO leadership noted the usefulness of training sessions offered by the state to help with this transition. Training sessions included meetings with the Division of Rehabilitation Services (DRS) and the Department of Aging (DoA)about their waiver services.

> *"We had a day and one-half down in Springfield and we got a binder from Aging. It was probably one of those three-inch binders that went through every single P & P [policy and procedure], admin code and again that was great because sometimes those things were spread out all over the place and here we had one nice binder. We pretty much started at the front and went all the through and got all the details surrounding the Aging waiver."* (MCO Leadership)

The MCOs also explained that part of the challenge in preparing for SP2 rollout involved working across state agencies with a different set of practices and strategies for maintaining records. *"And again two different agencies, one was sending things electronically in one format. The other was having their agency send them in on paper."* (MCO Leadership).

In summary, despite the fact that most enrollment in service package 1 occurred prior to and during the time of the first round of focus groups, members, caregivers, care coordination staff, and MCO leadership in the second round of focus groups discussed issues related to enrollment, including a lack of choice in the process and the complexities of rolling out Service Package 2. Enrollment continues to be an issue and will likely remain relevant over time, albeit at a reduced level from start-up, because new individuals become eligible for the ICP and a few people change plans each month.

2. Network Adequacy

Network adequacy refers to the sufficiency of the network to provide members with the correct healthcare services. Stakeholders who participated in the second round of focus groups reported

improvements to the network, specifically with regard to the availability of satisfactory PCPs and hospitals. MCO leadership continued to improve the network by adding PCPs and hospitals, as well as providing opportunities for out-of-network service providers to work with the MCOs when necessary. The following year 2 quotes provide comments from stakeholders about the adequacy of primary care providers, hospitals, and specialists, the use of out-of-network providers, and satisfaction with long-term services and supports and personal assistants.

Adequacy of Primary Care Providers

Satisfaction with finding primary care providers seemed to have increased for members. One member had to change doctors and described the process: *"I did a lot of calling back and forth to Medicaid and [MCO] to find a new primary care doctor and that wasn't a problem."* (Member). However, there were still concerns among some members and providers about the ability of MCOs to provide service near where members reside. *"There seem to be very few providers for some of our folks for both Aetna and IlliniCare. It's hard. [...] One thing we do is make sure they [our clients] get hooked to primary care physicians. You know that they contact their care manager, with the ICPs and you know it's a challenge because quite often the doctors are not close to where they live"* (Behavioral Health Provider).

MCO leaders felt that there were significant gains in expanding the network when it came to requests for primary care providers. One said, *"Well from the perspective of members, clearly we have been able to meet longstanding requests to have new providers come in, providers that they had relationships with."* (MCO Leadership). Additionally, they spoke of efforts to reconnect members with former PCPs once those PCPs came into the network: *"There was a little bit of disruption initially and this pre-dates, I think , most of us in the room where some of these centers were not [in network], with [university hospital E] being a big example. So we had to … reassign those members to other PCPs. Now that they [university hospital E] are in the network, if they have a history of having seen [members] in the past two years, members [will] be able to see their previous providers"* (MCO Leadership).

Adequacy of Hospitals

Comments regarding network expansions with regard to hospitals have been generally positive, especially with the addition of major university hospitals to the network. For example, *"But now, today, it has been a great increase and even with the university hospitals, it's been great. When we first started, it was hard to get them on board."* (Care Coordinator). Incentives provided to hospitals for joining the network were perceived to have had an effect on the number of hospitals joining the network. *"I don't even think those payments [that hospitals received in service package 2 if they became in-network] were huge, but it was helpful. It was a nudge"* (State Employee).

MCO leaders were pleased with the progress thus far. *"So Year 2 provided a different landscape of the network because those same hospital systems were now seeing how the program had been working for a year, were comfortable with the program, saw that it was actually happening and not going away. So some hospitals that would not contract with either health plan actually for the first year, did contract with us in Year 2… So those were big coups and with that came all of their physicians as well which added a lot. [University hospital] alone had over 700 physicians. So that was a big addition to the network"* (MCO Leader).

Despite this increase in hospitals, the discrepancies between the two MCOs with regard to what hospitals are covered has been problematic for some. *"And in [city D] a lot of our clients really benefit from going to [Hospital A] for a lot of their services. But they don't take (MCO A] insurance. [MCO A] is not hooked up with them. Only [MCO B]. So a lot of our clients have [MCO A] and that's a challenge for them"* (Behavioral Health Provider).

Adequacy of Specialists

MCO leaders expressed optimism about the expansion of the network with regard to specialists. *"Some of the specialists were waiting to see if their hospital was going to sign up. When they did, then we were able to contract with those specialists. So that definitely added to the network"* (MCO Leadership).

However, access to specialists within a reasonable distance remained a concern among members. For example, one member shared, *"I went to my doctor four weeks ago, almost a month and one-half and they told me they were going to try to find a specialist for a colonoscopy and I am still waiting on them to find a provider within the city that I live in so I don't have to go all the way up to [Chicago suburb]"* (Member). Additionally, providers expressed concerns about the lack of availability of local specialists. *"Some [members] are going without [seeing a specialist]. Some are traveling very far to get any coordination for specialty care… not good. And for people who at times have probably never left this area, it's very threatening and scary"* (Provider). One care coordinator added, *"We only get… a handful of doctors that are specialists and doctors that are willing to take the plan. So that's a challenge in helping the members find doctors and specialists who will take the plan."* (Care Coordinator)

While there have been efforts to streamline the process for referrals, there are still many concerns about the process for gaining access to specialists. For instance,

> *"I got out of the nursing home the day before Thanksgiving so it's plenty of time to heal for my hip. My back and my legs don't want to work in this cold… So I called the [hospital] and I talked with this [nurse] for half an hour and she said you have got to get a referral. My [primary care physician] won't refer me to [another kind of specialist]. He said I am not going to get involved in that. You have to get that from the guy [surgeon] that did your hip" (Member).*

In contrast, MCO leaders stressed the importance of primary care providers acting as advocates for their members. *"So the PCP may have a member that they are seeing that doesn't necessarily have a relationship with the specialist and that specialist designated existing [patient] members only. But the PCP's contact and relationship with that specialist breaks down barriers to get that member in"* (MCO Leadership).

Common Use of Out of Network Providers

Payments to and trial periods for out-of-network providers were seen as a positive step toward expanding the network. As one state employee stated, *"A lot of the providers were willing to do 90 day, 180-day trial periods to see how the MCOs operated. And I think once they realized okay we are going to get paid faster, the billing isn't as difficult as we thought, then they signed on."*

Long-term Services and Supports and Personal Assistants

Only a modest number of ICP members participating in the focus groups received long-term services and supports [LTSS]. These members generally received such services prior to the implementation of service package 2 and were pleased with its rollout. Others reported that those who were seeking to obtain coverage and had not previously been receiving SP2 services had more difficulty gaining access. From the perspective of the MCO leadership, LTSS network expansion went well. The large majority of providers who offer long-term supports and services joined their networks prior to rollout in February 2013. As one MCO leader explained,

> *"For the LTSS, we only contracted with those providers that were credential[ed and had already] contracted with the state. So the state did that credentialing piece. They would send us a list then of all of their nontraditional, the ACBS home and community-based services providers… and then we contracted with those providers."* (MCO Leadership).

