An Independent Evaluation of the Integrated Care Program

Final Report: Findings through the Third Year (FY14)

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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 (MMC) in Illinois is known as the Integrated Care Program (ICP) and 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). The program serves seniors and people with disabilities who are Medicaid-only eligible who originally resided in the suburbs of Cook County (not including the City of Chicago) or the five collar counties (DuPage, Kane, Kankakee, Lake, and Will counties). The program later expanded into other areas of the state but this study focuses only on the original area of collar counties in the Chicago area.

For the first two years, the 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.

The State of Illinois (through the Illinois Department of Public Health) contracted with the University of Illinois at Chicago (UIC) to conduct an independent evaluation of the ICP. This report presents results through the third full year (FY14) after ICP was implemented.

The results in this report are based on both qualitative and quantitative data, including focus groups conducted with stakeholders; yearly consumer satisfaction surveys; and analysis of Medicaid encounter data, MCO data, and reports the MCOs submit to the Department of Healthcare and Family Services (HFS). Many of the analyses include a comparison group of people in Fee-for Service (FFS) who would be eligible of ICP but lived in Chicago and were not eligible for ICP at the time period included in the analyses. The comparative analyses control for demographic and health differences between the groups. Consultation with an active advisory board and participation in various stakeholder, MCO, and HFS meetings provided direction to this evaluation.

This report is the final report of the four year evaluation of ICP. This final report is organized around key questions and the major findings for these questions are summarized below. Also included is a section on “lessons learned” and recommendations for the future of ICP and other Medicaid managed care initiatives for individuals with disabilities and older adults in Illinois.

A. Primary Research Questions and Findings

1. How has the program expanded?

Enrollment in the pilot regions remained steady and the ICP has expanded into Chicago.

- Very little switching between the plans occurs, as only 0.14% of enrollees switch between the plans each year. This accounts for 5% of the members who leave the plans each year (923.5 members leave ICP each month).
- In FY14, IlliniCare had 2100 more members per month than Aetna. HFS explained that this is because Aetna did not submit a provider enrollment file correctly to the client enrollment

broker. Later, the auto-enrollment process was adjusted to even out enrollment between the plans. Aetna's enrollment was still behind that of IlliniCare by the end of FY14.

- A discrepancy related to enrollment between HFS capitation payments and the data presented in the monthly Utilization Management reports submitted by each MCO exists.

2. What are the consumers' experiences?

Satisfaction with healthcare declined significantly for people in ICP immediately after the transition to the ICP; but in the second year, in comparison with the FFS Chicago group, the health services appraisal of the ICP enrollees was more positive. The number of unmet medical needs did not change significantly after the implementation of the ICP.

Health Services Appraisal

- Following the first year of ICP, enrollees reported a significant reduction in their satisfaction with their healthcare. In the second year of the ICP, people in the ICP group had a more positive health services appraisal than the Chicago group.
- In FY14 there were no significant differences in enrollees' health service appraisal based on the length of time enrolled in the ICP. The only significant factors related to health services appraisal were the number of unmet needs and overall health status.

Unmet Medical Needs

- Following the second year of ICP, there were no significant differences in the number of unmet medical needs for people in ICP versus people in Chicago.
- In FY14 the length of time in ICP was not significantly related to unmet medical needs. Enrollees with intellectual and developmental disabilities (IDD) or a mental health disability had a higher number of unmet medical needs than people without those conditions. People with higher overall levels of health status had fewer unmet medical needs.

Healthcare Quality

- When asked how the quality of their healthcare had been since enrolling in ICP, the majority of the respondents reported that their healthcare was about the same as before (51%). More people reported that their healthcare was better or much better (37% combined) after enrolling in ICP than those who reported it was worse or much worse (12% combined), indicating an overall general satisfaction with program quality among enrollees.

The ICP did not significantly impact enrollees' appraisal of their LTSS and did not change the number of unmet LTSS needs that they reported.

LTSS Appraisal

- The length of time that a person was enrolled in ICP did not make a significant difference on their rating of LTSS. Previous years of the research could not assess LTSS because those services were not included in ICP.

Unmet needs

- The length of time enrolled in ICP did not have a significant impact on the number of unmet LTSS needs reported. Older people, women, and enrollees in better health reported fewer unmet LTSS needs.

About half of enrollees in the ICP who receive personal support services report having considerable choice in directing their services.

- Over 50% of respondents who had personal support workers reported that they had "a lot of choice" regarding choosing their support person, deciding the tasks that person helps with, and scheduling the time that person comes. Hence, there are many enrollees who still need more opportunities for consumer direction.
- Nearly all of the enrollees who received a personal support worker said that the personal support worker usually or always had enough skills and knowledge to work with them and usually or always treated them with the respect.

Over time, the ICP has not had a significant impact on the enrollees' reported health, community participation, or employment.

- Longitudinally, the ICP did not significantly impact levels of community participation for enrollees. Additionally, in the second year of the ICP, there was no significant difference in community participation levels between ICP enrollees and people in the Chicago FFS group after controlling for demographic differences. Similarly, following the third year of the ICP, the length of time that a person was enrolled in the ICP was not related to their community participation level.
- The ICP did not have a significant impact on the employment status of people enrolled in the program. However, employment for people who are enrolled in the ICP is very low, as almost 80% of respondents reported being either retired or unemployed and not looking for work.
- The ICP did not have a significant impact on the enrollees' reported health status.

Enrollees reported a number of access issues with health providers' offices. MCOs currently only ask providers for self-assessment, although the MCOs have plans to conduct assessments of their own.

