Integrated Care Program: Frequently Asked Questions

1. **What is the Integrated Care Program (ICP) and where can I find more information?**

   The State of Illinois has contracted with two Managed Care Organizations (Aetna and Centene-IlliniCare) to establish an Integrated Care Program (ICP) for Medicaid clients. The initial phase of ICP serves nearly 40,000 seniors and persons with disabilities (SPD) covered by Medicaid in the counties of Lake, Kane, DuPage, Will, Kankakee and suburban Cook. ICP is being implemented in different phases (see question #3).

   The ICP model creates an integrated delivery system, bringing together primary care physicians, specialists, hospitals and a wide variety of other providers who will focus on the health, behavioral health and social needs of Medicaid clients in order to achieve improvements in health. Each client is assigned a care manager to coordinate his or her care and ensure that the needed services and supports are provided while avoiding unnecessary healthcare procedures.

   The Integrated Care Program is a collaboration among the Departments of Healthcare and Family Services, Human Services and Aging. You can find more information about the Integrated Care Program at www.hfs.illinois.gov.

2. **Who is eligible for the Integrated Care Program, Phase II (ICP II)?**

   ICP II adds long-term services and supports (LTSS) to the service package for the 40,000 individuals currently eligible for the ICP program. This includes nursing facility and home- and community-based services ("waivers") for those who need them.

3. **What are the different stages in the ICP and their respective timelines?**

   ICP Phase I began in May 2011 and covers nearly 40,000 Medicaid-enrolled seniors and persons with disabilities in the counties of Lake, Kane, DuPage, Will, Kankakee and suburban Cook.

   ICP Phase II begins Feb 1, 2013 and will add long-term services and supports (LTSS) to the service package of those individuals eligible for ICP.

   ICP Phase III will begin in 2014 and will cover persons with developmental disabilities.

   The full Care Coordination Roll-Out Plan can be found on the HFS website at:
   http://www2.illinois.gov/hfs/SiteCollectionDocuments/CareCoorPlan.pdf

4. **Have other states implemented similar models and what evidence is there for them?**

All states, except Alaska, New Hampshire and Wyoming, have all or a portion of their Medicaid population enrolled in an MCO (Managed Care Organization), and sixteen states have implemented Medicaid managed long-term services and supports programs for their disabled and elderly population groups. Just as every state Medicaid program is different, LTSS arrangements are very diverse across states. However, benefits of managed care include: predictable costs for states, improved access and care coordination for clients, delivery system innovation and improved outcomes.

An independent evaluation of the Integrated Care Program in Illinois is being conducted by the University of Illinois at Chicago and managed by the Illinois Department of Public Health.

5. How does ICP relate to the Affordable Care Act, Medicaid expansion and Medicaid reform law?

The Integrated Care Program is consistent with the principles of the Affordable Care Act and Illinois Medicaid reform law. The ACA envisions moving to an integrated care system, keeping people healthy through quality, coordinated care. The Illinois 2011 Medicaid reform law requires the Medicaid Program to enroll at least 50% of Medicaid clients into coordinated care/managed care by January 1, 2015, similar to the Integrated Care Program; this includes programs and providers serving Medicaid clients within the budgets of the Departments of Healthcare and Family Services, Human Services and Aging. If the General Assembly authorizes adoption of the new Medicaid eligibility thresholds under the ACA, the newly eligible population also will be enrolled in coordinated care.

6. Who will conduct eligibility determinations for ICP enrollees?

MCOs will not be responsible for determining eligibility for Medicaid. The Department of Human Services will continue to conduct eligibility determinations. The Determination of Need (DON) tool which screens for nursing facility level of care eligibility will continue to be performed by the current screeners.

7. Will providers continue to report to the state agencies on demographics, service and outcome data, as currently?

Yes.

8. If a current provider contracts with a Managed Care Organization under ICP II, can they still keep their contract with the state?

There is no immediate direct effect on current state contracts as a result of provider participation in the Integrated Care Program. Non-Medicaid contracts are not directly impacted. Medicaid contracts will continue untouched for the remainder of the fiscal year, during the transition period. Providers may contract with multiple MCOs and State agencies.

9. What is the appeals process and how will consumer complaints be addressed for individuals enrolled in managed care?

The Managed Care Organizations are required to have both a grievance procedure and an appeals process for service denials. In addition, if the internal appeal is not in favor of the enrollee, MCO enrollees can appeal a service denial to an external independent review organization certified by the Department of Insurance (DOI). Finally, MCO enrollees retain all of their Medicaid Fair Hearings Appeal rights. Information on all of these processes is contained in the MCO Member Handbook.

10. How will the state ensure that the MCOs are compliant?

MCO requirements are outlined in the contracts. In addition, subject matter experts from the sister agencies have participated in development of the implementation plan, and will work together to monitor the plan. HFS, in collaboration with the sister agencies, is working with a national consultant to develop clear procedures and reporting requirements for the MCOs. These reports, as well as claims files, will be provided to sister agencies to assist in monitoring utilization and quality indicators. In addition, state staff will make on-sight visits to MCOs to monitor activities.