A state employee added,

> *"We made sure they had a certain percentage of those [LTSS] providers before we said okay good, we're good to go live when we thought we were…when Service Package 2 came along, people[LTSS providers] realized it was real and inevitable and it was happening, and so they better jump on board."* (State Employee)

One member discussed their experience with getting a personal assistant:

> *"I have had no problems [with the ICP] for this year or the last year or whatever. I just got approved. I have got a physical disability and I just got approved for a personal assistant. Somebody to help me out at the house for like laundry and different stuff like that"* (Member).

In our first round of focus groups, provider network adequacy was a major concern raised by virtually all stakeholders. Concerns included having to change providers as their former providers were not "in-network," long wait times to see providers, provider's lack of awareness of member's medical history and conditions, and inaccessibility of physician specialists and specialty services. While there are still concerns among stakeholders about the adequacy of in-network providers, hospitals, and specialists, there have been improvements throughout the system in regards to stabilizing and expanding the network. The introduction of university hospitals to the network has been a boon to the program. Also both MCOs continued to pay out-of-network providers in large numbers. Overall, the process of getting members in touch with the medical providers they needed in order to obtain quality care appears to have gone more smoothly, if not yet as smoothly as desired by some members and providers, in the second full year of the program than in the first year.

3. Care Coordination

Care coordination refers to the process of engaging members in ICP services. Engaging members took many forms (e.g., assessments, care planning, prevention education, outreach, connecting members to PCPs, specialists, and supportive services). The process of care coordination within Year 2 affected each stakeholder group differently. The following year 2 quotes (from members, providers, care coordination staff, and MCO leadership) provide context for the role of care coordination from multiple perspectives. The quotes are categorized into six categories: 1) value and expansion of care coordination, 2) lack of

awareness of care coordination, 3) communication to facilitate care coordination, 4) the impact of transportation on care coordination. 5) care planning, 6) reduction in unnecessary hospitalization and ER visits, and an increase in use of primary care providers in order to prevent ER and/or hospital visits. Care coordinators and MCO leadership spoke about the extensive processes involved in developing and documenting care plans as well as the importance of care planning for ensuring quality care. In addition, care coordinators discussed the importance of member involvement in care planning. MCO care coordination staff indicated that they were checking in with both members and providers to see if services were necessary, and/or if other treatment plans or services would be a better fit for the patient (and perhaps less costly). Providers and members did not raise issues related to care planning or service utilization in focus groups.

Value and Expansion of Care Coordination

In the second round of focus groups, MCO leadership indicated the emphasis that they place on care coordination and its value. Care coordination staff consistently reported that they had more time and focus in the past year to coordinate care as opposed to the first year when they were investing much time in finding physicians who would see their members and "putting out fires." Care coordinators discussed conducting initial assessments, supporting the process of gaining authorizations for services and medications as well as participating in outreach efforts to build relationships with members and providers. Care coordinators shared strategies they applied to gain members' trust and to empower members.

> *"When you are out there doing the assessment, you are getting to know the member and talking with the member, but [also] I incorporate the member into the care plan, so that they are more willing and apt to participate and work on the care plan as opposed to dictating to them what they should and should not be doing."* (Care Coordinator)

Since the first round of focus groups, the process for care coordination has expanded to include coordinating long-term services and supports as part of service package 2.

Lack of Awareness of Care Coordination

Many of the ICP providers as well as members participating in the second round of focus groups were not aware of the role played by care coordinators within the ICP. Providers expressed uncertainly about their own role in care coordination as well. *"The care coordination piece [of the ICP], is that from the actual managed care to the patient directly or by the physician?"* (Provider). MCO care coordinators focused their efforts mostly on high and moderate risk individuals, which are a minority of those served by the ICP. Thus they are not necessarily the population that participating providers served, perhaps contributing to providers' lack of awareness. Many ICP members participating in focus groups did not fully understand care coordination and the role of their care coordinator and in some cases whether or not they had been assigned a coordinator. *"I didn't find this out until yesterday afternoon [that I had a MCO case coordinator]"* (Member). Members who were aware of their coordinators were often unclear about the distinct role the coordinator played. For one MCO, the ICP members with a low-risk health status are not assigned to a care coordinator and in the other MCO, ICP members do not receive intensive care coordination. Therefore, it is understandable if members with low-risk health statuses have limited knowledge about care coordination.

Some care coordinators shared challenges in awareness of the severity of some clients' health status accounting for a delay in coordinating members' care,

> *"some [members] kind of fell through the cracks. We're kind of picking them up now as claims have been coming through and they are showing up as more high risk or they are showing up as heavy dollar users, whatever. So we are kind of catching them on the back end at this point. So sometimes almost two years later." (Care Coordinator)*

Communication to Facilitate Care Coordination

To increase internal collaboration among staff members, MCOs facilitated interdisciplinary teams to communicate about member needs. In some instances, members shared aspects of their health that their PCPs were not aware of. *"One of my members…his wounds hadn't healed for two years. Something is not right about this picture…. But of course the PCP [said], 'Oh, we didn't know that. He did not communicate that to us.'"*

Externally, care coordinators communicated with PCPs to promote consistency and implementation of care plans. However, MCO leadership acknowledged that there was room for growth in this area, "…*there could be more communication in terms of what it is providers could expect from care coordination*." (MCO Leadership)

The Impact of Transportation on Care Coordination

Care Coordinators shared that transportation issues were a barrier for effective care coordination. Specifically issues of: prompt arrival of transportation, missed rides, accessibility of vehicles and accurate pick up times. "*I know ___ [name of care coordinator] was on the phone today … she will be on the phone for hours if you have a transportation issue.* (Care Coordinator)

In summary, in year 2, stakeholders who expressed comments about care coordination included: MCO leadership, care coordination staff, members, and providers. As a result of the role of care coordination staff, most of their perspectives reflected their experience on the job. The predominant theme across stakeholders beyond care coordination staff was a lack of awareness of care coordination occurring. There appears to be a lack of awareness and understanding of care coordination and the role of care coordinators in the ICP from the perspective of members, their family caregivers, and providers. One change between the year one focus groups with care coordination staff was that in year 1, care coordination came up substantially less, as the primary efforts of care coordinators had to do with conducting initial assessments and finding primary care physicians and specialists for their members. Whereas in year 2, care coordinators discussed coordination of care as central to their work.