Enrollee Experiences with Accessibility

- Enrollees reported experiencing problems with accessibility when they go to see a primary care provider. This is especially true for people who need a sign language interpreter. 68.2% of the 22 people who needed a sign language interpreter did not receive one.
- Providers fill out the self-assessment during credentialing and re-credentialing for both plans. Generally, most providers reported that their offices are accessible, although self-reports for specific aspects of accessibility are less than 50% (e.g. accessible exam tables), and often less than 10% (e.g. the availability of sign language interpreters or an accessible weight scale).
- Each MCO reported having plans to monitor provider accessibility through on-site assessments, although no data on occurrence of these assessments was available.

3. Has ICP led to rebalancing?

Capitation data provided by HFS, shows a slight trend towards rebalancing away from institutions.

- The rebalancing trend in the ICP for FY14 was slightly away from institutions (includes nursing facilities and ICFMRs), with 34 more individuals moving out of institutions than those moving into institutions by the end of the year. In all, 199 (5.8% of the 3,462 enrollees who started FY14 in institutions had moved into the community/waiver) versus 165 (0.5% of the 34,443 enrollees who began FY14 as a community resident or waiver members) moved into an institution. This finding is based on capitation payments made by the State to the MCOs.
- Both MCOs established special teams that focused on evaluating and transitioning Colbert members from the ICP and the FFS Medicaid program. As of May of 2015, the two MCOs had evaluated a combined total of slightly less than 5,000 Colbert members and had assisted in the movement of 600 members out of nursing facilities.

4. How has the transition to ICP impacted other State programs and agencies?

Other State agencies provided feedback that Medicaid data and information regarding transitioning their members to the ICP was difficult to obtain. HFS took steps to improve information exchange, although challenges still remain, especially for young adults transitioning out of the Division of Specialized Care for Children (DSCC).

Coordination with Existing State Agencies

- Key HFS sister agencies (Department of Aging, Division of Mental Health, Division of Rehabilitation Services, and Division of Alcohol and Substance Abuse) have met with HFS to discuss issues and problems encountered with the transition to managed care. HFS has addressed these issues in terms of increasing communications with the agencies, establishing policies to streamline communications, providing MCO reporting requirements and encounter data, and holding meetings in collaboration with HSAG to explain waiver performance measures.

Transition of Children to Adult Managed Care Program

- Children on the medically fragile technology dependent (MFTD) waiver are exempt from participation in ICP and continue to get their services through DSSC.
- There is a lot of confusing information that makes this transition difficult for these children and their families. Stakeholders indicate that these medically complex children who transition to adults, and their families, are finding it difficult to navigate and receive adequate and comprehensive medical services.

5. What are the primary managed care processes used by the MCOs, and to what extent are they effective?

The plans use different definitions to classify their requests as either inpatient or outpatient, which makes it difficult to compare the differential rate of requests; however, outpatient requests are fairly comparable and IlliniCare makes a decision on time for outpatient prior authorization requests 90% of the time, compared to 85% of the time for Aetna.

- Aetna and IlliniCare use different definitions to classify inpatient and outpatient requests. The rate of outpatient requests is similar between the plans, although the rate of inpatient requests is much higher for Aetna then IlliniCare (37.7 to 1.1 requests per 1,000 member months). The number of pharmacy requests was also different, 29.4 requests per 1,000 member months for IlliniCare compared to 18.7 per 1,000 member months for Aetna.
- IlliniCare decides about 90% of outpatient requests on time (88.9% for standard and 92.3% for expedited), compared to about 85% on time for Aetna (85.4% four standard and 85.2% for expedited).

The External Quality Review Organization for the State showed that each MCO improved on the majority of utilization of care and preventive medicine measures, although analysis of claims shows that preventive services slightly declined from FY12 to FY13.

- Both Aetna and IlliniCare offer a variety of health promotion activities to members. The MCOs manage their health promotion activities in different ways and also differ in their reliance on care coordinators to disseminate health promotion information to members.
- Aetna and IlliniCare each improved on 15 of the 17 quality outcome measures related to utilization of care and preventive medicine that were reviewed by the State's External Quality Review Organization.
- Between FY12 and FY13, both the percent of members that had a preventive service visit and the total number of visits per 1000 member months slightly decreased. In FY12, Aetna had 10.0 visits per 1000 member months (11.3% of members) compared to 9.8 visits (10.6% of members) in FY13. For IlliniCare, the number of visits per 1,000 member months decreased from 8.5 in FY12 to 8.4 in FY13 and the percent of members with a visit decreased from 10.0% to 9.7%.

6. How well do the MCOs communicate with enrollees and resolve complaints?

ICP enrollees have several options available to register complaints with the MCOs and obtain more information regarding the services available, including MCO Call Centers and formal grievance and appeals processes. Each MCO is also required to report critical incidents to the State. While good data exists for appeals, systematic information about how grievances and critical incidents are handled is lacking.

Call Centers

- Call centers serve as a way to educate members on their plan and healthcare services. Aetna had a shorter average time to answer calls, while IlliniCare had a lower percentage of abandoned calls. IlliniCare also reported reasons that a member would call the center, a feature that Aetna did not track.

