An Independent Evaluation of the Integrated Care Program

Final Report: Findings through the Third Year (FY14)

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List of Abbreviations

ACA	Affordable Care Act
ACE	Angiotensin Converting Enzyme
ADA	Americans with Disabilities Act
ADL	Activity of Daily Living
AOD	Alcohol or Other Drug Dependence
ARB	Angiotensin Receptor Blockers
BMC	Bureau of Managed Care
CCE	Care Coordination Entities
CCS	Clinical Classification Software
CCU	Coordinated Care Unit
CDC	Centers for Disease Control and Prevention
CDPS	Chronic Illness and Disability Payment System
CE	Continuously Enrolled
CPT	Current Procedural Terminology
CY	Calendar Year
DASA	Division of Alcohol and substance Abuse
DCFS	Department of Child and Family Services
DD	Developmental Disability
DHS	Department of Human Services
DID	Difference-In-Difference
DM	Disease Management
DME	Durable Medical Equipment
DMH	Division of Mental Health
DRS	Division of Rehabilitation Services
DSCC	Division of Specialized Care for Children
ED/ER	Emergency Department/Emergency Room
EDV	Encounter Data Validation
EQRO	External Quality Review Organization
FFS	Fee-for-Service
FTE	Full Time Equivalent
FY	Fiscal Year
HAS	Healthcare Services Appraisal
HBCS	Home and Community Based Services
HCUP	Healthcare Cost and Utilization Project
HEDIS	Healthcare Effectiveness Data and Information Set
HFS	Healthcare and Family Services
HIE	Health Information Exchange
HMO	Health Maintenance Organizations
HSAG	Health Services Advisory Group
HUD	Department of Housing and Urban Development
ICEB	Illinois Client Enrollment Broker
ICF/MR	Intermediate Care Facility for Individuals with Mental Retardation
ICP	Integrated Care Program
ICT	Interdisciplinary Care Team
IDoA	Illinois Department of Aging
IDPH	Illinois Department of Public Health

ILTCOP	Illinois's State Long Term Care Ombudsman
IMD	Institute of Mental Disease
IPSW	Inverse Propensity Score Weighting
LTSS	Long-Term Services and Supports
MCCN	Managed Care Community Networks
MCO	Managed Care Organization
MF/TD	Medically Fragile/Technology Dependent
MLR	Medical Loss Reconciliation/Ratio
MM	Member Months
MMAI	Medicare-Medicaid Alignment Initiative
MMC	Medicaid Managed Care
MTM	Medicaid Transportation Management
NEMT	Non-Emergency Medical Transportation
NF	Nursing Facility
NPI	National Provider Number
OIG	United States Office of the Inspector General
P4P	Pay for Performance
PA	Personal Attendant
PCP	Primary Care Provider
PM	Performance Measure
PMPM	Per Member Per Month
POS	Place of Service
PSA	Prostate Specific Antigen
PT	Physical Therapy
SMART	Strengthening Medicare and Repaying Taxpayers Act
SMHRF	Specialized Mental Health Rehabilitation Facility
SMI	Severe Mental Illness
SNF	Skilled Nursing Facility
SOP	Standard Operating Procedure
SP1	Service Package 1
SP2	Service Package 2
SPD	Seniors and People with Disabilities
SRO	Single Room Occupancy
TBD	To Be Determined
TBI	Traumatic Brain Injury
UIC	University of Illinois at Chicago
UM	Utilization Management
USPSTF	United States Preventive Services Task Force

Executive Summary

Over the past several years, the State of Illinois has been implementing and planning several programs to move Medicaid and Medicare recipients into systems of care coordination. The original, mandatory Medicaid managed care program (MMC) in Illinois is known as the Integrated Care Program (ICP) and began on May 1, 2011 with the goal of improving the quality of care and services that the Medicaid population receives, along with saving the State money on Medicaid expenditures (estimated at $200 million over the first 5 years). The program serves seniors and people with disabilities who are Medicaid-only eligible who originally resided in the suburbs of Cook County (not including the City of Chicago) or the five collar counties (DuPage, Kane, Kankakee, Lake, and Will counties). The program later expanded into other areas of the state but this study focuses only on the original area of collar counties in the Chicago area.

For the first two years, the ICP only covered acute healthcare services (Service Package 1), but beginning in February 2013 the Managed Care Organizations (MCOs) also became responsible for long-term services and supports (LTSS) (Service Package 2) for all of their members except for people on the developmental disability waiver.

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

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

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

A. Primary Research Questions and Findings

1. How has the program expanded?

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

- Very little switching between the plans occurs, as only 0.14% of enrollees switch between the plans each year. This accounts for 5% of the members who leave the plans each year (923.5 members leave ICP each month).

- In FY14, IlliniCare had 2100 more members per month than Aetna. HFS explained that this is because Aetna did not submit a provider enrollment file correctly to the client enrollment broker. Later, the auto-enrollment process was adjusted to even out enrollment between the plans. Aetna's enrollment was still behind that of IlliniCare by the end of FY14.
- A discrepancy related to enrollment between HFS capitation payments and the data presented in the monthly Utilization Management reports submitted by each MCO exists.

2. What are the consumers' experiences?

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

Health Services Appraisal

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

Unmet Medical Needs

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

Healthcare Quality

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

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

LTSS Appraisal

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

Unmet needs

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

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

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

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

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

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

Enrollee Experiences with Accessibility

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

3. Has ICP led to rebalancing?

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

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

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

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

Coordination with Existing State Agencies

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

Transition of Children to Adult Managed Care Program

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

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

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

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

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

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

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

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

Call Centers

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

Complaints, Appeals and Grievances

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

Critical Incidents

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

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

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

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

7. How well is care managed for ICP enrollees?

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

Care Coordinators

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

Caseloads

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

Training

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

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

Screening and Assessments

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

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

Opting out of case management

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

Care Plans

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

Service Plans

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

Risk Stratification

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

Face to face contact with members

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

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

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

MCO-Thresholds Pilot Projects

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

SNFist Services

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

Supportive Housing

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Supply of medications

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

Costs of medications

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

Drug formulary

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

Prior authorizations

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

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

Medication utilization

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

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

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

10. Mortality

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

B. Lessons Learned

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

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

1. Difficulty establishing a provider network

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

2. Payment of Providers

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

3. Enrollment and Dis-enrollment of Members

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

4. Collection and Dissemination of Data

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

5. Tracking the Hiring and Performance of Care Coordinators

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

6. Tracking of Member Complaints, Grievances, and Appeals

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

C. Recommendations

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

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

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

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

3. Continue to improve reporting standards for MCOs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Introduction

The previous year has been pivotal with regard to the Integrated Care Program (ICP), and Medicaid Managed Care (MMC) in Illinois more generally, for two primary reasons.

First, although the ICP began in 2011, FY14 marks the first full year that the Managed Care Organizations (MCOs) have provided Service Package 2 (SP2) services (long term services and supports). Although SP2 was included in ICP in February 2013, previous reports by the University of Illinois at Chicago (UIC) research team were not able to detail outcomes related to SP2, and this is the first year that sufficient data has been available to allow the team to perform an evaluation of long-term services and supports (LTSS).

Second, under Public Act 96-1501, at least 50 percent of Medicaid members were required to move from fee-for-service (FFS) to a "risk-based care coordination program" by January 1, 2015, and many additional managed care entities began operations during the last few months of FY14 in preparation for this change. These entities include three types of groups that work with the Medicaid seniors and people with disabilities (SPD) population:

1) Traditional insurance-based Health Maintenance Organizations (HMO) accepting full-risk capitated payments;
2) Managed Care Community Networks (MCCN), which are provider-organized entities accepting full-risk capitated payments; and
3) 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 FFS basis.

Each of these types of entities are not available in each area of the State, and several areas are still not included in mandatory managed care. The ICP pilot was originally targeted towards approximately 40,000 Medicaid members not eligible for Medicare and living in suburban Cook, DuPage, Kane, Kankakee, Lake and Will Counties. This report continues to primarily focus on the pilot area, and the results presented in this report do not typically include other areas of the State. Continuing to focus on the pilot area ensures that the evaluation results are comparable over time. Where additional areas are included, the evaluation team has clearly noted this.

The ICP originated with a focus on improving the quality of and access to services along with cost savings (the ICP was projected to save the State $200 million in the first five years of the program). As ICP was implemented, the State announced that it was "committed to an independent evaluation of the program" and contracted with UIC to conduct the evaluation. The purpose of the evaluation is to "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."

The first report released by UIC (March 2013) primarily covered Service Package 1 (acute healthcare). The second report (May 2014) also focused on acute healthcare, and began to provide analysis of the

costs of the program. This report includes both Service Package 1 and 2 along with a more substantive analysis of the economic impact of the ICP. Throughout this report, the research team has used a strong research design that includes statistical comparisons that match demographic differences with the SPD population receiving FFS Medicaid living in the city of Chicago (these people would be enrolled in ICP, except that they lived outside the pilot area).

In the last few months of FY14, this population began to enroll in ICP as ICP was introduced in Chicago. Again, the research team has taken steps to ensure that comparisons include only ICP pilot members and Chicago FFS recipients.

Evaluation Design and Methods

A. Evaluation Components

This report includes aspects of the three types of evaluation components: process evaluation, outcome evaluation, and economic impact evaluation. These are briefly described below.

1. Process Evaluation

The first component, process evaluation, is foundational to the research as a whole. The research team explored and described the processes used by the MCOs and the State of Illinois to implement the ICP. Examples of process evaluation conducted by the research team include enrollment in ICP, grievances and appeals procedures, requests for prior authorization, and the care coordination policies used by each MCO. In particular, the research team assessed the effectiveness of the MCOs in carrying out consumer "readiness" activities (awareness and knowledge of the program). The process evaluation component is primary focused on addressing "how" questions.

2. Outcome Evaluation

The majority of the work done by the research team related to the second component, an outcome evaluation. It addresses the overarching question, "What impact has the ICP had on the participants, the providers, and the State agencies?"

To isolate the effects of external factors on the outcomes being measured, the research team has used a comparison sample and, to the extent possible, statistically controlled for differences in the populations. Propensity score matching is used to match ICP members and comparison group members to allow more valid comparisons. This method is described in more detail in the next section.

The outcome evaluation component of this research is based on six guiding questions:

1) What impact did the ICP have on consumers' access to needed health and LTSS services?
2) What changes in service utilization have occurred since the ICP began for both inpatient and outpatient services?
3) What impact did the ICP have on health outcomes as measured by standard Healthcare Effectiveness Data and Information Set (HEDIS) measures?
4) What impact did the ICP have on consumer satisfaction?
5) What impact did the ICP have on Service Package 2 services and rebalancing initiatives?
6) What impact did the ICP have on consumer choice and quality of life?

3. Economic Impact Evaluation

The final component, economic impact evaluation, analyzed the impact of ICP on the costs of healthcare and LTSS. The research team used Medicaid encounter data (for FFS Medicaid during the baseline period of FY11) and encounter-like data from the MCOs (for FY12-FY14) along with Healthcare and Family Services' (HFS') capitation payments to evaluate change in what the State pays to provide healthcare and LTSS to the ICP population. Again, the team used a comparison sample and, to the extent possible, statistically controlled for differences in the populations. Propensity score matching was used to match

ICP members and comparison group members to allow more valid comparisons. This method is described in more detail on page 12.

Table 1: Demographics of FY14 Survey Respondents		
Demographic	**Suburbs**	**Chicago**
Sample Size	1,952	1,858
Valid Responses	572	468
Response Rate	29.3%	25.2%
Gender		
Female	342	260

4. SMART Act

The evaluation faced a unique challenge in that the Medicaid FFS program (and the comparison group used in this evaluation) was affected by the Illinois "Saving Medicaid and Resources Together" (SMART) Act enacted as of July 1, 2012. Initially, the Act was projected to save $1.6 billion by changing 62 aspects of the Medicaid program. These changes included:

1) Tightening and verifying client eligibility;
2) Reducing and/or eliminating optional Medicaid services (notably nonemergency dental care for adults, occupational therapy, physical therapy, speech therapy, and chiropractic services);
3) Increasing utilization controls on other mandatory Medicaid services;
4) Imposing increased cost sharing on members and third parties;
5) Adjusting provider rates; and
6) Expanding "care coordination" practices to reduce inefficiencies in the FFS system.

Many of these changes were detailed in the research team's previous report on the ICP (released in May 2014). On July 1, 2014, Illinois Public Act 98-0651 reinstated some of the services cut by the SMART Act. However, the results contained in this report do not extend beyond the time that benefits were reinstated by this legislation.

B. Data Collection Processes

This report is based on quantitative and qualitative data from a wide variety of sources. The quantitative data includes a consumer and family survey, HFS capitation payment data, HFS enrollment data, Medicaid encounter data from the State of Illinois, the reports that each MCO submits monthly/quarterly/annually to HFS, MCO claims data, and special MCO datasets on particular areas (e.g. convinces and appeals, transportation data, etc.). The qualitative data is primarily based on materials provided by and meetings with various stakeholders, including advocacy groups, provider groups, MCOs, and other State agencies.

The evaluation includes an advisory group that has met regularly throughout the previous year. The members of the advisory group have been active and frequently pointed the research team to new sources of data and issues to explore.

Male	225	196
Race		
Black	244	327
White	237	61
Hispanic Origin	69	76
Disability Type		
Int/Dev Disability	174	112
Mental Health	201	167
Physical Disability	357	257
Data Source: UIC 2014-2015 Enrollee Survey		

1. Consumer Survey

The research team developed and disseminated a consumer satisfaction survey at the baseline and following the first two years of ICP. The survey includes measures of unmet needs, satisfaction, access to services, self-rated health status, and questions related to respondents' experiences within ICP. The survey was developed in consultation with the ICP Advisory Board, Illinois Department of Public Health (IDPH), and groups of people with disabilities.

This survey is primarily a mailed survey, although a few respondents chose to do it over the phone. Surveys were sent to each of samples of ICP enrollees in the original ICP pilot areas and in Chicago. The samples were chosen at random, stratified by waiver status, except that people who answered the survey in the previous year were automatically included in the sample in order to have a longitudinal cohort to follow. This report includes analysis of both longitudinal (n=363) responses from this year and the previous year. The cross-sectional analysis includes 564 respondents from the ICP pilot areas and 460 from the Chicago group. Overall, the response rate is about 29% for the Suburbs and 25% for Chicago. Table 1 presents the demographics of survey respondents.

Follow-up efforts were made to each person in the sample to encourage them to complete the survey. Many surveys were returned with invalid addresses and many people could not be reached by phone. Approximately 29% of the phone numbers provided to the research team were either disconnected or wrong numbers.

2. Medicaid FFS claims data

There were two (2) different FFS claims datasets received from HFS. The first was a dataset of all FFS Medicaid claims for approximately 41,000 ICP eligible members just prior to the start of ICP, for the nine-month period of July 1, 2010 through March 31, 2011.

The second dataset was for all FFS claims for a comparison group of Medicaid members who lived in Chicago and would have been eligible for ICP except for living in Chicago. This dataset covered three fiscal years, from July 1, 2010 through June 30, 2013. There were between 65,000 and 70,000 ICP-eligible members in this dataset for each year.

The two datasets contained all FFS Medicaid costs incurred by the State for these members, including pharmacy and non-pharmacy costs.

3. MCO reports

The contracts between the MCOs and the State list certain regular reports (or deliverables) that the MCOs must submit to the State reporting on various topics and outcome measures. The UIC research team has been receiving the reports that were important for the project since December of 2011 and has continued to receive these reports since then as requested. The frequency of reporting varies by topic, with some reports submitted monthly and others submitted quarterly.

HFS Report Changes

During the summer of 2013, HFS made several important changes in how the plans submit the regular reports and how HFS reviews the reports. The improvements made by HFS in the reporting process include:

1) Development of standard templates that all MCOs use submitting data;
2) Key changes in the submission and storage of the reports; and
3) Increased involvement of HFS in the submission and review of the reports.

Templates and Process

HFS has developed standard templates for some reports. In general, they consist of two tabs. The first tab contains definitions of the data elements required in the report, while the second tab contains table with standard rows, columns, and headings for the MCOs to use to enter and display their data. Some of the reports (Utilization Management, Grievance and Appeals details, etc.) also have multiple tabs to break out each of the "special groups" (long-term care, disability waiver, TBI waiver, etc.) to supplement the second tab, which contains data on the entire MCO population.

The MCOs and HFS use Microsoft SharePoint technology in order to submit and review the reports. This technology provides a common workspace that each organization has access to in order to facilitate submission and review of the reports. The report completed by the MCO is uploaded into a shared document library, where HFS reviews it. The SharePoint site allows the MCOs to retrieve standard templates and shared documents that HFS has as well as see any announcements from HFS.

HFS Standard Operating Procedure

HFS has developed a Standard Operating Procedure (SOP) for each report for which there is a template to ensure that reviewers apply the same analysis to all of the MCOs share the same requirements. Each SOP is organized around two roles for HFS: gatekeeper and reviewer. Each SOP defines the following:

1) Purpose of the report.
2) Any documents or resources that HFS needs.
3) Specific review steps for the gatekeeper and reviewer.
4) Specific review questions for the reviewer, including questions for a “completeness check” and to review the “data analysis” sections.
5) Any relevant benchmarks (e.g. HEDIS or state-defined).
6) Follow-up and summary sections that include steps that the reviewer can follow to work with the MCOs on any concerns that they have noted on the report.

The gatekeeper role has four primary responsibilities: documenting receipt of the report, checking the report for completeness, communicating with each MCO about late or incomplete reports, and assigning a designated reviewer to each report for a complete review.

The reviewer also has four primary responsibilities: review the report using the SOP and complete the observation field in SharePoint, maintain personal notes and documentation of review, follow up with the MCO as necessary, and update the observation in SharePoint to reflect resolution.

Review of Changes to MCO Reports

HFS made several changes to the reports in the summer of 2013, which made them more standard. In the spring of 2015, HFS indicated that they were working on an amendment to the MCO contracts that would contain additional revisions to MCO reporting. The MCO reports are used throughout this evaluation.

While these reports have provided helpful information, they present challenges in reliably comparing the performance of the two MCOs on specific outcome measures. Most of the reports have improved considerably in terms of reliability and comparability since Year 1, and unlike past years, the research team used them more frequently as primary sources of data for some of the current report sections. However, a complicating variable was the inclusion of Chicago area members in the FY14 MCO reports because the service area expanded to the city of Chicago in February 2014. As a result, UIC asked for and received revised reports from both MCOs separating out the Chicago members from the members from the original pilot area.

4. MCO encounter data

Importance of complete and comparable encounter data

According to the section 1.53 of the MCO contract, an encounter is defined as "an individual service or procedure provided to an Enrollee that would result in a claim if the service or procedure were to be reimbursed as Fee-For-Service (FFS) under the HFS Medical Program." Encounter data is used minimally to set capitation rates, calculate outcomes for performance measures, and calculate the Medical Loss Ratio for determining whether the plans have met minimal criteria for spending on member benefits and quality improvement activities.

In its Encounter Data Validation report to the State in the fall of 2014, Health Services Advisory Group, Inc. (HSAG) stated that

> "Accurate and complete electronic encounter data are important to the success of the Illinois Healthcare and Family Services (HFS) Medicaid managed care program. HFS relies on encounter data submissions to monitor and improve the quality of care, establish performance measures, generate accurate reports, and set valid capitation rates. The completeness and accuracy of these data are essential to the overall management and oversight of its changing Medicaid managed care program."

The MCO contract contains a section entitled, "Failure to submit encounter data," that outlines the sanctions the State can take against a plan if the plan has not met the requirements related to encounter data. The State can impose a fine of $10,000 to $50,000 per month for non-compliance. The

contract also sets out guidelines in the contract regarding the submission of encounter data by the MCOs, the testing of the encounter data by the State, and eventual approval of the submissions.

Previous efforts

The original target date specified in the contract for the initial submission of encounter data was January of 2012, but the State and MCOs did not meet this deadline. In the Year 1 report, some of the problems that HFS and the MCOs had in producing a reliable post-ICP encounter dataset were described. These problems included education of the MCO staff of the HFS requirements, turnover of MCO staff, turnover of HFS staff, new HIPAA requirements regarding health data transactions, increased volume of transactions in the Medicaid system, and limited programming resources within HFS.

Illinois, like many other states, faces several challenges in making the transition from collecting data for a FFS system to a managed care system. These include:

1) transitioning the current State management information system from collecting data on claims to collecting and processing encounters, which often have different requirements, and
2) standardizing the collection of information from plans who have historically not submitted data to states and often have substantially different internal information infrastructures

The UIC Year 2 report described the continuing challenges that HFS and the MCOs faced during the next two years in trying to produce a complete and reliable encounter dataset. HFS staff worked with MCO staff to process their encounter data through the Medicaid warehouse in a "test" environment. Although progress was reported by HFS in terms of higher acceptance rates of the MCO submissions, as of the fall of 2013, HFS had not been able to produce a complete and reliable encounter dataset that could pass the checks in their production system.

At the time of the team's Year 2 report in the spring of 2014, the following recommendation was made specifically related to the collection of a complete and reliable encounter dataset:

> "The State should work closely with the MCOs to develop a specific and common set of data elements to ensure that encounter data for ICP members can be entered into a database maintained by the State until the time the State is able to maintain this encounter data in the current Medicaid claims database."

HSAG study

Since the team's last report in the spring of 2014, HFS has worked with two consultants to improve the situation. During FY14, the State contracted with HSAG to conduct an "Encounter Data Validation" (EDV) study designed to evaluate the quality of Illinois' Medicaid encounter data. Specifically the EDV study collected information "in support of developing policies and procedures surrounding the collection, monitoring, and ongoing improvement of encounter data as the department expands its managed care programs" (EDV Questionnaire Report, HSAG, October 2014).

HSAG worked with HFS to evaluate both the quality of submitted data as well the policies and procedures responsible for processing the encounter data for two MCOs, (Aetna and Meridian). HSAG developed customized questionnaires to collect needed information, tested and reviewed encounter

data, and interviewed key staff from the MCOs and HFS. As a result of their work, HSAG stated that areas for improvement:

> "consisted largely of deficiencies in policy and procedure documentation and monitoring of data submission by HFS. More importantly, these issues can be readily addressed through the codification of existing process information and the implementation of encounter data submission metrics."

HSAG made a list of recommendations, a few of which are listed below:

- The establishment of a time-limited workgroup with key HFS staff, MCOs, and other stakeholders to ensure data submission requirements are attainable, adhere to industry standards, and meet requirements for monitoring the Medicaid program. In response to this, HFS said:

"The HFS Encounters team established dedicated sessions with key stakeholders to review monthly MCO encounter submission report across pre-defined bill types and service categories to ensure encounter data requirements are consistently met. These sessions helped MCOs understand HFS billing and data requirements while reporting encounter utilization. HFS continues to engage with these MCOs on reviewing their encounter data for accuracy and completeness through this workgroup."

- The development of formal encounter data submission policies and procedures. In response to this, HFS said:

"HFS Encounter submission guidelines are already published on the HFS website. In most cases, HFS needs to works closely with MCOs to bring them onboard and certify their encounter for live submission. The HFS encounter data team shared various artifacts with MCOs in key areas to remediate the issues identified during the encounter processing. HFS continuously engages with MCOs for them to establish the correct framework for encounter submission for different plans."

- The development of a testing guide to aid MCOs in preparing data for, and remediating errors identified during testing. In response to this, HFS said:

"As part of MCO onboarding for encounter submission, HFS created and shared the encounter testing guide and test matrix with MCOs (the HFS minimal requirement for encounter certification). Additionally, HFS started creating technical documents for MCOs to remediate high density edits that are encountered during testing and live submissions. This gives MCOs clear insight into HFS business rules around encounter processing. While MCOs are expected to follow the billing guidelines elaborated under Chapter 200 for various provider specialties, the HFS encounter team is consistently working with MCO implementation partners to enhance their processes around encounter submission and reconciliation."

- The development of encounter data metrics, performance standards, and associated sanctions specific to encounter data to better align with HFS's institutional objectives and the goals. In response to this, HFS said:

"The primary priority for HFS at this point is to bring onboard different MCO contract/plans and provide them with timeframes to get most current with their encounter submission across the board. HFS plans to evaluate this option once all MCO contract/plans are certified by HFS for encounter reporting."

Work by Milliman

During FY14, HFS contracted with Milliman to assist in designing an "encounter data quality reporting process" that HFS would use to collect encounter data from the MCOs. Milliman designed a data collection form/report that the MCOs would use to submit their claim/encounter data. Milliman also created service category definitions that relied on APR-DRGs, Revenue Codes, EAPGs, CPT-4 codes, HCPCS codes, and provider types.

HFS has worked with the MCOs to implement the Encounter Utilization Monitoring (EUM) procedure that Milliman has designed. The EUM was implemented in January of 2015. HFS provided the following narrative on the EUM:

> "HFS implemented the EUM process with all certified MCOs. HFS implemented change controls for our internal warehouse team to derive EUM reports for various plans, for given reporting periods. Now that change control is implemented and results verified by key stakeholders, we have scheduled the first session with IlliniCare next month to review the metrics and potentially identify gaps in the encounter submission process. Our expectation is that MCOs will use the outcome of this discussion and CAP as a framework for their encounter submission for other reporting period and contract/plans. We are currently in the process of generating EUM reports for Aetna and HFS plan to meet with their team sometime in second half of August 2015 to discuss about their EUM process. The same process will be implemented with other MCOs this year with the objective of stream lining their encounter submission in a way that is accurate and complete."

Work by the UIC team

During the summer of 2014, while HFS was working to upgrade their capability to obtain reliable encounter data, the UIC team recognized the need to obtain its own reliable encounter data from the MCOs that could be used to determine changes in service utilization since the ICP started.

The primary goal of the undertaking was to obtain a complete dataset of claims, including encounters, for all services members received in the ICP.

With the help of HFS staff, the team defined a standard file structure that the MCOs would submit the encounter data in. The team requested all claims/encounters, both paid and denied, for any encounters that members had during time period. The team took steps to ensure the encounter data included claims paid by the regular FFS claims procedure that each MCO had in place AND those encounters paid by providers who are paid by the MCOs on a capitation basis. In addition, the team took steps to ensure that all encounters associated with bundled claims were reported.

The team received 2 years of claims that had a service date between January 1, 2012 and December 31, 2013. In all, the team received approximately 3.7 million drug encounters and 8.6 million other encounters from the MCOs. The team worked with both MCOs to further "clean" and enhance the claims dataset.

After receipt of the encounter data the research team conducted various "validation tests" on the data to determine whether there were any missing or invalid block of claims. As benchmarks during the test, the team used the Medical Loss Reconciliation (MLR) spreadsheets from the MCOs and monthly

Utilization Management reports the MCOs had previously submitted to HFS. When substantial variance was detected between the rates the team calculated from the claims data and the benchmark sources, the team worked with MCO staff to clarify, and in some cases, supplement the encounter data with missing claims.

At the end of this process, the team felt that it had a relatively complete and comparable dataset from both MCOs that permitted reliable analysis of service utilization during the two year period. The team calculated various utilization rates and compared those rates with ones calculated from a pre-ICP FFS claims dataset that HFS had supplied the team.

5. Special MCO datasets

As previously discussed, the research team was limited in its work due to the lack of any "official" post-ICP encounter data. To meet the needs of the research analysis, the team was able to obtain and use a an alternative encounter dataset (described above) of raw claims that the MCOs had paid their own providers, but had not necessarily been processed through the official HFS Medicaid warehouse. For some of the team's work, this alternative encounter dataset was sufficient; however, for other areas, the claim dataset did not provide data needed (e.g., turnover of care coordinators, completion of care plans) or did not provide sufficient detail for the research team's work. In those instances, the UIC team was able to work with the two plans to obtain "special" datasets focusing on specific areas not adequately covered by the claims dataset. These special datasets from the MCOs included areas such as risk stratification, care plans, care coordinator turnover and caseloads, prior approval requests, grievances, and appeals.

6. Capitated payment dataset provided by HFS to UIC

UIC also obtained a dataset of all capitated payments HFS made to the MCOs for ICP members for the first three years of the program (May 2011 thru June 2014). This data included the rate cell, amount paid, month, member, and the MCO being paid. This dataset was used primarily to calculate "official" enrollment for the plans.

7. Provider network dataset provided by HSAG to UIC

In 2013, HFS expanded the responsibilities of the ICP's external reviewer, Health Services Advisory Group (HSAG), to include the on-going monitoring of the development and maintenance of the MCO provider networks. HSAG worked with HFS and the MCOs to standardize the format that the MCOs would use to report the number of signed providers in their networks.

HSAG created standardized provider categories for the MCOs to use in reporting their providers, instituted an active protocol to detect and minimize duplications of providers, and expanded reporting to include counts of providers by counties within the ICP. As a result, the UIC team was able to obtain extensive provider network data for both MCOs from HSAG. The team used the HSAG Network Capacity Reports for December of 2013 and December of 2014 in the study's analysis of provider networks.

8. Medical Loss Ratio reconciliation dataset provided by HFS to UIC

The contract between the MCOs and the State specifies that each MCO spend at least 88% of the revenues it collects each year on member "benefit expenses." If they fail to do so, they have to refund the difference to the State. The UIC team requested and obtained the MCO cost dataset from HFS that it had used to calculate the official medical loss ratio (MLR) for calendar years 2011 and 2012. Because of system issues, HFS has not been able to complete Medical Loss Ratio reconciliation, but expects to do so soon.

9. HEDIS/State outcome measures dataset provided by HSAG to UIC

In 2013, the Health Services Advisory Group (HSAG) evaluated both MCOs for their performance on two sets of the three quality indicators. The two sets of indicators evaluated by HSAG were the Pay for Performance (P4P) measures and the non-P4P HEDIS measures for Service Package 1 (SP1). In addition, for the first time, HSAG evaluated the Service Package 2 (SP2) quality in 2014. Reports for outcome measures for both SP1 and SP2 were received and used for analysis by the research team.

10. Stakeholder input

In order to understand experiences with the ICP, the evaluation team held 15 meetings with 13 stakeholder groups during the summer, fall and winter of 2014 to solicit feedback and comments. Team members contacted stakeholder groups based on their involvement with the ICP and communications in previous years.

Stakeholder meetings were held with ICP members, the Division of Mental Health (DMH), the Division of Alcohol and Substance Abuse (DASA), the Division of Rehabilitation Services (DRS), the Department of Aging (DOA) providers and Coordinated Care Units (CCUs), the Illinois Hospital Association, home care providers, family physicians, Centers for Independent Living providers, HIV/AIDS providers, Thresholds, General Medicine, and IlliniCare SNFist providers and administrators. Meetings were guided by a general framework of questions developed based on services provided, and included opportunities for stakeholders to comment on their contact with members, MCOs, and HFS; general experiences on the process of providing services within the ICP, including contracts, assessments, billing, and authorizations; and positive factors and challenges encountered in the ICP. Team members took notes during conversations.

After the meeting, the evaluation team summarized issues and concerns raised by the group, and shared the summaries with stakeholders for feedback. Written comments and concerns were also shared with HFS, other “sister” State agencies (Department of Human Services, DMH, DASA, DRS, and IDoA), and with the two MCOs (Aetna and IlliniCare) for comment. In the winter and spring of 2015, stakeholders were invited to provide any updates on the status of their experiences with the ICP.

C. Comparison Group Matching and Difference in Differences Design

Much of the analyses presented in this report are concerned with describing the way that Aetna and IlliniCare have implemented the ICP, and with documenting the extent to which they are fulfilling their

contractual obligations. However, these analyses do not adequately address two fundamental questions about Medicaid Managed Care in Illinois:

- Is it cheaper for the State to pay for the healthcare costs of aged, blind, and disabled Medicaid members under the capitated ICP system or under the more conventional FFS system?
- Do aged, blind, and disabled Medicaid beneficiaries receive different amounts and types of health services under the ICP system than they would under the conventional FFS system?

It can be difficult to answer questions like these because they require knowledge of counterfactual scenarios, like: how much would the State have spent on ICP members if they had not transitioned to ICP? To help answer these questions, the research team created a matched comparison group of non-ICP members who closely resembled the ICP population. This matched comparison group was followed over time, before and after implementation of the ICP and it provides insight into the cost and utilization levels the ICP group would have experienced in the absence of ICP. The approach is explained in this section and the results are given for the Hospital/Emergency Room, physician (primary care positions and specialists), dental service, and pharmacy sections. In each case, the results estimate the cost and utilization effects of ICP.

1. Research Design and Constructing a Comparison Group

A pre-post design, in which subjects are compared before and after the start of a program, is a simple and intuitive evaluation strategy. However, pre-post comparisons are often misleading because many non-program factors may also change over time. This makes it hard to know whether changes in outcomes are due to the new social program or to some 'other' change that occurred over time. For example, healthcare utilization and spending patterns may vary over time due to changes in the economy, healthcare markets, federal health insurance programs, weather conditions, etc. Another option is to compare the post-ICP outcomes of the ICP members with the outcomes of aged, blind, and disabled Medicaid members from a non-ICP eligible geographical area, such as the city of Chicago. This approach avoids concerns about secular trends, but it suffers from a different problem: ICP exposure is not the only difference between the ICP and Chicago populations.

To address these problems, the research team adopted a two-step approach: matching to create a comparison group that resembled the ICP group, and a panel data "difference in difference" technique that accounts for common secular trends and adjusts for any pre-existing differences between the groups.

The matched comparison group was drawn from the large pool of Chicago Medicaid members who met the non-geographic eligibility criteria for ICP. The two groups were followed for three years. The ICP group consists of ICP-eligible Medicaid enrollees who lived in the ICP pilot area (5 collar counties and Cook County excluding the City of Chicago). The Chicago group is made up of people who would be ICP-eligible, except that they lived in Chicago proper, outside of the pilot area.

Since the Chicago Medicaid population has very different characteristics than the suburban Medicaid population, the research team used a method called Inverse Propensity Score Weighting (IPSW) to construct an analytic comparison group of Chicago Medicaid members who closely resembled the ICP sample with respect to:

1) Age

Table 2: Baseline Covariate Balance Before and After Matching

Structure; Gender; Race and Ethnicity (Asian, Black, White, Other, Hispanic);

2) Medicaid Waiver Category;
3) FY11 FFS Utilization;
4) FY11 Expenditures;
5) Health Status (The team used the Healthcare Cost and Utilization Project's (HCUP) Clinical Classification Software (CCS) to convert ICD9 codes from FY11 Medicaid claims to construct a set of variables indicating whether a person had a particular health condition. The matching procedure adjusted for a set of 260 different CCS categories.)

Table 2 reports the average characteristics of the people in the ICP and Chicago groups during the 9 month baseline period in FY11. The first column shows the characteristics of the suburban group. The second column shows the Chicago comparison group before the matching algorithm was applied, and the third column shows the characteristics of the matched Chicago comparison group used in the analyses. The matching algorithm also included a set of 260 clinical classification codes, but this list is not shown in the table to conserve space. The matching procedure creates a Chicago comparison group that closely resembled the ICP group before the transition to ICP. Historical utilization and demographic information was not available for about 30% of sample. To avoid removing this group of people from the later analysis, the matching procedure was designed to try to ensure that the matched Chicago sample included about the same proportion of people with no historical data as the ICP sample. Overall, the matching procedure was very successful at creating an analytic comparison group of Suburban and Chicago ICP eligible people who were very similar before the onset of ICP.

This report presents results from the FY14 cohort consists of everyone who met the non-geographic ICP eligibility criteria for at least one month during FY14 in Chicago, and everyone who received an ICP capitation payment for at least one month during FY14 in the ICP region.

	Suburbs	Raw Chicago	Matched Chicago
Demographics (proportion of sample with characteristic)			
Female	0.54	0.51	0.54
White	0.39	0.15	0.39
Black	0.36	0.67	0.37
Asian	0.08	0.02	0.08
DK Race	0.16	0.16	0.17
Hispanic	0.14	0.16	0.15
Age Structure (proportion of sample with characteristic)			
Age (mean age)	47.82	45.42	48.15
Over 65	0.18	0.06	0.17
Under 21	0.06	0.08	0.06
Age 21-30	0.17	0.13	0.17
Age 31-40	0.11	0.12	0.11
Age 41-50	0.18	0.22	0.18
Age 51-60	0.25	0.33	0.25
Age 61-70	0.12	0.09	0.11
Age 71-80	0.09	0.03	0.09
Age 81-90	0.03	0.01	0.03
91+	0.00	0.00	0.00
Past Utilization and Costs per month in FY11 (mean)			
ER Days	0.12	0.14	0.12
Inpatient Admissions	0.04	0.06	0.05
Number of Prescription Claims	4.42	3.70	4.30
Number of Physician Visits	1.32	1.22	1.34
Number of Dental Visits	0.04	0.04	0.04
Eligible Months FY11	8.83	8.87	8.84
Medicaid Expenditures	$1,661.72	$1,268.40	$1,552.04
Waiver Categories (proportion of sample with characteristic)			
Aging	0.02	0.04	0.02
Brain Injury	0.01	0.01	0.01
Community Residents	0.77	0.81	0.75
Developmental Disability	0.06	0.03	0.06
HIV/AIDS	0.00	0.01	0.00
ICF/MR	0.01	0.00	0.02
Nursing Facility	0.09	0.06	0.10
Physical Disability	0.04	0.05	0.04
Supportive Living	0.00	0.00	0.00
Technology Dependent	0.00	0.00	0.00
No Historical (FY11) Data (proportion of sample)	0.33	0.22	0.28
Sample Size	**27,857**	**53,174**	**53,174**
Data Source: HFS Claims Data and Demographic for FY11			

2. Analysis

The research team used panel data regression models to estimate the impact of ICP on costs and healthcare utilization. The outcome analysis was conducted at the level of the person-month in order to follow each person's costs and utilization patterns over time. Data quality was extremely poor during

the first few months of ICP adoption and then stabilized. To make progress, without biasing the findings, the analyses exclude data from April 2011 to December 2011. The analyses follow each person from January 2012 to December 2013.