Medical Care Planning - Paperwork and Follow up

The administrative role of care coordination staff is time consuming and coordinators raised concerns about their ability to meet members' needs when saddled with excessive paperwork and given their large caseloads. *"…It is very documentation centered. I mean you have to document everything…So say if you are on a phone with a member for an hour. You have gotten to the meat of what they need... after you get off of the phone with them [you] have to document everything"* (Care Coordinator).In many instances, the process includes follow up work: *"Yes, once you leave you have to write up a care plan and do the service planning. If they are a new member, you have to send the service planning*

documentation to the homemaker company or to DHS... Things are always changing so you got to keep up". (Care Coordinator).

Communication and Collaboration around Medical Care Planning

Several care coordinators and MCO leaders commented on the benefits of open communication and working with service providers on members' care plans. Care coordination staff will attend nursing home care plan meetings if invited: *"We provide the care plans that have been documented. We make sure the physician knows they [members] have contacted the plan and if they [members] have questions about the plan."* (MCO Leadership)

Outreach and Prevention

The following quote from an MCO leader illustrates the value the MCOs place on engaging with members as soon as possible following enrollment, in order to effectively begin the care planning process. "*By sticking to a primary model, when we reach that person that first time, [we] do the assessment, identify certain needs, engage the person in case management, and initiate the beginning of a care plan to catch that member with a higher degree of success."* (MCO Leadership). Care coordinators also commented on incorporating prevention of issues related to diet and housing.

Empowerment, Freedom of Choice

Care coordinators commented on promoting choice in healthcare by involving members in care planning. *"…I want to empower them because I am thinking so many [members are] used to people doing [everything] for them that they lay back and they don't [follow through and take charge of their health]. So my main thing is empowerment and freedom of choice."* (Care Coordinator)

In sum, care coordinators and MCO leadership provided context for understanding care plans from their respective roles. The administrative paperwork for care coordinators is required to monitor members' progress. Care planning as a process is extensive because the plan has to fit the individual health needs of members. Outreach was not an overt theme, but MCO leadership conveyed the importance of engaging members and providers in the care planning process. Care coordinators work with members to educate them about preventive practices that can improve health outcomes. In addition, care coordinators seek to empower members to be active participants in care plans.

Reducing Unnecessary Hospitalizations, ER Visits and Services

Care coordinators focused on reducing unnecessary hospitalizations and ER visits. They described a reduction in ER usage, and attributed it to building relationships with members so they could better advise them. Care coordinators mentioned that, "*[building strong relationships] makes a difference and going and visit[ing] with the members. It's just been really great."* (Care Coordinator).

Care coordinators described,

> *"[We] help our members try to stay more healthy and we try to encourage when we go out to the home to say, 'If you have a pain in your big toe, please don't go running to the emergency room. If it is something you can deal with, deal with it and go to your doctor tomorrow or call your doctor."* (Care Coordinator).

Care coordinators also spoke with providers to determine if services were necessary, and mentioned that there was *"some fall out from providers, from systems that…are just expecting the blank check."* (Care Coordinator).

Care coordinators described doing quality checks. We are checking and balancing this and saying,

> *"Do you really need to do this? Can't we do something a little bit less invasive? Or does this person really need to go to five providers?... Yes, he needs to go to a cardiologist, but does he really need to have five other providers? Is there something that you can handle as the PCP?"* (Care Coordinator)

Overall, care coordinators reported building relationships with members to ensure that certain services were medically necessary and encouraging members to see their primary care physicians. Providers and members did not discuss service utilization in focus groups. When comparing Year 2 to Year 1 for service utilization, care coordinators did report a reduction in ER admissions. While members did not specifically report avoiding a hospital or ER visit because of a preventive visit to a provider. However, as noted in the 'Grievances and Appeals' section, members did note having to go to the hospital or receive additional treatment as a result of not getting a certain service, prescription or procedure approved.

4. Access to Services: Prior Authorizations and Referrals

In the second round of focus groups, providers and members expressed concerns regarding access to necessary services, medication medical equipment and supplies, while MCOs expressed concerns regarding completion of the necessary forms and utilization of currently available resources. This seems to be an area that merits continued attention to difficulties.

Process Concerns regarding Services and Medication

Still, providers try to find ways to get their patients the services they need. One physician specialist described trying to obtain prior authorization for medication:

> *"I usually do a two-page individualized letter regarding the patient's history. I mean I just go on and basically somewhere in there I will say something like, 'It would be cruel and unjustified to deny this person this, this and this due to the fact they have been stable for X amount of….' But it is outlining every single thing they have tried, where they tried it, and everything I can gather and that is sometimes, not all the time, that is sometimes the only way that I can get someone [at the MCO] to actually say, 'Well, okay I guess we'll do it.' But I mean it literally has to go to that point."* (Provider)

Regarding prior authorization, MCO care coordination staff also voiced concerns over provider cooperation. For instance,

> *"You try to find out where the miscommunication is coming from. You check the system to see if any prior authorizations have been submitted, if the member is saying that the doctor did submit them. There is nothing in the system. You contact the doctor and say, 'You know, I heard you tried to get a prior authorization for this member's medication… Did you send it to the correct fax number? Did you have the right form? Then can you fax it again? …and then some providers, I guess they get agitated, which I mean I understand to a point. But if they are wanting to help their member and they really need*

that prescription medication, they kind of have to work with the process." (Care Coordinator).

Providers, too, reported having had concerns with the process.

"As far as the prior auths go…we're basically doing faxing because we simply can't wait on hold for long periods of time, and doctors have been hung up on. So we're really just doing faxing and the form for [MCO] requires medical records. They will not even consider a prior auth without substantiating supporting medical records. Well if you have a new client and you have only seen them once, all you have is one progress note" (Provider).

MCOs have been working to simplify the process,

"…we are really committed to moving barriers to the members getting necessary treatment particularly in some of the high-risk areas. To that end we have implemented a gold carding program for psychiatrists. For psychiatrists who are in our network, we removed the prior authorization requirement for behavioral medications, even those that at the upper tiers of the formulary. These are psychiatrists. They know what the drug profiles are. They use these drugs with a combination of others and most of the drugs are getting approved on review anyways." (MCO Leadership).

At the same time, MCOs also expressed concerns regarding resources already in place that are not being utilized to their full extent.

"But they [providers] can go to the website and pull down our authorization form and then that goes back to our prior authorization department. Physicians can do a prior authorization or a facility for that matter can do prior authorization through our provider portal. The utilization of that portal, however, by the network physicians is relatively low." (MCO Leadership)

Access to Medical Equipment and Supplies

Some members have expressed that they have been having access issues obtaining necessary medical equipment and other supplies. For instance,

"…I also need to get a sleeve and a glove and [after 3 months] I am still in the process of getting the glove. A lot of places that have medical supplies I was referred to by [MCO]. Once I called them to try to make appointments or get fitted or whatever, they told me they no longer did it or they did not accept [MCO insurance]." (Member).

Another shared their own difficulties: *"They referred me to medical supply places to go, and in going, they needed them to fax over some [documents] and they would deliver it to me. I have not gotten it yet. I have spoken back to the coordinator last week and it is still being worked on"* (Member).

