ILLINOIS DEPARTMENT OF Healthcare and Family Services

Frequently Asked Questions (FAQs)

Illinois' Medicaid Managed Care Organization

PURCHASE OF CARE REQUEST FOR PROPOSAL

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Background

What is risk-based (capitated) Medicaid managed care?

Medicaid managed care provides health benefits and additional services through contracted arrangements between the state Medicaid agency and managed care organizations (MCOs). MCOs accept a set per member per month (capitation) payment for these services, which creates a risk-based arrangement making MCOs responsible for managing the total cost of care for each enrolled member. This arrangement can improve care coordination, keeping beneficiaries healthier and reducing demand for services over time, in alignment with the goals of the patients, providers, MCOs and taxpayers.

Why does Illinois use capitated Medicaid managed care?

Illinois began transitioning its Medicaid program to mandatory managed care with the launch of the Integrated Care Program (ICP) for Seniors and Persons with Disabilities (Age 19 and older) in select counties who are eligible for Medicaid, but not Medicare in 2011. Public Act 96-1501 required the State to transition at least 50% of beneficiaries to a risk-based care coordination program by January 1, 2015. Today, approximately 65% of Medicaid members are enrolled in an MCO (i.e., approximately 2M out of 3.1M Medicaid members).

By contracting with MCOs, Illinois sought to ensure that the managed care system improves care in terms of quality, outcomes and experience. Managed care is also used to help manage Medicaid program costs and better manage utilization of health services by improving accountability and aligning incentives for managed care organizations. Contracting with MCOs brings new organizations with additional relevant experience and capabilities (often developed from serving other types of members or members across different states) into the Medicaid program to improve health system performance, health care quality, and outcomes for Medicaid members.

What is the current structure and scope of Illinois' capitated Medicaid managed care system?

Illinois currently has four distinct capitated Medicaid managed care programs which operate within 5 regions (Central Illinois, Greater Chicago, Metro East, Rockford and Quad Cities) consisting of 30 counties across the state.

- The **Integrated Care Program (ICP)** includes Seniors and Persons with Disabilities (Age 19 and older) who are eligible for Medicaid, but not Medicare. Today, ICP is a mandatory program for eligible Medicaid members across all 5 regions. There are currently 11 MCOs participating in ICP across these various regions.
- The **Family Health Plan and Affordable Care Act (FHP/ACA) Program** includes Medicaid-eligible children and families as well as adults newly eligible for Medicaid under the Affordable Care Act. Today, FHP/ACA is a mandatory program for Medicaid members across all 5 regions. The FHP/ACA program also exists on a voluntary basis in several additional counties outside of the 5 mandatory regions. There are currently 10 MCOs participating in FHP/ACA across these various regions, including 7 plans that also participate in ICP.

- The **Medicare-Medicaid Alignment Initiative (MMAI)** provides the full spectrum of Medicare and Medicaid Covered Services for "Dual Eligible" individuals through an integrated delivery system, including Seniors and Adults age 21 and over with disabilities that are eligible for Medicare and Medicaid. MMAI is a voluntary program for eligible Medicaid members across 2 of the 5 regions described above (Central Illinois and Greater Chicago). There are currently 7 MCOs participating in MMAI, all of which also participate in ICP.
- The **Managed Long-Term Services and Supports (MLTSS)** program provides Medicaid covered long-term care benefits for "Dual Eligible" individuals in an institutional long-term care setting or receiving services through a Home and Community-Based Services (HCBS) Medicaid waiver program. The MLTSS program does not integrate Medicare benefits in the way that MMAI does. MLTSS is a mandatory program for eligible Medicaid members who opt out of the MMAI program in just 1 of the 5 regions described above (Greater Chicago). There are currently 4 MCOs participating in MLTSS, all of which also participate in the ICP and MMAI programs.

Please refer to the HFS web site for the latest map and list of health plans across each of Illinois' Medicaid managed care programs, available at the following link: https://www.illinois.gov/hfs/SiteCollectionDocuments/CCExpansionMap.pdf

What is meant by a Request for Proposal (RFP) purchase of care process?

