Executive Summary

The State of Illinois Department of Healthcare and Family Service (HFS) is implementing a pilot project for integrated care for Medicaid recipients who are disabled or older adults, known as the Integrated Care Program (ICP). A main goal of this program is to improve the quality of care and services that consumers receive and to do so in an efficient and cost-effective manner. The state has committed to an independent evaluation of the program, which is being conducted by the University of Illinois at Chicago (UIC), to determine the extent that these goals have been met.

This evaluation considers qualitative and quantitative data from a variety of sources, including focus groups with stakeholders, a consumer satisfaction survey, analysis of Medicaid encounter and managed care organization (MCO) data, and stakeholder, MCO, and HFS meetings. The longitudinal consumer surveys include data from 181 participants at baseline and one year after ICP was implemented. The focus groups included 17 groups and 2 individual interviews with 110 consumers, caregivers, providers, MCO employees, and state employees .

Results from the first year of the Integrated Care Program (May 1, 2011 to April 30, 2012) are summarized below.

Challenges and Progress in Network Development

- *Initial challenges.* Progress in signing providers to formal contracts has proceeded at a slower pace than had been expected by the two plans and HFS. Part of this slow pace has been attributed to "provider reluctance." The number of formally signed providers for both plans was considerably less, for most types of providers, than the number of pre-ICP providers. However, it is difficult to compare the "capacity" of the new provider networks to the provider capacity that existed before implementation of the ICP. Unknown factors such as the number of locations per provider, the available hours per location, and the need for specific services among ICP members makes it difficult to determine whether the reduced number of signed post-ICP providers has had any negative effect on accessibility to and quality of services for members.
- *Steady progress.* Both plans have made steady progress, for most provider types, towards increasing the number of providers signed to formal contracts during Year 1. This is especially evident for general hospitals and physicians.
- *Continuation of Previous Providers.* Both plans continued to pay a considerable number of pre-ICP providers who refused to sign formal contracts past the mandatory 90-day "continuity of care" transition period.

This decision was made by the plans in large part due to the slow rate of formal network development. For some types of services, both plans rely to a considerable extent on individual providers who do not sign a formal contract with the plan but instead work for group providers who have a formal contract with the plan. During the focus groups, this was mentioned with regard to behavioral health services.

- *Use of out of network providers.* Of the over 900,000 claims submitted by the MCOs during the first year of ICP, 52% were in network and 48% were out of network for Aetna; and, 46% were in network and 54% were out of network for Illinois Care.

Timeliness of Payment of Providers

- *Time to process claims.* Each plan had 99% of their claims processed within 90 days. This data only accounts for "clean" claims, after they had been accepted by the clearinghouse. IlliniCare reported that 8% of claims were rejected by their clearinghouse, and it took an average of two days to convert these into a "clean" claim. This data is self-reported, and Medicaid claims data for Year 1, once it becomes available, will provide more information on provider payments.

Pace of Enrollment

- *Slowness of initial enrollment.* Two months into the program, each plan had less than 2000 members. Auto-enrollment began in July, and by the end of October each plan had over 15,000 members. At the end of the first year of ICP, both plans had over 17,000 members. Because of the slow initial enrollment, an average ICP member was enrolled in a plan for seven months out of the year.
- *High use of auto-enrollment*. Auto-enrollment decreased slowly but steadily from 70.6% in August 2011 to 62.4% in April 2012. This rate is still higher than the average of 37% that the Kaiser Family Foundation (2000) found in a review of 10 Medicaid managed care plans in the United States.

Processes Used for Risk Stratification

- *Use of different processes*. Aetna, IlliniCare and FFS Medicaid have different processes for identifying risk and stratifying members, which made comparisons difficult. The MCO contracts with the state allow them to use proprietary methods for this, and each plan has its own timelines for identifying risk, completing a health risk questionnaire, and starting a care plan. IlliniCare was more likely than Aetna to stratify a member as high risk,

both after a member's initial enrollment (17.6% to 2.2%) and at the end of the first year (13.3% to 5.9%).

- *Timeliness of risk stratifications*. Both plans reported that they assign an initial risk level within 90 days for over 99% of members. They complete a Health Risk Questionnaire within 90 days for about 40% of their members, and both plans noted having difficulty reaching many members.