During the first year of focus groups, obtaining referrals as well as quality, affordable prescriptions was a major concern for ICP members. Many participants in both the first and second year groups spoke about issues with the process of obtaining referrals or authorizations for services and durable medical equipment. As these services and essential medical items can be costly and difficult to obtain on their own, MCO support for members is essential to making the process as efficient and helpful as possible. ICP members expressed frustration with the process of getting access, especially authorizations, in both

year 1 and 2; however, ICP members in the year 2 focus groups had more complaints, possibly due to their increased use of or knowledge of the system.

5. Pharmacy/Medication

This theme refers to members' ability to obtain the medications prescribed by their providers. Stakeholders in the second round of focus groups voiced complaints regarding access to medications in the ICP, although members cited successes more frequently than providers and caregivers.

Specifically, members, providers, and MCO leadership spoke about barriers to obtaining medication. *"One of the medicines that I just had to have recently was not covered by them. And I had to try three other kinds prior to getting the one that the doctor wanted me to have."* (Member) Another member said, *"The only thing I don't like [is] the hard time you get when it comes to certain meds. You know as maybe the [MCO] rules change and they send you info like you didn't have to pay co-pay, but now you got to pay co-pay."* (Member).

The SMART Act mandated that those individuals receiving more than four medications have their cases reviewed prior to approving further prescription medication. While MCOs clearly did not institute a strict four medication limit, some members were under the impression that this rule was in effect: *"My primary physician told me eventually that they couldn't give me the regular prescriptions because [MCO] is only paying for four a month."* (Member).

Some members had success accessing medications,

> *"I got my medication on time. They [care coordination staff] even tell me, don't even let my medication get too low. If it gets to the point where they [care coordination staff] got to call into the doctor and the pharmacy, they are on it right there. I am pretty much good. They [prescriptions] are even delivered the same day or next day. So I don't have a problem with prescriptions, anything that is needed."* (Member)

Some MCO leaders discussed the need to adapt their coverage due to members' negative experiences accessing medications. Some had, in fact, made important policy changes to improve access for those members whose medications had previously been routinely reauthorized for good medical reasons.

With regard to changes in medication, members and providers reported primarily negative experiences with changes in medication and related outcomes. Although members had mixed experiences, care coordination staff's experiences were generally negative. Providers and MCO leadership also made comments regarding the lack of a 'grace period', which refers to time between when a medication is denied and when the medication is no longer provided to the member. Members and providers reported that at times the grace period could be so brief as to preclude planning and making a successful transition off that medication either to another medication or to no medication.

Access to Medication

Provider comments regarding members' ability to obtain required medications were largely negative:

> *"I have tried to submit all of their medications, right, for the four-script override as the first one comes in. In other words I talk to the pharmacy [and] say 'okay, when are they going to run out*

> *of the next three because I don't like to make multiple calls?' They'll say they are going to run out of them next three in 24, 48 hours. So give me all the meds we are going to be on. I will write 4-override script for all four of those and only the one that has run out will be approved. The other three will be denied until they are actually due. And it doesn't matter if they have been on it for one year or five years, seven years, ten years. It does not matter. You just start over again."* (Provider)

Another provider explained challenges in obtaining injectable medications for members, *"We are having a major problem with [MCO]. What is happening is that injectable clients are required to use mail-order pharmacy. So there is a breakdown, they're not getting their injectable medication and they are very unstable clients, probably our most unstable population."* (Provider).

Additionally, providers were frustrated with the process of obtaining authorizations for certain medications,

> *"I call it a typical Catch 22 and we're to ask for medication to stabilize a seriously mentally ill person. When you finally get to talk to whoever you are going to talk to to get the authorization for that, they'll say they will not authorize it because they will say, 'the patient has been noncompliant'; and I will say, 'of course a patient is noncompliant. They are seriously mentally ill. That's why they need the medication. We need to restart it.' 'But they are noncompliant.' …and it's literally like doing this over and over trying to explain to someone. Finally you get so frustrated and want to say, 'Do you [know] what serious mental illness means for some of these people? They are going to be noncompliant. They are not going to take the medications. That's what this means.' And it's like talking to the air."* (Provider)

Leadership of one MCO explained that they did not implement four drug limits or require new prior authorizations after the SMART Act was passed,

> *"We did a very extensive analysis of our drug use by our members and we have quite a few members that receive more than four drugs. And with very, very few exceptions, those drugs are tied to clinical conditions which need to be treated with those medications. And so we had planned… not to implement [the new limit], [which is] an overly, I think, restrictive prior authorization process for those drugs over four. As long as it is clinically appropriate, there is no additional prior authorization requirement [if a member needs more than 4 medications]. It's no different than before. We basically have not implemented that aspect [of the SMART Act]. It is also a distinction between the plans." (MCO Leadership)*

MCO Leadership also explained that the high cost and rate of inflation for specialty medications is a concern for them, "In general, the drug spend plan is a very significant issue… Specialty drug costs are increasing faster than the overall rate of health care inflation so that we are monitoring. The industry has pricing power." (MCO Leadership).

Change in Medication

The second round of focus groups had fewer members raise complaints and concerns about having to change medications than in the first year of the ICP; however, this issue still was problematic for several members we heard from, *"But some of what they recommended I am allergic to; and they keep insisting*

to the doctors put it and they said you can appeal it and my doctor did FIVE appeals; and he said he refused to put on there what they recommend because it had this same ingredients that I am allergic to." (Member).

Issues related to changing medications was also a concern voiced by providers,

> *"So you have people who have been stable on medication for ten years, twelve years and now they have to change their medication. That is heartbreaking that somebody out of the hospital, functioning in society, maybe having a job, really high functioning and now, 'Sorry, your meds are being taken away.' And we don't always have samples to give. If we do, it's temporary. And then they have been denied. They [the MCOs] have to try 'step therapy', they call it."* (Provider)

Challenges picking up medications at the Pharmacy

When members speak with care coordinators explaining that they are having trouble picking up their prescriptions at the pharmacy, the care coordinators do what they can to help,

> *"…nine times out of ten the pharmacy doesn't have our information, the group number, the bin number, PCN number. Once I give them that information and they run it through, [they say] 'oh they [member] can pick it up. No problem.' … I think a lot of the communication is with the pharmacies and they are still kind of saying, 'Is it [the MCO or its parent insurance company]'? They are still kind of fuzzy on that."* (Care Coordinator)

MCO care coordinators share some frustration in supporting members to obtain their prescriptions,

> *"…our pharmacy is in Arizona… [when calling them] you might get a tech who doesn't know [the status of the prescription] or somebody didn't do something right, but there is supposed to be an override. So let's say we spend all this time. We got an override put in. We tell the member okay you're good, go to the pharmacy. They get to the pharmacy [and tell me] 'I still can't get my medication.' And you are like what is the problem? So I'm calling our pharmacy internally [again]."* (Care coordination staff)

Grace Period

Behavioral health providers expressed frustration that grace periods were not built in for members who were being denied medications that they were currently taking.