Complaints, Appeals and Grievances

- About 55% of enrollees surveyed reported that they knew whom to call if they had a complaint, and 45% of enrollees did not know whom to contact if they had a grievance. This finding highlights a possible gap in member education regarding filing grievances and complaints concerning healthcare services to the MCOs, indicating that that grievances may go unreported by members due to lack of understanding regarding the complaint and grievance process.
- During the FY14 period, Aetna reported less than half of the number of appeals than they did for FY13, and IlliniCare reported over double the amount of appeals than they had in FY13. Overall, the MCOs overturned more standard appeals than they upheld (in favor of the member), 50% for Aetna and 62% for IlliniCare. Similarly, for expedited appeals, 72% were overturned, 50% for Aetna and 74% for IlliniCare.
- Both plans resolved over half of their expedited appeals within one day; however, the plans did not do as well resolving standard appeals within 15 days; IlliniCare resolved 49.8% and Aetna did not resolve any within 15 days.
- In FY14, Aetna received 389 grievances (down slightly from 408 in FY13 - 1.78 grievances per 1000 member months compared to 1.92) and IlliniCare received 443 (nearly twice the 224 received in FY13 - 1.59 grievances per 1000 member months compared to 1.06). Transportation was reported to be the leading reason for a grievance. Additionally, 18% of Aetna's grievances were related to quality of care, compared to 12.6% for IlliniCare. HFS does not require the MCOs to report on grievance outcomes aside from the number that they have closed; therefore, all grievance outcomes have been reported to the research team as "unknown."
- HFS does not require the MCOs to report the average number of days to resolve a grievance. While IlliniCare reports 15.8 days to resolve a grievance, this information was not available for Aetna. A lack of reporting and reporting requirements for grievance outcomes and days to resolution prevents a full understanding of the grievance process within the ICP.

Critical Incidents

- Aetna and IlliniCare each reported 37 critical incidents during FY14 for their waiver populations, and Aetna had 22 critical incidents for people who were not on a waiver, compared with 16 for IlliniCare. IlliniCare referred all but one of the critical incidents they received for follow-up; however, almost 90% of Aetna's critical incidents were not referred for follow-up. A data limitation exists here, as the reporting template does not require the MCOs to track specific referral entities. Although the template does include a column for tracking referrals, HFS only recommends that the MCOs use it.

The State ombudsman program is not available to enrollees in the ICP, although there is a need to include them.

- Most people enrolled with ICP are not eligible for Ombudsman services through Illinois's State Long Term Care Ombudsman (ILTCOP), except for people who are enrolled in a Medicaid waiver. The Ombudsman office does not track specific data related to ICP enrollees that have requested assistance. Staff have reported that they have received a number of requests and they are

hoping to start tracking the number of requests so that they can seek additional funding to open the program to all ICP members.

7. How well is care managed for ICP enrollees?

Each MCO has increased the number of care coordinators working with the ICP; however turnover is near 40%. The majority of the care coordinators (95%) were within contract standards for the size of their caseloads. Information regarding the training that the care coordinators receive is difficult to obtain.

Care Coordinators

- Number of Care Coordinators–The number of total care coordinators in the ICP nearly doubled each year for two years in a row. The number increased from 64 at the beginning of FY13 to the beginning of FY14 and then to 241 coordinators by the end of FY14.
- Turnover-The turnover of care coordinators was 19% in FY13; it increased to 38% for FY14.

Caseloads

- When considering caseloads of members who are classified as either medium or high risk, approximately 95% of the care coordinators were at or below the specified maximum caseload "weight" on a monthly basis. While Aetna did not exceed the maximum weight specified in the contract, IlliniCare exceeded the maximum weight of 600 for 6 of their 42 full-year coordinators.
- Almost 60% of the care coordinators had less than 50 medium/high risk members on their caseload on a monthly basis while approximately 95% of the care coordinators had less than 100 medium/high risk members on their caseload. Aetna did not exceed 100 members for any of their care coordinators while there were 4 of 42 coordinators for IlliniCare who exceeded a monthly average of 100 members.

Training

- There appears to be little consistent and comparable methods for the MCOs to report the training that their care coordinators received. However, beginning in 2014, HSAG has taken on this responsibility.

In the first three years of the ICP, each MCO has consistently completed less than half of the mandated initial screenings on time (within 60 days). Each plan uses different methods to stratify members into risk levels, and Aetna does not meet the contract requirement of 20% in high or medium risk. In FY14, they completed about 60% of care plans for people who needed them within 90 days. However, an independent evaluation found that many of these care plans were missing critical components, including the needs and goals of the member, as well as the signature of the member. Face to face contact between care coordinators and waiver members in FY14 was substantially less than what the contract required.

Screening and Assessments

- For the first 3 years of the ICP, both MCOs have consistently completed less than 50% of the mandated initial screenings for newly enrolled members within the required 60 days after enrollment.

- The two MCOs have determined that between 20 to 35% of new enrollees need further in-depth assessments based on the results of the initial screening. Of these additional assessments, between 60 to 75% have been completed within the required 60 days.

Opting out of case management

- There is great variability between the two plans in the number of members each reports as wanting to "opt-out" of case management. Aetna reports 15 times the number of members wanting to opt out of case management than IlliniCare does.

Care Plans

- For the first 3 years of the ICP, both MCOs determined that 15 to 30% of newly enrolled members needed a care plan.
- As of FY14, the two plans generally completed about 60% of care plans within the required 90 7days after enrollment.

Service Plans

- An independent third party check of service plans found a considerable number of plans for both MCOs were missing critical components, including member needs, member goals, and member signatures.

Risk Stratification

- The MCO contract with the State requires both plans to identify at least 5% of their members as "high risk" and that the total identified as either "high" or "medium" risk should be at least 20% of their membership. At the end of FY14, IlliniCare met that requirement (8.1% and 26.6%) but Aetna did not meet either requirement (2.3% and 15.6%).
- The risk levels reported by each plan are not comparable to each other because each plan uses its own risk methodology, which is used by the plans to allocate care coordination resources.
- Beginning in April of 2012, the State used its own risk adjustment method and began to adjust the capitation rates it paid the plans by calculating risk scores for each member and arriving at an overall risk factor for each plan. The State calculated a risk factor of 1.0100 for Aetna and a risk factor of 0.9896 for IlliniCare and based on these member risk factors, began paying Aetna a capitation payment that was 2.06% greater than IlliniCare's capitation rate.