The panel data regressions estimate the impact of ICP on average per member per month costs to the State and several measures of healthcare utilization. Each model was fitted to the matched analytical sample to account for baseline observable differences between the groups. The models control for a full set of month-year fixed effects to account for any secular time trends that might affect the results, and a full set of person fixed effects to account for any unobserved differences between the members of the Chicago and ICP samples that may have escaped the matching procedure. Finally, the models included an indicator variable that measured the onset of ICP. This variable never changes for the Chicago members but does change for the Suburban members. The regression coefficient on the "Overall impact of ICP" variable provides the estimate of the cost or utilization impact of ICP. In essence, the estimate is a measure of the average difference in costs or utilization between the two groups after accounting for baseline differences and time trends. This basic model was augmented to account for several changes in policy that may have affected the Chicago or ICP groups in different ways. In particular, this approach assesses the additional impact of the SMART Act and the substantial change in capitation rates (recapitation) that became effective in July 2013.

How has the program expanded?

A. Enrollment Summary

Table 3, below, compares enrollment in the Integrated Care Program during FY13 and FY14. Slightly more people (almost 2,500 members per month) were enrolled with either Aetna or IlliniCare in FY14 than in FY13. The average tenure was the same both years; the average member was enrolled for just over 10 months out of the year. There were slight increases in the number of new members per month and the number of members who departed each month.

Just over 2% of members leave each MCO each month. A very small percent (5% of people who leave a plan each month) switch to the other plan. This percentage is less than half of what it was in FY13 (11.4% versus 5.0%).Even fewer members who receive waiver or long-term care services leave the plans; only about 2% of waiver members leave either Aetna or IlliniCare.

Table 3: ICP Enrollment Summary (Rates)

Enrollment Measure	2 Year Comparison		FY14 Detail	
	FY13	FY14	Aetna	IlliniCare
Total Unique Members	**42,334**	**45,061**	**21,873**	**23,818**
Average Members per month	35,370.0	37,941.3	17,907.0	20,031.2
Average Tenure (Months)	10.1	10.1	9.8	10.1
New Members				
Average New Members per Month	687.3	758.5	426.3	332.2
Percent New Members (of Total)	1.9%	2.0%	2.4%	1.7%
Percent Auto-enrolled	43.0%			
Left ICP				
Departing Members (Average per Month)	754.0	923.5	415.1	508.5
% Departing Members (of Total Members)	2.1%	2.4%	2.3%	2.5%
% Waiver Members who Depart	N/A	2.0%	1.9%	2.2%
Switching Plans				
% Switched Plans (of Total Members)	0.24%	0.14%	0.15%	0.14%
% Switched Plans (of Departing Members)	11.4%	5.0%	6.0%	5.7%

Data Source: Capitation Payments from HFS to the MCOs for FY13 and FY14
Note: Only includes the original ICP pilot area and MCOs

Table 3 also shows differences in enrollment between Aetna and IlliniCare during FY14. Most of the figures are very comparable, except that IlliniCare had over 2,100 more members in an average month. According to HFS, this difference is because Aetna did not submit a provider enrollment file correctly to the client enrollment broker. Therefore, IlliniCare received approximately 2,500 new members more than Aetna in July 2013. According to HFS, to correct for this, auto-enrollment was subsequently

adjusted in FY14 so Aetna received approximately 100 more new members per month than IlliniCare. Aetna's enrollment was still behind that of IlliniCare by the end of FY14.

HFS began recording reasons for disenrollment in January 2014. Table 4 shows the reasons for disenrollment for Aetna and IlliniCare in the original 6 counties from January through December of 2014. During this time, 1,072 of people left Aetna and 1,014 people left IlliniCare. Almost a third of people in each plan (32.6% in Aetna and 33.1% in IlliniCare) disenrolled because the members "desired PCP in a different health plan." Similarly, 30.3% of the disenrollment from Aetna and 32.8% from IlliniCare were because the member was "dissatisfied with current health plan."

The number of disenrollments reported in this data does not match the number of people leaving ICP each month in the capitation payments. Table 3 showed that 923.5 people leave ICP each month during FY14, and this this enrollment data only shows 2,086 total disenrollments during the 2014 calendar year, which is about 174 people per month.

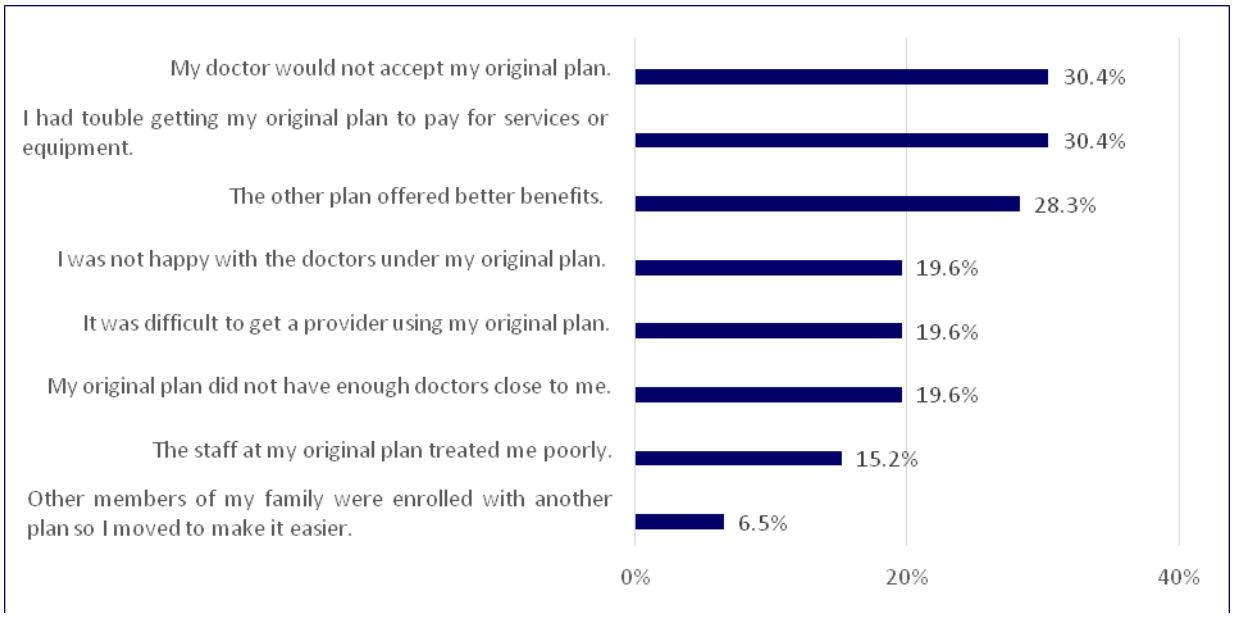
Table 4: Disenrollment Reasons

Disenrollment Reason	Aetna	IlliniCare
Desired PCP in a different Health Plan	349 (32.6%)	336 (33.1%)
Dissatisfied with current Health Plan	325 (30.3%)	333 (32.8%)
Enrollee would like to try another health plan	245 (22.9%)	190 (18.7%)
Enrolled in wrong Health Plan	94 (8.8%)	97 (9.6%)
Requires different PCP for special needs	30 (2.8%)	32 (3.2%)
Dissatisfied with current PCP	23 (2.1%)	23 (2.3%)
Moved and PCP too far	4 (0.4%)	2 (0.2%)
Not Applicable	2 (0.2%)	1 (0.1%)
Total	**1,072**	**1,014**

Data Source: HFS special dataset to UIC

The consumer survey conducted by the research team found that 49 of the respondents said that they had switched between Aetna and IlliniCare. The reasons that they provided for making the switch are shown in Figure 1. The two most frequently cited reasons were "my doctor would not accept my original plan" and "I had trouble getting my original plan to pay for services or equipment" (30.4% each). "The other plan offered better benefits" was the next most frequently cited reason for switching plans (28.3%).

Figure 1: Why did you switch plans? (FY14) (n=49 people who switched)

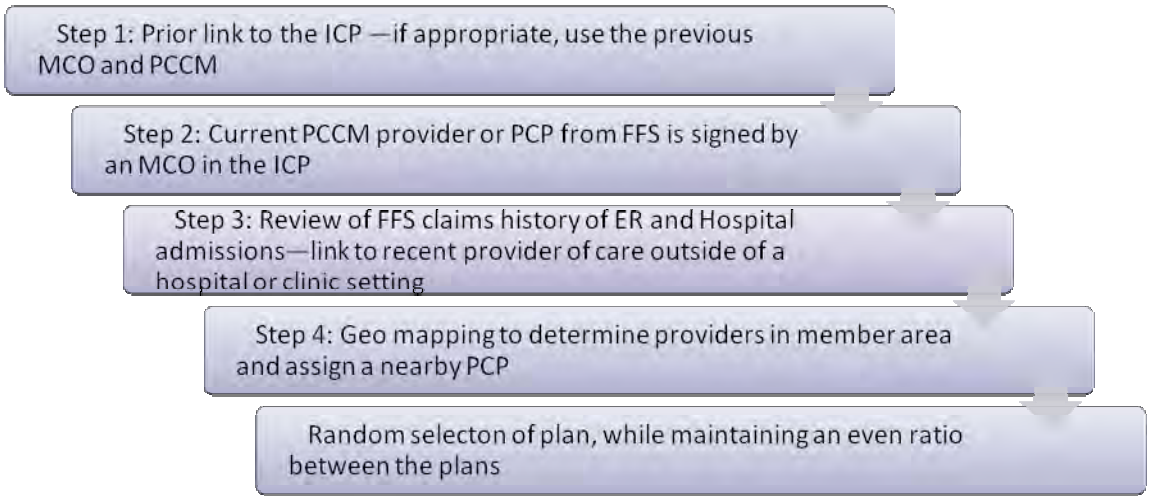


Data Source: UIC Enrollee Survey

B. Auto-enrollment

Individuals who are eligible for ICP must make a choice between enrolling with Aetna or IlliniCare (in the pilot region, other areas of the State now have additional options). The Appendix (Table 116) contains additional details about the enrollment process. If an eligible individual does not make an active choice, HFS uses a smart enrollment process to assign members to one of the MCOs. This process is detailed in Figure 2. Prior to randomly assigning a member to a plan, HFS uses a 4 step "smart" process to determine the member's "best fit" plan. Only after those steps are exhausted, a random assignment occurs.

Figure 2: Auto-enrollment Process



Data Source: HFS

One stakeholder told the research team that this enrollment process makes it very hard to for members to manage providers. In order for either auto or choice enrollment to be effective, an enrollee's primary care physician and specialists need to be in the same network. Otherwise, members are forced to choose between their primary care provider and specialists. The auto enrollment process favors primary care over specialists, which may make sense in most situations, but when a person with a disability needs to see a specialist (who may be one of only a few that can handle certain conditions), it may make more sense to put that individual in a network with that specialist rather than the primary care physician.

If a member regains eligibility for the ICP within 60 days after losing eligibility, the Illinois Client Enrollment Broker (ICEB) will assign that member back with their original plan as long as the member's eligibility status and geographic residence remains valid for participation in the previous program. If the member regains eligibility after 60 days, the ICEB will mail an enrollment packet letting the member know they have 60 days to select a plan and Primary Care Provider (PCP). If no choice is made, the ICEB will auto-assign the member to a plan and PCP.

Member enrollment into either MCO occurred due to either auto-enrollment or by way of the member's enrollment choice. In previous years, HFS has provided data relating to the rate of auto-enrollment by month; however, this data is not available for FY14.

C. Monthly Enrollment

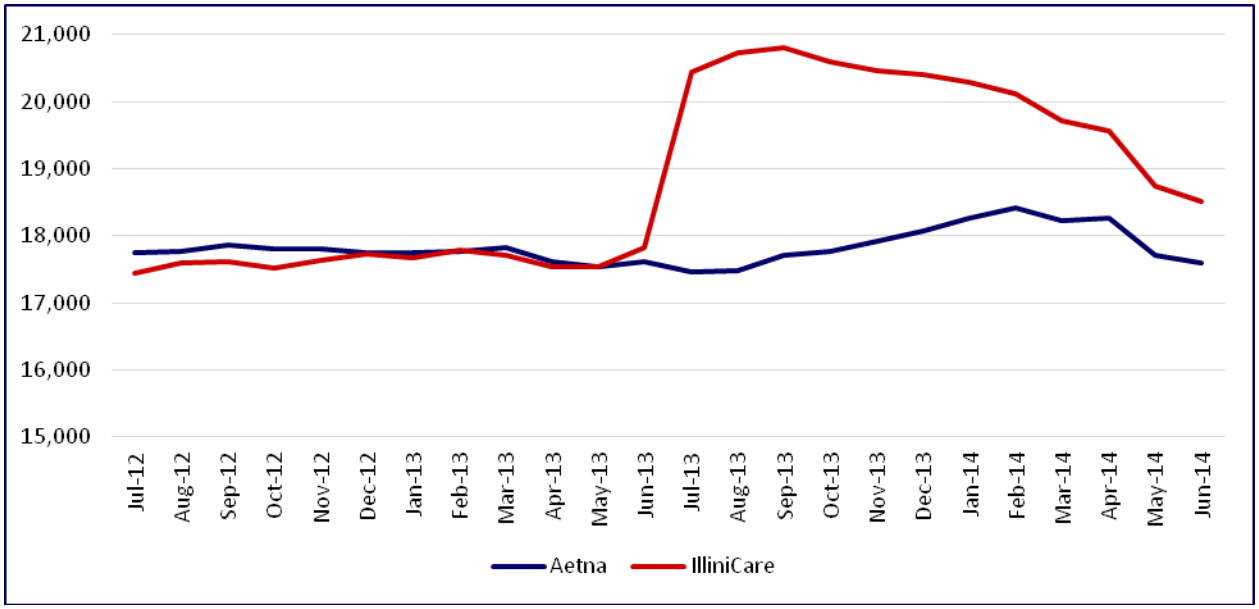
Table 5 shows enrollment in each MCO by month using two different data sources. The first source used is the capitation payments that HFS made to each plan during FY14. The second data source is the Utilization Management (UM) reports that each plan submits monthly to HFS listing Hospital admissions and visits to Emergency Departments. These monthly UM reports include total member enrollment as reported by each MCO (at the research team's request, each MCO re-ran their monthly UM reports to include only members in the original ICP pilot area). The columns on the right side of Table 5 show the difference between enrollment as calculated by capitation payments and enrollment as reported by the MCOs in their monthly UM reports.

For Aetna, in nine of the 12 months, they report on more members than they received capitation payments for. For IlliniCare, nine of the 12 months have more members with capitation payments than what is reported in the UM reports. While it is understandable that there will likely be some differences between the two sources due to lag time for HFS to make the capitation payments, the difference between capitation and reporting for IlliniCare is noteworthy. For the first five months of FY13, IlliniCare received, on average, over 1,800 additional capitation payments per month than the number of members that they were reporting in their monthly UM reports.

Figure 3 graphically shows enrollment in each MCO for the past two years (FY13 and FY14). This figure shows that historically the plans have been very even with regard to enrollment, but at the start of FY14, enrollment for IlliniCare jumped 2,500 members over Aetna. As explained before, this is because Aetna did not submit a provider enrollment file correctly to the client enrollment broker. Over the course of FY14, IlliniCare's members per month begin to converge with Aetna.

Table 5: Comparison of Enrollment by Source (Capitation Payments v. MCO Reports)						
Month	HFS Capitation Payments		MCO Utilization Management Reports		Difference between Sources	
	Aetna	IlliniCare	Aetna	IlliniCare	Aetna	IlliniCare
Jul-13	17,462	20,442	17,052	17,892	410	2,550
Aug-13	17,486	20,723	17,170	18,520	316	2,203
Sep-13	17,709	20,813	17,649	18,883	60	1,930
Oct-13	17,762	20,593	18,008	19,194	-246	1,399
Nov-13	17,925	20,472	18,216	19,408	-291	1,064
Dec-13	18,078	20,400	18,370	19,649	-292	751
Jan-14	18,257	20,293	18,552	19,899	-295	394
Feb-14	18,408	20,118	18,769	19,752	-361	366
Mar-14	18,234	19,713	18,994	19,702	-760	11
Apr-14	18,264	19,558	19,152	19,807	-888	-249
May-14	17,714	18,746	18,627	19,388	-913	-642
Jun-14	17,585	18,503	18,527	19,244	-942	-741
Ave	17,907	20,031.2	18,257.1	19,278.2	-351.0	753
Data Source: HFS Capitation Payments; MCO Updated Utilization Reports						

Figure 3: MCO Enrollment (FY13 and FY14)



Data Source: HFS Capitation Payment Data

What are the consumer experiences?

A. Impact of ICP on Health Services Appraisal

A key question addressed in the evaluation is the impact of ICP on consumers' perceived health services appraisal. To this end the research team developed and validated the Healthcare Services Appraisal (HSA) that comprises six survey items (α=.771 and test-retest reliability of r=.768): overall satisfaction with healthcare, satisfaction with their primary care physician, satisfaction with medical specialists, satisfaction with care coordination, satisfaction with the medical services received, and perception of the quality of care received. In previous years, the research team used this HSA scale to detect any differences between ICP enrollees and people receiving FFS Medicaid. In the second year of ICP, people in ICP had a more positive HSA than Medicaid enrollees in Chicago. However, because the Chicago comparison group is in the process of transitioning to ICP, an FFS comparison is no longer possible. Instead, the research team examined differences in HSA in relation to the length of time enrolled in ICP. Table 6 shows results of a regression analysis for Healthcare Services Appraisal that examines the impact of length of time in ICP while controlling for demographic variables, disability type, overall health status, and the number of unmet healthcare needs. The results showed that, of people who responded to the survey between September 2014 and March 2015, there were **no significant differences in HSA with regard to length of enrollment in ICP, disability type, or for any demographic factors.**

Table 6: Regression Analysis for Healthcare Services Appraisal (FY14)

	Unstandardized Coefficients		Standardized Coefficients		
	B	Std. Error	Beta	t	Sig.
Age	.001	.002	.014	.357	.721
Gender	.052	.050	.035	1.043	.297
White Minority	.098	.061	.057	1.605	.109
Hispanic Origin	.059	.071	.029	.829	.407
Overall Health Status	.011	.002	.193	4.821	.000**
Intellectual/developmental disability	-.087	.061	-.053	-1.439	.151
Physical disability	.003	.055	.002	.050	.960
Mental health disability	-.105	.056	-.070	-1.891	.059
Time Enrolled in ICP	.010	.031	.011	.313	.755
Unmet Medical Needs	-.079	.009	-.300	-8.384	.000**
R square: .191 **p<.01					

The only significant factors related to HSA were overall health status and the number of unmet medical needs. People with a higher overall health status (p<.001) and fewer unmet needs (p<.001) reported a more positive appraisal of their healthcare services. The length of time that a person was enrolled in managed care did not have a significant impact on Healthcare Services Appraisal in this last round of surveys; rather the more important factors are the extent to which people felt that their healthcare needs were being met and how good they feel their health is.

B. Impact of ICP on Unmet Healthcare Needs

In order to address the impact of ICP on unmet healthcare needs (given the loss of an FFS comparison group), as in the analysis of health services appraisal, we examined the impact of time in ICP on unmet healthcare needs while controlling for demographics, overall health status, and type of disability. The number of unmet healthcare needs measure was the number of medical /specialist services (out of 18 listed) that were needed, but not received. Table 7 shows the results of the unmet healthcare needs regression analysis. Again, **the length of time enrolled in ICP did not make a difference on the number of unmet medical needs.** People with higher levels of overall health had significantly (p<.001) less unmet medical needs, as did those respondents who identified as white (vs. respondents who identified as any other race) (p=.001). People with IDD (p=.002) and mental health disabilities (p=.025) had more unmet medical needs than people without those disabilities. Similar results were found in the second year of ICP, with no significant differences between the ICP group and the Chicago group.

Table 7: Regression Analysis for Unmet Medical Needs (FY14)

	Unstandardized Coefficients		Standardized Coefficients		
	B	Std. Error	Beta	t	Sig.
Age	-.008	.008	-.040	-1.017	.309
Gender	.030	.198	.005	.153	.878
White Minority	-.841	.241	-.129	-3.486	.001**
Hispanic Origin	.132	.280	.017	.470	.639
Overall Health Status	-.056	.009	-.257	-6.305	.000**
Intellectual/developmental disability	.746	.239	.120	3.126	.002**
Physical disability	-.112	.219	-.020	-.513	.608
Mental Health Disability	.493	.220	.086	2.242	.025*
Time Enrolled in ICP	-.086	.123	-.025	-.700	.484

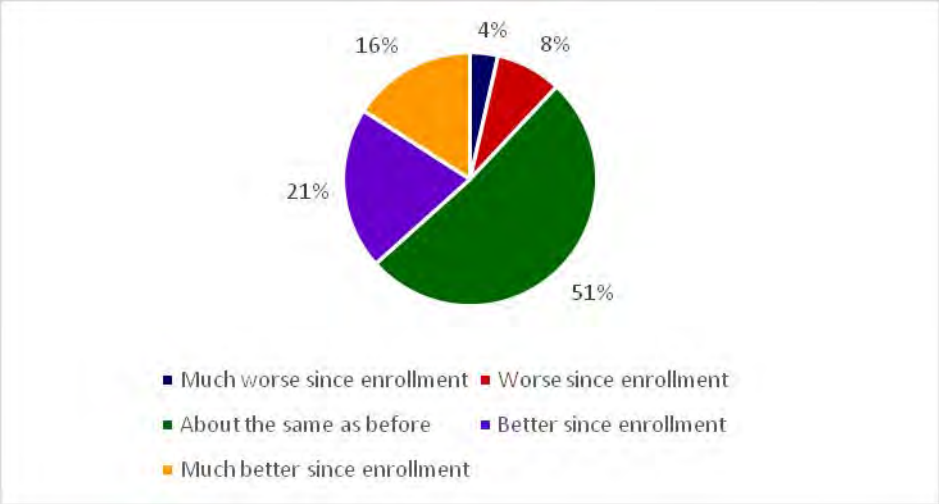
R square: .116
**p<.01

C. Impact of ICP on Perceived Healthcare Quality

Another survey question asked people how the quality of their healthcare had been since enrolling in ICP. The majority of the respondents (51%) said that their healthcare was about the same as before. More people reported that their healthcare was better or much better (37% combined) after enrolling in ICP then who reported that it was worse or much worse (12% combined).

The research team also used each person's reported health status (using the SF-12) as the dependent variable to see if health changed over time. Using the longitudinal data, there were no significant differences related to whether a person was enrolled in ICP and their health status compared to their health status in the previous year. This is true of an enrollee's overall health, as well as the physical and mental health components of that score.

Figure 4: How has the quality of your healthcare been since you enrolled? (n=535)



D. Longitudinal Analysis: does HSA and the number of unmet medical needs change when people transition from FFS to ICP?

Initially, from the baseline to the first year follow-up of ICP, the research team found a significant decline in satisfaction with Healthcare Services. However, there was not a significant change from the first to the second year of the ICP. In the Year 2 cross-sectional analysis, people in ICP reported higher HSA than people in Chicago. Previous reports from the research team did not find significant changes in unmet healthcare needs, neither longitudinally from the baseline to the first year, or between ICP and Chicago in the second year.

During the second year of this research, the research team collected 208 longitudinal surveys from people in the original ICP pilot region; these surveys represent responses prior to implementation of ICP and in the first year following. The research team attempted to also collect longitudinal surveys from the comparison group in Chicago for the year before and after implementation of ICP. However, HFS did not provide the correct ID numbers for people in the Chicago, so not everyone who had completed the survey in the past year received one during the current year. Only 59 longitudinal surveys could be collected from the Chicago group.

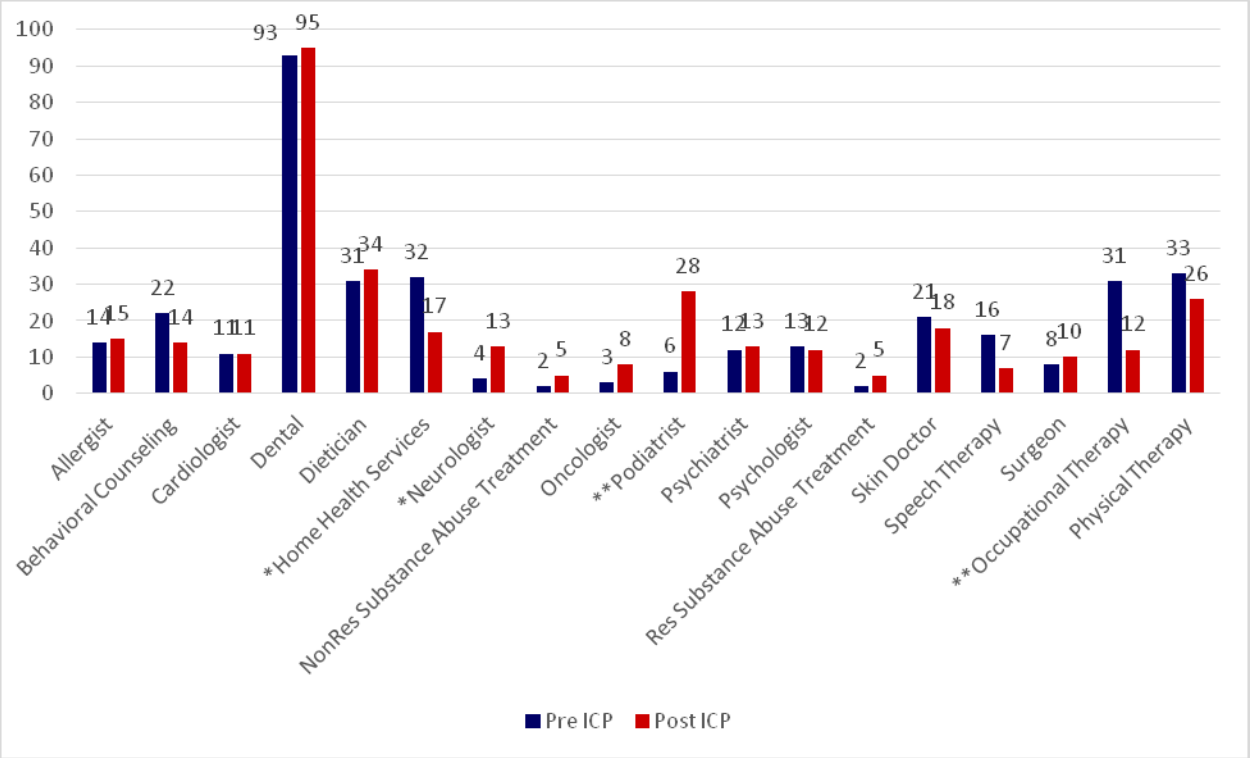
The research team combined all of the longitudinal surveys to compare the pre-implementation period with the post-implementation period, resulting in 267 longitudinal surveys. The research team used an ANCOVA analysis that controls for the location (i.e. ICP pilot region or Chicago) to determine whether there was a significant change from the pre-implementation time to post implementation. **Using the HSA measure, there was not a significant difference (p=.187) in survey respondents' appraisal of their Healthcare Services prior to and following ICP.** While the appraisal did not improve, it is noteworthy that it remained the same, especially because many stakeholders were concerned that ICP would lead to less satisfaction.

Similarly, the research team used ANCOVA to determine whether the number of medical needs changed following implementation of ICP. The results showed that there was a significant difference, with

significantly fewer unmet medical needs following implementation (1.28) compared to before implementation (1.33) (p<.001). **The implementation of ICP resulted in fewer reported unmet medical needs from baseline to year one after ICP implementation.** Whether the person lived in the ICP pilot region or Chicago was not significant.

Figure 5 shows the number of people who had unmet needs for medical services each time (out of 267). The differences for the unmet needs for one of these individual services are generally consistent pre and post-implementation. Unmet needs for services only increased significantly following implementation for podiatry (p=.000). On the other hand, significantly fewer people had unmet needs for occupational therapy (p=0.002), home health services (p=0.025) and neurology (p=0.049) after the implementation of ICP.

Figure 5: Unmet Needs for Medical Services (n=267 longitudinal surveys)



*p<0.05, **p<0.01

E. LTSS

1. Impact of ICP on LTSS Appraisal

To assess the impact of Service Package 2 on the consumers' long term services and supports (LTSS) Appraisal, we developed the LTSS Appraisal scale based on responses to 3 questions about long-term health and social services: satisfaction with LTSS, perceived quality of LTSS, and satisfaction with care coordination (α=.700). Table 8 shows a regression analysis for LTSS Appraisal, excluding people with IDD because Service Package 2 does not apply to them. This regression is set up identically as the one

previously shown for Healthcare Services Appraisal. **The length of time enrolled in ICP did not make a significant difference on the appraisal rating of LTSS.** Most demographic variables did not have a significant impact on the appraisal of LTSS. People with higher levels of overall health (p<.001) and who were women (p=.031) reported significantly higher levels of LTSS appraisal.

Table 8: Regression Analysis for LTSS Appraisal (FY14)

	Unstandardized Coefficients		Standardized Coefficients		
	B	Std. Error	Beta	t	Sig.
Age	.006	.004	.072	1.473	.141
Gender	.203	.094	.102	2.164	.031*
White Minority	-.059	.117	-.024	-.502	.616
Hispanic Origin	-.137	.132	-.050	-1.037	.300
Overall Health Status	.016	.004	.202	3.890	.000**
Physical disability	.148	.103	.073	1.428	.154
Mental health disability	-.014	.105	-.007	-.135	.893
Time enrolled in ICP	.023	.057	.019	.399	.690
R square: .049 *p<.05; **p<.01					

2. Unmet LTSS Needs

Table 9 shows the same regression output with the number of unmet long-term services and supports (LTSS) needs as the dependent variable. This variable measures the number of unmet needs from a list of 11 LTSS. **Length of time enrolled in ICP did not have an impact on the number of unmet LTSS needs.** However, identifying as white (vs. identifying as any other race) (p=.018) and having better health status (p=.000) related to significantly fewer unmet LTSS needs.

Table 9: Regression Analysis for Unmet LTSS Needs (FY14)

	Unstandardized Coefficients		Standardized Coefficients		
	B	Std. Error	Beta	t	Sig.
Age	-.011	.008	-.067	-1.518	.130
Gender	-.149	.184	-.035	-.811	.418
White Minority	-.527	.223	-.106	-2.369	.018*
Hispanic Origin	-.380	.256	-.065	-1.488	.137
Overall Health Status	-.039	.008	-.235	-4.970	.000**
Physical disability	-.103	.203	-.024	-.510	.610
Mental health disability	.117	.208	.026	.561	.575
Time enrolled in ICP	-.013	.113	-.005	-.116	.908
R square: .069 *p<.05; **p<.01					

F. Consumer Direction

Consumer choice is an important component in the delivery of LTSS to enrollees. 314 of the 1040 (30.2%) reported that they have a personal support worker (also known as a homemaker or personal assistant) in various waivers. Table 10 lists the responses to questions regarding personal choice and consumer direction in will those services. Most respondents that received LTSS felt that they had a lot of choice with regards to choosing their support person (55.1%), deciding the tasks the support persons assisted with (59.6%), and scheduling the time when the support person was to help (58.9%). Less than one in five respondents said that they only had a small amount of choice with these activities.

Table 10: How much choice do you have in your personal services and supports? (n=314)

Question	A small amount of choice	Some choice	A lot of choice
Choosing your support person?	59 (18.8%)	82 (26.1%)	173 (55.1%)
Deciding what tasks the person helps you with?	44 (14.0%)	83 (26.4%)	187 (59.6%)
Scheduling the time when the person helps you?	49 (15.6%)	80 (25.5%)	185 (58.9%)

Data Source: 2014-2015 Consumer Survey

Figure 6 shows the responses to the question asking if personal support workers have enough knowledge and skills to work with a respondent receiving such services. 238 of the 314 people with a personal support worker responded to this question. About 75% (177) consumers reported that their personal support workers all had enough skills and knowledge to work with them, and only seven people reported that their personal support worker did not have any of the skills and knowledge that they need.

Figure 6: Do you think your personal support workers have enough knowledge and skills to work with you? (n=238)

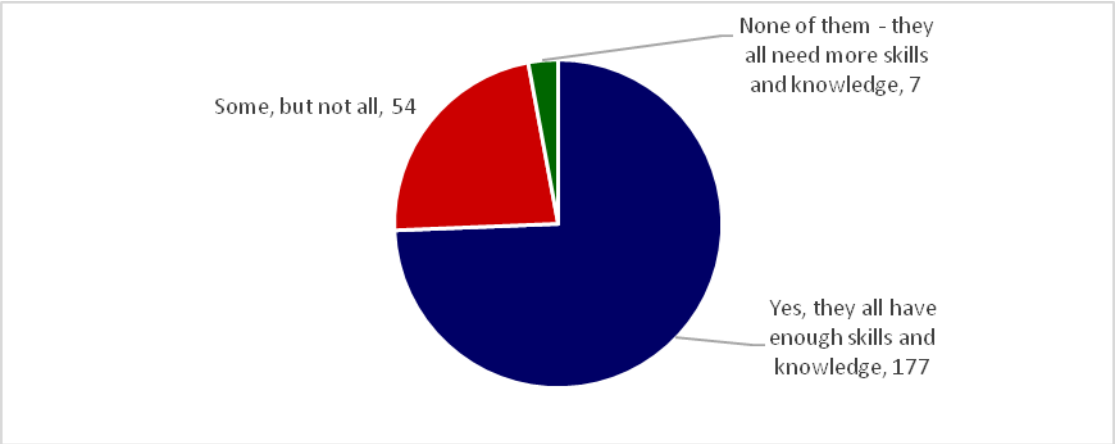


Figure 7 shows the responses to the question asking if personal support workers treated the respondent with respect. 253 people who have a personal support worker responded to this question, and 81.4%

said that the personal support worker always treated them with respect. Only nine respondents said that the personal support worker never treated them with respect.

Figure 7: Do you feel your personal support workers treat you with respect? (n=314)

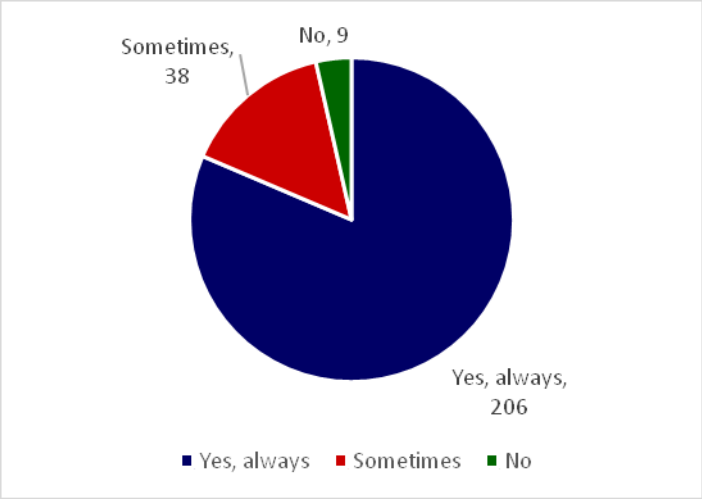
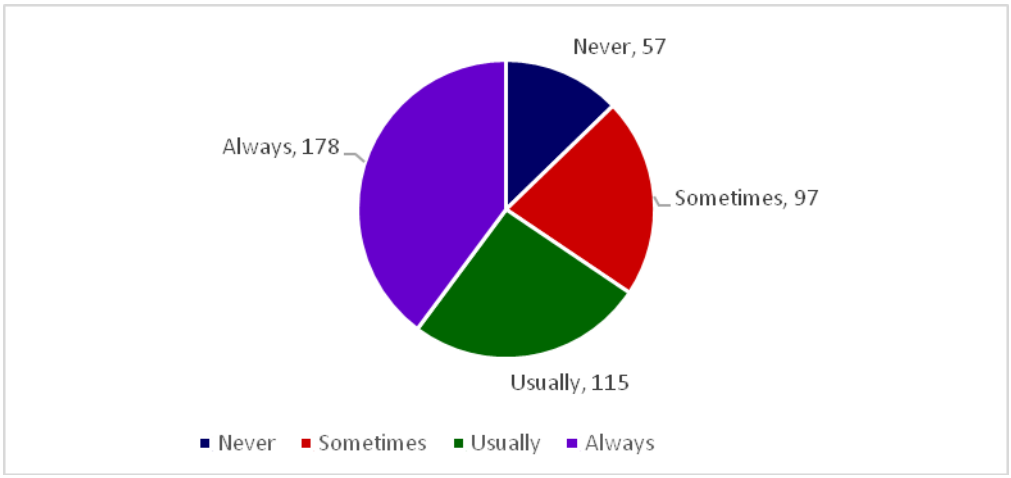


Figure 8 shows the responses to the question asking if enrollees received enough information to make informed choices about their services, including all long-term services and supports. 178 (39.8%) consumers reported that they always received enough information, while 115 (25.7%) respondents reported that they usually get enough information. 97 (21.7%) respondents felt that they only sometimes get enough information, and 57 (12.8%) respondents felt that they never got enough information to make informed choices about their services.

