

An Independent Evaluation of the Integrated Care Program: Results from the First Year*

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February 2013



* Report covers the first year of ICP
(May 1, 2011 to April 30, 2012)

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List of Abbreviations

ACSCs	Ambulatory Care Sensitive Conditions
AHPPAL	Assessment of Health Plans and Providers by People with Activity Limitations
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CCE	Care Coordination Entities
CDPS	Chronic Illness and Disability Payment
COC	Continuity of Care
DME	Durable Medical Equipment
DOA	Illinois Department on Aging
DRS	Illinois Department of Human Services/Division of Rehabilitation Services
ED	Emergency Department
FFS	Fee-for-service
HEDIS	Healthcare Effectiveness Data and Information Set
HFS	Illinois Department of Healthcare and Family Services
HMO	Health Maintenance Organizations
HSAG	Health Services Advisory Group
ICP	Integrated Care Program
IDPH	Illinois Department of Public Health
IHC	Illinois Health Connect
MCCN	Managed Care Community Networks
MCO	Managed Care Organization
NCQA	National Committee for Quality Assurance
PCCM	primary care case management
PCP	Primary Care Physician
PQIs	Prevention Quality Indicators
RFP	Request for Proposals
UIC	University of Illinois at Chicago
YHP	Your Healthcare Plus

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.

Background

I. Introduction

Over the last 20 years, many states have been moving more of their Medicaid enrollees into managed care programs. These have often taken two forms: risk-based MCOs or primary care case management (PCCM) programs. Risk-based MCOs receive a fixed per member per month fee in exchange for assuming the financial risk for all or most of the health services a member needs. For the PCCM programs, most of the risk remains with the state Medicaid agency, but the state typically pays primary care physicians or other providers a monthly fee to coordinate care across all providers for members.

By 2010, 47 states and DC had implemented some form of managed care that covered 71% of their Medicaid enrollees (National Association of State United for Aging and Disability, 2013). Although many of these states initially covered just health care services and excluded long term supports, states have begun integrating both health and long-term services and supports into their managed care initiatives. As of 2011, there were 21 states that had included long term services in their managed care programs—by 2014 this is projected to increase to at least 25 states.

During this time Illinois slowly joined the national trend. Since 1976, Illinois has had a managed care program for its Medicaid recipients but it was voluntary and enrollment was low (about 230,000 as of late 2012). In 2006, the state implemented Illinois Health Connect (IHC) as their PCCM program targeted at improving preventative services and coordinating services for enrollees and decreasing overall costs. By 2010, enrollment had grown to 1.9 million members (Illinois Academy of Family Physicians, 2010).

At the same time, a companion program, Your Healthcare Plus (YHP), was started to deal with some of the highest users of the state's Medicaid system. YHP enrollment grew to approximately 260,000 individuals by 2010. Members in YHP included adults with disabilities who have chronic or complex health issues, children and adults in the Family Health population with persistent asthma, high-frequency ED users in the Family Health population, and individuals in the elderly and physical disability waiver programs.

Despite some reported successes with the IHC and YHP programs, many legislators and policy makers felt that the overall healthcare delivery system for Medicaid members remained too fragmented and costly. In addition, the experiences of other states testing mandatory managed care programs that

included long term services and supports convinced some policy makers and legislators that more aggressive action was needed.

In February 2010, HFS issued a Request for Proposals (RFP) seeking two health maintenance organizations to provide adults with disabilities and older adults in the Medicaid program the full spectrum of Medicaid covered services through an integrated care delivery system. HFS received proposals from five vendors in June 2010 and awarded contracts to Aetna and Centene-IlliniCare.

The integrated Care Program (ICP) was targeted towards approximately 40,000 Medicaid members not eligible for Medicare and living in suburban Cook, DuPage, Kane, Kankakee, Lake and Will Counties. The ICP was projected to save the state \$200 million in the first five years of the program.

In 2011, the Medicaid reform law, Public Act 96-1501, was passed by the Illinois General Assembly. The legislation requires HFS to move at least 50 percent of Medicaid members to a “risk-based care coordination program” by January 1, 2015. To meet this goal, HFS has announced that this “care coordination” will be provided by three types of “managed care entities”:

- Traditional insurance-based Health Maintenance Organizations (HMO) accepting full-risk capitated payments;
- Managed Care Community Networks (MCCN), which are provider-organized entities accepting full-risk capitated payments; and
- Care Coordination Entities (CCE) which are provider-organized networks providing care coordination, for risk- and performance-based fees, but with medical and other services paid on a fee-for-service basis.

The state is also working with the federal government to provide better coordination of services under the unique demonstration called the “Medicare-Medicaid Alignment Initiative”.

As part of this overall effort, the state implemented 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 announced that it was “committed to an independent evaluation of the program” and contracted with the University of Illinois at Chicago (UIC), to conduct this evaluation and “determine the extent that these goals have been met.” The state also announced “this evaluation will ensure an efficient way of monitoring the implementation of the integrated care program and inform future expansions and/or changes to the program design. The evaluation will also serve as a mechanism for ensuring that consumers receive

quality services from their medical providers and achieve their personal health goals.”

II. Project Scope of Work

The scope of work that the UIC team is to deliver as part of its evaluation is specified in section 2.2 (“Supplies and Services”) of UIC’s contract with IDPH and Illinois HFS. In this section, the wording of the contract is reproduced and followed by a brief status update of how the research team has met each item during the first year of ICP and plans for the future, if applicable.

2.2.1. VENDORS SHALL ASSESS, EVALUATE, ANALYZE AND REPORT ON THE FOLLOWING OUTCOME ITEMS:

2.2.1.1. Vendors shall use HEDIS and CAHPS data as reported by the HFS integrated care vendors, Aetna and Centene-IlliniCare, to evaluate outcomes.

The evaluation team has received baseline data from HFS, although they are still waiting for the State to provide this (and most other) data for the first year of ICP. While waiting for this data to be made available, UIC has been working closely with each MCO to directly obtain special datasets that have not been through the State data clearinghouse. While many of these datasets are specific to the MCO’s operations, two of the datasets are specific to hospital and Emergency Room usage, which allows the evaluation team to explore some HEDIS and CAHPS measures. However, a more detailed analysis of HEDIS and CAHPS measures cannot be completed until the evaluation team receives official encounter data for the first year of the ICP.

It should be noted that some CAHPS measures are also included in the consumer survey (see 2.2.1.2), and the evaluation team has received 418 completed surveys for the baseline and 905 after the first year of ICP (497 in ICP and 408 for the comparison group).

The research team will complete analysis of HEDIS and CAHPS measures when appropriate data has been received. In addition, the evaluation team will work on additional analysis of the surveys when data collection is complete.

2.2.1.2. Vendor shall, in cooperation with IDPH develop and utilize a “functional status” health outcome tools for assessing outcomes for persons with disabilities.

In this spring/summer of 2011, the evaluation team developed a survey instrument that includes many CAHPS measures, satisfaction measures and questions regarding needed and received services. In addition, the survey includes existing scales on functional status, including Lawton’s scales on activities of daily living and instrumental activities of daily living, and the RAND-12, an

internationally recognized tool for assessing physical and mental health. This survey was developed in close conjunction with the advisory board and with input from community groups of people with disabilities. IDPH reviewed and approved the survey for use and it was distributed to a stratified and randomly selected sample of 2195 integrated care eligible consumers in July 2011.

In June 2012, the research team added a few items to this survey to account for long-term care and support services that will be incorporated into ICP in February 2013 as part of Service Package 2. Again, the advisory board and community groups of people with disabilities provided input on the survey before IDPH approved it. The survey was distributed to 2156 integrated care eligible consumers and an additional stratified randomly selected 2000 consumers who would be integrated care eligible but live in the city of Chicago to use as a comparison group.

As the evaluation continues, the research team will distribute the consumer survey to ICP clients and a comparison group in summer 2013. This report contains initial analyses of longitudinal survey responses from participants at the baseline and after one year of ICP, and these analyses will continue to be conducted as responses are received. In addition, the evaluation team will analyze the surveys for the complete ICP and comparison samples, controlling for demographic differences between the two.

2.2.1.3. Vendor shall assess outcomes through measuring prevention services, care coordination, admission to hospitals, admissions to nursing homes and trips to emergency rooms and use of quality indicators.

The evaluation team received baseline encounter data from HFS but is still waiting for similar data to cover the first year of ICP. In the interim, the research team has received from each MCO datasets on hospital and emergency room use by their members. Better data on services and care coordination will be available when the evaluation team receives official Medicaid encounter data from the state.

Once available, this data will be fully analyzed and supplemented/compared with data from the consumer survey and from additional focus groups and compared with data from the baseline period.

2.2.1.4 Vendor shall evaluate customer satisfaction with the integrated care program using CAHPS satisfaction data, other survey instruments, as may be approved by IDPH, which more accurately reflect the satisfaction of persons with disabilities.

As discussed in 2.21.2, the research team has developed a consumer survey specifically designed for people with disabilities, which assesses customer

satisfaction with their overall health care, specific services and specialties, and other factors. This survey was approved by IDPH, Initially, prior to implementation of the integrated care program, the research team received 418 surveys that have been used to establish a baseline. In addition, survey data for the first year of the integrated care program is now available for 497 ICP participants. Data on a longitudinal subset of 181 of them is presented in this report. Satisfaction also can be evaluated using qualitative data. A total of 110 people participated in focus groups during the first year of ICP, and this data has been used to assess satisfaction, especially in the words of people with disabilities themselves.

In the coming months, satisfaction will continue to be evaluated using responses to the consumer survey and data collected during focus groups and other meetings. In particular, the longitudinal survey data will be used to track satisfaction over time, and data from the ICP and comparison group will be analyzed to determine if there are any differences between traditional Medicaid and ICP.

2.2.1.5. Vendor shall assess proactive treatments for patients with chronic diseases and other non-acute illnesses both qualitatively and quantitatively.

The research team has captured data and stories on this qualitatively from the focus groups and other meetings. In addition, the consumer survey includes items on proactive, preventative treatments, and this report contains analysis of 181 longitudinal respondents.

The research team will continue to evaluate these sources as more data becomes available. Special attention will be given to comparisons with the baseline and with the comparison group to highlight differences over time and between traditional Medicaid and ICP. Further, when official Medicaid encounter data is available, the research team will be able to identify services a patient receives and any treatments after a specific service.

2.2.1.6. Vendor shall assess whether evidence exists that persons enrolled in the integrated care project select one plan over another based on an identifiable consumer demographic, such as disability or chronic condition.

The research team has received some summary data on enrollees from the integrated care vendors, but is still waiting on full data sets so that the research team can track identifiable consumer demographics and compare who enrolls in each plan.

The research team will continue to collect enrollee data from the integrated care vendors and HFS in order to identify any differences in consumer demographics and/or case mix.

2.2.2 VENDOR SHALL CONDUCT SURVEY RESEARCH AND FOCUS GROUPS AS FOLLOWS:

2.2.2.1. Vendor shall survey prospective enrollees in the integrated care program to establish baseline data with respect to obtaining the needed medical care, outreach regarding the integrated care program, effectiveness of outreach efforts which shall include awareness and program knowledge, choice of medical provider, choice of specialty services, satisfaction with medical care received and other similar factors.

The second consumer survey (which included questions regarding all the above information) was approved by IDPH and distributed to 2156 integrated care eligible consumers and an additional stratified randomly selected 2000 consumers who would be integrated care eligible but live in the city of Chicago to use as a comparison group. The research team has received 905 unique responses, 497 in the ICP and 408 in the comparison group. Data on a longitudinal subset of 181 of them is presented in of this report.

A survey for time 3 (two years after implementation of ICP) is being planned for the summer of 2013. This survey will be distributed to all respondents from time 2 (to produce more longitudinal data) and a stratified random sample from the eligible ICP population. Pending the availability of funding, the survey will also be distributed to a random sample of similar, traditional Medicaid recipients, to serve as a comparison group. This survey will be nearly identical to previous surveys, with any changes approved by IDPH.

2.2.2.2. The survey instrument(s) shall be designed similarly to be used both before implementation and after the integrated care model has started; any survey instrument(s) shall be approved by the IDPH before use.

In June of 2012, IDPH approved the survey for use following the first year of ICP. It includes all items from the baseline survey, with very little to no changes so that the research team can compare responses before and after the integrated care model has been in place. In addition, the second-year survey includes a few new items relating to long-term care and support services. During the 2nd year, a control/comparison survey is also being used for a population in the city of Chicago. This survey is identical to the integrated care survey, except for removing 5 questions specific to the integrated care program and its vendors.

The survey for time 3 (two years after implementation of ICP) is being planned for the summer of 2013. This survey will be nearly identical to previous surveys, with any changes approved by IDPH.

2.2.2.3. Vendor shall repeat the survey three months after implementation and each twelve months after implementation for the duration of this contract.

Because of delays at the beginning of the evaluation and the integrated care program, it was agreed that the research team would conduct a survey for the baseline and then every year after implementation. The first two surveys were conducted in 2011 and 2012. The third survey, for the period up to two years after the implementation of ICP, will be distributed in the summer of 2013.

2.2.2.4. Vendor may conduct focus groups of beneficiaries of the integrated care program upon consultation with and approval by the IDPH of a plan to collect information through focus groups of beneficiaries.

The research team devised a plan for focus groups that was approved by IDPH. During the first year of ICP, a total of 17 focus groups were conducted. Five of these groups were specific to consumers, and they included 35 integrated care program beneficiaries. In addition, focus groups included five caregivers of integrated care program beneficiaries.

The research team will continue to conduct focus groups with consumers. One change the research team made was to advertise the focus groups in the consumer survey mailing. This should make it easier to identify focus group participants in the future. The focus groups for the second year of ICP will be completed by August 2013.

2.2.2.5. Vendor may conduct focus groups of state staff and staff of the HFS integrated care vendors upon consultation with and approval by the IDPH of a plan to collect information through focus groups of such staff.

In addition to ICP beneficiaries (see 2.2.2.4), both state staff and staff from the MCO's participated in the focus group process. In the first year of ICP, 6 state staff members and 37 MCO staff participated in the focus groups. Similar participants will be recruited in the next year of the evaluation, with the next round of focus groups to be completed by August 2013.

2.2.3 VENDOR SHALL ALSO COMPLY WITH REQUIREMENTS IN CONDUCTING THE ASSESSMENT AND EVALUATION

2.2.3.1. Vendor shall abide by IDPH direction and management regarding the evaluation of the Integrated Care Program.

The research team has worked closely with and abided by IDPH direction and management throughout the evaluation. They have approved all of our research instruments. In addition, the research team meets with an advisory board and IDPH representatives on a monthly or bi-monthly basis for their input and

direction regarding the evaluation. These activities will continue for the duration of the evaluation.

2.2.3.2. Vendor shall analyze and report on the integrated care program as a whole and also each integrated care vendor in order to detect significant case mix or other differences between the two plans.

As data on the integrated care program continues to be delivered to the research team, analysis of that data is conducted on the program as a whole and then further analyzed by individual vendors in order to assess the integrated care program as a single program/policy and then to identify differences in the plans regarding who they are serving and their effectiveness in serving them. This report is an example of that commitment.

2.2.3.3. Vendors should comport with IDPH requirements for receiving Medicaid claims data.

The research team has comported with all IDPH requirements for receiving Medicaid claims data. The research team has been in close contact with state staff people who have been working with the research team to transfer data. They upload the data to secure FTP sites as password-protected files. This is a safe and efficient process, and the research team will continue to use it as a mechanism for receiving data.

2.2.3.4. Vendor shall assess specific areas related to cost and efficiency, including but not limited to: average cost of healthcare for purchase event, the percentage of premium dollars which goes towards reimbursing medical providers, providing services for enrollees when costs are risk adjusted for enrollees' health conditions, and trends regarding cost during the demonstration.

An economic impact assessment is a key part of our evaluation plan. The research team will analyze post-implementation data when they receive official Medicaid claims data. This includes a variety of indicators, including the average cost of healthcare for participants, the percentage of premium dollars which goes towards reimbursing medical providers, providing services for enrollees when costs are risk adjusted for enrollees' health conditions, and trends regarding cost. In addition, the research team will look at costs related to emergency room services and hospital services. However, until official claims data is available, the economic impact assessment component of this research will be underdeveloped.

2.2.3.5. Vendor shall incorporate appropriate factors to assess cultural competency in evaluations and analyses.

Throughout the evaluation, the research team has been careful to demonstrate cultural competency in the evaluation and analysis. The research team includes Dr. Fabricio Balcazar, an expert on issues of cultural competency. The entire department conducting the evaluation has extensive experience with research on and with people with disabilities to make sure that the research is appropriate. Furthermore, many of the aspects of the evaluation are participatory and include people with disabilities in the planning of the research and development of research instruments. The team has translated the survey and related information into Spanish, and has Spanish-speaking staff available to handle phone calls, so that Spanish-speaking integrated care beneficiaries have access to information and participate. These activities will continue for the duration of the evaluation.

2.2.3.6. Vendor shall include gender-sensitive indicators to be used to improve the measurement of outcomes and the quality of women's health.

The survey includes gender-sensitive indicators on outcomes and the quality of woman's health. Responses to the survey can be tracked over time to assess the impact of integrated care. This includes services and specialties specific to women. The results reported here are preliminary, and future reports will include more data on gender differences. In addition, the encounter data can be separated by gender and by service/specialty. When the research team has access to this data, the research team will perform analyses specific to women's health.

Methodology

The evaluation has been designed around three distinct, but interrelated, components (process evaluation, outcome evaluation and an economic impact evaluation). The first part of this section details these components, while the second part explains the data sources used within each.

I. Evaluation Components

A. Process Evaluation

A comprehensive evaluation should include assessment of process variables, as well as actual outcomes. Process variables for this evaluation include MCO organizational structure, formal policies and procedures, resource allocation, and how effective the companies were in carrying out consumer “readiness” activities (awareness and knowledge of the program).

A key factor in carrying out the process evaluation component of this study is the use of a capacity building framework. The capacity building process is facilitated when institutional factors such as strong leadership, resources and supports for program implementation are present along with strong individual factors such as consumer readiness (awareness and motivation) and competence (knowledge about the program), and when attention is given to contextual and cultural factors. As part of the capacity building process, the UIC team utilizes a logic model approach to evaluate the attainment of all project goals and outcomes of the integrated care program.

The UIC evaluation team examines process variables in terms of how well the rollout of the pilot project proceeded. The team evaluates this based on data in two main areas:

Area 1: Data collected from a review of MCO structure and policy/procedures

The process evaluation component evaluates the degree to which the MCO organizational structure, policies and procedures are adequate to create and maintain a provider network that is adequate to supply needed services and care for the enrolled Medicaid consumers. It includes a review of the MCOs’ organizational structure and written policies and procedures in areas, including peer review, utilization review, consumer grievances and complaints. The UIC evaluation collects much of the information for this section from the state’s annual review of their “Quality Strategy.”

One of the most critical stages of the pilot program was during the initial “production phase” of the program as consumers transition from the “regular”

Medicaid program to ICP. It is critical that the evaluation measures how well the MCOs planned for this transition. UIC uses relevant indicators to assess the degree to which each MCO went to prepare for the “roll-out” of the program related specifically to the needs of people with disabilities and elderly persons, including knowledge and experience of staff regarding disability and Americans with Disabilities Act policy, level of training, incorporation of stakeholders into the plan, proactive outreach measures, and consumer education efforts and information dissemination effectiveness.

Area 2: Data collected from selected focus groups

The UIC evaluation team conducts a focus group study to collect data from consumers, staff from the state and each MCO, caregivers and providers associated with ICP. In particular, the focus groups collect data regarding knowledge about existing Medicaid services available to them, how they feel about these services or lack of them, whether they have encountered any barriers to obtaining services, and whether participation in the pilot program has improved their access to needed health care.

To meet the objectives of the process evaluation, UIC continues to review and analyze the RFPs and the contracts of the two MCOs, conduct focus groups, meet with both MCOs to discuss how they will be meeting the contractual obligations, and obtain the available data sets from the MCOs. The process evaluation will be the focus of future reports, and most of the data in this report focuses on establishing a baseline and initial outcomes achieved and progress made by each MCO.

B. Outcome Evaluation

While the evaluation of process variables is an important part of assessing the quality of services provided to consumers in the pilot project, they do not necessarily correlate with better health outcomes in patients. For that reason, a rigorous evaluation of actual health outcomes is being conducted. The evaluation team is, to the extent feasible, trying to identify and statistically isolate the effects of external factors on the outcomes being measured in this part of the evaluation. Specifically, this part of the evaluation examines outcome measures related to four overarching questions.

- Did consumers gain increased access to needed services through the reduction of existing physical and other barriers, the increase in available services from existing providers, and an increase in existing services?

- Did an increase in prevention services and care coordination improve health and decrease costs through a decrease of admissions to hospitals and nursing homes and trips to hospital emergency rooms?
- Did enrollment in the managed plan result in improved health outcomes as measured by standard HEDIS measures?
- Did consumer satisfaction increase as a result of enrollment in the program as measured by standard CAHPS measures?

A number of different data sources are consulted to meet this objective, including the focus groups, a survey that the research team developed based on existing CAHPS measures, and "hard data" available to the team (e.g. raw data from the MCO's, Medicaid encounter data). The outcome evaluation is designed around four areas:

Area 1: Did consumers gain increased access to needed services?

Following a series of open meetings held by state officials from October of 2010, the research team decided it was necessary to develop a custom survey instrument to measure whether consumers have increased access to services. Existing instruments were determined to be inadequate due to the unique needs and circumstances of the ICP population. The survey includes indicators of: consumer travel distance to primary care physicians (PCP), consumer access to specialty providers, level of experience/knowledge of PCPs, facility ADA compliance, health maintenance, access to durable medical equipment (DME), transportation services, consumer choice, and MCO network adequacy. In addition, many of these topics are discussed in the focus groups.

Area 2: Did an increase in prevention services and care coordination improve health and decrease costs?

To determine whether the MCOs have increased quality of care and reduced costs in this area, the evaluation team is considering the following questions:

- What is the rate of emergency room visits for enrollees?
- What is the rate of hospital admissions for enrollees?
- What is the rate of readmission for enrollees who have been hospitalized previously?

The federal government and most states have identified Prevention Quality Indicators (PQIs) that are part of their Medicaid quality plans. PQIs are a set of measures that can be used with hospital inpatient discharge data to identify "ambulatory care sensitive conditions" (ACSCs). ACSCs are conditions for which

good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease. Future reports will contain additional analysis on this area.

Area 3: Did enrollment in the managed plan result in improved health outcomes?

The evaluation team has and continues to consult with stakeholders, the MCOs, and state officials about which health outcomes should be included in the study. Many are taken from existing HEDIS and state specific quality indicators. The NCQA publishes national benchmarks for HEDIS outcomes each year for Medicaid plans. The research team compares outcomes for the ICP population with those national benchmarks and comparisons are made with other Medicaid programs in Illinois. The evaluation has also been reviewing data on quality indicators for the year prior to the start of this pilot project to identify baseline trends that were in place before the implementation of ICP. Future reports will contain additional analysis on this area.

Area 4: Did consumer satisfaction increase as a result of enrollment in the program?

The evaluation team will use two approaches to evaluate consumer satisfaction with the new pilot project. The first approach includes analyzing data from the survey described in the next section. It includes standard CAHPS and HEDIS satisfaction indicators alongside custom measures of satisfaction. The second approach is to use data from the focus groups, which is an established method for gathering multiple perspectives from diverse groups.

C. Economic Impact Evaluation

It is crucial that in addition to assessing quality of care, measures are developed to measure the cost of care. The evaluation team is taking care to determine the extent to which costs change and shift as a result of factors within ICP and the extent to which they changed and shifted as a result of other factors outside of the control of the MCOs. When available, person-level counts of health care utilization, including emergency room visits and hospital re-admissions, will be statistically modeled as a function of MCO membership, measurement period, and the interaction between MCO membership and measurement period using random effects negative binomial regression. The models will include the duration of follow up for each beneficiary as an offset. Payments for health care services rendered during the pre and post implementation periods will also be modeled. Once the research team has received this data in its entirety, they will be able to assess costs at baseline for

the ICP Enrollees over the prior year compared with following enrollment in the ICP.

- Specific areas related to cost and efficiency that will be reviewed include:
- What is the current average cost of health care for participants?
- What percentage of premium dollars goes towards medical costs (i.e. medical loss ratio)?
- How do costs change over time and shift among different parties (public and private) change during the time of the demonstration.
- How efficient are the MCOs in providing services for enrollees when these costs are risk-adjusted for consumer health conditions (comparing NCQA published “Relative Resource Use” benchmarks to those of the MCOs)?

II. Data Collection

In conducting the overall evaluation, the UIC evaluation team will collect both quantitative and qualitative data and solicit input from all concerned stakeholders, including the Illinois Department of Healthcare and Family Services, the Illinois Department of Human Services, the Illinois Department of Public Health, advocacy groups, and consumers themselves. Much of the data is secondary data provided to the evaluation team, although the survey and focus group processes involve direct data collection. The methods the research team uses for these processes are described below.

A. Survey Processes

The research team has devoted much time and resources to develop and disseminate a consumer satisfaction survey at the baseline and following the first year of ICP. The research team decided that traditional CAHPS and HEDIS measures would be insufficient to capture the specific needs of people with disabilities and older adults in the ICP. Therefore, the research team also considered the Assessment of Health Plans and Providers by People with Activity Limitations (AHPPPAL) Survey, which is an instrument developed as part of a 5-year federal grant in 2003 to extend the traditional CAHPS survey to be more appropriate for persons with disabilities. It has revised wording and also included additional content that is more relevant for people with disabilities (Palsbo et al., 2010). The research team consulted with Dr. Palsbo to develop an initial set of questions and categories for the survey, before an extensive series of meetings with Medicaid consumers and advocates, policymakers and researchers, health care providers and the MCOs to get feedback on the survey. After these revisions, the research team presented the initial survey to the

Advisory Board and then to IDPH for official approval. For the follow-up survey, the research team kept the questions from the baseline survey and added a few others specific to the experiences under ICP and regarding long-term care and supports in preparation for the next phase of ICP. Again, the research team used a participatory process and received feedback on the new questions before receiving IDPH approval.

The baseline survey was distributed to a sample of ICP eligible beneficiaries in June 2011. This survey was intended to cover the year prior to implementation of ICP. A stratified random sample of 2195 people was sent the survey via mail, using a data set of contact information for 41,485 individuals provided by IDPH. This sample was stratified by one of ten different institutional groups or waiver program statuses: community resident, nursing facility resident, developmentally disability, physical disability, older adults, resident of an integrated care facility for people with intellectual disabilities, brain injury, HIV or AIDS, technologically dependent, or assisted living (in practice, being a resident of an integrated care facility for people with intellectual disabilities, having a brain injury or HIV or AIDS, being technologically dependent, or requiring assisted living were pooled to form an “other” category). Participants directly mail completed surveys to the UIC Department of Disability and Human Development. Some participants choose to complete the survey over the phone or online. The surveys are also available in Spanish. The surveys are then entered into a statistical software package (SPSS) for analysis.

Distribution of the follow-up survey, covering the first year of ICP, occurred in the summer of 2012. In order to obtain a large longitudinal subset, the research team distributed this survey to everyone who had completed one at baseline (381 participants). The research team also selected a stratified random sample (stratified by the groups identified in the previous paragraph) of 1775 additional people enrolled in ICP from data provided by IDPH. Therefore the total sample size for the ICP survey at time was 2156. In addition at this time, the research team distributed a similar survey (exactly the same except for questions specific to ICP being removed) to a sample of 2000 Medicaid eligible participants living in the city of Chicago. These people had the same characteristics as the ICP population and would be ICP eligible if they lived in the pilot area.

For each survey, the follow-up efforts are made to each person in the sample to encourage them to complete the survey. Many surveys are returned with invalid addresses and many people cannot be reached by phone. Since the research team cannot confirm contact with this person, they are not included in

the response rate. Data on the sample size, people with bad contact information and the response rate is included in Table 1.

Survey	Original Sample	Bad Address	Responses Received	Response Rate
Time 1				
- Baseline	2,195	979	418	34.3%
Time 2				
- ICP	2,156	905 ^a	489	39.2% ^a
- Comparison Group	2,000	380 ^b	412	25.4% ^b
Longitudinal^c				
- Completed Year 1	381	85	181	61.1%

^a This figure is an approximation. The research team is still conducting follow-up, and the number of bad contact information is a figure obtained by applying the percent of bad contact information obtained from those we have tried to reach to the entire sample.

^b These figures will increase when the research team has conducted follow-up. Currently the number of bad contact information only includes mail return to the sender, and does not consider telephone contact.

^c This group is also included in the Time 1 and Time 2 ICP surveys.

B. Stakeholder Focus Groups

The research team conducted a series of focus groups with interested stakeholders. ICP consumers and caregivers who were recruited by disseminating a flier through local disability advocacy and service organizations and through direct phone calls using the contact information provided by IDPH. This was an extremely labor-intensive process. Given the mobility and low income of Medicaid recipients, a significant proportion of the phone numbers received from the state were either disconnected or incorrect. In future years the survey offers participants the option to indicate their interest in a focus group, which should make recruitment smoother. Participants were recruited for particular groups based on disability type and geographical location. Service providers, managed care employees and leadership, and state employees were recruited through community organizations, hospitals and clinics, and direct contact.

During the first year of ICP, the research team conducted 17 focus groups and 2 individual interviews with 35 consumers and 5 caregivers residing in six counties (suburban Cook, Kankakee, Will, Kane, DuPage, & Lake), 27 providers, 37 managed care employees, and 6 state employees. See Table 2 for an overview of focus group participants.

**Table 2:
Focus Group Participant Demographics**

Participant Type	# of Focus Groups / Interviews	Gender	Age	Race / Ethnicity	Total
Consumer	5 / 1	Female: 49% (17) Male: 51% (18)	Range: 49- 70 Median: 54	White; 23% (8) Black; 51% (18) Hispanic: 3% (1) Unknown: 23% (8)	35
Caregiver	1 / 1	Female: 100% (5)	Range: 53- 61 Median: 54.5	White: 100% (5)	5
Provider	4 / 0	Female: 70% (19) Male: 30% (8)	Range: 27- 61 Median: 47	White: 67% (18) Black: 19% (5) Hispanic: 7% (2) American Indian: 7% (2)	27
MCO	6 / 0	Female: 78% (29) Male: 22% (8)	Range; 24- 63 Median: 41.25	White: 46% (17) Black: 38% (14) Other: 3% (1) Unknown: 3% (1)	37
State Employees	1 / 0	Female: 83% (5) Male: 17% (1)	Range: 36- 56 Median: 48	White: 100% (6)	6
Total	17 / 2				110

Each focus group was conducted at a public, accessible location (e.g., Centers for Independent Living, University Offices, Public Health offices, Community Agencies, etc.). At each focus group, members of the research team explained the purpose of the focus group and obtained informed consent. The focus groups were conducted by a facilitator using a semi-structured focus group guide (after receiving comments on this guide from the Advisory Council and receiving approval from IDPH). The focus group somewhere recorded digitally and transcribed verbatim to create a transcript for analysis. Additional research team members take notes at the focus groups to capture contextual information that may or may not be detected through transcription. Each focus

group lasted between 50 minutes and two hours. Following the focus groups/interviews, participants received \$50 as compensation for their time.

The research team used qualitative analysis/coding software (Atlas.ti) to assist with a mixed approach (grounded theory & apriori codes) to qualitative analysis. In general, the research team examined the data for themes that emerged during the analysis, as well as looking for themes on the pre-identified topics of transition, communication, network adequacy, quality of care, prevention, and coordination of care. The research team used multiple coders and analysts to ensure consistency and agreement on general themes. These themes are illustrated by descriptive quotes. The research team also used a combination of inductive and deductive coding to narrow themes into subthemes for each type of participant, allowing subthemes to emerge organically while also using the existing framework that guided the development of the focus group protocol.

III. Outcome Data

This report relies heavily on outcome data that the research team obtained. The outcome data consists of four main data source: 1) the baseline encounter data; 2) post implementation encounter data; and 3) special topic MCO reports that cover information not included in the encounter data, and 4) MCO datasets from their internal data warehouses. Listed below is a summary of our progress in obtaining data in each of these four areas.

A. Baseline encounter dataset

An encounter dataset contains all services and related data that are delivered to Medicaid enrollees. Most of the quality indicators, such as HEDIS and other specialized outcome measures, depend on having available a complete and reliable encounter dataset.

UIC received the baseline encounter dataset from HFS. It covers the period of July 1, 2010 through March 31, 2011, which is the 9 months just prior to start of the ICP program. This dataset contains all encounters that ICP eligible enrollees had during this time.

B. Post-ICP encounter dataset

In a capitated Medicaid program, it is more difficult to produce complete and reliable encounter data because of the way the payment method works. Unlike the fee for service program, the managed care plans are not paid for each service delivered but rather for each member covered for a month. Hence,

without encounter data, it is more difficult to determine the actual services delivered to the members.

State officials recognized the importance of maintaining a robust encounter dataset for the ICP program and put several provisions in their formal contracts with the two plans regarding this issue. First, the contracts state that HFS and the plans

“acknowledge and agree that they will work in good faith to implement mutually agreed upon system requirements resulting in the complete and comprehensive transfer and acceptance of Encounter Data and that such mutual agreement shall not be unreasonably withheld. The Department and Contractor further acknowledge and agree that such implementation shall be satisfactorily completed no later than January 1, 2012, unless the failure to do so is the fault of the Department” (Section 7.16.3).

In the same section, the contract outlines what could happen if either plan is found to be out of compliance on this issue:

“If Contractor does not demonstrate compliance with these requirements by the end of the thirty (30) day period following the notice, the Department, without further notice, may impose a late fee of \$10,000.00 to \$50,000.00. At the end of each subsequent period of thirty (30) days in which Contractor is out of compliance, the Department may, without further notice, impose an additional late fee of \$10,000.00 to \$50,000.00.”

The post-ICP encounter dataset was not available for the evaluation. HFS has been making slow but steady progress on this. Delays have resulted from various aspects related to regulations, programming, and staffing issues. More details regarding the reasons for the delay in producing encounter data for the ICP program are described in Appendix A.

C. MCO regular summary reports

As part of their formal contract with the state, there are regular reports the plans have to submit that contains information and data that either supplements or adds to the encounter dataset. These reports include but are not limited to the following areas: Risk identification, ER events, inpatient admissions, enrollment, drug utilization, radiology utilization, grievances and appeals, and prior authorization.

The UIC team began receiving these MCO reports in December of 2011. While these reports have given us some helpful information, they present challenges in reliably comparing the performance of the two MCOs on specific outcome measures in the reports.

The problems in these reports include differences in outcome measures, formats for summary tables, unknown data definitions and algorithms used, and differences in time periods; internal inconsistencies with data elements within the same report; and the failure to present the data in a drill down or filtered fashion.

Over the past year, the UIC team has seen evident progress by both plans and HFS to make these reports more consistent and comparable with each other. However, the reports have not yet reached the point where they can be used to reliably compare performance between the two plans.

D. Special MCO datasets

As previously discussed, the team was limited in its work due to the lack of any post-ICP encounter data. However, the UIC team was able to work with HFS and the two plans to obtain much of the data needed and would have received from the Year 1 encounter dataset.

With the assistance of HFS, the UIC team requested and received special datasets from the internal data warehouses of the plans related to ER visits, hospital admissions, drug usage, risk stratification, care plans, prior approval requests, grievance, appeals, enrollment, and radiology services. As a result, the UIC team has been able to conduct much of the analysis that it would have carried out if the official encounter dataset had been available.

IV. Summary of Data Sources

In addition to the survey and focus group data described in the previous sections, the research team also evaluated or anticipates evaluating other data sources. For instance, official Medicaid encounter data for the first year of the ICP is not yet available. To fill this gap, the MCOs have submitted data in the interim. The data sources available and anticipated are summarized in Table 3.

**Table 3:
Data Sources Available and Anticipated**

Data Source	Description	Status
<i>“Hard” Data Sources</i>		
- Baseline Encounter Data	Contains 3.4 million Medicaid claims paid by HFS for services provided to the ICP enrollees for the 9-month period between July 1, 2010 and March 31, 2011.	The research team obtained this dataset from HFS in July of 2011.
- Year 1 Encounter Data	Will contain all Medicaid encounters between consumers and providers that are part of ICP for the 12-month period of May 1, 2011 through April 30, 2012.	The research team is still waiting for this data, which is in the testing phase between HFS and the MCOs. The latest estimate the research team has is that it will be ready for analysis in late January or early February.
- MCO Regular Summary Reports	Summary reports submitted by the MCOs periodically (i.e. monthly, quarterly, annually, and as needed). Includes summary of enrollment, risk stratification, care management, service utilization, prior authorization, grievances, and other related information.	The research team has been obtaining these reports regularly since January of 2012, although the data still has limitations that prevent them from being comparable between the two plans on some outcome measures.
- Special MCO Data	Data provided by MCOs to supplement summary reports and fill the void with the absence of Year 1 encounter data. Include more detail and permit some comparisons to be made between plans and with baseline.	The research team has been obtaining these special datasets from the MCOs and HFS since the summer of 2012.
<i>Survey Data</i>		
- Time 1: Baseline	A consumer satisfaction survey was distributed to ICP eligible participants in order to collect data on medical services received and satisfaction with their healthcare for the year prior to implementation of ICP.	418 survey responses have been received. Data collection is closed.