Face to face contact with members

- Overall, coordinators from both MCOs in FY14 had not yet met the minimum contract requirements for face to face contacts with their waiver members on an annual basis. Aetna did not meet minimum requirements on any of the 4 major waivers while IlliniCare met requirements on 2 waivers.
- In terms of required face to face contacts for Service Package 2 assessments, care coordinators conducted about 80% of these in person with the member as required.

8. What innovative approaches do the MCOs use for members?

Aetna and IlliniCare piloted several innovative approaches to healthcare and LTSS, including partnerships with Thresholds and SNFist programs and work on supportive housing, although these initiatives have not been independently evaluated.

MCO-Thresholds Pilot Projects

- For many high cost users of behavioral health services, plans have previously had difficulty even locating members to engage them in care. The IlliniCare pilot began in 2012 with 10 of the highest risk members and grew to 50 members in March of 2013. The Aetna pilot began in February of 2014 with 10 of their highest risk members.
- For IlliniCare members, the pilot has been expanded and made a permanent program to cover all of the approximately 200 IlliniCare members served by Thresholds. Because the Aetna pilot sample size was very small and data have not yet been adequately explored, it is unclear whether the program will be expanded. Thresholds conducted its own evaluation, which indicated a 50% reduction in behavioral health hospital admissions, 55% reduction in 30 day readmissions, 58% reduction in 90 day readmissions, 63% reduction in costs for behavioral health inpatient hospitalization, and 53% reduction in emergency room (ER) usage for members in the pilot for the entire 12 months. However, an independent external evaluation has not been conducted.

SNFist Services

- IlliniCare SNFists cite high staff turnover at nursing facilities as a barrier to developing best practices for the SNFist model in nursing facility clinical management. In that environment, the SNFist model provides stability as a partial antidote to the change resulting from turnover.
- The SNFist model of service is promising in its potential; however there are questions regarding its actual implementation requiring additional review by the State: to monitor contracting practices; to clarify its definition of the SNFist role; and to assess the impact of SNFists on coordination of care, services utilized, costs and quality of care and movement of members from nursing facilities to less restrictive environments.

Supportive Housing

- MCOs have engaged supportive housing providers as partners in care coordination. MCOs do not provide supportive housing but rather work with agencies who do. After positive findings from demonstration projects (not independently verified), it appears MCOs are planning to expand their work with supportive housing providers. However there are system issues that make investment difficult.
- IlliniCare started to track their population of homeless people and those at risk of homelessness through questions on their screening surveys. Aetna is planning to start monitoring soon but has limited information.
- There continues to be a severe housing issue for people who are discharged from the criminal justice system. These individuals are disconnected from the healthcare system while in Jail and when they exit it is challenging for MCOs to find and engage them.

9. How have provider networks and service utilizations changed over time?

The MCO's have increased utilization of their in network providers compared to out of network providers and have increased the number of claims submitted electronically.

- The MCO's have increased the use of in-network providers from 54.6% to 60.4% between FY13 and FY14. IlliniCare uses in-network providers more frequently than Aetna (65.3% to 59.5%).
- Most claims were submitted electronically by providers in FY14 to Aetna (83.3%) and IlliniCare (86.0%), both of which increased from the previous year (77.4% and 74.1%, respectively).
- Aetna pays about 90% of both their paper (92.9%) and electronic (90.7%) claims on time, while IlliniCare pays over 99% on of both types of claims on time.
- After the date of a service, it takes longer for providers to submit a claim to Aetna (45.8 days) then IlliniCare (23.2 days). IlliniCare also pays claims faster after they have been submitted (9.2 days compared to 12.9 days for Aetna).

Following ICP implementation, the ICP resulted in additional costs to the State, especially following enactment of the SMART Act, compared to what would have happened in the absence of the ICP. After adjustment of the ICP capitation rates, costs for the ICP program decreased and were similar to what costs would have been for the members if they had remained in FFS.

- Using a matched sample to compare people in the ICP versus people in the Chicago FFS, initially, the ICP increased costs to the State by almost $104 per member per month, and when the SMART Act was introduced for FFS, the cost of the ICP increased by another $115 per member per month. However, after the new capitation rates were introduced, the ICP saved the State over $89 per member per month. Cumulatively, this means that the ICP cost the State about $130 per member per month compare to likely costs under FFS. After recapitation ICP and FFS cost about the same (and ICP may save money after MLR returns are accounted for).

Results for 3 out of 4 performance measures related to hospitals improved in CY13 compared to the baseline. Comparison of matched sample of people in the ICP compared with people in Chicago FFS showed that the ICP had a significant impact reducing ER utilization, but not inpatient hospital services.

- In CY13, both MCOs reported the rate of ED visits was lower than the baseline rate in FY10 (Aetna was 3.8% lower, IlliniCare was 4.8% lower).
- By CY13, both MCOs reported admission rates to hospitals that were substantially lower (decrease of more than 40%) than the baseline rate.
- For both CY12 and CY13, both MCOs had increased the number of ambulatory visits to members within 14 days of their discharge from the hospital to be more than 13% above the baseline rate.
- In CY13, both MCOs reported 30 day readmission rates that were above the FFS baseline.
- Using a matched sample to compare people in the ICP with people in Chicago FFS, the research team found that the number of people who went to the emergency room each month reduced by 5.4% and the average number of visits per month reduced by 12.3%. ICP did not have a significant impact on utilization of the inpatient hospital services.