Figure 8: Have you gotten as much information as you need to make informed choices about your services? (n=447)



G. Impact of ICP on Community Participation and Employment

The research team also analyzed the impact of the ICP on community participation. This measure was developed by the principal investigator and asks enrollees whether they had participated in a list of 13 activities in the last month, including visiting friends and family inside and outside of the enrollee's own

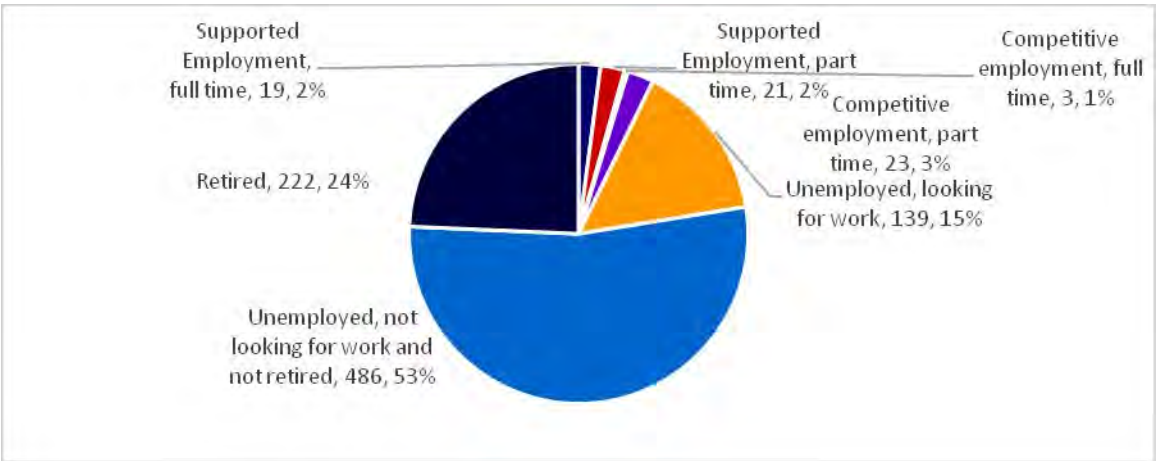
residence, going shopping, going to a movie, going to a park, attending a religious service, volunteering, and other activities in the community. In the previous year, there was not a significant difference in the community participation of people in the ICP versus people in Chicago FFS, after controlling for demographic factors. In the current year, there was no significant difference between people enrolled in ICP based on how long they have been enrolled, again after controlling for demographic differences. At both times, the only significant factors were age ($p<.01$; older people have less community participation), overall health status ($p<.001$; people with higher levels of self-reported health have more community participation), and the number of unmet medical needs ($p<.01$; people with a higher number of unmet medical needs have less community participation).

Longitudinal analysis of community participation showed that there was not a significant difference in the level of community participation in the year before a person entered ICP and following ICP implementation.

The research team also explored whether ICP impacted employment for enrollees. Regression analyses that included demographic differences did not show any significant differences in Year 3 (comparing people in ICP versus people in Chicago FFS) or in the current year (the length of time a person was enrolled in the ICP). Similarly, there was no significant difference regarding employment comparing people before and after ICP implementation.

Very few of the ICP enrollees who completed the survey were looking for work. Combined, almost 80% were either retired (24.3%) or unemployed and not looking forward (53.2%). 15.2% were unemployed but looking for work, and only 7.2% were employed, either competitively or in supported employment. More people were employed part-time (44) than were employed full-time (22). Of those people who were full-time, only three were full-time in competitive employment (see Figure 9).

Figure 9: Employment Status of Survey Respondents (n=913)

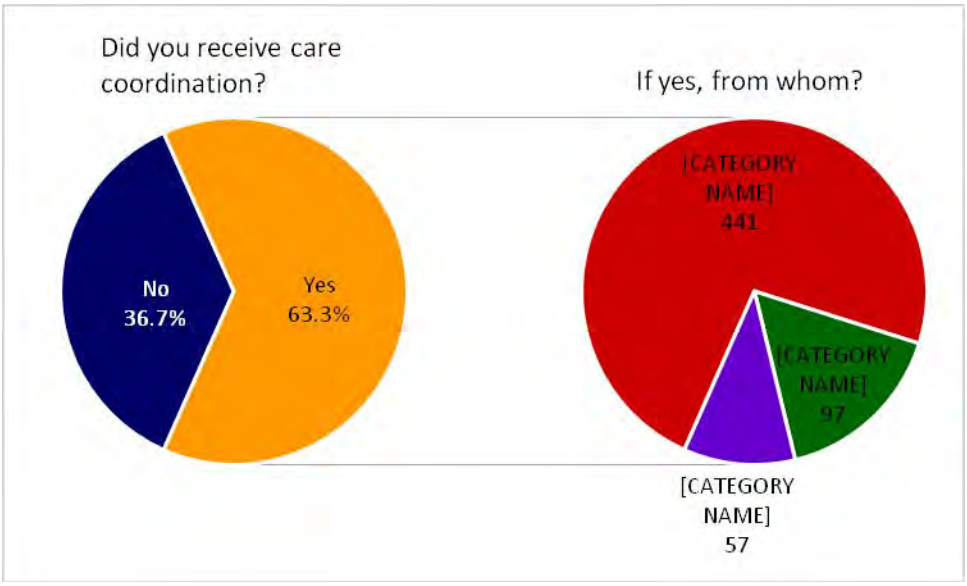


H. Consumer Experience with Care Coordination

In the enrollee survey, respondents were asked about various aspects of care coordination. The first of these questions asked whether the enrollee received care coordination, and if they did, who they received care coordination from. Over half (63.3%) of respondents indicated that they received care

coordination. Most enrollees received care coordination from the MCO (441 respondents, 74.1% of people receive care coordination). Enrollees could also indicate if they received care coordination from a community service (16.3%) or from someone else, possibly a family member (9.6%).

Figure 10: Did you receive care coordination? (FY14)



(n=1,003)

The remainder of the questions asked about experiences with a care coordinator. Figure 11 shows the frequency of care coordinator contact. Most enrollees reported that their care coordinator contacts them (either by phone or visits) every few months. About 17% reported that their care coordinator contacts them at least once a month; 12% reported that their care coordinator contacts them about once a year; and 18.2% reported that their care coordinator never contacts them. This data does not take into account the number of times the enrollee should be contacted given their risk category or waiver status.

Figure 12 shows the frequency which enrollees reported that their care coordinator took into account their wishes for their own care. Most enrollees (46.9%) reported that their care coordinator always took their wishes into account; 25.1% s reported that their care coordinator usually took their wishes for their own care into account; 18.8% reported that their care coordinator sometimes took their wishes into account; and 9.3% reported that their care coordinator never took their wishes for their own care into account.

Figure 11: How often did your care coordinator contact you by phone or visit you? (FY14) (n=441 people that received care coordination)

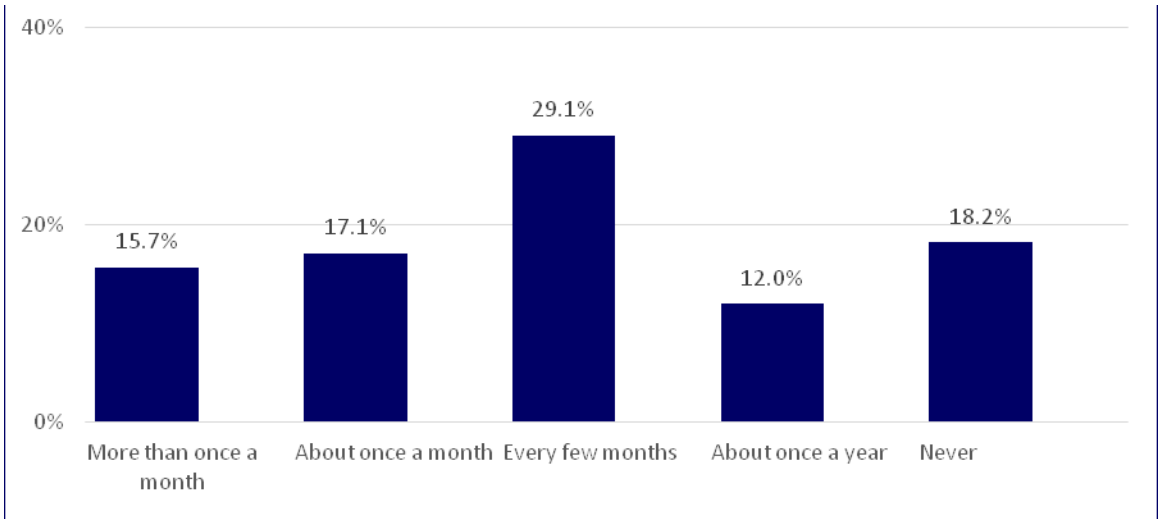


Figure 12: How often did your care coordinator take into account your wishes for your care? (FY14) (n=441 people that received care coordination)

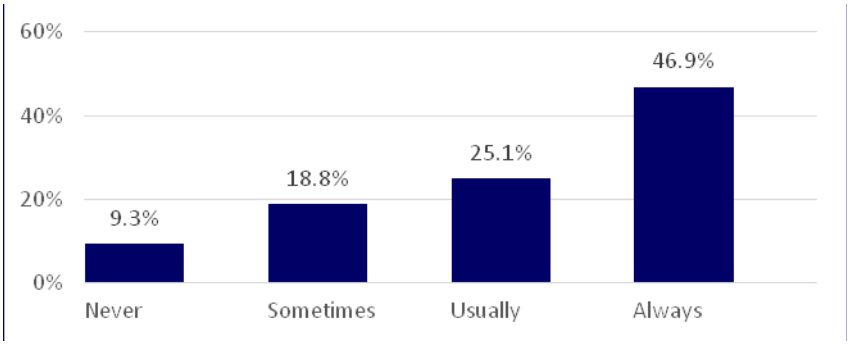


Figure 13 shows the extent to which enrollees felt that their care coordinator demonstrated knowledge of their medical history. Most enrollees (44.2%) felt that their care coordinator always demonstrated knowledge of their medical history; 27.8% felt that their care coordinator usually demonstrated knowledge; while only 18.4% felt that their care coordinator sometimes demonstrated knowledge of their medical history; 9.6% of enrollees felt that their care coordinator never demonstrated knowledge of their medical history.

Figure 14 shows the amount of input that enrollees have in developing a plan for their services with their care coordinator. Most enrollees reported that they have some input (44.9%); 35.0% reported that they have a lot of input; and 20.1% reported that they have no input in developing a care coordination plan.

Figure 13: How often did your care coordinator demonstrate knowledge of your medical history? (FY14) (n=441 people that received care coordination)

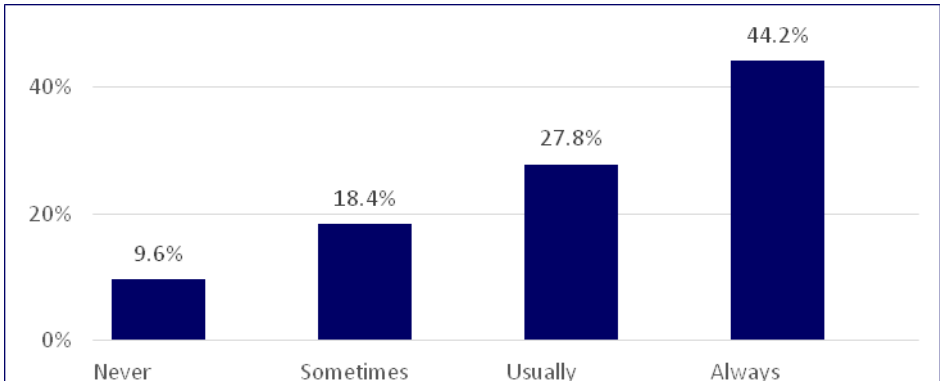
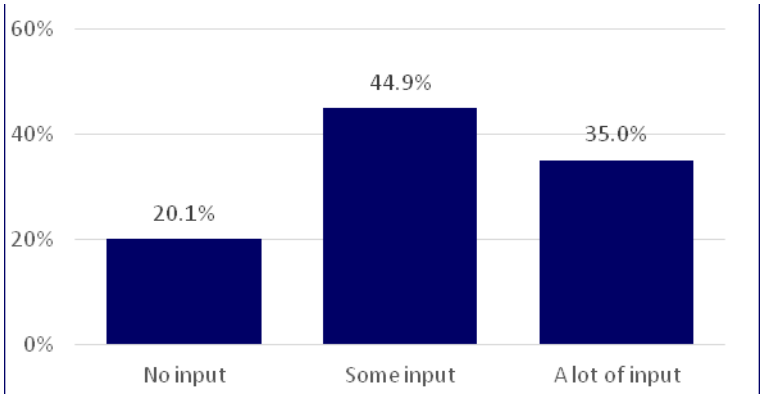


Figure 14: How much input do you have in developing a plan for the services you receive? (FY14) (n=441 people that received care coordination)



In summary, the consumer survey showed that the implementation of ICP had little impact on HSA and the number of unmet medical and LTSS needs. Most people felt that the quality of their healthcare was about the same as before implementation, and a larger percent of people felt that it was better after implementation than felt that it was worse. Longitudinal analysis also showed that the implementation of ICP did not significantly change the appraisal of healthcare, although it did reduce the number of unmet medical needs that a person has. The survey also showed descriptive results about care coordination, and most people said that they did provide a lot of input about their care and about developing a care plan, as well as being contacted frequently. However, there are still some people who said that they were not able to provide any input, so there is still room for improvement regarding MCO care coordination.

Has ICP led to rebalancing?

A. Rebalancing

One of the goals of ICP was to promote rebalancing of enrollees from institutional settings (state/private ICF/MRs, nursing homes) to the community (community residents, non-DD or DD waivers). Table 11 shows the movement of ICP Pilot Area enrollees based on the capitation rate cells HFS paid for each member in July 2013 and June 2014. 3,462 people were in institutional settings at the beginning of FY14; most were still in institutional settings (76.6%) at the end of FY14, while 4.8% became a community resident and 1.0% joined a waiver. Only 0.5% of the 29,422 people who began FY14 as a community resident and 0.6% of the 5,021 people who began on a waiver moved into an institutional setting.

Table 11: ICP Pilot Area Rebalancing From the Beginning to the End of FY14

Movement Type	Aetna	IlliniCare	Total N (%)
Institution			
Began FY14 in Institution	1,761	1,701	3,462
Stayed	1,387 (78.8%)	1,265 (74.4%)	2,652 (76.6%)
Moved to Waiver	18 (1.0%)	16 (0.9%)	34 (1.0%)
Moved to Community	85 (4.8%)	80 (4.7%)	165 (4.8%)
Left ICP	271 (15.4%)	340 (20.0%)	611 (17.6%)
Waivers			
Began FY14 in Waiver	2,432	2,589	5,021
Stayed	2,031 (83.5%)	2,092 (80.8%)	4,123 (82.1%)
Moved to Institution	15 (0.6%)	16 (0.6%)	31 (0.6%)
Moved to Community	40 (1.6%)	39 (1.5%)	79 (1.6%)
Left ICP	346 (14.2%)	442 (17.1%)	788 (15.7%)
Community			
Began FY14 in Community	13,269	16,152	29,422
Stayed	10,317 (77.8%)	12,274 (76.0%)	22,591 (76.8%)
Moved to Institution	69 (0.5%)	65 (0.4%)	134 (0.5%)
Moved to Waiver	200 (1.5%)	281 (1.7%)	481 (1.6%)
Left ICP	2,683 (20.2%)	3,532 (21.9%)	6,216 (21.1%)

Data Source: HFS Capitation Payments to MCOs
Note: Percentages displayed are based on row totals

Table 11 shows that the rebalancing trend in ICP is *away from* institutions (199 (5.8%) of the 3,462 enrollees who started FY14 in institutions) rather than *toward* institutions (165 (0.5%) of the 34,443 enrollees who began FY14 as a community resident or waiver member). Aetna and IlliniCare had similar rates of member movement during FY14. The research team did not have access to data that would allow comparison of rebalancing under ICP with the Medicaid population with disabilities not in the ICP pilot, so it is not possible to make any general conclusions about degree of improvement in the rate of rebalancing within ICP relative to members not in the ICP pilot program.

Table 117 in the Appendix shows this data by each capitation is the rather than collapsed into institution, waiver, and community.

Table 118 in the Appendix shows how often ICP members began and ended 2012 and 2013 in the same rate cell, as calculated by HSAG as one of the performance measures. These figures are very similar to what the UIC research team calculated, except that the UIC calculations are based on FY14 and HSAG completes their calculations by calendar year.

Simply tracking people from their ICP rate cell from month-to-month may not adequately capture all of the member movement that occurs. These rate cells often lag behind any movement for several months. When the UIC team met with Aetna and IlliniCare, they both made this point, specifically about nursing home admissions and departures.

B. Colbert Consent Decree

An important rebalancing effort to move people out of NF is the Colbert decree. In December, 2011, in the Colbert v. Quinn lawsuit, the court approved a consent decree requiring that 1,100 people now living in nursing homes would be offered the opportunity to receive the services they needed in community-based settings. According to Section 9.1.38 of the contract between the State and the MCOs, the MCOs "shall consult and cooperate with the State in meeting any obligations the State may have under any consent decree, including, but not limited to, the Colbert v. Quinn, No. 07 C 4735 (N.D. Ill.) and Williams consent decrees. Contractor shall modify its business practices, as required by the State, in performing under the Contract in order for the State to comply with such consent decrees and, if necessary, enter into any amendments to the Contract."

Both MCOs have taken steps to establish special teams to work with the "Colbert" members. Table 12 summarizes those efforts. Each MCO has established 4 special teams with 24-25 staff to work with Colbert members. As of May 31, 2015, the two MCOs together have received almost 4,000 referrals and transitioned nearly 800 Medicaid members out of NFs.

Table 12: Summary of Colbert Member Movement[1]

	Aetna	IlliniCare
Overview of Colbert Project		
Begin Date of Project	01/28/2013	1/14/2013
Number of special teams	4	4
Number of staff	25	24
Number of referrals made	**1,736**	**2,239**
Members found appropriate for transition	585	1,280
Members found NOT appropriate for transition or refused	1,151	959
Number of members transitioned	**378**	**421**
ICP members	90	109
FFS members	288	312

Data Source: HSAG Reports
[1]As of May 31, 2015

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

A. Coordination with Existing State Agencies

Over the last year, the research team has met with several of HFS's key sister agencies (Department of Aging, Division of Mental Health, Division of Rehabilitation Services, and Division of Alcohol and Substance Abuse) to talk about the transition to managed care. At these meetings, State agency staff raised a number of concerns, and the research team summarized these concerns and forwarded them to HFS for their response. A summary of these concerns and the HFS response is found in Table 13.

B. Transition of Children to Adult Managed Care Program

Transition to managed care for Medicaid adults with disabilities and complex medical needs is challenging. The transition for young adults with these conditions seems to be even more challenging as they receive many services as children may be jeopardized as they reach adulthood. Many children with complex medical needs are exempt from managed care until the age of 19. These children may be served by the Department of Child and Family Services (DCFS) or SSI, and for them, enrollment in the ICP is required after the age of 19. However, for those served by DSCC (Division of Specialized Care for Children), either through the MF/TD (medically fragile/technology dependent) waiver, the DSCC "core" program, or a combination of both, the transition to adult services has been slightly less clear. The DSCC core program serves 7,000 children at any one time; about 650 children are on the MF/TD waiver at any one time. Waiver eligibility is determined by diagnosis; core program eligibility is determined by diagnosis and financial need. At the time of Illinois' transition to ICP, confusion existed over whether these young adults were to be included in managed care programs at the age of 19 or to be excluded and continue to participate in the FFS Medicaid program.

Members from the UIC evaluation team interviewed La Rabida Children's Hospital case workers, physicians, advocates and families, as many children and young adults with significant medical needs are served at La Rabida medical centers and DSCC. The evaluation team also spoke with DSCC and MCO staff. According to La Rabida staff, young adults receiving FFS waiver services can continue with those services after age 19. They do not have to be enrolled in an MCO and, in fact, are the only group that is exempt from ICP enrollment after age 19. In these cases, DSCC continues to provide care coordination services, although staff often struggle to find providers for this group. Young adults who were part of the core program and not receiving waiver services must transition to an MCO who would then provide care coordination services. According to IlliniCare, this population can also apply to receive services through the Department of Rehabilitation Services (DRS), in the form of DRS's home care program.

Table 13: Coordination between HFS and "Sister" State Agencies	
Identified Concern	**HFS Response**
Difficulty coordinating between the State Medicaid agency and other State agencies	HFS meets regularly with sister agencies. Each week, the Bureau of Managed Care (BMC) discusses current issues that affect managed care and the waiver population with DHS-DRS, DHS-DMH or Illinois Department of Aging (IDOA). We collaborate to resolve problems and develop best practices as well as to facilitate improved relationships between the operating agencies and the contracted Managed Care Organizations.
	DHS staff join the weekly calls with the MCOs so they can stay abreast of issues being discussed between HFS and the MCOs.
	To aid in the communication between DRS and the MCOs, HFS established a policy to add an additional contact field in the electronic file sent to DRS from the MCOs. This field is populated with the MCO case manager's direct phone line for the waiver client and often also includes a direct email address. HFS, BMC staff and DRS staff followed up by checking the MCO files for compliance and outreached to the MCOs when they did not complete the field as required. Those MCOs corrected the fields as requested.
Difficulty obtaining data from HFS regarding enrollment changes of IDoA clients	HFS made changes to the weekly extract files that IDOA and DHS receive. Additional fields were included on the file to show more MCO-pertinent information.
	HFS provided the sister agencies with all of the MCO's reporting requirements, including contract outlines of the required deliverables. All waiver-specific template reports were included so sister agencies could review and determine what specific reports, if any, they wanted to review each month/quarter.
	DHS staff worked with HFS data and analytics staff to gain access and be trained on HFS' data warehouse in order to gain access to encounter data.
Need for more training of MCO Care Coordinators	HFS established a policy mandating that all MCO LTSS case managers complete the operating agencies' Home and Community Based Service (HCBS) waiver training. This was to help MCO LTSS case managers understand waiver requirements, how the operating agencies serve the waiver population, and how those agencies expect to work with the MCOs for managed care waiver members. The operating agencies have a sign in sheet for each training for HFS auditing purposes.
Need for MCOs to develop a "preferred" list of providers with IDoA	At implementation, IDOA requested that a provider list be in rotation for the MCOs. HFS included language in the contract with the MCOs that did not require the use of a 'preferred' list but instead requested MCOs to "fairly distribute" enrollees to Affiliated Providers who are willing and able to accept such enrollees and who meet quality standards. A 'preferred' list is not necessary with this language in place.
Lack of reporting of Critical Incidents	The MCOs are capturing reporting critical incidents. MCOs must comply with HCBS waiver reporting requirements to assure compliance with the Federal Waiver Assurances. There are processes and procedures in place to have the MCOs review reports of critical incidents, route to the appropriate Department within the MCOs, and if appropriate, send to an investigating authority. Is the concern that the sister agencies are not currently in receipt of critical incidents or the results of the critical incidents?
Need for tracking of Waiver Performance Measures	On June 16, 2014, HFS hosted a meeting titled *Quality Oversight of Integrated Care Program*; in collaboration with HSAG, HFS met with the operating agencies to explain how the external quality review organization and HFS oversee the waiver case management under MCOs and how those record reviews are handled.
Duplication of effort for some providers as they enter data into 2 systems (MCO claims warehouse and State agency data warehouse)	HFS has heard from several Mental Health and Substance Abuse providers who find that duplicate information is being entered into both the DHS system and the MCO system; however, DHS staff state that certain data must be captured in their subsystems due to State requirements. While it may be duplicative, this remains an Administrative Rule and contract requirement that the State requires.

Interview participants expressed the following concerns regarding this population as young adults turn 19:

- Adult providers are generally not well prepared to take young adults transitioning from pediatric services; these providers do not typically provide case management or social work services to assist families in processing paperwork for ordering equipment and supplies, completing nursing orders and updating the quarterly care plan.
- Adult providers who accept young adults transitioning from pediatric services only accept a limited number of new cases.
- Only limited information on the Managed Care Program, including the ICP, is available to pediatric providers, which hinders their ability to facilitate a smooth transition.
- For families, the MCO websites (ICP website in particular) provide limited information about provider's accessibility, ability, and/or comfort level in taking care of their children, making it difficult to choose an appropriate physician or care plan for young adults in the ICP.

According to Aetna, for those young adults who struggle to find providers in the ICP, arrangements can be made to support existing care when needed. A primary concern in this transition process is that the timing and criteria of moving the young adults into ICP program has historically not been uniform, creating confusion around when and to where each child will be moved. It makes proactive planning (e.g., flagging charts to alert providers that patients will be changing into the ICP program) difficult. Often, non-waiver children in the core program turn 19 and the transition to an MCO as a young adult does not happen quickly. As in the general ICP population, families are sent a letter regarding enrollment in the ICP. Families may not read or act on the letter; in these cases, young adults are automatically enrolled with an MCO. According to La Rabida staff, for those young adults who do get enrolled in the ICP, La Rabida staff will schedule one additional visit to help with transitioning. However, La Rabida staff typically do not advise them regarding the ICP or their MCO because staff do not have the necessary information. According to La Rabida staff, young adults only receive information regarding the ICP from letters and phone calls from the MCOs. However, according to Aetna staff, case managers are available to support continuation of care or connect these young adults to appropriate providers. IlliniCare staff note that, for those members receiving DRS home care services, they also conduct face-to-face meetings and are very involved in members' care.

Historically, several events complicated stakeholders' understanding of services for DSCC children. First, the Hampe v. Hamos lawsuit concerns individuals who age out of the MF/TD waiver program upon turning 19 years old and become ineligible for the MF/TD waiver program. The lawsuit was certified as a class action in November 2010 in the United States District Court for the Northern District of Illinois. The suit requested that the children served under the MF/TD waiver continue to receive waiver services after reaching the age of 19 and be excluded from any managed care programs. There are about 40 cases affected by this lawsuit currently. While the lawsuit was in progress, some young adults were enrolled in the ICP who should not have been based on the lawsuit's outcome. La Rabida staff fought for those young adults to be taken out of the ICP, although some are still enrolled, according to IlliniCare.

In May of 2011, at the start of the ICP (Service Package 1), some children under the MF/TD waiver continued to be served in the FFS Medicaid program as these waiver services were classified under

Service Package 2, which was not implemented with the initial rollout of the ICP. The status of children on the MF/TD waiver turning 19 and other children "aging-out" of the core program of the DSCC remained in question. In February of 2013, at the start of Service Package 2, HFS temporarily held the MFTD waiver out from the ICP, although it had been slated to be included in Service Package 2. HFS stated that "the MF/TD waiver services will be discussed at a later date."

In July of 2013, Federal Judge Ruben Castillo granted preliminary approval to a Class Action Settlement (Consent Decree) of the Hampe v. Hamos lawsuit. The settlement was reached to resolve the case and to continue to provide medically necessary benefits to Class Members after they turn 19 years old. Related to this decision, in July of 2014, HFS informed families with children receiving services through Medicaid that they should be enrolling in the ICP. However, those children receiving services through DSCC do not need to enroll in a managed care plan and may continue to receive services through DSCC. To address the confusion, the advocate group, MF/TD Waiver Families, notified families that:

- All children receiving MF/TD waiver services are exempt from managed care.
- All children who receive services from DSCC are exempt, even if they are not eligible for the MF/TD waiver.

However, to add to the confusion, this information provided by MF/TD Waiver Families was not accurate in the context of the Hampe lawsuit, as some children served by DSCC through the core program would still be required to enroll in ICP.

In FY11, pre-ICP, 23 children were on the MF/TD waiver, and costs to the State during this time for these children totaled $589,000. Based on capitation payments, it appears that 2 of those 23 were enrolled in the ICP as young adults during CY12. In CY13, HFS made capitation payments to MCOs for 11 of the 23 baseline waiver members.

In general, this population of young adults is used to receiving comprehensive supports. For those that move into the ICP, the lack of such supports can come as a shock. La Rabida staff have attempted to support this population in securing physicians for a smooth transition, although they are not compensated for these efforts. La Rabida staff suggest a partnership with the ICP to better transition this population, or an assigned MCO staff person to work specifically with this group. Aetna has also noted that it plans to make efforts in community outreach to improve communications among MCOs, providers, families, and this young adult population. There are many questions yet to resolve regarding eligibility for the MF/TD waiver, services provided by the MCOs, and access to physicians knowledgeable about their care.

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

A. Prior Authorization

Prior authorization is required for many services in the fee-for-service (FFS) Medicaid program, and managed care in general uses a system of prior authorization to control what services and medications are approved. In the Integrated Care Program (ICP), requests for prior authorization usually fall into one of three categories: inpatient, outpatient, and pharmacy. For most "standard" prior authorization requests, the MCO contracts require the request to be reviewed and decided on within 10 days, with a possible extension up to an additional 10 days. However, requests can be expedited "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" (MCO Contract Amendment 5). An expedited request has to be decided upon within three days. The FFS Medicaid program allows up to 30 days before a decision is required.

Aetna and IlliniCare use different definitions to classify inpatient and outpatient requests. These differences can be seen in Table 14 which shows the number of Prior Authorization Requests per 1,000 member months for FY14. The outpatient category had the largest number of prior authorization requests, 47.7 requests for every 1000 member months, followed by inpatient requests (18.2 requests per 1000 member months).

The rate of outpatient requests is similar between the plans, although the rate of inpatient requests is much higher for Aetna then IlliniCare (37.7 to 1.1 requests per 1000 member months). Most requests are standard for both outpatient and inpatient. Compared to FY13 rates, prior authorization requests were down in FY14 across all categories.

Table 14: Prior Authorization Requests (Rates)

Requests per 1,000 MM	ICP		ICP FY14 Detail	
	FY13	FY14	Aetna	IlliniCare
Inpatient				
Standard	25.2	18.0	37.4	1.0
Expedited	0.5	0.2	0.3	0.2
Total	25.7	18.2	37.7	1.1
Outpatient				
Standard	74.4	46.2	47.2	45.4
Expedited	4.0	1.5	0.6	2.2
Total	78.4	47.7	47.8	47.7

Data Source: Prior Authorization reports for FY14

Table 15 shows the types of requests that each plan classifies as inpatient and outpatient. Because of the difference in the number of standard requests (9,084 requests for Aetna and 269 requests for IlliniCare), the percentages are not equally weighted; a smaller percentage for Aetna may be greater than a larger number for IlliniCare in terms of raw numbers. One interesting difference is that Aetna

classifies 23.9% of inpatient requests as behavioral health, compared to only 4.1% for IlliniCare, and IlliniCare classifies 17.8% of their outpatient requests as behavioral health, compared to only 0.4% for Aetna. Most of this difference is likely due to different classification systems used by the MCOs, and different services that require prior authorization under each plan.

Table 15: Inpatient Prior Authorization Requests

Type of Request	Standard		Expedited	
	Aetna (N=9,084)	IlliniCare (N=269)	Aetna (N=66)	IlliniCare (N=44)
Behavioral Health	2,174	11	7	2
Durable Medical Equipment (DME)	0	0	0	0
Medical Inpatient	6,794	97	43	13
Medical Outpatient	0	0	0	0
Therapies	0	0	0	0
SNF	40	112	12	15
Rehab	76	49	4	14
Other	0	0	0	0

Data Source: Prior Authorization reports for FY14

Table 16 refers to the Outpatient Prior Authorization requests from Aetna and IlliniCare. Aetna's standard inpatient prior authorizations are mostly from Medical Inpatient at 62.1% and 18.7% of durable medical equipment (DME). IlliniCare's standard inpatient prior authorizations are mostly from Medical Outpatient (63.2%), Behavioral Health (17.8%), and DME (13.2%). Aetna reported 11,447 total events while IlliniCare had 12,620. For Expedited inpatient prior authorizations, Aetna reported mostly Medical Inpatient requests at 64.9% followed by Therapies at 14.2%. IlliniCare reported Medical Outpatient (88.5%), and DME (8.2%) as the largest types of requests.

Table 16: Outpatient Prior Authorization Requests (Percent)

Type of Request	Standard		Expedited	
	Aetna (N=11,447)	IlliniCare (N=12,620)	Aetna (N=148)	IlliniCare (N=624)
Behavioral Health	43	2,247	3	0
DME	2,139	1,670	19	51
Medical Inpatient	0	0	0	0
Medical Outpatient	7,111	7,974	96	552
Therapies	1,381	729	21	21
SNF	481	0	8	0
Rehab	292	0	4	0
Other	0	0	0	0

Data Source: Prior Authorization reports for FY14

Table 17 shows the percentage of prior authorization request that are decided on time. The proportion of decisions on time decreased for each type and speed of prior authorization request, except for expedited outpatient, which increased slightly from FY13 from 82.2% to 85.2%. IlliniCare decided a

higher proportion of requests on time in all categories. The lowest percent of decisions on time for IlliniCare is standard outpatient at 88.9%; their other decision times are over 90% on time. The Aetna rates are all below 85%, with expedited inpatient a particular challenge (28.8%). For pharmacy prior authorization requests, see "Processes used to control drug utilization" on page 117.

Table 17: Prior Authorization Decisions on Time (FY14) (Rates)

Decisions on Time (%)	ICP		ICP FY14 Detail	
	FY13-MCO	FY14-MCO	Aetna	IlliniCare
Inpatient				
Standard	99.7%	84.7%	84.3%	99.3%
Expedited	78.1%	53.6%	28.8%	90.9%
Outpatient				
Standard	99.2%	85.4%	81.5%	88.9%
Expedited	82.2%	85.2%	55.4%	92.3%

Data Source: Prior Authorization reports for FY14

B. Health Promotion and Prevention

1. Health Promotion Activities

As large managed care organizations, both Aetna and IlliniCare offer health promotion activities for their members. The primary activities available are summarized in Table 18. This section outlines the key aspects of each MCO's health promotion activities and is not a comprehensive analysis of all health promotion activities offered to members. Data on the extent of participation of ICP enrollees in these programs was not available. Table 19 describes how members learn about the health promotion activities available.

Table 18: Health Promotion Activities Available to Members

Are these health promotion services provided?	MCO	
	Aetna	IlliniCare
Krames On Demand© patient educational system and Health Libraries which provide free health literature	X	X
Voice recorded and live call reminders	X	X
Written pamphlets and notifications to members	X	X
Quarterly member newsletter	X	X
Preventative Health Calendar		X
Member Health Journal		X
Fluvention campaign		X
Safelink Text Message Program		X
Diabetic Annual Screening Program		X
Breast cancer screening - Patient Navigation Pilot		X
Transplant Care Program	X	X
High Risk Pregnancy Program	X	X
Sickle Cell Anemia Program	X	X
Welcome Home Program to reduce hospital readmission	X	X
Start Smart for Your Baby Program		X
Disease management	X	X

Data Source: IlliniCare Health 2014 Annual Report and interviews with MCOs

Table 19: How Do Members Learn About Health Promotion Activities?		
How do members learn about health promotion activities?	**MCO**	
	Aetna	**IlliniCare**
Where are resources located for member access?	Members can access resources through the Welcome packet, online at the Aetna website or through outreach to members.	Members can access resources online at the IlliniCare website or by calling the call center for information and materials.
What is the care coordinators role in health promotion?	Care coordinators' roles include conducting an initial Health Risk Questionnaire and Heath Risk Assessment to determine needs as well as generally being aware of and informing members of health education materials and programs.	Care coordinators' roles include conducting an initial and annual health screening and may refer them to services. They also have opportunities for home visits and to send Krames information to members by paper or electronically.
Data Source: IlliniCare Health 2014 Annual Report and interviews with MCOs		

Aetna has a Health Promotion Director who is responsible for promoting wellness services, developing materials and collaborating with care coordinators who are informed regarding health promotion literature and programs. Aetna's care coordination team collaborates with the Health Services department and the Health Promotion Director to update and educate each other on available resources.

Alternatively, IlliniCare manages its health promotion activities through multiple departments acting in inter- and intra-departmental collaboration. The marketing department manages events and the call center provides health education materials and services information to members. IlliniCare relies heavily on the care coordinators to assess patients and provide health literature, and to provide referrals for screenings, and other disease management programs. IlliniCare provides Member Journals to every member to encourage members to become more actively engaged with their healthcare. The journal includes places to write in their PCP's information, emergency contact numbers, as well as a wealth of health information including current medications and the dosages, questions for their doctor, and recent hospitalizations.

Aetna and IlliniCare use health promotion programs and literature which are derived from evidence-based practice guidelines and recommendations from nationally recognized and credible sources such as the Centers for Disease Control and Prevention (CDC), the American Diabetes Association, and U.S. Preventive Services Task Force (USPSTF). The primary health promotion activities for all members, not group-specific, is the evidence-based Krames On Demand patient education system and health education literature which focuses on health literacy and patient engagement for all types of people. The Krames system is available on both MCOs' websites. Additionally, both MCOs distribute mailings to targeted members based on a certain health topic/diagnosis. Aetna and IlliniCare also distribute quarterly newsletters to all MCOs' members focusing on various health topics.

IlliniCare expanded its CentAccount rewards program to incentivize completing actions consistent with HEDIS measures such as completing a health risk assessment, annual breast cancer screening, pre-natal

visits, or an annual visit with a primary care provider. Each HEDIS measure that is completed is rewarded with different point values. CentAccount rewards accrue into dollars and are loaded onto a pre-paid debit card where purchases are restricted to health related items. IlliniCare also targets and encourages members at health fairs to complete HEDIS measure activities while at their health fairs.

2. Prevention

Preventive services are important for healthcare in general, but especially for managed care organizations who have a vested interest in avoiding potentially more expensive service utilization in the future. Table 20 summarizes how preventive services have changed from FY11 through FY13. These services are limited to 6 CPT services that the Illinois Medicaid FFS program covers, and each MCO may cover additional preventive services.

Table 20: Prevention Services (as defined by Medicaid FFS)

Measure	FY11	FY12 (Jan-June 2012)		FY13	
		Aetna	IlliniCare	Aetna	IlliniCare
% of members with visit	9.2%	11.3%	10.0%	10.6%	9.7%
Visits per 1,000 MM	8.2	10.0	8.5	9.8	8.4
Data Source: MCO Claims; CPT codes: 99385, 99386, 99387, 99395, 99396, 99397					

Aetna and IlliniCare both improved on the percent of their members with a visit that included a prevention service as well as the total number of visits per 1000 member months compared to FY11 (Medicaid FFS). In FY13, Aetna has slightly higher rates than IlliniCare (10.6% compared to 9.7% of members who have a prevention visit, and 9.8 visits per 1000 member months compared to 8.4 visits per 1000 member months). These calculations are based on 15,555 "common" members (explained in another section). FY12 only refers to January to June 2012 (6 months).

Table 21: Preventive Counselling/Service Received (n=1040 respondents to UIC survey)

Service	Percent Received
Weighed at PCP	79.0%
PCP talked about healthy eating	63.3%
PCP talked about preventing sexually transmitted disease/infection	29.4%
PCP talked about birth control/family planning	11.4%
PCP talked about emotional health	45.5%
PCP talked about exercise	66.1%

The survey that the research team distributed asks enrollees about 6 preventive counselling or services that they received in the last year: being weighed and whether a PCP talked with them about their emotional health, birth control/family planning, preventing sexually transmitted disease/infection, healthy eating, and the importance of exercise. The average person received 2.8 of these 6 services, and a regression model that controlled for demographic factors showed that the number of services was not related to length of time a person was enrolled in ICP.

