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.