Performance measures for Nursing Facilities improved under the ICP compared to the State baseline rate. There were incentives in the contracts for MCOs to move people out of nursing homes, however these incentives have not been implemented.

- In both CY12 and CY13, MCOs had reduced the rate of urinary tract infections for nursing home members substantially as compared to the baseline rate.
- In both CY12 and CY13, MCOs had reduced the rate of bacterial pneumonia infections for nursing home members substantially as compared to the baseline rate.
- Although 3 new capitation rates with incentives to discourage admissions into and encourage movement out of nursing facilities were scheduled to go into effect in February of 2013, problems associated with programming of the capitation payment system prevented these payments from being implemented.

Although initially, signing physicians to MCO networks was slow, at the end of FY14, each MCO had more signed physicians than prior to the ICP. Following a group of "common members" over the years, outpatient visits to physicians in FY14 exceeded the baseline rate. Similarly, using a matched comparison of people in the ICP and people in Chicago FFS, physician visits significantly increased in the ICP compared to what would have happened if that population remained in FFS.

- By the end of FY14 (Year 3), both MCOs had each signed more PCPs for their networks that had been enrolled and available in the ICP area in the FFS Medicaid program before the ICP began.
- Outpatient visits to physicians in FY12 about 5% below the baseline level but by FY14 had surpassed the baseline level by slightly more than 12% (from 10,020 visits per 1,000 members to 11,312 visits).
- Using the matched sample, the research team found that the ICP did have a significant impact on the number of people who visited a physician each month, increasing the proportion of people by almost 3.5%. After the SMART Act was enacted, there was another significant increase of 2.5%. The ICP did not significantly impact the average number of visits to a physician each month, although after the SMART Act, the total number of visits for people in the ICP compared to what would have happened under FFS significantly increased by almost 45%.
- Similarly, using the matched sample, the number of people who received a dental service each month significantly increased by over 14% when the ICP became active, and after the SMART Act there was another significant increase by almost 40%. While ICP did not significantly impact the total number of dental visits each month, when the SMART Act was introduced, ICP significantly increased the average number of dental services received by almost 47% over what would have happened in the absence of the ICP.

The number of nurse practitioners, physical therapists, and speech therapists was lower for each MCO than had been available during the baseline. However, using a sample of "common members," the number of visits to each provider type exceeded the baseline rate for each MCO.

- In FY14, for **audiologists**, both of the MCOs had signed less than half the number that were available in the baseline period but the rate of visits for the combined plans exceeded the baseline rate (12.5 visits per 1,000 members in FY11 vs. 14.5 visits in FY14).

- For **nurse practitioners**, both of the MCOs had signed less than the number that were available in the baseline period but the rate of visits exceeded the baseline rate (116.7 visits per 1,000 members for the baseline, 141.5 visits for Aetna, and 137.2 visits for IlliniCare).
- In terms of signing **physical and speech therapists**, both MCOs signed substantially fewer individual providers than were available during the baseline. However, the number of visits reported by both plans for both providers in FY14 was more than double the baseline rate. When comparing the change in outpatient visits for these two provider types for ICP members from FY11 to FY13 more than doubled and the change in outpatient visits for the same period in the Chicago comparison group decreased substantially.
- For **occupational therapists**, the number of signed providers by the MCOs was substantially lower than the number available during the baseline. The number of visits by occupational therapists under the MCO networks was also substantially lower under the plans than had been in the baseline period. This decrease may be due in part to physical therapists performing some of these services in the MCO networks.

The number of community mental health providers and the number of visits to these providers decreased since baseline. Both of these measures have been showing increases from the first year follow-up to FY14. Utilization of alcohol and substance abuse providers also decreased since baseline.

- Each year the number of community mental health providers increased and by FY14 the number of providers per 1,000 members was slightly more than half of the baseline rate. Aetna has reported a substantially higher rate of providers in FY14 than IlliniCare (7.3 per 1,000 members vs. 4.8 providers).
- Outpatient visits per 1,000 members for community mental health providers have steadily increased each year in the ICP but in FY14 were still about 12% below the baseline rate in FY14 (3,750 visits vs. 4,239 visits per 1,000 members). The difference between Aetna and IlliniCare in FY14 was substantial–Aetna exceeded the baseline rate with 4,912 visits per 1,000 while IlliniCare was below the FY11 rate with 2,612 visits per 1,000 members.
- Visits to community mental health providers decreased by about 23% in FY13 as compared to the baseline. Visits for the Chicago FFS control group declined less than 5% for the same time period.
- Outpatient visits to alcohol and substance abuse providers decreased by more than 80% in FY13 as compared to the baseline. During the same time period, visits for the Chicago FFS control group increased by about 25%.
- In terms of 14 day follow-up after discharge from mental health admissions, both plans were below the State baseline in CY12 but IlliniCare had exceeded the baseline in CY13. For 30 day follow-up after discharge, for both CY12 and CY13, both plans were below the baseline rate.

The number of signed providers for durable medical equipment (DME) and homecare agencies increased compared to the baseline. Utilization of these providers also increased compared to baseline.

- For **DME providers**, the number of signed providers in FY14, when compared to the baseline, is up slightly while the number of encounters is up substantially for both plans.