Prior Approval/Authorization of Services

- *Differences in processes.* Each plan has a process for receiving requests for prior approval/authorization of services. Their contracts with the state vary, as Aetna is required to respond to a request within 10 days and IlliniCare within 14 days. Plans reported meeting these requirements over 96% of the time.
- *Expedited requests.* Aetna reported 14,185 requests for prior approval, none of which were expedited, while IlliniCare reported 15,114 requests (7.7% expedited). Each plan approved over 99% of the non-expedited requests. IlliniCare also approved nearly 99% of their expedited requests.
- *Nature of requests.* Almost 35% of the requests were for inpatient services, and the next largest category was for durable medical equipment at 13%. Only Aetna reported data on requests for pharmacy prior approval. They approved 82.3% of their 6,424 non-expedited requests, and 80.8% of their 1,468 expedited requests.

Changes in Emergency Department Events

- *Decrease in emergency room (ER) use.* There was a 6.9% decrease in the rate of ER visits per full-time member equivalent, 1.43 per full-time member per year during the baseline to 1.34 during the first year of ICP.
- *Decrease in high frequency users.* There was a significant (p=0.000) decrease 39% in the percentage of high-frequency emergency department users between the baseline (15.3% were frequent users) and the first year of ICP (9.3%).
- *Decrease in ER to hospital admission.* The rate of ER visits resulting in an inpatient hospital admission decreased significantly (p=0.000) from 20.3% during baseline to 17.3% during the first year of ICP, a 15% decrease.

Changes in Hospital Admissions

- *Decrease in hospital admissions.* There was an 18% reduction in the rate of hospital admissions for a full-time member equivalent per year: 0.56 at baseline to 0.46 in ICP's first year.

- *Decrease in length of stay.* The length of stay in a hospital also decreased significantly ($p<0.05$) from an average stay of 3.6 days per full-time member equivalent at base line to 2.7 days in the first year of ICP, a 25% decrease.

Changes in Transportation Services

- *Differences in procedures from FFS.* The MCOs have very different procedures for requesting transportation than FFS Medicaid; the MCOs use a general contractor that only requires members to make a single phone call.
- *Fewer denials.* The MCOs denied much fewer requests for transportation than the FFS Medicaid program. Part of this may be because FFS Medicaid allows post-approval, and the two MCOs do not.
- *Difference in types of vehicles used.* There were differences in the types of vehicle each plan uses. FFS Medicaid uses "medicars" more often than the MCOs (19.8% of rides compared to 6.7% for Aetna and 7.7% for IlliniCare). Aetna relied heavily on "taxis" (88.3% of rides compared to less than 5% for both IlliniCare and FFS Medicaid).

Nature and Outcomes of Grievances and Appeals

- *Improved data.* Each plan has a system for reporting on grievances and appeals. These systems contain more data than is available for the FFS Medicaid system, which represents an improvement in the system.
- *Nature of grievances.* IlliniCare acknowledged a problem with tracking grievances initially, so they only reported 47 grievances in the first year compared to 324 for Aetna. For both plans, transportation was the most frequent grievance type (63.6% for Aetna and 38.3% for IlliniCare).
- *Outcomes of grievances.* Aetna reported that 3.4% of their grievances were withdrawn, compared with 2.1% for IlliniCare. The rest of the grievances were closed, meaning the plan acknowledged the grievance formally with a member. Aetna did this in an average of 24.1 days, and IlliniCare averaged 31.6 days.
- *Nature of appeals.* Aetna reported 50 appeals, while IlliniCare reported 135. Nearly 3-quarters had to do with medical necessity (76% for Aetna and 73.3% for IlliniCare).
- *Resolution of appeals.* The plans use different categories to report the resolutions of appeals. Aetna reported 52% of their appeals were "approved" and IlliniCare reported 76.3% of their appeals to be "appeal-overturned." Each of these categories appear to mean that the original decision was overturned and the appeal went in the member's favor. Aetna averaged 18.9 days to make a decision on an appeal, while IlliniCare took 10.2 days.