Table 22 shows the results of performance measures relating to screenings and influenza immunizations as calculated by HSAG. Aetna and IlliniCare both surpassed the baseline rate for influenza immunizations in 2013 and 2014. However, the rates for cervical cancer screenings were lower in 2013 then the baseline, but both improved to be higher than the baseline in 2014.

Table 22: Preventive Care: Performance Outcomes						
Description		Baseline Rate	Aetna		IlliniCare	
			2013	2014	2013	2014
ICCI	Care Coordination - Influenza Immunization	9.92%	13.08%	14.09%	10.72%	12.03%
SCOL	Colorectal Cancer Screening	NA	NA	30.82%	NA	36.81%
BCS	Breast Cancer Screening	NA	NA	46.09%	NA	47.58%
CCS	Cervical Cancer Screening	40.81%	31.87%	43.85%	37.55%	43.39%
ABA	Adult BMI Assessment	NA	NA	70.58%	NA	68.98%
Data Sources: HSAG Reports						

Table 23: Performance Measures - Access to and Utilization of Care						
Description		Base Rate	2013		2014	
			Aetna	IlliniCare	Aetna	IlliniCare
Comprehensive Diabetes Care (CDC)						
CDC	1. HbA1c Testing	77.13%	83.39%	79.69%	85.62%	85.42%
CDC	2. Nephropathy Monitoring	75.42%	80.47%	82.78%	80.53%	85.65%
CDC	3. LDL-C Screening	75.63%	80.84%	75.50%	83.63%	80.56%
SCDC	4. Statin Therapy (80% of Eligible days)	40.85%	41.21%	38.32%	48.86%	42.11%
SCDC	5. ACEI / ARB Therapy (80% of Eligible days)	38.38%	40.40%	38.10%	51.88%	41.67%
CDC	Comprehensive Diabetes Care - HbA1c Testing (DD Population)	79.05%	80.26%	79.03%	83.95%	70.97%
Congestive Heart Failure (CHF)						
ICHF	1. ACEI / ARB Therapy 80% of the Time	32.40%	44.61%	36.48%	55.81%	39.41%
ICHF	2. Beta Blockers 80% of the Time	30.40%	68.90%	78.70%	88.07%	81.69%
ICHF	3. Diuretics 80% of the Time	34.47%	42.65%	42.86%	55.97%	45.14%
Coronary Artery Disease (CAD)						
ICAD	1. Cholesterol Testing	76.01%	77.52%	74.72%	78.70%	79.79%
ICAD	2. Statin Therapy 80% of the Time	42.74%	45.75%	43.38%	53.90%	47.48%
ICAD	3. ACEI / ARB Therapy 80% of the Time	36.59%	40.88%	37.69%	50.96%	39.37%
PBH	4. Persistence of Beta-Blocker Treatment After a Heart Attack	35.00%	86.00%	87.80%	93.33%	96.43%
Pharmacotherapy Management of COPD Exacerbation (PCE)						
PCE	1. Systemic corticosteroid dispensed within of 14 days of the event	62.08%	69.97%	72.37%	69.21%	77.11%
PCE	2. Bronchodilator dispensed within 30 days of the event	78.13%	89.47%	90.79%	89.40%	89.88%
SPR	3. Use of Spirometry Testing in the Assessment and Diagnosis of COPD	29.67%	NA	NA	NA	NA
Data Source: HSAG Reports						

Table 23 shows more performance measures calculated by HSAG relating to access to and utilization of care. Aetna had a higher rate in 2013 than the baseline for each measure, and for all except for two measures, they had higher rates in 2014. IlliniCare had lower rates on five of the measures than in the baseline. In 2014, IlliniCare improved from 2013 for all but two measures.

In summary, health promotion activities are very important to Aetna and IlliniCare; however, there is little evidence of the impact that the health promotion activities have on enrollees. With regard to prevention services, each MCO has improved over the baseline on most of the measures, and there has been improvement from 2013 to 2014 as well.

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

A. Call Centers

One of the primary ways that MCO's educate members on their plan and services that they offer is through their call center. This section reviews the data and information contained in the FY14 annual reports produced by Aetna and IlliniCare. The annual reports focused on two measures for the performance of call centers: the average time that it took a representative to answer a call and the call abandonment rate (the percent of calls that were not answered). These are displayed by month in Table 120 in the Appendix. In most months, Aetna took a shorter time to answer calls (ranging from 2-13 seconds versus 7-17 seconds), while IlliniCare had a lower percentage of abandoned calls (ranging from .6 to 3.3% versus 1.5 to 4.7%). IlliniCare's goal was to have an abandonment rate of less than 4%, while Aetna's goal was less than 5%, which both plans met.

The Appendix also includes Table 119, which shows the reasons why an enrollee placed a call to the IlliniCare call center. While there were a number of reasons for calling and they were fairly evenly distributed, calls to be transferred to a vendor (e.g. transportation) (10.8%) and calls for information on eligibility (9.3%) were the most frequent reasons for contacting the call center. Data for Aetna was not available.

B. Complaints

According to the MCO contract with the State, a complaint is 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" (MCO Contact, Section 1.29). Complaints can be divided into two types: appeals and grievances. According to the contract, an "Appeal means a request for review of a decision made by Contractor with respect to an Action" (Section 1.18), while a 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 " (Section 1.64).

Appeals are usually prospective (a member wants to receive services or medication in the future and is looking for approval). Specifically, an appeal is a request for review of a decision made by the MCO with respect to:

- denial or limitation of authorization or a requested service
- reduction, suspension, or termination of a previously authorized service
- denial of payment for a service
- failure to provide services in a timely manner
- failure to respond to an appeal in a timely manner, or
- denial of an Enrollee's request to obtain services outside of the Contracting Area if they live in a rural community (MCO Contract, Sections 1.18 and 1.8).

A grievance is an expression of dissatisfaction by a member or authorized representative. Grievances include complaints and requests for disenrollment, or any other matter that is not classified as an appeal. Grievances are usually retrospective (while receiving services through the MCO, members

experienced a situation that they found unsatisfactory). One of the core differences between a grievance and an appeal is that an appeal asks for a decision to be reconsidered, whereas a grievance does not (MCO Contract, Section 1.64).

Grievances not resolved to the member's satisfaction can be escalated to a Grievance Committee for further review, and then to HFS. Appeals that are not resolved to the member's satisfaction can be escalated to external review, a fair hearing process, or both (MCO Contact, Section 1.64).

Table 121 in the Appendix outlines the differences between complaint, grievance, and appeal in the MCOs' contracts. Table 122 in the Appendix compares the complaint process between FFS Medicaid, Aetna, and IlliniCare. Table 124 in the Appendix illustrates the responsibilities of the MCOs according to the contract with the state, in handling grievance and appeal processes.

Table 24 shows the number of appeals and grievances for each MCO in FY13 and FY14. In both years, IlliniCare received more appeals requests than Aetna. Aetna reduced the number of requests for appeals by over half between FY13 and FY14, while IlliniCare increased by over 78%, from 160 requests to 285. Aetna had more grievances per 1,000 member months then IlliniCare in both FY13 and FY14. However, the number of grievances for Aetna decreased from 1.92 to 1.78 grievances per 1,000 member months, while IlliniCare's numbers increased from 1.06 to 1.59 grievances per 1,000 member months.

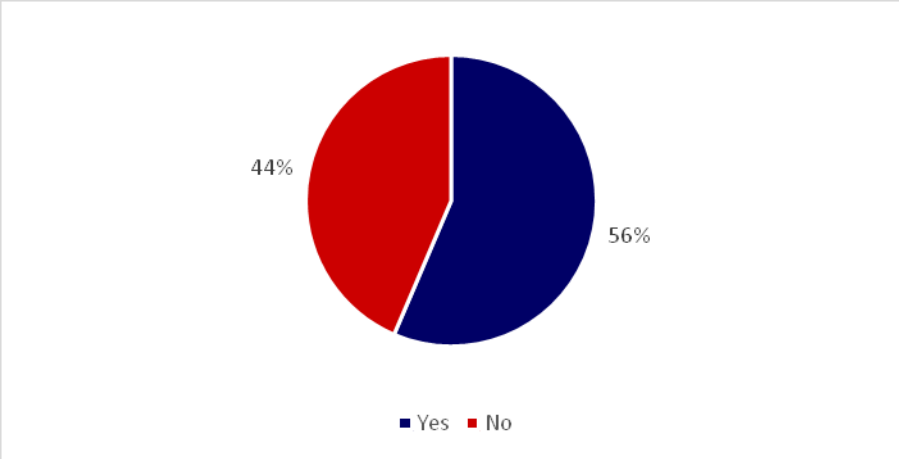
Table 24: Number of Complaints

Type of Complaint	FY13		FY14	
	Aetna	IlliniCare	Aetna	IlliniCare
Standard Appeals	92	160	44	285
Standard Appeals per 1000 Member Months	0.43	0.76	0.20	1.03
Expedited Appeal			4	39
Expedited Appeals per 1000 Member Months			0.02	0.14
Grievances	408	224	389	443
Grievances per 1000 Member Months	1.92	1.06	1.78	1.59

Data Source: FY14 special datasets on Grievances and Appeals from Aetna and IlliniCare

The consumer survey included a question related to filing consumer complaints. Figure 15 shows whether or not an enrollee knows who to contact if they have a complaint about services. About 56% of enrollees reported that they knew who to call if they had a complaint, and 44% of enrollees did not know who to contact if they had a grievance. This finding from the consumer survey highlights a possible gap in member education regarding filing grievances and complaints concerning healthcare services to the MCOs. While MCOs report working to resolve formal grievances filed by enrollees, many grievances may go unreported by members due to lack of understanding regarding the complaint and grievance process. Underreporting may affect the successful provision and delivery of services by MCOs and may also shape the overall consumer experience.

Figure 15: If you have a complaint about the services you receive do you know who to call? (n=522)



C. Appeals

Table 25 lists the standard appeal types for FY13 and FY14 according to the categories that HFS requires the MCOs to report on. In FY14, for standard appeals, the most frequent category for Aetna was medical necessity (36.4%) followed by other (34.1%) and pharmacy (29.5%). Medical necessity was also the most frequent reason for an appeal in IlliniCare, but at a much higher percent (94.9%). All of Aetna's expedited appeals (four of them during FY14) are listed as other, while medical necessity is the most frequent reason (94.9%) for an expedited appeal in IlliniCare (N=39).

Table 25: Types of Appeals FY14 (Percent)

Type of Appeal	FY13 Standard Appeals		FY14 Standard Appeals	
	Aetna (N=92)	IlliniCare (N=160)	Aetna (N=44)	IlliniCare (N=285)
Access to Care	13.0%	0.0%	0.0%	0.0%
Dental Issues	0.0%	0.0%	0.0%	0.0%
LTSS Services	0.0%	0.0%	0.0%	0.0%
Medical Necessity	85.9%	33.8%	36.4%	94.9%
Other	1.1%	2.5%	34.1%	5.1%
Pharmacy	0.0%	63.8%	29.5%	0.0%
Quality of Care	0.0%	0.0%	0.0%	0.0%
Transportation	0.0%	0.0%	0.0%	0.0%

Data Source: FY14 special dataset on Grievances and Appeals from IlliniCare and summary report for FY14 produced by Aetna

Table 26 shows the resolutions for the appeals that each MCO received during FY14. Overall, the MCOs overturned more standard appeals than they upheld (in favor of the member), 48% for Aetna and 62% for IlliniCare. Similarly, for expedited appeals, 72% were overturned, 50% in Aetna and 74% in IlliniCare.

Table 26: Appeals Resolutions

ICP Population	FY14	ICP FY14 Detail	
		Aetna	IlliniCare
Number of Standard	**329**	**44**	**285**
Overturned	60%	48%	62%
Partially Upheld	0%	0%	0%
Unknown	1%	2%	1%
Upheld	38%	50%	36%
Number of Expedited	**43**	**4**	**39**
Overturned	72%	50%	74%
Partially Upheld	0%	0%	0%
Unknown	0%	0%	0%
Upheld	28%	50%	26%

Data Source: FY14 special dataset on Grievances and Appeals from IlliniCare and summary report for FY14 produced by Aetna

The plans are expected to resolve standard appeals within 15 days and expedited appeals within one day. Table 27 shows how long it takes each plan to resolve their appeals. Both plans resolve over half of their expedited appeals within one day (100% of the 4 appeals for Aetna and 87.2% of 39 appeals for IlliniCare). The plans do not do as well resolving standard appeals within 15 days; IlliniCare resolves 49.8% and Aetna resolves 52.3% within 15 days.

Table 27: Timeline to Appeals Resolutions

Measure	FY14	ICP FY14 Detail	
		Aetna	IlliniCare
Mean Days to Expedited Appeal Resolution	2.3	0.5	2.5
Mean Days to Standard Appeal Resolution	13.9	15.0	13.7
% of Expedited Appeals Resolved Within 1 Day	88.4%	100.0%	87.2%
% of Appeals Standard Resolved Within 15 Days	50.2%	52.3%	49.8%

Data Source: FY14 special dataset on Grievances and Appeals from IlliniCare and summary report for FY14 produced by Aetna

D. Grievances

In the ICP, each plan is required to report the number and types of grievances that they receive, although there is no formal procedure that each MCO must follow to respond to a grievance. Each plan has their own internal procedures and they "close" all of the grievances by notifying the member that they have received the grievance and dealt with it. Amendment 4 to the MCO contract amends section 5.26 of the MCO contracts with the language of "corrective action" for grievance resolutions, although it encourages informal resolutions. The reports each MCO submits to HFS do not adequately track this data and what happens with a grievance. This is a concern, because grievances are a primary way that enrollees can complain to an MCO and hope for better service in the future.

Figure 19 in the Appendix shows IlliniCare's grievance process (Aetna did not provide detail on their grievance process). Members who are not satisfied with the resolution of their grievance have the right to have their grievance reviewed by a Grievance Committee. The Grievance Committee must include at least one Plan member. The Plan would allow the member a reasonable opportunity to present

evidence, and allegations of act or law, in person and in writing. A resolution letter would be given to the member within five business days of the Grievance Committee's determination. The resolution letter must include the names, titles, and any qualifying credentials of the members of the Grievance Committee conducting the review, a statement of the reviewers' understanding of the grievance, and the Plan's decision clearly stated with the results of the resolution process. Despite including this information in the letter, all grievances are still reported as "closed."

Table 28 shows the types of grievances that each plan receives. As in previous years, transportation was the leading reason for a grievance (76.6% of Aetna and 63.2% of IlliniCare). 18% of Aetna's grievances were related to quality of care, compared to 12.6% for IlliniCare. These categories are provided by HFS, and although definitions are given, each plan may classify its grievances differently.

Table 28: Type of Grievances (Percent)

Type of Grievance	FY13		FY14	
	Aetna (N=409)	IlliniCare (N=224)	Aetna (N=389)	IlliniCare (N=443)
Access to Care	1.2%	6.3%	0.3%	3.6%
Dental Issues	0.0%	0.0%	0.0%	3.2%
LTSS Services	0.0%	0.0%	0.0%	0.0%
Medical Necessity	0.0%	0.0%	0.3%	1.6%
Other	1.2%	17.0%	4.9%	15.8%
Pharmacy	0.0%	0.4%	0.0%	0.0%
Quality of Care	17.4%	25.0%	18.0%	12.6%
Transportation	80.1%	51.3%	76.6%	63.2%

Data Source: FY14 special dataset on Grievances and Appeals from IlliniCare and summary report for FY14 produced by Aetna

Table 29 shows the grievance resolutions. Every grievance outcome is unknown outcome; HFS does not require that the MCOs report outcomes aside from the number they have closed. HFS told the team that their data systems did not collect this information during FY14, but it will be available in future years.

Table 29: Grievance Resolutions

Grievance Resolution	FY14	ICP FY14 Detail	
		Aetna	IlliniCare
Outcome Unknown	100%	100%	100%

Data Source: FY14 special dataset on Grievances and Appeals from IlliniCare and summary report for FY14 produced by Aetna

Table 30 shows the timeline it takes for each MCO to resolve their grievances. HFS requires that grievances be resolved within 90 days, and all of the grievances received by each plan are resolved within that timeline. IlliniCare takes an average of 18.5 days to resolve a grievance.

Table 30: Timeline to Grievances Resolutions

Measure	ICP eligible		ICP FY14 Detail	
	FY13-MCO	FY14-MCO	Aetna	IlliniCare
Mean Days to Resolution	20.5	19.0	19.5	18.5
% Resolved Within 90 Days	99%	100%	100%	100%
Data Source: FY14 special dataset on Grievances and Appeals from IlliniCare and summary report for FY14 produced by Aetna.				

E. Critical Incidents

A critical incident is a report or observation of neglect, abuse, exploitation, or other issue such as death, potential fraud, violence, or threat of violence. A critical incident is typically reported in one of two ways: a provider reports a critical incident to the MCO, or a care coordinator observes an issue that requires reporting to law enforcement, Office of Inspector General (OIG), or Adult Protective Services. Examples of critical incidents include, but are not limited to, a personal assistant claiming more hours than s/he worked, evidence of neglect or abuse, or a member reporting to the MCO that he or she is being abused. Table 125, in the Appendix, displays the definition of a critical incident and also describes the process of how each MCO handles a critical incident. Aetna did not provide information on the process used to report critical incidents.

Prior to Service Package 2, each MCO tracked critical incidents internally. After the implementation of Service Package 2, HFS required each MCO to submit a regular report with details of each critical incident that they receive. The research team aggregated the reports for FY14, and the types of critical incidents reported by each MCO are shown in Table 31, broken out into enrollees who are on a waiver and enrollees who are not. Aetna and IlliniCare each reported 37 critical incidents during FY14 for their waiver populations, the majority of which were classified as other. In addition, Aetna had 22 critical incidents for people who were not on a waiver, compared with 16 for IlliniCare.

Table 31: Type of Critical Incidents (FY14)

Type of Critical Incident	Waiver Population		Non-Waiver Population	
	Aetna (N=37)	IlliniCare (N=37)	Aetna (N=22)	IlliniCare (N=16)
% Abuse	8.1%	27.0%	9.1%	43.8%
% Exploitation	8.1%	8.1%	0.0%	0.0%
% Neglect	5.1%	5.1%	0.0%	6.3%
% Other	78.4%	59.5%	90.1%	50.0%
Data Sources: Aggregated monthly Critical Incidents detail report submitted to HFS for FY14				

Table 32 shows where the critical incidents were referred for follow-up. IlliniCare referred all but one of the critical incidents they received for both the waiver population (2.7% not referred) and the non-waiver population (6.3% not referred). However, almost 90% of Aetna's critical incidents were not referred, both for the waiver population (89.2%) and the population not on a waiver (90.9%). IlliniCare referred a large portion of their critical incidents to "other" entities, which may include home health agencies, families, and other State departments (40.5% of waiver population critical incidents and 31.3% of non-waiver population critical incidents). They also reported a large number of critical incidents to local authorities, such as police or fire departments (21.6% of waiver population critical incidents and

31.3% of non-waiver population critical incidents). This may be a limitation of the data, because the reporting template does not require the MCOs to track specific referral entities. The template does include a column for tracking referrals, but HFS only recommends that the MCOs use it.

Questions that are often asked about their critical incident process, including what constitutes a critical incident and how it gets reported is included in Table 125 in the Appendix.

Table 32: Critical Incidents Referred (FY14)

Type of Appeal	Waiver Population		Non-Waiver Population	
	Aetna (N=37)	IlliniCare (N=37)	Aetna (N=22)	IlliniCare (N=16)
% Referred to Adult Protective Services	2.7%	16.2%	9.1%	18.8%
% Referred to Local Authorities	0.0%	21.6%	0.0%	31.3%
% Referred to HFS/OIG	0.0%	18.9%	0.0%	12.5%
% Referred to Other	8.1%	40.5%	0.0%	31.3%
% Not Referred	89.2%	2.7%	90.9%	6.3%

Data Sources: Aggregated monthly Critical Incidents detail report submitted to HFS for FY14

F. Ombudsman Program

Many states now have ombudsman programs to advocate for seniors and people with disabilities within systems of managed care. In August 2013, the Illinois Act on the Aging was amended in order to expand Illinois's State Long Term Care Ombudsman (ILTCOP) from serving solely individuals receiving long-term care services to also including individuals in managed care. However, this program was primarily developed for the MMAI (Medicare-Medicaid Alignment Initiative) program that serves people who are eligible for both Medicaid and Medicare. Most people enrolled with ICP are not eligible for ombudsman services through this program, except for people who are enrolled in a Medicaid waiver. Waiver members are eligible for the ILTCOP.

Although the Ombudsman office does not track specific data related to ICP enrollees that have requested assistance, staff have reported that they have received a number of requests. They indicated that they are hoping to track the number of requests that they receive from ICP enrollees so that they can seek additional funding so that the program can be opened up to all ICP members.

The ILTCOP offers several services that would be of use for ICP members. These include:

- follow up on critical incidents,
- a complaints and grievance program,
- staff who can access medical records and provide information/advocacy, especially when a member cannot get a hold of their care coordinator,
- education and general information to members,
- input on policy recommendations on systematic issues to the State.

How well is care managed for ICP enrollees?

A. Care Coordinators

1. Number and Turnover of Care Coordinators

An important aspect of the Integrated Care Program (ICP) is care coordination. The following analyses examined the turnover and caseloads of care coordinators. Table 33 summarizes the number of care coordinators the two plans had for FY13 and FY14. At the beginning of FY13 (on July 1, 2012), the two MCOs had a total of 64 care coordinators. At the end of FY13, on June 30, 2013, this number had nearly doubled to 120. During FY14, as Service Package 2 was rolled out, the number of care coordinators for the two plans doubled again to 241 on June 30, 2014.

Table 33: Number of Care Coordinators

MCO	FY13				FY14			
	# Began Year	# Left during Year	# Added during year	# Ended Year	# Began Year	# Left during Year	# Added during year	# Ended Year
Aetna	25	14	52	63	63	39	87	111
IlliniCare	39	3	21	57	57	29	102	130
TOTAL	**64**	**17**	**73**	**120**	**120**	**68**	**189**	**241**

Data Sources: FY13 and FY14 for Aetna is from October 2014 "special dataset"; FY13 and FY14 for IlliniCare is from January 2015 "special dataset"

Table 34 summarizes the rate of turnover among care coordinators for the two plans during FY13 and FY14. In calculating the turnover rate, the UIC team used the number of staff working at the start of the fiscal year ("starters") as a base and calculated the turnover rate for the number of "starters" who left during the fiscal year.

Table 34: Turnover of Care Coordinators

MCO	FY13			FY14		
	# Began Year	# Left during Year	Turnover	# Began Year	# Left during Year	Turnover
Aetna	25	9	36.0%	63	27	42.9%
IlliniCare	39	3	7.7%	57	19	33.3%
TOTAL	**64**	**12**	**18.8%**	**120**	**46**	**38.3%**

Data Sources: FY13 and FY14 for Aetna is from October 2014 Special dataset; FY13 and FY14 for IlliniCare is from January 2015 Special dataset

For FY13, the combined turnover of the MCOs was 19% (Aetna's turnover rate was 36.0%; IlliniCare had a turnover rate of 8%). For FY14, the turnover rate for the two MCOs rose to 38% (Aetna was 43% compared to 33% for IlliniCare). Not all of the care coordinators that "left" ended their employment with the MCO; some of those that left the job of care coordinator assumed another position with the organization.

2. Caseloads

Section 5.12 of the contract ("Caseload Requirements") specifies the maximum number of members that care coordinators can have on their caseload. Due to the fact that many care coordinators may have a "blended" caseload of members of varying risk levels and waiver groups, the contract specifies the maximum weight of a coordinator's caseload as being 600 from month to month. Weights are assigned as follows: member with a "low" risk has a weight of 1; "moderate" risk has a weight of 4, and "high" risk has a weight of 8.

The MCOs do not report caseload information to HFS. To obtain this information, the UIC research team obtained special datasets from the MCOs listing all care coordinators that were hired and the number and types of members on the caseloads of these care coordinators. As the team analyzed this data, it became apparent that the two plans had different philosophies regarding the formal assignment of "low risk" members to their care coordinators. Aetna formally assigned very few "low risk" members to their care coordinators while IlliniCare on paper assigned almost all of their "low risk" members to their care coordinators. Both MCOs indicated that the great majority of time spent by care coordinators was on medium and high risk members and that both MCOs used their general Disease Management programs to coordinate and manage care for their low risk members. As a result, the research team decided to exclude the low risk members from calculation of caseloads and include only the medium and high risk members.

The team then calculated caseloads for each care coordinator using two different methods: 1-calculating the average monthly number of medium and high risk members assigned to each coordinator; and 2-calculating the average monthly number of "risk points" as specified by members' risk levels as outlined by the contract (excluding the low risk members from the calculation).

Table 35 lists the monthly average number of medium and high risk members assigned to the care coordinators who were in place for all 12 months in FY14. About two-thirds of the Aetna coordinators had less than 50 medium or high risk members assigned to them. The remainder of Aetna coordinators had between 50 and 99 members assigned to them. Table 35 also shows that about half of IlliniCare coordinators had between 50 and 99 members assigned to them, with most of the remainder having less than 50 members. However, 4 of the 42 IlliniCare coordinators averaged between 100 and 199 medium or high risk members per month while none of Aetna's did.

Table 35: FY14 Monthly Caseload (# of high or medium risk members)

Average monthly caseload	Aetna (# of coordinators)	IlliniCare (# of coordinators)
Less than 50 members	47	16
50-99 members	21	22
100-199 members	0	4
200 or more members	0	0
TOTAL Coordinators	68	42

Data Source: MCO Special dataset

Table 36 also summarizes caseload information but from the perspective of weighting the risk level of the member (counting only medium and high risk members). As stated previously, the monthly

maximum should not exceed 600 points. According to Table 36, all of Aetna's coordinators stayed below the monthly maximum, while most but not all (86%) of IlliniCare's coordinators stayed below the required maximum.

Table 36: FY14 Monthly Caseload (weighted by "risk points")

Monthly risk point range	Aetna (# of coordinators)	IlliniCare (# of coordinators)
At or below 600 points	68	36
Above 600 points	0	6
TOTAL Coordinators	68	42
Data Source: MCO Special dataset		

HSAG informed the UIC research team that they are now under contract with the State to monitor caseloads of care coordinators and assess whether the MCOs are in compliance with the contract provisions. At the time that this report was published, HSAG had conducted their first round of evaluations for this area but results had not yet been finalized. However, HSAG shared the methodology and tools that they used during this review (see Table 128 in the Appendix).

B. Care Plans

1. Screening and Assessment

One of the most important responsibilities of the MCOs is to provide individualized care management to all members, customizing the "intensity" of this care management based on the member's individual need or "risk level." Specifically, according to Section 5.14.1.1 (Health Risk Screening) of the contract:

> "Contractor shall have a Health Risk Screening, and make its best efforts to administer the Health Risk Screening and, if needed, a behavioral health risk assessment to all new Enrollees within sixty (60) days after enrollment, to collect information about the Enrollee's physical, psychological and social health. Contractor will use the results to guide the administration of more in-depth health assessments."

The MCOs do not currently report to HFS how many of the health risk screenings are completed within the 60 day time period and how many new enrollees are determined to need "more in-depth assessments." To obtain this information, the UIC team asked for and received a Special dataset from each MCO listing all new enrolled members, enrollment date, and date that the initial screening was completed. Table 37 summarizes the percent of screenings completed for each the first 3 years of the ICP, along with the percent of screenings that were completed within 60 days of enrollment, as required.

As seen in Table 37, the number of screenings completed within the required 60 days has ranged between 25% and 50% for the two plans for the first 3 years of the ICP. In FY14, the number of screenings completed within 60 days of enrollment was less than 40% for both plans. The MCOs noted that this low rate is partially attributable to the MCOs not having accurate contact information for the member, making it difficult to find some members.

The proportion of new enrollees determined to need additional assessments beyond the initial screening has generally ranged between 20-35% for the two plans. These figures differed substantially in FY14 for the two —Aetna determined that slightly less than 20% of its new enrollees needed in-depth assessments while almost double the proportion of IlliniCare's new enrollees were determined to need the additional assessments. In terms of completing the needed assessments within 60 days, the plans ranged from completing 60-75% of the additional assessments on time in FY14.

Table 37: Initial Health Screenings

	FY12		FY13		FY14	
	Aetna	IlliniCare	Aetna	IlliniCare	Aetna	IlliniCare
Initial Screening						
Initial Screenings completed within 60 days (of new enrollments)	30.7%	33.5%	27.2%	48.4%	29.4%	37.6%
In-depth Assessments						
% of new enrollments needing In-depth assessment	27.7%	21.4%	32.7%	24.6%	19.3%	34.5%
% care plans completed within 60 days (of those needed)	33.0%	37.5%	74.0%	60.3%	76.4%	61.6%

Data Source: FY12 and FY13 data is from previous special datasets supplied by MCOs. FY14 is from recently received special datasets sent in fall and winter of 2014.

2. Risk Stratification

Predictive modeling is a process to assist with care coordination and to assign proper resources and services to members. Per contract section 5.10.3, the MCOs "shall have a predictive modeling and health risk stratification engine that Contractor will use to proactively identify high-risk enrollees and monitor gaps in care." The predictive modeling reports are be considered alongside other surveillance data across all enrollees on a monthly basis by the MCOs to identify any risk level changes.

The MCOs are to stratify all enrollees identified for its Care Management Program to determine the appropriate level of intervention based on the information obtained in the care management assessment (health risk screening, health risk assessment, predictive modeling, and surveillance data). According to contract section 5.11.2, enrollees shall be assigned to one (1) of three (3) levels: low or no risk, moderate risk, and high risk.

In the low risk level, the MCO are to provide prevention and wellness messaging, as well as education materials targeted toward the enrollee's specific condition. In the moderate risk level, the MCO is responsible for providing problem-solving interventions. Enrollees in the high risk level are to receive "intensive Care Management to ameliorate past ineffective healthcare or lack of social support." No less than twenty percent (20%) of enrollees are to be assigned by the MCOs to moderate risk and high risk

levels combined, and no less than five percent (5%) of enrollees are required to be assigned to the high risk level.

Table 38 shows percentages of enrollees who are classified into each risk level as of June 2014. Overall, 8.1% of IlliniCare's enrollees are classified as high risk, 18.5% are moderate risk and 73.4% are low risk. For Aetna, 2.3% of enrollees are classified as high risk, 13.3% are classified as moderate risk, and 84.4 percentage of enrollees are classified as low risk. While IlliniCare meets the contract requirement of both having 5% of its members classified as high risk and 20% of its members classified as either medium or high risk, Aetna does not meet the contract criteria, with only 15.6% in those two categories. Members in the moderate and high risk levels require additional staff resources related to care plan development and ongoing staff contact.

Table 38: Risk Stratification of Members (FY14)

Risk Level	Aetna Percent of Total	IlliniCare Percent of Total
Low	84.4%	73.4%
Moderate	13.3%	18.5%
High	2.3%	8.1%

Data Source: CM.DM Summary Monthly Report MCOs submit to HFS

There are several limitations associated with the data in Table 38. First, the figures for Aetna contain some Chicago and Rockford members while the IlliniCare figures only contain members from the original 6 county area. Aetna was not able to provide the data with the Chicago and Rockford members removed.

The second limitation of the data in Table 38 is that the risk levels reported by each plan are not comparable to each other as each plan uses its own risk methodology. Hence the higher rates of high risk members reported in Table 38 for IlliniCare do not mean that IlliniCare actually had a greater proportion of members with greater health needs than Aetna, but rather that using their own classification methods, IlliniCare is reporting a higher proportion of "high risk" members than Aetna is.

Given the limitations of the risk levels assigned by each MCO, beginning in April of 2012, the State used its own risk adjustment method and began to adjust the capitation rates it paid the plans by calculating risk scores for each member and arriving at an overall risk factor for each plan. According to Section 7.4.1 of the contract, starting with CY12, the "capitation rates calculated under this Agreement will be adjusted in accordance with the Chronic Illness and Disability Payment System (CDPS) using the CDPS + Rx version 5.2 and standard weights."

According to the contract, member claims and diagnosis codes in those claims were to be used to calculate risk scores for members, which would lead to an overall "risk adjustment factor" being calculated for the MCO. The contract also stipulated that "all risk scores shall be budget neutral to the Department or normalized to a 1.0000 value between the MCOs. The risk scores shall also be budget neutral to the Department within each individual rate cell."

The capitation rates were not risk adjusted for the first year from May 1, 2011 through March 31, 2012. Effective 4/1/2012, the first risk adjusted rates went into effect. Table 39 shows the effect of this risk adjustment of the rate for the "community resident" capitation cell (all cells were adjusted using the same risk factor).

For example, in April of 2012, the new full monthly rate for community residents of $985.35 went into effect. The State had calculated a risk factor of 1.0100 for Aetna, so its rate was increased to $995.20 per month. IlliniCare had a risk factor of 0.9896 and its monthly rate was reduced to $975.10. Although the contract specifies that the risk factors are to be re-calculated each calendar year, the same risk factors have been used since the original calculations for April of 2012.

Table 39: Risk Adjustment of Capitation Rates ("Community Resident" Cell Only[1])

Effective Date	Full Rate	Aetna		IlliniCare	
		Risk Factor	Adjusted Rate	Risk Factor	Adjusted Rate
4/1/2012	$985.35	1.0100	$995.20	0.9896	$975.10
3/1/2013	$890.59	1.0100	$899.50	0.9896	$881.33
1/1/2014	$928.69	1.0100	$937.98	0.9896	$919.03

Data Source: Communication with HFS
[1]All capitation cells were adjusted; only the "community resident" cell is shown in this table.

3. Disease Management Program

Generally, members deemed a "low" risk level are not be assigned to a specific care coordinator but instead are enrolled in the MCOs Disease Management (DM) program. The MCO's DM Program is a program that employs a set of interventions designed to improve the health of individuals, such as those with chronic health conditions. Each plan encourages members classified as "low" risk to participate in the various activities of the DM program. However, there is a provision that permits members to refuse to participate in the DM program ("opt out").

Table 40: Members Opting Out of Care Management

Opt Out	Aetna (FY14)	IlliniCare (FY14)
Total Population	577 (3.2%)	31 (0.2%)
Special Groups		
Assistive/Supportive Living	0 (0.0%)	0 (0.0%)
Behavioral Health	0 (0.0%)	3 (0.3%)
Brain Injury	0 (0.0%)	0 (0.0%)
Developmental Disabilities	34 (3.1%)	1 (0.1%)
Elderly	0 (0.0%)	1 (0.1%)
HIV/AIDS	0 (0.0%)	0 (0.0%)
Long Term Care	0 (0.0%)	0 (0.0%)
People with Disabilities	0 (0.0%)	1 (0.1%)

Data Source: Active Participation Monthly Reports as of 6/30/2014

The top row of Table 40 ("total population") summarizes the overall rate of all members within each plan that chose to "opt out" of care management as of the end of FY14 (June 30, 2014). The other rows of the table list the opt-out rates for special groups. As can be seen, the proportion of members opting out of case management differs substantially between the two plans; the rate is about 15 times greater for Aetna members (3.2%) than the rate for IlliniCare members (0.2%).

4. Individualized Care and Service Plans

If a member is classified at either the moderate or high risk level, the member receives more intensive and targeted care coordination. According to Section 5.14.8.1 of the contract, "Contractor shall assign an ICT [Interdisciplinary Care Team], with a Care Coordinator, to the Enrollee and the ICT will develop a comprehensive person-centered Enrollee Care Plan for Enrollees stratified as high or moderate risk and for Enrollees in a HCBS Waiver. The Enrollee Care Plan must be developed within ninety (90) days after enrollment." The exceptions to the 90 day requirement are enrollees receiving HCBS Waiver services, for whom this period can be extended up to 180 days in some cases.

While some members needing an individual care plan are identified within the initial 90 days after enrollment, there are some members who are initially determined NOT to need a care plan but later, due to changed circumstances, are then determined to need a care plan. Section 5.14.7 of the contract requires each plan to "analyze predictive modeling reports and other surveillance data of all Enrollees monthly to identify risk level changes" - if such risk level changes are detected, the need for an individual care plan for a member may change.

Currently, the MCOs do not submit any reports to HFS indicating how many newly enrolled members are determined to need a care plan and how many care plans are completed within the required time period. To obtain this information, the UIC team received a special dataset that tracked members' need for a care plan, both the number of members that were identified as needing a care plan within the initial enrollment period and those members who were later determined after the initial enrollment period to need a care plan.

Table 41 summarizes the results of the special dataset that the MCOs supplied regarding care plans.

Table 41: Percent of New Members Needing Care Plan

Care Plan	ICP - Aetna			ICP – IlliniCare		
	FY12 (n=13,420)	FY13 (n=3,096)	FY14 (n=14,972)	FY12 (n=21,263)	FY13 (n=5,116)	FY14 (n=18,354)
Need for Care Plans						
Yes-at enrollment	0.2%	10.8%	10.0%	1.3%	1.9%	5.2%
Yes-NOT at enrollment but later	28.0%	19.1%	5.9%	23.1%	18.0%	19.9%
No-did NOT need Care Plan	71.7%	70.1%	84.1%	75.6%	80.1%	74.8%
Completion of Care Plans within 90 days						
% completed within 90 days (of those who needed one at enrollment)	1.6%	58.8%	60.5%	63.7%	77.4%	62.9%

Data Source: MCO Special Datasets

For the first 3 years of the ICP, the number of new enrollees needing care plans has generally been similar for the 2 MCOs, ranging from 15% to 30% for Aetna and from 20% to 25% for IlliniCare. However, the proportion of members that were identified as needing the plan upon enrollment versus the

proportion of members being identified later differed substantially between the two plans. For example, in FY14, about two thirds of the Aetna members needing care plans were identified in the initial enrollment period while only about one quarter of the IlliniCare members were identified during the initial enrollment period.

In terms of actual completion of the care plans, both plans reported that they completed approximately 60% of the needed care plans within the required time period. As previously noted in regard to the completion of homeless screenings, this low rate is partially attributable to the MCOs not having accurate contact information for the member, making it hard to locate some members.