**Table 3:
Data Sources Available and Anticipated**

- Time 2: ICP	A consumer satisfaction survey was distributed to ICP eligible participants in order to collect data on medical services received, satisfaction with healthcare, and long-term services and supports. This survey is identical to Time 1, with the addition of a few questions specific to ICP.	489 survey responses have been received. Data collection is ongoing along with active follow-up.
- Time 2: Comparison Group	A consumer satisfaction survey was distributed to Medicaid eligible participants in order to collect data on medical services received, satisfaction with healthcare, and long-term services and supports. These individuals would be eligible for the ICP program but they live outside the pilot area. This survey will be used to compare ICP with traditional Medicaid.	412 survey responses have been received. Data collection is ongoing.
- Longitudinal Data	Surveys for Time 2 were distributed to all current ICP eligible participants who completed the baseline survey. This longitudinal data is the most accurate way to make comparisons over time (i.e. prior to and following implementation of ICP).	181 survey responses have been received. Data collection is ongoing along with active follow-up.
Focus Group Data		
- First Year of ICP	Focus groups were conducted to gather information and personal stories and experiences regarding ICP. This includes multiple stakeholders (consumers, caregivers, MCO staff, government staff, providers, etc.).	Focus groups have been conducted with 110 participants. Focus groups are complete for the first year of ICP.
Other Anecdotal and Written Data		
- Stakeholder Meetings, Materials and Interviews	The research team attends multiple stakeholder meetings. Sometimes a stakeholder provides written data to the research team or wants to have a short conversation about praise or concerns for ICP. Notes and materials from these meetings or interviews are used in the process evaluation.	This data is collected on a periodic, ad hoc, basis. The research team will continue to participate in these activities.
- MCO Contracts and Reports	Each MCO signed a formal contract with the state and submits reports on a regular basis. The research team uses these as data to show whether each MCO is meeting their requirements and obligations to the state.	This data is collected as it is available. The research team will continue to collect and review this data as it is available.

Major Findings

I. Description of ICP Members at Baseline

This section provides a brief description of the ICP members and the services they received prior to implementation of the ICP.

A. Members

Data received from HFS indicated that 41,443 people were eligible for ICP during the baseline. Almost 95% of these members (39,120) had at least one encounter with a provider during the baseline period of 9 months (July 1, 2010 through March 31, 2011) (see Table 4). Of the members who had at least one claim during the baseline period, almost 90% of them had at least one encounter with a physician. Slightly more than 25,000 of the members had 3 or more office visits with a physician.

Item	# of members
Total eligible ICP members	41,443
Did NOT receive any service during baseline	2,323
Received some type of service during baseline	39,120
Members who had at least 1 encounter with a physician	34,576
Received 1 or more office/home visits	29,889
Received 3 or more office/home visits	25,004
Monitored by a physician receiving PCP payment for medical home	20,784

Table 5 shows the 10 groups to which ICP members were classified into by HFS and demographics for each group. Overall, about 54% of the members were female with the mean age of 49 years. Approximately 49% of the members were white, 41% were black, and the remainder was mostly Asian- American.

ICP Groups	# ¹	Female	Mean Age ²	White	Black	Other ³	Hispanic
Aging (Older Adults & Disabled Brain Injury)	1,153 (2.9%)	73%	70	50%	20%	30%	11%
Community residents	29,128 (74.5%)	56%	50	47%	42%	11%	19%
Developmental Disability	2,445 (6.3%)	41%	41	65%	32%	3%	13%
HIV/AIDS	92 (0.2%)	45%	49	24%	75%	1%	7%
ICF/MR	468 (1.2%)	53%	35	71%	26%	3%	9%
Nursing Facility	3511 (9.0%)	39%	53	57%	40%	3%	9%
Physical Disability	1,865 (4.8%)	58%	42	45%	50%	4%	15%
Supportive (Assisted) Living	1 (0.0%)	100%	66		100%		0%
Technology Dependent	21 (0.1%)	43%	19	60%	35%	5%	27%
Unknown	59 (0.2%)						
Total	39,120	54%	49	49%	41%	10%	17%

¹ Includes only those who had encounter during the baseline period

² Age at encounter

³ Includes Asian, Hawaiian, Pacific Islander, American Indian, and Multi-race

Table 6 below breaks out the eligible ICP members by county. Suburban Cook County had almost 60% of the entire ICP population prior to start of the program. The other 5 counties ranged from Kankakee with 3.4% of the ICP population to DuPage with 11.7%. Table 6 also summarizes the number of physicians who had encounters with members during the baseline period. Again, Cook County has the greatest share, with almost two-thirds of the entire number of physicians who had any encounters with ICP members. Will county had almost 10% of the members but less than 4% of the participating baseline physicians. Similarly, Kankakee had 3.4% of the members but only 1.4% of the participating physicians. For a graphical representation of the location of these members and physicians, see Appendix B.

Table 6
Summary of ICP Members and Physicians at Baseline

County	Members		Physicians ¹	
	#	%	#	%
Will	3,702	9.7%	474	3.7%
Kane	2,573	6.8%	680	5.3%
Cook	22,360	58.9%	8,376	65.8%
Kankakee	1,299	3.4%	175	1.4%
Dupage	4,443	11.7%	2,151	16.9%
Lake	3,609	9.5%	883	6.9%
Total	37,986	100.0%	12,739	100.0%

¹ Physicians reporting at least 1 encounter with ICP members

B. Providers and Services

There were almost \$500 million in claims submitted for the ICP eligible population during the 9-month baseline period. More than half of the services were for long-term care and inpatient hospital services. Table 7 provides a summary of baseline services by major service groups.

Table 7:
Summary of Baseline Claims by Major Service Group

Category	Claims	Payments	% of Payments
Long Term Care	45,547	\$160,561,659	32.3%
Inpatient Hospital	16,746	\$135,944,208	27.3%
Waiver	865,932	\$92,746,255	18.6%
Physicians	1,379,320	\$37,778,060	7.6%
Outpt. Hospital	76,616	\$31,531,482	6.3%
Other	283,891	\$17,443,256	3.5%
Equip & Supplies	89,664	\$9,708,246	2.0%
Clinics	149,519	\$5,675,200	1.1%
Transportation	191,224	\$3,834,254	0.8%
Lab & X-ray	248,458	\$2,170,699	0.4%
Pharmacy ¹	2,300	\$383,880	0.1%
Total	3,349,217	\$497,777,198	100%

¹ Does not include the price of drugs

The “long-term care” category included 11 types of services, with ICR/MR, Intermediate, and Skilled constituting more than 90% of the costs for this category (these service types are not shown in Table 7; for this detail, see Table B-2 in Appendix B). There were 5 types of inpatient hospital services,

with general hospitals making up almost 85% of the cost for this category. Physicians had the most claims of any of the categories but only ranked fourth in terms of total cost.

Table 8 summarizes the baseline services by major provider group. Inpatient institutions accounted for almost two-thirds of the costs of baseline services. Waiver providers for eight (8) different waivers accounted for about one-sixth of the cost. For more detail on the provider types within each major group, see Tables B-2 in Appendix B.

Major Provider Group	Claims	Payments	%
Inpatient Institutions	283,816	\$326,060,929	65.5%
Waiver Providers	771,868	\$82,583,543	16.6%
Individual Practitioner (Doctor)	1,264,198	\$34,220,286	6.9%
Unclassified Service Providers	62,507	\$20,835,378	4.2%
Commercial Providers	324,717	\$11,434,183	2.3%
In-Home Service Providers	135,303	\$6,931,823	1.4%
Outpatient Institutions	160,935	\$6,270,206	1.3%
Transportation Provider	320,572	\$4,857,835	1.0%
Other Service Providers	11,167	\$3,511,867	0.7%
Individual Practitioner (Non-Doctor)	14,028	\$1,056,205	0.2%
PrePaid Services	106	\$14,943	0.0%
Total	3,349,217	\$497,777,198	100.0%

II. Development of Provider Network

This section will track the efforts of the two plans to develop their provider networks for ICP members. It briefly notes the federal and state minimum standards for provider networks for Medicaid managed care programs and lists some concerns that various stakeholder groups expressed prior to implementation of the program. This section also summarizes goals of HFS and the two plans regarding the provider networks.

This section describes the process the two plans used in tracking the growth of their networks, including conducting GeoAccess analysis of their networks, submitting regular lists of signed providers to HFS, and periodically updating stakeholder groups on the progress they had made. Specifically, this section

details the progress that the two plans had in signing major hospitals and physicians to their plans and document provider “reluctance” the two plans encountered. The UIC team also document the steps the plans took in response to the initial slow growth of their networks, including extending the minimum “continuity of care” period for members, paying out of network providers, and recruiting other providers who were not signed to formal contracts or paid as out-of-network providers but were still available to ICP members.

Throughout this section, the UIC team provide summary information which frequently link to more detailed information in the Appendix section.

A. Brief Description of Providers prior to ICP implementation

For the 9 months immediately prior to the start of the ICP, a total of 24,736 providers had submitted at least one claim for ICP eligible members; slightly less than 19,000 of them (76.6%) were “local” providers giving their billing address within or near the boundary of the ICP catchment area (see Table 9).

Provider Group	Local providers^b	Distant providers	Total providers
Physicians	12,141	2,936	15,077
Other providers	6,813	2,846	9,659
TOTAL	18,954	5,782	24,736

^a Providers who submitted claims during 9 month period prior to ICP (7/1/10-3/31/11)
^b Located within the 6 county ICP area or within 30 miles of the outer boundary

This section looks only at physicians as a separate provider group in the table above but greater detail for 28 different provider types is in Appendix C.

B. Criteria identified for evaluating “adequacy of provider network”

To identify criteria that could be used in evaluating the “adequacy of provider networks,” the UIC team consulted federal regulations and state requirements, solicited feedback from public stakeholder groups, and met with HFS and both plans regarding their goals for the new provider networks.

1. Federal Medicaid standards

Federal Medicaid regulations (CFR 438.207) do not articulate any minimum criteria related to provider networks for Medicaid managed care programs. The federal regulations require states to ensure that networks are “sufficient to provide adequate access to all covered services” and require the state to

monitor the network and take into account the "expected utilization" of services based on "the characteristics and health care needs of specific Medicaid populations represented in the particular MCO."

The closest that the federal regulations come to specifying minimum standards for a provider network is by requiring the state to ensure that the provider network has "numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services" and take into account the "numbers of network providers who are not accepting new Medicaid patients" (CFR 438.206 (b)(iii)).

2. State requirements

Development of the provider network was identified as the most important factor during the pre-award process. Prior to the awarding the contracts, the state held numerous public stakeholder meetings to solicit feedback and comments. A frequently voiced concern was whether the new provider networks would be capable of delivering the required services to consumers. This theme was echoed in focus groups with consumers, caregivers, providers and MCO staff during the first 18 months of implementation.

The state required that each plan "establish, maintain, and monitor" a provider network that "is sufficient to provide adequate access to all Covered Services under the Contract" taking into account several "considerations":

- 5.5.1.1.1 Anticipated number of Enrollees;
- 5.5.1.1.2 Expected service utilization, in light of the characteristics and health care needs of Contractor's Enrollees;
- 5.5.1.1.3 Number and types of Providers required to furnish the Covered Services

For its managed care programs (voluntary and mandatory), Illinois currently sets the following minimum provider to member ratios:

Area	Minimum Criteria
Primary Care	At least 1 FTE for each 1,200 enrollees
Specialty Care	None for adults
Hospital Care	Contractor must establish and maintain network of affiliated providers, including hospitals that is sufficient to provide adequate access to all services under the contract
Dental	None

3. Experiences of other states

A review of the literature found that other states vary widely in the criteria used in setting minimum standards for provider networks in their Medicaid managed care programs. These criteria have included provider to member ratios, minimum travel or distance times, and density of providers in geographic regions ¹. The UIC team has summarized the criteria used by states for evaluating primary care for their Medicaid managed care programs in Table C-1 in Appendix C.

4. Discussions and feedback from Stakeholder meetings

During the formal focus groups the UIC team conducted, the issue of adequacy of the new provider networks was raised by virtually all stakeholders, and led to problems of many consumers needing to switch primary and specialty providers, long wait times to see providers, extensive travel time, and inaccessibility to specialty services for consumers. Especially for this population and its often complex needs, specialty services are necessary, and many consumers expressed discontent with switching providers they were comfortable with and had been seeing for years.

In addition to structured focus groups, during the winter of 2011/12, the UIC team met with the following provider, consumer, and advocate stakeholder groups to obtain comments regarding the ICP: Access Community Health Network, Age Options, the ARC, Bleeding Disorders Alliance of Illinois, Centers for Independent Living, Community Behavioral Health Association, Illinois Alcoholism and Drug Dependence Association, Illinois Academy of Family Physicians, Illinois Association of Rehabilitation Facilities, Illinois Home Care Association, Illinois Hospital Association, Illinois Program for Autism and Developmental Disabilities, and the Mental Health Summit.

Several key questions of interest regarding provider networks emanated from these meetings:

- Will the state or the plans establish any minimum provider ratios or numbers, by provider types or specialties, for the new provider networks?
- To what extent will the new provider networks sign up existing providers so as to give enrollees a choice to retain their current PCPs and specialty providers?

- What arrangements will the plans make for those members who have an ongoing meaningful relationship with a provider who refuses to sign a formal contract with the plan?
- How many "new" Medicaid providers will the plans sign to their networks?
- How accessible will the new provider networks be in terms of geographic dispersion and physical accessibility?

5. Discussions and feedback from meetings with HFS and MCO staff

After multiple discussions with both HFS and the two plans to determine their priorities for developing the provider network and any suggestions they had regarding outcome measures to evaluate their network development, several key points emerged:

- During the first year, the plans would focus on maximizing "continuity of care" for members as they transitioned from the traditional FFS Medicaid system to the new ICP program;
- Both plans would prioritize their outreach efforts to local providers who had an active ongoing relationship with members;
- The goal of the initiative was not necessarily to duplicate the existing array of providers but to develop a "size right" coordinated provider network with adequate types and amount of services.

C. Description of process MCOs used in developing their new networks

1. Results of geographic analysis conducted by the two plans for their own provider networks shortly after ICP implementation during the summer of 2011

The formal state contract between the state and the plans requires each plan to conduct geographic analysis of the provider network on a quarterly basis (Section 5.5.3). Specifically, it requires both plans to "plot Enrollee and Affiliated Provider locations by zip code and analyze the information, considering the prevalent modes of transportation available to Enrollees, Enrollees' ability to travel, and Enrollees' ability to be in an office setting".

During the summer of 2011, both plans underwent their mandated readiness review, which was conducted by Health Services Advisory Group (HSAG), the external contractor employed by the state to conduct the reviews. As part of this review, both plans submitted their most recent geographic analysis of

their network. The report submitted by Aetna was dated July 15, 2011 while IlliniCare's report was dated August 22, 2011.

The two plans conducted similar but not identical surveys. Table 11 lists seven (7) features found in at least one of the two reports. Of the 7 main features, both plans included 4 of them but differed on three of them. For example, IlliniCare's report did not list providers by zip code but did identify them by county level, while Aetna did not calculate member to provider ratios. Although both plans calculated the average distance to the nearest single provider, IlliniCare also listed the average distance to the nearest number of providers (2, 3, 4 and 5), which Aetna did not.

Outcome measure	Aetna	IlliniCare
Lists # of providers per county	Yes	Yes
Lists # of providers by zip code	Yes	No
Calculates % of members within 30 miles of provider	Yes	Yes
Lists average distance from member to nearest provider	Yes	Yes
Includes maps with provider locations	Yes	Yes
Calculates member to provider ratio	No	Yes
Lists average distance of nearest 2, 3, 4, and 5 providers	No	Yes

The two plans also differed on what provider types and physician specialties they included in their reports (see Table 12). Together, the two plans analyzed 43 different physician specialties and non-physician provider types—however, less than half of these provider categories (19) were common across both plans. For example, of the 23 physician specialties listed by one or both plans, only 13 of them were shared by both plans. This makes any meaningful comparison between the geographic reports for the two plans very difficult.

Table 12:¹

GeoAccess Provider Types (Summer 2011)				
Provide Category	Total	Aetna	IlliniCare	Both Plans
Physician Specialties	23	20	16	13
Other Provider Types	20	14	13	6
Total	43	34	29	19

¹ Provider types and physician specialties included in at least one of MCO reports

Table 13: GeoAccess results (Summer of 2011)		
Provider Type	Aetna ¹	IlliniCare ²
PCPs ³	979	367
Physician Specialists	407	718
Hospitals	17	24 ⁴

¹ # of providers reported by Aetna's GeoAccess report of 7/15/11
² # of providers reported by IlliniCare's GeoAccess report of 8/22/11
³ Includes "Family Practice Physicians" for both plans and "Primary Care" for Aetna
⁴ Includes the average of two totals (13 and 35) reported for hospitals

Table 13 lists the numbers of physicians and hospitals reported by each plan during the summer of 2011. Aetna's report listed 1,386 physicians in July of 2011 while IlliniCare's report listed 1,085 physicians. For additional detail on all provider types included in the two reports, see Appendix C.

We asked HFS if they would comment on the GeoAccess reports submitted by the plans and they responded:

"The plans reported geo access data monthly and HFS staff analyzed the data to determine adequacy of networks. Based on the analysis, HFS staff responded asking the plans for detailed explanations on how any shortages or perceived shortages would be addressed. Certain geo-access areas or particular specialties, such as neurosurgeons were closely monitored by HFS.

While the contract required monthly reporting, HFS changed this to weekly, reporting prior to and during the implementation stage, to better monitor all network activity. Even after the effective date HFS continued to require weekly reporting of hospitals, PCPs, specialists etc. and any downtrend trends were addressed immediately."

2. Periodic updates on the provider networks given by the two plans during public stakeholder meetings

The go-live date for the ICP program was May 1, 2011. Prior to this date, on 4/7/11, HFS held a public stakeholder meeting to update interested parties on the program. During this meeting, HFS expressed “disappointment” with the number of providers who had signed formal contracts with the two plans and stated that they were working to put in place new incentives to encourage hospitals and other providers to join the new networks.

Over the first 6 months of the program, HFS held three (3) more public meetings during which the two plans gave updates regarding their provider networks. Table 14 below summarizes the information the plans released publicly at these meetings.

Date	PCPs		Specialists		Hospitals	
	Aetna	IlliniCare	Aetna	IlliniCare	Aetna	IlliniCare
6/14/11	659	708	1,758	1,063	29	37
8/10/11	1,815	1,302	3,152	3,047	46	42
11/16/11	1,850	1,561	3,227	3,600	50	47

The public updates that the two plans made at these three public meetings included numbers for only physicians (PCPs and specialists) and hospitals. The plans did not report numbers for other types of providers at the public meetings. Table 14 does not include all public updates that occurred during Year 1, only those for the first six months of ICP.

3. Reports of "provider reluctance" to sign with either plan

During the summer of 2011, the UIC team had received reports from several sources that many providers were reluctant to sign with either plan and that many were “waiting it out” to see how serious the state was in actually implementing mandatory managed care. In our discussions with HFS and the two plans, the UIC team asked about their experience with provider “reluctance” and invited all three parties to submit any comments they might have on the topic.

The state characterized provider reluctance as follows:

“The primary problem that arose during the ICP implementation was network access, specifically to specialty providers and teaching hospitals. However, the ICP networks are more established now - many of the teaching hospitals have signed on with the ICP

Plans, along with their providers of primary and specialty care (See ICP Hospitals attachment). In addition, HFS created additional incentives for those hospital systems that have not enrolled in ICP to participate, such as faster HIE payments and conditioning receipt of current supplemental payments to joining managed care networks. Evidenced by the growing ICP networks, HFS believes that providers have accepted the movement toward managed care in Illinois"

Aetna described their experience with provider recruitment as follows:

"It is Aetna Better Health's desire to build a quality network that meets the needs of our members. While we have experienced significant network growth, we maintain our efforts to include all Medicaid providers that were actively engaged with members prior to the implementation of the ICP program. The biggest challenge we experience is provider resistance. We have experienced many providers that did not want to participate in a managed care program or no longer wanted to participate in Medicaid."

IlliniCare noted the following experiences with signing up providers:

"The recruiting of providers (Service Package I) included hospitals, physicians and other medical providers in the targeted six county service area and while historically these providers had serviced the ICP population/membership, there was no such mandate that they had to continue to serve the population/membership under the newly established ICP. With that backdrop, numerous providers did not or would not sign on to become network providers with either of the ICP health plans by the end of the first year of operation.

Examples of the provider reluctance or resistance include the two largest hospitals in [county] not joining the ICP program until almost 11 months after the effective date of the ICP. Other larger tertiary hospitals did not agree to participate until the middle part of 2012; others continue to refuse to join the network including the State of Illinois' own affiliated entity, the University of Illinois at Chicago Hospital. When a hospital either chooses not to participate or limits its participation, that decision also influences the physicians who are affiliated with that hospital as well."

4. Number of providers that were signed to formal contracts with the new networks

In July of 2011, the UIC team received the first official provider files for both plans from HFS. Tables 15A (Aetna) and 15B (IlliniCare) list the number of unique providers signed by the two plans for two points during the summer of 2011 and a third point at the end of the first year on 4/30/12.

Provider Type	7/14/11	9/21/11	4/30/12
Physicians	831	1,310	4,518
Other providers	197	294	2,862
ALL providers	1,028	1,604	7,380

As of 7/14/11, the provider file for Aetna listed a total of 1,028 unique providers; by the end of the year the number of total signed providers was 7,380. For greater detail on signed providers for all 28 provider types the UIC team tracked, see Appendix C.

Table 15B indicates that IlliniCare listed had signed a total of 2,171 unique providers by July 14, 2011. By the end of Year 1, the number had quadrupled to almost 5,000 providers.

Provider Type	7/14/11	9/21/11	4/30/12
Physicians	1,980	2,345	3,828
Other providers	191	232	947
ALL providers	2,171	2,577	4,775

5. Number of “active” physicians who had signed contracts with the new provider networks

As discussed previously, there were 15,077 distinct physicians who submitted a claim during the baseline period. However, some of these physicians did not necessarily have a consistent and ongoing relationship with the ICP members but instead might have had only “passing” contact with members during emergencies or for one-time health issues. These physicians were probably not as critical for recruitment into the new provider networks as those physicians who had some type of ongoing relationships with ICP members.

Table 16 lists two sub-groups of physicians, those that had an ongoing relationship with at least one ICP member and those physicians who were paid a special monthly fee to provide members with a “medical home.” For the first group, there were 5,236 physicians (about one third of all baseline physicians) who had 3 or more office visits with at least one member during the baseline period. Of these physicians, only about 17% of them had signed a contract with either plan at the 2-month mark. However, at the one-year mark, the number of signed physicians in this group had increased to 42%.

In terms of the second group of physicians who were paid a monthly fee by HFS to provide members with a “medical home”, only about one fifth of them had signed with either plan at 2 months, but the number of signed physicians for this group had increased to almost half by the 1 Year mark.

Measure	# of baseline physicians	Signed with either plan ¹	
		2 Months	1 Year
All physicians “active” with at least one member during baseline ²	5,236	17.4%	42.3%
All physicians paid as PCP to provide medical home during baseline ³	2,085	20.9%	48.6%

¹ Baseline physicians who signed with at least one of the two plans

² Physician saw at least one member 3 or more times in his/her office during baseline period

³ Physicians paid a monthly fee by Medicaid to provide “medical home” for their patients

6. Number of “high volume” hospitals which joined the new provider networks

The UIC team thought it important to track the success of the two plans in signing hospitals that had served ICP members during the baseline period but recognized that some of these hospitals were located downstate or even out of state and had little ongoing connection with ICP eligible members. In fact, more than half of the hospitals in the baseline period had submitted 11 or fewer claims for the entire year. In reviewing the claims data for the baseline period, the UIC team identified 49 hospitals that had submitted 1,000 or more claims during the baseline period.

Since these 49 hospitals accounted for approximately 93% of the total claims submitted by all hospitals during the baseline period, the UIC team thought it made sense to focus on these 49 hospitals for a more detailed analysis. The UIC team further divided these 49 hospitals into two additional subgroups, hospitals that had submitted 5,000 or more claims and those that had submitted 10,000 or more claims during the baseline period.

Table 17A summarizes how many of the "high volume" hospitals joined either of the two plans by the 2 month mark. For example, of the 49 hospitals that submitted 1,000 or more claims during the baseline period, 27 of them had joined one of the plans by the 2-month mark (for a complete listing of all 49 "high volume" hospitals, see Table C-4 in Appendix C). Twenty-four of these hospitals had joined Aetna's network at the 2-month mark and 20 had joined IlliniCare's network.

Table 17A: # of "high volume" hospitals signed by two plans (at 2 Months)						
Measure	# of hospitals	# of baseline claims	Signed Hospitals (at 2 months)			
			Aetna	IlliniCare	Either plan	
Hospital with 10,000 or more baseline claims	6	85,087	2	3	3	
Hospitals with 5,000 or more baseline claims	16	158,009	4	5	6	
Hospitals with 1,000 or more baseline claims	49	232,124	24	20	27	

Table 17B shows what progress had been made by the 1 year mark for these hospitals. For example, of the 16 hospitals with 5,000 or more baseline claims, as previously indicated in Table 17A above, 6 of them had signed to one of the plans by 2 months; by the 1-year mark this figure had doubled to 12 hospitals (Table 17B). For the top group of 6 hospitals with 10,000 or more claims, 3 of them had signed with one of the plans at 2 months; at the one-year mark Table 17B shows that a fourth hospital had signed up, with 2 of them remaining unsigned by either plan.

Table 17B: # of "high volume" hospitals signed by two plans (at 1 Year)				
Measure	# of	# of	Signed Hospitals (at 1	

	hospitals	baseline claims	year)		
			Aetna	IlliniCare	Either plan
Hospital with 10,000 or more baseline claims	6	85,087	3	3	4
Hospitals with 5,000 or more baseline claims	16	158,009	8	10	12
Hospitals with 1,000 or more baseline claims	49	232,124	31	33	38

7. Number of providers that continued to be paid by the plans as out-of-network providers

Both plans, as part of their contract with the state, were required to continue payments to providers who were delivering "an active, ongoing course of treatment" to ICP members for at least 90 days after enrollment (Section 5.16.4). During the summer of 2011, the UIC team heard that one or both plans were considering extending this minimum continuity of care period due to the slow rate of signing providers to formal contracts. The UIC team asked both plans to describe what additional steps they took, if any, to extend the minimum continuity of care time period specified in the contract.

Aetna responded as follows:

"In 2011, Aetna Better Health extended the mandated transition of care period from 90 days after enrollment to the end of calendar year 2011 for all members with effective dates from May 2011 through September 2011. This extension was based on a recommendation of the health plan's Medical Management team with the intent to maintain established patient and practitioner relationships, especially for those Aetna Better Health members with complex medical needs. Authorizations were provided to continue services with providers who were either reluctant or refused to enter into contractual agreements with Aetna Better Health. This also allowed more time for providers to learn about ICP and contract with our network."

IlliniCare gave us the following narrative:

"IlliniCare recognized the need to take action to extend the mandated 90 day Continuity of Care (COC) period for ICP enrollees. Many providers that had previously been serving the ICP population continued to be reluctant to participate in the network. Among these were providers that had a long standing relationship with

enrollees and were involved in complex ongoing care. To better serve IlliniCare's population, the Plan extended the COC period through December 2011. The extended period gave IlliniCare and the provider community more time to solidify relationships. Additionally, after the COC period, IlliniCare continued to support enrollee relationships with non-participating providers that followed IlliniCare's prior approval process."

The UIC team also tried to determine the extent to which both plans continued to pay baseline providers who had not signed a formal contract with the plan. The UIC team requested each plan to provide us with a list of the out-of-network payments they made to providers for Year 1 and linked it to the number of providers each plan signed to formal contracts.

Tables 18A (Aetna) and 18B (IlliniCare) lists the number of signed providers, number of unsigned providers who nevertheless continued to be paid during Year, and a total of the unduplicated number of providers for both of these categories. As can be seen in Table 18A, Aetna paid considerably more physicians as out of network than the number they actually signed to contracts (Appendix C breaks out similar data for the other 27 provider types).

**Table 18A:
Signed and Paid providers for Year 1 (Aetna)**

Provider Type	Signed or Paid Providers		
	Signed Providers ¹	Paid Providers ²	Total Signed and Paid Providers ³
Physicians	4,518	7,079	11,597
Other providers	2,862	294	3,156
ALL providers	7,380	7,373	14,753

¹ Unique number of providers signed to formal contract by end of Year 1

² Unique number of providers who were NOT signed to formal contract by end of Year 1 but were paid as out-of-network provider during Year 1

³ Total number of unique providers either signed or paid during Year 1 (unduplicated count)

Table 18B below lists similar information for IlliniCare for Year 1. Again, similar to Aetna, IlliniCare paid considerably more physicians as out-of-network providers than the number of physicians they had signed to formal contracts.

**Table 18B:
Signed and Paid providers for Year 1 (IlliniCare)**

Provider Type	Signed or Paid Providers		
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	Signed Providers ¹	Paid Providers ²	Total Signed and Paid Providers ³
Physicians	3,828	6,783	10,611
Other providers	947	1,057	2,004
ALL providers	4,775	7,840	12,615

¹ Unique number of providers signed to formal contract by end of Year 1

² Unique number of providers who were NOT signed to formal contract by end of Year 1 but were paid as out-of-network provider during Year 1

³ Total number of unique providers either signed or paid during Year 1 (unduplicated count)

8. Recruitment of other unsigned and unpaid providers who the plans reported as being “available” to members

As the UIC team met with both plans and discussed their progress in developing their provider networks, the plans made us aware of other providers that were available for ICP members but would not be in the count of either signed or paid providers discussed previously. This section attempts to identify, as best as possible, these additional “available” providers that each of the two plans reported to us.

Both plans submitted lists of providers that they said were available to ICP members but would not likely show in either the list of signed or paid non-par providers. IlliniCare explained the circumstances for these additional “available” providers as follows:

“There are certain categories of providers that are not easily measured on an individual count basis. Registered nurses do not contract with the plan as individuals. They are usually part of an entity -- a clinic or a hospital perhaps. Therefore, the plan does not credential or contract with them, or, by extension, track them on an individual basis. Further, the plan does not direct members to certain categories of providers: physical therapists (PT), occupational therapists (OT), speech therapists (ST), or audiologists. Again, these providers do not typically contract with the plan on an individual basis (they do so as part of a group or entity).

The plan does not therefore make referrals to these categories on an individual basis. The plan does make referrals to their groups or entities...So while members certainly have access to these types of providers, UIC do not promote them to the public on an individual basis.

Also, it should be noted that many providers within these categories are not Medicaid certified on an individual basis. Some are Medicaid certified in conjunction with the group that employs them. In order to comply with our state contract, we cannot contract with providers not Medicaid certified and we therefore are prevented from achieving complete coverage relative to the baseline of providers for a particular category."

As part of our earlier process to tabulate the number of signed and out-of-network providers for each plan, the UIC team used a process of "provider verification" where the UIC team attempt to link either the provider's Illinois Medicaid ProviderID or their federal NPI number to a state-wide table of all Illinois Medicaid providers that HFS had given us. For some of the additional providers the plans gave us, the UIC team was able to "verify" them through this process. However, for many of these additional providers, the UIC team was not able to verify them as Illinois Medicaid providers either because a valid Medicaid ProviderID or NPI was not supplied or their provider ID did not match to a provider in the state's provider table. Overall, the two plans together identified 3,463 of these additional providers. For more detail of these providers, see Tables C-7 to C-11 in Appendix C.

D. Summary of Findings

Due to the number and the complexity of the previously discussed factors, describing the baseline provider environment that existed prior to the ICP and presenting data that will permit a meaningful comparison with the two subsequent new provider networks is a challenging task. Having said that, the UIC team feel there are several general summary statements that can be made regarding the development of the new provider networks:

1. 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" to joining a managed care network.
2. 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, 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.

3. 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.
4. 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 apparently was made by the plans in large part due to the slow rate of formal network development that took place during Year 1.
5. 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. This is especially evident for behavioral health services.
6. It is extremely difficult to compare the "capacity" of the new provider networks to the provider capacity that existed before implementation of the ICP. Such a comparison is not merely an "apples to apples" count of providers but rather a calculation that includes many different and complex variables.

Finally, while it is somewhat helpful to look at general provider numbers for the two plans, it is also important to look at the specific types of providers that are included in the network. For more detail on 28 specific provider types that the UIC team tracked, see Appendix C.

III. Payment of Providers

A. Provider concerns

During our focus groups and meetings with other stakeholders, many providers discussed problems they were having with submitting bills to receiving timely payments from the two plans. Some of these issues included changes in billing codes, significant policy change related to NPIs for all individual providers, rejected claims with no reason given, timely feedback regarding submitted claims, inability to get billing questions answered in a timely manner, significant delay in paying approved claims, and inconsistent billing procedures between the two MCOs.

Of particular concern to some of the substance abuse providers was the failure to be paid for the residential portion of services by either the state or the MCOs. In addition, many mental health providers questioned the wisdom of ending the "Value Options" billing system for the rest of the Medicaid population

at the same time that a new billing system was imposed on them for the ICP population.

B. Response from the plans about complaints

In our discussions with the two plans, the UIC team shared the feedback the UIC team had received from providers about billing and payment problems. Listed below is the response of the two plans to these complaints.

1. Aetna

Billing Submission Changes:

"The biggest challenge for provider payments has been related to the configuration of our system to collect individual provider information from the Community Mental Health Centers (CMHCs)...Aetna Better Health's initial billing submission required the CMHC to include the billing entity and the rendering provider (an individual provider) for the claim to be processed accurately.

In many cases the rendering provider was an individual without a Medicaid ID number and this created major challenges as the rendering provider information would not be accepted without the Medicaid ID number. Realizing the challenges caused by this billing policy, we changed to a group-to-group billing methodology in May of 2012. Group-to-group billing allows the rendering provider to be the CMHC, which is the standard billing approach that the CMHCs used with HFS. We believe this change has addressed the CMHC billing issues."

CPT Codes and Modifiers:

"The second biggest issue has been resolving CPT code and service modifier issues that are different for our claim system but were acceptable in the state's claim submission process. This especially affected DME, dialysis and behavioral health providers and has been addressed."

2. IlliniCare

"IlliniCare did not identify payment problems with a considerable number of providers. IlliniCare has consistently met its payment turnaround standards with no significant exceptions. This statement is supported by data. IlliniCare believes it is important for UIC to understand why claims are rejected up front (this is based on the definition of a clean claim). Usually these rejections are because of

incorrect billing information, such as, a missing NDC or RIN, etc. These issues are not the plan's fault and outside of the MCO's control which is why claims that fall into this category are not counted towards timeliness."

C. Contractual requirements

Section 5.25 of the contracts between the state and the two plans, "Timely Payments to Providers", stipulates that the plans "must pay 90 percent (90%) of all Clean Claims from Providers for Covered Services within thirty (30) days following receipt. Contractor must pay 99 percent (99%) of all Clean Claims from Providers for Covered Services within ninety (90) days following receipt."

D. Findings and Discussion

Table 19 summarizes the claims that were resolved and paid during the first year of the ICP. A little over 900,000 claims were submitted and cleared for payment, of which almost 60% were submitted electronically. Half of the claims for the two plans were paid to out of network providers.

**Table 19:
Billing Outcomes**

Outcome Measure	Aetna	IlliniCare
Total claims adjudicated	508,194	403,804
Paper vs. Electronic		
- Electronic	307,581 (61%)	225,303 (55.8%)
- Paper Claims	200,613 (39%)	178,501 (44.2%)
In-network vs. Out-of-network		
- In network	265,684 (52%)	186,307 (46.1%)
- Out of network	242,510 (48%)	217,497 (53.96%)
Total # of Claims Processed within 30 days	459,716 (90%)	399,849 (99.0%)
Total # of Claims Processed within 90 days	501,193 (99%)	400,153 (99.1%)

Both plans met their contractual obligations to pay 90% of all "clean" claims within 30 days of receiving them and 99% of clean claims within 90 days. These rates seem to compare very favorably with publicly quoted time delays of 150 to 160 days for the typical bill in the fee for service Medicaid program.

Despite the positive results regarding payment times for Year 1, there are several cautions that must be mentioned. First, it should be noted that this data is self-reported by the two plans, as official claims for Year 1 were not yet available. Second, the payment times listed in Table 19 are for clean claims,

meaning the rates measure the time it takes the MCO to pay the claim after it receives the claim. However, many providers initially complained about the challenge and time it took to produce a “clean” claim and have the submitted bill successfully move through the billing clearinghouse to the plan.

The UIC team asked each plan for data on how long it takes the typical claim submission to make its way through the clearinghouse and convert into a “clean” claim. IlliniCare reported that there were 225,303 claims processed through their clearinghouse for Year 1. Of these, 92% were converted to a clean claim without being rejected and that the average time to process an original request into a clean claim was 2 days. The top 5 reasons for rejection of claims were: member not eligible on the data of service, invalid member, incorrect date of birth, and invalid procedure code.

Aetna reported that the rejection rate of claims for their clearinghouse averaged 2.7% for Year 1.