- For **home care agencies**, the number of signed providers was up by 50% or more for both MCOs in FY14 as compared to the baseline. In terms of outpatient visits, both plans were below the baseline rate in the first year of the ICP but both increased outpatient visits considerably over the next two years. In fact, by FY14, both MCOs were reporting 2-3 times the number of outpatient visits per 1,000 members as had been reported for the baseline.

Each MCO increased the supply of medications used by their members. The overall cost of medications decreased, largely because each MCO used generic medications more than the FFS program. About 60% of requests for prior authorization for medication are approved. About 99% of standard requests are approved on time, and Aetna only makes a decision on 46% of the expedited pharmacy requests within the one day time period (compared to 85% for IlliniCare). Each MCO improved on all 4 performance measures relating to monitoring "persistent" medications compared to the baseline.

Supply of medications

- The number of prescriptions paid for by the MCOs in FY14 increased bY10% over the number paid for during the FY11 baseline
- The days' supply per script approved by the MCOs in FY14 increased by 2% over the number paid for during the FY11 baseline
- The total number of days' supply of medications per 1,000 member months increased by 12% in FY13 when compared to the FY11 baseline. For FY11-FY13, the Chicago comparison group decreased by 23%.

Costs of medications

- Cost per script by the MCOs in FY14 was 7.5% less than the average cost in FY11.
- Despite the increase in the days' supply, the average cost per 1,000 member months decreased by almost 5% in FY13 when compared to the FY11 baseline. The average cost for Aetna members decreased by less than 1% while costs for IlliniCare members decreased by about 8%.

Drug formulary

- MCOs increased the usage of generic medications by almost 8% in FY14 when compared to the baseline rate in FY11.
- Almost 97% of the scripts for both plans were written for medications on the MCO's formulary.

Prior authorizations

- There is no data on the number of prior authorizations for medications that are required in the FFS Medicaid program.
- The number of authorizations required per 1,000 member months by the plans in the ICP decreased by 9% from FY13 to FY14.
- Approximately 60% of prior requests for medications were approved.
- Both MCOs rendered their decision (approve/deny) for "standard" requests 99% of the time within the required 10 days.
- Overall, 55% of the "expedited" requests are decided within the required 24 hour time span; however, the rates for the two plans are very different. In FY14, Aetna rendered their decision

on 46% of expedited requests within 24 hours, while IlliniCare rendered a decision 85% of the time within 24 hours.

Medication utilization

- In any given month, about 60% of members were utilizing medications.
- In terms of proper follow-up and monitoring of 4 different classes of "persistent" medications, both plans exceeded the FFS baseline rate for all 4 classes in both FY13 and FY14.
- In any given month, between 30-40% of members were using at least 1 psychotropic medication.
- In any given month, about 20% of members were using at least 1 anti-depressant medication.

The MCOs have increased utilization of nonemergency transportation more than the Chicago FFS Medicaid enrollees. The MCOs also spend more money on transportation than FFS.

- Using a matched sample, the number of outpatient visits where transportation was provided increased significantly more for ICP members than for Chicago members in FFS. Some groups of members, such as people with physical disabilities, older adults, and community residents had a significant increase in nonemergency transportation as a result of the ICP, but for other groups, such as individuals with developmental disabilities and those in long-term care, the number of outpatient visits where transportation was provided decreased significantly as a result of the ICP.
- Among those with at least one non-emergency transportation trip, the average percent of outpatient visits where transportation was provided was around 40% for ICP and 27% for Chicago in FY13, showing that consumers are using other forms of transportation to go to outpatient visits.
- Transportation costs went up from FY11 to FY13, but MCOs spent significantly more on transit than what was spent on transit for members in the Chicago comparison group. This difference was especially pronounced in individuals with HIV and people with physical disabilities. MCOs appear to be spending more on transportation but also are providing a higher level of service.

10. Mortality

The research team was not able to complete analysis of mortality within the ICP as the data available was not consistent or reliable for analysis of this important topic.

B. Lessons Learned

This subsection contains many of the overall impressions and "lessons learned" in the process of conducting the ICP evaluation. These lessons learned apply not only to ICP implementation but also to other managed care programs focused on older adults and on intellectual and developmental disabilities.

Recommendations to address many of these issues are found in the next subsection.

1. Difficulty establishing a provider network

- Initially, the development of the provider networks took longer than the State anticipated. This was due in part to some providers, especially larger hospitals, seeming to engage in a game of "wait and see" if the State was serious about mandatory managed care for this population of persons with severe disabilities and needs.
- There was confusion among members, MCOs, and sister State agencies regarding the transition of waiver members into the ICP.
- There was confusion over how many and what types of providers had signed on to the new MCO networks. Stakeholders reported difficulty to determine whether providers could see them under the managed care system.

2. Payment of Providers

- Many existing providers were not familiar with Medicaid billing; even providers that had Medicaid billing experience found that the MCOs used different forms, billing codes, and procedures to process claims. As a result, some providers who had previously served ICP members through FFS were unable to bill or encountered long delays in submitting claims.

3. Enrollment and Dis-enrollment of Members

- It was apparent that all parties (HFS, MCOs, enrollment broker, and members) were initially challenged by the initial enrollment process. Conversations with MCO staff and members indicated that many were overwhelmed by the process. As of July of 2014, the State still continued to have problems tracking enrollment, disenrollment, and associated data.
- The State made adjustments to the auto-enrollment process. However, it would be preferable if more people actively chose their plan rather than being auto-enrolled.