> *"If there is a denial, there is no grace period. They are just cut off, which is dangerous to the patient who is abruptly cut on a medication. They can have discontinuation [syndrome] sometimes. They can have seizures and there is absolutely no consideration for the harm that could be done and that is dangerous and that is concerning also."* (Provider)

On the other hand, MCOs were proud of their flexibility and lenience when it came to easing members into the transition to ICP,

> *"With the transition [to the ICP] the education component that we supplied, we did mention that with the transition…I think it was a 90-day period, we were continuing the members' current therapy no questions asked. And if they [members] were already at an injectable point, we would*

not obviously request them to fail on orals again. So that was part of the, I guess, misconception that they [providers] had."(MCO Leadership)

In summary, members, care coordination staff, providers, and MCO leadership discussed their experiences with medication during the second round of focus groups. Although members had some positive experiences with accessing medications and pharmacies, member and provider experiences with medication issues were overwhelmingly negative, similar to responses in the first round of focus groups. Participants cited members' struggles to get the medication they needed, having to change from medications that were working, and a lack of communication with pharmacies covered by MCOs. Although the MCOs viewed their adherence to a grace period as a success of their plans, many other participants did not perceive this period as an effective accommodation for members. One MCO reported making policy changes to eliminate prior authorizations of medications for those who had been on multiple medications for good continuing medical reasons over a period of time.

6. Dental Services

This theme refers to comments regarding the dental services covered by Aetna and IlliniCare. In the second round focus groups, several members and caregivers felt that dental coverage was inadequate, although some caregivers commented on their satisfaction with their dental coverage for preventative procedures (primarily cleanings). In contrast with members and caregivers, MCO leadership expressed their valuing of dental coverage for prevention and treatment.

Communicating about the Adequacy of Dental Coverage

The leaders of both MCOs conveyed to us that they chose not to reduce dental services covered to ICP members even though dental coverage was significantly reduced in July of 2012 by the SMART Act for those in other areas of Illinois who were receiving fee-for-service Medicaid coverage: *"I think our sense is that restricting services is not the most cost effective way to manage people. So getting them the right things, and we chose to keep the dental benefit…"* (MCO Leadership).

Several members were unaware of the MCO's policy and reported hearing that their coverage had become more limited, *"I'm just hearing that all you can do now is get a tooth pulled and that is it. And it got to be emergency. In other words, we ain't got no dental."* (Member). However, another parent caregiver of an ICP member was aware of the MCO's support of routine dental coverage and stated, *"He [son] has gotten two dental cleanings with [MCO] …We haven't paid a nickel for that. Now if they find a cavity, I understand that's not covered. That they will only extract the teeth rather than trying to save them."* (Family Caregiver).

In general, issues related to dental services discussed in the second round of focus groups were similar to those discussed in the first round of groups. Members, caregivers, and MCO leadership were all concerned about the adequacy of dental coverage, as well as the importance of covering dental services for the ICP population: members and caregivers feared that needed services would not be covered, and MCO leaders asserted the value of covering such services and were doing so. The main issue seems to be how to most effectively communicate to MCO members that they still have both routine and emergency dental coverage

7. Long Term Services and Supports (LTSS)

Long Term Services and Supports refer to nonmedical services provided to help individuals live in the community or in nursing homes, such as providing personal care assistance. These services were offered through the Integrated Care Plan beginning in February of 2013; previously they were offered through the Division of Rehabilitation Services to those with disabilities or the Department on Aging for seniors. The second round of focus groups revealed that participating members who had received Long Term Supports and Services previously from the Division of Rehabilitation Services (DoRS).transitioned smoothly to the ICP. Others who had not previously been receiving services reported more difficulty. Relatedly, MCOs reported difficulty locating and tracking members. Care coordinators had to use several avenues (e.g., going by members' last place of residence, contacting the member's doctors, etc.).in order to contact members regarding LTSS issues. In addition, MCO leadership discussed the delays as well as challenges in the rollout of service package two.

Difficulty Locating Members

Many care coordinators expressed difficulty with locating members, primarily because this particular population tended to be, "*very mobile. And it is because a lot of times their lifestyle, their [limited] finances"*. (Care coordinator). Care coordinators used various methods, including "*about 50% of [the time we locate members by] doing the drivebys. Sometimes I have to contact the doctor. I have to contact the DHS counselor because they are the ones that are paying out the personal assistance of some of my members.*" (Care Coordinator).

Delays and Challenges to Service Package 2 Rollout

Furthermore, there were delays in rolling out Service Package 2, *"there is a lot of data that needed to be transferred about the members' service plans because we had to keep those in place for the first 180 days…And again two different agencies, one was sending things electronically in one format. The other was having their agency send them in on paper."* (MCO Leadership)

Members Satisfied with processes for obtaining Personal Assistants

The members who had personal assistants reported being happy with their freedom to choose who was hired and in general seemed pleased with the process of obtaining their assistants. *"Well, I had the opportunity [to choose my PA]. It wasn't no stranger. I knew somebody that was willing to do it. So it worked out fine for me. I know a few guys who have a complete stranger, but I got a family friend that comes by*." (Member)

The roll-out of LTSS did not occur until Year 2 of data collection, so we were unable to compare Year 1 to Year 2. Furthermore, there was also a delay in the roll-out of Service Package 2. Care coordinators spoke of using more unconventional methods to reach members (e.g., stopping by the members' homes), and members reported being satisfied with being able to select their personal assistants.

8. Transportation

Transportation refers to comments about transit services provided to ICP members to facilitate access to healthcare. During the second round of focus groups, as in the first, members and care coordinators reported struggles with the convenience, reliability, and travel experiences related to ICP-covered

transportation services, although some members appreciated the transportation services. MCO leaders pointed out that they had more complaints about transportation than any other area of service, but that the proportion of complaints filed was very small compared to the total number of trips taken. They also noted complaints from transportation providers about some members whom providers did not want to serve.

System Convenience

Members and providers had mixed reviews of the convenience of accessing the transportation system.

> *"If you call and make an appointment, they usually [used to] call you a day before and … tell you what time the cab is for. They don't do that no more. [They say] 'Oh we're not allowed to do that.' For me I'm on the inside of the building. I can't hear when the cab comes up in my apartment, then what?"*(Member)

Some members talked about negative health outcomes associated with challenges securing transportation.

> *"One time I did go out without [an appointment for] a while because I couldn't get transportation. It was a big mess. And I went without my meds for a month and ended up like a total 'wound up clock' the whole month. Because I didn't have it[medication] one month, it must have been withdrawal."* (Member)

Some providers had positive experiences with their members using the ICP transportation, *"We have had success with that [ICP-provided transit] as well. It is a pretty easy system for them to access to call for the transportation. That has been a good resource."* (Provider).