A Request for Proposal (RFP) solicits proposals from eligible Managed Care Organizations for participation in the State's Medicaid Managed Care system. The RFP determines the scope of the program, included populations and services to be covered. It also sets forth the RFP purchase of care process, and the process by which the state will receive and review proposals. The outcome of the RFP purchase of care process will be the State's announcement to award a number of contracts to MCOs to serve beneficiaries under the terms of the RFP.

Rationale

What are the State's objectives in pursuing this RFP purchase of care process?

The State of Illinois recently launched an ambitious Health and Human Services (HHS) Transformation. Announced by Governor Bruce Rauner in his 2016 State of the State address, the transformation "puts a focus on prevention and public health; pays for value and outcomes rather than volume and services; makes evidence-based and data-driven decisions; and moves individuals from institutions to community care to keep them more closely connected with their families and communities."[1] For more information on the HHS Transformation, visit https://www.illinois.gov/sites/hhstransformation/Pages/default.aspx.

The Illinois HHS Transformation seeks to improve population health, improve experience of care, and reduce costs. It is grounded in five (5) themes:

- Prevention and population health;
- Paying for value, quality, and outcomes;

[1] "Governor Bruce Rauner's State of the State Address: As Prepared for Delivery," Illinois Government News Network, January 27, 2016, https://www3.illinois.gov/PressReleases/ShowPressRelease.cfm?SubjectID=2&RecNum=13470.

- Rebalancing from institutional to community care;
- Data integration and predictive analytics; and
- Education and self-sufficiency.

A key factor in achieving this transformation is the creation of a high-functioning Medicaid managed care system. The rapid implementation of managed care, while a positive step, did not allow for the optimization of the program's operation. Simplifying its structure will provide greater transparency and efficiency for both beneficiaries and providers who may struggle in navigating the current system.

Another focus area of the State in this transformation has been the integration of behavioral and physical healthcare as a means to improve outcomes for the entire population. In October 2016, the State of Illinois submitted an 1115 Demonstration Waiver Proposal to the Centers for Medicare and Medicaid Services (Federal CMS) to support Illinois's vision of a transformed behavioral health system and true physical and behavioral healthcare integration. More information on the 1115 Demonstration Waiver, including the full text of the proposal and a frequently asked questions document, is available on the HFS web site. The State has set forth the following five (5), specific goals for the RFP purchase of care process:

- Align State and MCO objectives to enhance quality and improve outcomes;
- Increase integration of behavioral and physical health;
- Streamline current managed care programs and reduce complexity for members and providers;
- Achieve greater managed care coverage across Illinois; and
- Bring fiscal sustainability to Illinois' Medicaid program by managing costs, without compromising quality or access.

Why has Illinois decided to pursue this RFP purchase of care process at this time?

Given the transformation goals described above, an RFP process is essential at this time to implement the State's priority initiatives and, of equal importance, improve the value, quality, outcomes of Illinois' Medicaid program.

Furthermore, on April 25, 2016, the federal Centers for Medicare and Medicaid Services (Federal CMS) issued a comprehensive set of rules and regulations which seeks to align Medicaid managed care with other health insurance coverage programs, and strengthens key consumer protections. This final rule is the first major update to Medicaid and CHIP managed care regulations in more than a decade.[i]

Many of the most important provisions of this rule will go into effect on January 1, 2018 or January 1, 2019 and will require significant updates to the State's Medicaid managed care programs and contracts. The best way to ensure compliance with these provisions is to begin an RFP process now that will lead to a new set of revised contracts in full compliance with the rule on January 1, 2018.

How will this process be impacted by potential changes the Federal Government and new presidential administration is considering to the Affordable Care Act and Medicaid?

Since its inception in 1965, Medicaid has constantly evolved and it will continue to do so. States are regularly asked to adapt to new rules and directives from Washington. Given this ever-changing

landscape, the State believes it is even more important to pursue this RFP purchase of care process at this time for several reasons:

- No actions to be taken by the Federal Government will alter or diminish the pressing challenges facing the Illinois healthcare system and Medicaid program, such as those described in Governor Rauner's HHS Transformation and the State's 1115 Demonstration Waiver proposal;
- There has been little, if any, discussion to-date of changing either the requirements or timing of the Medicaid and CHIP Managed Care Final Rule described above as a priority of the new administration;
- It is anticipated that changes to be considered to federal laws and regulations increase the imperative for Illinois to improve its ability to enhance accountability in the healthcare system and improve healthcare value by managing costs while ensuring quality and outcomes for members;
- The Federal Government remains supportive of states pursuing improvements to their Medicaid managed care systems;
  Restructuring and simplifying the managed care program will give Illinois added flexibility to adapt to any federal changes and protect our ability to serve the state's most vulnerable residents. .