4. Collection and Dissemination of Data

- Most of the data collected from the MCOs on a monthly or quarterly basis was initially reported in vastly different formats using different key definitions. To upgrade the reports the State hired an outside contractor and the data became more comparable and focused.
- Sister State agencies had problems obtaining data from the Medicaid system regarding former waiver members.
- The State was unable to collect reliable encounter data from the MCOs regarding services their providers had delivered. The State has recently hired 2 contractors to implement a new procedure for collecting encounter data from the MCOs.
- Capitation payments did not always track member movements from one rate cell to another rate cell, or changes in the capitation cells were substantially delayed.
- Mortality data continues to be a challenge to obtain regarding many Medicaid member groups, including the ICP members.
- HFS initially met with interested stakeholder groups frequently in the pre-ICP period and for the first year after implementation to provide these groups with data regarding the ICP. However, since the first year of the ICP, these meetings have been rare.

5. Tracking the Hiring and Performance of Care Coordinators

- In the second year of the ICP, the number of care coordinators doubled and in the third year, the number doubled again. This substantial increase in the number of new care coordinators was accompanied by reports by members and advocates of unavailability of care coordinators or inability of care coordinators to answer members' questions. There was high turnover among some of the care coordinators.
- Sister State agencies and advocates expressed concerns regarding how much and what types of specialized training care coordinators were receiving related to waiver services and the needs of waiver members.
- There were questions as to what types of caseloads care coordinators had and how often members were transferred to other care coordinators.
- HFS recognized that there were key issues related to the hiring, training, and retention of care coordinators that required careful tracking and monitoring and hired HSAG to assume these new responsibilities.

6. Tracking of Member Complaints, Grievances, and Appeals

- Initially, there was confusion among the MCOs as to the difference between member complaints and grievances and what information had to be reported for each.
- Both MCOs were unable to provide information related to resolution of grievances and what steps the MCOs have taken in response to grievances.

C. Recommendations

1. Ensure that provider networks are adequate before managed care programs go live.

- The State should have a backup plan if an insufficient number of providers sign up to the new networks.
- The initial transition period for members to keep their existing providers as they move from FFS to managed care should be closer to 12 months (the initial period was 3 months for SP1 services and 6 months for SP2 services).
- Pro-active steps should be taken by the State to foster meaningful cooperation between existing care coordinators for waiver members and the MCO care coordinators as waiver members transition into the managed care environment.
- Pro-active steps should be taken to ensure that sister State agencies (IDoA, DHS, and DPH) are actively involved in the pre-planning and first year of the transition to the managed care program.
- Counting of providers must be done in an environment of defining provider groups and certain minimal data elements to be collected for the provider network. Initially, each MCO reported their own providers using their own definitions. Subsequently, the State hired HSAG to assume the responsibility of collecting data on the provider networks and much of the inconsistencies have been eliminated.

2. Ensure that providers have the information they need to transition to managed care.

- Extra time needs to be devoted by the MCOs and the State in educating some of the inexperienced but critical providers in the billing process providers must now adhere to.
- State currently tracks how long it takes for the MCOs to pay "clean" claims but it should also track how long it takes providers to submit successful claims and the reasons for claim rejections. This will help ensure that otherwise qualified providers do not self-select out of the MCO networks. HFS said that the Bureau of Managed Care does ask these questions at the quarterly meetings with the MCOS.

3. Continue to improve reporting standards for MCOs.

- While the comparability and reliability of MCO reports have improved considerably since the ICP began, it is apparent that there remain some areas where the plans are using different definitions for some of the report terminology and measures. HFS and the MCOs should continue to work together to create common definitions for these reports. In response to this recommendation, HFS replied: "It is impossible to apply the same terminology and definitions given the operational variances and numerous systems used across all 10 ICP health plans - not just Aetna and IlliniCare. Report reviewers are aware of what drives differences and are able to monitor performance and make business decisions." Still, UIC recommends a greater standardization of these reports so that consumers, legislators, and other stakeholders can make better comparisons between the plans.

4. Improve coordination, data and information sharing, and communication with stakeholder groups.

- In meetings with stakeholders, including providers and community agencies, a frequent frustration expressed was not knowing who to contact regarding their complaints and suggestions. HFS should consider assigning a dedicated point person for stakeholder groups to contact with concerns.
- Coordination between HFS and senior agencies has improved, but there is still room for improvement. Many sister agencies do not have adequate information to work seamlessly within the managed care system.
- The team recommends that HFS begin holding regular stakeholder meetings at least quarterly each year to disseminate select information regarding the ICP. This would include updates on provider network, grievances and appeals, and other topics that the State deems as important. HFS has continued to improve the regular collection of data from the MCOs but very little of it has been released to the public. HFS should create a committee of HFS staff, MCO staff, and external stakeholders to decide which data could be shared with the external public and at what intervals.
- When the results of special reports regarding performance measures and other special areas of interest are published, a special meeting should be held with stakeholders to release these results and answer any questions/concerns related to the report. Stakeholders have informed the research team they are unaware of these special reports.

- The State should upgrade the current capitation payment system to focus on two problems:
  - Ideally recognize within 3 months when a member has moved to a new capitation cell and adjust the payment for that member.
  - Implement the 2 "plus" rates and the 90 day freeze rate related to movements into and out of the nursing facility capitation cell.