IV. Enrollment

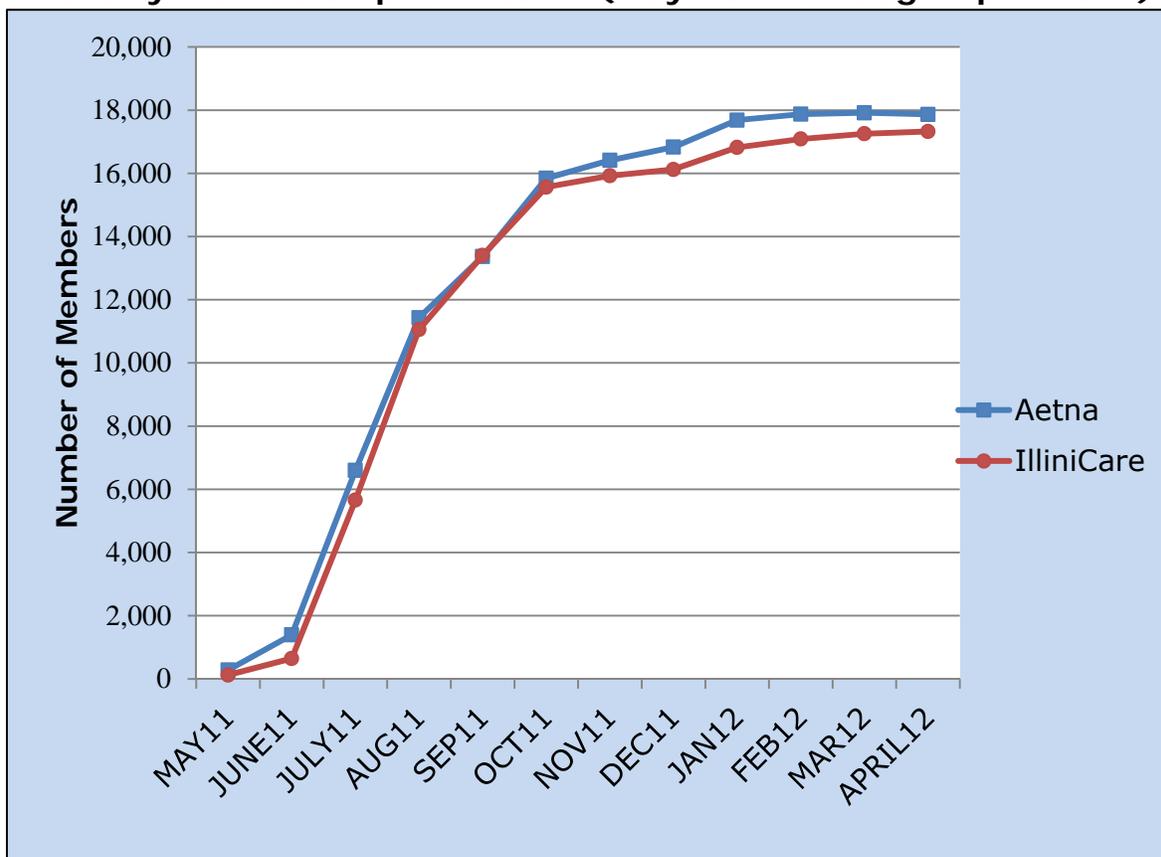
A. Tracking Enrollment for Year 1

Both plans started enrolling members in May of 2011. Enrollment was slow for the first two months of the program and, by the end of June 2011, both plans had enrolled less than 2,000 members each (see Figure A). Beginning in July, the start of auto-enrollment, enrollment accelerated and by October both plans had enrolled over 15,000 members. At that point the pace of enrollment began to level off. By the end of Year 1 on 4/30/12, each MCO had over 17,000 current members.

Table 20 provides more detail on the monthly additions and subtractions for each plan over the first year of ICP. The membership trends for each plan are similar throughout the first year, although Aetna has slightly more members at most points during the year. Membership in each plan began to increase rapidly in July 2011, when eligible participants who had not enrolled began to be auto-enrolled. The State continues to make retroactive adjustments to membership as additional data is received, so these figures may change slightly.

Figure A

Monthly Membership for Year 1 (May 2011 through April 2012)



**Table 20:
Month By Month Membership**

Month	Aetna			IlliniCare		
	Begin	Adds	Drops	Begin	Adds	Drops
May 2011	0	281	13	0	124	27
June 2011	268	1125	45	97	549	120
July 2011	1,348	5253	302	526	5134	870
Aug 2011	6,299	5132	510	4790	6265	1221
Sep 2011	10,921	2445	497	9834	3569	1066
Oct 2011	12,869	2976	469	12,337	3228	1196
Nov 2011	15,376	1037	401	14,369	1555	1099
Dec 2011	16,012	820	392	14,825	1298	979
Jan 2012	16,440	1244	319	15,144	1677	823
Feb 2012	17,365	508	342	15,998	1089	783
Mar 2012	17,531	385	406	16,304	950	781
April 2012	17,510	355		16,473	852	

Note: Drops for April 2012 will be included in data for Year 2

B. Decreasing Auto-Enrollment Over Year 1

All eligible members in the ICP geographic area are required to select one of the two plans. For those members who do not make a selection within the specified time period, Section 4.1 of the contracts between the two plans and the state outline a procedure for “auto assignment” to one of the two plans.

In 2000, the Kaiser Family Foundation prepared a report on 10 Medicaid managed care programs across the United States. They found that the average auto enrollment rate across those programs was 37%. Problems associated with high rates of auto-enrollment in those states are listed in Table 21.

**Table 21:
Problems with High Auto-Enrollment**

Auto-enrolled beneficiaries are often do not have adequate information on how their new health plan works¹

Beneficiaries who are auto-enrolled are assigned to low bidding, inadequately financed managed care plans¹

States' auto-enrollment procedures do not account for beneficiaries' recent use of providers, distance of plans from home or limited-English speaking abilities¹

Auto-enrollment is viewed by states as an alternative to client education¹

Auto-enrollment often results in separating family members into different plans, unnecessarily burdening individuals with multiple providers and extended wait times¹

Auto-enrolled Medicaid recipients will continue to use hospital emergency rooms instead of the primary care providers in the health plan to which they have been assigned²

¹ Kaiser Family Foundation, 2000

² National Health Law Program, 2012

Auto-enrollment for ICP began in July 2011. Table 22 shows the rate of auto-enrollment for each month for the last 9 months of Year 1. This data shows a slight, but steady, decrease in the percentage of people auto-enrolled over the course of the first year, which is depicted graphically in Figure B. The “Recommendations” section has several suggestions regarding the need to provide better education and assistance to members about enrollment.

Figure B:
Rates of Auto-Enrollment for Year 1 (August 2011 through April 2012)

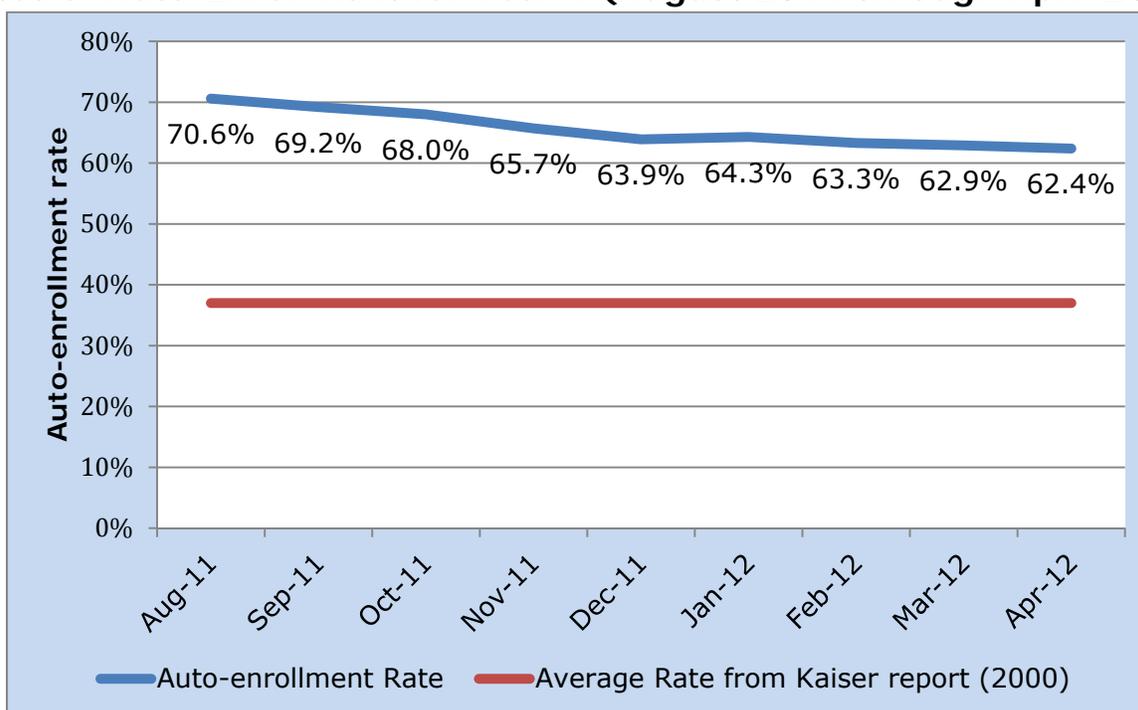


Table 22:
Auto-Enrollment and Member Choice Over Year 1

Month	Auto assigned	Self choice
August 2011	70.6%	29.4%
September 2011	69.2%	30.8%
October 2011	68.0%	32.0%
November 2011	65.7%	34.3%
December 2011	63.9%	36.1%
January 2012	64.3%	35.7%
February 2012	63.3%	36.7%
March 2012	62.9%	37.1%
April 2012	62.4%	37.6%

C. Enrollment Measures

Overall, Aetna had 21,301 total unique members at some point during the year, while IlliniCare had 20,954 (see Table 23 below). Aetna also had slightly more member months over the first year (154,244 to 148,706 for IlliniCare). On average, each member was enrolled with a plan for just over seven months.

**Table 23:
Enrollment Outcome Measures**

Measure	Aetna	IlliniCare
Year End Enrollees (4/30/2012)	17,865	17,338
Total Distinct enrollees during Year 1	21,301	20,954
Total Member Months (12 months)	154,244	148,706
Average Member Months per enrollees	7.2	7.0

Table 24 below lists further detail on length of enrollment of members in each plan. While the figures contained in Table 24 are not particularly relevant for Year 1 (program startup), these will be important measures to track during Year 2, the first full year of operation. Because of the slow initial enrollment, each plan had less than 1% of its members enrolled for the full first year.

Most members (almost three out of four for each plan) were enrolled for six months or more (in total, not continuous) while just over a quarter were enrolled for less than six months. Since this was a start-up year, it is not surprising to find the type of distribution in Table 24. However, in Year 2, the UIC team will review enrollment data to see if whether the membership stabilizes for the year. In addition, the UIC team will be analyzing data regarding the reasons that a member changes from one plan to the other plan.

**Table 24:
Outcome Measures Regarding Enrollment Time**

Measure	Aetna		IlliniCare	
	#	%	#	%
Members enrolled for 12 months	201	0.9%	96	0.5%
Members enrolled for 9 months or more	9,610	45.1%	9,245	44.1%
Members enrolled for 6 months or more	15,665	73.5%	15,113	72.1%
Members enrolled for less than 6 months	5,636	26.5%	5,841	27.9%

V. Risk Stratification of Members

A. Overview of Risk Stratification Process

Following enrollment, all ICP participants go through a process known as risk stratification. The purpose of this process is to identify members who are at risk of adverse health events and need more staff resources and attention from the plan. Table 25 below gives a brief overview of the process that HFS uses for the typical Medicaid member compared to the process used by the two plans for ICP members.

**Table 25:
Overview of Risk Stratification Process**

Item	FFS Medicaid	ICP-Aetna	ICP-IlliniCare
Brief summary of Risk stratification process	The FFS Medicaid program does not typically conduct a formal risk stratification process for its members.	Aetna uses its own software to analyze claim and other related data to assign risk scores and an overall risk score.	IlliniCare uses its own software to analyze claim and other related data to assign risk scores and an overall risk score.
Is an overall risk level assigned?	No	Yes	Yes
Is development of care plan contingent on risk level?	No	Yes	Yes
Are care manager caseloads contingent on risk level?	No	Yes	Yes
Is payment for member contingent on risk level?	No	No	No

It should be noted that although the FFS Medicaid program does not typically conduct a formal risk stratification process for its members upon enrollment, at one time, the high-risk members that were placed in the YHP care coordination program (about 10% of the total Medicaid population), did receive a formal risk stratification¹. For the YHP members who were classified as “ABD” and not living in long term settings, approximately 4% of them were classified as high risk, 35% of them were classified as medium risk, and the remaining 61% classified as low risk. As of June 30, 2012, Illinois stopped operation of the YHP.

Both plans use their own specialized software to analyze claim and other related data to assign an overall risk score to the member. In addition, contingent on the risk level, each plan is required to develop a care plan and assign them to a case manager whose maximum caseload is dictated by the risk level of members.

¹ Personal correspondence from Dr. Fredric D. Leary, Senior Medical Director, McKesson Health Solutions

B. Overview of Risk Groups

Each plan uses its own software and methodology to calculate risk scores and place an individual into one of three levels of risk: Low, Medium, and High Risk. Tables 26A, 26B and 26C provide an overview of the characteristics of each risk level. The differences are that higher levels of risk receive more interventions, required the development of individual care plans and are monitored by case coordinators with smaller caseloads.

**Table 26A:
Overview of Low Risk Groups**

Item	Aetna	IlliniCare
General Interventions	Prevention and wellness messaging and specific education materials	Outreach and intervention
Enrollee Care Plan	None required	None required
Care Coordinator Caseloads	None specified	1:150 for SMI; 1:200 for DD; 1:300 for Physical or Chronic Disability/Condition

**Table 26B:
Overview of Moderate Risk Groups**

Item	Aetna	IlliniCare
General Interventions	Problem-solving interventions.	Outreach and intervention
Enrollee Care Plan	Within 120 days of being identified as medium risk member	Within 90 days of being identified as medium risk member
Care Coordinator Caseloads	1:250 for all medium risk members	1:100 for SMI; 1:150 for DD; 1:150 for Physical or Chronic Disability/Condition

**Table 26C:
Overview of High Risk Groups**

Item	Aetna	IlliniCare
General Interventions	Intensive Care Management	Outreach and intervention
Enrollee Care Plan	Within 45 days of being identified as high risk member	Within 90 days of being identified as high risk member
Care Coordinator Caseloads	1:50 for all high-risk members	1:45 for SMI; 1:60 for DD; 1:60 for Physical or Chronic Disability/Condition

C. Initial and Year End Risk Levels

Because each plan uses its own risk methodology, risk levels or summary of risk levels for one plan are not directly comparable to those of the other plan (in the “Recommendations” section, the UIC team present some suggestions that could reduce this shortcoming). In recognition of this, the reader should note that the figures in Table 27 below are not directly comparable in terms of determining which plan had more “high” risk members and the presence of more “high” risk members does not indicate that a plan is more responsive to or has better services for members with a higher level of needs. However, the data presented in Table 27 does provide some useful general information.

Table 27 describes the initial risk levels that enrollees were assigned by each plan shortly after enrollment. It shows that 2.2% of Aetna’s enrollees were initially classified as “high risk,” compared to 17.6% of IlliniCare’s enrollees. Again, this does not necessarily mean that IlliniCare has riskier or more needy enrollees, only that the risk process that the two plans used placed a different proportion of their members in the “high” risk level.

**Table 27:
Summary of Initial Risk Levels**

Initial Risk Level	Aetna		IlliniCare	
	#	%	#	%
High	466	2.2%	3,035	17.6%
Medium	1,063	5.0%	2,455	14.2%
Low	19,890	92.8%	11,753	68.2%
Unknown/Missing	14	0.1%	0	0.0%
Total	21,433	100.0%	17,243	100.0%

¹Data Source: MCO Datasets

Note: because each plan uses their own risk methodology, these numbers are not directly comparable, and should not be used as an indication of the responsiveness to and services offered to members in higher risk levels.

After a member’s initial first risk level is assigned, risk scores may be recalculated, most often due to “triggering” events such as ED visits or hospital admissions. Table 28 shows the risk scores for those members who were enrolled with each plan at the end of Year 1 (April 30, 2012). The percentage of people in each risk level became more similar for the plans at the one-year mark, although IlliniCare still classified twice as many members (13.3% versus 5.9%) as “high risk” than Aetna did at the end of Year 1.

**Table 28:
Summary of Year End Risk Levels**

Year End Risk Level	Aetna		IlliniCare	
	#	%	#	%
High	1,068	5.9%	2,132	13.3%
Medium	1,887	10.5%	1,497	9.3%
Low	15,071	83.6%	12,422	77.4%
Total	18,026	100.0%	16,051	100.0%

Data Source: MCO Summary Reports (4/30/2012)

Note: because each plan uses their own risk methodology, these numbers are not directly comparable, and should not be used as an indication of the responsiveness to and services offered to members in higher risk levels.

D. Timelines

The formal contracts between the state and the two plans specify the time period after enrollment in which the plan must assign their initial risk level to a member. Initially, the state set different time requirements for each plan (see Tables 29A and 29B below) but has amended the contracts for both plans to reflect consistent criteria for both plans. It should be noted that Aetna was not able to provide information on the number of both High risk and Moderate risk people for whom care plans were developed within the specified timeframes (45 and 120 day, respectively).

**Table 29A:
Assignment of Initial Risk Level**

Outcome Measure	Aetna		IlliniCare	
	Criteria	%	Criteria	%
Completion of Health Risk Questionnaire (HRQ)	N/A ¹	41.4%	Within 90 days of enrollment	38.2%
Assignment of Initial Risk Level	N/A ¹	99.9%	Within 90 days of enrollment	99.4% ²

Data Source: MCO Datasets

¹ Aetna has no time requirement specified in their contract for completing the HRQ-- rate calculated for "within 90 days of enrollment" was calculated for comparison purposes only.

**Table 29B:
Development of Member Care Plans**

Outcome Measure	Aetna		IlliniCare	
	Criteria	%	Criteria	%
Development of care plan for "HIGH" risk members	Within 45 days of being identified as HIGH risk member		Within 90 days of being identified as HIGH risk member	25.8% ³
Development of care plan for "MODERATE" risk members	Within 120 days of being identified as MODERATE risk member		Within 90 days of being identified as MODERATE risk member	64.7% ⁴

Data Source: MCO Datasets

Aetna was unable to supply data for the time to develop care plans for high and moderate risk members

VI. Prior Approval/Authorization of Services

A. Overview of Prior Approval Process

Both MCOs and the traditional fee for service Medicaid require prior approval/authorization for some services. Each has its own process for requesting this authorization, and these processes are summarized in Table 30. Requests for authorization must be submitted by a provider, and while the traditional Medicaid program had to make a decision within 30 days, the MCOs have to make a decision within 10 days. For each plan, decisions on expedited requests must be made within three days.

Currently, HFS does not collect data on requests for prior approvals for traditional Medicaid participants. The MCOs track data on approvals, denials, regular vs. expedited, and timelines for making a decision on a request. Availability of this type of data for ICP members represents "value added" feature that has been added by the new ICP program as compared to the traditional fee for service Medicaid program.

**Table 30:
Prior Approval Process**

Item	FFS Medicaid	ICP-Aetna	ICP-IlliniCare
How to Submit Request	Mail-Yes; Fax-Yes; Phone-Yes; Online-Yes	Mail-No; Fax-Yes; Phone-Yes; Online-Yes	Mail-No; Fax-Yes; Phone-Yes; Online-Yes
Timelines	Decisions must be made within 30 days of receipt of a properly completed request. If decision is not made within the 30 days, it is automatically approved. Some Items (braces, wheelchairs, hospital beds, medical supplies less than \$100) require decision within 21 days)	Requests for authorizations shall be reviewed and decided within ten (10) days after receiving the request for authorization from a Provider, with a possible extension of up to ten (10) additional days. Expedited requests will be decided within 3 days.	Requests for authorizations shall be reviewed and decided within fourteen (14) days after receiving the request for authorization from a Provider, with a possible extension of up to ten (10) additional days. Expedited requests will be decided within 3 days.
How to expedite request	Expedited approval may be requested by the Provider by calling 1-877-782-5565	Unknown	Unknown
Availability of Information regarding requirements for specific services	Unknown	Requirements for prior authorization for specific services was not publicly available on plan's website -- registered provider must log into a secure web portal to determine if prior authorization is required for specific service.	Plan posted a "lookup" feature that permitted provider to key in procedure code that would display prior authorization procedures for specific service. In addition, a summary listing of services and prior authorization requirements as posted on the plan's website.

Tables D-1 and D-2 in Appendix D are Aetna's precertification list and IlliniCare's Covered Benefits, respectively. They explain when prior approval is needed and what services that process covers. In numerous meetings with both plans regarding prior authorization requests, it became clear that both plans had very different policies for provider requests that made comparison of the two plans difficult.

B. Non-expedited vs. Expedited Requests

Combined, both plans reported receiving over 29,000 prior authorization requests for non-pharmacy services (pharmacy requests are reported separately below). These included both “regular” requests for services that should be approved or denied in 10 days and “expedited” requests that a provider or member may submit. According to section 5.16.6 of the contracts with the plans,

“If the Physician indicates, or Contractor determines, that following the ordinary review and decision time frame could seriously jeopardize the Enrollee’s life or health, Contractor shall authorize or deny the Covered Service no later than seventy-two (72) hours after receipt of the request for authorization.”

During meetings with both plans, it became clear that the criteria for “expedited” requests differ between the two plans. Aetna did not report any “expedited” non-pharmacy requests for Year 1, although they do track “urgent” requests, which they explained were not the same as expedited requests. IlliniCare reported that about 8% of their requests were “expedited” requests (see Table 31). The UIC research team has made a suggestion in the “Recommendations” section of this report to clarify with each plan as to how they define and classify “expedited” requests.

Plan	Regular Requests		Expedited Requests		Total Requests	
	#	%	#	%	#	%
Aetna	14,185	100.0%	0	0.0%	14,185	100.0%
IlliniCare	13,956	92.3%	1,158	7.7%	15,114	100.0%
Total	28,141	96.0%	1,158	4.0%	29,299	100.0%

C. Non-expedited Requests

1. Types of requests

The research team asked each plan to report the number of prior requests they had received by the type of request. Both plans did so, with Aetna defining 61 categories and IlliniCare using 31 categories to classify their requests. The UIC team worked with both plans to construct a crosswalk table that ultimately used 14 categories. Each plan submitted feedback on

fitting their categories into the ones used in the research team. The number of requests by type is shown in Table 32 for non-expedited requests.

Table 32:
Types of Regular Prior Approval Requests 1

Request Type	Both Plans		Aetna		IlliniCare	
	#	%	#	%	#	%
Inpatient	9,802	34.8%	4,554	32.1%	5,248	37.6%
DME	3,651	13.0%	2,381	16.8%	1,270	9.1%
Outpatient	2,932	10.4%	1,107	7.8%	1,825	13.1%
Medical tests/scans	1,621	5.8%	1,617	11.4%	4	0.0%
Homecare/Hosp/LTC	1,580	5.6%	989	7.0%	591	4.2%
Community Services	1,173	4.2%	-	0.0%	1,173	8.4%
Therapy	997	3.5%	619	4.4%	378	2.7%
Vis/Hearing/ Speech	436	1.5%	431	3.0%	5	0.0%
Osteo/Ortho/ Prosth	124	0.4%	61	0.4%	63	0.5%
Transportation	95	0.3%	91	0.6%	4	0.0%
Transplant	79	0.3%	67	0.5%	12	0.1%
Cardiac	48	0.2%	40	0.3%	8	0.1%
Psych Services	5	0.0%	0	0.0%	5	0.0%
Other	5,598	19.9%	2,228	15.7%	3,370	24.1%
Total	28,141	100.0%	14,185	100.0%	13,956	100.0%

¹ Does not include pharmacy

2. Outcomes for non-expedited requests (non-pharmacy)

Each plan reported the approval and denial rates for these requests (see Table 33). Each plan reported that they approved more than 99% of the submitted requests.

Table 33:
Outcomes for Regular Prior Requests

Outcome	Aetna		IlliniCare	
	#	%	#	%
Approved	14,044	99.0%	13,838	99.2%
Denied	141	1.0%	118	0.8%
Total	14,185	100.0%	13,956	100.0%

3. Regular Timeline Compliance

Each plan's contract with the state requires the plan to make a decision on each non-expedited request within 10 days (Aetna) or 14 days (IlliniCare). Table 34 reports the compliance rate for each of the plans. For non-

expedited requests, Aetna averaged 3.3 days to make a decision, while IlliniCare responses averaged 4.8 days. In terms of their contractual requirements, Aetna responded to requests within 10 days 95.8% of the time while IlliniCare met their requirement of 14 days 96% of the time.

Table 34:
Prior Approval-Timeline Compliance

Measure	Aetna	IlliniCare
Mean number of days to decision	2.7	4.8
% of regular requests answered within 10 days	96.6%	N/A
% of regular requests answered within 14 days	N/A	96.0%

D. Expedited Requests (non pharmacy)

1. Types of requests

Expedited requests were categorized in the same way that regular requests were. Table 35 lists expedited requests by type for IlliniCare. Aetna reported that they did not have any expedited requests for Year 1.

Table 35:
Types of Expedited Prior Approval Requests 1

Request Type	Both Plans		Aetna		IlliniCare	
	#	%	#	%	#	%
Outpatient	333	27.8%	0	0.0%	333	27.8%
Inpatient	332	27.7%	0	0.0%	332	27.7%
DME	75	6.3%	0	0.0%	75	6.3%
Homecare/Hosp/LTC	56	4.7%	0	0.0%	56	4.7%
Therapy	14	1.2%	0	0.0%	14	1.2%
Community Services	5	0.4%	0	0.0%	5	0.4%
Osteo/Ortho/Prosth	2	0.2%	0	0.0%	2	0.2%
Transplant	1	0.1%	0	0.0%	1	0.1%
Medical Scans/Tests	-	0.0%	0	0.0%	-	0.0%
Cardiac	-	0.0%	0	0.0%	-	0.0%
Psych Services	-	0.0%	0	0.0%	-	0.0%
Other	380	31.7%	0	0.0%	380	31.7%
Total	1,198	100.0%	0	0.0%	1,198	100.0%

¹ Does not include pharmacy

2. Expedited Outcomes

Table 36 contains data on outcomes for expedited prior approval requests for IlliniCare. Approximately 1.1% of requests were denied.

Outcome	Aetna		IlliniCare	
	#	%	#	%
Approved	0	0.0%	1,185	98.9%
Denied	0	0.0%	13	1.1%
Total	0	0.0%	1,198	100.0%

Aetna did not report any expedited requests

3. Expedited Timeline Compliance

Each plan's contract with the state requires them to make a decision on expedited prior approval requests within 3 days. Aetna did not report any expedited requests, so Table 37 contains data for IlliniCare, only.

Expedited Requests	Aetna	IlliniCare
Mean number of days to decision for expedited requests	N/A	1.7
Percent of expedited requests decided within 3 days	N/A	91.0%

Aetna did not report any expedited requests

E. Pharmacy Prior Approval Requests

Requests for prior approval for pharmacy related services are tracked separately from other services. Aetna reported 6,424 regular pharmacy requests and 1,468 expedited pharmacy prior approval requests. IlliniCare reported 8,164 regular pharmacy requests and 1,222 expedited pharmacy prior approval requests. The results of the outcomes are included in Tables 38 and 39, respectively.

Outcome	Aetna		IlliniCare	
	#	%	#	%
Approved	4,124	82.3%	4,112	57.6%
Denied	753	15.0%	1,949	27.3%
Void	1,412	0.0%		
Withdrew	133	2.7%		
Appeal	2	0.0%	88	1.2%
Invalid			1,027	
Other			988	13.8%
Total	6,424	100.0%	8,164	100.0%

Outcome	Aetna		IlliniCare	
	#	%	#	%
Approved	973	80.8%	678	63.7%
Denied	226	18.8%	199	18.7%
Void	264	0.0%		
Withdrew	5	0.4%		
Appeal			11	1.0%
Invalid			157	0%
Other			177	16.6%
Total	1,468	100.0%	1,222	100.0%

VII. Emergency Department Events

Across the states, the volume of service provided by hospital emergency departments (EDs) has been increasing rapidly (Florida Center for Health Information & Policy Analysis, 2010). Analysis of a national sample of EDs found that adults with Medicaid accounted for the most of the increase (Tang et al., 2010). Since persons who have no or limited access to regular health care providers or continuity in their care typically use ED as their primary health care provider, the UIC team felt it important to review of use of emergency departments by members of both plans for Year 1.

A. Rate of Emergency Department (ED) Utilization

National data of ED utilization indicated that adult Medicaid enrollees made 17.7 million ED visits, a rate of 947 visits per 1,000 population, in 2007 (Tang et al., 2010). The rate was twice as high as that of uninsured population (422 visits

per 1,000 population) and five-times higher than that of privately insured patients (188.7 visit per 1,000 population).

Summarized in Table 40 is the rate of ED visits by ICP enrollees before and after the implementation of the ICP. During the nine-month baseline period (07/01/10 – 03/31/11) prior to the start of the program, the ICP members made a total of 42,815 ED visits. During the 12-month period after program implementation (05/01/ - 04/30/12), the members made 33,823 ED visits (i.e., 15,299 by members who signed up with Aetna, and 18,524 by those who signed with IlliniCare).

The first row shows the rate of ED visit “per 1,000 members per month” which accounts for the difference in the reference period for baseline and Year 1, and for the number of members enrolled in each month across the two reference periods and the two MCOs. The second row shows the annual rate of ED visits further adjusted for each “full time member equivalent” for Year 1. The rate has decreased 6.9% from 1.43 per full time member per year during the baseline period to that of 1.34 in Year 1.

	Baseline (n = 42,815)	Year 1 ^a (n = 33,823)	Year 1 by MCOs	
			Aetna (n = 15,299)	IlliniCare (n = 18,524)
per 1,000 member month	118.9 ^b	111.9	99.1 ^c	124.7 ^d
per “full time member equivalent”	1.43 ^e	1.34	1.19 ^f	1.49 ^g

^a Mean of rates from Aetna and Illini combined

^b 359,945 total member months was used for baseline

^c 154,244 total member months was used for Aetna

^d 148,706 total member months was used for IlliniCare

^e 29,995 full time member equivalents (FTME) was used for baseline

^f 12,854 full time member equivalents (FTME) was used for Aetna

^g 12,392 full time member equivalents (FTME) was used for IlliniCare

Data source: Medicaid encounter/claims data (baseline), MCO self-reported data (Year 1)

B. Frequent Emergency Department Users

Frequent ED users, typically referred as “frequent flyers,” are those who use ED services on a frequent basis. The definition of “frequent use” varies widely in the literature the UIC team reviewed from “2 visits per year” to “10 visits in two years.” However, commonly used definitions fall in the range of three to six visit per year (LaCalle & Rabin, 2010). For the purpose of this evaluation, the

UIC team defined “frequent users” as 5 times for the 9 month baseline period and 6 times during the 12 months of Year 1.

Table 41 summarizes the proportion of frequent ED users before (i.e., baseline) and after (i.e., Year 1) the implementation of the ICP. During the baseline period, 14,840 ICP members visited ED at least once. Of these baseline members, 15.3% were “high frequency” users, while 9.3% of them were “high frequency” users during Year 1 (both plans combined). As a result, the proportion of high frequency users of ED services for Year 1 was 39% lower than that of baseline. The difference was statistically significant using a Chi-square test, $\chi^2(1, N = 27,484) = 223, p = .000$.

Table 41:
Emergency Department Visits By Frequency of Use

	Baseline ^a	Year 1 ^{b,c}	Year 1 by MCOs ^{b,c}	
	(n = 14,840)	(n = 12,644)	Aetna (n = 6,299)	IlliniCare (n = 6,345)
High frequency User	15.3	9.3	7.3 ^b	11.3 ^b
Low frequency User	84.7	90.7	92.7	88.7

^a High frequency user was defined as 5 or more visits for the 9 month baseline period.

^b Based on Aetna/IlliniCare combined data

^c High frequency user was defined as 6 or more visits for the 12 month period of Year 1.

Data source: Medicaid encounter/claims data (baseline), MCO self-reported data (Year 1)

C. Emergency Department Use That Resulted in Inpatient Admission to Hospital

Hospital-based care accounts for approximately 30% of total national health expenditures and 50% of hospital admissions originate from the ED. Thus, it is estimated that inpatient admissions to hospitals from ED visits accounted for 15% of total health care expenses (Smulowitz et al., 2012).

The rate of ED visits by ICP members who converted to hospital inpatient admission between baseline and Year 1 is summarized in Table 42. Of 42,815 ED visits during baseline, 8,707 visits, or 20.3%, resulted in same day hospital admissions. The admission rate for both plans combined for Year 1 was 17.3%, which represents a significant 15% reduction from baseline, $\chi^2(1, N = 76,638) = 116, p = .000$.

	Baseline (n = 42,815)	Year 1 ^a (n = 33,823)	Year 1 by MCOs	
			Aetna (n = 15,299)	IlliniCare (n = 18,524)
Converted to Hospital Admission	20.3	17.3	15.7	18.6
Not Converted to Hospital Admission	79.7	82.7	84.3	81.4

^a Based on Aetna/IlliniCare combined data

Data source: Medicaid encounter/claims data (baseline), MCO self-reported data (Year 1)

VIII. Hospital Admissions

U.S. health care spending reached \$2.7 trillion in 2011, or \$8,680 per person. Hospital based care represents 31% of the national spending, or \$850 billion (Centers for Medicaid and Medicaid Services, 2012). Policy makers are looking into cost-containment mechanisms to control hospital admission through various means including preventing avoidable inpatient admissions, reducing length of hospital stay, and reducing quick readmission to hospital after discharge.

A. Inpatient Hospital Admission Rate

Table 43 summarizes the inpatient hospital admission rate among ICP enrollees from baseline to Year 1. The number of hospital admissions decreased from 16,684 for the nine-month baseline period to 11,653 for the twelve-month period in Year 1. However, some of this decrease could be due to the gradual start up of the ICP program so the hospital admission rate is adjusted to “full time member equivalent” for each period, to accommodate for the difference in time periods and members enrolled during the two time periods. These adjusted rates are shown in Table 43. The rate for Year 1, 0.46 admissions for full time member equivalent per year, was 18% lower than that for Baseline (i.e., 0.56 admission for full time member equivalent).

**Table 43:
Hospital Admission Rates**

	Baseline ^a (n= 16,684)	Year 1 ^b (n= 11,653)	Year 1 by MCOs	
			Aetna (n= 6,121)	IlliniCare (n= 5,532)
per 1,000 member month	46.4 ^c	38.45	39.7 ^d	37.19 ^e
per full member per year	0.56	0.46	0.48	0.45

Data source: Medicaid encounter/claims data (baseline), MCO self-reported data (Year 1)

^a Excludes 32 admissions without hospital admission

^b Aetna/Illini combined data

^c 359,945 member months was used for baseline

^d 154,244 member months was used for Aetna

^e 148,706 member months was used for IlliniCare

B. Hospital Admission Length of Stay

Hospital length of stay is a common measure of the duration of a single episode of hospitalization. Due to the high cost of inpatient hospital admissions, reduction of the average length of hospital stay is considered a major way to contain health care costs (Taheri et al., 2000).

Table 44 summarizes the length of hospital stays of ICP enrollees in baseline and in Year 1. For the 16,684 admissions that occurred during the baseline period, the average length of stay per hospital admission was 6.41 days. The average length of stay during Year 1 was 6.04 days per admission, which was significantly shorter than at baseline ($p < .05$). The average number of days per “full time member equivalent” shown in the second row, for Year 1 was 2.7 days, which is 25% shorter than that for baseline (i.e., 3.6 days)

**Table 44:
Length of Hospital Stays**

Length of Stay ^{a,b}	Baseline ^b (n= 16,684)	Year 1 ^b (n= 11,653)	Year 1 by MCOs	
			Aetna (n= 6,121)	IlliniCare (n= 5,532)
Mean days per admission(S.E.)	6.41 (.07)	6.04 (.08)	5.63 (.08)	6.06 (0.1)
Mean days per “full time member equivalent”	3.6	2.7	2.7	2.7

^a Same day discharges (i.e., no overnight stay at hospital) are treated as one night stay.

^b Exclude admissions without hospital admission #, admission date and/or discharge date.

Data source: Medicaid encounter/claims data (baseline), MCO self-reported data (Year 1)

IX. Transportation Services

Transportation is a critical service that allows many persons receiving Medicaid to successfully attend medical appointments. Transportation is provided door-to-door and is especially important for persons with disabilities and older adults who face additional challenges using public transportation. The cost of public transportation and having access to a private vehicle can also prevent people from being able to get to medical appointments.

Transportation services are complex in that they involve considerable coordination of the individual member, a transportation provider and the medical provider across a large geographic network. In addition, most trips involve taking more than one person in a vehicle and thus making multiple stops. Efficiency within this system is critical in order to get people to appointments on time and to keep costs low.

Transportation was a major concern voiced at public stakeholder meetings. In addition, for at least one of the plans, almost two thirds of the official complaints recorded for Year 1 were related to transportation services. This section seeks to describe the changes in the transportation service provided to members and highlight some initial trends observed in the first year of the ICP program.

A. Transportation Procedures

Both plans have made some substantial changes to how transportation services are delivered to members. The two plans are similar, in terms of having a general contractor administer the program and coordinate individual transportation providers. FFS Medicaid has a general contractor specifically for prior-approval but doesn't coordinate individual transportation providers.

Requesting a ride under the ICP appears to be a more streamlined process than for members of the FFS fee for service program because the MCOs have a one-step process for approving and scheduling a ride and have eliminated the step of contacting individual transportation providers. The current fee for service system does not specify the number of days required for advance notice in order to provide a ride and it accepts many post-approvals for transportation. Aetna requires three calendar days to approve and schedule transportation, while IlliniCare requires two days. Table 45 compares some procedures for the transportation services. For more details on the processes of the three systems, see Table E-1 in Appendix E.