Reliability/Wait Times

With regard to reliability and wait times, members, providers, MCO care coordinators, and MCO leadership all discussed primarily disappointing experiences with the reliability of transportation services, including timeliness for scheduled appointments, canceled appointments, and wait times on return trips.

> *"…I have to wait hours for the [transportation] company …You expect …you might have to wait a half-hour to an hour for [your] ride to come back. But you would expect them to be back in that time frame. You don't want to have to wait another two, three hours for transportation… and that has happened so many times. I was at the point where I was ready to drop [my MCO] because of this."* (Member)

MCO care coordinators explained that,

> *"…[the problems with transportation] affects our credibility, we all have horror stories about it. I have a member, she just became effective June 1st and she didn't have a primary care [physician. So I am like talking this really convincing talk about primary care and how it is so great. Here's your primary care doctor. Schedule an appointment. No ride. They cancelled. Second time, third time. On the third time she is going to have to wait until one day when her sister is off work to take her because the doctor who she has never seen is saying, 'You're wasting my time.' So we*

are like tongue-tied…I say okay I'll try to figure it out and I try to calm them down; but then it gets to a point where okay that's half of my day gone to one member in a transportation issue, and then I got the other 86 members." (Care Coordinator)

While the majority of feedback on this topic was negative, some members were very appreciative to have the benefit,

"…my cart they will put it in the trunk; and if they have to pick somebody up, they will let me know. [They ask] How long will you be? And I tell them probably an hour and then they'll tell me, 'Well, I have to go to [x hospital] and pick up a guy and take him home. So I might be a little late.' But… it's free, totally free. And I think that's a great idea. And they'll take you to the pharmacy to get your medicine too— for free." (Member)

Travel Experience

Several members explained that their biggest concerns with transportation had to do with the experience of shared rides,

"They'll pick you up and then take the person that was in the front seat to the doctor. Then they'll go get somebody else and you are still in the back. Take them in another direction. Then take you to the doctor. When they come back to pick you up the van is full. You have to get in where you fit in, then go back home." (Member)

Other members were more concerned with what they felt was a lack of professionalism, *"They bring their personal cars and vans and they are very filthy."* (Member), *"I never heard guys cuss so much in my life. 'Dude, we have to come all the way here and drive you two miles and only get 4 bucks.'"* (Member).

In addition to raising issues around late and missed rides, Care Coordinators talked about concerns about their members' health,

"When you are finally done dealing with [transit company] and all the hoops you had to jump through with them, then the vendor who they contacted, the cab company, might not show up, might show up in an inappropriate vehicle, might show up and the vehicle is full of smoke and the member has COPD." (Care Coordinator)

MCO leaders noted that problems arise from the providers' perspective as well. The members sometimes presented difficulties for the transportation providers in not being available in a timely way and in treating these providers disrespectfully. Therefore, some providers have indicated their reluctance to serve some individuals.

Efforts to Evaluate/Improve

MCO leadership recognized the importance of transportation and talked about how they monitored complaints and tried to improve upon services.

"We measured that [complaints] against total trip lengths, opportunities for something to go wrong if you will. And that has been less than a tenth of a percent when you look at total trip lengths itself. But we take every incident that is reported seriously. And so we have a process where at least standing monthly we meet with [transit company] as

> *we do with all of our vendors…to review and discuss any issues that were raised. 100% of those are logged in and followed up by [transit company]. If it needs escalation for appeal or if a member [is] not happy with the way a complaint was recently handled by [transit company], those then come to the plan for additional review and action. So actually if you just look across Year 1 and 2, it's been relatively flat in terms of changes. So you have had some ups and downs, but overall you are looking at a 12-month to 12-month basis. There has not been an increase if you will in number of complaints, but you haven't seen significant decreases. They are relatively flat."* (MCO Leadership)

Additionally, MCO leadership mentioned that they were open to changing their contracted transit companies if services were not adequate: *"So historically we have used_____ [transit company]. We are assessing our transportation relationship primarily because we have noticed that there has been sort of some issues with the services that have been delivered…"* (MCO Leadership). Subsequently, this MCO changed their transit company.

In summary, members, care coordination staff, providers, and MCO leadership all shared experiences with transportation during the second round of focus groups in 2013. Despite the fact that some focus group participants acknowledged their satisfaction with the incorporation of transportation into MCO-covered services, a majority of those who spoke on this topic had negative experiences with transportation services, similar to participants in the first round of focus groups. They cited issues with system convenience, reliability, wait times, and comfort or safety while travelling. This time we also learned about transportation providers concerns with MCO members. Due to these issues, MCO leadership and staff are making efforts to evaluate and improve the transportation services available to members.

9. Quality of Care

In the second round of focus groups, participants had mixed to positive views about quality of care. On the one hand, members comments regarding quality of care were mostly positive They felt their PCPs and specialists had adequate knowledge and were able to help them. On the other hand, there was concern that cumbersome administrative processes can negatively affect providers' ability to provide adequate care. The focus is on whether patients feel they are getting the care they need in order to remain healthy and manage their health conditions. State employees gave a specific definition of quality of care:

> *"The right care with the right type of provider at the right time. To me, the crux of the program is the care coordination which is insuring that the clients are actually getting access to the services they need to hopefully reduce their costs in the long run to keep them out of the hospital, keep them healthier"* (State employee).

Primary Care Providers

Members did tend to feel their providers were knowledgeable supporters who provided quality services. For instance,

> *"I go see my primary doctor every three months and my mental health doctor every three months and a dentist every four months and then an eye doctor every six months and they are doctors that are willing to give their time cheap for us. […] They're helpful. They are not lacking*

in education or knowledge. They know what they are doing. This is my experience. And they have been nice and helpful" (Member).

Another member shared their experience with their primary care provider, who goes above and beyond for his patients.

"It's [primary care] been pretty good to me. They [primary care provider] keep me on my feet what I need to do for me to keep myself right. He gets on me like if I go in and I tell him I forgot to bring my medication for the afternoon he says, 'Do you want to live?' I like the way he talks because I have congestive heart failure. I got to stay on top of [that]. He reminds me that I need to do this if I want to keep living… He needs me to participate." (Member).

Specialists

Similarly, some members seem to be content with the quality of care provided by specialists. For example, one particularly satisfied member shared,

"I love [my specialist]. She understands me. I can call and talk to her about my problems, anything and she will listen and she will give me some feedback and I like that. Because I don't have nobody here, and I can talk to her. We been knowing each other for years" (Member).

There were, however, some concerns about how various administrative processes can affect quality of care. For instance,

"I think we all just want to do our job and I think everybody is just getting frustrated whether it's managed care or whether it is some of the, you know, the paperwork that comes with managed care that erodes the time that we actually have with patients and really being able to be good clinicians..." (Provider).