The State will be working closely with Federal CMS under the administration to identify all possible interdependencies between the State's plans and forthcoming changes to federal laws and policies as they arise.

How will this RFP improve the Medicaid system?

The state has consistently received feedback that the current managed care construct is overly complex and places unnecessary burdens on beneficiaries and providers who need to navigate the system. Creating a more transparent structure with clearer guidelines will make the system more manageable for people in need of care and for the caregivers who provide those services.

Scope

Which segments of the Medicaid population are included in the scope of this RFP?

This RFP will include all segments of the Medicaid population currently covered under the ICP program, the FHP/ACA program, and the MLTSS program. These segments will be included in all counties in the state over time, regardless of whether the programs currently exist in those counties. The MMAI program will not be included in the scope of this RFP and members of the Medicaid population that reside in MMAI counties will continue to have the option to enroll in the MMAI program on a voluntary basis.

Furthermore, several Medicaid-eligible populations that are not currently covered by any of the State's existing Medicaid managed care programs will be included in the scope of this RFP as described below.

Are any new populations being added that are not covered by the existing managed care program?

The State will be extending managed care coverage to Medicaid-eligible children that have thus far been excluded from the programs. This includes children eligible for Supplemental Security Income (SSI), and children who are or have previously been under the care of the Department of Children and Family Services (DCFS). HFS and DCFS are collaborating in the development of the contract that will serve DCFS youth in care to ensure that the unique needs of this population are addressed.

The State intends to allow children eligible for Supplemental Security Income (SSI) to be included in any of the managed care plans that will be awarded a contract as a result of this RFP based on their county of residence. For children who are or have previously been under the care of the Department of Children and Family Services (DCFS), the State intends to issue a separate contract with one of the MCOs that receives a contract award to serve the unique needs and requirements of this population.

It is important to note that the RFP does not expand eligibility for Medicaid coverage, but does extend the benefits of managed care coverage to more existing residents to broaden care coordination and enhance healthcare outcomes.

Which types of services will be included in the scope of this RFP?

For most Medicaid members, the RFP and resulting contracts will include all Medicaid-covered medical and behavioral health services currently covered under the ICP and FHP/ACA managed care programs. Medicaid-covered long-term services and supports including nursing facility services and care provided through home and community-based services (HCBS) waivers operating in the State of Illinois will also be included. The RFP does not reduce coverage for any existing services nor require any additional services.

Developmental disability waiver services and services from intermediate care facility providers for developmental disabilities (ICF/DD) will not be included in the contracts resulting from this RFP, though respondents to the RFP will expected to demonstrate readiness to provide such services in the future.

Detailed service inclusions and exclusions will be specified in the RFP and associated materials.

What will be the scope of the contracts the State signs as a result of this RFP?

All contracts as a result of this RFP will include all covered populations and services as described above, with the exception of children who are or have previously been under the care of the Department of Children and Family Services (DCFS). A separate contract with one of the MCOs that receives a contract award will be signed to serve the unique needs and requirements of this population.

What parts of the state will be included in the scope of this RFP?

The State intends to award two types of contracts as a result of this RFP: 1) Statewide contracts that cover all 30 counties in the 5 mandatory managed care regions that currently exist (including Cook County), as well as the additional 72 counties not currently part of one of the 5 mandatory managed care regions over time; and 2) Cook County-only contracts.

The separate contract for children who are or have previously been under the care of the Department of Children and Family Services (DCFS) will be awarded to one of the plans that has received a statewide contract of the first category described above.

The State will announce a phased implementation plan for counties that do not currently have mandatory managed care for all included populations.

How many contracts does the State intend to award through this RFP purchase of care process?

The State intends to award 3-5 contracts of the first type, and an additional 1-2 contract(s) of the second type.

Will the State accept proposals from MCOs that are new to Illinois, as well as those that currently operate here?