**Table 45:
Comparison of FFS Medicaid and ICP Procedures**

Item	FFS Medicaid	ICP - Aetna	ICP - IlliniCare
General structure of provider and administrator	Administrator (First Transit) manages the prior approval but does not manage transportation providers	Ride Right LLC, manages the transportation benefit and coordinates the transport by individual transportation companies	First Transit manages the transportation services and coordinates the transport by individual transportation companies
How to request ride	<ol style="list-style-type: none"> 1. Call or by internet 2. Obtain approval 3. Receive list of 3 transportation providers 4. Schedule a ride with a specific provider 	Single phone call to transportation contractor who schedules the ride	Single phone call to transportation contractor who schedules the ride
Prior Approval Needed	Yes	Yes	Yes
Post Approval Allowed	Yes within 20 work days of date of transport and in special cases 90 days	No	This is a limited benefit on an individual consideration basis only.
Advance Notice needed	Advanced notice encouraged, but accept prior and post approval	3 calendar days	2 days

B. Requesting transportation

The research team was able to obtain data from FFS Medicaid and both plans for their transportation call centers for the baseline period and the first year of ICP. Table 46 includes a summary of calls that were received by the call centers and details of the trips that were scheduled such as number of rides scheduled, cancellations, denials, and the number of complaints. For more detailed information regarding call center data, see Table E-2 in Appendix E.

There are certain limitations to the data gathered from the three call centers that should be noted:

- The FFS data is for May 2010-April 2011 and covers the entire state of Illinois, while data for the MCOs covers the first year of ICP (May 2011-April 2012) and the six-county ICP pilot area. The difference in coverage area may result in some measures that are not directly comparable,

although looking at the percentages in each table does give an indication of how the MCOs are doing in relation to each other and in relation to the previous Medicaid system.

- Most members were not enrolled with ICP for the entire first year, whereas it is likely that members reported for the FFS Medicaid program were members for a larger percentage of the year. The 'Average speed to answer' variable does not include time spent on hold and does not indicate the total amount of time and members spent on the line.
- The data for this section is self-reported data by HFS and the two plans and not based on official claims data.

Despite the above limitations, there are several initial trends worth noting when comparing data for Year 1 of the ICP to that of the FFS Medicaid program:

- The percentage of rides denied for both plans under the ICP is considerably lower than the rate for the FFS Medicaid program.
- Neither of the plans accepted post-approvals of rides except for special situations and both reported none for Year 1. HFS reported that 40% of their rides had post-approvals.
- The percentage of rides completed is higher for both of the two plans compared to the rate for the FFS program.
- IlliniCare scheduled a larger percentage of rides within 48 hours than Aetna did (53.5% to 11.8%). It should be noted that Aetna requires an extra day of notice for rides. HFS was not able to report a comparable rate for the FFS program.
- IlliniCare's call center was the quickest to answer the phone when a member called (12 seconds) and Aetna's took 25 seconds, while FFS members had to wait nearly a full minute (59 seconds) to have their call answered.

Measure	FFS Medicaid	ICP-Aetna	ICP - IlliniCare
% of Rides completed	69.6%	84.4%	91.2%
% of Rides cancelled	7.2%	13.9%	9.6%
% of Rides denied	30.4%	1.7%	0.1%
% of Rides booked within 48 hrs		11.8%	53.5%
% of Rides booked –Prior approval	60.0%	100%	
% of Rides booked –Post approval²	40.0%	0	
% of Complaints	<0.1%	0.5%	0.3%
Average speed to answer (in sec)	0:59	0:25	0:12

Note: IlliniCare and HFS have not been able to supply some data in this table

¹over a one year time period and for single trip legs

²Rides that were approved after the ride occurred, when either member or provider submitted the request for post approval. Only FFS Medicaid accepts these.

C. Transportation Trip Details

Trips paid by Medicaid can involve a variety of vehicle types and trip details. Table 47 lists the different vehicle types and compares the utilization rates for them between the FFS program and the two plans for the first year of the ICP. (For more detail on these rates, see Table E-4 in Appendix E and for an explanation of the vehicle types, see Table E-3).

Some of the limitations with the utilization data for vehicle types are:

- The HFS data is for May 2010-April 2011 and covers the entire state of Illinois, while data for Aetna and IlliniCare covers the first year of ICP (May 2011-April 2012) and the six-county ICP pilot area.
- The classification of vehicles is not exactly comparable; however Aetna provided a crosswalk between their vehicle types and HFS'. For example, Medicar under HFS is a para-lift vehicle for Aetna, a taxi is considered a "cab vehicle" for Aetna, and Aetna places "bus and stretcher" into other. A crosswalk is provided in Appendix E. Illinicare used the same

classification as the FFS program as both had the same administrator, First Tranist.

Taking these limitations into account, there are several initial trends worth noting:

- The data shows some changes in the categories by which members are transported. Both Aetna (6.7%) and IlliniCare (7.7%) relied less on “medicars” than did the FFS program (19.8%). Medicars are wheelchair-accessible vehicles and typically serve persons who are in need of a higher level of medical attention or need a vehicle with a wheelchair lift.
- Aetna reimbursed members for using “private cars” at a rate nearly three times as much as under the FFS program (2.9% to 1.0%). According to the data provided, it does not appear that IlliniCare reimburses members for trips in private vehicles.
- Aetna utilized “taxis” at a much higher rate (88.3%) than did either IlliniCare (4.6%) or the FFS program (3.7%).

More research will be done in the future to better understand the choices the plans have made regarding transportation types and whether there is any impact on the member population regarding those choices.

Table 47:
Comparison of FFS Medicaid and ICP Transport Service Types

Vehicle Type*	FFS Medicaid	ICP-Aetna	ICP-IlliniCare
	%	%	%
Service Car	74.4%	0%	86.2%
Medicar	19.8%	6.7%	7.7%
Taxi	3.7%	88.3%	4.6%
Ambulance	1.1%	0.4%	1.1%
Private Car	1.0%	2.9%	0
Other Transportation	< .1%	1.8%	0.4%
Total	100%	100%	100%

*Based on FFS categories of service

X. Grievances and Appeals

Member grievances and appeals are important as they provide a vehicle that allows members and providers to voice concerns and disagreements with MCO services and decisions. Both federal regulations and the language of the contracts of the two plans with the state detail the rights of members and responsibilities of plans in this area.

From meeting with stakeholder groups, reviewing the experiences in other states, and talking with both plans and HFS, the UIC team developed a list of six (6) key questions of interest for this area:

1. What is the difference between a complaint, grievance, and an appeal?
2. What responsibilities do the plans have to respond to complaints, grievances, and appeals?
3. What are the response times are required of the plans?
4. How many and what types of complaints, grievances, and appeals were filed?
5. What was the outcome of the complaints, grievances, and appeals that were filed?
6. Did the plans meet their requirements in terms of response times for complaints, grievances, and appeals that were filed?

The rest of this section attempts to answer these questions. The section begins with a general overview of the process, then focuses on each of the six questions above, and concludes with a general summary of the area.

The UIC team has spent considerable time with HFS and the two plans reviewing and discussing grievances and appeals. While it is true that the two plans apparently report more precise data in this area than the current fee-for-service Medicaid program does, it remains difficult to make reliable comparisons. There are still questions of definitions, classifications used for reporting purposes, and other issues which must be clarified in the future with the plans.

Despite these limitations, the data the plans have reported in this area is summarized below. This data hints at the future "value" the ICP will add to the Medicaid program regarding the availability of more data regarding member complaints, grievances, and appeals. As HFS works with the two plans to resolve the current reporting problems and inconsistencies, the data for this area for the ICP has the potential to be much more complete and useful than the data reported for the Medicaid FFS program.

A. General Overview of Process for Service Package I

Member rights to a grievance and appeals process are protected under Federal Medicaid regulations (42 CFR 438.4). An appeal "is a request for review of an action" taken by an MCO, while a grievance is "an expression of dissatisfaction about any matter other than an action." That Federal regulation (42 CFR 438.4) provides further detail about the rights of members to appeal decisions that a managed care plan may make.

Table 48 gives an overview of the process that each MCO has in place to submit a grievance. The table also includes a comparison column for the traditional fee for service Medicaid program. Each of the MCOs has its own process for filing grievances and appeals. Under each system, either the MCO or the State has 30 days to respond to the grievance. In all cases, if a member is not satisfied with the response to the grievance, he/she can appeal the response to HFS through the state's "Fair Hearing" process.

Item	FFS Medicaid	ICP-Aetna	ICP-IlliniCare
How to Submit Grievance	Mail-Yes; Fax-No; Phone-Yes; Online-No	Mail-Yes; Fax-Yes; Phone-Yes; Online-No	Mail-Yes; Fax-Yes; Phone-Yes; Online-No
Initial Response Timeline	Member/Provider files "complaint" with Illinois Health Connect--which has 30 days to respond.	Member/Provider files "grievance" with plan--plan has 30 days to respond but may ask for an additional 14 days.	Member/Provider files "grievance" with plan--plan has 30 days to respond but may ask for an additional 14 days.
2nd Level	If member/provider not satisfied, he/she may file "appeal" with HFS thru the "Fair Hearing" process.	If member/provider not satisfied, he/she may file "appeal" with HFS thru the "Fair Hearing" process. Providers do not have right to Fair Hearing unless they have received written authorization from the member.	If member/provider not satisfied, he/she may file "appeal" with HFS thru the "Fair Hearing" process.

B. Differences between a complaint, grievance, and an appeal

The contracts between the state and the two plans have very specific language as to the definition of a complaint, grievance, and an appeal. Table 49 below summarizes that difference, citing the contract section and language of the contract. It should be noted that an appeal is contingent on the definition of an "action" taken by the plan. A grievance then is any other complaint other than

what an appeal is. It is unclear as to when a complaint becomes either an appeal or a grievance matter.

Section ¹	Question	Contract Language
1.29	What is a complaint?	Complaint means a phone call, letter or personal contact from a Participant, Enrollee, family member, Enrollee representative or any other interested individual expressing a concern related to the health, safety or well-being of an Enrollee.
1.18	What is an appeal?	Appeal means a request for review of a decision made by Contractor with respect to an Action.
1.8	From the definition of appeal above, what kind of "action" is section 1.18 referring to?	Action means (i) the denial or limitation of authorization of a requested service; (ii) the reduction, suspension, or termination of a previously authorized service; (iii) the denial of payment for a service; (iv) the failure to provide services in a timely manner; (v) the failure to respond to an Appeal in a timely manner, or (vi) solely with respect to an MCO that is the only contractor serving a rural area, the denial of an Enrollee's request to obtain services outside of the Contracting Area.
1.64	What is a grievance?	Grievance means an expression of dissatisfaction by an Enrollee, including Complaints and requests for disenrollment, about any matter other than a matter that is properly the subject of an Appeal.

¹ Contract section

C. Responsibilities of the plans

The contracts between the state and the two plans have very specific language regarding the responsibilities that the plans have to respond to complaints, grievances, or appeals filed by members (see Table 50). These responsibilities include what information the plans are required to track, do formal meetings with the member have to be held, and what types of response is required of the plan.

**Table 50:
Responsibilities of the Plans**

Section ¹	Question	Contract Language
Attachment XIII	What information does the plan need to track for grievances and appeals?	Contractor shall submit a detailed report on Grievances and Appeals providing Enrollee Medicaid number, Enrollee name, description of Grievance, date received, incident date, date resolved, source of Grievance, status (open or closed), reason closed, incident summary and resolution summary, grouped by incident type.
5.26.2, 5.26.1.3	Does a formal meeting have to be held for a grievance or appeal?	A formally structured Grievance Committee that is available for Enrollees whose Grievances cannot be handled informally; Contractor must have a committee in place for reviewing Appeals made by its Enrollees.
	What action does the plan have to take in response to a complaint?	Not specified
5.26.1	What action does the plan have to take in response to a grievance or an appeal?	Contractor's procedures must: (i) be submitted to the Department in writing and approved in writing by the Department; (ii) provide for prompt resolution, and (iii) assure the participation of individuals with authority to require corrective action.
5.26.1	Can a grievance be appealed?	All Grievances shall be registered initially with Contractor and may later be appealed to the Department.
5.26.1.4	Can a member appeal to an external party?	Final decisions under the Managed Care Reform and Patient Rights Act procedures and those of the Grievance Committee may be appealed by the Enrollee to the Department under its Fair Hearings system.

¹ Contract section

D. Timelines for Response

Table 51 below lists the timelines the plans have to meet in response to the filing of a complaint, grievance, or appeal. Since the formal contracts between the state and the plans did not mention specific time periods, the minimum time periods specified in the federal regulations (CFR 438) is applicable.

Table 51:

Timelines for "complaint", "grievance" and "appeal"

Section ¹	Question	Contract Language
	What is the timeline for responding to a complaint?	Not specified
438.408 (b) (1)	What is the timeline for responding to a grievance?	Within 90 days of receiving grievance
438.408 (b) (3)	What is the timeline for responding to an appeal?	Within 45 days of receiving grievance
5.26.1.2	Can a grievance be expedited?	The plan must have procedures "to ensure expedited decision making when an Enrollee's health so necessitates."
438.408 (b) (2)	What is the timeline for expedited appeal?	Within 3 working days of plan receiving appeal

¹ Code of Federal Regulations section

E. Number and types of complaints, grievances, and appeals

1. Grievances

Each plan submitted the number and types of grievances that their members had submitted during Year 1. Of 324 grievances that Aetna reported, the majority (63.6%) had to do with transportation services. IlliniCare's most frequent category was also transportation (38.3%). See Table 52 for more details. During Year 1, IlliniCare became aware of a problem with how they were tracking and reporting grievances, so their count for Year 1 is undercounted. They have worked with HFS to correct this problem.

**Table 52:
Number and Types of Grievances**

Grievance Type	Aetna		IlliniCare	
	#	%	#	%
Member Transportation	206	63.6%	18	38.3%
Potential Quality of Care	55	17.0%	4	8.5%
Potential Quality of Service	44	13.6%	7	14.9%
Access and Availability	16	4.9%	12	25.5%
Dental related issue	2	0.6%	5	10.6%
Non contracted provider	1	0.3%	1	2.1%
Total	324	100.0%	47¹	100%

¹During Year 1, IlliniCare became aware of a problem with how they were tracking and reporting grievances, so their count for Year 1 is undercounted.

Source: MCO Data Sets

2. Appeals

Table 53 lists appeals by type as reported by each plan. The data from Aetna shows that most (76%) of the appeals had to do with medical necessity; IlliniCare's rate for this type is similar (73.3%).

**Table 53:
Types of Appeals**

Appeal Type	Aetna		IlliniCare	
	#	%	#	%
Medical Necessity	38	76.0%	99	73.3%
Pharmacy Denial	4	8.0%	24	17.8%
Dental related issue	6	12.0%	4	2.9%
DME	1	2.0%	7	5.2%
Non contracted provider	1	2.0%	1	0.7%
Total	50	100.0%	135	100%

IlliniCare was not able to provide this data.

Source: MCO Data Set

3. Data from the fee for service Medicaid program

We asked HFS for data regarding the number of complaints, grievances, and appeals filed by members of the fee for service Medicaid program, in the hopes that we would be able to obtain a benchmark that could be used for comparison of data that the plans reported. In response to our request, HFS prepared an annual summary report entitled "Non Billing Issues-Issue Descriptions." This document listed 17 categories corresponding to different

state programs and the number of complaints and grievances for the each program for the period of May 1, 2011 through April 30, 2012.

For these 17 categories, the number of complaints were summarized and a range for the "approximate time for resolution" was given that ranged from 24 hours to 30 days. Specific complaints were not listed but examples of the most common issues in each category were given. For the entire 12-month period, which corresponds with the first year of ICP, 2,776 issues were reported. For a complete copy of this report, see Appendix F.

F. Outcomes of complaints, grievances, and appeals filed by members and providers

1. Grievances

Tables 54 shows the number of grievances received, and the status of the grievances that were received for each plan. Aetna reported receiving 324 grievances, of which 11 were withdrawn, and the remaining 313 were "closed" IlliniCare reported 47 grievances, 46 of which were "closed" and one that was withdrawn.

Decision	Aetna		IlliniCare	
	#	%	#	%
Closed	313	96.6%	46	97.9%
Withdrawn	11	3.4%	1	2.1%
Total	324	100.0%	47	100%

Source: MCO Data Set

2. Appeals

Tables 55 (Aetna) and 56 (IlliniCare) describe the number of and resolutions for appeals filed by members of each plan. Aetna reported 50 appeals, while IlliniCare reported 135. Both plans use different categories to track the "resolution" of the appeals they receive, making it difficult to compare outcomes of appeals between the two plans. IlliniCare's categories are written in terms of the original decision, so "Appeal-Upheld" means that the original decision by the plan was upheld. Aetna's categories are similar, although they use different language; for instance, "Denied" means that the appeal was denied. Therefore, Aetna's "Denied" is likely equivalent to IlliniCare's "Appeal-Upheld;" IlliniCare overturned over three-quarters

(76.3%) of its original appeals decisions, and Aetna overturned just over half (52%).

Table 55: Aetna Appeals Resolutions		
Decision	Aetna	
	#	%
Approved	26	52.0%
Denied	17	34.0%
Partial	3	6.0%
Closed	2	4.0%
Other	1	2.0%
Withdrawn	1	2.0%
Total	50	100.0%

Source: MCO Data Set

Table 56: IlliniCare Appeals Resolutions		
Decision	IlliniCare	
	#	%
Appeal - Overturned	103	76.3%
Appeal - Upheld	27	20.0%
Upheld External Independent Review	3	2.2%
Informal Resolution	1	0.7%
Overturned External Independent Review	1	0.7%
Total	135	100.0%

Source: MCO Data Set

G. Compliance of plans with required response times

Table 57 below lists the time it took each plan to reach resolution for grievances and appeals. Each plan, according to their contract, has 30 days to make a decision on grievances and appeals and relay that to a member. Aetna provided data showing that the average time they took to reach a decision on an appeal request is 18.9 days and 24.1 days for a grievance. The time for IlliniCare to reach a decision on the appeals was 10.2 days and 31.6 days for grievances.

**Table 57:
Timeline Compliance with Grievance and Appeal Resolution**

Measure	Aetna	IlliniCare
Mean Days to Grievance Resolution (notify member they received it)	24.1	31.6
Mean Days to Appeals Resolution	18.9	10.2

IlliniCare was not able to provide this data
Source: MCO Data Set

XI. Member Survey: Results of Longitudinal Data

A. Introduction

This report is based on longitudinal data for 181 ICP participants who completed the survey at the baseline (for the year prior to ICP implementation) and after the first year after ICP implementation. Future reports will consider additional survey data, including from the comparison group. These longitudinal responses use a matched-pairs design to identify changes in responses following implementation of ICP. Specifically, this report looks at services and equipment needed and received, consumer satisfaction with ICP, and preventative care received.

Table 58 presents demographic information on the 181 longitudinal participants. The majority of these respondents are female (53.6%) and speak English as their primary language (80%). The respondents are well distributed racially with 45.9% white, 35.4% black, and 14.4% Asian. Only 9.4% were of Hispanic descent. At the time of the baseline survey, the mean age was 49.5, and at the time of the next survey the age was 50.73. In order to facilitate analysis, the respondents were placed into one of four groups based on self-reported disability: Intellectual or Developmental Disability (40.3%), Mental Health (19.3%), Physical Disability (27.6%, also includes sensory impairments), and those who did not fit into one of those groups (12.7%). It is important to note that the average participant was only in ICP for 7.1 months, so the respondents were likely not enrolled in ICP for an entire year.

**Table 58:
Demographics of Longitudinal Survey Respondents**

Demographic	# (n=181)	%
Female	97	53.6%
Hispanic Origin	17	9.4%
White	83	45.9%
Black	64	35.4%
Asian	26	14.4%
English Language	144	80.0%
No Disability Group	23	12.7%
ID/DD Group	73	40.3%
Mental Health Group	35	19.3%
Physical Disability Group	50	27.6%
Mean Age	Baseline=49.5; Year 1=50.73	

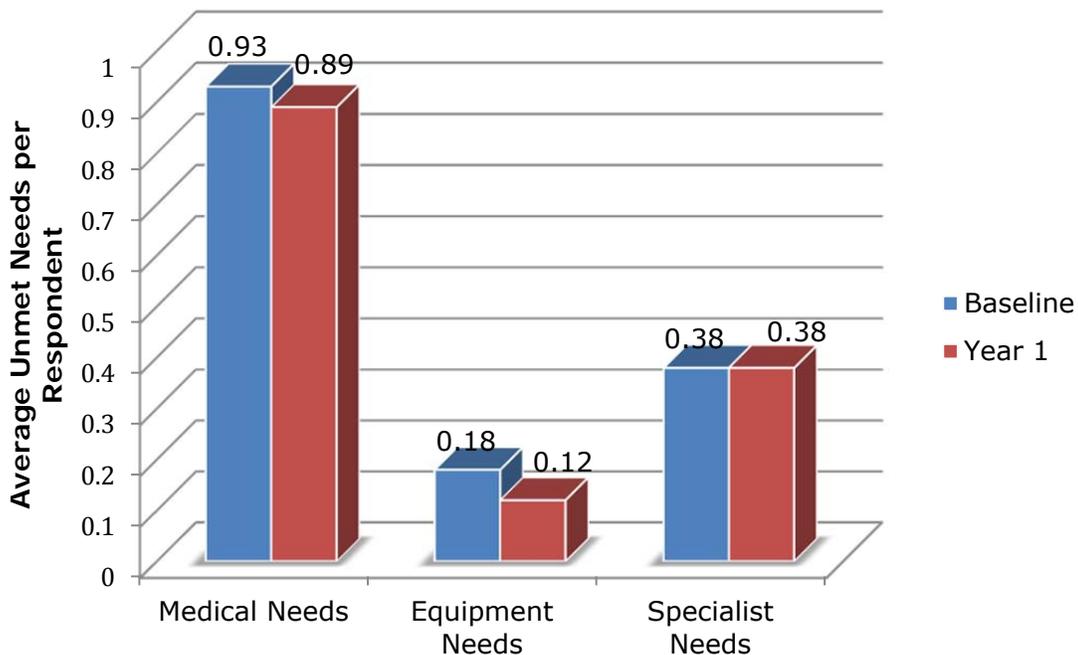
B. Services Needed and Received

The longitudinal data did not reveal any significant differences in overall unmet needs and services received per person. This finding held for each individual service, as well as for scales of the average unmet needs per respondent. Figure C shows the average number of unmet needs per respondent at baseline and one year after ICP implementation.

In these scales, Medical Needs includes Behavioral Health Counseling, Dental Services (including dentures), Dietician, Home Health Services, Occupational Therapy, Personal Assistance/Support Person, Physical Therapy, Speech Therapy, and other medical services; Equipment Needs includes Breathing Equipment, Feeding Tube, Mobility Equipment, and any other medical equipment; and Specialist Needs includes Allergist, Cardiologist, Neurologist, Oncologist, Optometrist, Podiatrist, Psychiatrist, Psychologist, Rehab/Physical Medicine, Skin Doctor, Surgeon, and any other medical specialist. Again, no differences were found looking at each of these areas individually, with the exception of dietician services, which had more unmet needs after the first year of ICP.

Furthermore, when the analyses were conducted for each group, the only significant difference was for dietician services, which had more unmet needs after the first year of ICP for people in the Physical Disability group only. Thus, with this one exception, the provision of services and unmet need for services did not change significantly after a year of ICP as compared to the baseline.

Figure C
Longitudinal Unmet Needs: All Groups

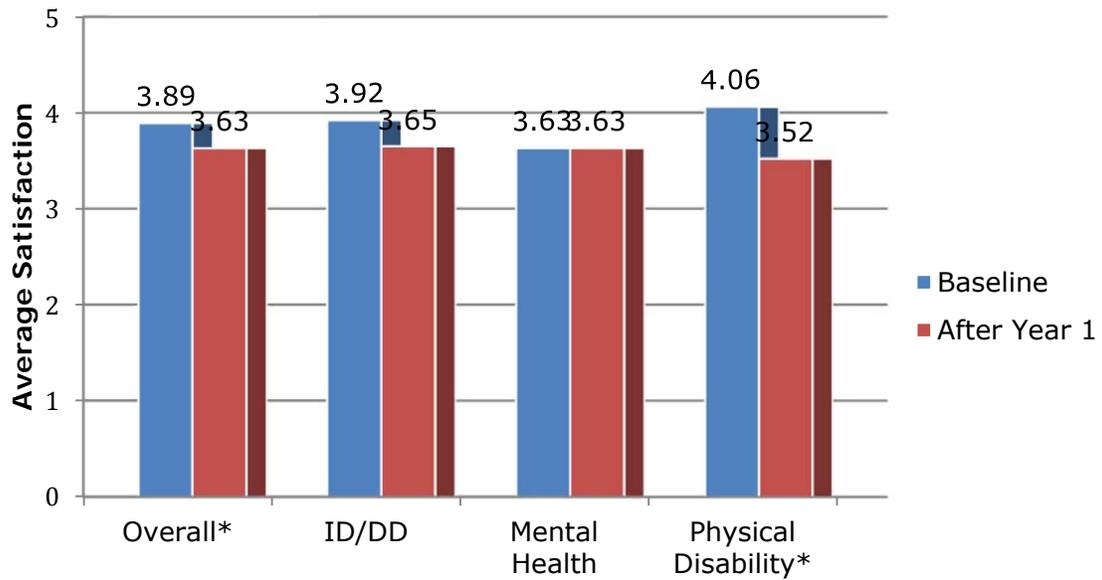


* No statistically significant differences at .05 level

C. Satisfaction

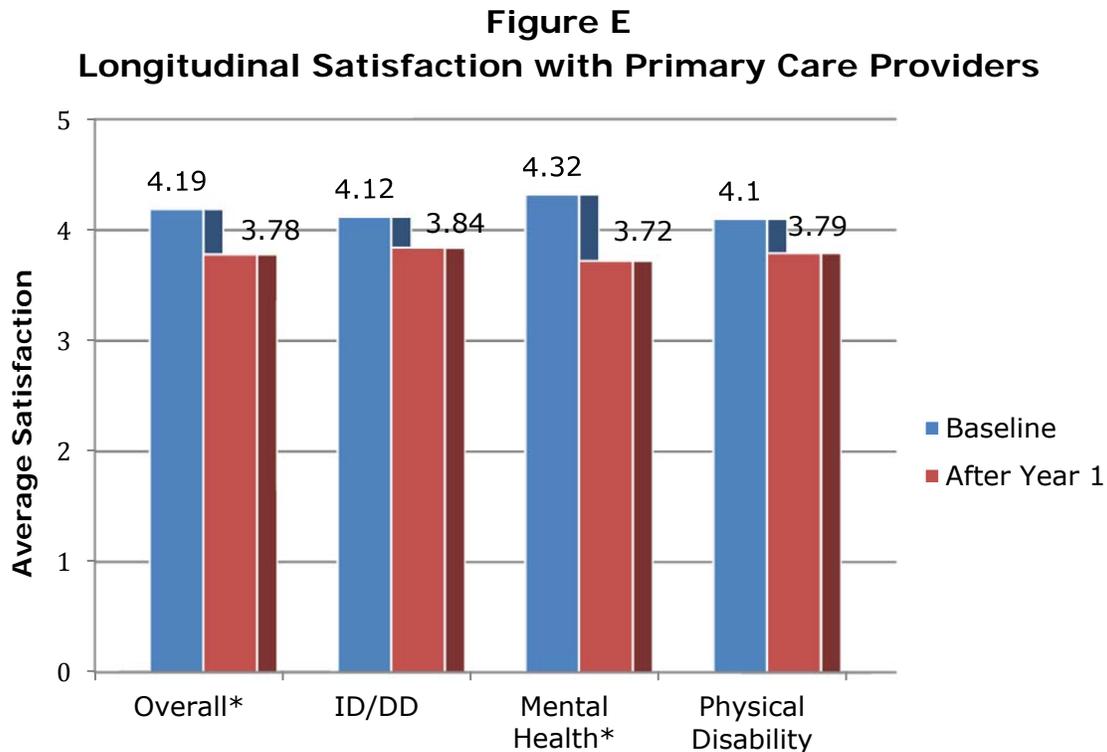
Despite the lack of significant findings on differences in services provided or unmet, the survey data shows significant differences with respondents' satisfaction with these services. The primary question on satisfaction asked people to mark their satisfaction with their health care on a scale of 1 (Very Dissatisfied) to 5 (Very Satisfied). The overall satisfaction with services dropped significantly from baseline to one year later (3.89 to 3.63; $p=0.021$). Upon further investigation by group, the research team found that this difference is mostly attributed to the physical disability group (scores went from 4.06 to 3.52; $p=0.01$) with no significant differences in the ID/DD and Mental Health groups. See Figure D.

Figure D
Longitudinal Satisfaction with Health Care



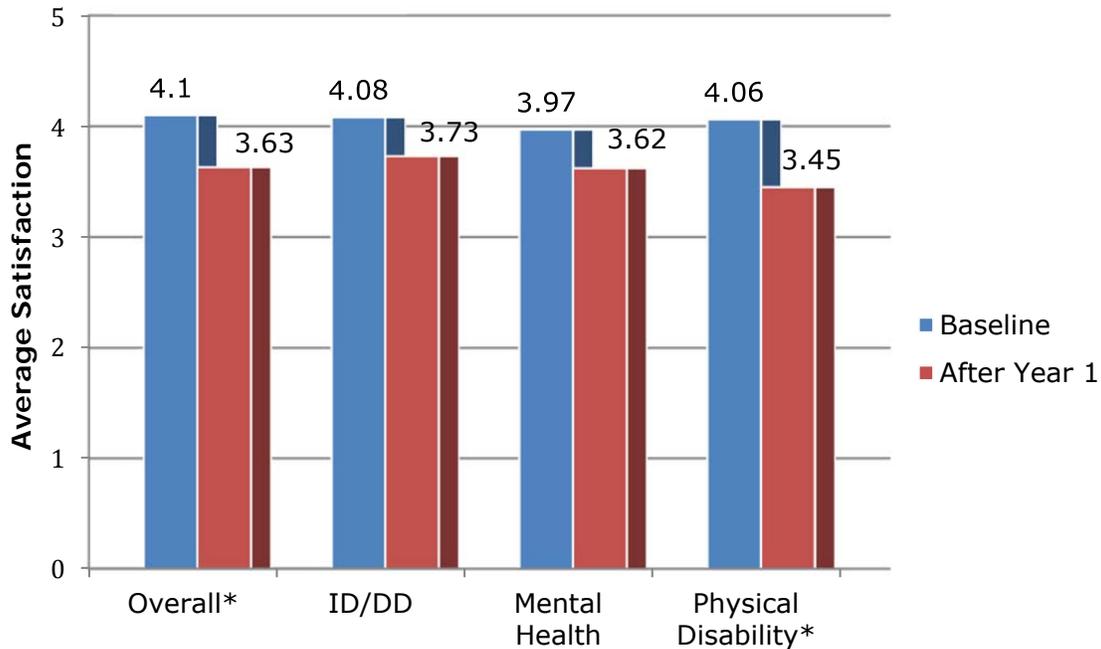
* Difference is statistically significant at .05 level

In regard to satisfaction with specific aspects of health care, two aspects showed significant differences from baseline to one year after: satisfaction with primary care physician and satisfaction with medical services. Satisfaction with primary care providers showed a significant decrease (4.19 to 3.78, $p=0.002$). While every group showed a decrease in this measure, the decrease was only statistically significant for the Mental Health group (4.32 to 3.72; $p=0.044$). See Figure E.



Satisfaction with medical services received went from 4.1 to 3.63 ($p=0.001$), with the difference only holding for the physical disability group (4.06 to 3.45; $p=0.002$). See Figure F for this data. As the research team receives additional survey information, these differences may change and/or become significant for additional groups. As analysis progresses, the research team will be seeking to identify the reasons for decrease in satisfaction.

Figure F
Longitudinal Satisfaction with Medical Services

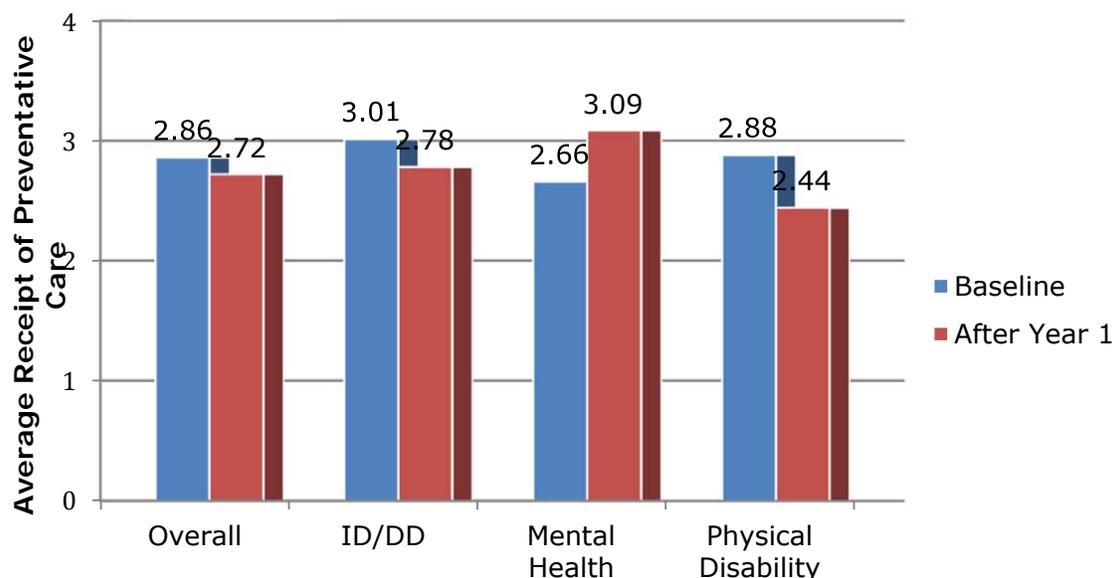


* Difference is statistically significant at .05 level

D. Preventative Care

The survey contains six questions on preventative care and whether a respondent's primary provider discussed or provided these items. Preventative care includes having a discussion about healthy eating habits, exercise and physical activity, behavioral/emotional health, birth control and family planning, and sexual health and STDs, and being weighed by the provider. There were no significant changes from baseline to one year later in number of these preventative activities that occurred overall (2.86 to 2.72). Also there were no significant differences among the different groups. See Figure G.

Figure G
Longitudinal Receipt of Preventative Care



* No statistically significant differences at .05 level

In addition, there were no significant differences by individual items or by disability groups over time. The one exception was in providers having a discussion of exercise and physical activity with a respondent. For this item, there was a significant difference in the Physical Disability group, with fewer respondents receiving this service after the first year of ICP compared to the baseline (81.6% to 60.0%, $p=0.018$).

XII. Focus Group Findings

The focus group and interview findings concerning the first year of the ICP are presented in terms of the following major themes: (1) enrollment, (2) MCO provider networks, (3) billing/provider payments, (4) outreach to providers, (5) accountability of MCOs, (6) prescription medication, (7) training of MCO staff, (8) prevention, and (9) overall implications of the ICP on quality of care. The example quotes and explanations of themes below represent illustrative perspectives on the issues that were most salient to participants.

A. Enrollment

Because of the transitional context of the first year of Phase One of ICP, enrollment into the ICP was an issue relevant to all stakeholder groups. Issues have arisen around the enrollment period with regard to information provided,

choice/auto-assignment, and contact from the MCOs. A number of consumers had little difficulty with the enrollment process, especially those who were proactive, those who were supported by engaged family caregivers and those who had care coordination support from community agencies or the MCOs. For example, family caregivers were active in seeking to understand the new plans of each MCO and what that would mean for their family members with disabilities.

"That was one of the reasons I chose [one MCO] for my adult child with a disability over [the other MCO] because it did give two dentals a year versus one." –a family caregiver

However, as enrollment proceeded from May 1, 2011 forward, many consumers expressed difficulty understanding managed care, the transition, and the information provided to them.

"Then one day I just got the package in the mail and since my other medical card wasn't coming on time, I checked it out, saw a little member card in there so I called to find out what was going on."—a consumer

Providers and MCO staff noticed this confusion.

"So even with explaining it, it was very troublesome for our clients to understand the difference [between the two plans]...I believe that's probably a big reason why there has been a lot of auto enrollment." --a provider

"A lot of the members were complaining because they didn't have a choice in the matter. They wanted regular Medicaid. They didn't want to go to managed care." -a MCO staff

MCO leaders noted that providers as well as consumers were unclear as well at the start:

"They [consumers] didn't understand the integrated care program and the providers didn't really understand what the state was doing and that the state was mandating a certain subset of enrollment to be in a managed care program and that they were calling it integrated care."

Such confusion was understandable given the novelty of the program, but it likely played a role in consumer choice being circumscribed with more than two-thirds of consumers being auto enrolled initially.

B. MCO Provider Networks

A major issue during the transition and in general has been the nature and adequacy of the networks of providers that MCOs are developing to provide health care. This issue was raised by virtually all stakeholders, and led to problems for many, but not all, of these consumers who needed to switch primary and specialty providers. Consumers who were able to continue receiving care from the same health care providers were more likely to find the networks to be meeting their needs. For example, a number of those receiving behavioral health from an agency that was in their network reported a smooth transition. Also, some who had to change primary care providers reported liking their new health care providers better than their previous ones. Other consumers and their family caregivers reported long wait times to see providers, lack of awareness of medical history and conditions, and inaccessibility to specialty services for consumers. Especially for this population and its often complex needs, specialty services are necessary, and many consumers and their family members expressed discontent with switching from providers they were comfortable with and had been seeing for years.