Additionally, state employees appreciated an effort by MCOs to improve care by adding a *"quality of life survey [for members]…there are specific things that they are asking in this survey that hit on self-directed care and their quality of life and things like that [to allow MCO staff to be more responsive to members' needs]"* (State Employees).

Overall, members showed contentment with the services provided by their primary care specialists and specialists, and providers expressed commitment to getting their patients the services they need in order to maintain their health. MCOs' continued monitoring of members' satisfaction with quality of care, as well as improvements to administrative processes, will likely prove to maintain and improve members' perceptions of quality of care.

10. Accountability

Few ICP members in the second round of focus groups talked about specific experiences with filing grievances/appeals or voicing official complaints. Participants commented more generally on interactions with MCO employees. Regarding communication, providers indicated that they experienced more outreach from MCOs than in the first year of the ICP. However, providers still remained concerned about MCOs controlling medical decisions and the potential implications for patient outcomes. State employees were satisfied with the level of responsiveness from the MCOs.

Appeals

Although some focus group members were unfamiliar with the formal grievance and appeal procedure, others reported having unsuccessfully gone through the appeals process. One member in particular said that due to cancer, she lost 150 pounds and underwent several surgeries, which resulted in her facial/jaw structure changing so her old dentures no longer fit. After being denied for new dentures by her MCO she said that she appealed and lost, *"[they told me] in order to be eligible [I had to wait] for my five years to be up exactly from the first time that I saw the first the doctor"* (Member).Without adequate teeth, she was limited to a soft diet.

Several providers spoke about their frustrations with both authorizations and the appeals processes. Providers expressed a particular concern with the length of the appeals process, and how that may impact a patient's health outcomes. "*We have criteria by which we assess a patient and we match them to the service they need based on what that assessment reveals. [MCOs policies are such that do we need to have patients] fail at the lower level of care first before we'll even consider giving you what you really need? That makes absolutely no sense and that is absolutely not about quality"* (Provider).

Providers that did discuss appeals typically felt that they were able to end with a positive result; however, they also felt that the process ought not to have been necessary, *"We have actually been able to go through two different levels of appeals and we have been able to reverse it every time. And we were getting ready to go to an external appeal with [MCO] twice now… It was almost like a textbook case [in regards to why this member should receive this particular service]. And in the course of that, what we found out is we were sending them [MCO] all the information they wanted. However they weren't reading everything we sent them"* (Provider).

Communication with MCOs

Many members appreciated the fact that they had a care coordinator "*At least you can talk to somebody…"* (Member); however, both members and providers commented on difficulties making contact with the same MCO employees over time presumably due to high turnover rates or systemic issues related to how the cases are assigned and tracked. Providers also commented on a lack of respect for or awareness of their expertise from MCO staff and in the MCO processes. However, some providers did indicate that MCO care coordinators had reached out to them to offer their support. MCO care coordinators expressed concern that state agencies were not giving adequate attention to some of their most vulnerable clients.

MCO Accountability/Responsiveness to Queries

Overall billing problems, especially in the initially problematic area of behavioral health seem to be substantially less than in year 1. For instance, one billing staff member said she had problems with 80% of the billings in year 1, a huge challenge, and now in year 2 there were problems with about 20% of them, still a significant amount but much reduced from year 1. Therefore, in year 2 providers continued to share some disappointment with the ability of the MCOs to address data and billing issues, stating that *"there are promises on top of promises and they never get met. And now with the whole turnover [of MCO staff] of course we are at a hiatus because these people have to come up to speed…"* (Provider). However, providers also emphasized that MCOs had made an effort to reach out to them, *"Going into*

positives, I know that [MCO's] case managers will go out of the way to call and just say we're just calling you to find out are things okay? Do you need to reach out to anybody to assist you? And a couple of times our therapists have utilized it[this kind of help]." (Provider). State employees were satisfied with the level of responsiveness of the MCOs, *"I haven't had too much problem [with responsiveness to complaints]."* (State Employee).

MCO's expertise and respect for/awareness of expertise of providers:

Providers reported feeling that the MCOs' structure and processes were not respectful of the providers' medical expertise, thereby making their jobs more difficult. *"Who are we talking to on the receiving line [at the MCOs]? Like what's their level… we clinically have an appreciation of the impact of mental illness on compliance. But are the recipients of our conversations well informed like that? Because sometimes it obviously doesn't seem like we are talking to someone that really understands the issues at hand."* (Provider)

Inconsistencies/Lack of information within MCOs: Issues and improvements

Providers raised concerns with inconsistencies between MCOs with regard to what was covered and for paperwork (e.g., procedures for obtaining prior authorizations), as well as a general lack of information available. MCOs noted the challenges of getting providers to use their websites and avail themselves of information provided. Care coordinators also mentioned efforts to improve MCOs' accountability and responses to members through procedural changes, such as being *"assigned one person…So you engage and you stay with that person in the hopes not to have them kind of fall off the radar."* Participants in the year 2 focus groups commented generally on interactions with MCO employees. During year 2, providers indicated that there was more outreach from MCOs than in the first year. However, providers still remain concerned about MCOs giving medical advice and the potential implications for patient outcomes.

Concern about accountability of state agencies to members

Some care coordinators were concerned about members not receiving adequate treatment and/or assessment from state agencies, and gave an example of individuals with traumatic brain injury, who

> *"are supposed to do a reassessment every six months. And we see … where it has gone two and three years before an assessment has been done on this individual. And sometimes if somebody has a set-back, they may be had an original stroke which created a traumatic brain injury for them, eight months later they have maybe a mini stroke of some form or a fall that creates a broken bone on top of now they have had another mini stroke."* (Care Coordinator)

Concerns regarding grievances and appeals

Both members and providers expressed frustration with the grievances and appeals process of the MCOs in both the first and second year of data collection. Some members shared disappointment and concern that because they did not win their appeals for denied services, that it exacerbated their existing conditions and caused secondary conditions. Some providers expressed similar concerns as the members during both the first and second year of focus group interviews.

11. Billing and Payment

In the second round of focus groups, issues with billing were less prevalent. While issues appear to be occurring with some frequency and frustration, they were less common than in the first year. Providers appreciated the improvement and simultaneously emphasized difficulty with the billing process, while members were frustrated with incorrectly receiving bills meant for MCOs.

Billing Process

The impression MCO leaders shared about the billing process has been fairly positive. For example, *"From my perspective in being in those meetings and actually sitting face-to-face with the providers…, they [providers] were actually very excited about [MCO] coming on, I think, primarily because they are going to get paid faster"* (MCO Leadership). However, there are still some challenges. For instance, one care coordinator expressed that providers are not happy with the billing process and reimbursement rates. *"Sometimes they [providers] will open up and start talking about they don't like our reimbursement rate and they are not paid enough to fill out these forms"* (Care Coordinator). The MCOs recognized that the process can be difficult, especially for newer providers. *"But the biggest challenge was bringing in the waiver service providers, community-based organizations who until then had been doing reimbursement in invoice-type billing. They were not familiar with the form types that we use. Even the terminology itself was hard in many cases"* (MCO Leadership)

Education strategies have been implemented in order to help providers with the billing process.