What innovative approaches do the MCOs use for members?

A. MCO-Thresholds Pilot Projects

As part of the Integrated Care Program (ICP), Managed Care Organizations (MCOs) have initiated an innovative approach for behavioral healthcare. Intensive teams from a major behavioral health provider are addressing behavioral healthcare needs of a population of high users of services. In 2012, Thresholds, a large community-based behavioral health agency, proposed a pilot program to IlliniCare and Aetna to coordinate care for some of the ICP's highest cost members with behavioral health issues. Both MCOs were very receptive to the idea of partnering with a provider. The UIC Evaluation Team spoke with Thresholds, Aetna and IlliniCare staff regarding this pilot program specifically.

1. Development of Pilot Program

Within this pilot program, Aetna and IlliniCare each partnered with Thresholds to better support: (1) members with a high use of emergency and inpatient mental health hospital services, and (2) those who did not have or were not utilizing current connections to behavioral or physical health providers in the community. As Thresholds bills only for Rule 132 services (established for providers to receive Medicaid reimbursements for mental health services), eligible members were those who had:

- A behavioral health need as a primary issue, or
- A behavioral health need as an issue secondary to a medical need.

The goal of the pilot program was to reduce the use and cost of emergency and behavioral health inpatient hospitalization services and increase utilization of outpatient services by:

- Making contact with these very high users of services
- Building a working therapeutic relationship with them
- Engaging them in behavioral health services, in particular, outpatient follow up and care.

Ultimately, the intent is to improve the quality of life of members participating in the project. For many of these high cost users, plans have previously had difficulty even locating members to engage them in effective care. The IlliniCare pilot began in 2012 with 36 of the highest risk members and grew to 50 members in March of 2013. The Aetna pilot began in February of 2014 with 10 of their highest risk members.

2. Services Provided

Thresholds created an integrated care team specifically to serve ICP members, including a licensed team leader, a registered nurse, a therapist, and several Community Support Specialists (BA and MA level); the MCOs have not co-located staff within Thresholds. The program relied on close communication between the Thresholds team and MCO care coordinators for coordinating services. For example, Cenpatico, which focuses on behavioral health and is affiliated with IlliniCare, coordinated meetings among Thresholds, hospitals, and IlliniCare staff to facilitate the process of allowing Thresholds staff to act as discharge coordinators for members who were hospitalized. Other Thresholds staff responsibilities included:

- Locating members and building working relationships with them
- Conducting assessments complementary to MCO assessments
- Ensuring that members' basic housing needs were met
- Connecting members with services
- Arranging member appointments
- Following up on progress.

MCOs provided a per member, per month (PMPM) rate to Thresholds to finance this new team and enable Thresholds to be compensated for efforts to initially engage members, as well as for services. Thresholds was guaranteed the PMPM payments for the 12-month pilot. If members lost coverage, left the program, or resisted repeated attempts at engagement, new members were added to the pilot to keep the total number served consistent at either 10 or 50. Table 42 shows the number of members served through Thresholds for both MCO pilots.

Table 42: Members served through Thresholds Pilot

	Aetna Pilot	IlliniCare Pilot
Start of pilot	10	36
End of pilot	10	50
Members served for full 12-month program	6	22

To further improve its ability to serve members, Thresholds worked with both MCOs to demonstrate that members were receiving the appropriate level of care using care plans and evidence-based practices in order to achieve preferred provider status. Preferred provider status allows Thresholds to avoid the MCOs' prior authorization process for approvals.

3. Pilot Program Experiences

Qualitative evaluation of the IlliniCare pilot has been conducted by the Thresholds Research and Evaluation Department, and IlliniCare and Thresholds worked together on a claims-based evaluation. Thresholds is now conducting a qualitative evaluation of the Aetna pilot, and an analysis of these claims has begun. UIC staff interviewed leaders from Thresholds; read relevant available material from Thresholds, Aetna and IlliniCare; and discussed the project with IlliniCare and Aetna leaders.

Both Aetna and IlliniCare staff describe the program as beneficial. With regard to initially engaging members in services, Thresholds reports and the MCOs confirm that Thresholds staff "got out and hit the streets and found almost every member," which has proven difficult in the past. Thresholds staff also went directly to hospitals to identify MCO members. After enrollment in these pilots, members have been more routinely accessing primary care and psychiatric services from the consistent providers, and their medications appear to be more under control. Aetna stated that "the overall program has been a success." The following outcomes were reported in the first year by the IlliniCare and Thresholds evaluation:

- 50% reduction in behavioral health hospital admissions for all members in pilot
- 55% reduction in 30 day readmissions for all members in pilot

- 58% reduction in 90 day readmissions for all members in pilot
- 63% reduction in costs for behavioral health inpatient hospitalization for members in the pilot for the entire 12 months
- 53% reduction in ER usage for members in the pilot for the entire 12 months.

According to Aetna's annual report, in the Aetna pilot Thresholds also successfully exceeded 75% on the HEDIS 30 day follow up score. This score measures the percentage of members who had a face-to-face visit with a licensed clinician or RN within 30 days after discharge. The IlliniCare pilot did not measure HEDIS scores.

With regard to cost, IlliniCare staff noted that the pilot program broke even, and led to "cost shifting", meaning that dollars spent on inpatient services were instead spent on the community-based pilot services. Thresholds staff commented that existing FFS rates do not come close to covering the cost of intensive outreach efforts needed to engage people who have high hospital admissions and are not connected to outpatient health providers. It is important to ensure that the capitated rate covers the cost of providing services without exceeding the value added. Thresholds leadership staff commented that the capitated payment system, driven by quality and outcome measures, makes the most sense for providing service to their members, as opposed to the FFS model.

For IlliniCare members, the pilot has been expanded and made a permanent program to cover all of the approximately 200 IlliniCare members in need of intensive behavioral healthcare who are served by Thresholds. Currently Aetna pilot members are served in a single high intensity Thresholds program. The Aetna pilot has been continued for another 6 months until July 31, 2015 for a total of 18 months. Because the Aetna pilot sample size is very small and the period for the pilot program has been extended, the data may not be sufficient for meaningful analysis and have not yet been fully available. A follow up review in the summer of 2015 is planned.

4. Future Directions

Thresholds has added a new program with IlliniCare that engages their members in a growing number of hospitals (six as of July 2015) during mental health admissions and links people to services in the community at discharge. Aetna is considering further expansion of the pilot. Additional consideration includes opportunities to implement Thresholds onsite representation at high volume facilities to improve Aetna member engagement post discharge. Thresholds is also planning to expand this hospital-community linkage program and is in conversations with other hospitals. To this point, hospitals have been receptive because they see the services as useful in the process of serving members' serious behavioral health needs. Thresholds is confident that outcomes of these programs will demonstrate the value of providing services to this population in this way. The current findings are all from internal sources and have not been verified by the UIC evaluation team or another outside source. HFS, IDPH, MCOs and/or Thresholds may find it valuable to have an external evaluation of this promising pilot program to independently identify its costs and benefits.

B. SNFist Services

Aetna and IlliniCare have contracted with providers of skilled nursing facility services (SNFists) as listed in Table 43. Both Aetna and IlliniCare have conducted evaluations of SNFist services, detailed in their annual reports. Additionally, SNFist providers have collected data on the effectiveness of the SNFist model. Data presented in this report are based on communications with and reports from these sources. The UIC team did not conduct an independent evaluation of SNFists services in the ICP.

Table 43: Contracted SNFist Providers

Aetna SNFist Providers	IlliniCare SNFist Providers
General Medicine	Awakened Alternatives
	In Home Medical Group
	Oak Medical
	General Medicine (prior to FY 2015)

The goals of the SNFist model are to:

- Work with nursing facilities (NFs) and relevant staff to coordinate care for members in long-term care facilities following hospital discharge
- Prevent unnecessary emergency room (ER) use and hospitalizations/re-hospitalizations
- Focus on quality medical care including patient care oversight and communication with others involved
- Prevent unnecessary assessment testing and treatment expenses

Unnecessary treatment expenses include those covering ER visits and re-hospitalization that could be prevented by providing quality care in NFs, and continuity of quality care for members when they are medically ready to live successfully in a less restrictive, less costly environment. Some preliminary evaluation information from SNFist providers suggests the benefits that could result from adopting this model. For more information on success that General Medicine records in this area, refer to its website (https://www.generalmedicine.com/general-medicine-post-hospitalist-company-achieves-high-quality-measures-decreasing-health-care-spending/). Data are not available concerning the SNFist's work and outcomes for the ICP. The UIC evaluation team met with individuals from all four SNFist providers to better understand the role of SNFists in long term care within the ICP. The UIC team also discussed the SNFist role with the MCOs and made unsuccessful efforts to discuss the ICP with NFs.

1. Pilot Program Development

For the first two years of the ICP, both Aetna and IlliniCare contracted with the same company, "General Medicine PC." According to General Medicine, in the spring of 2014, it ended its agreement with IlliniCare to provide SNFist services. Subsequently, IlliniCare contracted with three (3) agencies to provide SNFist services in specific geographic regions of the ICP. Aetna continued to employ General Medicine PC for SNFist services.

Both MCOs' agreements include capitated payments and performance-based incentives which incorporate operational as well as clinical metrics. Through Service Package 2, MCOs are paying for

nursing home care, including the cost of an attending physician if the physician renders and bills for covered services to MCO members without developmental disabilities.

2. Process of SNFist Care Coordination

IlliniCare SNFists receive lists of patients who are in the hospital, and daily lists of patients who have been discharged from IlliniCare. Before discharge, SNFists, hospital staff, and an IlliniCare social worker ensure that the patient can be transitioned to a NF. Patients are then followed by an IlliniCare SNFist program specialist (social worker) in days 1 through 4 after discharge, and by an RN from day 5 on. In contrast, Aetna SNFists are contacted electronically or by phone call by case management staff at Aetna when a member is in a nursing home. SNFists have up to 72 hours after hospital discharge to make contact with a member in a NF, and have extended time—30 days—to make contact with behavioral health patients in a NF.

Regarding health assessments, both MCOs report conducting them for their members based on their risk status or anticipated need for medical care. Aetna indicated that it conducts health assessments for all their ICP members residing in NFs. IlliniCare indicated that after conducting health assessments they subsequently provide SNFist medical services for members who have moderate or high health risks.

General Medicine, the SNFist organization that provides all of the SNFist services for Aetna, indicates that they emphasize a directive approach in which the SNFist physician provides services directly. According to General Medicine PC, their staff act as attending physicians and are responsible for the overall plan of care for the members they serve.

Another dimension of SNFist services concerns medication. SNFists have identified a lack of medication reconciliation between the hospital and the NF as leading to re-hospitalization for some members. Therefore, in the IlliniCare SNFist model at hospital discharge, SNFists review discharge orders, compare them to the patient's prior records, update the medication in the electronic medical records such as IlliniCare's TruCare system, and ensure that hospital and NF medications match up. Similarly, General Medicine clinicians perform medication reconciliation at the time of admission to nursing homes in the Aetna model. During the health risk assessment, which is to be completed within the first 60 days of eligibility, annually, and upon significant change, medications are again reviewed. SNFists are not primarily hospital discharge-planning groups, but rather are based in the NF. For both MCOs, members are divided into low, medium, and high acuity or risk groups.

IlliniCare SNFist staff reported that using this model, 96 patients have been or are in the process of being transitioned out of a skilled NF into the community. Aetna's SNFist staff also have been active in facilitating the move of NF residents into the community. General Medicine data shows that 17% of ICP patients have transitioned back to the community. The UIC team was not able to confirm the figures reported by either MCO for number of transitioned members.

Table 44: SNFist Model for High, Medium, Low Risk Members					
High Risk Members		**Medium Risk Members**		**Low Risk Members**	
Aetna	**IlliniCare**	**Aetna**	**IlliniCare**	**Aetna**	**IlliniCare**
Seen by SNFist providers 3 -5 times weekly	Seen by SNFist providers once a month, or more if necessary, to provide or recommend care and prevent re-hospitalization	Seen by SNFist providers 2-3 times monthly?	Seen by SNFist providers every 6 months to provide or recommend care, or as often as clinically necessary.	Seen by SNFist providers monthly	Seen by SNFist providers every 6 months to provide or recommend care, or as often as clinically necessary.
SNFists and Aetna have regular weekly rounds meetings to discuss high acuity members	SNFists and IlliniCare long-term services team have regular weekly rounds meetings to discuss high acuity members	Focus on transitioning members into the community or the most appropriate facility	Focus on transitioning members into the community or the most appropriate facility	Focus on transitioning members into the community or the most appropriate facility	Focus on transitioning members into the community or the most appropriate facility
Data Source: Interviews with SNFists and MCOs					

Aetna and IlliniCare SNFists serve varying numbers of members, and distribution of staff varies among the four providers: General Medicine, Oak Medical Group, Awakened Alternatives, and In-Home Medical Group. Table 45 provides a general overview of the type and number of staff that each SNFist has reported to the research team. It must be noted that the number of staff listed in Table 45 are estimates provided by each SNFist to the research team, include both part time and full time staff and are therefore not directly comparable.

Table 45: SNFists Staffing Overview and Members Served[1]					
Staff Type	**Aetna**	**IlliniCare**	**Oak Medical**	**IlliniCare Detail Awakened Alternatives**	**In Home Medical Group**
Members Served	1,628	2,200	800	500	900
Physicians on Staff	10	9	9	0	0
RNs on Staff	0	6	1	3	2
NPs on Staff	18	16	5	3	8
LNPs on Staff	0	1	0	1	0
Clerical/Coordination Staff	7	6	1	2	3
[1] Number of staff are estimates, are not FTEs, and were not confirmed by UIC					

3. SNFist Responsibilities

The research team had conversations with the MCOs and the SNFist about the general responsibilities that the SNFist staff had related to members living in nursing facilities. In general, the parties agreed

that SNFists act as either the leader or a member of the long-term care team with regard to care in nursing homes, and make efforts to communicate with NF and MCO staff to provide the best care for patients.

There were differences as to whether the role that the SNFist performed was a consultant or as an attending physician. IlliniCare and their 3 SNFists indicated that their SNFist staff assumed primarily a consultative role; one IlliniCare SNFist organization has been able to place one of its physicians as the attending physician in one NF, and that physician has reported success in this role. He indicated he is able to intervene medically, act as the primary order writer, and feel more comfortable providing a variety of services to prevent ER visits. General Medicine indicated that all of its physicians act as the attending physician, although Aetna has informed the research team that there are times when it considers General Medicine as working in a consultative role with the NF.

SNFists cite a need to collaborate with all stakeholders in order to achieve the best care and cost savings in this program. However, one barrier to this approach within a primarily consultative model is the fact that SNFists are not the point of contact for services when an emergency arises that may seem to require hospitalization. Moreover, consulting SNFists may influence, but usually are not ethically or practically able to control, how attending physicians care for their patients. However, if the SNFists are the attending as was reported to be true in a very few cases for IlliniCare and for all cases for Aetna, then they can direct care for the member, assure quality care and avoid unnecessary hospitalizations.

SNFists describe education of NF staff and members as a primary responsibility. For example, IlliniCare SNFists have been able to educate nursing staff on navigating the IlliniCare system. IlliniCare has partnered with Thresholds to do interventions in the NFs for behavioral health members when SNFists identify a need. According to IlliniCare staff, as many as 75% of members in NFs may need behavioral health treatment.

According to General Medicine, about one third of its patients with a behavioral health diagnosis living in NFs are hospitalized annually, often unnecessarily. Behavioral health patients provide a particular opportunity for the SNFist model to make an impact, because some of those patients are transferred back and forth between NFs and psychiatric facilities without therapy, and the pattern may become entrenched. IlliniCare reports being in the process of identifying 6 NFs whose staff will receive applied behavior analysis training, in collaboration with SNFists, in the near future to improve their capacity to work with behavioral health issues.

IlliniCare SNFists cite relationship building as crucial to their work; rapport among providers is necessary to trust in the care recommended and provided. Organizational change is necessary in most NFs for the SNFist model to work most effectively. Using positive HEDIS and utilization data, IlliniCare and SNFists are working together to contact owners and administrators of NFs in order to obtain their support for the SNFist role in their organizations. SNFists also work to educate NF staff to contact them rather than send a member to the emergency room when a medical issue arises. Under the Aetna model, NF staff must contact the SNFist (who is the attending physician) rather than send a member to the ER when a medical issue arises. They seek to recognize issues earlier using common medical tests such as urinalysis

and X-rays. Then members' health issues can be identified and treated in place at an earlier stage instead of sending them to the hospital or ER later.

4. Challenges in the SNFist Model

In general, SNFists and MCOs see a potential ability to coordinate member care using the SNFist. SNFists and IlliniCare point to improved member health, improved HEDIS compliance comparisons, fewer potentially avoidable hospital admissions and readmissions, reduced readmission penalties, shorter hospital stays, more members moving out of NF into less restrictive living arrangements, related reductions in healthcare spending, and, for those who remain in NFs, a possible increase in NF length of stay, i.e., living longer, as important indicators of the success of this model. General Medicine's website (https://www.generalmedicine.com/) includes further detail regarding its reported national success in these areas.

Table 46: SNFists Report Challenges and Solutions

Challenges	Solutions
High staff turnover in nursing homes	Assuming low turnover among SNFist staff, they provide stability as a partial antidote to the change resulting from NF staff turnover.
For goals assessed by HEDIS measures, if no bill or claim exists through the NF system, the State cannot track the service. Because the facility needs to bill through their system in the capitated model, patients might receive extra, unfunded services in order to meet the goals assessed by HEDIS measures.	Possibility for SNFists becoming approved by NFs/MCOs to provide and be compensated for physician services. Also with such approval the ensuing records better document the achievement of HEDIS standards. At present if no claim exists, a chart review can be conducted to document whether the HEDIS standard has been completed. General Medicine details on its website how its services can result in positive outcomes (https://www.generalmedicine.com/).
Data Source: Interviews with SNFists	

In general, SNFists and MCOs see a potential ability to coordinate member care using the SNFist. SNFists and IlliniCare point to HEDIS compliance comparisons, hospitalization data, a decrease in hospital admissions, an increase in members' health, members moving out of NFs into less restrictive living arrangements and--for those who remain in NFs- a possible increase in NF length of stay, i.e., living longer, as important indicators of the success of this model.

C. Supportive Housing

Housing is a challenge for most individuals on Medicaid. For ICP members, housing can be a particularly significant challenge because of the needs for accessible units for themselves and their families. While, accessible and affordable housing is available for some, many continue to find it challenging and moving residences occurs more frequently than is desired for many members. In addition, pressures from the housing market can push people out of neighborhoods as rent prices increase above their spending threshold.

Supportive housing is intended for individuals or families who are homeless and disabled. Prior to the Affordable Care Act of 2010 only about 50% of the homeless population was covered under Medicaid or any other insurance program. Now that the Affordable Care Act (ACA) is being implemented in Illinois, the intention is that everyone who is eligible will receive coverage.

The need for supportive housing has grown since the Williams, Ligas and Colbert consent decrees. The State of Illinois hired 3 statewide housing coordinators for long term care reform to help tackle this growing need. In general, the Department of Housing and Urban Development, (HUD) is the major funding source for the development of supportive housing. HUD defines those eligible for supportive housing as "HUD Homeless". While funding from HUD for new housing units has halted, funding for existing units continues and keeps individuals housed who are in supportive housing. While these services are available to ICP enrollees, the MCOs need to proactively address the housing needs of the clients.

Figure 20 in the Appendix illustrates the general process used by supportive housing agencies to help homeless, disabled individuals to obtain stable, permanent housing.

1. Current situation in Illinois

Experts on supportive housing in Illinois explained that housing resources are too piecemeal. There are many different State divisions (Mental Health, Family Services, Department of Children and Family Services) that control housing geared towards different populations. In the City of Chicago, a central referral service prioritizes who gets open units. However, there is a huge backlog of people wanting permanent supportive housing that has a subsidy attached, which is why short-term housing is also an important part of this process. MCOs cannot fill out the application for the central referral system and if a member is not connected to an agency that can help them fill it out, they will not get on the waitlist.

Individuals who are candidates for supportive housing cannot go directly into it. They first go into short term respite housing where they can work with a case manager to help ascertain their eligibility. Stakeholders caution that short term housing often turns into more permanent situations because there is alternative housing, such as Specialized Mental Health Rehabilitation Facilities (SMHRFs).

One of the major challenges for supportive housing in Illinois is that almost all of the units run by supportive housing agencies are filled with only a 5-10% vacancy rate. The problem is that most people don't "move on" to a new housing situation. The main reason for this is the high cost of housing in the Chicago area and the lack of availability of HUD Housing Choice Vouchers. This is illustrated in Figure 20 in the Appendix.

2. What MCOs Are Doing Now?

Table 47 describes some similarities and differences in how the two MCOs are approaching housing.

Table 47: Comparison of Housing Practices among MCOs		
Item	**MCOs**	
	Aetna	**IlliniCare**
How many members are homeless or on the verge of homelessness?		Approx. 950 and 467 with severe mental illness or substance abuse issues
How is homelessness tracked?	Through case notes from care coordinators	Initially from case notes. Now there is a question on the HRA and when asking for demographic information.
Does your organization pay for any permanent housing?	No	No
Does your organization pay for any temporary housing? If so what kinds and for whom	No	Transitional housing at Interfaith House –pay to keep beds free for members discharged from hospitals.
Data Source: MCO Staff		

Supportive housing agencies, State of Illinois representatives and the MCOs met in March 2014 to discuss collaboration and the role supportive housing can play in healthcare. As part of their existing coordinating services, supportive housing agencies find homeless individuals and get them housed. Currently, the MCO's Case Coordinators rely on help from housing Case Managers at supportive housing agencies to actually find members. Often, the only time MCOs can locate 'hard to reach' members is when they are admitted to the hospital. It is clear that supportive housing agencies play a key role for the homeless population that is not part of the ICP.

There are critical differences between MCO Case Coordinators and housing Case Managers. Several stakeholders commented that Case Coordinators are mostly operating from a medical model; whereas, Case Managers have a more holistic, person-centered planning approach and operate from more of a social model. Case Managers meet in the community and Care Coordinators typically call on the phone. At this point there is little incentive for them to work together. Case managers are often paid through grant programs and have different metrics and accountability that may not align with the goals of Care Coordinators. Consumers pay a price for this mismatch because they receive multiple messages from different sources. Still, collaboration is improving because MCOs are becoming aware of the personal role that case managers at community based agencies play and the need to involve them within their model of care.

3. Hospital Discharges

When members are discharged from hospitals it can be a particularly vulnerable situation. Hospitals are technically required to make a "safe" discharge but this may not always be the case and homeless individuals end up in shelters. It is the policy of most shelters that individuals need to leave for the day but if a person is recovering from a hospital this can cause serious health risks.

If a member is admitted to the hospital, the hospital is supposed to notify the MCO about discharge and the Care Coordinator will try to help coordinate temporary housing. Case coordinators may meet members in the hospital to discuss options, which may include a residential setting if there are substance abuse issues, nursing home if medically necessary, or other temporary housing that may be

provided by community mental health centers. Aetna requires that there be a discharge plan based on a template they provide.

4. Demonstration Projects

Currently, Medicaid does not reimburse for housing or support services. MCOs are also not expected to cover housing services through their current contracts. However, both MCOs are experimenting with demonstration projects to assist with some housing services. If these demonstrations work well, MCOs plan to scale them up.

Aetna is extending its pilot with Thresholds (a community based behavioral health and housing provider) for another 6 months (See Section page 61 for a description of the Thresholds project). Aetna is also planning a partnership with a Coordinated Care Entity (CCE), who will help in providing more in-person care coordination in the community for people with severe mental illness (SMI), and complex physical health problems. CCE care coordinators will attempt to establish closer relationships than can be achieved by MCO care coordinators who work largely by phone. Furthermore, Aetna plans to work with a community partner who has connections with the criminal justice system and better knowledge of discharge for individuals with SMI being discharged from jails.

IlliniCare is working with Interfaith House on a transitional housing pilot program and paying to keep beds free for members from hospitals discharges. It is for short-term housing and the average length of stay is 90-120 days. This pilot will serve people who still have medical needs after discharge and can benefit from continued care from nurses and doctors. IlliniCare is planning to scale up its pilot program with Thresholds to a full program. Thresholds helps to attain housing for members with SMI. IlliniCare pays a per-member per-month (PMPM) fee for the services provided. IlliniCare is also exploring some creative options for real estate focused ventures through investment partnerships that could include Single Room Occupancy (SRO) conversations. They are also exploring rental subsidies for the SMI population.

5. Conclusion

Despite the demonstration projects considerable barriers still exist for the MCOs in regards to supportive housing:

- MCO contracts are 1 year, whereas supportive housing has multiyear needs for Individuals who need to stay in stable housing. It is difficult for MCOs to provide housing services, which often require at least a year commitment, because they don't know if the individual will be a member from month to month.
- Transportation is a continuing barrier to homeless members. Transportation benefits only apply to medically necessary appointments and not to members who need to travel to look at potential apartments.
- There continues to be a severe housing shortage for people who are discharged from the criminal justice system. These individuals are disconnected from the healthcare system while in Jail. MCOs have no information regarding when a new member will be discharged from jail. This is a new population that is now covered under the ACA.

More work on supportive housing in managed care is needed. This includes linking claims with data on members using supportive housing and examining the impact of supportive housing on healthcare and long-term services and supports utilization and cost.

How have provider networks and service utilization changed over time?

A. Introduction

This section focuses on the providers available to ICP enrollees, and the utilization of provider services. The section also contains information on payments made to those providers, including how long it takes a provider to submit a claim to the MCO and how long it takes the MCO to pay that claim. The first two subsections focus on the development of adequate provider networks and the submission of provider claims. The final subsection focuses on analysis of overall costs to the State that ICP has had. The sections that follow focus on specific provider types.

1. Defining an adequate provider network

There is no consistent standard among the states in defining an adequate sized provider network in managed Medicaid care programs. Some states use provider to member ratios; some use travel distances and times between providers and members; while others use the average time it takes members to secure an appointment with a provider to calculate access that members have to the provider network.

Illinois has required the MCOs to report on the number of signed or "available" providers in their network, initially on a monthly basis and currently on a quarterly basis. The UIC team obtained this information from HFS and used enrollment data to calculate overall provider to member ratios for the provider networks of both plans. These rates were then compared to existing rates in place for the ICP eligible group just prior to implementation of the ICP.

While provider to member ratios provide a crude measure of network adequacy, calculating the "available" providers alone is not sufficient. For example, experience in Illinois and other states has shown that providers may be signed to agreements with a specific MCO but may not be able or willing to serve new Medicaid members. There have been reports from numerous states of provider networks in Medicaid managed care programs that had inflated counts through either duplicated providers or providers that were unwilling to serve Medicaid members. In addition, during focus groups and general stakeholder meetings, the research team received feedback from some members and advocates that some of the physicians listed in the MCO network directory, for various reasons, were not actually available to them for service.

For this reason, the UIC team used a second measure of network adequacy to supplement the number of signed or available providers. The team reviewed claims from the MCOs to determine how many of the signed physicians actually had submitted claims for members. The team reviewed paid claims for the first 3 years of the ICP to calculate the number of billing or "active" providers who actually delivered services to ICP members.

However, larger provider networks are not necessary always "better." Although a comparison of the number of providers before ICP and afterwards can be helpful, a smaller, better coordinated provider network may be more responsive to members than a larger uncoordinated array of providers. A simple comparison of the count of physicians and dentists is not the sole determinant of the effectiveness of a provider network. Of course, there is a minimum number of providers needed to ensure adequate

member choice and the delivery of timely quality services. However, there may reach a point where the number of providers may exceed the capacity of an organization to effectively manage and coordinate care. The reader is cautioned to consider this when comparing counts of providers in the subsequent sections for the various provider types.

2. Changes in Service Utilization

In talking with State officials, MCO staff, consumers, and other stakeholders, the research team formulated the following questions to guide the team's analysis of the provider networks, the changes in service utilization, and the payment of providers:

2) How has the provider network changed during the ICP?
   - o number of signed providers
   - o number of providers who served members and submitted claims

6) How have inpatient services changed?
   - o number of Emergency Department visits
   - o number of admissions and length of stay for admissions
   - o follow-up after discharges and the number of re-admissions

7) How have outpatient services changed?
   - o location or place of service (POS) for outpatient services
   - o types of providers for outpatient services

8) How has the payment to providers changed?
   - o amount paid to providers
   - o amount of time it takes for providers to submit "clean" claims
   - o amount of time it takes MCOs to pay providers for "clean" claims

In the FY11 baseline, just prior to the start of the ICP, there were slightly more than 40,000 Medicaid members living in the 6 county region who were eligible for the ICP. Of these, approximately 30,000 members were grouped into the "community" capitation group while the remaining 10,000 were spread across waiver and long term care member groups.

For the purpose of analyzing changes in service utilization for Service Package 1 services for the first three years of the ICP, the research team identified those "community" members who were in all four time periods (FY11 [baseline], FY12, FY13, and FY14). Table 48 shows the number of members for each of these 4 time periods. For example, of the 30,000 community members in the baseline period, a little over half (15,555) were also in each of the first 3 years of the ICP. For more detail on the process used to compare the three claims datasets (FFS, Aetna, and IlliniCare) and how the samples were drawn for each year, see "Summary of Service Utilization Analysis" in the Appendix.

Table 48: "Common" Community Members Used In Service Utilization Analyses							
Measure	**FFS-FY11**	**Year 1 (FY12)**		**Year 2 (FY13)**		**Year 3 (FY14)**	
		Aetna	**IlliniCare**	**Aetna**	**IlliniCare**	**Aetna**	**IlliniCare**
Distinct members	15,555	7,967	7,775	8,047	7,842	7,780	7,550
Member months	139,995	47,292	46,038	94,695	91,965	44,215	42,600
FTE members	11,666.3	3,941.0	3,836.5	7,891.3	7,663.8	3,684.6	3,550.0
Time Period	July 2010-March 2011	Jan. 2012-June 2012		July 2012-June 2013		July 2013-Dec. 2013	
Data Source: HFS Medicaid Claims (FY11); HFS Capitation Payments to MCOs (FY12 thru FY14)							

Table 49 summarizes the number of outpatient visits by Place of Service (POS) for the "community" members who were in the FY11 FFS group and who were enrolled in the ICP as of FY14. There are 6 major POS categories listed in Table 49 – two of them, Ambulatory Surgical Treatment Centers and Laboratories, showed little change overall in FY14 as compared to FY11 (although there were substantial differences between the two MCOs on both).

Table 49: Summary on Service Days by Place of Service (POS) (Visits per 1,000 FTE Members)[1]						
Place of Service	**Historical Comparison**				**Year 3 Detail (FY14)**	
	Baseline (FFS-FY11)	**Year 1 (FY12)**	**Year 2 (FY13)**	**Year 3 (FY14)**	**Aetna**	**IlliniCare**
Ambulatory Surgical Treatment	23.2	23.0	25.8	23.9	14.7	33.5
Clinics	1,248.3	1,106.7	1,285.9	1,412.4	1,387.7	1,438.0
Laboratory	1,164.8	994.9	1,068.3	1,162.9	902.1	1,433.5
Outpatient Hospital	5,887.8	5,594.3	5,857.4	6,441.4	7,252.1	5,600.0
Patient's Home	1,580.5	1,390.9	1,695.5	2,604.7	2,217.3	3,006.8
Practitioner's Office	10,691.6	8,980.0	8,750.6	8,746.0	10,064.4	7,377.7
Unknown Outpatient	416.6	296.0	167.2	217.7	425.8	1.7
Source: FFS and MCO claims [1]Excludes Hospital Emergency Department visits						

The biggest change occurred for the POS of "Patient's Home", for which both MCOs reported large increases for FY14 when compared to the baseline rate. Aetna reported a 40% increase in visits per 1,000 members in the home while IlliniCare reported a 90% increase. This increase is supported by large increases in the recruitment of home healthcare providers and corresponding increases in visits by these providers as noted later in this section.

Overall, visits for clinics and outpatient hospital locations also increased, although there were again differences between the two plans. Visits for Practitioners' offices decreased slightly (about 5%) for Aetna and by about 30% for IlliniCare.

3. Payment of Provider Claims

Although some providers are capitated (e.g., most dental services), the majority of providers have to submit a claim to each MCO in order to be paid for providing services. The MCOs submit regular reports to HFS regarding the claims they have paid. Table 50 uses these reports to compare the percentage of in-network and out-of-network claims in ICP for FY13 and FY14. In ICP, the MCOs used in network providers about 60% of the time in FY14, slightly higher than 56% in FY13. IlliniCare used in-network providers at a slightly higher rate than Aetna during FY14 (65% to 60%).

Table 50: Claims by Network Status (Percent)

Network Claims	FY13		FY14	
	Aetna	IlliniCare	Aetna	IlliniCare
In-network claims	54.6%	60.4%	59.5%	65.3%
Out-of-network claims	45.4%	39.6%	40.5%	34.7%

Source: MCO Adjudicated Claims reports to HFS

Claims can be submitted to each MCO either electronically or by paper. Table 51 shows the modes of claims submissions in FY14. Most claims were submitted electronically for both MCOs, which was slightly higher than during FY13 when both plans reported that about 75% of the claims were electronic. A major difference for providers with regard to submission mode is that electronic claims are required to be paid within 21 days, while paper claims are required to be paid within 30 days. Table 52 shows the claims paid on time for each mode of submission (electronic and paper) for FY13 and FY14. In FY14, IlliniCare reported that they paid 99.7% of their electronic claims within 21 days (up from 99.0% in the FY13) and 99.0% of paper claims within 30 days (up from 96.9% in FY13). Aetna reported that they paid 90.7% of electronic claims within 21 days (fewer than the 95.4% they reported in FY13) and 92.9% of paper plans within 30 days (lower than the 96.4% they reported in FY13).

Table 51: Mode of Submission

Claims Submissions Mode	FY14	
	Aetna	IlliniCare
Electronic claims (%)	83.3%	86.0%
Paper claims (%)	16.7%	14.0%

Data Source: MCO Adjudicated Claims reports to HFS

Table 52 data has two key limitations. First, the MCOs use different definitions regarding which claims they report on the monthly reports they submit to HFS. One MCO informed the team that they submit only the final adjudicated claim in the month that it is finalized while the other MCO informed the team it submits the original claim and all subsequent adjustments of claims for the report. This differing definitions could affect the results reported in Table 52.

Table 52: Timeliness of Payments

Claims Paid by Deadline	FY13		FY14	
	Aetna	IlliniCare	Aetna	IlliniCare
Electronic claims paid within 21 days	95.4%	99.0%	90.7%	99.7%
Paper claims paid within 30 days	96.4%	96.9%	92.9%	99.0%

Data Source: MCO Adjudicated Claims reports to HFS

The second limitation of Table 52 is that it reflects time it takes to pay claims after the claim has been successfully received by the MCO. The research team heard numerous complaints from providers that they have had a difficult time working with the claims clearinghouse and the MCOs to successfully navigate the claims submission process each MCO has set up.

Due to these two limitations, the research team decided to review the actual claims for both MCOs and determine the amount of time that it takes for a provider to successful submit a claim to the MCO and how much time it takes the MCO to pay the claim after it has been successfully submitted. Table 53 summarizes the results of this analysis for all claims and more detail on specific provider groups is described in subsequent sections. The "Service to Submission to MCO" measure is the time between the last date on the claim to the date the claim is successfully received by the MCO claims system and the "Submission to MCO to Paid" measure is the time between the date received in the MCO claims system and payment is made to the provider.

Table 53: Service to Submission to MCO and Submission to MCO to Paid

All Provider Types	Aetna			IlliniCare		
	FY2012[1]	FY2013[2]	FY2014[1]	FY2012[1]	FY2013[2]	FY2014[1]
Days from Service to Submission to MCO	43.3	41.7	45.8	35.9	25.4	23.2
Days from Submission to MCO to Paid	21.4	15.0	12.9	21.1	12.8	9.2
Number of Claims	277,260	662,295	378,760	237,891	525,901	331,468
Unique Providers Submitting a Claim	10,591	13,324	11,930	10,678	13,769	13,242

Source: MCO Special Datasets for Services Provided in CY12 & CY13
[1]6 months of data
[2]12 months of data

Across all three years, providers who submitted claims to IlliniCare took less time each subsequent year to submit the claim to the MCO after the service was performed. IlliniCare also improved its time each year. However, there is not much difference in time over the years for providers working with Aetna, and during FY14, providers took almost 46 days to have the claims submitted after performing the service. During FY12, both MCO's took about 21 days to pay the claim after they received it in their system, and each MCO reduced the amount of time that it took to pay the claims from year-to-year, though Illini Care reduced the time (down to 9.2 days) more than did Aetna (down to 12.9 days).

"Payment of Providers" on page 164 in the Appendix includes detail on spending for individual provider types as well as data on how long it takes those providers to submit a claim to the MCO and how long it takes each MCO to pay the claim.

4. Overall Impact of ICP on Cost

Design

The goal of the analysis in this section of the report was to understand how ICP has affected the state's cost of providing health services to disabled and older adults who qualify for the Medicaid program in

Illinois. At the outset, it is important to note that ICP targets a population of older and disabled adults who would be covered by the Medicaid program in Illinois even in the absence of ICP. Viewed in this light, ICP is an alternative way of organizing and financing health care services that the state was already paying for and would continue to pay for in the future. Hence, this section is designed to quantify the incremental difference in costs associated with the transition to ICP. In other words, the team tried to measure how much more (or less) it costs the state to provide care through ICP rather than the conventional FFS Medicaid program operating in other parts of the state.

To pursue this line of analysis, the team combined two analytical techniques. First, the team constructed a comparison group of Medicaid FFS residents who resided in Chicago and who – given their characteristics – would have been enrolled in ICP if they had lived in the pilot region. There were many more people in the Chicago sample than in the suburban sample, and - on average - their demographics, prior Medicaid expenditures, disabilities, and health conditions were quite different from the members of the suburban ICP sample. To avoid bias from these pre-existing differences, the team employed a technique called inverse propensity score weighting (IPSW) to match ICP enrollees with members of the Chicago sample with similar factors including demographics, prior Medicaid expenditures, disabilities, and health conditions. In this context, the IPSW approach can be viewed as a kind of risk adjustment that helps make the two groups comparable. The method was quite successful: an analysis of historical claims data shows that prior to the matching of two baseline groups, the costs for the two groups were quite dissimilar but after the matching, the ICP/Suburbs sample and the matched Chicago sample were very similar.