"I am not happy with this system at all. The thing is that you've had relationships with your doctors that you have been seeing and all of a sudden you've got to stop going to them because obviously the hospital system is not taking this [MCO] or [that MCO]."-a consumer

A primary concern was the perceived lack of specialists. Both family caregivers and MCO staff commented on this point. For example,

"I still don't have an urologist who understands what her condition is. And I still don't know who I can go to for follow-up on the urology. The urologist at ____hospital could still see her, but they said they can't because they are not enrolled in [MCO]."-a family caregiver

"What is the immediate issue now?" [Specialists.] And they'll [consumers] tell you, 'I don't have an endocrinologist. I don't have an urologist.'"-a MCO staff

"At Thanksgiving she [daughter] fell and broke a bone in her foot. So when I called this new doctor they said okay take her to the emergency room at the local hospital that accepted her. We were there several hours and they just bandaged it up. And they said,

well there were no orthopedic doctors that could do anything. Now what do I do?"-a family caregiver

Some consumers and providers mentioned the longer travel times as a drawback with the smaller networks of providers:

"I know coworkers that have had clients that have been diagnosed here in ___ County...and there is no specialist in this area to address it, so they are sent to Chicago."-a provider

MCO leadership noted the developing nature of the networks and their improvement over time:

"...we went live [May 2011] with, what was the number, something like 28 hospitals. We are now [15 months later] up to I think 56."-a MCO leader

MCO staff explained how their leaders recognized the shortcoming of their networks early on and made accommodations to ensure quality care while the network issues were being worked out.

"We were having some battles with nonparticipating providers not wanting to see our members because they weren't contracted and what not. And management made a decision which I felt was good as to leave the decision in our hands and the clinicians' hands. If there is a compelling reason why this person needs to stay with this nonparticipating provider, then they can have it. And we put a process in place so that they can continue their care there."-a MCO staff

State employees noted that with assertiveness that consumers may be able to obtain the services they seek:

"They [consumers] have this perception, here are all our panels and 90% of them say not accepting new patients so they look at it and go, 'There's no place where we can go.' And actually if they went, 'I would really like to go here' and they went to the plan with that, they could probably get in."—a state employee

Not all caregivers found this more assertive path a useful one:

"I received forms and then the (advocacy group) actually said that you could send a letter to your doctor, to the specialist and to the state requesting a one-to-one type of negotiation. I did all that and nothing came of it."—a family caregiver

As a transitional issue, the developing network has been less than optimal. The MCOs recognize this issue and have been working both to recruit more providers into their networks and to pay many out-of-network providers in order to maintain continuity of care for consumers. Given the concerns raised about the adequacy of the networks in Year 1 and the strengthening of networks over time, the research team will examine the responses of focus groups members on this theme in Year 2 of the ICP.

As both MCOs struggled to recruit providers to expand their networks MCO outreach to providers was a major focus during year. The challenges as well as the continued efforts and improvements were followed closely by providers and state employees.

"MCO 1 met with us several times and MCO 2 I think once they came out. And they also did follow-ups with our staff specifically [about] Rule 132. We had some billing issues but we worked through those." –a provider

The state employees were happy with the follow through showed by the MCOs.

"The CEO's [of MCOs] have all come out and said, "I'll come out and talk to you. I'll be happy to call you." They always did what they said. So whenever I followed up with those provider types, "Did you get that call? Is everything okay? Do you have any questions?" They're like, "Nope everything has been taken care of," and they were more at ease. So I guess a success for me was just how compassionate I think the health plans are about wanting to make this program work." –a state employee

"I remember like it was yesterday, but we did a great deal of community outreach. That was very important. So that was ... reaching out to advocates. We had a series of meetings specifically with the CMHC's[community mental health centers] just because we knew they were going to become very important." –MCO Leadership

C. Billing/Provider Payments:

Concerns regarding the billing of MCOs and payment to providers were frequently discussed by those involved with those aspects of the ICP from quite different perspectives. Many provider organizations often found the transition to new ways of handling billing to be a major change that consumed substantial amounts of time for their office personnel:

“Both companies require something completely different _____. I don’t bill the same things the same way for either. The requirements are different.” –a behavioral health provider

MCO staff pointed out the challenging atmosphere that has existed in Illinois between those who pay and those who seek to be paid for providing health care under Medicaid and the challenges the MCOs face in starting up a new program given that difficult atmosphere:

“They [providers] are mad because they haven’t been paid, but it hasn’t been MCO. The state has to pay them so they are like, ‘well pay us, and we’ll continue seeing them’. And some of them were like, ‘We don’t want to deal with you anymore.’ So they’re doing that. But we’re [MCO staff] the bad guys.” (in reference to providers)—a MCO staff

MCO leaders and state personnel noted the benefits of the new ICP in regard to payment of providers:

“I can’t stress.... Enough, every group that we have met with we stressed to them that when we talked to the providers we are going to pay them no less than they are getting paid today [viz., Medicaid rates prior to the Integrated Care Program] and we are going to pay them on time.”—a MCO Leader

“They [providers] are billing MCO 1, billing MCO 2 and they are getting paid.”—a state employee

These different views reflect the development of the ICP. During the first year many providers had challenges adapting to the new billing procedures of the MCOs. The MCOs needed to become more familiar with existing methods and policies regarding billing for Medicaid services in Illinois, especially for behavioral health services. Moreover, the timeliness of payment was a function of not only how long it took MCOs to process claims that were in order, but also the time it took providers to prepare claims in a way that was acceptable to the new expectations of the MCOs. These problems seem to be lessening over time, at least for larger providers that were able to devote significant resources to addressing the changes.

D. Accountability of MCOs

Issues related to support from MCOs, including outreach, care coordination, and responsiveness were discussed across stakeholder groups. Inconsistencies

across provider networks, services covered, billing processes, pre-authorization process, and information availability all led to confusion among consumers, caregivers, and providers as to how to best manage care. Consumers and caregivers were mixed in their experiences with MCO staff. For example, one consumer reported a lack of responsiveness to his illness:

"Maybe a couple of weeks ago when I had the cold and flu. I called [MCO] to see where I had to go and what was the procedure, and I called the representative of the lady in the letter and was waiting and waiting and waiting [for a callback]."—a consumer

Fortunately, he was able to recover on his own without need for medical intervention. In contrast, one caregiver found valuable help:

"[MCO] staff has been helpful at the beginning trying to find us doctors. There was a [name] person at [the MCO] who was helping initially with the sign up and finding doctors for me and when I had the problem with his billing."—a family caregiver

Some providers found their MCO very responsive and straightforward:

"They really have worked hard and they set their system up correctly. They have not made us change our system to fit their model...I can always pick up the phone and get somebody."—a provider

Another provider reported difficulty with the timeliness of preauthorization:

"[MCO] finally approved, one day less than a month later, 12 visits (this is the funny part) for the patient and since this had started on April 12th, the dates of the authorization because they only give you them for four weeks. So it was May 11th they approved her from April 12th to May 12th. So I had one day to see her. So it was going to expire in one day, and then [staff] got involved. On May 17th we actually were able to get correspondence back from [the MCO] finally a week later that they had extended the end date so the patient did get 12 visits but it was going to cover through June 12th." —a provider

MCO staff explained that they reach out to consumers who have greater health care needs:

"We have this outreach queue where we have to outreach to these members and depending on who we get in contact with, we will help them out."-a MCO staff

MCO leaders indicated that they connect with community groups to gather relevant input about the ICP:

"We have identified a point person here at the health plan that those advocacy groups can reach out to... So soliciting that feedback from them whether it is individual face-to-face meetings which occur on a regular basis proactively when we are reaching out to them. But then also conversely they reach out" –a MCO leader

State employees indicated that another kind of MCO accountability in the ICP is ensuring that providers with care teams with needed health care competencies:

"we actually required them[the MCOs] to have a care team with the right types of providers on that team where if they need the mental health behavioral health person on the team, their case manager, their PCP's are part of that team. And the client is a part of that team. Things are a work in progress, but I think it is a really good model." –a state employee

In sum, there are many kinds of accountability that the MCOs are held to in the ICP. Some of them have been met very well during this first year and others are in the process of being addressed.

E. Coordination of Care

One of the primary objectives of the ICP is the coordination of care. Both MCOs made substantial efforts to assess their consumers' level of need and provide care coordination to those with great healthcare needs.

MCO staff spoke most frequently about care coordination, usually in very positive terms. The following example details some of the benefits of successful care coordination for all involved:

I have a young lady, she loved to go to the emergency room every week for her pain medicine. She never went to see a provider, a PCP. She didn't believe in it. She had been doing this for the last 20 years, I guess. So I get on the phone with her and I said, "Listen, why don't we work together on this?" She said, "Why are you calling me? I never heard of this insurance calling" and just panicking. And I said, "What I want to do is give support to you and I want to call the doctor up with you on the phone." And when I call the doctor he was like, "Hey that girl never show up" And I begin to educate him, and I said, "We are going to work as a team

to help her.” And it worked out and to this day she hasn’t been in the hospital since March[several months earlier] and I thought that was good for her. And we had nurse, everyone involved. So it made a difference and she needed housing and we got that. So it worked out. It takes a team to do this. –MCO staff

MCO staff also noted the challenges they encounter in coordinating care from providers:

“I had a member who needed an oncologist and he needed a referral to the oncologist from his primary care physicians. It was very difficult to coordinate that about the things he needed from his primary care office to his oncology office. And setting up that appointment and getting that all to work together and that’s about a week to finally get that all worked up because to get the doctor’s office sometimes they take their time.” –MCO staff

And occasionally there are coordination challenges from other units in the MCO:

“And you would think that there would be a lot of continuity between all the departments. There is not. That is actually frowned upon.” –MCO Staff

MCO staff also report developing positive coordination on treatment teams and with PCPs. Consumers from several groups reported their positive reaction to being able to reach someone on the phone at their MCO with whom they could discuss their care and its coordination.

In sum, there are clear challenges to coordinating cases, positive case coordination is reported by MCO staff in a number of instances for those with significant needs. Many consumers did not report being aware of efforts of MCO staff to coordinate care, yet in many consumer groups one or more consumers appreciated being able to reach an MCO staff person on the phone to discuss their healthcare needs and care coordination.

F. Prescription Medication

The ability to obtain quality, affordable prescriptions was a major concern for stakeholders. From the perspective of consumers, the transition led to both positive and negative changes. Over the course of the year, the MCOs and the state did show some flexibility in what they would cover but explained their preference for less costly options when available:

“She [a family caregiver] had an issue actually with us on drug prior approval because she was convinced that only the brand version of an anticonvulsant

would work for her kid and not the generic version. It happened to be a very expensive drug wherein the difference in cost was close to \$1,000 a month.” -a state employee

One consumer explained how fortunate she felt that her expensive medications were being covered in the ICP:

“For an example the anti-nausea pill costs \$100 and there are people who have regular insurance and it wouldn’t cover that and I am able to say that I am lucky [because the MCO covers my prescription for this pill].” –a consumer

Several providers raised the issue of having to transition clients from one medication to another (often brand name to generic):

“The only other complaint I’ve heard is from our nurse and it [is] just with the medications. A lot of changes, a lot of meds they were on weren’t accepted. So it is coming up with different medications.” –a provider

The MCO staff explained that over the course of the year they have worked to adjust their formularies to cover medications which were not originally included but have been deemed necessary.

“There are two new generation antipsychotics and now those will go through which they weren’t before. And now like people are getting their meds kind of grandfathered in for the most part.” -MCO staff

The MCO leadership also explained their process.

“But we do try and get members to try the generic medications initially and then and if needed they can move to a brand.”-MCO leadership

More generally, the state indicated the importance of paying for more expensive medication only when there was good scientific evidence that it worked more effectively than other options.

In sum, there was clearly frustration on the part of some consumers, caregivers and providers about not having access to the medications previously being used. To a lesser extent some consumers held positive views regarding support provided for their prescriptions. A primary difference was whether or not consumers needed to alter their previous medications and how well their new medications were working. Finally, the MCOs were somewhat flexible in adding new medications to their formularies.

G. Training of MCO Staff

Because of the distinct healthcare needs of this Medicaid population of people who have disabilities and/or are older, training of MCO staff was discussed by MCOs at both the staff and leadership level. Each group indicated their understanding of the value of training.

While many staff had years of experience prior to working for the ICP pilot, all reported participating in some training. Those who had been hired more recently were generally positive about their training. Some but not all care coordination staff felt that their initial training was lacking, especially as the plans were ramping up in 2011:

"I would say the number 1 thing [needed] is better training at the beginning. If you have a good basis, if everyone is trained the same way and you have a common goal of what they want you to do. It just seems like I started on the floor and I didn't have any training. It was like, 'Here you go...'. And if I was corporate, I would want each care coordinator to know the rule and know how to do it."
MCO staff

MCO staff commented on the need for, the lack of and the presence of training for cultural competence:

"I never before working here heard of a language called Urdu. To say that I understand that culture, to say that I can be empathetic or sympathetic, I don't think I can because I don't understand it. I have experienced the male role in that family, but I could only be an observer of it." -MCO staff

"I don't think we have done a cultural thing. I mean we did disabilities education and ___ disability training. I would say "No" [to cultural competence training]." -MCO staff

"We had a cultural competence training, but you can never be an expert in culture, but you just have to have the attitude of not judging." -MCO staff

The leadership also emphasized the importance of training for both healthcare-related and plan-specific issues as well as how to best work with people with disabilities.

"Then we have also done a specific training for our care coordinators because it is so important for them to understand how things work both in Chicago and the system and how social security

works. How they can ask people questions. So we actually gave them a seven-week course. It was two hours a week. So it was seven modules over seven weeks and all the care managers went through it. It was done by health and disability advocates.” –MCO Leadership

H. Prevention

Consistent with the findings of the consumer survey, most consumers and providers interviewed did not have much awareness of the prevention focus of the MCOs during year one. Those who noted the efforts that the MCOs were making were appreciative. For instance, one consumer was impressed with the follow-up to her emergency room visit by the staff of her MCO:

“After I registered with MCO 1, they have a person that calls every now and then to do a routine survey and check up on me to question me, to ask me how my asthma is doing because that is my main condition. They want to know how often the asthma affects me, how often I have to go to the doctor; I’m not going to the emergency room. They have a host of questions that they have to ask and they keep a record of data of what’s going on with me and my conditions.”—a consumer

These kinds of individually tailored MCO staff responses may have contributed to the reduction in ER visits in the first year of the ICP relative to use of ERs prior to the ICP.

Some caregivers recognized prevention efforts geared toward the ICP consumer population but felt as if the prevention efforts were targeted either too narrowly on people with the most common chronic health conditions (e.g., diabetes and asthma) or too generally for people without complicated conditions.

One parent expressed this frustration with a lack of prevention efforts specialized to her daughter

“We get notices to get flu shots. Those kind of things. It is not going to affect her [viz., the specific situation of her daughter who has a developmental disability].”—a family caregiver

MCO care coordination staff and the MCO leadership explained the extent of the mailings and other general prevention efforts.

“We also have a journal being developed that’s almost done to go out to the members that has like did you get your reminders. Did you get these labs done? Did you get your mammogram if you are

over 50 and you are a female? Did you get this if you are male? Reminders of things to do preventatively? And also they get to find out about some preventative like the free clinics set up to go and check your blood pressure or like different stuff for them.” -MCO staff

“Some of the on-hold messages on the phones speak to the members about the importance of [seeing a] PCP, getting preventative care. We do annual mailings for breast cancer and cervical cancer screenings, also for Early Prevention Screening Diagnostic and Treatment evals as well for those members that are age appropriate.” –MCO leadership

On balance those preventive efforts that consumers recognized, they generally valued, especially those targeted to their specific needs. More generally, it is unclear whether consumers were not very attuned to the prevention efforts being made, whether the prevention efforts had not yet reached those who participated in the focus groups and interviews, or whether these efforts were not widespread.

I. Implications of Transition on Quality of Care

While many stakeholders who participated in focus groups felt it was too early to tell in year one whether the quality of their care would be improved or not in the ICP, some stakeholders, felt that the transition itself affected the delivery of services.

“She has had too much Clonazepam and she is having an adverse reaction. It happens to people with CNS damage so she called the PCP. So I took her into the PCP and this is in January. They say this is beyond our scope in family practice.” – a caregiver

“And it causes a delay in the treatment and care and sometimes...it may be something that they need addressed right away and they don’t have their medications or they don’t have treatment or they may end up having an evaluation, and to me that is dangerous.” –a behavioral health provider

Providers emphasized their commitment to quality care regardless of what type of payment system they were working within. However, some felt it was very important to consider the added burden with regard to time spent completing new paperwork or costs that they were absorbing until agreements could be made for them to be covered under the ICP. Behavioral health seems to be an

area that required more adjustments for both the providers and the MCOs during the first year.

"It [ICP] is not changing our quality of care. Our quality has stayed the same because even if they say right now, "Group home we are not going to authorize your services." We didn't kick the client out because it is the right thing to do and we're fighting to get it covered...if anything, we've continued our quality of care even with the barriers." –a behavioral health provider

Some MCO staff expressed frustration at the emphasis on quantity of contact and felt it came at the expense of quality:

"...when I got home an email from corporate came down and said the managers, 'How many calls are people making [per hour]? We expect them to make 20 to 25.' That's three minute per person per phone call. You can't even do a questionnaire in that [amount of time]. That's not quality care. That's where the corporate doesn't understand what we're doing." –a MCO staff

In sum, there were reports of some problems in care related to the transition. Differing perceptions about quality of care were expressed by caregivers, providers and MCO staff. Future data collection may help indicate if concerns have been addressed or continue.

J. Conclusions

Because these focus groups and interviews occurred during the initial phase of implementation of the ICP, the primary themes that were raised concerned the process of enrollment and the adequacy of the network of providers assembled by the managed care companies. In general, the results of these focus groups illustrate very diverse experiences of the state's transition to integrated care for Medicaid recipients. From a consumer perspective, the transition to integrated care was largely inconvenient and rushed. For caregivers of consumers with severe healthcare needs, this struggle was intensified. For providers who participated in the focus groups, their commitment to quality of care was uncompromised, although more work was often required to maintain that quality during the transition. For the MCOs, the transition presented struggles accessing and serving a population with diverse needs and creating a provider network. For the state, unexpected issues in rolling out the plan prevented a seamless transition. However, despite the difficulty associated with transitioning to an entirely new system—integrated care—stakeholders were able to identify

some strengths of the program, in comparison to the previous Medicaid system..

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. There were many other issues discussed in focus groups, but below are the most salient issues across groups (consumers, caregivers, providers, MCO staff, MCO leadership, and state employees) during year one.

Enrollment: consumers expressed difficulty understanding managed care, the transition, and the information provided to them. Managed care staff also commented on feeling overwhelmed at the start of the transition.

Adequacy of provider network: This issue was raised by virtually all stakeholders, and led to problems of many consumers in the early stage who needed to switch primary and specialty provider and who experienced long wait times to see providers, long travel times, and inaccessibility to specialty services for consumers. Especially for this population and its often complex needs, specialty services are necessary, and many consumers expressed discontent with switching providers they were comfortable with and had been seeing for years. However, managed care staff and leadership made considerable efforts to reach out to providers and bring them on to the network.

Billing: Providers reported initial lack of communication and inaccessibility to manager level staff at the MCOs to work out billing issues. Additionally, there was confusion around paperwork and what would or would not be covered and for how long. Initially these difficulties led to excessive additional paperwork in the ICP as compared to the prior system which strained the capacities of some clinics and small providers. There were some initial issues in processing payments to providers, but MCOs appeared committed to ensuring providers are paid in a fair and timely manner.

Outreach to Providers: MCOs reached out to providers to build their networks of care and to address emerging concerns as the ICP developed over the first year. While these efforts did not always result in positive solutions to challenging issues, they led to clear progress in building provider networks and in solving problems.

Accountability of MCOs: MCOs are accountable to many stakeholders in many different ways. Mixed reports indicated different areas of strengths and areas for improvement. Accounts included a lack of response, a slow response to very

helpful responses and complex team creation. MCO responsiveness helped address some of the multiple diverse requests and concerns over time. With a system as complex as the ICP that accountability and related responsiveness to addressing problems is an area meriting ongoing attention.

Coordination of Care: Managed care staff stressed their efforts to coordinate care, and the difficulties (time, ability to reach consumers) associated with it. Although consumers did not frequently report awareness of MCO staff's coordination efforts, in several groups consumers reported satisfaction with their ability to reach an individual at their managed care company to discuss their healthcare, access and coordination when necessary.

Prescription medication: Although some consumers, caregivers and providers expressed issues with changing pharmacies and formularies, many, especially those who did not need to change their medications, were satisfied with their ability to obtain quality prescriptions.

Training of managed care staff: Because of the distinct healthcare needs of this population, MCOs provided specialized training about the Medicaid and Illinois policies to their staff, which was perceived as useful. Training for working with people with disabilities was also provided. Some MCO staff expressed the need for additional training related to better serving consumers from different cultures.

Prevention: Consumer awareness of preventive measures was generally low, possibly because their focus was often on immediate healthcare issues and needs. Nonetheless, some preventive efforts were made both universal and tailored to those with the greater health care needs. Future data may indicate whether consumers become more aware of the preventive efforts being made as they have more experience with the ICP.

Quality of care and the transition: There were reports of some problems in care related to the transition. Differing perceptions about quality of care were expressed by caregivers, providers and MCO staff. Future data collection may help indicate if these concerns have been addressed or continue.

The focus groups and interviews captured the full range of stakeholder perspectives from consumers and caregivers to providers, MCO staff and leadership and state employees. These varying perspectives indicate the complexity of the many dimensions of the ICP, its initial challenges and its efforts to sustain and strengthen the healthcare of Medicaid recipients in suburban Chicago using a system of managed care.

XIII. Readiness Review

A. Federal and state requirements

Prior to the enrolling of Medicaid members in a managed care program, the state is required to contract with an External Quality Review Organization to assess whether the MCO is in compliance with state and federal standards related to the Medicaid managed care (42 C.F.R. § 438.358, subparts D and E). The assessment of the Managed Care Organizations' (MCOs) participating in the Integrated Care Program (ICP) readiness to provide health care to HFS Medicaid beneficiaries was performed both prior to the start of actual operations and on an ongoing basis to monitor health plan performance and their ability to serve aged, blind and disabled beneficiaries.

The readiness review is referenced in the formal contract between the state and the two plans and states that

"The Contractor is not entitled to any enrollment until it has passed a desk Readiness Review conducted by the Department, or otherwise received notice from the Department, indicating to the Department's satisfaction that Contractor is ready to provide services to Enrollees in a safe and efficient manner" (Section 4.17).

B. Results of independent external review

The state of Illinois contracted with Health Services Advisory Group, Inc. (HSAG) to conduct this review. The review included a comprehensive readiness review for both of the MCOs, identified degree of compliance with the relevant federal and state standards and the requirements specified in the contracts the state had with the two plans.

To complete the readiness review HSAG assembled their team and carried out activities that were in compliance with State and federal guidelines for determining compliance of MCOs with Medicaid managed care regulations. For a detailed listing of these activities, see Table G-1 in Appendix G. For both plans, the review period covered May 1, 2011, to July 19, 2011.

The readiness review consisted of a desk review and an on-site review for each plan. The desk review included a review of the documents each MCO had submitted to HSAG prior to the on-site portion of the readiness review. The on-site activities included reviewing additional documents and records, observing systems demonstrations, and interviewing key MCO staff regarding the implementation of the ICP.

The readiness reviews included significant involvement of the MCOs. This involvement initially included MCO implementation staff and then transitioned to key MCO staff from each department. The key staff were involved in preparation for the readiness review including, but not limited to, quality, utilization management, disease management, case management, provider services, member services, and delegation oversight. HSAG provided technical assistance to the MCOs to facilitate the transition of pre-implementation activities to the post implementation activities. This transition was accomplished through a staged readiness review process spanning from pre-implementation through post implementation and into corrective action plan follow up as is described below²:

Pre-implementation Phase

- Review of desk review of documents required by the MCO contract to be prior approved and/or documents describing key functions of the MCO.
- Development of a tracking tool to monitor the documents due for review, documents received and in process of review or revision or complete.
- Conducting biweekly conference calls with the each MCO and HFS to maintain communication and track the progress towards implementation.
- Providing Feedback and technical assistance provided to the MCOs to facilitate the revisions to the documents as needed
- Providing and review of pre-assessment form, onsite document review list, onsite review agenda, file review sample submissions, readiness review tool and file review tools.

Early Implementation Phase

- Onsite review within 90 days of implementation.
- Systems demonstrations for care management, provider directory, prior authorizations, call center, and grievance and appeals systems.
- File reviews of care management cases, pre-delegation assessments, grievances and appeals, credentialing, and denial of services requests.
- Review of network adequacy reports.
- Compilation of review findings included deficiencies requiring corrective action plan.

Corrective Action Follow-up Phase

- Submission of corrective action response, corrective action work plan, and supporting documents to validate implementation of corrective actions.
- Onsite corrective action visit including technical assistance for any remaining unresolved corrective action actions.

² Personal correspondence from Margaret DeHesse, Executive Director, State & Corporate Services, Health Services Advisory Group

- Ongoing monitoring and feedback on compliance issues as approved by HFS.

Advantages to the staged process of readiness review included:

- Extensive review of documents describing the MCOs structure and operations prior to enrollment of participants.
- Review of actual care management cases, denial of service requests, and grievances and appeals resolution processes in addition to the desk review of policies and procedures and key documents.
- Identification of deficiencies in the implementation of processes described in the MCO policies and procedures and key documents including those items considered critical elements or high risk that would impact implementation of the program and the MCOs ability to accept new membership.
- Ongoing monitoring and follow up of the implementation process of the integrated care program.

In addition to the extensive readiness reviews conducted with the selected health plans, HFS requested that HSAG conduct an operations review prior to the awarding of contracts for the Integrated Care Program. This unique process allowed HFS to identify which of the bidding MCOs had the appropriate infrastructure, information systems and experience to meet the needs of the ICP population. For this review, HSAG visited the administrative offices of all MCOs bidding for the ICP contract and reviewed the health plans' systems and operations to assess their ability to manage the type of population served by the ICP.

Then, as described above, the selected health plans underwent an extensive readiness review process on the two plans prior to the program implementation date of May 1, 2011. As a result, all policies and procedures that had been identified during the readiness review phase as insufficiently meeting State and federal requirements were brought into compliance prior to implementation. Therefore, the State felt it would be more beneficial for HSAG to conduct the formal onsite portion of the review after implementation, in order to accurately assess how the MCOs had implemented the ICP program and if the members were being managed effectively. Employing this strategy allowed the review to include assessment of the actual functioning of systems, policies and procedures the MCOs had put in place and to sample actual member cases. The onsite portion of the review was conducted in July and August 2011.

In addition, in May 2012, HSAG conducted an additional onsite follow-up with each MCO on implementation of correction action process.

The results of the readiness reviews are summarized below in Tables 59 (Aetna) and 60 (IlliniCare). These two tables list each standard reviewed, the number of elements for each standard and the compliance result for each of the elements. HSAG assigned each element a score: Met, Not Met, Partially Met, or Not Applicable (NA). For any element assigned a Partially Met or Not Met finding, the MCO was required to develop a corrective action plan to identify how the plan would become compliant with the required element.

1. Aetna

There were a total of 269 elements applicable to Aetna's review (see Table 59). Aetna was found to be in compliance with 241 (90%) of the applicable elements. For each of the 28 elements out of compliance, Aetna developed a corrective action plan that HSAG monitored for compliance and eventual resolution. As of January 2013, Aetna had resolved 20 of the deficiencies, while 8 remained outstanding.

Table 59:
Summary of Readiness Review Conducted during Summer of 2011 (Aetna)

#	Standard	# Elements	# Met	Action Needed	% Met
I	Availability of Services	12	10	2	83.3%
II	Assurance of Adequate Capacity and Services	23	18	5	78.3%
III	Coordination and Continuity of Care (Including Transition of Care)	38	32	6	84.2%
IV	Coverage and Authorization of Services	17	16	1	94.1%
V	Credentialing and Recredentialing	42	41	1	97.6%
VI	Subcontractual Relationships and Delegation	19	16	3	84.2%
VII	Enrollee Information/Enrollee Rights	26	23	3	88.5%
VIII	Confidentiality	2	1	1	50.0%
IX	Enrollment and Disenrollment	9	8	1	88.9%
X	Grievance Process	35	35	0	100.0%
XI	Practice Guidelines	6	4	2	66.7%
XII	Quality Assessment and Performance Improvement Program	26	26	0	100.0%
XIII	Health Information System	6	6	0	100.0%
XIV	Fraud and Abuse	8	5	3	62.5%
Totals		269	241	28	89.6%

2. IlliniCare

HSAG found 271 of the elements to be applicable to IlliniCare (see Table 60). IlliniCare was found to be in compliance with 223 (82%) of the applicable elements. For each of the 48 elements out of compliance, IlliniCare developed a corrective action plan that HSAG monitored for compliance and eventual resolution. As of January 2013, IlliniCare had resolved 38 of the deficiencies, while 10 remained outstanding.

Table 60:
Summary of Readiness Review Conducted during Summer of 2011 (IlliniCare)

#	Standard	# Elements	# Met	Action Needed	% Met
I	Availability of Services	12	10	2	83.3%
II	Assurance of Adequate Capacity and Services	19	9	10	47.4%
III	Coordination and Continuity of Care (Including Transition of Care)	45	35	10	77.8%
IV	Coverage and Authorization of Services	17	14	3	82.4%
V	Credentialing and Recredentialing	42	40	2	95.2%
VI	Subcontractual Relationships and Delegation	19	16	3	84.2%
VII	Enrollee Information/Enrollee Rights	26	24	2	92.3%
VIII	Confidentiality	2	1	1	50.0%
IX	Enrollment and Disenrollment	9	7	2	77.8%
X	Grievance Process	35	31	4	88.6%
XI	Practice Guidelines	6	4	2	66.7%
XII	Quality Assessment and Performance Improvement Program	25	19	6	76.0%
XIII	Health Information System	6	6	0	100.0%
XIV	Fraud and Abuse	8	7	1	87.5%
Totals		271	223	48	82.2%

According to HSAG, no deficiencies were identified in the readiness review that would impact either MCO's ability to provide adequate services to ICP members. The State determined that both MCOs had sufficient infrastructure and processes to provide benefits and services to enrollees in accordance with State and federal regulations. HSAG informed us that the number and types of elements found to be not met for the two plans was "fairly typical" of the experience in other states and that nothing in either review merited delaying enrollment of members.

Conclusion

This section includes a summary of the findings contained in this report, as well as the recommendations that the UIC formulated after consideration of these results. The final section notes some of the changes that the state has already made in an attempt to improve the Integrated Care Program.

I. Summary of Findings

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. This is especially evident for 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 IlliniCare.

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.

II. Recommendations

These recommendations are not only specific to the ICP but may have relevance to other managed care initiatives that the state may undertake. In addition, in some cases, the plans and/or HFS have indicated they have already implemented some of the suggestions below and we have indicated this when possible.

Goal 1. Improve development of new provider networks and continuity of care from previous providers.

- a. HFS could clarify what specific responsibilities each plan should have in terms of signing local providers that have existing relationships with members.**

During the transition to a managed care system, there is often uncertainty and apprehension among existing members and providers as to whether relationships can be maintained. Any steps that could clarify what will happen in this area could reduce this apprehension and uncertainty. HFS has indicated that they have amended the contracts of both plans to require them to sign contracts with any willing providers if they accept the payment rates and Quality Assurance requirements of the plan

- b. 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.**

The plans differ considerably in the provider types and specialties they use in their geo-mapping reports that are used to evaluate the adequacy of their provider networks.

HFS has amended the contracts, effective July 2012, of both plans to increase consistency between the plans in this area. HFS could review the 28 provider types tracked for this report and consider them for inclusion in the geo-access reports.

- c. HFS should consider specifying minimum provider ratios for some categories of providers in addition to geographic access standards.**

Federal regulations specify that the "number and types" of providers based on the needs of prospective members should be specified prior to the start of a managed Medicaid program. Some states, including Illinois, rely to a great degree on geographic access standards (i.e. 99% of members being within 30 miles of the closest provider) and do not specify a minimum provider ratio for most provider types.

For some provider types, having a minimum provider ratio in addition to a geographic standard may be advisable. For example, by placing 1 provider, such as podiatrist, at 3 specific points in the ICP catchment area (Barrington, Woodridge, and Manteno), a plan could apparently meet the geographic standard and have 100% of their members within 30 miles of a provider.

For some provider types or specialties, having 3 providers responsible for 18,000 members might be acceptable while for others it might not be acceptable. HFS should review different provider types and decide if there are any that would benefit by coupling a minimum provider ratio with the geographic standard (for more detail on how 3 individual providers could theoretically cover the entire ICP area, see Appendix C).

d. HFS should consider better defining the information that it requires the plans to report in their affiliated provider reports.

It is hard to determine the capacity or “adequacy” of a provider network merely by counting the number of providers signed by a plan. Other factors such as willingness to accept Medicaid members and time availability of providers at specific locations factor into this calculation. A review of the literature indicates that this type of missing information is a common problem in other states as well as Illinois.

It is recommended that HFS consider including two additional requirements for plans for reports of signed providers: 1) number of new Medicaid patients providers are willing to accept and 2) the provider availability at each reported location (in terms of hours per week).

e. HFS should consider instituting regular reviews of the provider files to ensure accuracy of the network listings.

Maintaining the accuracy and completeness of provider listings is a complex and challenging task. Providers frequently move or change hours without informing the plans. HFS has said that it has begun “checking” provider files on an occasional basis, when time permits. In the future, HFS, like other states have, should institute a more regular process of periodically checking a small sample of provider files for accuracy of phone number, location, specialty, and provider availability.

f. Consider lengthening the "continuity of care" post-enrollment period from 3 months to 12 months.

Other states are finding that lengthening the amount of time that consumers may keep their current providers, regardless of whether they join the plan's

network, minimizes the disruption of care for "complex" members. Many of these members have spent considerable time identifying a team of providers who can assist them in their care. Giving more time to the consumer to make the transition to the new managed care environment without having to worry initially about finding new providers should reduce problems during transition.

Goal 2. Strengthen communication and involvement with stakeholder groups, providers, and state agency directors.

- a. HFS should consider hosting a public meeting to discuss the results of the formal readiness review with stakeholder groups.**

- b. Encourage the active participation of other state agencies in the formal readiness.**

State social service agencies in many states, including Illinois, have often been described as "silos," isolated from other state agencies as each delivers services to targeted consumers. If true, this points to the need for an active role of "sister" state agencies of HFS in the formal readiness review process to make sure that key issues (e.g. pre-approval of services, billing) associated with these agencies are identified and thoroughly discussed prior to implementation of the program.

HFS said they have taken steps to increase participation of other agencies in the readiness review performed for Service Package II.

- c. Establish a regular process to publicly update stakeholder groups on the progress of provider network development.**

HFS should consider hosting bi-monthly meetings that would update the public on the progress the plans are making on developing their provider networks. These meetings could initially educate stakeholders on how the new provider networks will differ from the existing array of providers. Advocates, providers, and other stakeholders often expect that the new provider network will look essentially the same as the baseline array of providers. If significant changes are expected in how the new provider network will "look", these changes could be publicly communicated to stakeholders as part of these meetings.

These meetings could also serve to update the public on the progress that the plans are making in developing their networks and answer any questions or concerns that public groups might have. The results could be reported

using the provider categories that are included in the geo-access reports, summarizing the number of providers that are signed to formal contracts for each provider category and other unsigned but available providers that the plans are including as part of their network (this report could borrow from the template in Appendix C that we have developed with the plans for this report).

- d. 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.**

This person would be a key liaison with the Department on Aging (DOA), the Department of Human Services/Division of Rehabilitation Services (DRS), the Department of Public Health (DPH) and the Department of Insurance (DOI) to ensure that consumer protections and quality assurances are maintained for consumers as they transition into the managed care system. HFS has said that they have designated one of their employees to be the “main liaison” to other state agencies for Service Package II.

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.

- a. Create a claims billing "test" environment to identify potential billing problems with network providers (especially for providers new to Medicaid).**

There are many smaller providers who have little or no experience with either commercial or Medicaid billing and have instead reported service data to other state agencies instead of billing for services. These providers need some training on billing issues. In fact, Aetna has indicated that they have increased the amount of training it has provided to Service Package II providers regarding billing issues.

- b. Develop a representative sample of case mix scenarios to test the proposed care management structure of the MCO.**

Many of the needs of persons with disabilities are complex and challenging and may be new to managed care plans with limited experience with this population. Case managers for the plans might benefit from taking part in training scenarios with actual cases constructed from claims data and care plans pulled for some of the more “challenging” members.

Engaging in this type of reality based problem solving prior to implementation would also expose MCO case managers to existing community staff experienced with the “scenario” cases and give the MCO staff a “head start” on building partnerships with community case managers.

Goal 4. Support the enrollment and transition processes for new members.

a. Continue and expand the use of system “navigators” for newly enrolled members.

In the ICP startup, HFS used a “community helper” program to assist ICP eligible individuals in making the decision regarding what plan to enroll with. These community helpers were existing trusted community-based organizations involved with the current population (i.e. area agencies on aging, independent living centers). Conversations with some of these agencies and with HFS, show mixed comments as to the success of the program.

It seems clear that the likely low health literacy among the ICP population would be a strong reason to continue and expand the program to include focused outreach and education to members in the hopes that the rate of auto-enrollment would decline and more members would be able to make a proactive choice.

b. Expand the use of “smart assignment” when auto-enrollment needs to occur.