5. Ensure existing data systems are updated to maintain accuracy of member enrollment and eligibility.

- It has been difficult to establish correct enrollment figures for the ICP program. Enrollment figures calculated from capitation payments made by HFS to the MCOs do not typically match MCO data. Ideally, all reporting entities should be using the same enrollment data for their reports.
- The existing State legacy system that tracks FFS enrollment and movement within the system is inadequate for tracking enrollment and member movement in the managed care environment and needs to be either upgraded or replaced.
- The current auto enrollment process emphasizes primary care physicians over specialists. For many people with disabilities, a specialist may be more important, because specialists are rarer and it can be difficult to find one with knowledge of specific conditions. Hence, in those cases a specialist should be assigned to the person in the auto-enrollment process rather than a primary care physician. Before the State uses primary care as the second step in the auto enrollment process, the enrollment broker should reach out to the member by telephone to explain the options and encourage the eligible individual to make an active choice on MCOs rather than being auto enrolled.
- The State should convene a task force that includes representatives from HFS, the MCOs, DSCC, parents and other stakeholders to clarify policy about the transitioning of young adults into managed care programs when they age out of DSCC.

6. Facilitate more transparent and responsive options for reporting grievances within the Integrated Care Program.

- HFS should provide additional guidance to the MCOs regarding what data to report concerning the investigation and resolution of grievances. The more information that HFS can provide the public in this area, the higher the probability that stakeholders will have confidence in the complaint and grievance process.
- The research team has shared recommendations with HFS for improving the grievance and appeals report that the MCO's submit quarterly. The team believes that the current report does not adequately track closures of grievances that the MCOs receive. The outcomes for appeals are clearly listed and make sense; however, for grievances, the report simply asks for the number of grievances closed.
- Currently, the Illinois Ombudsman program does not cover enrollees in the ICP, unless the individual is a waiver member. Funding for this program should be increased so that the program has the resources needed to allow ICP enrollees to use services for issues specific to

managed care, such as care management. In many states, ombudsman programs have been essential for ensuring that managed care participants receive services that they need.

7. Continue effort to collect encounter data from the MCOs.

- The State has recently begun implementing recommendations made by the Health Services Advisory Group and by Milliman to improve the collection of encounter data from the healthcare plans. The research team recommends that the State continue this new program.

8. Ensure that plans to monitor provider accessibility are implemented.

- Ideally, independent checks of accessibility would occur in addition to the self-assessment, and these checks would occur on a regular cycle (e.g., every provider every 3-5 years).
- HFS has developed detailed guidelines that will be used in MMAI. The research team recommends that these guidelines also be used for the ICP.
- The current policies in place regarding accessibility of provider offices need to be more specific in order to better meet the needs of members with disabilities. The provider self-assessment process currently in place is not sufficient; a third party verification process has not been formalized by HFS and the MCOs have not been required to report these results on a regular basis.

9. Monitor and support care coordinators employed by the MCOs through training and coordination with other State services.

- The State should ensure that caseloads are tracked and reported by the MCOs on a regular basis to ensure that the contract requirements on maximum members and maximum caseload "weight" are in compliance.
- The State should revise its present reporting to track face-to-face contacts between care coordinators and members of special groups. This process should be changed from reporting an overall average contact rate for special member groups to reporting contacts for each applicable member, as the contract requires.
- The State should require MCOs to report training received by care coordinators in a standard and regular format–including training date, hours, topic, and type of instruction.
- The State should develop mechanisms to help MCOs implement inventive approaches to care coordination for specific members. For instance, the State should examine and support opportunities for innovative approaches to helping MCOs invest in supportive housing.
- Develop a pathway for MCOs to become aware of and be able to engage with their new members who are exiting the criminal justice system so that they do not become homeless and exacerbate existing health issues.

10. Ensure that nursing facility residents receive appropriate services and transition to the community when possible.

- Examine the definition of SNFist and be sure it is aligned with best practices in the SNFist field today. In particular, consider prioritizing and requiring the use of SNFists in an attending role, given the reported difficulties that SNFists often have with a consultative role.

- The State should review and seal contracting procedures for SNFists.
- State should have an independent party review the SNFist role in the ICP, the processes and methods used, the cost and health outcomes of members receiving SNFist services, and the impact the SNFist has had on member movement in and out of nursing facilities
- State should upgrade the current capitation payment system to permit the payment of the 2 "plus" rates and the 90 day delay in full nursing facility rate payment for new NF admissions as specified in the MCO contracts. This would strengthen the incentives for proper nursing facility placements.

11. Collect better information on mortality within the ICP and other managed care initiatives.

- The State needs to continue evaluation work around mortality in ICP and other managed care initiatives.
- In order to adequately assess mortality, high quality data on deaths and enrollment is needed. Similarly, complete demographic data is needed to compare different groups of people and adjust for different demographic compositions.
- HFS should work to ensure that the enrollment data is accurate and that it gets updated when members die.
- Illinois Department of Public Health should work to keep official death records up to date so that any statistics developed on mortality are accurate.

12. Continue to upgrade the reporting process for network capacity.

- Develop a data dictionary that will provide definitions for all provider types and locations.
- Develop a standard crosswalk of provider types/specialties that would map the MCOs' provider types to common standard groups and categories, allowing for more meaningful comparisons regarding the count of providers. HSAG currently uses the federal CMS HSD table definitions and HFS contract requirements. The development and enforcement of such a crosswalk would be time-consuming and challenging to maintain across the wide array of MCOs but the increase in comparable data across the various networks would be worth the time investment.
- Dissemination of results measuring network capacity should take place at least once per year in a public meeting to permit questions and answers from interested stakeholders.

13. Continue evaluation activities related to the ICP and other managed care programs in the State.

- The State should continue to fund evaluations that utilize matching schemes to compare people in ICP and other models of managed care programs. Matching the groups is a way that the State can be sure to remove any existing differences in the groups so that results can be attributed directly to the managed care program.
- The State should continue evaluation work on mortality related to the ICP and other managed care programs in the State.
- The State should commit to evaluations that explore consumer experiences and outcomes between the ICP and other managed care programs, such as MMAI and the CCEs.