Using the second analytical technique, the team estimated the incremental effects of ICP on the state's costs using a "difference in difference" regression model. This approach is designed to further adjust for any remaining differences between the groups that may have escaped the matching process and to adjust for any time trends or time varying factors that may have affected both groups during the ICP rollout. In essence, the estimated cost effects come from comparing the change in costs (before and after the onset of ICP and other key events) observed in the ICP group with the change in costs observed in the matched Chicago comparison group. A basic assumption is that – in the absence of ICP – the two groups would have trended similarly over time. In that case, differential changes over time in the ICP and matched Chicago group show the effect of ICP: if costs increased more rapidly in the ICP group than in the matched Chicago group, that excess or incremental growth can be attributed to the implementation of ICP. For more detail on the study's design, see "Comparison Group Matching and Difference in Differences Design" on page 12.

Analytical Approach

The analysis was conducted at the member month level. It begins with expenses incurred by the state for the period of July 2010 thru April 2011, the 10 month baseline period immediately prior to the start of ICP. This period is referred to as the study baseline or "pretest" time period. Member costs in both groups are followed through December 2013. The analysis examines how the introduction of ICP in May 2011 differentially affected costs in the ICP group. After ICP began, two other changes occurred that may have affected the relative costs of the suburban ICP and Chicago FFS groups: the SMART Act took effect in July 2012, and the ICP capitation rates were recalculated and new rates took effect in March

2013. The empirical analysis examined the initial effect of ICP along with the incremental effects of the SMART Act and the new capitation rates.

Measuring Costs

Each member's gross monthly cost is defined as the sum of any FFS expenditures and any capitation expenditures made by the state on behalf of the member during the month. One complication with the gross cost measure arises because the MCOs are contractually required to spend a fixed percentage of their capitation revenue on health services. When the MCOs do not meet this "medical loss ratio" (MLR) requirement, they are required to refund the excess revenue to the state. To account for these payments, the team mainly worked with a net cost measure, which deducted a per member per month (PMPM) average MLR refund from each ICP members monthly gross costs. Data on MLR refunds received by the state for 2013 plan year are not yet available. Due to the uncertainty of any refunds the MCOs would owe the state for CY13, the team included 2 slightly different models for the primary cost analysis: 1 model that assumed no MLR refunds were paid by the MCOs during CY2013 and 1 model that assumed that the MCOs would make a MLR refund to the state in CY2013 and it would be the same as the 2012 refund ($62.20) PMPM. Caution should be used when interpreting these results since the team did not know whether there would be refunds made by the MCOs and if so, the amount of these refunds.

Data on net total costs are available from July 2010 to June 2013. However, after June 2013 the team did not have complete data on the state's FFS expenditures on services covered under Service Package 3. In order to analyze the effects of ICP for a longer time period, the team constructed a second measure of costs consisting of all non Service Package 3 FFS and capitation expenditures made by the state on behalf of each member of the Chicago and Suburban samples. These figures were also adjusted for the MLR refund to make it possible to track each member from July 2010 to December 2013.

To summarize:

- Net Total Cost (without Service Package 3). Costs include all FFS and capitation expenditures on services for Service Packages 1 and 2 during the period from July 2010 to December 2013. Spending on SP3 services were removed from monthly spending measures associated with both the Chicago and Suburban samples, as the state continued to pay for SP3 services from the Medicaid FFS program since the ICP did not implement the SP3 component. As a result, removing Service Package 3 costs throughout the entire analysis should not substantially change the results; SP3 costs for each group would have been about the same.

The analysis does not include the period between April 2011 and December 2011; these are the first months following implementation of ICP and the data during this transition period from FFS to the ICP was not consistent or complete enough for analysis.

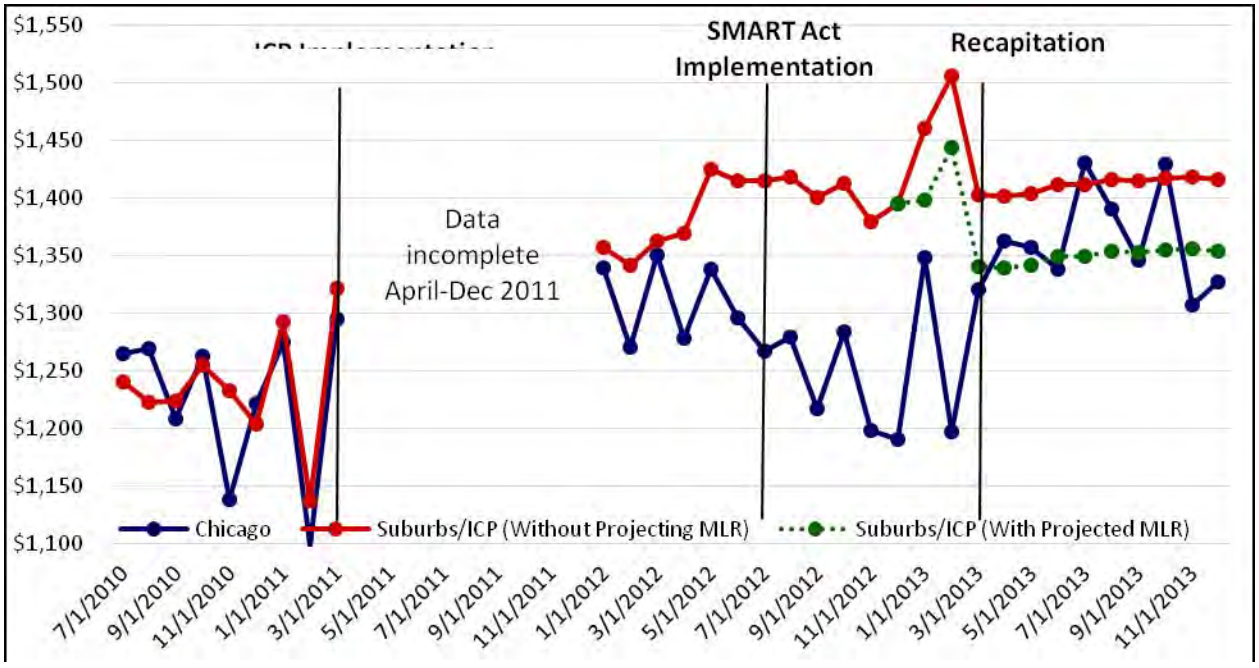
Additionally, the research team used regression analysis to determine the overall impact of each of three (3) policy changes (1-start of the ICP; 2-implementation of the SMART Act; and 3-recalculation of capitation rates in March of 2013). These are presented as regression coefficients, which are estimates of the average incremental impact of each reform after it was implemented through the end of the analysis periods. , several of them overlap and are cumulative. Effect estimates were calculated for:

- The initial effect of ICP, which begins in January 2012 and remains in place through the end of the analysis.
- The incremental effect of the implementation of SMART Act on the ICP group. This effect begins in July 2012 and remains in place through the end of the analysis; to determine the coefficient for the TOTAL impact of ICP during the SMART Act, this coefficient needs to be added to the previous coefficient.
- The incremental effect of the change in capitation rates. The new rates took effect in March 2013 and continued through the end of the analysis. To determine the overall effect of ICP during the period after the new rates took effect, all three effects are combined.

Results: Impact of ICP on Costs through December 2013, Excluding Service Package 3 Throughout

Figure 16 plots the PMPM costs of the Chicago and ICP/Suburbs from July 2010 through December 2013, including any payments for Service Package 3 services to members of either group during this period. The green dotted line projects what the cost of the ICP/Suburbs would under the assumption that the 2013 MLR refund is the same as the 2012 MLR refund. This is a projection and the actual value of the refund may be more or less than the amount shown in the graph. The distance between the lines reflects the impact of ICP (and the interaction of ICP with the SMART Act and recapitation). During the baseline, the ICP/suburbs group cost about $1,237 PMPM (under FFS at the time) compared to about $1,226 for the Chicago group. The average difference between the two groups during this period was only about $11. As before, the two groups appear to follow a very similar time trend and we adopted the same common trends assumption described for the analysis of total costs. The common trend assumption implies that the cost differential between the suburban and Chicago samples would have stayed the same over time in the absence of an ICP effect.

Figure 16: ICP and FFS Costs (July 2010-December 2013, excluding Service Package 3)



The figure makes it clear that the difference in costs between the two groups expanded considerably after the implementation of ICP. The gap grows over the initial months of adoption and then expands much further after the adoption of the SMART Act. Following the revised capitation rates, the gap between the two groups decreased substantially. When the projected MLR refunds are incorporated into the analysis costs were actually lower in the ICP group than they were in the Chicago group for some months.

The research team also conducted regression analysis that estimated the overall impact of each policy change from implementation of the ICP in May 2011 through December 2013. Without including any projection of MLR refunds for CY13, the overall impact of ICP implementation was $103.89, which is a 8.40% change from the baseline, relative to the FFS group. The implementation of the SMART Act had another $115.10 (9.30%) impact, and the overall impact of ICP during the SMART Act was to increase cost by $218.99 (17.70%). Recapitation decreased ICP costs by $89.32, a 7.22% decrease. The overall impact after ICP implementation, during the SMART Act, and following recapitation was an increase in costs for the ICP group of $129.67 (10.48%). These results are reported in Table 54 (Model 1).

When the analysis included projected refunds from the MCOs for MLR for CY13, the regression showed an overall impact of ICP implementation to be $103.82, which is a 8.39% change from the baseline, relative to the FFS group. The implementation of the SMART Act had another $96.86 (7.83%) impact, and the overall impact of ICP during the SMART Act was an increase in cost of $200.68 (16.22%). Recapitation decreased ICP costs by $132.99, a 10.75% decrease. The overall impact after ICP implementation, during the SMART Act, and following recapitation was an increase in costs for the ICP group of $67.69 (5.47%). This data can also be found in Table 54 (Model 2).

Table 54: Regression Analysis: Impact of ICP on Net State Cost (Matched Sample through December 2013, excluding SP3 services)

Factor	Coefficient (Std Err)	Percent Change	Overall Impact
Model 1: PMPM Cost Without Projecting MLR Refund for CY13			
ICP Implementation (January 2012-December 2013)	$103.89*** ($24.12)	8.40%	$103.89 (8.40%)
Additional impact following SMART Act implementation (July 2012-December 2013)	$115.10*** ($14.24)	9.30%	$218.99 (17.70%)
Additional impact after recapitation (March-December 2013)	-$89.32*** ($17.76)	-7.22%	$129.67 (10.48%)
Model 2: PMPM Cost After Projecting MLR Refund for CY13			
ICP Implementation (January 2012-December 2013)	$103.82*** ($24.12)	8.39%	$103.82 (8.39%)
Additional impact following SMART Act implementation (July 2012-December 2013)	$96.86*** ($14.24)	7.83%	$200.68 (16.22%)
Additional impact after recapitation (March-December 2013)	-$132.99*** ($17.76)	-10.75%	$67.69 (5.47%)

Notes: Within R^2=0.001; Data Source: FFS and MCO claims for July 2010-Dec. 2013
Baseline (Pre ICP) Mean Cost PMPM = $1,236.99**p<.01; ***p<0.001; Regressions were weighted using inverse propensity score weights and include controls for month-year fixed effects, member fixed effects, and the onset of the SMART Act and Recapitation events in the Chicago group. These additional parameters are suppressed in the table to conserve space.

Limitations

There are several important limitations related to the results presented in this section. These include:

1) The costs analyzed do not account for any changes in administrative costs for HFS upon implementation of the ICP. The research team did not analyze the effects of ICP on the state's administrative costs. These administrative costs may or may not materially affect the conclusions reached here: HFS has indicated that there are costs associated with operating and monitoring ICP, but they also note that the costs of operating the FFS program may also fall somewhat as resources are shifted away from FFS tasks and to ICP tasks. The net effect of these changes is unknown and is beyond the scope of the present analysis.
3) As noted previously, the State has not yet made any "plus rate" payments to the MCOs for moving people from nursing homes or instituted payment freezes for people moving into nursing homes. HFS has indicated that they intend to eventually adjust previous capitation payments as outlined in the contract but have not yet done so. Again, it is not known whether the net effect of these adjustments will be an increase or decrease of costs to the state.
4) Even when the analyses project MLR refunds for CY13, these are likely not accurate. The impact of MLR may be greater or less than what the analysis projected. However, the difference is likely not too great, as MLR PMPM refunds for CY11 and CY12 were similar, so it is reasonable to expect CY13 to be similar as well.

Conclusion: Costs and Benefits of the ICP

Overall, these analyses suggest that it costs more for the state to provide care for disabled and older adult Medicaid members through the ICP model than it would cost to cover them under the conventional FFS program. When cost estimates are made using the total cost measure that includes all capitation and FFS costs, the team estimated that as of December 2013, ICP increased the state's costs by about $130 PMPM. Using projected MLR refunds reduces this effect estimate somewhat and implies that ICP increased the state's costs by about $68 PMPM for non SP3 costs as of December 2013.

Implementation of the ICP caused the state to incur more costs for the ICP members under the ICP than it would have cost the state to cover the same population under the FFS Medicaid system. Without including projections for the MLR for CY13, the overall impact of ICP was to increase costs by $103.89 PMPM (as of December 2013). When the analysis included projections for MLR in CY13, the increase was $103.80 PMPM.

Following recapitation, after the implementation of the SMART Act, the overall impact of ICP was to increase PMPM costs by $129.67 (as of December 2013). When the analysis included projections for MLR in CY13, the increase was reduced to $67.69.

One important pattern observed in the analysis is that the SMART Act had a pronounced effect on costs among the Chicago comparison group and not on the ICP group. Some of the cuts included in the SMART Act were rescinded in July 2014. This will likely increase costs for FFS, and decrease the relative

additional cost of ICP. This may reduce the cost differential between the ICP and FFS programs, although the data needed to extend the analysis to that time period is not available at present.

Even if the ICP does cost slightly more than FFS, it is also important to consider the additional benefits under the ICP. This report covered many areas and outcomes that compared performance measures and quality indicators for the ICP and with either baseline measures of the FFS Medicaid system or with a FFS comparison group. The team identified and reviewed 39 of these measures for which there was data. Table 150150 in the Appendix provides details for these 39 areas. Overall, the team concluded that when comparing ICP outcome data with FFS Medicaid outcome data, ICP had a positive impact in most (27) of the areas covered and a negative impact in only one area.

In addition, the State also benefits from capitated payments because they are more stable than FFS, which can fluctuate greatly by month. This can be seen in Figure 16. Immediately after ICP was implemented, monthly costs for the ICP group became more stable, and after Service Package 2 was included in capitation (after February 2013), the ICP group becomes even more stable (noted in Figure 16 where all of the services are capitated after February 2013). It is a benefit to the State that with capitation it can more accurately predict their costs than under FFS.

B. Physician Services

1. Network Development

Physicians-signed and active

To assess the degree of ICP network development, the team examined changes in availability and use of primary care physicians (PCPs) specialists, and three other medical professionals (chiropractors, dentists, and podiatrists) from the baseline to FY14, Table 55 lists the number of signed PCP physicians per 1,000 members for the baseline and first 3 years of the ICP. During the baseline period, there were slightly more than 90 available PCPs for every 1,000 members of the ICP eligible group. For the first two years of the ICP, both MCOs were below the baseline rate but by FY14 both plans reported a higher rate of PCPs than what had existed in FY11.

Table 55: # of Signed and Billing Physicians per 1,000 members

Primary Care	Pre-ICP (FFS) FY11[1]	FY12[2]		FY13[3]		FY14[3]	
		Aetna	IlliniCare	Aetna	IlliniCare	Aetna	IlliniCare
Primary Care Physicians							
Signed	91.3	63.1	61.2	80.8	72.4	118.1	102.4
Active (billed)	89.6	50.8	44.2	48.6	53.1		
Specialists							
Signed	378.0	141.5	114.3	308.6	257.2	244.3	185.4
Active (billed)	213.9	110.4	96.8	228.0	170.8		

[1]FY11: Statewide HFS Medicaid Provider Table
[2]FY12: MCO Provider Affiliation Files (June 30, 2012)
[3]FY13 & FY14: HSAG Network Capacity Reports

However, when focusing on only the number of PCPs who actually saw members and submitted claims, both MCOs reported substantially fewer PCPs than the corresponding baseline rate (49 to 53 "active" PCPs per 1,000 members in FY13 vs. 90 "active" PCPs for the baseline).

Table 55 indicates that by the end of FY14, compared to the first year of the ICP, both MCOs had substantially increased the number of signed medical specialists. However, this number was still considerably less than the number of specialists that had been available during the baseline period.

However, when focusing only on medical specialists who actually saw members and submitted claims, the MCOs reported rates that were much closer to the baseline rate for medical specialists. Aetna exceeded the baseline rate in FY13 while IlliniCare was about 20% below the baseline rate of billing specialists.

Table 56 lists the number of signed providers for three (3) additional medical professions. The number of signed chiropractors per 1,000 members in FY14 for both MCOs remains less than half of the baseline rate (1.2 to 1.4 vs. 3.7). In terms of dentists, IlliniCare has slightly exceeded the baseline rate in FY14 while Aetna reported a rate of about half of the baseline rate. For podiatrists, both MCOs have increased the number signed over the first three years but still remain below the baseline rate.

Table 56: # of Providers per 1,000 Members (Other Signed Medical Professionals)

Provider Type	Pre-ICP (FFS) FY11[1]	FY12[2]		FY13[3]		FY14[3]	
		Aetna	IlliniCare	Aetna	IlliniCare	Aetna	IlliniCare
Chiropractors	4.2	0.8	0.2	1.3	0.5	1.5	1.3
Dentists	39.4	17.6	5.8	24.0	28.2	21.9	42.9
Podiatrists	10.7	4.0	3.5	8.2	6.0	8.4	7.0

[1]FY11: Statewide HFS Medicaid Provider Table
[2]FY12: MCO Provider Affiliation Files (June 30, 2012)
[3]FY13 & FY14: HSAG Network Capacity Reports

Physicians-coverage by county

Table 57 shows the number of primary care physicians by county in January of 2014 and January of 2015 for the two plans. IlliniCare had a higher number of primary care physicians in all of the counties except for Kankakee in January of 2015. IlliniCare reported only about one third of the number of PCPs in Kankakee County as did Aetna. The year before (January 2014) Aetna had a higher number of primary care physicians in Cook, DuPage, and Kankakee counties compared to IlliniCare.

Table 57: Physicians – PCPs by County				
County	Aetna		IlliniCare	
	Jan 2014	Jan 2015	Jan 2014	Jan 2015
Primary Care Physicians				
Cook County	2,155	2,295	1,713	3,097
DuPage County	296	317	259	421
Kane County	84	69	96	127
Kankakee County	70	71	20	39
Lake County	199	194	229	320
Will County	85	93	90	138
Data Source: HSAG Network Capacity Report				

2. Changes in Service Utilization of Outpatient Services

Table 58 shows the change in service utilization in the ICP outpatient services (chiropractors, dentists, physicians, and podiatrists) from the baseline period in FY11 thru the first 3 years of the ICP. Outpatient visits to physicians started out in FY12 about 5% below the baseline level but by FY14 had surpassed the baseline level by almost 13% (from 10,020 visits per 1,000 members to 11,312 visits). Visits for the other 3 medical professionals in FY14 were below the FY11 baseline level, though for Aetna there was a slight increase in podiatry visits.

Table 58: Outpatient Services – Physicians (Visits per 1,000 FTE Members)						
Provider Type	Historical Comparison				Year 3 Detail (FY14)	
	Baseline (FFS-FY11)	Year 1 (FY12)	Year 2 (FY13)	Year 3 (FY14)	Aetna	IlliniCare
Chiropractors	49.0	31.8	13.7	9.1	4.8	13.2
Dentists	465.6	493.1	266.9	287.3	328.0	247.4
Physicians	10,019.6	9,522.2	9,796.4	11,312.3	12,060.6	10,579.0
Podiatrists	174.9	122.9	141.6	137.1	180.5	94.6
Data Source: FFS claims (FY11) and MCO claims (FY12 thru FY14)						

Table 59 shows the change in visits for the ICP for the period of FY11 to FY13 and compares it to the Chicago comparison group population. As can be seen, visits to physicians in FY13 for the ICP was about 2% below the baseline rate while the comparison group reported a very slight increase in visits (0.3%).

Table 59: Percent Change in Service Utilization-ICP vs. Chicago Comparison Group (Visits per 1,000 Members)						
Provider Type	ICP		Chicago Comparison		Percent Change	
	FY11-FFS	FY13-MCO	FY11	FY13	ICP	Comparison
Chiropractors	49.0	13.7	17.6	0.0	-72.0%	-100.0%
Dentists	465.6	266.9	437.0	85.8	-42.7%	-80.4%
Physicians	10,019.6	9,796.4	9,538.1	9,563.7	-2.2%	0.3%
Podiatrists	174.9	141.6	210.6	103.7	-19.0%	-50.8%
Data Source: FFS Claims (ICP-FY11 and Chicago (FY11 and FY13) and MCO Claims (FY13)) Note: Excludes Hospital Emergency Department Visits						

3. Analysis of Physician and Dental Utilization Using a Matched Sample

The analyses presented above only include "common members" who were enrolled in Medicaid prior to ICP and still in ICP during FY14. This does not account for new ICP members, who may have differences from those "common members" (e.g. demographic differences and varying health issues). To account for these differences and use the entire population of people enrolled in ICP, the research team also used a difference in difference design with a matched comparison group to assess the impact of ICP by estimating what would have happened with the ICP group regarding the utilization of physician and dental services if ICP had not been implemented (see the section entitled "Comparison Group Matching and Difference in Differences Design" on page 12 for more details). The research team used two measures of utilization for these analyses: the proportion of people who had at least one physician or dental visit in a given month and the average number of physician visits or dental services per person in a given month.

Physician Utilization

To put the effect estimates in perspective, the research team examined the utilization levels of eventual ICP members during the 9 months before the ICP program actually started. During each month of the pre-test period, about 32.1% of the ICP group visited a physician at least once. After ICP implementation, the proportion of members who received at least one physician service per month significantly increased by 1.1 percentage point, which is a 3.4% increase in the proportion of people who visited a physician at least once each month compared to the baseline. The introduction of the SMART Act also significantly increased the proportion of members who received at least one physician service per month in the ICP group by 2.5% compared to what would have happened if the ICP had not been implemented. The proportion of people who received at least one physician service per month following recapitation cannot be calculated because the data on physician utilization does not extend past recapitation. These results are found in Table 60.

Table 60: Impact of ICP on Physician Utilization (Matched Sample[1])

Factor	At Least One Physician Service PMPM		Average Physician Services PMPM	
	Coefficient (Std Err)[2]	Percent Change	Coefficient (Std Err)[2]	Percent Change
Pre ICP Mean Utilization PMPM	**0.3211914**		**0.8786986**	
Overall Impact of ICP (January 2012-December 2013)	0.011*** (0.003)	3.43%	-0.007 (0.012)	-0.80%
Additional impact following the SMART Act (July 2012-December 2013)	0.008*** (0.002)	2.49%	0.391*** (0.010)	44.50%

Notes: Within R^2=0.001; Data Source: FFS and MCO claims for July 2010-Dec. 2013
**p<.01; ***p<0.001
[1]Controls for person effects, month-year effects, and uses Inverse Propensity Score Weights

The research team also looked at the average number of physician services received by a member in a month. Before the start of ICP, the average member in the ICP group had .88 physician visits each month. After ICP implementation, there was not a significant change in the average physician visits per month. When the SMART Act was enacted, there was a significant increase in the average number of physician visits per month for the ICP group, almost a 45% increase over what would have happened had this group remained in FFS.

Dental Utilization

Prior to the implementation of ICP, 2.8% of the eventual ICP group received at least one dental service per month. After the ICP implementation, this increased by .4 percentage points, a significant increase of 14.4% over the baseline. When the SMART Act was introduced, there was another significant increase in the proportion of members who received at least one dental service per month by 1.1 percentage points, a 39.5% increase for the ICP group compared to what would have happened if they remained in FFS. After the ICP was recapitated, there was not a significant impact on the ICP group with regard the proportion of members with at least one dental service per month. These results are in Table 61.

The research team also analyzed the average number of dental services PMPM. Prior to the ICP, on average, a person received .03 dental services each month. After the ICP was implemented, there was no significant impact on the average number of dental services received by a member each month. However, after the SMART Act was introduced, the average number of dental services significantly increased by 46.6% over what would have happened with the ICP group if the ICP had not been implemented. After the ICP was recapitated, there was not a significant impact on the ICP group with regard to the average number of dental services received per member per month. These results are in Table 61.

Table 61: Impact of ICP on Dentist Utilization (Matched Sample[1])

Factor	At Least One Dental Service PMPM		Average Dental Services PMPM	
	Coefficient (Std Err)[2]	Percent Change	Coefficient (Std Err)[2]	Percent Change
Pre ICP Mean Utilization PMPM	**0.0278741**		**0.0343741**	
Overall Impact of ICP (January 2012-December 2013)	0.004*** (0.001)	14.35%	0.000 (0.001)	0.00%
Additional impact following the SMART Act (July 2012-December 2013)	0.011*** (0.001)	39.46%	0.016*** (0.001)	46.55%
Additional impact of re-capitation (March 2013-December 2013)	0.000 (0.000)	0.00%	-0.000 (0.001)	0.00%

Notes: Within R^2=0.001; Data Source: FFS and MCO claims for July 2010-Dec. 2013
**p<.01; ***p<0.001
[1]Controls for person effects, month-year effects, and uses Inverse Propensity Score Weights

4. Payment of Providers

Table 62 shows that each MCO pays claims from the four medical provider types (chiropractors, dentists, physicians, and podiatrists) within a short amount of time (13.2 days or less for Aetna and nine days or less for IlliniCare). However, there is a difference in how long it takes these providers to submit claims to the MCO's after providing the service. Providers take a much longer time to submit a claim under Aetna than IlliniCare. IlliniCare also shows improvement in the length of time that it takes to submit a claim over the years. For Aetna each provider type takes longer to submit a claim in FY14 than it had in FY13. It takes dentists 99 days to submit a claim in FY14 (compared to 12.9 in IlliniCare).

Table 63 shows spending for outpatient visits for the 4 medical professional types. This analysis only uses the "common members" who were enrolled in ICP during all of the years of the analysis. For example, spending for physicians grew overall by slightly more than 50% from FY11 to FY14 (from $564,000 per 1,000 members to $850,000). The difference between the two MCOs in the growth of spending for physicians was considerable-IlliniCare spending in FY14 was about 20% over the baseline rate while Aetna's spending in FY14 was 80% above the baseline rate. Spending on the other 3 medical professionals decreased.

Table 62: Service to Submission to MCO and Submission to MCO to Paid: Medical Practitioners

Provider Type	Aetna			IlliniCare		
	FY2012[1]	FY2013[2]	FY2014[1]	FY2012[1]	FY2013[2]	FY2014[1]
Days from Service to Submission to MCO						
Chiropractors	12.9	12.5	22.6	17.5	12.7	19.0
Dentists	102.2	33.6	99.0	64.5	27.0	12.9
Physicians	41.6	44.1	54.7	34.7	23.9	23.2
Podiatrists	62.1	30.7	54.4	66.1	29.4	26.1
Days from Submission to MCO to Paid						
Chiropractors	19.2	13.2	11.6	16.0	12.2	8.1
Dentists	24.0	11.8	10.2	13.2	6.0	5.3
Physicians	17.9	12.5	13.2	15.9	10.2	8.0
Podiatrists	17.5	12.3	12.7	18.0	15.6	9.0
Number of Claims / Number of Unique Providers						
Chiropractors	173 / 11	120 / 8	36 / 4	178 / 14	188 / 10	52 / 5
Dentists	25 / 6	29 / 4	31 / 4	2,820 / 227	3,533 / 275	2,881 / 251
Physicians	156,000 / 8,482	353,129 / 10,483	207,782 / 9,521	132,508 / 8,600	280,757 / 10,844	167,424 / 10,242
Podiatrists	1,628 / 146	4,389 / 178	1,709 / 146	2,225 / 160	3,955 / 190	1,599 / 169

Data Source: MCO Special Datasets for Services Provided in CY12 & CY13
[1]Six months of data; [2]12 months of data

Further analysis, which are shown in Section "Additional Detail on Physician Spending" in the Appendix, suggested that the increased spending by the MCOs for outpatient physician visits was driven more by an increase in the number of visits than by increases in the average payment for these visits.

Table 63: Outpatient Spending for Medical Professionals ($ per 1,000 FTE members)				
Provider Type	Historical Comparisons		FY14 Detail	
	Baseline (FFS-FY11)	Year 3 (FY14)	Aetna	IlliniCare
Chiropractors	$426	$170	$50	$287
Dentists	$42,026	$27,852	$26,927	$28,759
Physicians	$564,185	$850,702	$1,030,265	$674,744
Podiatrists	$9,222	$7,556	$11,568	$3,624
Data Source: FFS claims (FY11) and MCO claims (FY14)				

C. Other Individual Providers

1. Network Development

Table 64 lists five (5) additional individual practitioners. For Nurse Practitioners, both MCOs have increased the signing of these professionals each year but remain below the baseline rate. For the other 4 provider types, both MCOs remain in FY14 at less than half of the baseline rate that was reported for FY11.

Table 64: # of Providers per 1,000 Members (Signed Individual Practitioners)							
Provider Type	Pre-ICP (FFS) FY11[1]	FY12[2]		FY13[3]		FY14[3]	
		Aetna	IlliniCare	Aetna	IlliniCare	Aetna	IlliniCare
Audiologists	3.7	0.3	0.6	1.3	1.7	1.4	1.2
Nurse Practitioners	40.4	9.8	6.0	29.9	19.1	23.1	30.3
Occupational Therapists	16.2	0.2	0.3	0.4	0.6	4.0	0.5
Physical Therapists	19.8	0.3	0.4	0.9	1.1	4.5	1.0
Speech Therapists	25.1	0.2	0.3	1.0	0.8	4.7	0.3
[1]FY11: Statewide HFS Medicaid Provider Table [2]FY12: MCO Provider Affiliation Files (June 30, 2012) [3]FY13 & FY14: HSAG Network Capacity Reports							

2. Changes in Service Utilization

Table 65 summarizes the service utilization rates for the individual practitioners listed in Table 64 above. Service days for Nurse Practitioners decreased by slightly more than 20% in Year 1 but by Year 3, the rate of visits to Nurse Practitioners for both MCOs had increased and by FY14 exceeded the baseline rate. Similarily, visits to audiologists in FY14 exceeded the baseline rate.

Table 65: Outpatient Services-Individual Practitioners (Visits per 1,000 FTE Members)						
Provider Type	Historical Comparison				Year 3 Detail (FY14)	
	Baseline (FFS-FY11)	Year 1 (FY12)	Year 2 (FY13)	Year 3 (FY14)	Aetna	IlliniCare
Audiologists	12.5	6.9	9.5	14.5	17.4	11.8
Nurse Practitioners	116.7	99.6	101.8	139.3	141.5	137.2
Occupational Therapists	42.9	10.9	11.5	12.9	12.3	13.5
Physical Therapists	40.6	93.5	102.2	98.7	104.3	93.1
Speech Therapists	6.3	4.5	6.9	17.5	15.3	19.7
Data Source: FFS claims (FY11) and MCO claims (FY12 thru FY14)						

The rate of visits for occupational therapists has remained about 25-30% of the baseline level for all 3 years of the ICP. However, the rate of visits for physicial therapists and speech therapists have both increased under the ICP as compared to the baseline rate. Visits to physicial therapists have more than doubled—a review of the claims indicates that about 5% of ICP members for both MCOs received a visit in FY13 compared to less than 1% in FY11 before the program started. Most of the increase in physical therapy visits is because of the increased number of initial physical therapy evaluations that the MCOs were completing-the rate for the baseline was about 6 evaluations per 1,000 members and the rate was 10 times that for the MCOs.

Visits for speech therapists were below the baseline rate in the first year, went slightly above it in the second year, and in FY14 was almost 3 times the number of visits per 1,000 members as in the baseline. Most of this increase for both MCOs seems to be related to substantially more evaluations and treatment for swallowing problems).

Table 66 lists the rate of change for these provider types for the ICP and the Chicago FFS comparison group from FY11 to FY13. The biggest difference between the ICP and comparison group is for the physical therapists and speech therapists—the SMART Act had a negative effect on the rates for the FFS comparison group while the rates for the ICP members rose substantially over the baseline.

Table 66: Percent Change in Service Utilization-ICP vs. Chicago Comparison Group (Visits per 1,000 Members)						
Provider Type	ICP		Chicago Comparison		Percent Change	
	FY11-FFS	FY13-MCO	FY11	FY13	ICP	Comparison
Audiologists	12.5	14.5	21.2	21.9	16.2%	2.9%
Nurse Practitioners	116.7	139.3	57.0	83.8	19.4%	47.0%
Occupational Therapists	42.9	12.9	11.7	0.9	-69.9%	-92.6%
Physical Therapists	40.6	98.7	23.5	12.6	143.1%	-46.5%
Speech Therapists	6.3	17.5	6.4	0.1	177.8%	-99.1%
Data Source: MCO Claims Note: Excludes Hospital Emergency Department Visits						

3. Change in Spending

Table 67 compares the spending per 1,000 members for the baseline and for FY13, the second year of the ICP. There were substantial increases in spending for Audiologists and Nurse Practitioners and large decreases for the other provider types.

Table 67: Outpatient Spending for Individual Practitioners ($ per 1,000 FTE members)

Provider Type	Historical Comparisons		FY14 Detail	
	Baseline (FFS-FY11)	Year 3 (FY14)	Aetna	IlliniCare
Audiologists	$1,843	$2,906	$3,060	$2,754
Nurse Practitioners	$7,420	$11,130	$12,743	$9,550
Occupational Therapists	$124	$0	$0	$0
Physical Therapists	$1,440	$322	$151	$489
Speech Therapists	$39	$4	$8	$0
Data Source: MCO Special Datasets				

D. Hospital Services

1. Network Development

Prior to ICP Implementation

Development of the hospital provider network was difficult during the period prior to the ICP implementation and at least during the first year after implementation. The go-live date for the ICP program was May 1, 2011. Prior to this date, on April 7, 2011, 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 networks.

Summer of 2011

During the summer of 2011, the UIC team received reports from several sources that many providers were reluctant to sign with either plan and were “waiting it out” to see how serious the State was in actually implementing mandatory managed care. During this same time period, HFS held three (3) more public meetings during which the two plans gave updates regarding their provider networks. Table 68 lists the number of hospitals that HFS and the MCOs reported assigned to the two networks.

Table 68: Signed Hospitals (Year 1 and Year 2)

Date	Aetna	IlliniCare
Public updates by HFS		
6/14/2011	29	37
8/10/2011	46	42
11/16/2011	50	47
UIC analysis of MCO provider files		
6/30/2012	68	66
6/30/2013	71	79
Data Source: Year 1 annual report by UIC		

The UIC team interviewed staff of both MCOs to gain further insight to the slow development of the networks. According to Aetna:

> "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."

Staff at IlliniCare had similar comments:

> "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."

Interviews with State HFS staff echoed these comments:

> "The primary problem that arose during the ICP implementation was network access, specifically to specialty providers and teaching hospitals."

The research team asked HFS staff what steps they had taken to increase the development of the provider networks. Staff outlined several steps they had taken:

> "While the contract required monthly [provider network and geo-access] 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."

In addition, HFS staff indicated that had pushed for special legislation to "motivate" hospital providers in particular to sign with the MCO networks:

> "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."

Prior to implementation of the ICP, analysis by the UIC research team indicated there were at least 120 hospitals in the HFS Medicaid provider table that had submitted at least 1 claim for ICP eligible members during FY11, prior to start of the ICP. However, this analysis also indicated that many of these hospitals were not regular participants in the care of ICP-eligible members prior to the start of the ICP, with some hospitals being located downstate or even out of state. In fact, more than half of the hospitals in the baseline period had submitted 11 or fewer claims for the entire year.

Further analysis of the claims data for the baseline period revealed that 49 hospitals had submitted 1,000 or more claims each 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 to see how many of these "active" providers had signed to one of the MCO networks.

Table 69 summarizes the number of these "high volume" hospitals that had signed with either of the MCO networks during the first year of the ICP. For example, of the 16 hospitals with 5,000 or more

baseline claims, 4 of them had signed with Aetna after 2 months of operation while 5 had signed with IlliniCare. By the 1-year mark of the ICP, this figure had doubled for both MCOs. For the top group of 6 hospitals with 10,000 or more claims, however, progress was slower. By the end of the first year, only 4 of these highest volume hospitals had signed with 1 of the MCOs.

Table 69: Signed "High Volume" Hospitals

Hospital Group	# of Hospitals	As of 6/30/2011		As of 6/30/2012	
		Aetna	IlliniCare	Aetna	IlliniCare
Hospital with 10,000 or more baseline claims	6	2	3	3	3
Hospital with 5,000 or more baseline claims	16	4	5	8	10
Hospital with 1,000 or more baseline claims	49	24	20	31	33

Data Source: Year 1 annual report by UIC

Subsequent progress since Year 1

During the first 2 years of the ICP, the MCOs submitted monthly files to HFS listing all providers they had signed to their network. Table 68, previously discussed, lists the signed hospitals reported by the 2 MCOs at the end of the first two years of the program.

Beginning with the third year of the ICP, State officials stopped the monthly submission of provider files by the MCOs and hired HSAG to take over the responsibility of monitoring and reporting on the provider networks. HSAG expanded on the number of provider types and specialties monitored, added provider coverage by county within the ICP, and took steps to eliminate duplicate counting of providers.

Table 70 shows the number of acute care hospitals reported by the 2 plans to HSAG in January 2014 and 2015. IlliniCare reported a decrease in the number of hospitals from 2014 to 2015 in Cook County, while Aetna reported an increase.