When auto-enrollment does occur, every attempt should be made to make “smart” use of service utilization data to match enrollees either with the plan with the greatest number of the member's individual providers in their network or with the plan that has providers with expertise relevant to member's needs. Such an expansion might require an upgrade to the data that is currently available during the enrollment process. The current auto-enrollment process does have a bias towards equalizing enrollment between the plans and HFS could consider expanding the use of “smart assignment” in the process, even if it means negating the “equal enrollment” provision.

Goal 5. Improve consistency of reporting requirements for MCOs.

a. Improve overall consistency of data reporting.

HFS required the two plans to report a considerable amount of data regarding services provided during Year 1. However, differences in format, time period covered, outcome measures reported, and other issues made

comparisons between the two plans difficult. HFS has taken action in this area:

“The HFS Bureau of Managed Care compliance manager is working with a vendor (Navigant Consulting) to review operations reports (beginning with Aetna Better Health and IlliniCare Health Plan reports), assess reporting requirements and revamp the information collected as necessary to be able to use reports to compare the Plans to each other and against other benchmarking data. The consultants are developing a work plan outlining the estimated level of effort and key project milestones and deliverables before they can embark on this task. This area has been identified as high priority and as a result, work is anticipated to begin in one to three months”

b. Standardize the reporting of data regarding member complaints.

Similar to the data for prior authorization, the data for grievances for ICP members seems to be better collected than similar data for fee for service Medicaid members but there is still room for improvement. There is some confusion between the two plans about what a reportable complaint from members and/or providers is and when that complaint becomes a formal grievance. HFS has said that this confusion has been clarified and corrected for Year 2.

A second problem noted in this area was inconsistencies between the two plans on how grievances are tracked, classified, and “resolved”. The two plans used considerably different categories for reporting the “types of grievances” received and different categories for classifying the levels of resolution for grievances. Until these inconsistencies are resolved, it is very difficult to reliably compare the two plans in this area.

HFS has informed us that they have been working with the two plans to increase the comparability of the tracking and reporting of grievances and appeals between both plans. This has resulted in increased standardization of the processes which will be used by both plans in the future.

c. Standardize the requirements of the two plans regarding the reporting of Prior Authorization statistics.

HFS should be commended for the amount of data they are requiring the plans to track and report for service pre-approvals requests--these reporting requirements appear to be more complete and detailed than those for the

fee for service Medicaid program. However, there are still improvements that could be made in this area.

There were differences between the two plans on the categories used for reporting "types of requests" and confusion regarding the definition used to determine the difference between a "non-expedited" and an "expedited" request from a member or provider. HFS could take the lead in creating a cross-walk table between the two plans that would standardize the reporting of "types" of requests and clarify the definition of an expedited request.

d. Identify and annually release to the public comparable risk stratification data for the two plans.

The two plans are required to assign a risk level of high, medium, or low risk to all enrolled members. These assignments are used by the plans to identify members most likely to suffer adverse health outcomes and/or high levels of health resources. Based on this risk, decisions regarding intensity of care management, case coordinator caseloads, and other decisions regarding the intensity of follow up with members are made. It should be noted that HFS has recently amended their contracts with each plan to include the requirements that "Contractor shall assign no less than five percent (5%) of its Enrollees to this [high-risk] level" (Section 5.14.2.3.) and "Contractor shall assign no less than twenty percent (20%) of its Enrollees to moderate risk and high risk levels combined" (Section 5.14.2.2).

At the present time, each plan is permitted to use its own methodology to determine the member's risk level. This makes it difficult to compare outcome measures for each of the risk groups between the two plans. While each plan needs to have a degree of flexibility to use its own business process to carry out its work, it would be helpful if HFS could publish risk data that permits some basic comparisons to be made between the two plans. One possibility is for the state to consider summarizing risk scores for each plan based on some diagnostic or other grouping and making these average risk scores publicly available. HFS currently uses the Chronic Illness and Disability Payment System (CDPS) to calculate risk scores to determine capitation rates for each plan, which could help in this process.

Another related area where public reporting of data might be helpful involves the MCOs' risk stratification. Each of the risk stratification methodologies used by the two plans seeks to predict the likelihood of a member having either an ER event or an inpatient admission over the next year. HFS should

annually measure how effective these scores are in predicting actual ER events or hospital admissions.

- e. **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.**

HFS said that they have amended the contracts for both plans effective February 2013 and have “standardized the timelines required for development of care plans for high and moderate risk members.”

III. Future Evaluation Directions

Some of the analysis for this report was limited by not having access to the claims dataset for Year 1. Anticipating that we will soon have access to this data, we have compiled a list of areas that are important to study further in the upcoming year. Furthermore, as Phase II is being implemented we will be expanding the evaluation to include measures pertaining not only to health care but also to long-term services and supports.

In the next phase we plan to continue to collect the administrative data from HFS and the MCOs, to analyze the actual Medicaid encounter data, to expand and follow up with our consumer surveys, and to continue to hold focus groups.

1. Analyze the rate and circumstances of non-emergency dental services as compared to emergency dental services.

During 2006, there were more than 120 million hospital-based emergency department visits in the United States (Nalliah, et. al, 2010). Almost 3% of these were primarily attributed to dental caries. Untreated dental problems can be especially hard on adults with disabilities and “special needs.” Individuals with disabilities and the elderly may have physical and other limitations that interfere with good oral self-care and some medications may reduce saliva flow, which is a natural defense against cavity-causing bacteria (McGinn-Shapiro, 2008).

Once the Year 1 claims data is available, we plan on analyzing dental services and compare it to the baseline claims. Areas of focus will include non-emergency services provided by dentists, emergency department visits for dental problems, and hospital admissions related to dental problems.

2. Determine the extent to which both plans have implemented fully operational “medical homes” for their members who need them.

There is a national movement towards including fully functional “medical homes” and “medical neighborhoods” as foundational components in state Medicaid managed care initiatives. It appears that some elements of the medical home concept are being established in the ICP program. For example, Aetna has indicated they have begun a pilot with 60 physician practices to include a care management payment (one of the key attributes of paying for a medical home, along with fee for service and shared saving/pay for performance). Aetna reports paying \$2 to \$7 per patient per month to the physician practices. We will follow up with both Aetna and IlliniCare to learn more about progress they have made in this area.

3. Determine the number of “new” providers the plans recruited to the Medicaid program.

Some stakeholders expressed hope that new managed care initiatives in Illinois would bring providers into the program that were new to the Medicaid program. The preliminary data we have indicates that the plans did recruit some providers that had never participated in the Illinois Medicaid program before. However, our dataset is not yet complete and we hope to collect further data in the upcoming year which will clarify to what extent the recruitment of “new” Medicaid providers has occurred.

4. What impact did the plans have on the rate of psychotropic medications usage of members?

We have received some preliminary data from the plans concerning the prescription of medications for members which we have begun analyzing. There are concerns that individuals on multiple psychotropic medications may be at an increased risk for adverse drug reactions. We plan to review what utilization processes the plans have in place to monitor the possible over-prescription of medications that may occur.

5. What impact has ICP had on members who were “high users”?

We hope to identify a sample of “high service users” from the baseline sample and track their service utilization for the first two years of the ICP. We believe that analyzing this sample of individuals will permit us to get a better picture of how the “transition of care” actually occurred for members who had the greatest need.

6. What impact has the ICP program had on members who are part of the class action?

We have had initial discussions with state officials about the possibility of tracking some of the ICP members who are part of one or all of the three class action groups of Williams, Ligas, and Colbert and how they are faring under the dual forces of managed care and a class action settlement. Given additional resources, this could be another area we investigate in the next year.

7. Determine what impact the service reductions in the new SMART legislation have had on ICP members.

There has been speculation as to how the service limitations imposed by the SMART Act will affect ICP members. When the claims data for Year 1 becomes available, we hope to conduct an analysis on service utilization levels and the impact, if any, that the new service limits might be having on ICP members.

8. What impact has the ICP program had on costs?

Since the projected costs savings was a major factor for implementing the ICP, we expect that once the ICP claims data becomes available, we will review the costs of services and compare these figures to the baseline costs.

9. Determine whether the rate of "non-emergent" visits to hospital emergency departments has changed since ICP implementation.

Studies suggest that a significant proportion of ED users have "non-emergent" or "preventable conditions" that could have been successfully dealt with in non-emergency settings. In our review of the literature, we found that rates of "non-emergent" visits in various states ranged from 47% to 74%. An early national study revealed that 43% of ED users had non-serious illnesses or injuries that could have been treated in facilities other than EDs, and that the majority of these ED users chose to seek services from EDs even though there were other non-urgent care facilities available in their community (General Accounting Office, 1993).

During Year 1, we collected some preliminary data from both plans in this area. However, we concluded that without official claims data, it was not possible to make reliable comparisons between the baseline rates of "non-emergent" visits and the rate for Year 1 of the ICP. We will work with both plans and HFS to refine this data for further analysis.

10. Determine whether there has been any substantial change in the readmission rate for hospital discharges.

Hospital readmissions are sometimes indicators of poor care or missed opportunities for better coordinated care, or failure of the transition process from the hospital to the community. While not all of readmissions are avoidable, some are (Boutwell et al., 2011). A national study reported the 7 day, 14 day, and 30 day readmission rate for Medicaid enrollees as 7.6%, 12.5% and 20.8%, respectively for those aged between 18 and 44 years. The rate for middle aged Medicaid enrollees, ages 45 to 64, was slightly higher for each of the 3 measures (8.1%, 14.2% and 24.4%, respectively) (Wier et al., 2011).

Similar to what we reported above for “non-emergent” visits to emergency departments, we have collected some preliminary data from both plans in this area. However, that without official claims data, it was not possible to make reliable comparisons between the baseline rates of hospital readmissions and the readmission rates for Year 1 of the ICP. We will work with both plans and HFS to refine this data for further analysis.

11. Determine reasons for disenrollment and movement from one plan to the other.

The UIC team has recently received enrollment data from HFS that will permit us to track the rate of members transferring from one plan to the other. This data will be analyzed to determine whether there are any helpful indicators or trends that might guide future planning

In a related enrollment issue, although we received a dataset of 41,443 persons who were eligible for the ICP program just prior to it’s start, we noted that at the end of Year 1, only about 34,000 members had enrolled with either of the plans. In discussions with the plans and HFS about this, there was speculation that this "reduction" might have several causes:

- Some of the assumptions regarding eligibility (i.e. disability, address, not being eligible for Medicare) used to draw this dataset might have been wrong or changed; or
- some persons who had previously used both Medicaid and private insurance made a decision to no longer to utilize Medicaid under the new ICP provisions. The UIC team will explore the reasons for this reduction further in Year 2.

12. Determine the extent that provider offices are physically accessibility to members with disabilities.

One of the major concerns voiced during public stakeholder meetings was the lack of physical accessibility for provider offices. Both plans are required to work with the providers in their network to ensure that office locations, examination rooms, and equipment are fully accessible. In Year 2, we will review what processes both plans have in place to evaluate the physical accessibility of provider offices.

13. Document and compare the credentialing and reporting of physician specialties used in the ICP program to the process used in the FFS Medicaid program.

We have been impressed with the credentialing process that both plans use for their physician specialties. We have data from both the FFS program and the two plans in terms of the process that is used to track and report specialties. Although the data in its present state is not comparable between the FFS program and the two plans, we hope to review this area closer in the future as the populations covered by Service Package II will likely be closely involved with various specialties.

14. Analyze the degree of success that both plans have had in developing individualized care plans for their members that integrate both health and long-term supports.

We will work with HFS and both plans to develop methods and tools that will permit us to measure the success that the plans have made in developing individualized care plans for members that are person-centered and built around each member's specific preferences and needs. We will also try to determine the extent that the case coordination staff interact with existing case management staff and how they integrate both "covered" and "non-covered" services the member might need.

15. Assess the degree to which participants report satisfaction, self-determination, and self-direction regarding their long-term services and supports.

With input from our evaluation advisory board we will include measures in our consumer survey that reflect the degree to which people have control over their supports and their satisfaction with the supports provided.

16. Assess outcomes for individuals including health and function, residential status, community participation, employment, and overall well-being.

Include validated measures to assess outcomes over time for participants in the ICP program. Some of these measures have been included in the phase 1 evaluation, while others will be added in the next round of the surveys.

References and Works Consulted

- American Association on Health Disability. (2012). *State Dual Eligible Demonstration Projects-Summary of Key Consumer Issues and Recommendations*. Letter to Ms. Melanie Bella, Centers for Medicare and Medicaid Services submitted by American Association on Health Disability and 32 other national social service groups. Retrieved from <http://www.ncpssm.org/Portals/0/pdf/dual-eligible-demonstrations.pdf>
- Association for Community Affiliated Plans. (2011). *Ensuring Access Through Strong Provider Networks (ACAP Fact Sheet)*. Retrieved from <http://www.communityplans.net/Portals/0/Fact%20Sheets/Ensuring%20Access%20Through%20Strong%20Provider%20Networks.pdf>
- Bailit Health Purchasing LLC. (2009). *Network Adequacy in the Commonwealth Care Program*. Submitted to the Blue Cross Blue Shield of Massachusetts Foundation. Retrieved from <http://bluecrossmafoundation.org/sites/default/files/090422NetworkStandardsFINAL.pdf>
- Bernstein, S. L. (2006). Frequent emergency department visitors: the end of inappropriateness. *Annals of emergency medicine, 48*(1), 18-20.
- Billings, J., Parikh, N., Mijanovich, N. (2000a). *Emergency Department Use in New York City: A Substitute for Primary Care?* (Issue Brief). New York, NY: The Commonwealth Fund. Retrieved from http://www.commonwealthfund.org/usr_doc/billings_eduse_433.pdf
- Billings, J., Parikh, N., Mijanovich, N. (2000b). *Emergency Room Use: The New York Story* (Issue Brief). New York, NY: The Commonwealth Fund. Retrieved from http://www.commonwealthfund.org/usr_doc/billings_nystory.pdf
- Boutwell, A. E., Johnson, M. B., Rutherford, P., Watson, S. R., Vecchioni, N., Auerbach, B. S., et al. (2011). An early look at a four-state initiative to reduce avoidable hospital readmissions. *Health Aff (Millwood), 30*(7), 1272-1280.
- Centers for Medicare & Medicaid Services. (2012). *National Health Expenditures 2011 Highlights*. Retrieved from <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/highlights.pdf>
- Centers for Medicaid & Medicaid Services, U.S. Department of Health and Human Services. (2011). *MA Health Services Delivery Provider & Facility Specialties and Network Adequacy Criteria Guidance*. Retrieved from http://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/downloads/CY2013_HSD_Provider_Facility_Specialties_Criteria_Guidance_111011.pdf

- Centers for Medicaid & Medicaid Services, U.S. Department of Health and Human Services. (2003). *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al.* Retrieved from <http://dss.mo.gov/mhd/mc/pdf/p-standardsrev.pdf>
- Committee on the Future of Emergency Care in the United States Health System. *Hospital-Based Emergency Care: At the Breaking Point*. Washington, DC: The National Academies Press, 2007.
- DeLia, D. (2006). *Potentially Avoidable Use of Hospital Emergency Departments in New Jersey*. A Report to the New Jersey Department of Health and Senior Services. Rutgers, NJ: The Institute for Health, Health Care Policy and Aging Research, Rutgers Center for State Health Policy.
- Ferber, J. (1996). Auto-assignment and enrollment in Medicaid managed care programs. *Journal Of Law, Medicine & Ethics*, 24(2), 99. Retrieved from <http://web.ebscohost.com/ehost/pdfviewer/pdfviewer?sid=d94fe355-679a-4ac6-aa78-67539b92ccf9%40sessionmgr112&vid=2&hid=107>
- Florida Center for Health Information and Policy Analysis, A. f. H. C. A. (2010). *Emergency Department Utilization Report 2009*. Tallahassee, FL: Agency for Health Care Administration. Retrieved from http://floridahealthfinderstore.blob.core.windows.net/documents/researchers/documents/ED%20Utilization%20Report%202009_2010-10-08.pdf
- General Accounting Office. (1993). *EMERGENCY DEPARTMENTS: Unevenly Affected by Growth and Change in Patient Use* (GAO/HRD-93-4). Washington, D.C: General Accounting Office.
- Georgia Department of Audits and Accounts Performance Audit Operations. (2008). *Limited Review of Accessibility for Medicaid Managed Care Members* (Special Examination 08-36). Retrieved from <http://www.audits.ga.gov/rsaAudits/searchReports.aud>
- Health & Medicine Policy Research Group & SEIU Healthcare. (2012). *Consumer Protections and Quality Assurances In Managed Long-Term Supports and Services Programs*. Unpublished paper.
- Healthcare Cost and Utilization Project. (2011). *HCUP Facts and Figures: Statistics on Hospital-Based Care in the United States, 2009*. Retrieved from <http://www.ncbi.nlm.nih.gov/books/NBK91984/>
- Illinois Academy of Family Physicians & Robert Graham Center. (2010). *Illinois Health Connect and Your HealthCare Plus: A Case Statement*.
- Integrated Care Resource Center. (2012). *Low-Cost, Low-Administrative Burden Ways to better Integrate Care for Medicare-Medicaid Enrollees* (Technical Assistance Brief).

- Retrieved from http://www.chcs.org/usr_doc/ICRC_-_Low_Cost_Approaches_to_Integration2_FINAL.pdf
- Jordan, R. (2012). Medicare To Penalize 2,217 Hospitals For Excess Readmissions. *Kaiser Health News*. Retrieved from <http://www.kaiserhealthnews.org/stories/2012/august/13/medicare-hospitals-readmissions-penalties.aspx>
- Kaiser Commission on Medicaid and the Uninsured (2010). *Medicaid and Managed Care: Key Data, Trends, and Issues* (Policy Brief). Retrieved from <http://www.kff.org/medicaid/upload/8046.pdf>
- Kaiser Commission on Medicaid and the Uninsured (2011). *A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey*. Retrieved from <http://www.kff.org/medicaid/upload/8220.pdf>
- Kaiser Commission on Medicaid and the Uninsured (2011). *Examining Medicaid Managed Long-Term Service and Support Programs: Key Issues to Consider* (Issue Paper). Retrieved from <http://www.kff.org/medicaid/upload/8243.pdf>
- Kaiser Commission on Medicaid and the Uninsured (2012). *People with Disabilities and Medicaid Managed Care: Key Issues to Consider* (Issue Paper). Retrieved from <http://www.kff.org/medicaid/upload/8278.pdf>
- Kaiser Commission on Medicaid and the Uninsured. (2000). *Mandatory Medicaid Managed Care – Plan and Enrollee Perspectives on the Enrollment Process* (Issue Paper). <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13736>
- LaCalle, E., & Rabin, E. (2010). Frequent users of emergency departments: the myths, the data, and the policy implications. *Annals of emergency medicine*, 56(1), 42-48.
- McGinn-Shapiro, M. (2008). Medicaid Coverage of Adult Dental Services. *State Health Policy Monitor*, October 2008.
- Nalliah, R.P. et al. (2010). Hospital Based Emergency Department Visits Attributed To Dental Caries in the United States, *Evidence Based Dental Practice*, 2010 (10), 212-222.
- National Association of States United for Aging and Disabilities. (2013). *State Medicaid Integration Tracker. Review of State Medicaid Integration Plans*. 9th Ed. Washington, DC: NASUAD. Retrieved from <http://www.nasuad.org/documentation/Integration%20Tracker%20January%202013.pdf>
- National Health Law Program. (2012). *Medicaid Managed Care: Enrollment and Education* (Fact Sheet #1). Retrieved from http://www.medicaidmattersmd.org/MMC_Fact_Sheet_1_Enrollment_Education_Final.pdf

- Oddone, E. Z., & Weinberger, M. (2012). Hospital readmission rates: are we measuring the right thing? *Ann Intern Med*, 157(12), 910-911.
- Office of Program Analysis & Government Accountability, an office of the Florida Legislature. (2008). *Medicaid Reform: Reform Provider Network Requirements same as Traditional Medicaid; Improvements needed to Ensure Beneficiaries have Access to Specialty Providers* (Report No. 08-64). Retrieved from <http://www.oppaga.state.fl.us/MonitorDocs/Reports/pdf/0864rpt.pdf>
- Palsbo, S. E., Diao, G., Palsbo, G. A., Tang, L., Rosenberger, W. F., & Mastal, M. F. (2010). Case-Mix Adjustment and Enabled Reporting of the Health Care Experiences of Adults With Disabilities. *Archives of Physical Medicine and Rehabilitation*, 91, 9, 1339.
- Pitts, S. R., Carrier, E. R., Rich, E. C., & Kellermann, A. L. (2010). Where Americans get acute care: increasingly, it's not at their doctor's office. *Health Aff (Millwood)*, 29(9), 1620-1629.
- Raven, M., Gould D.A. (2012). *Time and Again: Frequent Users of Emergency Department Services in New York City* (Issue Brief). New York, NY: United Hospital Fund. Retrieved from <http://www.uhfnyc.org/publications/880847>
- Smulowitz, P. B., Honigman, L., & Landon, B. E. (2012). A Novel Approach to Identifying Targets for Cost Reduction in the Emergency Department. *Annals of emergency medicine* (in press).
- Sommers, A. S., Boukus, E. R., & Carrier, E. (2012). Dispelling myths about emergency department use: majority of Medicaid visits are for urgent or more serious symptoms. *Res Brief* (23), 1-10, 11-13.
- South Carolina Public Health Institute. (2011). *A Report on Frequent Users of Hospital Emergency Departments in South Carolina*. Columbia, SC: South Carolina Public Health Institute. Retrieved from <http://scphi.org/wordpress/wp-content/uploads/2011/02/Report-on-Frequent-Users-of-ED-in-SC-FINAL.pdf>
- Taheri, P. A., Butz, D. A., & Greenfield, L. J. (2000). Length of stay has minimal impact on the cost of hospital admission. *J Am Coll Surg*, 191(2), 123-130.
- Tang, N., Stein, J., Hsia, R. Y., Maselli, J. H., & Gonzales, R. (2010). Trends and characteristics of US emergency department visits, 1997-2007. *JAMA*, 304(6), 664-670.
- The Kaiser Family Foundation. (2012). *The Kaiser Family Foundation State Health Facts*. Retrieved from <http://www.statehealthfacts.org>
- Wier, L. M., Barrett, M., Steiner, C., Jiang, H.J. (2011). *All-Cause Readmissions by Payer and Age, 2008* (Statistical Brief #115). Agency for Healthcare Research and Quality. Retrieved from <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb115.pdf>

Appendices

The appendices are split by topic into seven sections. The contents of these sections are listed below.

Appendix A: Data Production

Listing of factors that contributed to the delay in producing encounter data for the ICP program. [From HFS]

Appendix B: Baseline Members

Figure B-1	Location of Baseline Physicians and Consumers
Table B-2	Services by Provider Type
Table B-3	Providers by Service Type
Table B-4	Summary of Baseline Services
Table B-5	Provider Group Detail

Appendix C: Provider Network

Table C-1	Summary of State Provider Adequacy Requirements for Primary Care
Table C-2	Use of GeoAccess Mapping by MCOs (Provider Types)
Table C-3	Use of GeoAccess Mapping by MCOs (Physician Specialties)
Table C-4	Signing of high volume hospitals at 2 months and 1 Year
Table C-5	Description of how the Provider Network tables were constructed
Table C-6	Additional filters used for Provider Network tables
Table C-7	Summary of Aetna Provider Network (Individual Practitioners-1 Year)
Table C-8	Summary of Aetna Provider Network (Group Providers-1 Year)
Table C-9	Summary of IlliniCare Provider Network (Individual Practitioners-1 Year)
Table C-10	Summary of IlliniCare Provider Network (Group Providers-1 Year)

Table C-11 Summary of other “available” providers

Appendix D: Prior Approval

Table D-1 Aetna’s Precertification List

Table D-2 IlliniCare’s Covered Benefits

Appendix E: Transportation

Table E-1 Comparison of Transportation Services

Table E-2 Additional Detail on Transportation Call Centers

Appendix F: Grievances and Appeals

Listing of Complaints Received by HFS for Illinois Medical Programs
(5/1/2011 to 4/30/2012) [From HFS]

Appendix G: Readiness Review

Table G1 Readiness Review Activities Performed

Appendix A: Data Production

Related to the delay in the production of encounter data for Year 1 of the ICP, we asked for an explanation from HFS of the reasons for the delay. HFS responded with a narrative listing the following factors that contributed to the delay in producing encounter data for the ICP program:

- 1.** Educating the MCOs on Illinois specific requirements required several months of weekly meetings.
- 2.** The transition from the Implementation team to the permanent MCO staff caused some delay. Some of the information and documentation previously provided was not transferred by the Implementation team to the appropriate MCO staff.
- 3.** Responding to numerous questions related to billing and claim submission required input from various staff within HFS. Due to retirements within the last couple of years, resources are scarce and a many of the staff with specific knowledge are no longer around which resulted in some delay for getting responses from HFS.
- 4.** Started out testing with 4010 version of the HIPAA transactions. Since the deadline for implementing the 5010 version was near and testing was close to being completed, our BIS staff decided we should have the MCOs stop programming and mapping for the 4010. MCOs had to redirect their resources and switch gears and start working on the 5010 version of the 837P, 837I and 837D. All this required significant programming and testing.
- 5.** Processing the MCO test files requires manual intervention from HFS staff. Many different staff persons are involved in the process. At the same time the Integrated Care MCOs were testing, the 3 Voluntary MCOs were also testing the 5010 transactions with HFS. The volume of files coming in was significant. The same staff that works on new development, troubleshooting, production problems and daily processing are the same ones that are responsible for handling the HIPAA test files.
- 6.** Once files are processed, remittance files are produced for the MCOs. The MCOs must review files and try and determine the cause of errors. This requires assistance from HFS staff. Once again, there are very limited HFS resources for this task. Depending on the errors, it may take reprogramming on the MCO's part or it may be something that can be corrected and resubmitted right away. Either case, files must be resubmitted and the entire process starts again.

7. Appendix B: Baseline Members

Figure B-1:

Baseline Physicians and Consumers

March 31, 2011 (Prior to Implementation)

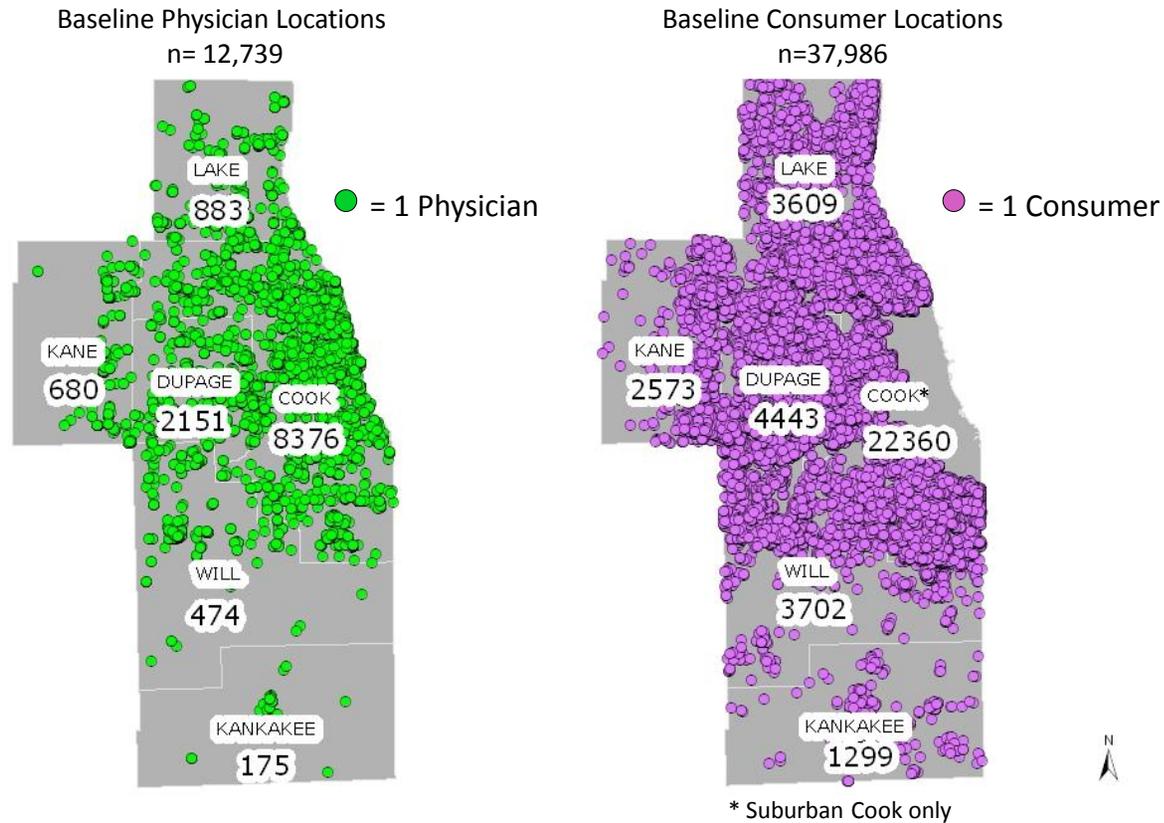


Table B-2**Services by Provider Type (7/1/10 - 3/31/11)**

Service Type	Provider Type	Members	Claims	Payments
Alcohol and Substance Abuse Rehab. Services	Department of Alcohol and Substance Abuse Provider	662	10,710	\$935,377
	General Hospitals	33	136	\$51,240
Anesthesia Services	Nurse Practitioners	452	676	\$86,080
	Physicians	4,984	5,425	\$1,152,508
Audiology Services	Audiologists	279	663	\$18,168
	General Hospitals	167	323	\$8,286
	Local Education Agencies	7	7	\$58
	Rehabilitation Hospitals	4	6	\$180
Auto transportation (private)	Other Transportation Providers (Non-Registered)	41	526	\$1,997
	Waiver service provider--Adults (DHS/DDD)	27	1,252	\$24,152
Capitation Services	Prepaid health plan--Health maintenance organization	16	64	\$8,784
	Prepaid health plan--Managed care community network	7	32	\$6,144
	Prepaid health plan--Prescription drug plan	4	10	\$15
Chiropractic Services	Chiropractors	108	1,124	\$9,791
Clinic Services (Physical Rehabilitation)	General Hospitals	315	1,608	\$370,694
	Rehabilitation Hospitals	201	647	\$192,945
Clinical Laboratory Services	Independent Laboratories	20,677	231,992	\$2,005,240
Dental Services	Dentists	8,191	36,940	\$1,491,857
	Federally Qualified Health Centers	804	3,691	\$127,841
Electronic Home Response/EHR Installation(MARS), MPE Certification(Provider)	Waiver service provider--Disability (DHS/DRS)	163	1,206	\$33,502
	Waiver service provider--Elderly (DOA)	171	786	\$20,750
	Waiver service provider--HIV/AIDS (DHS/DRS)	5	15	\$420
	Waiver service provider--TBI (DHS/DRS)	54	341	\$9,524
Emergency Ambulance Transportation	Ambulance Service Providers	7,540	25,662	\$1,931,739
	Hospital-Based Transportation Providers	64	194	\$13,261
Environmental modifications (waiver)	Waiver service provider--Adults (DHS/DDD)	5	11	\$30,615
	Waiver service provider--Children's support (DHS/DDD)	1	3	\$15,000
Exceptional Care	ICF/MR	32	307	\$2,778,278
	Nursing Facilities	40	272	\$1,744,955
General Clinic Services	Encounter rate clinic	2,701	21,353	\$2,179,282

Table B-2**Services by Provider Type (7/1/10 - 3/31/11)**

Service Type	Provider Type	Members	Claims	Payments
	Federally Qualified Health Centers	10,171	96,742	\$2,606,541
	Rural Health Clinics	113	570	\$21,424
Healthy Kids Services	Certified local public health department	11	11	\$108
	Federally Qualified Health Centers	39	50	\$133
	General Hospitals	68	133	\$1,465
	Healthy Kids (EPSDT) screening clinics	28	54	\$652
	Local Education Agencies	39	65	\$437
	Nurse Practitioners	10	12	\$210
	Physicians	227	341	\$16,343
	Rural Health Clinics	1	2	\$0
	Home Care	Hospice	143	457
Home Health Services	Certified local public health department	2	31	\$2,821
	Home Health Agencies - In Home	1,271	17,750	\$1,372,451
Homemaker	Waiver service provider--Disability (DHS/DRS)	160	1,033	\$1,608,738
	Waiver service provider--Elderly (DOA)	1,083	65,418	\$4,163,131
	Waiver service provider--HIV/AIDS (DHS/DRS)	3	20	\$32,994
	Waiver service provider--TBI (DHS/DRS)	31	180	\$356,026
Inpatient Hospital Services (General)	General Hospitals	7,848	12,388	\$110,565,426
Inpatient Hospital Services (Physical Rehabilitation)	General Hospitals	148	164	\$1,493,385
	Rehabilitation Hospitals	111	127	\$2,034,684
Inpatient Hospital Services (Psychiatric)	General Hospitals	2,438	3,398	\$14,861,992
	Psychiatric Hospitals	59	116	\$986,947
LTC - Intermediate	Nursing Facilities	2,910	22,072	\$59,779,552
	Nursing facility--(Demonstration facility)	282	2,760	\$6,056,309
LTC - MR Recipient between ages 21-65	Federally Qualified Health Centers	17	82	\$2,046
LTC - Skilled	Nursing Facilities	1,148	7,779	\$23,639,353
LTC - Specialized Living Center - Intermediate MR	ICF/MR	17	181	\$726,204
LTC - Supportive Living Facility (Waivers)	Waiver service provider--Supportive living facility (HFS)	90	620	\$1,149,676
LTC Full Medicare Coverage	Nursing Facilities	6	13	-\$1,535
LTC--Developmental training (level I)	ICF/MR	451	3,860	\$4,911,432
LTC-ICF/MR	ICF/MR	395	4,292	\$17,022,254
	State-operated facility (DHS)	292	2,737	\$39,682,025
LTC--ICF/MR skilled pediatric	ICF/MR	53	505	\$2,750,574

Table B-2**Services by Provider Type (7/1/10 - 3/31/11)**

Service Type	Provider Type	Members	Claims	Payments
LTC--NF skilled (partial Medicare coverage)	Nursing Facilities	8	13	\$2,869
Medical equipment/prosthetic devices	Audiologists	65	125	\$45,231
	General Hospitals	54	114	\$38,750
	Other Providers of Medical Equipment/Supplies (Non-registered)	5,074	19,576	\$4,527,637
	Rehabilitation Hospitals	37	90	\$25,367
	Waiver service provider--Children's support (DHS/DDD)	1	3	\$912
Medical Supplies	Audiologists	97	163	\$1,810
	General Hospitals	29	48	\$629
	Other Providers of Medical Equipment/Supplies (Non-registered)	4,700	51,123	\$4,545,341
	Rehabilitation Hospitals	10	11	\$131
	State-operated school (DHS)	5	379	\$8,417
Medicar Transportation	Ambulance Service Providers	497	4,803	\$56,519
	Medicar Provider	1,468	44,402	\$461,050
Mental Health Rehab Option Services	Community mental health provider	4,378	104,801	\$5,107,262
Midwife Services	Nurse Practitioners	7	8	\$435
Non-Emergency Ambulance Transportation	Ambulance Service Providers	2,076	6,319	\$431,453
Nurse Practitioners Services	Nurse Practitioners	2,360	7,655	\$259,360
Nursing service	Local Education Agencies	69	1,993	\$120,128
	Registered nurse	11	1,922	\$541,666
	State-operated school (DHS)	7	805	\$46,004
	Waiver service provider--Adults (DHS/DDD)	1	123	\$1,826
Occupational Therapy Services	Community Health Agencies - In home	1	2	\$74
	General Hospitals	264	1,548	\$23,176
	Local Education Agencies	32	441	\$11,868
	Occupational Therapists	118	470	\$15,298
	Rehabilitation Hospitals	65	363	\$10,616
	State-operated school (DHS)	4	26	\$1,785
Optical Supplies	Opticians / Optical Companies	5,277	14,767	\$146,547
	Optometrists	3,240	3,332	\$100,232
	Physicians	442	456	\$13,666
Optometric Services	Optometrists	2,921	2,986	\$55,181
Other Transportation	Local Education Agencies	12	361	\$9,645
Outpatient Services (ESRD)	General Hospitals	377	3,973	\$7,152,065
Outpatient Services (General)	Ambulatory Surgical Treatment Centers	285	400	\$278,998