Longitudinal Member Survey of Satisfaction and Services

- *No significant changes in services needed and received.* The longitudinal survey results, based on 181 ICP participants who completed a survey during the baseline and after the first year of ICP, did not find any significant differences in the amount of medical services, specialty services or medical equipment that respondents needed and received from the baseline to the first year.
- *Lower satisfaction with health services.* Despite similar levels of services, participants expressed significantly lower satisfaction with their healthcare in general (3.89 to 3.63; p=0.021), satisfaction with their primary care provider (4.19 to 3.78, p=0.002), and satisfaction with medical services (4.1 to 3.63; p=0.001). These were measured on a five-point scale, from very dissatisfied (1) to very satisfied (5).
- *Generally, no significant changes in preventative services.* Overall, the respondents did not report any significant differences in the amount of preventative care they received. When broken down by group, fewer people with physical disabilities reported having a discussion with a provider about exercise and physical activity (81.6% to 60%; p=0.018).

Focus Groups Findings

While there were both positive and negative responses to the transition to the ICP from consumers, those who were most positive tended to have the most straightforward needs and those who were most negative tended to have more complex issues. The primary themes that emerged during the focus groups were:

- *Confusion regarding enrollment.* Both consumers and MCO staff expressed confusion and feeling overwhelmed during the transition to integrated care.
- *Concern about adequacy of provider network.* Stakeholders were concerned about whether the network was adequate. MCO staff reported making considerable efforts to improve their networks.
- *Initial confusion with billing.* Initially, there was confusion around the managed care process and additional paperwork for providers to get bills approved, but the MCOs noted that they have been working to pay providers in a fair and timely manner.
- *Outreach to providers.* MCOs reached out to providers to build their networks, which often helped to clarify providers' confusion and fears.
- *Accountability of MCOs.* Stakeholders urged ongoing attention to the accountability of MCOs.
- *Coordination of care.* MCO staff stressed their efforts to coordinate care, although consumers were often unaware of these efforts. Consumers who

did receive care coordination were generally satisfied with the communication.

- *Challenges with prescription medication.* Some stakeholders had issues changing pharmacies and formularies, and others were satisfied with their ability to obtain quality prescriptions.
- *Usefulness of training by MCO staff.* MCOs trained staff on Medicaid and Illinois policies and working with people with disabilities, which was useful.
- *Lack of awareness of prevention efforts.* Although both universal and tailored preventative measures were offered, consumers had low awareness of them and were more concerned with immediate healthcare issues and needs.

Goal 1. Improve development of new provider networks and continuity of care from previous providers.
HFS could clarify what specific responsibilities each plan should have in terms of signing local providers that have existing relationships with members.
HFS should take steps to clarify and have consistency in what provider types and specialties will be included in the Geo-mapping process conducted by the MCOs.
HFS should consider specifying minimum provider ratios for some categories of providers in addition to geographic access standards.
HFS should consider better defining the information that it requires the plans to report in their affiliated provider reports.
HFS should consider instituting regular reviews of the provider files to ensure accuracy of the network listings.
Consider lengthening the "continuity of care" post-enrollment period from 3 to 12 months.

Goal 2. Strengthen communication and involvement with stakeholder groups, providers, and state agency directors.
HFS should consider hosting a public meeting to discuss the results of the formal readiness review with stakeholder groups.
Encourage the active participation of other state agencies in the formal readiness.
Establish a regular process to publicly update stakeholder groups on the progress of provider network development.
Designate an HFS staff member whose primary responsibility will be to work with the various state departments who have a current active role in providing and monitoring services for managed care members.

Goal 3. Expand the state's "readiness review" process to include more public participation and to accommodate the needs of smaller, less experienced Medicaid providers.
Create a claims billing "test" environment to identify potential billing problems with network providers (especially for providers new to Medicaid).
Develop a representative sample of case mix scenarios to test the proposed care management structure of the MCO.

Goal 4. Support the enrollment and transition processes for new members.
Continue and expand the use of system "navigators" for newly enrolled members.
Expand the use of "smart assignment" when auto-enrollment needs to occur.

Goal 5. Advance consistency of reporting requirements for MCOs.
Improve overall consistency of data reporting
Standardize the reporting of data regarding member complaints.
Standardize the requirements of the two plans regarding the reporting of Prior Authorization statistics
Identify and annually release to the public comparable risk stratification data for the two plans.
HFS should consider revising the contracts for the two plans regarding the timelines required for development of a care plan for medium and high risk members.