Table 70: Total Acute Hospitals in Network

County	Aetna		IlliniCare	
	Jan 2014	Jan 2015	Jan 2014	Jan 2015
Cook County	47	53	49	41
DuPage County	3	3	8	6
Kane County	4	4	4	4
Kankakee County	2	2	1	1
Lake County	5	5	4	4
Will County	3	3	5	5

Data Source: HSAG Network Capacity Reports

2. Changes in Service Utilization (Inpatient)

Emergency Department Visits

Emergency Department visits is a P4P measure ("AMB-Ambulatory Care-ED Visits"). The State calculated the ED visit rate for calendar year (CY) 2010 for 32,545 Medicaid members living in the original pilot area that were deemed as eligible for the ICP at the time. Criteria used for this calculation included any ED

visits that did NOT result in an inpatient admission and excluded "mental health or chemical dependency visits."

Originally, HFS calculated the baseline rate at 178.23 ED visits per 1,000 member months. Upon subsequent review by HFS, it was discovered that the method used to calculate the baseline rate was not in full compliance with the HEDIS criteria. After HFS corrected their methodology to fully comply with the HEDIS criteria, a revised baseline rate of 78.70 ED visits per 1,000 members.

Table 71 lists the rates for ED visits reported by the MCOs and accepted by the State for the ICP's first two years. Aetna reported a rate of 76.93 ED visits per 1,000 member months, which was 2.2% below the baseline rate for CY10. IlliniCare reported a rate of 80.55, which was 2.4% above the baseline rate.

For CY13, both of the MCOs reported a lower rate of ED visits, when compared to Year 1. Aetna reported a rate of 75.69 ED visits per 1,000 member months, which was 3.8% below the baseline rate, while IlliniCare reported a rate of 74.93, 4.8% below the baseline rate.

Hospital Admissions

For CY10, HFS calculated the admission rate among the fee for service ICP eligible members as 40.4 admissions per 1,000 member months (see Table 71). For CY12, both MCOs reported rates between 27 and 28 admissions per 1,000 member months, substantially lower than the baseline rate. By CY13, both plans had decreased further to less than 25 admissions per 1,000 member months.

Table 71: Inpatient Outcome Measures (General Acute Hospitals)

Measure	Baseline (FFS) CY10	CY12		CY13	
		Aetna	IlliniCare	Aetna	IlliniCare
AMB-ED Visits (per 1,000 MM)*	78.70	76.93	80.55	75.69	74.93
Admissions (per 1,000 MM)*	40.4	27.7	27.3	23.4	24.8
Ambulatory visit within 14 days of hospital discharge (%)	46.9%	54.1%	51.0%	52.9%	54.5%
Readmissions within 30 days of discharge (%)*	8.3%	7.9%	12.8%	8.6%	11.7%

Data Source: HSAG Quality Report
*Note: A lower score is better

Follow-up after discharge

Another of the P4P targets the amount of followup care each plans provides members after a hospital discharge. Specifically, the measure requires each hospital discharge to be followed with an ambulatory care visit within 14 days of discharge. Table 71 lists the State calculated FFS baseline rate for ICP eligible members in CY10 as 46.9% (meaning that 46.9% of FFS members discharged from a hospital received a followup ambulatory care visit within 14 days of discharge).

For CY12, Aetna reported that 54.1% of their discharged members received a visit within 14 days while IlliniCare reported 51% of their members received a visit. In CY13, both MCOs again exceeded the baseline rate, with Aetna at 52.9% and IlliniCare at 54.5%.

Re-admissions within 30 days of discharge

Another performance measure established by the State tracks the number of re-admissions to hospitals that members have. The State calculated that 8.3% of the ICP eligible members in CY10 were re-admitted to a hospital within 30 days with the same general diagnosis after an earlier discharge. Table 71 indicates that for CY12, Aetna slightly improved to a rate of 7.9% while IlliniCare increased re-admission to 12.8%. In CY13, both plans had more re-admissions than in the baseline, as Aetna slightly increased from baseline and IlliniCare improved slightly from CY12 but continued to be substantially above the baseline rate.

3. Analysis of ER and Hospital Utilization Using a Matched Sample

The analyses presented above only include "common members" who were enrolled in Medicaid prior to of ICP and still in ICP during FY14. This does not account for new ICP members, who may have differences from those "common members" (e.g. demographic differences and varying health issues). To account for these differences and use the entire population of people enrolled in ICP, the research team also used a difference in difference design with a matched comparison group to assess the impact of ICP by estimating what would have happened with the ICP group if ICP had not been implemented (see the section entitled "Comparison Group Matching and Difference in Differences Design" on page 12 for more details). The research team used two measures of utilization for these analyses: the proportion of people who had any emergency room (ER) visit or any inpatient hospital visit in a given month, and the average number of ER visits or inpatient hospital visits per person in a given month.

Emergency Room Utilization

To put the effect estimates in perspective, the research team examined the utilization levels of eventual ICP members of the eventual ICP cohort during the 9 months before the ICP program actually started. Each month during the pre-test period, about 7.4% of the cohort visited an ER at least once. After the start of the ICP, the mean utilization per member per month significantly decreased by about 0.4 percentage points; using the matched sample comparisons the ICP program reduced ER utilization rates by about $(0.4 + 7.4) \times 100 = 5.4\%$ each month on average compared to the baseline. However, there were no significant differences following the SMART Act or ICP recapitation. These results are found in Table 72.

The research team also looked at the average number of ER visits per member in a given month. Before the start of ICP, the average member in the ICP group went to the ER about 0.1 times per month. The numbers are low because most people have no visits at all in a given month. The matched difference in difference regressions imply that the introduction of the ICP program reduced ER visits by about .013 visits per member per month, which translates to a 12.3% reduction relative to the baseline level of ER visit rates. However, there were no significant differences following the SMART Act or ICP recapitation. These results are found in Table 72.

Table 72: Impact of ICP on ER Utilization (Matched Sample[1])				
Factor	**At Least One ER Visit PMPM**		**Average ER Visits PMPM**	
	Coefficient (Std Err)[2]	**Percent Change**	**Coefficient (Std Err)[2]**	**Percent Change**
Pre ICP Mean Utilization PMPM	**0.0739878**		**0.10549**	
Overall Impact of ICP (January 2012-December 2013)	-0.004** (0.001)	-5.4%	-0.013*** (0.002)	-12.32%
Additional impact following the SMART Act (July 2012-December 2013)	0.001 (0.001)	1.35%	-0.003 (0.002)	-2.84%
Additional impact of re-capitation (March 2013-December 2013)	-0.002 (0.001)	-2.7%	-0.002 (0.002)	-1.90%
Notes: Within R^2=0.001; Data Source: FFS and MCO claims for July 2010-Dec. 2013 **p<.01; ***p<0.001 [1]Controls for person effects, month-year effects, and uses Inverse Propensity Score Weights				

Inpatient Hospital Visits

Prior to the implementation of ICP, the baseline inpatient hospital utilization rate was 0.0294006, which means that in each month, approximately 2.9% of Medicaid enrollees had one or more inpatient hospital visits each month. After the start of the ICP, the proportion of the ICP members who went to the hospital each month decreased by about .01 percentage points, or 3.4% below baseline, although this was not a statistically significant finding. When the SMART Act was introduced, the proportion of people with any inpatient hospital visits significantly increased by a further .03 percentage points, or 10.2%. Following the ICP recapitation, there was no a significant change in the number of people who received inpatient hospital services each month. These results are found in Table 73.

Table 73: Impact of ICP on Inpatient Utilization (Matched Sample[1])				
Factor	**At Least One Hospital Visit PMPM**		**Average Hospital Visits PMPM**	
	Coefficient (Std Err)[2]	**Percent Change**	**Coefficient (Std Err)[2]**	**Percent Change**
Pre ICP Mean Utilization PMPM	**0.0294006**		**0.0362129**	
Overall Impact of ICP (January 2012-December 2013)	-0.001 (0.001)	-3.40%	-0.002 (0.001)	-5.23%
Additional impact following the SMART Act (July 2012-December 2013)	0.003*** (0.001)	10.20%	0.005*** (0.001)	13.81%
Additional impact of re-capitation (March 2013-December 2013)	0.000 (0.001)	0.00%	-0.000 (0.001)	0.00%
Notes: Within R2=0.001; Data Source: FFS and MCO claims for July 2010-Dec. 2013 **p<.01; ***p<0.001 [1]Controls for person effects, month-year effects, and uses Inverse Propensity Score Weights				

The research team also analyzed the average number of inpatient hospital visits per member per month. Prior to the ICP, the average member had about .04 inpatient hospital visits per month. Again, following

the implementation of the ICP, there was not a significant change in the average number of inpatient visits PMPM. After the SMART Act was introduced, the average number of inpatient hospitalizations significantly increased by 13.8% for the ICP group over what would happened in FFS. Following the ICP recapitation, there was not a significant change to the number of people who received inpatient hospital services each month. These results are found in Table 73.

4. Payment of Providers

Table 74 summarizes the cost information the MCOs reported to the State as part of the Medical Loss Ratio reconciliation process. The table lists costs the UIC team calculated from the FY11 baseline period for the ICP population and the costs reported for CY11 and CY12 (first two years of the ICP) by the MCOs. Inpatient costs for CY11 were about 25% higher than inpatient costs during the baseline period and in CY12, they had increased another 7% over CY12. Overall, inpatient costs per 1,000 members in CY12 was reported to be almost $3.5 million, more than 42% above the inpatient costs for the year before the ICP started.

Table 74: Spending for Hospitals (ICP Group; $ per 1,000 FTE Members)

Type of Service	FY11 FFS	MCO Historical Comparison		CY12 MCO Detail	
		CY11	CY12	Aetna	IlliniCare
Inpatient	$2,445,952	$3,256,698	$3,488,206	$3,785,765	$3,183,472
Outpatient	$1,206,258	$897,122	$1,004,947	$1,233,121	$771,271
TOTAL	**$3,652,210**	**$4,153,821**	**$4,493,154**	**$5,018,886**	**$3,954,743**

Data Source: FY11 from FFS claims; CY11 and CY12 from Medical Loss Ratio reconciliation by HFS

Table 74 also includes the detail on the two MCOs for CY12 and shows that hospital costs for Aetna were substantially higher than those reported for IlliniCare. Costs per 1,000 members were about 27% higher for Aetna than IlliniCare in CY12 (in CY11, Aetna costs were 30% higher than IlliniCare costs). In relation to the FY11 FFS baseline, both MCOs reported higher costs in CY12, with Aetna's figure about 37% higher than the baseline figure and IlliniCare's 8% higher.

The team reviewed hospital claims for the Chicago comparison group for approximately the same period of time (FY11 thru FY13) to see what changes occurred for the ICP eligible population in the FFS Medicaid program. Table 75 lists hospitals costs for each of these three years. In comparing costs for the two FFS groups during the baseline period, hospital costs for the Chicago group were substantially higher than for the pilot ICP group--35% for total hospital costs and 50% for inpatient costs.

Table 75: Spending for Hospitals (Chicago FFS Group; $ per 1,000 FTE Members)

Type of Service	FY11 (FFS)	FY12	FY13
Inpatient	$3,692,197	$3,688,036	$3,771,415
Outpatient	$1,237,023	$1,482,010	$1,502,694
TOTAL	**$4,929,220**	**$5,170,046**	**$5,274,109**

Data Source: FFS Claims

In reviewing the cost changes from FY11 to FY13, Table 75 shows increases for the Chicago comparison group but ones that were much smaller than for the ICP. Inpatient hospital costs for the comparison

group increased slightly more than 2% while overall hospital costs increased about 7% for the two year period, substantially lower than the 23% increase reported by the MCOs for a similar time period.

This analysis is based on "common members" in the ICP or FFS each year. Because this is not matched with a Chicago comparison group, the differences are not necessarily due to ICP.

E. Behavioral Health Utilization

1. Network Development

Table 76 lists the number of signed community mental health providers for the baseline and the first 3 years of the ICP. Each year the number of providers increased and by FY14 the number of providers per 1,000 members was lower than at baseline but slightly more than half of the baseline rate. Aetna has reported a substantially higher rate of providers in FY14 than IlliniCare (7.3 per 1,000 members vs. 4.8 providers).

Table 76: Signed Providers – Community Mental Health Centers

Measure	Historical Comparison				Year 3 Detail (FY14)[3]	
	Baseline (FFS-FY11)[1]	Year 1 (FY12)[2]	Year 2 (FY13)[3]	Year 3 (FY14)[3]	Aetna	IlliniCare
# of Providers	425	104	263	273	159	114
# of members	41,094	43,642	43,040	45,691	21,873	23,818
Providers per 1,000 members	10.3	2.4	6.1	6.0	7.3	4.8

[1]FY11: Statewide HFS Medicaid Provider Table
[2]FY12: MCO Provider Affiliation Files (June 30, 2012)
[3]FY13 & FY14: HSAG Network Capacity Reports

Table 77 lists individual behavioral health providers that the MCOs reported to HSAG in January of 2015. In some cases the same provider may be duplicated across counties. Therefore, the figures in Table 77 should be taken only as a relative proxy for the strength of the MCO network in terms of signed individual behavioral professionals.

Table 77: Behavioral Health Providers (6 county coverage)[1] as of December 31, 2014

Provider Type	Cook County		Other Counties	
	Aetna	IlliniCare	Aetna	IlliniCare
Mental Health Counselor	64	335	116	154
Psychiatrist	312	244	120	86
Psychologist	135	66	13	25
Social Worker	63	160	38	45

Source: HSAG Network Capacity Report
[1]Sum of providers across 6 counties; likely to be duplicated count

2. Changes in Service Utilization

Table 78 shows that outpatient visits per 1,000 members for community mental health providers has steadily increased each year in the ICP but in FY14 was still about 12% below the baseline rate in FY14

(3,750 visits vs. 4,239 visits per 1,000 members). The difference between the Aetna and IlliniCare in FY14 was substantial–Aetna exceeded the baseline rate with 4,912 visits per 1,000 while IlliniCare was below the FY11 rate with 2,612 visits per 1,000 members.

Table 78: Outpatient Services-Behavioral Health Providers (Visits per 1,000 FTE Members)

Provider Type	Historical Comparison				Year 3 Detail (FY14)	
	Baseline (FFS-FY11)	Year 1 (FY12)	Year 2 (FY13)	Year 3 (FY14)	Aetna	IlliniCare
Community mental health provider	4,238.9	2,304.6	3,264.2	3,750.1	4,911.9	2,611.7
Department of Alcohol and Substance Abuse Provider	328.0	41.1	63.3	35.6	29.7	41.4
TOTAL	**4,566.9**	**2,345.7**	**3,327.5**	**3,785.7**	**4,941.6**	**2,653.1**

Data Source: FFS claims (FY11) and MCO claims (FY12 thru FY14)

Table 79 lists the rate of change for behavioral health providers in the ICP and Chicago FFS comparsion group from FY11 to FY13. The team found a reduction in visits for community mental health providers for both groups during this two year period, but it was much larger for the ICP. However, as noted previously, the rate of visits in the ICP increased each year and is now only about 15% below the baseline. However, the ICP and the comparison group reported very different results for the FY11-FY14 period for alcohol and substance abuse providers. The rate of visits for these providers decreased by about 80% in the ICP while the rate increased by more than 25% for the Chicago comparison group. As noted previously one can not necessarily attribute these differences in the groups to the ICP as this does not take into account differences in the demographics or health conditions for the two groups. This analysis only uses the "common members" and does not match the groups on those differences.

Table 79: Percent Change in Service Utilization-ICP vs. Chicago Comparison Group (Visits per 1,000 Members)

Provider Type	ICP		Chicago Comparison		Percent Change	
	FY11-FFS	FY13-MCO	FY11	FY13	ICP	Comparison
Community mental health provider	4,238.9	3,264.2	5,581.4	5,307.5	-23.0%	-4.9%
Department of Alcohol and Substance Abuse Provider	328.0	63.3	983.2	1,238.5	-80.7%	26.0%

Data Source: MCO Claims
Note: Excludes Hospital Emergency Department Visits

The State tracks 12 quality outcome measures related to behavioral health services. They include measures related to Admissions and Discharges, Assessment and Treatment, and Medications. The next 3 tables summarize rates reported for calendar years 2012 and 2013 and how they compare to the FFS baseline rates.

Table 80 lists 6 quality measures related to Admissions and Discharges for behavioral health services. The first, Mental Health Utilization-Inpatient, lists both MCOs below the baseline rate of 6.11% for CY12. However, in CY13, both plans reported higher rates, with Aetna above the baseline rate. The second measure, related to "intensive" outpatient and "partial" hospitalization, has both MCOs substantially below the baseline rate for both years. In fact, the rates are all less than 10% of the baseline rate.

Table 80: Mental Health Performance Measures (Admissions and Discharges)

Description		Baseline Rate	CY12		CY13	
			Aetna	IlliniCare	Aetna	IlliniCare
MPT	Mental Health Utilization - Inpatient Total	6.11%	5.62%	4.20%	8.49%	5.36%
MPT	Mental Health Utilization - Intensive outpatient/partial Hospitalization Total	2.74%	0.24%	0.12%	0.20%	0.15%
FUH	Follow-Up After Hospitalization for Mental Illness, 7- Day follow-up	34.67%	25.93%	23.03%	26.19%	39.49%
FUH	Follow-up After Hospitalization for Mental Illness (FUH) - 30 day follow-up	55.42%	44.03%	40.90%	49.59%	55.11%
IIMR	Inpatient Mental Hospital 30-Day Readmission Rate*	24.20%	23.34%	27.61%	23.93%	25.28%
MPT	Mental Health Utilization - Outpatient Total	23.32%	21.03%	15.19%	21.55%	14.39%

Data Source: HSAG Reports
*Note: A lower score is better for this measure.

The third measure in Table 80 is "Follow- up after Hospitalization-7 day followup after discharge." Both plans were below the baseline in CY12 but IlliniCare had exceeded the baseline in CY13. A related measure is "Follow-up after Hospitalization-30 day followup after discharge." For both years, both plans were below the baseline rate.

The fifth measure in Table 80, Inpatient Mental Hospital 30 day readmission rate after discharges. For both years, Aetna was below the baseline rate while IlliniCare was above the baseline rate. The last measure in Table 80 is "Mental Health Utilization-outpatient." For both years, both MCOs were below the baseline rate.

Table 81 lists 4 outcome measures related to Assessment and Treatment for behavioral health services. The first measure, "Behavioral Health Risk Assessment-completed within 60 days", has no baseline rate since these risk assessments are not completed for the FFS Medicaid population. In CY12, both plans completed about a quarter of their assessments within the required 60 days. In CY13, Aetna improved slightly and IlliniCare reported a substantial improvement.

The last two measures in Table 81 relate to the percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received appropriate treament. The last two measures include "the percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis" and at the percentage who receive treatment over 30 days after the first visit.

Table 81: Mental Health Performance Measures (Assessment and Treatment)

Description	Baseline	CY12	CY13

			Aetna	IlliniCare	Aetna	IlliniCare
IBHR	Behavioral Health Risk Assessment Completed within 60 Days of Enrollment	N/A	24.89%	27.70%	24.03%	44.42%
IBHR	Follow-up Completed within 30 Days of Positive BHRA	N/A	29.41%	38.77%	20.45%	7.87%
IET	Alcohol and Other Drug Dependence Treatment - Initiation	45.71%	51.53%	53.56%	44.29%	49.69%
IET	Alcohol and Other Drug Dependence Treatment - Engagement	8.97%	6.12%	5.00%	7.75%	6.68%
Data Source: HSAG Reports						

The second measure also relates to behavioral health risk assessments but is focused on follow-up for those members with a "positive" finding on the assessment. Again there is no FFS State baseline—Aetna was between 30 to 40% for both years while IlliniCare was lower for both years, with a substantial decrease in CY13.

Table 82 lists 2 measures related to the prescription and monitoring of medications for behavioral health services. The first measure focuses on "members 18 years of age and older with a diagnosis of major depression and were treated with antidepressant medication, and who remained on an antidepressant medication treatment." The second measure focuses on "members 19–64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period."

Table 82: Mental Health Performance Measures (Medications)

Description		Baseline Rate	CY12		CY13	
			Aetna	IlliniCare	Aetna	IlliniCare
Behavioral Health Measures (Percentages)						
AMM	Antidepressant Medication Management – Acute	52.05%	55.44%	49.31%	76.99%	50.82%
AMM	Antidepressant Medication Management - Continuation	41.52%	47.67%	36.11%	64.52%	36.07%
SAA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	N/A	80.89%	70.97%	81.29%	76.20%
Data Source: HSAG Reports						

3. Payment of Providers

Table 83 compares the spending per 1,000 members for the baseline and for FY13, the second year of the ICP. By FY13, spending for the community health providers within the ICP had almost reached the baseline level but the difference between the two MCOs was substantial, with Aetna reporting twice the rate of spending for these providers than IlliniCare. Spending for alcohol and substance abuse providers in FY13 was still substantially below the baseline rate for both MCOs.

Table 83: Outpatient Spending for Mental Health Providers ($ per 1,000 FTE members)				
Provider Type	**Historical Comparisons**		**FY14 Detail**	
	Baseline (FFS-FY11)	**Year 3 (FY14)**	**Aetna**	**IlliniCare**
Community mental health provider	$289,253	$286,486	$399,817	$175,431
Department of Alcohol and Substance Abuse Provider	$31,963	$4,625	$6,342	$2,943
Data Source: MCO Special Datasets				

F. Nursing Facilities

1. Network Development

From the start of the ICP in May of 2011 through January of 2013, the MCOs were only responsible for services needed by members living in Nursing Facilities (NF) during their initial 90 days after admission to the NF. After the 90 days the financial responsibility for the NF stay transferred back to the State. On February 1, 2013, the MCOs assumed total responsibility for members living in NFs including being responsible for both the skilled and custodial days members spent in the NF.

The roll-out of Service Package 2 (SP2) began on February 1, 2013, when the MCOs became responsible for the long term supports and services (LTSS) of members (except members with developmental disabilities) in addition to their basic medical needs covered by Service Package 1. Both MCOs added additional staff to handle the new responsibilities associated with SP2, including members living in NFs.

According to Aetna's 2013 annual report, "The SPII program began on February 1st with approximately 1,400 members in Nursing Facilities /IMDs." No numbers were available for IlliniCare for the beginning of the SP2 roll-out but according to IlliniCare's 2014 annual report, "IlliniCare currently has 2,127 members who reside in 230 nursing facilities. Seventy-three percent of the facilities have fewer than 10 members."

An important feature added for members during the SP2 rollout was the increased focus on the role of the SNFist (SNF=skilled nursing facility) services in the ICP. The contract summarized SNFist services as follows:

5.5.10 SNFist Program. Contractor shall provide SNFist services, either through direct employment or a sub-contractual relationship. The SNFist program shall provide intensive clinical management of Enrollees in Nursing Facilities. Contractor shall implement one of the following for each Enrollee in a Nursing Facility:

> **5.5.10.1** When appropriate or necessary, the Care Management team will include an additional facility-based Provider (Physician or nurse practitioner) who will deliver care in identified Nursing Facilities.
>
> **5.5.10.2** For all other Enrollees, Care Management through the SNFist program shall be performed by field-based Registered Nurses who will work within each assigned Nursing Facility to provide Care Management and care coordination activities.

For more details regarding the SNFist program see Section "SNFist Services" on page 64.

2. Performance Measures Results

Table 84 lists results for three (3) performance measures the State established regarding care and services provided in NFs. For the first 2 measures, admissions for urinary tract infections and admissions for bacterial pneumonia, both MCOs had substantially lower rates in both CY12 and CY13 than the baseline FFS rate. The third measure, prevalence of hospital acquired pressure ulcers, did not have a State baseline.

Table 84: Long-Term Care Utilization Measures

Description		Baseline Rate	2012		2013	
			Aetna	IlliniCare	Aetna	IlliniCare
IUTI	Long Term Care Urinary Tract Infection Admission Rate*	2.17	0.42	0.48	1.04	0.42
IBPR	Long Term Care Bacterial Pneumonia Admission Rate*	2.42	0.76	0.83	1.01	1.48
IPPU	Long Term Care Prevalence of Hospital Acquired Pressure Ulcers*	N/A	N/A	N/A	0.00	0.97

Data Source: HSAG Reports
*A lower rate is better

3. Payment to Providers

Table 85 shows the capitated rates for NFs, waiver-other, and the community members, both before and after the introduction of Service Package 2. In January of 2013, just prior to the introduction of SP2, the "nursing facility" rate was $1,161 higher than the "community" member rate ($2,146 vs. $985 per month). But in February, with the addition of SP2 capitation payments, the difference between the two cells more than quadrupled to $4,911 ($5,897 vs. $985). Although it is understandable that the NF cell rate needs to be greater due to the needs of the members and the intensity of the 24 hour services they receive in a NF, it was feared that the substantial difference between the NF rate and the rates for the "Community" and "Waiver-Other" cells could introduce an incentive to maintain members in NFs when they no longer needed such services or to admit clients to NFs when they did not need the level of care provided by NFs.

Table 85: History of Capitation Rates

Time Period	Nursing Facility	Community Residents	Waiver-Other
Phase One: Service Package 1 only[1]			
May 2011-April 2012	$2,126.65	$971.35	$1,704.16
April 2012-January 2013	$2,146.33	$985.35	$1,726.74

Phase Two: Addition of Service Package 2			
February 2013	$5,896.52	$985.35	$3,422.86
SP1	$2,146.33	$985.35	$1,726.74
SP2	$3,750.19		$1,696.12
March 2013-Dec 2013	$5,523.63	$890.59	$3,482.71
SP1	$1,773.44	$890.59	$1,786.59
0 SP2	$3,750.19		$1,696.12
January 2014-June 2014	$5,656.91	$928.69	$3,308.93
SP1	$1,473.48	$928.69	$1,701.98
SP2	$4,183.43		$1,606.95
[1]State FFS Medicaid continues to pay for Service Package 2 services			

To deal with this potential issue, the State formally introduced 3 rate adjustments to reduce the incentive to either keep in or admit members to NFs when they did not need this care level (see Table 86). There were 2 "plus" rates put into the MCO's contract that paid a "bonus" to the MCO for discharging a member from a nursing facility. In addition, there was a 3 month delay in the regular and higher NF rate being paid to an MCO for admitting members from either a waiver or community placement.

Table 86: Contractual Incentives Related to NF Admissions/Discharges

Rate Summary	Specific Details
Encourage Discharges from Nursing Facilities	
HCBS Other Waivers Plus	Section 7.1.1 and 7.12 introduced the "HCBS Other Waivers Plus" rate following discharge from NF to a Waiver placement that paid "plus" rate in addition to the regular waiver cell rate for the 3 months following discharge from the NF.
Community Residents Plus	Section 7.1.3 introduced the "Community Residents Plus" rate that paid an extra "plus" rate on top of the regular community capitation rate for 3 months following discharge from NF to a community placement.
Discourage Admission to Nursing Facilities	
90 Day Delay in Payment of NF Rate	Section 7.1.4 specifies that "for the first three (3) months an Enrollee is a resident of a NF following the month of admission to a NF, the Department will pay the Capitation rate being paid during the month of admission, and not [emphasis added] the Capitation rate for the Nursing Facility rate Cell."
Data Source: State-MCO contract	

Table 87 lists the "plus" rates that went into effect in February of 2013. For example, during the period of March thru December of 2013, the MCO would receive an extra $9,196.50 for a member moving from a NF to a Waiver-Other placement ($3,065.50 per month for 3 months). For members being admitted to a NF from a waiver placement, the MCO would continue to be paid at the lower Waiver monthly rate ($3,422.86) for 3 months after admission rather than the higher NF rate ($5,896.52).

Although the contract stipulates the above payments, HFS had not yet been able to implement the rates listed in Table 86 as of June 2015 due to the necessary re-programming in their Medicaid warehouse that had not yet occurred. According to HFS, they have discussed options to eventually make these payments but no decision had been made as of June 2015.

Table 87: Summary of "Plus" Rates[1]		
Time Period	**Community Plus**	**Waiver-Other Plus**
February 2013	$375.02	$3,065.50
March 2013 thru Dec 2013	$375.02	$3,065.50
Jan 2014 thru June 2014	$418.34	$3,324.61
July 2014 thru Dec 2014	$438.35	$3,461.93

[1]Scheduled to go into effect as of Feb. 2013, with the introduction of Service Package 2. As of June 2015, not yet implemented

G. Ancillary Providers

1. Network Development

Table 88 lists various ancillary providers and how they have changed in numbers for the first three years of the ICP. The number of signed laboratories per 1,000 members is slightly below the FY11 rate but the other provider types in Table 88 now exceed the baseline rate in FY14, some substantially so.

Table 88: # of Providers per 1,000 Members (Signed Ancillary Providers)							
Provider Type	**Pre-ICP (FFS) FY111**	**FY122**		**FY133**		**FY143**	
		Aetna	**IlliniCare**	**Aetna**	**IlliniCare**	**Aetna**	**IlliniCare**
Ambulatory Surgical Treatment Centers	0.7	0.1	0.1	0.3	0.3	3.3	1.8
DME Providers	11.1	9.3	11.8	14.5	14.8	13.7	14.7
Home Health Agencies	5.2	1.3	1.1	4.1	4.7	7.5	8.1
Independent Laboratories	1.1	0.6	1.4	1.2	1.8	1.0	1.0

[1]FY11: Statewide HFS Medicaid Provider Table
[2]FY12: MCO Provider Affiliation Files (June 30, 2012)
[3]FY13 & FY14: HSAG Network Capacity Reports

2. Changes in Service Utilization

Table 89 lists visits made by specific additional provider types.Two of these types, "independent labs" and "DME providers" accounted for more than 75% of the baseline visits for this catetgory of providers. For labs, in FY14, the combined MCOs were above the State baseline but Aetna was above the baseline while IlliniCare was below it. For DME providers, both plans were substantially above the baseline rate in Year 3. For home care agencies, both plans were below the baseline rate in the first year of the ICP but both had considerably more visits for these providers over the next two years. In fact, by FY14, both MCOs were reporting 2-3 times the number of visits per 1,000 members as had been reported for the baseline.

Table 89: Summary of Service Days for Ancillary Providers (Visits per 1,000 FTE members)						
Provider Type	**Historical Comparison**				**FY14 Detail**	
	Baseline	**Year 1**	**Year 2**	**Year 3**	**Aetna**	**IlliniCare**

	(FFS-FY11)	(FY12)	(FY13)	(FY14)		
Ambulatory Surgical Treatment Centers	15.9	2.8	3.3	5.5	3.9	7.1
DME Providers	790.5	737.9	828.0	1,047.7	1,024.7	1,070.2
Home Health Agencies - In Home	343.6	196.6	372.4	1,047.4	816.0	1,274.1
Independent Laboratories	1,164.9	978.7	1,054.6	1,243.3	999.5	1,482.1
Data Source: MCO Claims Note: Excludes Hospital Emergency Department Visits						

Table 90 lists the rate of change for these ancillary providers from FY11 to FY13 and compares the change to the change for the Chicago FFS comparison group during the same time period. Table 90 reports a large decrease for Ambulatory Surgical Centers (comparison group had a small increase) and a small decrease for Independent laboratories (the comparison group had a larger increase). Home health agencies and DME providers reported increases under the ICP for the first two years.

Table 90: Percent Change in Service Utilization-ICP vs. Chicago Comparison Group (Visits per 1,000 Members)

Provider Type	ICP		Chicago Comparison		Percent Change	
	FY11-FFS	FY13-MCO	FY11	FY13	ICP	Comparison
Ambulatory Surgical Treatment Centers	15.9	3.3	3.0	3.1	-79.2%	4.1%
DME Providers	790.5	828.0	787.0	677.7	4.7%	-13.9%
Home Health Agencies - In Home	343.6	372.4	179.0	215.7	8.4%	20.5%
Independent Laboratories	1,164.9	1,054.6	994.1	1,221.3	-9.5%	22.9%
Data Source: MCO Claims Note: Excludes Hospital Emergency Department Visits						

3. Payment of Providers

Table 91 compares the spending per 1,000 members from the FY11 baseline with spending in FY14. Spending in FY14 for DME providers, Home health agencies, and labs increased over the baseline level. Spending for pharmacies stayed about the same while spending for Outpatient surgical centers decreased in FY14 when compared to FY11.

Table 91: Outpatient Spending for Ancillary Providers ($ per 1,000 FTE members)

Provider Type	Historical Comparisons		FY14 Detail	
	Baseline (FFS-FY11)	Year 3 (FY14)	Aetna	IlliniCare
Ambulatory Surgical Treatment Centers	$10,854	$2,690	$168	$5,162
DME Providers	$156,359	$180,682	$178,442	$182,878
Home Health Agencies - In	$23,459	$119,684	$81,009	$157,582

Home				
Independent Laboratories	$51,143	$57,431	$47,082	$67,572
Data Source: MCO Special Datasets				

H. Waiver Services

This section reviews the network of waiver providers and services delivered in FY14 and compares those results to those reported for the pre-ICP waiver members in FY11. It focuses on the 4 largest of the 9 waivers (Disability-DRS; TBI-DRS; HIV\AIDS-DRS; and Elderly-IDoA). Specifically, this section analyzes changes for the 1,709 members of these 4 waivers who were in the FFS program just prior to the start of the ICP and remained as ICP members as of FY14. Services for Personal Attendants (PA) were excluded from the service utilization analyses in this section as the MCOs are not responsible for paying the PAs through their claim process-this remains a responsibility of the regular Medicaid FFS system.

Tracking and analyzing waiver providers is typically more challenging than tracking "traditional" providers primarily because waiver providers are not required to obtain a federal National Provider Number (NPI). Less than 1% of waiver providers in the Illinois provider registration table report having an NPI compared to 90-100% of most other provider types. Since most MCOs and clearinghouses that process claims have their systems set up to accept claims with NPIs filled in, claims from Waiver providers may be missing the regular standard provider identification, making it difficult to conduct meaningful analysis on services these providers deliver. Due to this limitation, this section will not report the number of outpatient visits as most other sections have but instead will focus on dollars spent on waiver members for various services.

The research team met with stakeholder groups, waiver providers, and various State agencies that had responsibility for the State waivers. There were four (4) principle concerns about how the MCOs would implement the ICP that repeatedly surfaced during these meetings:

- **Providers**-will there be any restrictions placed on current waiver providers from participating in the new ICP provider networks?
- **Services**-will waiver members still be able to exercise freedom of choice in selecting providers to deliver needed long-term supports and services (LTSS)?
- **Individualized service plans**-will waiver members still have adequate input into the development of individual care/service plans to meet their needs?
- **Care coordination**-will care coordinators continue to have the necessary face-to-face contact with members and be knowledgeable and receive training in LTSS that are related to Medicaid waivers?

As a result of these discussions, the research team addressed the following questions when reviewing the provider network and changes in service utilization for waiver members:

1) What are the differences between providers who enroll with the Medicaid program as designated "waiver service" providers and other enrolled providers in the Medicaid program?
2) What LTSS in Service Package 2 (SP2) are required in the ICP?

3) How many and what type of providers have signed with the MCOs to provide LTSS to waiver members?
4) Has the spending for SP2 services changed under the ICP?
5) How has the proportion of SP2 claims submitted by designated "waiver service" providers changed under the ICP?
6) Has the amount of face to face contact between care coordinators changed under the ICP?
7) What changes were made in the development and monitoring of individual care/service plans under the ICP?
8) Do the care coordinators for the MCOs receive the same type and amount of training as the care coordinators for waiver members in the FFS Medicaid system?

1. Network Development

Differences between providers who enroll with the Medicaid program as designated "waiver service" providers and other enrolled providers in the Medicaid program

The Illinois Medicaid program enrolls and pays 77 different provider types of which 9 are associated with waivers and are called "waiver service" providers, one for each waiver. These providers, in addition to the regular registration process, typically have to go thru additional steps or meet additional qualifications to become a "waiver services" provider. This often includes enrollment with and screening by the "operating" State agency responsible for the waiver (i.e. Department of Aging, Department of Human Services).

There may be special training and unique knowledge/experience that a "waiver service" provider possesses, including knowledge of disability and LTSS. Many of these enrolled "waiver service" providers, unlike other enrolled Medicaid providers, have had ongoing experiences with waiver members, including the delivering of LTSS. They may be unlicensed and frequently could be a friend, family member, or an advocate.

Required long-term supports and services included in ICP's Service Package 2 (effective February of 2013)

Table 92 lists the SP2 services that the MCOs are required to provide for each waiver (depending on member need). Some services, such as "Adult Day Service" and "Homemaker" are required services for all 4 waivers. Other services, such as "Behavioral Services", "Prevocational Services", and "Supported Employment", are required only for the TBI waiver. Table 92 also lists the CPT or other procedure codes that the State and the MCOs have typically required providers to use when submitting claims for these waiver services.

The research team worked with HFS and the MCOs in identifying the CPT codes typically used in claims for these services. Any outpatient claims having a CPT code listed in Table 92 were classified as a Service Package 2 service and any outpatient claims not listed in Table 92 were classified as a Service Package 1 service.

Number and types of providers signed with the MCOs to deliver SP2 services to waiver members

Since the start of SP2, HSAG has tracked waiver providers that MCOs list as being available to deliver waiver services for specific counties. The research team pulled the raw data from HSAG's December 2014 Network Capacity Report and calculated the number of unique providers that each MCO listed as being available to deliver waiver services. Table 93 summarizes the number of these unique providers. Although the provider counts in Table 93 are unduplicated within a specific waiver service, the provider counts are at times duplicated across waiver services since some providers deliver more than one type of service. As a result, simply adding the provider counts in Table 93 will over-count the total number of distinct providers in the MCO's network. In all but one type of service (Personal Emergency Response System) IlliniCare had more waiver providers in their network than did Aetna.