Table B-2**Services by Provider Type (7/1/10 - 3/31/11)**

Service Type	Provider Type	Members	Claims	Payments
	General Hospitals	28,894	66,916	\$22,583,550
Pharmacy Services (Drug and OTC)	General Hospitals	186	2,300	\$383,880
Physical Therapy Services	Community Health Agencies - In home	4	40	\$1,412
	Local Education Agencies	23	320	\$9,974
	Physical Therapists	230	1,598	\$55,204
	State-operated school (DHS)	4	78	\$4,076
Physician Services	Certified local public health department	962	3,274	\$101,648
	Dentists	28	45	\$3,334
	General Hospitals	18,183	139,986	\$5,414,201
	Imaging Services	717	1,178	\$134,344
	Local Education Agencies	11	17	\$2,078
	Nurse Practitioners	64	401	\$1,603
	Optometrists	5,661	8,210	\$301,546
	Physicians	247,871	1,189,714	\$30,627,263
	Rehabilitation Hospitals	83	166	\$34,081
	Rural Health Clinics	103	676	\$2,692
	School Based / Linked Health Clinics	2	7	\$148
	State-operated school (DHS)	2	6	\$1,470
Podiatric Services	Podiatrists	5,132	15,625	\$448,565
Portable X-Ray Services	Imaging Services	1,492	6,081	\$75,074
Psychiatric Clinic Services (Type 'A')	General Hospitals	387	1,506	\$160,500
	Psychiatric Hospitals	11	21	\$5,440
Psychiatric Clinic Services (Type 'B')	General Hospitals	129	566	\$287,848
	Psychiatric Hospitals	2	4	\$1,717
Psychologist service	Federally Qualified Health Centers	57	280	\$7,422
	Local Education Agencies	66	262	\$13,128
	State-operated school (DHS)	3	3	\$230
Service Car	Ambulance Service Providers	893	4,752	\$31,633
	Medicar Provider	3,834	195,728	\$1,552,560
	Taxicabs and Livery Companies	658	31,225	\$324,836
Social work service	Federally Qualified Health Centers	302	25,597	\$636,205
	Local Education Agencies	167	1,960	\$40,876
	State-operated school (DHS)	5	133	\$3,772
SOPF--MI recipient over 64 years of age	State-operated facility (DHS)	1	9	\$186,865
SOPF--MI recipient under 22 years of age	State-operated facility (DHS)	1	1	\$16,444
Speech Therapy/Pathology Services	Community Health Agencies - In home	1	28	\$1,175

Table B-2**Services by Provider Type (7/1/10 - 3/31/11)**

Service Type	Provider Type	Members	Claims	Payments
	General Hospitals	74	332	\$4,630
	Local Education Agencies	137	2,380	\$80,977
	Rehabilitation Hospitals	28	175	\$2,718
	Speech Therapists	61	206	\$7,126
	State-operated school (DHS)	2	34	\$1,370
Targeted case management service (mental health)	Community mental health provider	2,601	12,682	\$449,449
	Waiver service provider--Adults (DHS/DDD)	854	20,986	\$686,836
	Waiver service provider--Children's support (DHS/DDD)	51	1,530	\$52,448
Taxicab Services	Taxicabs and Livery Companies	100	6,961	\$52,787
Waiver service (depends on HCPCS code)	Local Education Agencies	4	309	\$13,076
	Registered nurse	6	129	\$24,014
	State-operated school (DHS)	4	386	\$1,683
	Waiver service provider--Adults (DHS/DDD)	4,608	634,622	\$50,863,363
	Waiver service provider--Children's residential (DHS/DDD)	43	4,412	\$1,099,780
	Waiver service provider--Children's support (DHS/DDD)	72	4,394	\$322,055
	Waiver service provider--Disability (DHS/DRS)	1,934	23,073	\$17,228,926
	Waiver service provider--Elderly (DOA)	73	5,780	\$223,703
	Waiver service provider--HIV/AIDS (DHS/DRS)	96	1,120	\$739,368
	Waiver service provider--TBI (DHS/DRS)	394	4,940	\$3,919,798

Table B-3
Providers by Service Type (7/1/10 - 3/31/11)

Provider Type	Service Type	Members	Claims	Payments
Ambulance Service Providers	Emergency Ambulance Transportation	7,540	25,662	\$1,931,739
	Medicar Transportation	497	4,803	\$56,519
	Non-Emergency Ambulance Transportation	2,076	6,319	\$431,453
	Service Car	893	4,752	\$31,633
Ambulatory Surgical Treatment Centers	Outpatient Services (General)	285	400	\$278,998
Audiologists	Audiology Services	279	663	\$18,168
	Medical equipment/prosthetic devices	65	125	\$45,231
	Medical Supplies	97	163	\$1,810
Certified local public health department	Healthy Kids Services	11	11	\$108
	Home Health Services	2	31	\$2,821
	Physician Services	962	3,274	\$101,648
Chiropractors	Chiropractic Services	108	1,124	\$9,791
Community Health Agencies - In home	Occupational Therapy Services	1	2	\$74
	Physical Therapy Services	4	40	\$1,412
	Speech Therapy/Pathology Services	1	28	\$1,175
	Mental Health Rehab Option Services	4,378	104,801	\$5,107,262
	Targeted case management service (mental health)	2,601	12,682	\$449,449
Dentists	Dental Services	8,191	36,940	\$1,491,857
	Physician Services	28	45	\$3,334
Department of Alcohol and Substance Abuse Provider	Alcohol and Substance Abuse Rehab. Services	662	10,710	\$935,377
Encounter rate clinic	General Clinic Services	2,701	21,353	\$2,179,282
Federally Qualified Health Centers	Dental Services	804	3,691	\$127,841
	General Clinic Services	10,171	96,742	\$2,606,541
	Healthy Kids Services	39	50	\$133
	LTC - MR Recipient between ages 21-65	17	82	\$2,046
	Psychologist service	57	280	\$7,422
	Social work service	302	25,597	\$636,205
General Hospitals	Alcohol and Substance Abuse Rehab. Services	33	136	\$51,240
	Audiology Services	167	323	\$8,286
	Clinic Services (Physical Rehabilitation)	315	1,608	\$370,694
	Healthy Kids Services	68	133	\$1,465
	Inpatient Hospital Services (General)	7,848	12,388	\$110,565,426
	Inpatient Hospital Services (Physical Rehabilitation)	148	164	\$1,493,385
	Inpatient Hospital Services (Psychiatric)	2,438	3,398	\$14,861,992

**Table B-3
Providers by Service Type (7/1/10 - 3/31/11)**

Provider Type	Service Type	Members	Claims	Payments
	Medical equipment/prosthetic devices	54	114	\$38,750
	Medical Supplies	29	48	\$629
	Occupational Therapy Services	264	1,548	\$23,176
	Outpatient Services (ESRD)	377	3,973	\$7,152,065
	Outpatient Services (General)	28,894	66,916	\$22,583,550
	Pharmacy Services (Drug and OTC)	186	2,300	\$383,880
	Physician Services	18,183	139,986	\$5,414,201
	Psychiatric Clinic Services (Type 'A')	387	1,506	\$160,500
	Psychiatric Clinic Services (Type 'B')	129	566	\$287,848
	Speech Therapy/Pathology Services	74	332	\$4,630
Healthy Kids (EPSDT) screening clinics	Healthy Kids Services	28	54	\$652
Home Health Agencies - In Home	Home Health Services	1,271	17,750	\$1,372,451
Hospice	Home Care	143	457	\$2,576,490
Hospital-Based Transportation Providers	Emergency Ambulance Transportation	64	194	\$13,261
ICF/MR	Exceptional Care	32	307	\$2,778,278
	LTC - Specialized Living Center - Intermediate MR	17	181	\$726,204
	LTC--Developmental training (level I)	451	3,860	\$4,911,432
	LTC--ICF/MR	395	4,292	\$17,022,254
	LTC--ICF/MR skilled pediatric	53	505	\$2,750,574
Imaging Services	Physician Services	717	1,178	\$134,344
	Portable X-Ray Services	1,492	6,081	\$75,074
Independent Laboratories	Clinical Laboratory Services	20,677	231,992	\$2,005,240
Local Education Agencies	Audiology Services	7	7	\$58
	Healthy Kids Services	39	65	\$437
	Nursing service	69	1,993	\$120,128
	Occupational Therapy Services	32	441	\$11,868
	Other Transportation	12	361	\$9,645
	Physical Therapy Services	23	320	\$9,974
	Physician Services	11	17	\$2,078
	Psychologist service	66	262	\$13,128
	Social work service	167	1,960	\$40,876
	Speech Therapy/Pathology Services	137	2,380	\$80,977
	Waiver service (depends on HCPCS code)	4	309	\$13,076
Medicar Provider	Medicar Transportation	1,468	44,402	\$461,050
	Service Car	3,834	195,728	\$1,552,560

Table B-3**Providers by Service Type (7/1/10 - 3/31/11)**

Provider Type	Service Type	Members	Claims	Payments
Nurse Practitioners	Anesthesia Services	452	676	\$86,080
	Healthy Kids Services	10	12	\$210
	Midwife Services	7	8	\$435
	Nurse Practitioners Services	2,360	7,655	\$259,360
	Physician Services	64	401	\$1,603
Nursing Facilities	Exceptional Care	40	272	\$1,744,955
	LTC - Intermediate	2,910	22,072	\$59,779,552
	LTC - Skilled	1,148	7,779	\$23,639,353
	LTC Full Medicare Coverage	6	13	-\$1,535
	LTC--NF skilled (partial Medicare coverage)	8	13	\$2,869
Nursing facility--(Demonstration facility)	LTC - Intermediate	282	2,760	\$6,056,309
Occupational Therapists	Occupational Therapy Services	118	470	\$15,298
Opticians / Optical Companies	Optical Supplies	5,277	14,767	\$146,547
Optometrists	Optical Supplies	3,240	3,332	\$100,232
	Optometric Services	2,921	2,986	\$55,181
	Physician Services	5,661	8,210	\$301,546
Other Providers of Medical Equipment/Supplies (Non-registered)	Medical equipment/prosthetic devices	5,074	19,576	\$4,527,637
	Medical Supplies	4,700	51,123	\$4,545,341
Other Transportation Providers (Non-Registered)	Auto transportation (private)	41	526	\$1,997
Physical Therapists	Physical Therapy Services	230	1,598	\$55,204
Physicians	Anesthesia Services	4,984	5,425	\$1,152,508
	Healthy Kids Services	227	341	\$16,343
	Optical Supplies	442	456	\$13,666
	Physician Services	247,871	1,189,714	\$30,627,263
Podiatrists	Podiatric Services	5,132	15,625	\$448,565
Prepaid health plan--Health maintenance organization	Capitation Services	16	64	\$8,784
Prepaid health plan--Managed care community network	Capitation Services	7	32	\$6,144
Prepaid health plan--Prescription drug plan	Capitation Services	4	10	\$15
Psychiatric Hospitals	Inpatient Hospital Services (Psychiatric)	59	116	\$986,947
	Psychiatric Clinic Services (Type 'A')	11	21	\$5,440
	Psychiatric Clinic Services (Type 'B')	2	4	\$1,717
Registered nurse	Nursing service	11	1,922	\$541,666
	Waiver service (depends on HCPCS code)	6	129	\$24,014
Rehabilitation Hospitals	Audiology Services	4	6	\$180
	Clinic Services (Physical Rehabilitation)	201	647	\$192,945

Table B-3**Providers by Service Type (7/1/10 - 3/31/11)**

Provider Type	Service Type	Members	Claims	Payments
	Inpatient Hospital Services (Physical Rehabilitation)	111	127	\$2,034,684
	Medical equipment/prosthetic devices	37	90	\$25,367
	Medical Supplies	10	11	\$131
	Occupational Therapy Services	65	363	\$10,616
	Physician Services	83	166	\$34,081
	Speech Therapy/Pathology Services	28	175	\$2,718
Rural Health Clinics	General Clinic Services	113	570	\$21,424
	Healthy Kids Services	1	2	\$0
	Physician Services	103	676	\$2,692
School Based / Linked Health Clinics	Physician Services	2	7	\$148
Speech Therapists	Speech Therapy/Pathology Services	61	206	\$7,126
State-operated facility (DHS)	LTC--ICF/MR	292	2,737	\$39,682,025
	SOPF--MI recipient over 64 years of age	1	9	\$186,865
	SOPF--MI recipient under 22 years of age	1	1	\$16,444
	Medical Supplies	5	379	\$8,417
	Nursing service	7	805	\$46,004
	Occupational Therapy Services	4	26	\$1,785
	Physical Therapy Services	4	78	\$4,076
	Physician Services	2	6	\$1,470
	Psychologist service	3	3	\$230
	Social work service	5	133	\$3,772
	Speech Therapy/Pathology Services	2	34	\$1,370
	Waiver service (depends on HCPCS code)	4	386	\$1,683
Taxicabs and Livery Companies	Service Car	658	31,225	\$324,836
	Taxicab Services	100	6,961	\$52,787
Waiver service provider--Adults (DHS/DDD)	Auto transportation (private)	27	1,252	\$24,152
	Environmental modifications (waiver)	5	11	\$30,615
	Nursing service	1	123	\$1,826
	Targeted case management service (mental health)	854	20,986	\$686,836
	Waiver service (depends on HCPCS code)	4,608	634,622	\$50,863,363
Waiver service provider--Children's residential (DHS/DDD)	Waiver service (depends on HCPCS code)	43	4,412	\$1,099,780
Waiver service provider--Children's support (DHS/DDD)	Environmental modifications (waiver)	1	3	\$15,000
	Medical equipment/prosthetic devices	1	3	\$912
	Targeted case management service (mental	51	1,530	\$52,448

Table B-3
Providers by Service Type (7/1/10 - 3/31/11)

Provider Type	Service Type	Members	Claims	Payments
	health)			
	Waiver service (depends on HCPCS code)	72	4,394	\$322,055
Waiver service provider--Disability (DHS/DRS)	Electronic Home Response/EHR Installation(MARS), MPE Certification(Provider)	163	1,206	\$33,502
	Homemaker	160	1,033	\$1,608,738
	Waiver service (depends on HCPCS code)	1,934	23,073	\$17,228,926
Waiver service provider--Elderly (DOA)	Electronic Home Response/EHR Installation(MARS), MPE Certification(Provider)	171	786	\$20,750
	Homemaker	1,083	65,418	\$4,163,131
	Waiver service (depends on HCPCS code)	73	5,780	\$223,703
Waiver service provider--HIV/AIDS (DHS/DRS)	Electronic Home Response/EHR Installation(MARS), MPE Certification(Provider)	5	15	\$420
	Homemaker	3	20	\$32,994
	Waiver service (depends on HCPCS code)	96	1,120	\$739,368
Waiver service provider--Supportive living facility (HFS)	LTC - Supportive Living Facility (Waivers)	90	620	\$1,149,676
Waiver service provider--TBI (DHS/DRS)	Electronic Home Response/EHR Installation(MARS), MPE Certification(Provider)	54	341	\$9,524
	Homemaker	31	180	\$356,026
	Waiver service (depends on HCPCS code)	394	4,940	\$3,919,798

Table B-4
Summary of Baseline Services
(July 1, 2010 thru March 31, 2011)

Category	ServiceType	Members	Claims	Paid
Clinics	General Clinic Services	11,039	120,319	\$4,952,618
	Psychologist service	139	590	\$23,311
	Social work service	499	28,610	\$699,271
Equip & Supplies	Medical equipment/prosthetic devices	4,549	20,907	\$4,771,858
	Medical Supplies	4,185	53,728	\$4,701,944
	Optical Supplies	4,550	15,029	\$234,444
Inpatient Hospital	Inpatient Hospital Services (General)	6,345	12,802	\$115,197,437
	Inpatient Hospital Services (Physical Rehabilitation)	262	299	\$3,620,790
	Inpatient Hospital Services (Psychiatric)	1,736	3,615	\$16,585,821
	SOPF--MI recipient over 64 years of age	3	22	\$437,156
	SOPF--MI recipient under 22 years of age	5	8	\$103,004
Lab & X-ray	Clinical Laboratory Services	15,190	242,392	\$2,096,678
	Portable X-Ray Services	1,460	6,066	\$74,020
Long Term Care	Exceptional Care	70	595	\$4,568,283
	LTC - Intermediate	2,797	25,164	\$66,353,102
	LTC - MR Recipient between ages 21-65	17	86	\$2,145
	LTC - Skilled	1,122	7,981	\$24,085,556
	LTC - Specialized Living Center - Intermediate MR	17	181	\$726,204
	LTC Full Medicare Coverage	6	13	-\$1,535
	LTC--Developmental training (level I)	458	3,930	\$4,989,915
	LTC--ICF/MR	682	7,076	\$57,037,598
	LTC--ICF/MR skilled pediatric	53	505	\$2,749,783
	LTC--NF skilled (partial Medicare coverage)	8	13	\$2,869
	SOPF--MI recipient non-matchable	1	3	\$47,739
Other	Alcohol and Substance Abuse Rehab. Services	577	11,266	\$1,017,713
	Anesthesia Services	4,074	6,267	\$1,267,527
	Audiology Services	458	1,073	\$29,086
	Capitation Services	22	96	\$13,521
	Chiropractic Services	106	1,166	\$10,163
	Dental Services	7,509	33,946	\$1,280,898
	Healthy Kids Services	410	708	\$19,989
	Home Care	156	513	\$2,874,452
	Home Health Services	1,299	19,394	\$1,474,556
	Mental Health Rehab Option Services	3,639	125,700	\$6,166,140
	Midwife Services	6	9	\$438
	Nurse Practitioners Services	2,092	7,992	\$268,542
	Nursing service	102	5,441	\$783,511
	Occupational Therapy Services	446	3,256	\$75,071
	Optometric Services	2,988	3,107	A-15\$57,456

Table B-4
Summary of Baseline Services
(July 1, 2010 thru March 31, 2011)

Category	ServiceType	Members	Claims	Paid
	Physical Therapy Services	241	2,518	\$86,819
	Podiatric Services	4,547	15,837	\$454,216
	Speech Therapy/Pathology Services	305	4,133	\$142,240
	Targeted case management service (mental health)	3,260	41,469	\$1,420,919
Outpt. Hospital	Clinic Services (Physical Rehabilitation)	517	2,295	\$565,037
	Outpatient Services (ESRD)	354	4,128	\$7,499,991
	Outpatient Services (General)	19,940	67,987	\$22,994,531
	Psychiatric Clinic Services (Type 'A')	397	1,586	\$173,218
	Psychiatric Clinic Services (Type 'B')	135	620	\$298,705
Pharmacy	Pharmacy Services (Drug and OTC)	184	2,300	\$383,880
Physicians	Physician Services	35,227	1,379,320	\$37,778,060
Transportation	Auto transportation (private)	70	1,644	\$27,680
	Emergency Ambulance Transportation	5,833	26,156	\$1,971,747
	Medicar Transportation	1,996	30,485	\$341,135
	Non-Emergency Ambulance Transportation	1,784	6,020	\$416,513
	Other Transportation	77	1,812	\$46,446
	Service Car	3,652	120,506	\$996,875
	Taxicab Services	115	4,601	\$33,858
Waiver	Electronic Home Response/EHR Installation(MARS), MPE	453	3,354	\$90,607
	Environmental modifications (waiver)	13	28	\$105,732
	Homemaker	1,168	108,985	\$9,221,891
	LTC - Supportive Living Facility (Waivers)	79	613	\$1,140,855
	Waiver service (depends on HCPCS code)	4,350	752,952	\$82,187,171
			3,349,217	\$497,777,198

Appendix C: Provider Network

Table C-1				
Summary of State Provider Adequacy Requirements for Primary Care¹				
General Criteria	Specific Criteria	# of states	Specific States	Comment
Provider Ratios	PCP Ratio	11	CA, CO, CT, HI, MA, MD, MI, NM, RI, SC, TN	Ranges from 1:387 to 1:2000
	FTE PCP ratio	4	FL, NJ, NV, VA	Ranges from 1:1500 to 1:2000
	FTE Physician	1	IL	1:2000
Geographic	Travel time/distance	11	DE, IN, KY, MN, MO, MS, NM, TN, TX, WI, WY	From 30/30 to 60/60
	# of PCPs within distance	6	GA, MA, MD, NE, PA, WA	
Wait times	Appointments	4	MN, NM, NV, RI, TN	
Other Criteria	Annual recalculation	1	AZ	
	Minimum number of providers	3	DC, NY, OH	
	"Sufficient number"	1	UT	

¹ Extracted from National survey by Kaiser Commission on Medicaid-2010

Table C-2
Use of GeoAccess Mapping by MCOs
(Provider Types)

Provider Type	Included in Survey?		# of Providers	
	Aetna	IlliniCare	Aetna	IlliniCare
Audiologists	Yes	Yes	4	4
Behavioral Health Providers	Yes	Yes	53	3,154
Chiropractors	Yes	No	20	
Clinical social worker	Yes	No	140	
Community mental health provider	No	Yes		185
Counselors	Yes	Yes	143	760
Department of Alcohol and Substance Abuse Provider	No	Yes		37
Federally Qualified Health Centers	Yes	Yes	29	45 ¹
General Hospitals	Yes	Yes	17	24 ²
Home Health Agencies	Yes	Yes	14	8
Independent Laboratories	Yes	No	61	
Non-licensed providers	No	Yes		1,789
Nursing Facilities	Yes	No	74	
Durable Medical Equipment Providers	Yes	No	45	
PhD	No	Yes		66
Physicians	No	Yes		207
Podiatrists	Yes	Yes	42	44
Psychology	Yes	No	37	
Radiology Center	Yes	No	6	
Registered nurse	No	Yes		85
			685	6,339

Dates of survey were 7/15/11 for Aetna and 8/22/11 for IlliniCare

¹ Mean of 2 surveys that were conducted; 1 survey reported 11 providers; 1 survey reported 79 providers

² Mean of 2 surveys that were conducted; 1 survey reported 13 providers; 1 survey reported 35 providers

20 provider types reported

7 reported by both plans

13 reported by only 1 plan

Table C-3
Use of GeoAccess Mapping by MCOs
 (Physician Specialties)

Specialty	Included in Survey?		# of Providers	
	Aetna	IlliniCare	Aetna	IlliniCare
Allergy & Immunology	Yes	No	8	
Cardiology	Yes	Yes	47	104
Dermatology	Yes	No	3	
Endocrinology	Yes	No	5	
Family Practice Physicians	Yes	Yes	273	367
General Preventative Medicine	Yes	No	4	
Hematology & Oncology	Yes	No		34
Infectious Diseases	Yes	Yes	42	69
Nephrology	Yes	Yes	66	66
Neurology	Yes	Yes	15	35
Neuro-Surgery	Yes	No		18
Obstetric-Gynecology	Yes	Yes	103	111
Oncology	Yes	No	5	
Ophthalmology	Yes	Yes	54	64
Orthopedic Surgery	Yes	Yes	3	20
Otolaryngology	Yes	Yes	5	19
Physical Medicine/Rehabilitation	Yes	No	6	
Primary Care	Yes	No	706	
Pulmonary Diseases	Yes	Yes	2	49
Rheumatology	Yes	Yes	9	30
Surgery General	Yes	Yes	23	61
Urology	Yes	Yes	7	24
Vascular Surgery	No	Yes		14
TOTALS			1,386	1,085

Dates of survey were 7/15/11 for Aetna and 8/22/11 for IlliniCare

23 total Specialties

13 reported by both plans

10 reported by only 1 plan

Aetna--"The methodology used by Aetna Better Health for GEO Access reporting was defined by our Network implementation team and the National Recruiting Center. The selected provider and service categories were identical to the categories used in other states. The emphasis was on Primary Care Physicians (rolled up into one category) and the 23 nationally recognized specialty categories. The primary focus of the reported data is on member access defined as the distance from the member's location to the nearest provider and the distance to the second nearest provider. The success metric is the percentage (%) of members that meet or exceed those criteria. Aetna Better Health attained an aggregate score of 100% for all but one of the

Table C-4**Listing of Baseline Hospitals and MCO signings at 2 months and 1 Year**

Hospital	City	2 Months		1 Year		Baseline Claims
		Aetna	IlliniCare	Aetna	IlliniCare	
CHRIST HOSPITAL	OAK LAWN	No	No	Yes	No	17,997
PROVENA (Elgin, Aurora, Kankakee, and Joliet)	JOLIET	Yes	Yes	Yes	Yes	15,508
FOSTER G MCGAW HOSPITAL	MAYWOOD	No	No	No	No	15,206
INGALLS MEMORIAL HOSPITAL	HARVEY	No	No	No	No	13,286
EVANSTON HOSPITAL	EVANSTON	No	Yes	No	Yes	12,774
OAK FOREST HOSPITAL	OAK FOREST	Yes	Yes	Yes	Yes	10,316
CENTRAL DUPAGE HOSPITAL	WINFIELD	No	No	Yes	Yes	9,278
UNIVERSITY OF ILLINOIS HOSP	CHICAGO	Yes	No	Yes	No	9,057
VISTA MEDICAL CENTER WEST	WAUKEGAN	No	No	Yes	Yes	8,654
UNIVERSITY OF CHICAGO HOSPITAL	CHICAGO	No	No	No	Yes	8,504
RUSH UNIVERSITY MEDICAL CENTER	CHICAGO	No	No	No	No	8,137
MT SINAI HOSP MED CTR CHICAGO	CHICAGO	No	Yes	No	Yes	6,885
ST JAMES HOSP AND HLTH CTRS	OLYMPIA FIELDS	Yes	Yes	Yes	Yes	6,285
SILVER CROSS HOSPITAL	JOLIET	No	No	Yes	Yes	5,638
ELMHURST MEMORIAL HOSPITAL	ELMHURST	No	No	No	Yes	5,335
ST ALEXIUS MEDICAL CENTER	HOFFMAN ESTATES	No	No	No	No	5,149
ALEXIAN BROTHERS MED CTR	ELK GROVE VLGE	No	No	No	No	4,965
NORTHWESTERN MEMORIAL HOSP	CHICAGO	No	No	Yes	Yes	4,474
SHERMAN HOSPITAL	ELGIN	Yes	Yes	Yes	Yes	3,813
RIVERSIDE MED CTR	KANKAKEE	Yes	No	Yes	No	3,787
EDWARD HOSPITAL	NAPERVILLE	No	No	No	Yes	3,502
ADVOCATE CONDELL MEDICAL CTR	LIBERTYVILLE	Yes	No	Yes	No	3,368
NORTHWEST COMMUNITY HOSPITAL	ARLINGTON HGTS	No	No	No	No	3,231
COPLEY MEMORIAL HOSPITAL	AURORA	No	No	No	No	2,884
MACNEAL HOSPITAL	BERWYN	Yes	Yes	Yes	Yes	2,848
SAINT MARGARET MERCY SO	DYER	No	No	No	No	2,565
MERCY HOSPITAL MEDICAL CENTER	CHICAGO	Yes	Yes	Yes	Yes	2,516
GOTTLIEB MEMORIAL HOSPITAL	MELROSE PARK	No	No	No	No	2,282

Table C-4**Listing of Baseline Hospitals and MCO signings at 2 months and 1 Year**

Hospital	City	2 Months		1 Year		Baseline Claims
		Aetna	IlliniCare	Aetna	IlliniCare	
HINSDALE HOSPITAL	HINSDALE	Yes	Yes	Yes	Yes	2,269
OUR LADY RES MED CTR	CHICAGO	Yes	Yes	Yes	Yes	2,212
VHS WESTLAKE HOSPITAL INC	MELROSE PARK	Yes	Yes	Yes	Yes	2,139
ST MARY OF NAZARETH HOSPITAL	CHICAGO	Yes	Yes	Yes	Yes	2,111
METROSOUTH MEDICAL CENTER	BLUE ISLAND	No	Yes	No	Yes	2,093
CHILDRENS MEMORIAL HOSPITAL	CHICAGO	No	No	No	No	2,034
OAK PARK HOSPITAL	OAK PARK	No	No	No	No	1,910
SWEDISH COVENANT HOSPITAL	CHICAGO	Yes	Yes	Yes	Yes	1,829
JACKSON PARK HOSP FOUNDATION	CHICAGO	Yes	No	Yes	Yes	1,757
VHS WEST SUBURBAN MEDICAL CNTR	OAK PARK	Yes	Yes	Yes	Yes	1,594
ST FRANCIS HOSPITAL	EVANSTON	Yes	Yes	Yes	Yes	1,562
PALOS COMMUNITY HOSPITAL	PALOS HEIGHTS	Yes	No	Yes	Yes	1,509
RESURRECTION MEDICAL CENTER	CHICAGO	Yes	Yes	Yes	Yes	1,404
GLENOAKS HOSPITAL	GLENDAL HGT	Yes	Yes	Yes	Yes	1,344
ADVENTIST BOLINGBROOK HOSPITAL	BOLINGBROOK	Yes	Yes	Yes	Yes	1,294
LORETTO HOSPITAL	CHICAGO	Yes	No	Yes	No	1,195
METHODIST HOSPITAL OF CHICAGO	CHICAGO	Yes	No	Yes	Yes	1,175
LA GRANGE MEMORIAL HOSPITAL	LAGRANGE	Yes	Yes	Yes	Yes	1,152
LITTLE COMPANY OF MARY HOSP	EVERGREEN PARK	No	No	No	Yes	1,149
LAKE FOREST HOSPITAL	LAKE FOREST	No	No	Yes	Yes	1,101
DELNOR COMMUNITY HOSPITAL	GENEVA	No	No	Yes	Yes	1,047

Table C-5**Description of how the Provider Network tables were constructed**

Step	Description
1	Obtained dataset of all claims paid for ICP eligible population for baseline period.
2	Obtained state provider table from HFS listing all Medicaid providers for Illinois as of 8/2012
3	Identified all providers in the baseline who had 1 or more claim during baseline period (called "baseline providers")-filtered these providers by unique Medicaid ProviderID to avoid duplicate counts of providers with multiple claims and/or locations
4	Divided baseline providers into local (in catchment area or within 30 miles of boundary) and non-local
5	Divided the "local" baseline providers that were individual practitioners into "active" (3 or more office visits during baseline period) and non-active
MCO providers	
6	Obtained a monthly "CEB Provider File" as specified in Attachment XIII of state contract with MCOs from HFS listing all "affiliated" providers in the MCO network
7	Took 2 "snapshots" of the provider network at the 2 month and 1 Year mark of ICP program by analyzing the July 2011 and June 2012 CEB provider files
8	Identified distinct providers by querying list by unique Medicaid ProviderID (first 9 characters) to avoid duplicate counts of providers with multiple locations
9	Divided unique providers into two initial groups: 1) matched with ProviderID in the state-wide Medicaid provider file ("verified Medicaid providers"); and 2) could NOT match MCO provider with a ProviderID in the state-wide Medicaid provider file ("unverified Medicaid providers")
10	We then attempted to match the recognized Medicaid providers to the baseline providers in Step 5 above. For those that were matched, we termed them "signed baseline" providers. For those not matched to the baseline group, we termed them "other signed" providers.
11	We requested and obtained from both plans a list of providers who had been paid as out of network (non-par) providers for Year 1 (May 1, 2011 through April 30, 2012).
12	As a first step in classifying this "paid non-par" group, we excluded any providers who had been identified as a signed provider in step 10 above. This would ensure that we did not count the same provider twice, once as a signed provider and once as a paid non-par provider.
13	We then attempted to match the remaining paid non-par providers to the baseline providers in Step 5 above. Those that were matched, were termed "unsigned but paid non-par baseline" providers. Those not matched to the baseline, were termed "other unsigned but paid non-par" providers.
14	We notified both plans that some of the names in their CEB provider files could not be matched to the state provider file ("unverified Medicaid providers" in step 9 above). Both plans felt that many of these unverified providers were actually available providers that should be counted but did not show in the CEB file or paid file for various reasons. We invited both plans to submit any additional names of these "available" providers and any documentation that would clarify the status of these providers.
15	Both plans submitted lists of additional "available" providers that they felt had not yet been counted.

Table C-5**Description of how the Provider Network tables were constructed**

Step	Description
16	In working with these additional lists of "available" providers, we first excluded any providers that had already been included in our table as either a signed or paid non-par provider.
17	For the remaining "available" providers, we attempted to match them by ProviderID or NPI with names in the official state-wide provider table. For those that we had a match for, we included them in the column "Other Available Network Providers." For the other "available" providers for which they could not be matched to an entry in the state-wide provider table, we invited the plans to write a narrative regarding these providers and we would include the narrative as a footnote to the table.
Summary	
	<ul style="list-style-type: none"> We ended with 6 different classifications of providers, 5 of them counted under a column in the table and 1 not counted in the table but accompanied by a narrative from the plan
	<ul style="list-style-type: none"> The 5 types included in the table were 2 types of signed providers, 2 types of paid out of network providers, and 1 that we identified as "Other Available Network Providers", which unsigned and unpaid but available providers that could be matched to the state provider file.
	<ul style="list-style-type: none"> All 5 types in the table shared two characteristics: 1) we could match them to a ProviderID or NPI in the state-wide provider file; and 2) they were not duplicated across the 5 columns.
	<ul style="list-style-type: none"> The 6th type, "unsigned and unpaid but available" provider that could NOT be matched to a row in the state-wide provider file, could be a duplicate of another provider already in our table but was identified by the plan as being an additional "available" provider in their network.

Table C-6**Additional filters used for Provider Network Tables**

Which provider types should be included in the analysis?	The HFS Medicaid database tracks 77 different provider types. Of these, 54 provider types had delivered one or more encounter to ICP eligible members during the baseline period. We reviewed these 54 provider types and determined that about half of them could be excluded from our analysis either due to very low encounter levels or relevance for Service Package 1. As a result, we decided to include 28 provider types for our analysis related to the new provider networks.
Should all providers within a particular provider type, regardless of location or volume of claims, be used in the analysis	We considered whether to exclude some providers, due to either their location in relation to the 6 county catchment area or due to the level or type of activity they had with members during the baseline period.
Defining and including "local" providers	Since a priority of state and MCO staff was to recruit "local" providers to minimize the travel required of members, we only included those providers whose primary location was either within the catchment area or within 30 miles of the area's outer boundary. Hence, we excluded about 20% of the 23,000 providers who had at least 1 encounter with the ICP eligible population during the 9 months baseline period immediately prior to the start of the ICP.
Defining and including providers who had "ongoing" member relationships	The formal contracts between the state and the two plans specified that each plan would permit providers who had an "active, ongoing course of treatment" with members but had refused to sign a contract with the plan to continue as an "out-of-network" provider for at least 90 days. We defined "active ongoing" providers as providers who had seen at least one member in his/her office 3 times or more during the 9 month baseline period.