Yes, the RFP will be open both to proposals from MCOs that are currently operating in one or more of the State's Medicaid managed care programs as well as plans that are not. All MCOs that intend to submit a response to the RFP will be required to meet the same proposal requirements regardless of whether they are currently participating in the State's Medicaid program.

Process and timeline

What are the key milestones and dates associated with the RFP purchase of care process?

The full, final timeline associated with the RFP purchase of care process is contained in the RFP document. Key milestones include Offeror conference(s) and deadline(s) for the submission of questions from Offerors on the RFP and related materials during the months of March and April. The final due date for the proposals is May 15, 2017.

When does the State expect to know the results of the RFP purchase of care process?

The State intends to announce contract awards during the month of June. A full timeline associated with the RFP process is contained in the RFP document.

When will the contracts go into effect as a result of this RFP purchase of care process?

New contracts will go into effect on January 1, 2018. A full timeline associated with the RFP purchase of care process is contained in the RFP document. The State will announce a phased implementation plan for any elements of the new contracts (e.g., covered populations, services and/or counties) that will not be effective immediately on January 1, 2018.

What will happen to the State's current MCO contracts as a result of this process?

The State anticipates that all contracts for managed care organizations participating in one of the managed care programs included in the scope of this RFP (i.e., ICP, FHP/ACA and MLTSS) will terminate when the new contracts take effect. MMAI contracts will not be affected as a result of this RFP purchase of care process. All provisions of existing MCO contracts will remain fully in force until termination and MCOs will be responsible for any and all costs of care incurred while its contract is in force.

Will members of the current Medicaid MCOs need to switch health plans as a result of this process? If so, how will this process be managed?

It is likely that a portion of Illinois Medicaid members that are currently enrolled in MCOs will need to switch plans once old contracts terminate and new contracts begin. HFS will work to minimize the need for changes in coverage where practical, and ensure smooth transitions of coverage and care wherever possible. Improving the experience of care for all Medicaid members is a top priority for this process, and HFS recognizes that this begins with ensuring a seamless transition process for members whenever changes are necessary.

How will providers be affected by this RFP and the new contracts?

. As described above, a key objective for this process is to, "streamline current managed care programs and reduce complexity for members and providers." HFS looks forward to working with providers as the new contracts are implemented to ensure this objective is fully realized. HFS will also be working closely with DCFS and providers who serve DCFS youth to ensure a smooth transition as this population is brought into managed care coverage.

How long will the new MCO contracts last once they are finalized?

New contracts that result from this RFP will have an initial term of four years from the effective date, with possible annual extensions for up to an additional four years, for a total potential contract term of eight years.

Public Comment and Contact Information

How will the State keep stakeholders, partners, Medicaid clients and their families informed?

The State will make every effort to keep the public (including stakeholders, partners, Medicaid clients and their families) informed, where allowed, at appropriate points during the RFP purchase of care process, and will issue a public announcement of contract awards once finalized. After contract awards are announced and once implementation begins, HFS will regularly communicate progress towards implementation and work with all those who are affected by changes to ensure a successful transition to the new program.

How will the State involve stakeholders, partners, Medicaid clients and their families in planning and development throughout this process?

The State is always open to feedback on the strategy, operations and performance of its Medicaid program, and is confident that the RFP purchase of care process that has been designed incorporates significant feedback that has been received since inception of the mandatory managed care program in Illinois, the HHS Transformation and the development of the 1115 Demonstration Waiver throughout 2016. Questions can always be sent to HFS via the contact information provided below.

Will stakeholders, partners and Medicaid clients have an opportunity to submit questions and comments as a part of this process? If so, how?

Consistent with the State's norms for a purchase of care process, there is no time period dedicated to public comment as part of this RFP. However, questions can be sent to HFS via the contact information provided below.

Illinois Department of Healthcare and Family Services
Division of Medical Programs
Bureau of Managed Care
201 South Grand Avenue East
Springfield, IL 62794

Where will the State post RFP and bid materials?

The RFP and bid materials will be posted on the HFS web site at the following link:
https://www.illinois.gov/hfs/info/MedicaidManagedCareRFP

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[i] https://www.medicaid.gov/medicaid/managed-care/guidance/final-rule/index.html