> *"So we wanted to make sure that providers knew how to bill. One of the things that we are also doing as we are moving forward with the implementation of the MMAI [Medicare-Medicaid Alignment Initiative]is that all of the health plans have gotten together and we have a standardization call where we are going through all of the Service Package 2 billing codes … It has been fairly easy because we are all using the same codes. There has only been two or three instances where we maybe use this modifier and we use that modifier. But consistently and conceptually [it] is all the same. So that has been really nice, but that initial education was a challenge"* (MCO Leadership)

Coordinating Payments

Members and providers still have concerns regarding the coordination of payments. For instance, one member shared a conversation they had with their provider. *"Before I never received a bill and I am getting the bills from the cancer hospital [for] testing and things that were done back in December and they are just now telling me, 'Could you do something because we are not getting paid.'"* (Provider), Another provider added, *"We still are having the same [billing] issues that we had two years ago. We still have outstanding claims from 2011 and 2012 with both companies. Right now within the last six months, eight months with [MCO], they turned over all of their staff which makes it very difficult. I mean everybody [in their billing department] has turned over there."* (Provider).

While some groups still felt frustrated and some problems continue, it appears that overall, stakeholders are more familiar with and confident in the billing process. Additionally, MCOs report they are keeping abreast of complaints within the system and are working toward streamlining the process, making it easier for providers and members.

C. Focus Group Conclusions

Overall in this second round of focus groups the issues raised were often similar to those which emerged in the first round, but the tone both in reporting them and in addressing them was more matter of fact. Members, caregivers, providers and MCO care coordinators expressed fewer dire concerns. MCO care coordinators, MCO leaders and state staff expressed a stronger problem solving attitude than during the transition that characterized the first round of focus groups. The Integrated Care Program had launched and experienced over a year of full-enrollment and things were more settled during 2013 when the second round of focus groups was conducted. Member **enrollment** in the ICP was more routine and stable, and disenrollment or switching between managed care companies (MCOs) was not a common issue in focus groups. Care coordinator and state staffing levels and experience had improved. The **provider networks** were much stronger, although many times those who provide services are not in network. The **billing** procedures were better understood and used, although a number of bills are still problematic. Members were more likely to have physicians and so **care coordinators** were more able to manage the care of the high and moderate risk members on whom they were intended to focus. We came away with a sense that while problems, sometimes significant problems, remain to be fully and effectively addressed, there is a willingness and competence among MCO care coordinators and leadership and Bureau of Case Management staff in HFS to do so.

Care coordination seems to be working better for members who are high or moderate risk, but the capacity of the MCOs to address those receiving long-term supports and services remains to be demonstrated. Overall awareness of the existence and role of care coordinators is limited across certain stakeholder groups (i.e., members, caregivers, providers), perhaps because a great majority of members are considered low risk and by design have minimal interaction with care coordinators.

Health **care planning** continues to be a struggle, although MCOs are completing care plans for more members in a timely way than in year one. Nonetheless, there is room for much improvement here. The comments obtained from care coordinators and MCO leaders about the potential of care plans to empower members in addressing health needs and in providing an effective blueprint for engaging diverse providers to provide quality care coordination suggest the potential benefits skillful, timely care planning may yield over time.

Providers and care coordination staff discussed some frustration over the process of communication around obtaining **prior authorizations** and members shared some concerns related to challenges getting the **referrals** for services, equipment, and specialists that they felt were needed. Care coordinators spoke of **limiting potentially unnecessary service use.** While fewer ER visits and hospital stays may reduce costs in the short run, they will need to be offset by other services and supports to sustain and enhance members' health over time. To date there were few signs that other key stakeholders- members, caregivers and providers- have accepted this goal as part of the ICP. Instead members and family caregivers are more likely to be concerned with gaining access to and providers with being paid for providing adequate care.

Access to **medication** and communication around MCO policies related to the MCO's approach to the SMART Act's four medication review rule and **dental** services led to concerns among members,

caregivers, and providers. However, MCOs seem to be making efforts to ensure that, even in the context of the SMART Act, members receive sufficient medication and dental services, as MCOs recognize the value of covering these forms of care.

The transition to providing **Long Term Services and Supports** through Service Package 2 seems to have gone more smoothly than the transition to medical services in Service Package 1. The start was delayed so that by the time Service Package 2 of the ICP began there were good service networks in place for LTSS. Those members who previously receiving services and transferred from Aging or Rehabilitation Services to the MCOS reported smooth transitions and no interruption of services, and the care coordinators assigned to assess LTSS recipients were enjoying their visits with their new clients. However, we heard that some who had not previously been receiving services were challenged to obtain them.

Transportation was one of the most commonly raised concerns which affected access to care. Some members appreciated the transportation services; however, many voiced concerns. Care coordinators shared that issues with prompt arrival of transportation, missed rides, accessibility of vehicles and accurate pick up times were a barrier to effective care coordination. MCOs both noted how infrequently these problems arose given the number of trips requested and also described the actions they were taking to address transportation concerns.

In the second round of focus groups, members spoke positively about the **quality of care** received from primary care providers and specialists. Providers emphasized their commitment to high quality care and expressed concerns about the ICP's increased requirements for documentation which cut into the time they had available to provide care. MCOs and state employees clearly grasp the importance of commitment to quality care from providers.

With regard to **accountability** of the MCOs, providers remained concerned about MCOs controlling medical decisions and the potential implications for patient outcomes. On the other hand, state employees were satisfied with the level of responsiveness to their inquiries from the MCOs. In contrast, although MCOs reported a number of **appeals** were successful, providers and members were generally not happy with the time and effort involved to making an appeal or the reality of losing it when that happened. Members did appreciate being able to **communicate** directly with a person when they had concerns or questions, something that was not readily available under the prior fee-for-service form of Medicaid. However, with care coordinator turnover some members indicated a loss of a relationship without its replacement and providers were concerned about the training and expertise of some care coordinators.

In the second round of focus groups, issues with **billing** were less prevalent than in the first round of focus groups. While issues appear to be occurring with some frequency and frustration, they were notably less common than in the first year. Providers appreciated the improvement and simultaneously emphasized remaining difficulty with the billing process, while members were frustrated with incorrectly receiving bills meant for MCOs.

Overall, we saw, as we did a year ago, that the views of the Integrated Care Program varied with member, family caregivers, and providers seeing more problems, and MCO care coordinators, MCO

leaders, and state staff seeing more strengths. The infrastructure to provide the medical services of Service Package 1 that began in May of 2011 is now more established. The ICP is functioning more smoothly after a challenging startup of about 18 months duration. Issues remain in developing more adequate networks, providing timely care plans, enhancing transportation services, and resolving differences between providers and MCOs on billing matters. We see an improvement over the start-up period with room for continuing improvement in the next year.