Table C-7
Summary of Aetna Provider Network (Individual Practitioners-1 Year)
 (Individual Practitioners-1 Year)

Provider Type	Baseline Providers ¹			Aetna Provider Network (Year 1)						
	Grand Total ²	Local ³	Local and "active" ⁴	Signed as Providers ⁵		Paid as non-par during Year 1 ⁸		Other Avail. Network Providers ¹¹	Total Available Providers ¹²	
				Local and "active" ⁶	Other ⁷	Local and "active" ⁹	Other ¹⁰			
Audiologists	61	44	22	2	4	4	15	2	27	
Chiropractors	52	40	32	2	17	4	3		26	
Dentists	950	828	705	212	186	3	3		404	
Nurse Practitioners	521	402	72	15	205	19	209		448	
Occupational Therapists	48	41	6	2	2	1	3	13	21	
Opticians / Optical Companies ¹³	28	22	3	1	4	0	2		7	
Optometrists	362	299	173	63	70	12	22		167	
Physical Therapists	108	90	40	2	4	4	16	13	39	
Physicians	15,077	12,141	4,592	1,460	3,043	1,582	5,497	5	11,587	
Podiatrists	316	273	178	52	36	63	62		213	
Speech Therapists	25	23	0	0	5	0	0	8	13	

¹ Any provider that submitted 1 or more claim for ICP eligibles during 9 month period of July 1, 2010 thru March 31, 2011 (just prior to ICP "go-live" date)

² All providers with 1 or more claim during baseline period

³ Only those baseline providers in the ICP catchment area

⁴ Only those baseline providers in the ICP catchment area AND who had at least one member who they saw 3 or more times in an office/home setting

⁵ Any provider listed in the official MCO provider as being a signed provider at the 1 Year checkpoint

⁶ Any signed provider who was from the "local and active" group of baseline providers

⁷ Any other signed provider that was not a "local and active" baseline provider

⁸ Any provider not signed by the MCO during Year 1 but continued to be paid at least one time as out of network provider

⁹ Any "local and active" baseline provider who was not signed by MCO but continued to be paid as out of network provider paid during Year 1

¹⁰ Any provider who was not a "local and active" baseline provider, not signed by MCO but continued to be paid as out of network provider during Year 1

¹¹ Providers not signed or paid during Year 1 but available to deliver services to ICP members (typically part of a group practice)

¹² Non-duplicated count of "signed", "paid", and "available" providers with the MCO network

¹³ Aetna provided us a list of 123 individual providers without ProviderID or NPI--they could not be verified as Medicaid approved providers

Table C-8

**Summary of Baseline Providers and Aetna Provider Network
(Group Providers-1 Year)**

Provider Type	Baseline Providers ¹		Aetna Provider Network (Year 1)					Total Available Providers ¹¹
	Grand Total ²	Local ³	Signed as Providers ⁴		Paid as non-par during Year 1 ⁷		Other Avail. Network Providers ¹⁰	
			Local ⁵	Other ⁶	Local ⁸	Other ⁹		
Ambulance Service Providers	290	217	0	0	188	5		193
Ambulatory Surgical Treatment Centers	30	24	2	0	10	1		13
Certified local public health department	14	6	2	0	3	0	1	6
Community mental health /behavioral health provider	89	67	16	0	9	0	9	34
Department of Alcohol and Substance Abuse Provider	44	38	7	0	3	0	17	27
Federally Qualified Health Centers	43	30	17	0	1	0	1	19
General Hospitals	301	106	52	16	32	6		106
Home Health Agencies - In Home	108	89	17	16	24	1		58
Hospice	31	27	11	3	13	0		27
Imaging Services	72	65	7	12	15	0		34
Independent Laboratories	89	26	7	7	12	7		33
Medicar Provider	218	185	0	0	3	0	7	10
Nursing Facilities	269	229	53	8	18	0	26	105
Other Providers of Medical Equipment/Supplies (Non-registered)	386	264	99	36	44	7		186
Psychiatric Hospitals	7	7	1	0	2	0	1	4
Rehabilitation Hospitals	5	4	0	0	3	0		3
Taxicabs and Livery Companies	75	60	0	0	0	0	1	1

¹ Any provider that submitted 1 or more claim for ICP eligibles during 9 month period of July 1, 2010 thru March 31, 2011 (just prior to ICP "go-live" date)

² All providers with 1 or more claim during baseline period

³ Only those baseline providers in the ICP catchment area

⁴ Any provider listed in the official MCO provider as being a signed provider at the 1 Year checkpoint

Table C-8

Summary of Baseline Providers and Aetna Provider Network (Group Providers-1 Year)

⁵ Any signed provider who was a "local" baseline provider

⁶ Any other signed provider that was not a "local" baseline provider

⁷ Any provider not signed by the MCO during Year 1 but continued to be paid at least one time as out of network provider

⁸ Any "local" baseline provider who was not signed by MCO but continued to be paid as out of network provider paid during Year 1

⁹ Any provider who was not a "local" baseline provider, not signed by MCO but continued to be paid as out of network provider during Year 1

¹⁰ Providers not signed or paid during Year 1 but available to deliver services to ICP members (typically part of a group practice)

¹¹ Non-duplicated count of "signed", "paid", and "available" providers with the MCO network

Table C-9
Summary of Baseline Providers and IlliniCare Provider Network
 (Individual Practitioners-1 Year)

Provider Type	Baseline Providers ¹			IlliniCare Provider Network (Year 1)					
	Grand Total ²	Local ³	Local and "active" ⁴	Signed as Providers ⁵		Paid as non-par during Year 1 ⁸		Other Avail. Network Providers ¹¹	Total Available Providers ¹²
				Local and "active" ⁶	Other ⁷	Local and "active" ⁹	Other ¹⁰		
Audiologists	61	44	22	2	11	0	7		20
Chiropractors	52	40	32	1	3	2	8		14
Dentists	950	828	705	91	40	87	73	37	328
Nurse Practitioners	521	402	72	6	125	21	182	16	350
Occupational Therapists	48	41	6	1	6	1	2		10
Opticians / Optical Companies	28	22	3	1	2	2	2	19	26
Optometrists	362	299	173	32	24	11	10		77
Physical Therapists	108	90	40	4	4	7	5	1	21
Physicians	15,077	12,141	4,592	1,258	2,569	1,548	5,235	187	10,797
Podiatrists	316	273	178	54	24	51	53		182
Speech Therapists	25	23	0	0	7	0	1	2	10

¹ Any provider that submitted 1 or more claim for ICP eligibles during 9 month period of July 1, 2010 thru March 31, 2011 (just prior to ICP "go-live" date)

² All providers with 1 or more claim during baseline period

³ Only those baseline providers in the ICP catchment area

⁴ Only those baseline providers in the ICP catchment area AND who had at least one member who they saw 3 or more times in an office/home setting

⁵ Any provider listed in the official MCO provider as being a signed provider at the 1 Year checkpoint

⁶ Any signed provider who was from the "local and active" group of baseline providers

⁷ Any other signed provider that was not a "local and active" baseline provider

⁸ Any provider not signed by the MCO during Year 1 but continued to be paid at least one time as out of network provider

⁹ Any "local and active" baseline provider who was not signed by MCO but continued to be paid as out of network provider paid during Year 1

¹⁰ Any provider who was not a "local and active" baseline provider, not signed by MCO but continued to be paid as out of network provider during Year 1

¹¹ Providers not signed or paid during Year 1 but available to deliver services to ICP members (typically part of a group practice)

¹² Non-duplicated count of "signed", "paid", and "available" providers with the MCO network

Table C-10
Summary of Baseline Providers and IlliniCare Provider Network
 (Group Providers-1 Year)

Provider Type	Baseline Providers ¹		IlliniCare Provider Network (Year 1)					Total Available Providers ¹¹
	Grand Total ²	Local ³	Signed as Providers ⁴		Paid as non-par during Year 1 ⁷		Other Avail. Network Providers ¹⁰	
			Local ⁵	Other ⁶	Local ⁸	Other ⁹		
Ambulance Service Providers	290	217	2	0	2	221		225
Ambulatory Surgical Treatment Centers	30	24	3	1	1	9		14
Certified local public health department	14	6	3	0	1	2		6
Community mental health /behavioral health provider	89	67	28	1	10	3		42
Department of Alcohol and Substance Abuse Provider	44	38	6	1	4	4		15
Federally Qualified Health Centers	43	30	16	0	1	0	3	20
General Hospitals	301	106	54	12	19	115		200
Home Health Agencies - In Home	108	89	18	10	22	15	1	66
Hospice	31	27	7	2	6	22	1	38
Imaging Services	72	65	3	2	5	16	7	33
Independent Laboratories	89	26	10	14	2	28	2	56
Medicar Provider	218	185	1	0	0	1		2
Nursing Facilities	269	229	98	16	1	22	3	140
Other Providers of Medical Equipment/Supplies (Non-registered)	386	264	126	47	25	48	7	253
Psychiatric Hospitals	7	7	1	0	0	1		2
Rehabilitation Hospitals	5	4	2	0	0	1		3
Taxicabs and Livery Companies	75	60	1	0	0	0		1

¹ Any provider that submitted 1 or more claim for ICP eligibles during 9 month period of July 1, 2010 thru March 31, 2011 (just prior to ICP "go-live" date)

² All providers with 1 or more claim during baseline period

³ Only those baseline providers in the ICP catchment area

⁴ Any provider listed in the official MCO provider as being a signed provider at the 1 Year checkpoint

⁵ Any signed provider who was a "local" baseline provider

⁶ Any other signed provider that was not a "local" baseline provider

Table C-10
Summary of Baseline Providers and IlliniCare Provider Network
(Group Providers-1 Year)

⁷ Any provider not signed by the MCO during Year 1 but continued to be paid at least one time as out of network provider

⁸ Any "local" baseline provider who was not signed by MCO but continued to be paid as out of network provider paid during Year 1

⁹ Any provider who was not a "local" baseline provider, not signed by MCO but continued to be paid as out of network provider during Year 1

¹⁰ Providers not signed or paid during Year 1 but available to deliver services to ICP members (typically part of a group practice)

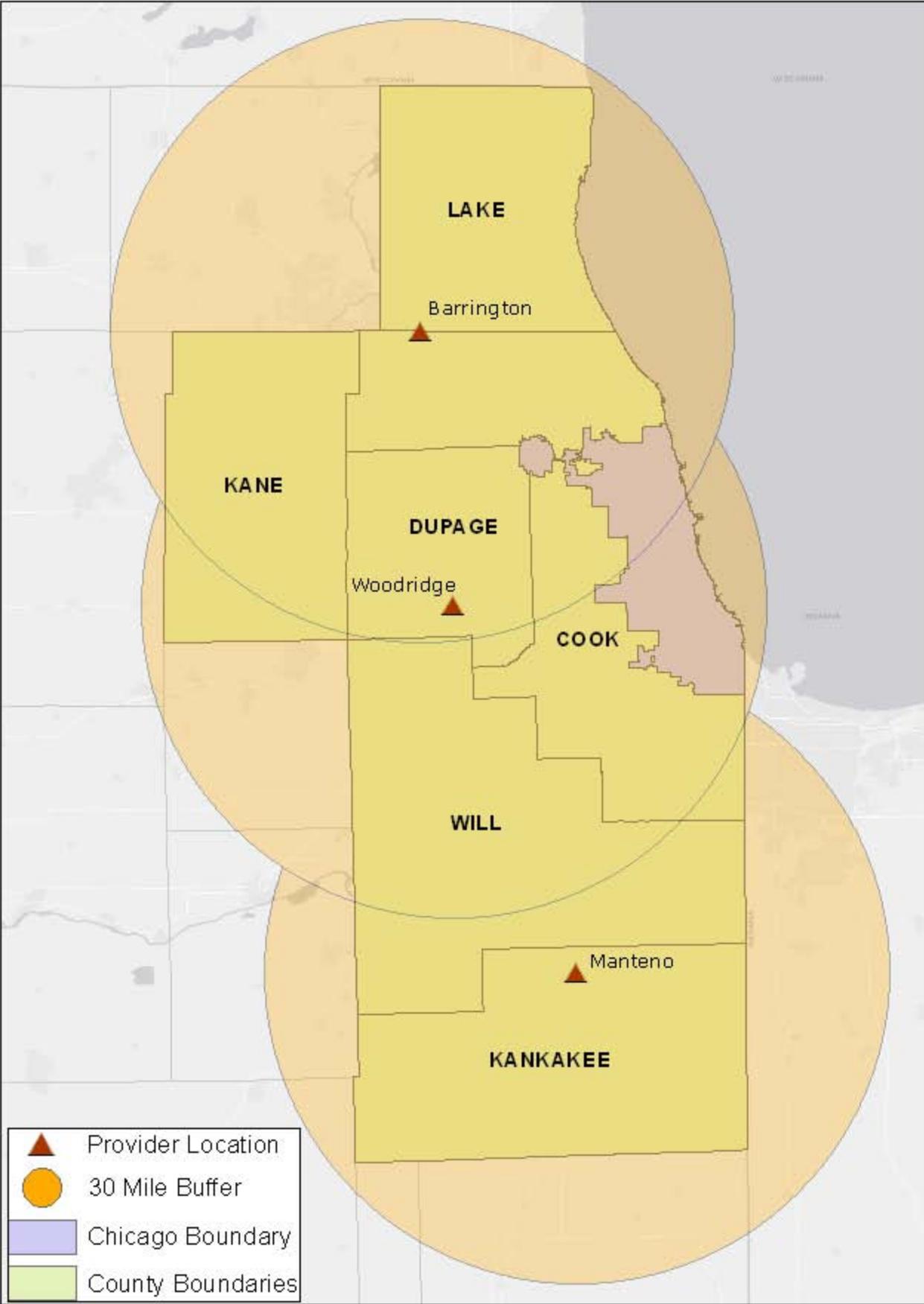
¹¹ Non-duplicated count of "signed", "paid", and "available" providers with the MCO network

Table C-11
Summary of other "available" providers

Provider Type	Aetna	IlliniCare
Individual Practitioners	<p>1-Aetna submitted a list of 41 individual providers who were not signed to formal contracts or paid as out-of-network providers but were verified as Illinois Medicaid providers. They included the following: Audiologists (2), Occupational therapists (13), Physical therapists (13), Physicians (5), and Speech Therapists (8).</p> <p>2-Aetna submitted a list of 146 "behavioral health" providers who could not be verified as Illinois Medicaid providers</p> <p>3-Aetna submitted a list of 123 "vision specialists" who could not be verified as Illinois Medicaid providers</p> <p>4-Aetna asked that we note that "the number noted [in our master provider network table] for Occupational, Physical and Speech Therapists does not include those therapists contracted with Plan under a hospital agreement."</p>	<p>1-IlliniCare submitted a list of 262 individual providers who were not signed to formal contracts or paid as out-of-network providers but were verified as Illinois Medicaid providers. They included the following: Dentists (37), Nurse Practitioners (16), Opticians (19), Physical therapists (1), Physicians (187), and Speech therapists (2).</p> <p>2-IlliniCare submitted a list of 2,927 "behavioral health" providers who could not be verified as Illinois Medicaid providers</p>
Group Providers	<p>1-Aetna submitted a list of 63 individual providers who were not signed to formal contracts or paid as out-of-network providers but were verified as Illinois Medicaid providers. They included the following: Public health departments (1), CMHCs (9), DASA (17), FQHC (1), Medica provider (7), Nursing facilities (26), Rehabilitation Hospitals (1), and Taxicab companies (1)</p>	<p>1-IlliniCare submitted a list of 24 individual providers who were not signed to formal contracts or paid as out-of-network providers but were verified as Illinois Medicaid providers. They included the following: FQHCs (3), Home Health agencies (1), Hospice (1), Imaging services (7), Independent labs (2), Nursing facilities (3), and DME providers (7).</p>

Providers mentioned in this table were NOT signed to a contract, NOT paid as a out-of-network provider during Year 1, but identified by the plans as available providers for ICP members.

Figure C-12
Minimum Providers Needed to Meet 30 Mile Requirements



Appendix D: Prior Approval

Figure D-1

Aetna Better Health Precertification/Prior Authorization List (PA)

The following provides a list (but is not all inclusive) of services requiring PA. Please note that the PA requirements may vary based on the specific code and location of the service. This document is available through Aetna Better Health's provider portal and represents the majority of services requiring authorization. Code specific details are provided on the portal as well.

- **All services provided by non-participating providers**
- **All inpatient services**
 - Mental Health and Substance Abuse
 - Surgical and non-surgical
 - Skilled nursing facility
 - Rehabilitation
 - Hospice
- **Outpatient Services** vary based upon the code and are location specific. Please check the code specific listings for details. Listed below are selected services requiring precertification.
 - **Behavioral Health Outpatient**
Please refer to code specific listing as requirements may vary
- **Surgical Services**
Please refer to code specific listing as requirements may vary
- **Therapies**
All therapy services require authorization with the exception of therapy diagnostic analysis and therapy evaluations
- **DME**
Please refer to code specific listing as requirements may vary. In general, the following require authorization
 - Hospital beds
 - Wheelchairs and components
 - Oxygen
 - CPAP
- **Orthotics/Prosthetics**
 - Implantable devices
 - Electronic devices
 - Implantable breast prosthetics
 - Injectable bulking agents
- **Home health and home based services including hospice**
- **Injectables**

- Therapy management services provided by a pharmacist
- Please refer to code specific listing
- **Imaging**
 - MRI
 - MRA
 - Angiography
 - PET scans
 - Some CT scans based on code
- **Other**
 - Acupuncture
 - Sleep studies
 - Osteopathic manipulation and chiropractic services
 - Hearing and vision services vary,
 - Please refer to specific code
 - Genetic or infertility counseling or testing services
 - Enteral feeding supply and formulas, additives, all pumps
 - Supply based services vary, please refer to specific code
 - All unlisted codes require authorization

Aetna Better Health does not cover services that are:

- *Cosmetic*
- *Investigational or experimental, or*
- *Infertility services.*

No authorization is required for emergency services.

Par providers that utilize the secure Web Portal increase efficiency as it allows them to also:

- Verify Eligibility
- Verify Codes that require PA
- Submit and verify PA requests
- Check claims status
- Retrieve PCP roster

Table D-2			
Covered Services and Limitations (IlliniCare)			
Service Type	Authorization Required?	Services/Comment	Benefit Limitation
Abortion	Not Required	Appropriate HFS Form 2390 must accompany claim submission	
Air Ambulance – Fixed Wing	Required	Prior authorization required for Fixed Wing Air Ambulance Service	
Chiropractic Services	Required	Prior authorization required after 12 visits per calendar year	Limited to the treatment of the spine by manual manipulation to correct a subluxation of the spine
Dialysis- Freestanding Dialysis Center	Not Required		
Dental Anesthesia	Required	Inpatient	
Dental Practice Visit	Required	Considered for members with developmental disabilities	
Durable Medical Equipment (DME) and medical supplies	Required	Required for purchases of DME \$500 or greater, oxygen, bi-pap, c-pap, O2 concentrator, ventilator, wound vac, bone growth stimulators, custom wheelchairs, neuro stimulators, scooter	
Emergency Room Services	Not Required		
Enteral and Parenteral Nutrition for Home Use	Not Required		
EPSDT	Not Required		Limited to under 21 yr of age.
Eye Glasses	Not Required		Limited to 1 exam and 1 pair of glasses per year
Family Planning	Not Required		
Genetic Counseling	Required		
Hearing Aids	Not Required		Limited to 1 every three years
Home Health Care Service	Required	Including but not limited to: skilled nursing services, home health aide, personal care attendants, therapies, hospice and wound therapy, IV infusion	
Hospice Care	Required		
Hospital Inpatient Service	Required	Elective acute and emergency admissions, skilled nursing facilities, subacute hospitals, rehabilitation hospitals and inpatient hospice	
Hysterectomy	Required	Payment for the services provided will be made only when the health plan receives a paper HFS 2360 accompanied by the signed documentation as evidence that the individual or her representative has been informed orally and in writing prior to the surgery that the procedure will render the individual permanently incapable of reproducing. Written consent to perform sterilization must be obtained on the HFS 1977 .	
Laboratory Svc	Not Required	Exception: genetic testing listed above.	
Neuro-Psych Svc	Required		

Table D-2**Covered Services and Limitations (IlliniCare)**

Orthotics and Prosthetic	Required	Prior authorization required for purchases of \$500 or greater	
Out-of-Network Physician/Facility/ Service	Required	Except ED services and Family Planning Service	
Out-of-State Physician/Facility/ Services	Required	Except ED services.	
Outpatient Therapy (OT, PT, ST)	Required	Initial Evaluation does not require authorization. Physical Therapy 6 visits allowed before prior authorization is required. Prior authorization required for Speech and Occupational Therapies and Cardiac Rehabilitation services	
Pain Management Service	Required	Epidural injections, neurostimulators and nerve blocks for back and neck pain	
Physician Assistant and Nurse Practitioner	Not Required		
Physician Office Svc	Not Required		
Plastic Surgeon	Required	All services in office setting. Services that are for cosmetic purposes only are not a covered benefit	
Podiatrist Svc	Required	3 visits allowed before authorization is required	
Prescription Drug	Not Required	Authorization requirements as stated in the Preferred Drug List	
Radiology Service	Required	Prior authorization required for CT, MRA, MRI, PE	
Sleep Study	Not Required	Sleep study required prior to approval for CPAP for sleep apnea	
Specialty Injection/ Infusion (infusion in home setting applies to home health benefit limits)	Required	See Biopharmaceutical Authorization List on Plan website and PD	
Sterilization Procedures	Not Required	Must submit HFS Form 2189 with Claim	
Surgery-Elective	Required	Including but not limited to: Blepharoplasty ; Breast Reconstruction ; Breast Reduction Surgery ; Rhinoplasty/Septoplasty ; Mastectomy for Gynecomastia ; Varicose Vein Treatments; Scar Revisions; Bariatric Surgery; Cochlear Implants; Oral Surgery	
Transplant	Required	All transplants including pre and post transplant services	
Transportation	Required	Non-emergent air transport and non-emergent ambulance transport	
Ultrasounds – pregnancy	Required	2 allowed in a 9 month period – any additional will require authorization with the exception of those ordered by perinatologists	

Appendix E: Transportation

Table E-1			
Comparison of HFS Medicaid and ICP Procedures			
Item	HFS Medicaid	Aetna	IlliniCare
General structure of provider and administrator	First Transit administers the non-emergency transportation prior approval program. Individual transportation companies provide the transport services	Ride Right LLC, manages the transportation benefit. Individual transportation companies provide the transport services	First Transit manages the transportation services. Individual transportation companies provide the transport services
How to request ride	First Transit maintains two toll free numbers, one for Participants, and the other for providers. Medical providers can also fax their requests. First Transit also maintains a secure web portal where Long Term Care, Dialysis Centers and Transportation providers can submit their requests. If you are a Member, First Transit will assist in finding qualified providers by giving three randomly selected transport providers in their service area. Member is responsible for arranging transportation once approved;	A member or authorized representative calls the Ride Right LLC toll free telephone number to schedule transportation to and from their medical appointments covered under the Aetna Better Health of Illinois benefit package.	The program provides a single point of contact by calling IlliniCare's toll free number for both their medical and transportation needs. When the member or provider says, "transportation" the call is automatically routed to First Transit to assess the member's transportation needs.
Prior Approval Criteria	Trips must be for department approved medically necessary care, provided by an enrolled transportation provider, to the nearest medical provider that meets the participant's needs and provided in the least expensive mode that meets the participant's medical needs on the date of transport.	Members must be on the eligibility file for approval of rides. Prior authorization is required for trips over 50 one way miles, trips out of state and certain medically related services.	All trips require prior approval of First Transit in order to effectively dispatch services. First Transit obtains prior approval from the IlliniCare in situations such as out of state transport and services over 50 miles one way.
Post Approval Allowed	Yes within 20 work days of date of transport and in special cases 90 days	No	This is a limited benefit on an individual consideration basis only.
How is eligibility determined		Ride Right receives an eligibility file from Aetna Better Health of Illinois which determines eligibility for transportation services. If Ride Right receives a request from a member that does not appear on the eligibility file for the time period of the request, Ride Right confirms eligibility with Aetna Better Health Member Services	IlliniCare sends a complete membership file on a monthly basis and a change file on a daily basis.
Para-Transit Service reimbursed		Yes	Tickets for transportation are purchased for the members and mailed to them for their use.
Advance Notice needed	Advanced notice encouraged, but accept prior and post approval	3 calendar days	2 days

Table E-1

Comparison of HFS Medicaid and ICP Procedures

Item	HFS Medicaid	Aetna	IlliniCare
What kind of trip data is available?	Historical and current prior approval data	Member name, ID, phone, DOB, pick up/drop off address, vehicle mode, transportation provider, total mileage, pick up/drop off times	All member demographic information including name, address, and phone number. Completion of trip, exact pick up and drop off times, mode of transportation and provider information such as license plate and servicing agency.
Provider credentialing	Criminal background check is performed. Certified Safety Training completed.	Each provider contracted with Ride Right, including their drivers and vehicles, must meet stringent guidelines, complete the credentialing process, submit annual re-credentialing procedures and comply with all Ride Right, Aetna and State guidelines	Each transportation provider is required to complete a rigorous safety inspection and is monitored closely to ensure that appropriate insurance levels are maintained. Every driver must complete and pass a drug screen, criminal background check, physical, safety training as well as maintain an excellent driving record through the Department of Motor Vehicles.
Safety Training of providers	"All providers must certify that all drivers and employee attendants have completed a safety program approved by the department, prior to transporting participants of the department's Medical Programs. The safety training certification is required every three years. It is the provider's responsibility to re-certify. Medicar and service car providers must maintain documentation of their driver and employee attendant certifications. "	MTM recommends Drivers and attendants receive certified training in First Aid and CPR. MTM also encourages the drivers to receive Defensive Driving Training.	The State of IL requires all drivers to complete a safety training process every three years to maintain their certification. First Transit verifies that this training has been completed. First Transit also provides a refresher training course for all providers if requested.

1. Information was supplied directly from each MCO and from phone correspondence with HFS non-emergency transportation prior approval program (NETSPAP).
2. HFS cited sources:
 - a. Handbook for providers of Transportation Services: Chapter T-200 Policy and Procedures for Transportation Services
 - b. TITLE 89: SOCIAL SERVICES, CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES, SUBCHAPTER d: MEDICAL PROGRAMS, PART 140 MEDICAL PAYMENT, SECTION 140.491 LIMITATIONS ON MEDICAL TRANSPORTATION
 - c. Enrollment: <http://www.hfs.illinois.gov/enrollment/>

Table E-2
Comparison of FFS Medicaid and ICP Call Center Data¹

Measure	FFS Medicaid ²		Aetna		IlliniCare	
	#	%	#	%	#	%
Rides booked	5,814,548		72,508		57,714	
Rides completed	4,046,633	69.6%	61,197	84.4%	52,607	91.2%
Rides cancelled	421,241	7.2%	10,114	13.9%	5,043	9.6%
Rides denied	1,767,915	30.4%	1,197	1.7%	64	0.1%
Members serviced ³	100,517		8,177		7,185	
Avg completed rides/member	40		7		7	
Unique members serviced			8,177			
Proportion of members receiving transportation			45%			
Rides booked same day			2,093	2.9%	1,298	2.3%
Rides booked under 48 hrs			7,236	11.8%	30,871	53.5%
Rides booked –Prior approval	3,469,237	60.0%	72,508	100%		
Rides booked –Post approval	2,343,311	40.0%	0	0		
Complaints	1,088	0.02%	332	0.5%	153	0.3%
Total call received	456,022		43,057		33,929	
Average speed to answer (in sec)	0:59		0:25		0:12	
Abandonment rate		3.6%		2.5%		1.2%

¹Over a one year time period and for single trip legs

²HFS Medicaid covers all Illinois Medicaid members and is for May 2010 to April 2011. Aetna and IlliniCare is for six Northeastern Illinois counties and is from May 2011 to April 2012

³Based on sum of monthly totals (contains duplicates)

Note: IlliniCare and HFS have not been able to supply some data in this table

**Table E-3
Description of Transport Service Types**

Service Type*	FFS Medicaid
Service Car	Transportation by passenger vehicle of a patient whose medical condition does not require a specialized mode.
Medicar	Transportation of a patient whose medical condition requires the use of a hydraulic or electric lift or ramp, wheelchair lockdowns, or transportation by stretcher when the patient's condition does not require medical supervision, medical equipment, the administration of drugs or the administration of oxygen, etc.
Taxi	Transportation by passenger vehicle of a patient whose medical condition does not require a specialized mode.
Ambulance	Emergency and Non-emergency Ambulance - Transportation of a patient whose medical condition requires immediate treatment of an illness or injury. The destination of an emergency ambulance is a hospital or another source of medical care when a hospital is not immediately accessible. Non-emergency ambulance is transportation of a patient whose medical condition requires transfer by stretcher and medical supervision.
Private Car	Transportation by passenger vehicle of a patient whose medical condition does not require a specialized mode.
Other Transportation	Transportation by common carrier, e.g., bus, train or commercial airplane.
*Descriptions from the HFS "Handbook for providers of Transportation Services: Chapter T-200 Policy and Procedures for Transportation Services"	

Table E-4: Comparison of FFS Medicaid and ICP Transport Service Types						
Service Type*	FFS Medicaid		ICP-Aetna		ICP-IlliniCare	
	#	%	#	%	#	%
Service Car	4,323,541	74.4%	0	0%	45,355	86.2%
Medicar ¹	1,151,327	19.8%	4,075	6.7%	4,048	7.7%
Taxi ²	214,447	3.7%	54,009	88.3%	2,418	4.6%
Ambulance ³	64,261	1.1%	219	0.4%	594	1.1%
Private Car ⁴	58,530	1.0%	1,788	2.9%		
Other Transportation ⁵	2,439	< .1%	1,106	1.8%	192	0.4%
Total**	5,814,545	100%	61,197	100%	52,607	100%

*Based on FFS categories of service
**Total based on Single Trips (legs)
Aetna crosswalk categories:
¹ Aetna/MTM vehicle Type P- Para lift vehicle
² Aetna/MTM vehicle Type C- Cab Vehicle
³ Aetna/MTM vehicle Type A- Ambulance
⁴ Aetna/MTM vehicle Type G- Gas Reimbursement (Member owned vehicle/Private Car)
⁵ Aetna/MTM vehicle Type B&S- Bus and Stretcher

Appendix F: Grievances and Appeals

Non Billing Issues – Issue Description

Type of Issue	Examples of Issues	Approx. Time for Resolution (from when supervisor sends to contact)	Number of Issues May 2011-Apr. 2012
All Kids County Code 180	Assist, Moms and Babies, Share, Premium, and Rebate Cases. Examples of Issues: <ul style="list-style-type: none"> • Child showing inactive with an active medical card • Client is unable to get medication • Attempted to contact caseworker (with 3 messages in Client comments database) • Adding baby (if baby is needing services within 24-48 hours) 	<ul style="list-style-type: none"> • 1 week • 24-48 hours • 48 hours • 24 hours 	97
Billing	(Go to Billing Issues database)	<ul style="list-style-type: none"> • 30 days 	678
DHS Local Office	Examples of Issues: <ul style="list-style-type: none"> • Child showing inactive with an active medical card • Client is unable to get medication 	<ul style="list-style-type: none"> • 24 hours • 24-48 hours 	447
DME (Durable Medical Equipment)	Examples of Issue(s): <ul style="list-style-type: none"> • Checking on prior approval • Wrong equipment received • Equipment not delivered • Rental equipment 	<ul style="list-style-type: none"> • 1 week • 1 week • 1 week • 1 week 	70
Dental Quest	Examples of Issue(s): <ul style="list-style-type: none"> • Client is showing ineligible in Dental Quest’s computer system. 	<ul style="list-style-type: none"> • 24 hours 	90
HBWD (Health Benefits for Workers with Disabilities)	Examples of Issue(s): <ul style="list-style-type: none"> • Client is unable to get medication • Client requests to speak with supervisor 	<ul style="list-style-type: none"> • 24-48 hours • 48 hours 	0

Appendix F: Grievances and Appeals

Non Billing Issues – Issue Description

Type of Issue	Examples of Issues	Approx. Time for Resolution (from when supervisor sends to contact)	Number of Issues May 2011-Apr. 2012
IHC (Illinois Health Connect)	Examples of Issue(s): <ul style="list-style-type: none"> ● IHC is showing that the client is not eligible ● Trying to locate a provider ● Showing eligible for IHC when part of excluded population 	<ul style="list-style-type: none"> ● 24-48 hours ● 24-48 hours ● 24-48 hours 	68
IHW (Illinois Health Women)	Examples of Issue(s): <ul style="list-style-type: none"> ● Checking on status of enrollment, re-enrollment, or application (it has been longer than 4 weeks since they sent their form) ● Client wants IHW cancelled but no longer has the card to return ● Made several requests on sending new card ● Made several request on changing address ● Client is unable to get medication 	<ul style="list-style-type: none"> ● 24-48 hours ● 24-48 hours ● 24-48 hours ● 24-48 hours 	7
(LTC) Long Term Care	Examples of Issue(s): <ul style="list-style-type: none"> ● Client is requesting to speak with supervisor because of LTC segment not being removed and no longer in a facility 	<ul style="list-style-type: none"> ● 1 week 	5
Medicare	Examples of Issue(s): <ul style="list-style-type: none"> ● Adding Medicare A & B segments ● QMB Status ● System Discrepancy with “6” screen ● Combining Cases ● Ending Medicare A & B segments 	<ul style="list-style-type: none"> ● 1 day ● 1 week ● 1 week ● 1 day ● 1 day 	599
Medicare D	Examples of Issue(s): <ul style="list-style-type: none"> ● Medication coverage ● System discrepancy ● Low Income Subsidy 	<ul style="list-style-type: none"> ● 1 week ● 1 week ● 1 week 	68

Appendix F: Grievances and Appeals

Non Billing Issues – Issue Description

Type of Issue	Examples of Issues	Approx. Time for Resolution (from when supervisor sends to contact)	Number of Issues May 2011-Apr. 2012
MCO (Managed Care Organization)	<p>Examples of Issue(s):</p> <ul style="list-style-type: none"> • Client is unable to disenroll from MCO by calling either the MCO or Client Enrollment Broker (CEB) • Client is unable to resolve billing issues with MCO (see health care choices chapter for specific information necessary). 	<ul style="list-style-type: none"> • 1 week • 1 week 	58
Optical	<p>Examples of Issue(s):</p> <ul style="list-style-type: none"> • Glasses ordered but not received (After six weeks) • Wrong prescription • Provider complaint 	<ul style="list-style-type: none"> • 1 week • 1 week • 1 week 	172
TPL (Third Party Liability) / Credible Coverage	<p>Examples of Issue(s):</p> <ul style="list-style-type: none"> • Client requests to speak with supervisor due to discrepancy in TPL • Client has requested letter of credible coverage several times and has not received the requested information 	<ul style="list-style-type: none"> • 1 week • 1 week 	7
Transportation	<p>Examples of Issue(s):</p> <p><u>Emergency-(Go to Billing Issues Database)</u></p> <ul style="list-style-type: none"> • Client is receiving bill for ambulance service (billing issue) <p><u>Non-Emergency</u></p> <ul style="list-style-type: none"> • First Transit not able to find a provider or unwilling to help • Showing client as being ineligible when client is eligible 	<ul style="list-style-type: none"> • 30 days • 1 week • 1 week 	7
Veterans Care	<p>Examples of Issue(s):</p> <ul style="list-style-type: none"> • Client is unable to get medication • Client requests to speak with supervisor 	<ul style="list-style-type: none"> • 24-48 hours • 48 hours 	1
Other	<p>Examples of Issue(s):</p> <ul style="list-style-type: none"> • Restrictions • Checking on prescription prior approval 	<ul style="list-style-type: none"> • 24-48 hours • 24-48 hours 	402

Table 1—Readiness Review Activities Performed	
For this step,	HSAG...
Step 1:	Established the review schedule.
	Before the review, HSAG coordinated with HFS and the MCOs to set the schedule and identified members of the HSAG readiness review team for each MCO.
Step 2:	Prepared the data collection tool for reviewing the standards and submitted it to HFS for approval.
	To ensure that all information was collected, HSAG developed a readiness review tool and file review tools consistent with State and federal requirements and protocols. To create the readiness review tool standards, HSAG used the requirements specified in the Contract for Furnishing Health Services Integrated Care Program by a Managed Care Organization.
Step 3:	Prepared and submitted the pre-assessment form and agenda to the MCOs.
	<ol style="list-style-type: none"> 1. Pre-assessment Form: The pre-assessment form required the MCOs to describe their organization and its functions and contained a list of desk review documents that the MCOs were required to submit prior to the on-site readiness review, as well as a list of documents required for the on-site portion of the readiness review. In addition, the pre-assessment form provided the MCOs with the purpose, timelines, and instructions for submitting the data required for sampling for the file reviews. 2. On-site Agenda: The on-site agenda was developed to assist each MCO's staff in planning for participation in the on-site readiness review, assembling requested documentation, and addressing logistical issues.
Step 4:	Forwarded the readiness review tool and file review tools to the MCOs.
	Prior to the on-site review, HSAG forwarded the MCO-specific readiness review tool and file review tools to assist each MCO in preparing for the readiness review.
Step 5:	Participated in a pre-on-site conference call with HFS and the MCO.
	Prior to the on-site readiness review, HSAG representatives conducted a teleconference with the MCOs and HFS to exchange information, confirm the dates for the on-site review, and complete other planning activities to ensure that the on-site review was completed methodically and accurately.
Step 6:	Responded to the MCOs' questions related to the review and provided additional information needed before the review.
	Prior to conducting the reviews, HSAG maintained contact with the MCOs as needed to answer questions and to provide information to key members of the management staff. This telephone and/or e-mail contact gave MCO representatives the opportunity to ask for clarification about the request for documentation for HSAG's desk review and on-site readiness review processes. HSAG communicated regularly with HFS about HSAG's discussions with the MCOs and its responses to their questions.
Step 7:	Received data files from the MCOs and HFS, then selected and posted samples to HSAG's FTP site prepared for each MCO.
	HSAG generated unique record review samples based on data files supplied by the MCOs and HFS. In addition to the MCO file review, HSAG conducted a delegation oversight file review of the MCOs' delegated vendors, credentialing, grievances, denials, and appeals. With the exception of credentialing, on the first day of the on-site readiness

Table 1—Readiness Review Activities Performed	
For this step,	HSAG...
	review the MCO provided a list of the grievances, denials and appeals since the “go live” date of May 1, 2011, and HSAG randomly selected a sample of 10 files and an oversample of 5 files (if available) for each file review. The MCO provided a list of credentialed providers prior to the on-site review. HSAG selected a sample of 10 with an oversample of 5 providers and provided the list to the MCO 10 days prior to the on-site review.
Step 8:	Received the MCOs’ documents for HSAG’s desk review and evaluated the information before conducting the on-site readiness review.
	<p>HSAG reviewers used the documentation received from the MCOs to gain insight into each MCO’s structure and operations, access to care for its members, and quality assessment and performance improvement program. HSAG also used the documentation to begin compiling the information and preliminary findings before the on-site portion of the review. During the desk review process, reviewers:</p> <ul style="list-style-type: none"> ◆ Documented findings from the review of the materials submitted by the MCOs as evidence of their compliance with the requirements. ◆ Identified areas and issues requiring further clarification or follow-up during the on-site interviews. ◆ Identified information not found in the desk review documentation that HSAG would request during the on-site readiness review.
Step 9:	Conducted the on-site portion of the readiness review.
	<p>During the on-site readiness review, MCO staff members were available to answer questions and to assist the HSAG review team in locating specific documents or other sources of information. During the on-site review, HSAG:</p> <ul style="list-style-type: none"> ◆ Conducted interviews with Aetna staff. HSAG used interviews to obtain a complete picture of an Aetna’s compliance with contract requirements, to explore any issues not fully addressed in the documents, and to increase overall understanding of the MCO’s performance. ◆ Reviewed information, documentation, and systems demonstrations. Throughout the on-site review process, reviewers used the readiness review tool to identify relevant information sources and to document findings regarding compliance with the standards. This activity included a review of applicable policies and procedures, meeting minutes, quality studies, reports, records, and other documentation. ◆ Received and reviewed files designated for the file reviews. Reviewers used standardized monitoring tools to review records and to document findings regarding compliance with contract requirements and the MCOs’ policies and procedures. ◆ Summarized findings at the completion of the on-site review. As a final step, HSAG reviewers met with staff members from Aetna and HFS to provide a high-level summary of the preliminary findings from the on-site readiness review.
Step 10:	Calculated the individual scores and determined the overall compliance score for performance.
	HSAG reviewed all standards in the readiness review tool for each MCO. HSAG analyzed the information to determine the organization’s performance for each of the elements in the standards. HSAG used <i>Met</i> , <i>Partially Met</i> , and <i>Not Met</i> scores to document the degree to which the MCOs complied with the requirements. HSAG used a designation of <i>NA</i> if an individual element did not apply to an MCO during the period

Table 1—Readiness Review Activities Performed	
For this step,	HSAG...
	covered by the review.
Step 11:	Prepared a report of findings and required corrective actions.
	After completing the documentation of findings and scoring for each of the 14 standards, HSAG prepared a draft report for each MCO that described HSAG’s readiness review findings, the scores it assigned for each requirement within the standards, and HSAG’s assessment of the organization’s compliance and any areas requiring corrective action. The reports were forwarded to HFS and the applicable MCO for their review and comment. Following HFS’ approval of each draft report, HSAG issued final reports to HFS and the applicable MCO.