MCO's are required to report on an extensive set of quality assurance data elements, including Health and Quality of Life Performance Measures, the draft of which is found on HFS website, tab "Integrated Care Program". Appendix A outlines the Consumer Protections under ICP.

11. How does the care coordination program affect the Screening Assessment and Support Services (SASS) program?

SASS will continue to be performed as it is today, for children only. ICP currently is for adults only.

12. How are the Colbert Consent Decree and ICP II related?

These are two separate initiatives of the State, although there is overlap of some Medicaid clients and the two MCOs. The Colbert Class Members include Medicaid clients residing in Cook County nursing facilities. The goal is to inform Class Members about opportunities to return to the community and to enable those who are interested in doing so, where appropriate. The two MCOs involved in ICP II (Aetna, Centene-IllinoisCare) also have separate contracts to provide care coordination services to conduct outreach, assessments and to help Class Members transition to the community. Some Class Members in suburban Cook County will already be in Aetna or IlliniCare and will be served in the community under the ICP contracts. For other class members, while Aetna and IlliniCare will provide care coordination services, all other services will be funded through existing fee-for-service systems.

13. How do providers that serve, or are interested in serving, ICP II clients get involved?

Providers are encouraged to contact the managed care companies and request information about inclusion in their provider network:

Centene-IlliniCare
Preston Medrano
Director, Network Development
Office: 866-329-4701 ext. 47824
pmedrano@centene.com

Aetna
Office: 866-212-2851
Prompt for Providers (press 2) and then can select 5 to speak to a Provider Services Representative

APPENDIX A

Integrated Care Program: Consumer Protections

Grievances and Appeals

- Every MCO is contractually obligated to have internal grievance and appeal procedures that not only handle issues of denied services but any complaint.
- The Department of Healthcare and Family Services (HFS) receives regular reports from the MCOs of all grievances and appeals and their resolution.
- Under the "Illinois Managed Care Reform and Patient's Rights Act", MCO enrollees have the right to appeal the denial of any service to an external independent review by an entity certified by the Department of Insurance to conduct these reviews.
- In addition, any denied service can be appealed through the HFS fair hearings process.
- The result of all these provisions is that beneficiaries in MCOs have more appeal rights than in the fee-for-service system.
- Plans are required to have consumer advisory councils.

Contractual Financial Incentives

- The first protection for consumers to receive necessary services, particularly preventive, maintenance and community based services, is the "all-in" risk based nature of the contract. Plans are responsible for the cost of any hospitalization or nursing home admission and the cost of every bad health outcome. In a mandatory program, they have no opportunity to entice the costly patient to disenroll. Unlike MCOs serving fairly healthy populations, the risk factor for fragile patients creates a strong incentive to keep them health and in the community.
- The minimum Medical Loss Ratio (MLR) in the contracts is a further incentive to provide services. This provision requires that at least 88% of capitation premium revenue received from the state be spend on direct services to enrollees or returned to the state. This ratio is higher than the national standard of 85% contained in the Accountable Care Act. Also, the contractual definition of what is a direct service is tighter than that recommended by the National Association of Insurance Commissioners.
- Pay-for-Performance withholds are a further incentive to quality care. Under the contracts, a percentage of capitation payments is withheld each month and MCOs must earn this money back by meeting various quality metrics. There are 14 metrics that are tied directly to incentive payments covering quality issues for chronic diseases, hospital readmissions, care coordination, mental health treatment, and long term care rebalancing. Each quality metric met is worth close to $1 million to the MCO. This provides a strong incentive to hit the quality targets.
- The contracts also have a minimum performance provision related to the quality metrics. After the first year, if performance on any pay-for-performance quality metric drops more than 1% below the baseline, the plan loses the ability to earn any pay-for-performance money no matter how well they perform on all the other metrics. This is a very strong incentive to focus on all areas of quality.

Monitoring

- Plans are required to provide complete claims level detail encounter data to HFS showing all services rendered to enrollees. As this encounter data is used to measure both quality metrics and MLR, there are severe consequences to MCOs that do not provide complete encounter data
- MCOs will be accountable for the "Health and Quality of Life Performance Measures" for Seniors and Persons with Disabilities.
- The Department has increased its data analytics/data warehouse staff to be able to more thoroughly monitor encounter data for concerns.
- The Department is purchasing a data analytics tool to sit on top of the data warehouse so that it has greater analytical ability.
- The Department has hired an experienced compliance officer and has contracted with a national consulting company to review all monitoring activities and develop new processes and ensure all are performed. Additional monitoring staff are being hired for the HFS Bureau of Managed Care.
- The Department also has a contract with an External Quality Review Organization that performs readiness reviews, audits quality measure reporting and develops and monitors corrective action plans.
- The state has contracted with the University of Illinois at Chicago (UIC) to perform an ongoing independent evaluation of the managed care initiatives with periodic reporting to promote continuous quality improvement.