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Governor Quinn's Integrated Care Program for Medicaid Beneficiaries

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What is the State planning to do?

- The Department of Healthcare and Family Services (HFS) has identified Aetna and Centene-IlliniCare as the two successful bidders to establish an Integrated Care Program to serve nearly 40,000 seniors and adults with disabilities whose health care is paid for by Medicaid (called AABD in Medicaid).
- These clients reside in the counties of Lake, Kane, DuPage, Will, Kankakee and suburban Cook County.
- These Medicaid clients will have a choice of a medical home (doctor or clinic) with either of the two companies selected.

What is an Integrated Care Program?

- The model brings together local primary care physicians, specialists, hospitals, nursing homes, and other providers where all care is organized around the needs of the patient in order to achieve improvements in health.
- Integrated care is an essential feature in national healthcare reform -- recognizing that Medicaid (and other payers) should not simply pay for medical procedures after people get sick, but should focus on improving health outcomes.
- This is a new era in care management: keeping people healthy through more coordinated, better care, thereby saving avoidable, unnecessary healthcare costs.
- Integrated delivery systems exist; they are also called "accountable care organizations".

- Kaiser Permanente and HealthCare Partners in California are great examples of integrated, accountable, and coordinated health care organizations.
- Mayo Clinic and Cleveland Clinic here in the Midwest are also prominent examples.
- Savings accrue because the patient does not leave the care and oversight of the primary care physician and support care managers in a coordinated system.

What was the Request for Proposal process?

- Governor Quinn recognized early in his administration some flaws in the fragmented fee-for-service Medicaid system and within months set in process a new model for integrated care for Medicaid clients.
- The Department of Healthcare and Family Services released a Request for Proposal (RFP) in February 2010 for qualified, experienced and financially sound Health Maintenance Organizations (HMOs) to enter into risk-based contracts providing the full spectrum of Medicaid covered services for this population.
- HFS held a mandatory Bidders Conference on February 18, 2010.
- HFS received close to 700 questions on the RFP from vendors and interested parties.
- Dozens of meetings were held with stakeholders, disability community advocates and labor organizations.
- HFS received comprehensive proposals from five vendors, and conducted an extensive evaluation process over four months.
- Aetna and Centene-IlliniCare received the highest combined scores for responsiveness to the proposal and careful reference checks.
- The Business Enterprise Program (BEP) Utilization Plan Subcontracting Goal was set for this procurement at 20 percent of the administrative portion of the capitation payment; Aetna and Centene-IlliniCare met this requirement.

Who are the two companies selected?

- Centene has over 25 years experience in Medicaid managed care programs in 9 states (Arizona, Texas, Florida, Ohio, Indiana, Georgia, South Carolina, Wisconsin and Mississippi) serving 1.5 million enrollees, including older adults and persons with disabilities, enrollees dually eligible for Medicare and Medicaid and persons in Long Term Care and Home and Community Based waivers. They have extensive experience serving enrollees with chronic medical conditions, developmental and physical disabilities, and serious mental illness. Centene operates behavioral health, life and health management, a nurse advice line, and medication treatment compliance. They offer the whole package in integrating health care solutions that address the complex needs of the Medicaid population.

Several of Centene's specialty division subsidiaries hold accreditations through National Committee for Quality Assurance (NCQA) or Utilization Review Accreditation Committee (URAC). [Medical providers interested in joining the Centene-IlliniCare network should call the IlliniCare Network Team at 866-329-4701.](#)

- Aetna Better Health, Inc. has over 20 years experience in Medicaid managed care programs in 9 states (Arizona, California, Connecticut, Delaware, Florida, Maryland, Missouri, Pennsylvania and Texas) serving 1.3 million enrollees, including comprehensive care management to more than 277,000 aged and disabled health plan enrollees in 8 states. Aetna and its subsidiaries have four disease management programs that are NCQA accredited; Aetna's Illinois commercial line currently holds NCQA accreditation, and its affiliate, Delaware Physicians Care was ranked by NCQA as one of the top 25 health plans in the U.S. for the second year in a row. [Medical providers interested in joining the Aetna network should call the Aetna Provider Recruiting Office at 866-827-2701.](#)

What quality safeguards will be required?

- The contract will reinforce Illinois' system of consumer-directed care for disabled Medicaid clients in the selection and hiring of personal assistants, as well as a continued commitment to current collective bargaining protections and requirements for personal assistants.
- The contract will include pay-for-performance measures that incentivize spending on care that produces healthy, quality-of-life outcomes. These pay-for-performance incentives and quality outcomes will be further developed and monitored in consultation with disability community advocates.
- The RFP made clear and the contracts will be drafted to withhold payments to the managed care companies that do not spend their capitation payments on care that produces these quality outcomes. The contracts will not allow the companies to profit from denial of needed services.
- The contract will have a high medical loss ratio (MLR) guarantee of 88% -- higher than the MLR of 85% required by the national healthcare reform law. This means that 88% of revenue from the contract must be spent on services to Medicaid recipients. This high MLR is meant to ensure that services are not denied in order to increase profits or other administrative spending.

How much will the state save?

- The goal of this Integrated Care Program is to provide better care; healthier Medicaid clients will save healthcare dollars over the long term.
- The 5-year contracts will cost \$450 million annually for capitation payments to the two managed care companies.
- The savings/cost avoidance estimates over the 5-year contract are estimated at nearly \$200 million, as a result of:

- Automatic savings every year due to rates set for the companies at 3.9% below what is otherwise estimated to be spent on care for these Medicaid clients; and
- Lower growth rates (or estimated cost inflation) over time because of requirements for enhanced coordination of services and focus on prevention, especially as more services are added in Phases II and III.

What are the next steps?

- HFS will facilitate meetings between the selected managed care companies and disability community advocates, social service organizations and labor organizations to address outstanding issues.
- HFS will negotiate and finalize contracts with the managed care companies by the end of year.
- Phase I services -- covering all medical services under Medicaid -- are expected to begin in January, 2011. Phases II and III -- including long-term care services for the AABD population -- will be designed in consultation with stakeholders during 2011.
- An independent evaluation of the Integrated Care Program will be conducted by the University of Illinois at Chicago and managed by the Illinois Department of Public Health.

For more information on the Integrated Care Program, please contact the Department of Healthcare and Family Services at hfs.medicairdirector@illinois.gov or at 1-800-226-0768.