Table 92: Required Service Package 2 (SP2) Services (MCO Contract-Attachment II)

Service	Waiver				Procedure Code
	Aging	DRS	HIV	TBI	
Adult Day Service	X	X	X	X	S5100
Adult Day Service Transportation	X	X	X	X	T2003
Behavioral Services (MA and PhD)				X	H004; H2019
Environmental Accessibility Adaptions-Home		X	X	X	S5165
Habilitation-Day				X	T2020; T2021
Home Delivered Meals		X	X	X	S5170
Home Health Aide		X	X	X	G0156; T1004; T1019; T1021; S5130
Homemaker	X	X	X	X	S5130
Nursing, Intermittent		X	X	X	G0154; T1000;
Nursing, Skilled (RN and LPN)		X	X	X	T1002; T1003; G0152
Occupational Therapy		X	X	X	G0152
Personal Emergency Response System (PERS)	X	X	X	X	S5160; S5161
Physical Therapy		X	X	X	G0151
Prevocational Services				X	T2014
Respite		X	X	X	T1005
Specialized Med. Equipment/Supplies		X	X	X	T2028
Speech Therapy		X	X	X	G0153
Supported Employment				X	T2019

Data Source: Services from MCO contracts; Procedure codes from FFS claims and communication with MCOs

Table 93: Number of Signed Providers[1] (By Service Type)

Service Type	Aetna	IlliniCare
Group Providers		
Adult Day Services	32	51
Adult Day Service Transportation	24	40

Day Habilitation	8	11
Environmental Home Modifications	6	28
Home Delivered Meals	10	14
Home Health Aide	84	129
Homemaker Services	82	132
Nursing Intermittent	12	126
Nursing Skilled	61	128
Occupational Therapy	61	85
Personal Emergency Response System	8	5
Physical Therapy	63	91
Pre-Vocational Services	5	12
Respite Care Services	30	56
Specialized Medical Equipment	9	47
Speech Therapy	59	80
Individual Practitioners		
Occupational Therapist	0	16
Physical Therapist	0	22

Data Source: HSAG Network Capacity Report, December 2014
[1]Unduplicated count of providers within "Service Type" across network but count may be duplicated across "Service Type" as providers may provider more than 1 service type

2. Changes in Service Utilization

During FY11, the year before the ICP began, there were almost 3,400 ICP-eligible waiver members from the 4 major waivers living in the 6 county ICP area. Of these members, a little over half of them (1,709) were still enrolled with either Aetna or IlliniCare as of FY14 (see Table 94). The research team reviewed FFS claims from FY11 and MCO claims from FY14 for these "common" members to determine how services had changed for these members during the first 3 years of the ICP.

From May 2011 thru January 2013, the MCOs were responsible for paying for all of the Service Package 1 (SP1) services (acute healthcare) that waiver members needed, while the State continued paying through the Medicaid FFS program for Service Package 2 (SP2) services (LTSS). Effective February 2013, the MCOs became responsible for paying for SP2 services. So for FY14, which began in July 2013, the MCOs were totally responsible for SP2 services.

Table 94: "Common" Waiver Members

Measure	Baseline (FFS-FY11) July 2010 – March 2011	Year 3 (FY14) July 2013 – December 2013	
		Aetna	IlliniCare
Distinct Members	1,709	793	940

Member Months	15,168	4,350	5,210
FTE Members	1,264.0	362.5	434.2
Data Source: FFS claims (FY11) and Capitation payments from HFS to MCOs (FY14)			

Spending on outpatient services (both SP1 and SP2) for waiver members

Table 95 summarizes the total spending for each of the 4 waivers for Medicaid FFS program in FY11 and the two MCOs in FY14. For example, for the Aging waiver, the FFS Medicaid program paid almost $11,300 in average annual claims for these waiver members. In FY14, both MCOs exceeded the baseline average by more than 35%. Overall, the figures listed in Table 95 indicate that for three of the waivers (Aging, TBI, and DRS), both MCOs in FY14 exceeded the baseline average cost per member. In the fourth, the HIV/AIDS waiver, Aetna exceeded the baseline rate while IlliniCare was about 20% below the baseline rate.

In interpreting these results there are several aspects to consider. First, more spending does not automatically translate to "better" care and higher quality. Second, all of the members in the waiver groups in Table 95 are 3 years older than they were in FY11. As members age, their needs may have increased and the expense of care for these members might have also increased. Third, FY14 was a transition year and the MCOs had to keep all waiver services in place for at least 180 days, which impacts how much flexibility the plans had in changing service levels for FY14. Additional study should be undertaken to determine any future trends. However, given these cautions, the research team thought it was important to report the FY14 spending levels as they compare to the FFS baseline levels.

Table 95: Average Annual Waiver Spending ($ per FTE Member)

Groups	SP1	SP2	Total
Aging Waiver			
Baseline-FY11	$1,886	$9,387	$11,273
Aetna-FY14	$3,516	$12,213	$15,729
IlliniCare-FY14	$4,434	$12,986	$17,420
TBI Waiver			

Baseline-FY11	$2,709	$2,548	$5,257
Aetna-FY14	$4,013	$2,359	$6,372
IlliniCare-FY14	$3,905	$2,033	$5,938
HIV/AIDS Waiver			
Baseline-FY11	$3,907	$1,532	$5,440
Aetna-FY14	$6,373	$2,257	$8,631
IlliniCare-FY14	$2,974	$1,336	$4,309
Disabilities Waiver			
Baseline-FY11	$3,971	$3,033	$7,004
Aetna-FY14	$5,747	$2,641	$8,388
IlliniCare-FY14	$6,304	$1,998	$8,302
Data Source: FFS claims (FY11) and MCO claims (FY14)			

Proportion of claims submitted by designated "waiver service" providers for SP2 services as compared to other Medicaid providers

As mentioned previously, in discussions with other State agencies, and with case managers for the waiver programs, a major concern was whether the MCOs would take active steps to retain the previous experienced ("waiver service") providers once SP2 was implemented. The research team discussed this concern with the two MCOs and HFS and inquired as to any steps that were taken to increase the likelihood of retaining existing waiver providers. The team was told that prior to the SP2 program going "live", both MCOs actively recruited and contacted existing waiver providers in the service area. These efforts included holding "Lunch and Learn" sessions for providers covering such topics such as prior authorization of services and submitting claims. Both MCOs estimated that they were able to secure contracts with a "substantial majority" of the existing waiver providers who were enrolled with the State. (For more detail on steps that Aetna took to increase the successful transition of waiver members and providers to their network, see Table 139 in the Appendix).

To check whether the MCOs retained a "substantial majority" of prior waiver providers, the research team reviewed claims for SP2 services from the FY11 baseline period and claims from both MCOs for FY14 for the same waiver members who were still enrolled in the ICP as of FY14. The team calculated total claims paid for these members and the proportion of those claims going to the "waiver service" providers as compared to other Medicaid providers. It was thought that this comparison would provide some evidence as to how active the pre-ICP waiver providers continued to be after the rollout of SP2.

Table 96 summarizes the spending for SP2 services for the 4 combined waivers for FY11 and FY14 and lists the proportion of those SP2 dollars that was paid to waiver providers as compared to how much other Medicaid providers were paid (greater detail on each of the 4 waivers can be found in Tables 135-138 in the Appendix).

Table 96: Estimated Payments to "Waiver Service" Providers (SP2 Services)[1]

Provider Type	# of Providers	$ Paid for SP2 Services	Percent SP2 $ Paid
FFS (FY11)			
"Waiver Service" providers	150	$4,955,323.65	86.5%
All other Medicaid providers	149	$770,894.44	13.5%

Total	299	$5,726,218	100.0%
Aetna (FY14)			
"Waiver Service" providers (est.)[2]	58	$1,090,496.21	60.5%
All other Medicaid providers	65	$712,588.63	39.5%
Total	123	$1,803,085	100.0%
IlliniCare (FY14)			
"Waiver Service" providers (est.)[2]	47	$1,318,952.75	63.6%
All other Medicaid providers	85	$755,853.39	36.4%
Total	132	$2,074,806	100.0%

Data Source: FFS claims (FY11) and MCO claims (FY14)
[1]Includes the following waivers: Elderly, Disability, HIV, and TBI.
[2]May be an undercount of claims due to missing Provider IDs for an unknown number of providers.

During FY11, SP2 claims for the "common" waiver clients totaled almost $5 million and almost 87% of these claims were submitted by providers designated as "waiver service" providers. The research team reviewed FY14 claims from Aetna and IlliniCare and confirmed that at least 60-65% of the SP2 claim dollars had been paid to "waiver service" providers. This calculates to 70-75% of the baseline level.

The estimates in Table 96 for both MCOs are likely undercounts because the claims systems of both MCOs do not always pick up state Provider IDs. Since the vast majority of "waiver service" providers do not have a NPI, it seems likely that some claims from these providers could be counted instead under the "All other Medicaid providers" line.

As a result, even with likely undercounting, the claims that the UIC team reviewed indicates that both MCOs apparently have been successful in transitioning a "substantial majority" of previous waiver providers into their networks and serving their waiver members.

3. Amount of face to face contact between care coordinators and waiver members

According to the contract, care coordinators providing care management should maintain contact with assigned enrollees "as frequently as appropriate." This would include both face to face contact with the member and other types of contact.

The contract lists some events for which face-to-face contact is required. These include but are not limited to: 1) the initial health risk assessment (Section 5.14.6.1), 2) development of the member's service plan, 3) whenever members have a "significant change" in their condition (Section 5.14.7), or 4) when a member requests a reassessment (Section 5.14.7). Generally, face-to-face contact must take place at minimum every three months for waiver and long term care members, with the exception of HIV waiver members, who require monthly face-to-face contact (as of November 2013, the face to face requirement for HIV waiver members has been decreased to 6 times per year).

Table 97 shows the number of average face-to-face contacts with members that the MCOs reported for the fiscal year. As can be seen, Aetna did not meet the minimum requirements for face-to-face contact for any of the four (4) waiver groups while IlliniCare met the requirements for 2 of the 4 waivers (Brain Injury and HIV/AIDs). The MCOs said that these lower rates of contact are partially because the State did not identify waiver members in a timely manner and indicate that rates of face-to-face contact of have improved since FY14.

Table 97: Annual Face-to-face Contacts (contacts per FTE member)				
Waiver Group	Aetna (FY14)		IlliniCare (FY14)	
	Contract requirement	Actual average contacts reported by MCO	Contract requirement	Actual average contacts reported by MCO
Brain Injury	4	2.5	4	5.9
Elderly	4	2.3	4	2.1
HIV/AIDS	6	5.0	6	6.9
People with Disabilities	4	2.6	4	2.7
Data Source: MCO Outreach Reports to HFS				

Tracking the "average annual contacts per member" for a group does not guarantee compliance with the actual contract requirements. The contract specifies that each member shall receive the minimum contact, not that the overall waiver group average shall meet the contract specification. However, the data in Table 97 can serve as a proxy measure until the time that HFS and the MCOs adjust the measure.

4. Changes made in the development and monitoring of individual care/service plans under the ICP

The Health Services Advisory Group (HSAG), as the External Quality Review Organization (EQRO) for Illinois, completed an annual review of the federal waiver performance measures for the ICP for FY14. Table 98 summarizes compliance with the performance measures that related to care plans.

Performance Measure (PM) 37D lists both MCOs as having completed 99-100% of care plans within 12 months of the review date. PM 38D specifies that the care plan should be updated as the member's needs change. Aetna scored 40% and IlliniCare scored 70% on this measure.

PM 31D, 32D, 33D, and 39D relate to the content found in the written care plan. Both Aetna and IlliniCare generally scored above 50% for these measures except for PM 39D, which relates to the type, amount, and frequency of services being specified in the care plan. Both Aetna and IlliniCare scored below 10% for this measure.

Consumer participation is measured by PM 35D and 41D. Both plans scored very high (93% and 97%) on giving members the "opportunity to participate in choosing types of services and providers" but very low in obtaining signatures of the member on the care plan.

There are 2 PMs related to personal assistants (26C and 49G). Aetna was rated at 45% for having completed the personal assistant evaluation while IlliniCare received a score of 77%. In terms, of having the name of the backup personal assistant, both plans scored well below 50%.

Any performance measures that HSAG finds in less than 100% compliance is required to enter "remediation" by the MCO. In the next annual review, HSAG will conduct "validation reviews" to ensure that MCOs have complied with the non-compliance findings. HSAG will draw a sample of members from each waiver and their records examined to ensure remediation occurred and was reported accurately by the MCO.

In addition to remediation, the State can also use other techniques it deems appropriate, such as corrective action plans, sanction letters, financial penalties, and suspension/termination from the program. According to HFS, no other actions other than remediation has been used with either Aetna or IlliniCare as of June 2015.

Table 98: Care Plans - Waiver Performance Measures

PM#	Description	Aetna	IlliniCare
Completion and Update of Care Plans			
37D	PD, HIV, and Elderly Waivers—The most recent care plan is in the record and completed in a timely manner.	100%	99%
38D	Care plans and service plans are updated when the enrollee needs it changed.	40%	70%
Content of Care Plans			
31D	The most recent care plan includes all enrollee goals as identified in the comprehensive assessment.	64%	72%
32D	The most recent care plan includes all enrollee needs as identified in the comprehensive assessment.	31%	79%
33D	The most recent care plan includes all enrollee risks as identified in the comprehensive assessment.	66%	85%
39D	The most recent care plan includes the type, amount, and frequency of services (including the number of hours each task is to be provided per month).	0%	7%
Consumer Participation			
35D	The most recent care plan includes signature of enrollee (or representative) and case manager, and dates of signatures.	0%	1%
41D	The enrollee has been given the opportunity to participate in choosing types of services and providers	93%	97%
Personal Assistants			
26C	The personal assistant evaluation is completed and in the record at the time of the most recent assessment/reassessment (BI, HIV, and PD Waivers).	45%	77%
49G	BI, HIV, PD Waivers—The most recent care plan includes the name of the backup personal assistant (PA) service (if receiving PA).	11%	38%

Data Source: HSAG Home and Community-Based Service (HCBS) Waivers-Summary of Findings and Recommendations (January 19, 2015)

5. Type and amount of training related to disability and waiver services that MCO care coordinators receive

According to Section 5.11.2.2 of the MCO contracts, care coordinators who serve members on waivers must receive at least 20 hours of training per year, prorated to 1.5 hours per month. (For more detail on specific training requirements, see Table 1 in the Appendix). Although the MCOs do track training that their own coordinators receive, the research team was not able to collect comparable data on the topic for the two MCOs. The team was informed, that beginning in CY 2014, HSAG will begin collecting information regarding the training of care coordinators. At the time that this report was published, HSAG had conducted their first round of evaluations for this area but results had not yet been finalized.

However, HSAG shared with the research team the methodology and tools that they used during this review (see Table 129 in Appendix A).

I. Pharmacy

1. Impact of SMART Act

In July 2012 (start of FY13), the SMART Act took effect in Illinois and made substantial changes to the traditional Medicaid program. The impact of some of these changes is documented in the research team's Year 2 report. Specifically, related to pharmacy services in the State's FFS program, changes included a) tightening of the prior authorization process, b) increase in the co-pays for members, and c) increased use of generic medications. It was expected that these changes would have an impact on the medication usage of both the Chicago FFS comparison group and the ICP population enrolled with the MCOs.

The Year 2 report, for the Chicago FFS comparison group, compared drug utilization for FY11 (just prior to the start of the ICP) on certain measures with the rates found for FY13 (after the first year of the SMART Act). Overall, the days' supply of meds per 1,000 member months decreased by about 23% (from 100,022 to 76,831 days per 1,000 MM) while costs for the Chicago comparison group decreased by about 29% during the same time period (from $282,321 to $200,668 per 1,000 MM). It seemed reasonable that the SMART Act was a contributing factor for much of this decrease. This is shown in Table 99.

Table 99: Initial Impact of SMART Act on Chicago and FFS Comparison Group

Measure	ICP		Chicago		Percent Change	
	FY11-FFS	FY13-MCO	FY11	FY13	ICP	Chicago
Scripts/Utilization						
% Utilizing members	77.70%	79.80%	79.30%	80.20%	2.7%	1.1%
Scripts per 1,000 MM	3,783.30	4,332.00	3,899.50	2,836.40	14.5%	-27.3%
Days' supply per script	25.7	25.9	25.7	27.1	0.8%	5.4%
Days' supply per 1,000 MM	97,752.10	112,220.90	100,022.10	76,831.10	14.8%	-23.2%
Cost						
Cost per script	$73.29	$61.06	$72.40	$70.75	-16.7%	-2.3%
Cost per 1,000 MM	$277,259	$264,516	$282,321	$200,668	-4.6%	-28.9%

Source: HFS claims and MCO encounters

At the same time, unlike the Chicago FFS comparison group, the days' supply of medications for ICP members saw an increase of about 27% while costs also decreased, although by a smaller % than the decrease reported for the Chicago FFS comparison group (for more detail, see Table 100 in next section).

2. FY14 Update

The research team again reviewed drug utilization data to determine what changes had occurred during FY14 in supply and costs of medications for ICP members. The team also reviewed the drug formularies

and the prior authorization processes the MCOs used to control drug utilization and the tracking of certain drug classes the State required the MCOs to report on.

3. Days' supply of Medications

Table 100 shows that the days' supply of medications per 1,000 member months decreased by about 2% from FY13 to FY14 for ICP members but was still about 12% above the FFS baseline of FY11. In addition, the number of scripts per 1,000 MM and days' supply per script approved by the MCOs in FY14 were also higher than were the corresponding rates for the FY11 baseline group.

Table 100: Pharmacy-Days' supply and Cost (ICP Population)

ICP Population	ICP eligible			ICP FY14 Detail	
	FY11-FFS	FY13-MCO	FY14-MCO[1]	Aetna	IlliniCare
Days' supply					
Days' supply per 1,000 MM	97,752	112,221	109,914	113,382	106,596
Scripts per 1,000 MM	3,783	4,332	4,170	4,295	4,049
Days' supply per script	25.8	25.9	26.4	26.4	26.3
Cost					
Cost per 1,000 MM	$277,259	$264,516	$264,642	$275,269	$254,477
Cost per script	$73.29	$61.06	$63.47	$64.08	$62.84

Source: MCO reports to HFS
[1]FY14 = July 2013 – February 2014

Costs of medications

Cost per script paid by the MCOs in FY14 increased by about 4% from the cost in FY13 but was still about 13% less than the average cost per script during the FY11 baseline period. The average cost per 1,000 member months increased slightly (by 0.6%) in FY14 when compared to the FY13 average cost. However, when compared to the FY11 baseline, cost per 1,000 member months was still more than 4% lower in FY14 than in the baseline.

Processes used to control drug utilization

The MCOs in the ICP used common methods to review and restrict medication usage including the use of generic substitutes for brand names, the use of standard drug formularies, and use of prior authorization requests. For example, Table 101 shows that the 2 MCOs increased the usage of generic medications by almost 8% in FY14 when compared to the baseline rate in FY11. In addition, about 96% of the scripts for both plans were written for medications on the MCO's formulary (it was not possible to obtain similar data from the State for the FFS population).

Table 101: Pharmacy Scripts Drug Formulary (FY14)

ICP Population	FY11-FFS	FY13-MCO	FY14-MCO	ICP FY14 Detail	
				Aetna	IlliniCare
Generic vs. Brand Scripts					
Generic Scripts (%)	80.0%	86.5%	86.4%	86.0%	86.9%
Drug formulary					

% Scripts from formulary	N/A	97.3%	96.7%	96.0%	97.4%
Source: MCO Special Datasets					

Table 102 summarizes prior authorization requests for medications under the ICP (the research team requested but was not able to obtain data regarding prior authorization of medications for the regular Medicaid FFS program). For the ICP, the number of prior authorizations requests reported per 1,000 member months for the two plans decreased by 9% from FY13 to FY14.

There are two types of requests: standard and expedited. For standard requests, the required turn-around time for a decision from the plan is 10 days, however, if the MCO or provider believe the member's condition requires a speedier decision, the request can be "expedited" and the plan is required to render a decision within 24 hours.

Table 102 indicates that approximately 55% to 60% of requests, regardless of whether they are standard or expedited requests, are approved by both plans. Both MCOs rendered their decision (approve/deny) on "standard" requests 99% of the time within the required 10 days.

Table 102: Pharmacy Prior Authorization Requests

Year	ICP eligible		ICP FY14 Detail	
	FY13-MCO	FY14-MCO	Aetna	IlliniCare
# of Total Requests	11,371	12,694	4,528	8,166
TOTAL requests per 1,000 MM	26.8	24.4	18.7	29.4
STANDARD requests per 1,000 MM	21.8	21.6	14.5	27.8
EXPEDITED requests per 1,000 MM	5	2.8	4.1	1.6
Standard Requests-outcomes				
% Decision made within 10 days	99.4%	99.2%	99.5%	99.1%
% Approved	55.0%	59.4%	66.6%	56.1%
Expedited Requests-outcomes				
% Decision made within 1 day	92.0%	55.4%	46.2%	84.5%
% Approved	62.3%	56.1%	50.0%	75.3%
Data Source: MCO Special Datasets				

In terms of expedited requests, for the two plans combined, 55% of the "expedited" requests were decided within the required 24 hour time span. However, the rates for the two plans are substantially different. In FY14, Aetna decided 46% of expedited requests within 24 hours, while IlliniCare rendered a decision 85% of the time within 24 hours.

Tracking of specific classes of drugs

The State requires the MCOs to track ongoing medication usage by its members from several perspectives. For instance, the State tracks how well the plans "monitor" members (typically conducting at least 1 test per year) who are on 4 different classes of "persistent" medications. These drug classes include angiotensin converting enzyme (ACE) inhibitors, angiotensin receptor blockers (ARB)], digoxin, diuretics and anticonvulsants. Table 103 lists the baseline rate for the FFS Medicaid program and the

rates for all four drug classes for both MCOs for CY12 and CY13. For both years, both of the plans exceeded the baseline rate for appropriate monitoring and follow-up on these medications.

Table 103: Annual Monitoring of Patients on Persistent Medications						
Description		Baseline Rate	CY 2012		CY 2013	
			Aetna	IlliniCare	Aetna	IlliniCare
MPM	Patients on ACEI or ARBs	86.00%	89.59%	89.21%	89.89%	90.66%
MPM	Patients on Digoxin	81.46%	94.04%	91.61%	86.81%	93.37%
MPM	Patients on Diuretics	86.60%	89.38%	89.66%	89.97%	91.71%
MPM	Patients on Anticonvulsants	74.49%	80.72%	78.77%	81.21%	80.21%
MPM	Patients on Persistent Medications - Total	84.12%	87.84%	87.67%	88.24%	89.33%
Data Source: HSAG Reports						

Table 104 lists the % of members utilizing at least one medication from specific drug classes. It should be noted that for Tables 104, each MCO decides which medications are categorized into which drug class, thus making the comparisons in the two tables somewhat tentative.

Table 104: Usage of multiple meds in same drug class (60 days or more)					
Drug Class	Criteria (# of meds)	FY13[1]		FY14[2]	
		Aetna	IlliniCare	Aetna	IlliniCare
Any Psychotropic medication	5	0.6%	0.2%	0.6%	0.2%
Any ADHD medication	2	0.0%	0.0%	0.0%	0.0%
Any antidepressant medication	3	0.3%	0.2%	0.2%	0.2%
Any antipsychotics	2	2.3%	1.6%	1.8%	1.9%
Any atypical antipsychotics	2	1.1%	1.6%	0.8%	0.5%
Any benzodiazepine or benzodiazepine hypnotics	2	0.4%	0.4%	0.4%	0.3%
Data Source: MCO Reports for HFS [1]June 30, 2013 [2]June 30, 2014					

In any given month, about 60% of members are using at least one type of medication (the rate is typically closer to 80% of the members when an entire year is considered). Between 30-40% of members typically use at least 1 psychotropic medication. (See Table 140 in the Appendix for details on the types of medications used by MCO members)

The State and the MCOs also track the number of members who are using multiple drugs within specific drug classes (see Table 104). For example, in FY14, the proportion of Aetna members using 5 or more psychotropic medications was small but was 3 times the number of IlliniCare members (0.6% vs. 0.2%).

4. Analysis of Prescription Drug Utilization Using a Matched Sample

The research team conducted analyses of the changes in prescription pharmacy utilization, comparing people in the ICP group with people in the FFS group. These groups have several baseline differences. To account for these differences and use the entire population of people enrolled in ICP, the research team used a difference in difference design with a matched comparison group to assess the impact of ICP by

estimating what would have happened with the ICP group regarding prescription drug utilization if ICP had not been implemented (see the section entitled "Comparison Group Matching and Difference in Differences Design" on page 12 for more details). The research team used two measures of utilization: the proportion of people who had any prescription drug utilization in a given month and the average number of prescriptions received each month per person.

To put the effect estimates in perspective, the research team examined the utilization levels of eventual ICP members during the 9 months before the ICP program actually started. Each month during the pre-test period, about 54.5% utilized at least one prescription. After the start of the ICP, the proportion of members with at least one pharmacy service per member per month significantly increased by about 10.5 percentage points; about 19.3% more members had at least one prescription in a given month than during the baseline. These results are found in Table 105.

Table 105: Impact of ICP on Pharmacy Utilization (Matched Sample[1])

Factor	At Least Pharmacy Service PMPM		Average Pharmacy Services PMPM	
	Coefficient (Std Err)[2]	Percent Change	Coefficient (Std Err)[2]	Percent Change
Pre ICP Mean Utilization PMPM	**0.5448659**		**4.007529**	
Overall Impact of ICP (January 2012-December 2013)	0.105*** (0.003)	19.27%	0.201*** (0.030)	5.02%
Additional impact following the SMART Act (July 2012-December 2013)	0.022*** (0.002)	4.04%	0.760*** (0.017)	18.96%
Additional impact of re-capitation (March 2013-December 2013)	-0.005** (0.002)	-0.92%	0.211*** (0.014)	5.27%

Notes: Within R^2=0.001; Data Source: FFS and MCO claims for July 2010-Dec. 2013
**p<.01; ***p<0.001
[1]Controls for person effects, month-year effects, and uses Inverse Propensity Score Weights

When the SMART Act was introduced, the proportion of members with at least one prescription per member per month increased by 2.2 percentage points, significantly increasing the number of enrollees who received at least one prescription each month by 4.0%. After the ICP was recapitated, there was a significant reduction in the proportion of people who received at least one prescriptions by .5 percentage points, or 0.9% of the ICP population.

The research team also looked at the average number of prescriptions received per member in a given month (as opposed to the proportion of the enrollees who used prescription drugs each month, which is shown above). Before the start of ICP, the average member in the ICP group received just over 4.0 prescriptions per month. After the implementation of the ICP, this increased significantly by .2 services per month, a 5% increase in the average number of prescriptions per member per month over the baseline. When the SMART Act was introduced and pharmacy services were reduced in FFS, the effect on the ICP population was an increase of .76 prescriptions on average per month, almost a 19% increase. After ICP recapitation, there was another significant increase by .21 prescriptions per month, another 5.3% increase. Taken together, after ICP was implemented, SMART Act was introduced, and

recapitation, the number of pharmacy services received by a member in a month increased by over 1.1 prescriptions on average for the ICP group compared to what would have happened in FFS. This is also shown in Table 105.

J. Accessibility of Provider Offices

Accessible provider offices are essential to meeting the needs of members with disabilities and ensuring quality healthcare.

1. Enrollee Experiences with Accessibility

The enrollee survey asked a number of questions about experiences with accessibility in primary care providers' offices. As noted in Table 106, enrollees do experience some problems with accessibility when they go to see a primary care provider. This is especially true for people who need a sign language interpreter as 61% of the 18 people who needed a sign language interpreter did not receive one. It is not clear whether respondents asked for one and whether they followed the procedures for receiving a sign language interpreter that each MCO uses. About 29% of respondents reported rarely or never being able to get on the examination table, while fewer than 20% of respondents noted rarely or never being able to use and move around the restroom. These findings are similar to last year's findings and indicate that there are still many offices without accessible examination tables and restrooms.

Table 106: Responses to UIC Survey Questions about Accessibility

Question	N	% Always	% Usually	% Rarely	% Never
How often were you able to get on the examination table?	889	51.4%	19.1%	18.3%	11.1%
How often were you able to use and move around the restroom?	791	68.9%	12.6%	8.6%	9.9%
If you needed a sign language interpreter, how often did you receive one?	18	5.6%	16.7%	16.7%	61.1%

Data Source: Special datasets provided by MCOs for FY13 and FY14

2. MCO Contracts

According to the MCO's final contract, "All Provider locations where Enrollees receive services shall comply with the requirements of the Americans with Disabilities Act (ADA). Contractor's network shall have Provider locations that are able to accommodate the unique needs of Enrollees" (section 2.8, p. 25). The contract made ADA compliance and accommodations a key point for the MCOs to consider when setting up provider networks. However, there are no other requirements specified for provider accessibility other than this very general criteria. Guidance on access to medical care from the Department of Justice, details what it means under the Title II, Title III of the ADA and Section 504 of the Rehabilitation Act of 1973 to provide "full and equal access to healthcare services and facilities" (ada.gov, 2010). Access to examination rooms as well as medical equipment (lifts, weight scales, exam tables, exam chairs, and radiologic equipment) are critical to providing equal access. This section

examines how MCOs have translated this language into assessments of providers and will discuss the strengths and limitations of their approach.

MCOs track whether provider offices are accessible for members through a provider self-assessment (either one overall item or a short series of questions) included as part of their enrollment form completed as part of their contracts with the MCOs.

Monitoring provider office accessibility is a slight improvement from the complete lack of monitoring under FFS. However, there are inherent deficiencies in self-assessment especially if they are reduced to one overall question on ADA compliance, which the provider may or may now have knowledge about. Currently, these self-assessments are not supplemented or verified by independent checks by the MCOs or a third party organization.

The feedback from the consumer survey indicated that there were still some problems with the accessibility of exam tables and restrooms. The MCOs collected data on specific aspects of provider office accessibility rather than merely asking providers a less reliable global question on accessibility.

3. Self-Assessment Process

Table 107 summarizes the self-assessment process that is completed by providers in both MCOs. Information was taken from conversations and documents provided by MCOs. The Medicaid FFS program does not have any self-assessment procedures for determining accessibility of offices.

Table 107: Self-Assessment Procedures for Assessment of Office Accessibility

Definition or Process Questions	ICP-Aetna	ICP-IlliniCare
1. How is the self-assessment completed by providers?	Each provider completes information on accessibility as part of the provider applications	Provider completes a self-assessment paper form upon credentialing.
2. When does the provider fill out the self-	During credentialing	During credentialing

assessment?		
3. How often is the self-assessment updated?	During re-credentialing	During re-credentialing, every 3 years
4. What components of accessibility are captured through the self-assessment? (number of questions per category)	Handicap Accessible (1), Accommodates: Developmentally Disabled (1), Physically Disabled (1), ASL (1), TDD/TTY(1), has Adjustable Exam table (1)	Parking (2), routes (1), entry ways (6), signage (1), elevators (1), restrooms (7), exam rooms (1), equipment (2), & accommodations (1).
Note questions arose from relevant contract sections: In section 2.7.3, page 24 of the final contract, "During the credentialing and re-credentialing process, Contractor will confirm the languages used by Providers, including American Sign Language, and physical access to Provider office locations." In section 2.8, page 25 of the final contract: "All Provider locations where Enrollees receive services shall comply with the requirements of the Americans with Disabilities Act (ADA). Contractor's network shall have Provider locations that are able to accommodate the unique needs of Enrollees." Data source: Conversations with MCO, Aetna provider application form, IlliniCare Self-Assessment ADA form		

4. Self-Assessment Results

Table 108 summarizes the self-assessment data by provider office locations. It highlights the components of provider offices. The results indicate that there is room for improvement in terms of the accessibility of different aspects of provider offices. The rates of offices with accessible exam tables, restrooms, weight scales and sign language interpreters is much smaller than the rates of 100% and 90.5% for the overall measure of accessibility. This exemplifies the reason that a one question overall assessment is not useful or accurate. IlliniCare does not collect data on availability of sign language interpreters and Aetna does not collect information about restrooms or weight scales.

Table 108: Self-Assessment of Office Accessibility and Components (Rates)

ICP Population	ICP eligible			ICP FY14 Detail	
	FY11-FFS	FY13-MCO	FY14-MCO	Aetna	IlliniCare
Total Office Locations		4,934	6,777	3,545	3,232
% of offices self-reported accessible		79.0%	95.5%	100.0%	90.5%
Components of Offices					
Exam table			27.6%	50.5%	2.4%
Restroom				N/A	6.0%
Weight scale				N/A	2.4%
Sign language				4.6%	N/A
Data Source: Special datasets provided by MCOs for FY13 and FY14					

As these results demonstrate, there is no clear common criteria that all providers use in their overall self-assessment. Providers seem to apply their own definitions. The self-assessment process alone is inadequate. Realizing that a third party verification process is needed, the MCOs have begun conducting on-site assessments, though we have not received any of the data collected through these assessments. Table 143 in the Appendix shows the MCOs' plans for conducting on-site assessments of provider office accessibility as indicated in previous documents sent from MCOs and conversations with their representatives. In addition, the research team was notified by HSAG that they have developed tools to

evaluate ADA compliance of providers in the MMAI managed care program in Illinois and will begin using these tools for their next review of the ICP. These tools will provide much more detail and data regarding provider accessibility than the current self-assessment tools used by the ICP.

K. Transportation

Transportation is often cited as a barrier to accessing healthcare among Medicaid recipients. It is important to examine the quality of transportation provided as well as whether MCOs are meeting the demand for transportation, ensuring that members are able to keep consistent appointments with their medical providers. This section focuses on the non-emergency transportation services (NEMT) services provided by the MCOs.

1. Has the process that members use to request and schedule NEMT changed?

Similar to Fee-For-Service (FFS) Medicaid, both MCOs used a transportation broker who manages scheduling of trips, prior authorizations and payment to individual transportation providers. Unlike FFS where the State pays the broker's claims, the MCOs pay a capitation to the transportation broker who then makes the payments to individual providers. Both MCOs had a contract with the same transportation broker in FY14, Medicaid Transportation Management (MTM) for Non-Emergency Medical Transportation (NEMT). IlliniCare contracted with First Transit for the first part of FY14.

There have been several improvements to NEMT as part of the ICP. They include:

- As part of MCO procedures, additional entities, such as Care Coordinators are able to schedule trips for members.
- FFS Medicaid has more strict regulations on members having to go to the closest appropriate medical provider and least expensive mode of transport. While MCOs have similar goals, these are not part of their guidelines.
- FFS Medicaid seems to have more strict eligibility criteria for who is eligible for NEMT. MCOs highlight that every member is eligible. However, MTM, uses a screening process to make sure that people who have personal automobiles, have family/friends that provides rides, utilize paratransit or can take public transportation do not use the NEMT service.
- Similar to FFS Medicaid, members in the ICP can get reimbursed for gas mileage when using their personal vehicles.
- MCO care coordinators have access to an online scheduling program that they can use to schedule rides for members.
- Lastly, unlike in FFS Medicaid, MCOs allow members to stop at pharmacies after medical visits on their trip home to obtain medications.

2. Has the amount of NEMT transportation provided changed (Trips requested, trips approved, trips completed)?

NEMT trips are scheduled through a call center by members, providers as well as Care Coordinators. Table 109 displays Non-Emergency Medical Transportation (NEMT) data for FY13 and FY14 on the number of trips scheduled, completed, and the reasons that trips were not completed. While HFS also uses a transportation broker to provide transportation services to Chicago members, they were not able

to provide data on scheduling of NEMT in FY11 or any subsequent years. Based on last year's report, transportation brokers for the MCOs and HFS collected similar scheduling information and had a dedicated call center. IlliniCare's previous transportation vendor did not collect data on scheduling, and in 2014 they changed transportation vendors.

IlliniCare has a slightly higher percentage of completed trips and a smaller percentage of cancellations by the provider than Aetna. However, IlliniCare had more cancellations by members and more member "no shows". Cancellations from providers occur for many reasons, such as operator errors, wrong information, and no transportation vendor being available. Data was not provided on the number of cancellations by providers or denials in FY13. One of the limitations of the data is that it does not show whether members cancelled or did not show up because they were forced to find other means of transportation as a result of providers being late. IlliniCare's transportation vendor did not collect scheduling information for FY13 or the first part of FY14.

Table 109: Non-Emergency Medical Transportation (NEMT) Trip Completion (Rates)

ICP Population	ICP FY13		ICP FY14	
	Aetna	IlliniCare*	Aetna	IlliniCare**
Total requested trips	131,738		213,297	89,554
Total denied trips	N/A		2,468	1,212
Total approved trips	131,738		210,829	88,342
Total completed trips	115,427		138,062	62,040
% of approved trips completed	87.6%		65.5%	70.2%
Reasons for non-completion because of member actions				
% of trips with member "no show"	29.7%		17.6%	22.0%
% of trips canceled by member	65.3%		19.1%	48.5%
Reasons for non-completion because of provider actions				
% of trips with provider "no show"	5.0%		0.9%	1.0%
% of trips canceled by provider	N/A		61.6%	26.9%

*No data was available in FY13 from IlliniCare
**IlliniCare data is only for the 2nd part of FY14 when they changed vendors
Data Source: Special datasets provided by MCOs for FY14 and FY13

3. Has the proportion of members using NEMT transportation changed?

To examine the use of transportation services, special datasets were provided to UIC from each MCO's transportation broker. HFS provided claims data for members in FFS Medicaid before and during the ICP. In order to make equivalent comparisons, a new metric called Travel Days was developed and represents a day when a member utilized a transportation service. A travel day may have several trips and each trip may include several claims submitted by a transportation provider. The number of travel days per year could be compared across groups and years.

Table 110: Non-Emergency Medical Transportation Utilization

ICP Population	ICP eligible			ICP FY14 Detail	
	FY11-FFS	FY13-MCO	FY14-MCO*	Aetna*	IlliniCare
% of members utilizing NEMT**	14.6%	16.1%	20.5%	21.0%	18.3%
Travel days per utilizing member per year***	18.7	17.2	13.6	15.2	15.9

Table 110 below, shows 20.5% percentage of members utilized non-emergency medical transportation (NEMT) in FY14 compared to 16.1% in FY13 and 14.6% in the baseline period (FY11). Details on each MCO also show that the percentage of members utilizing NEMT was 21.0% for Aetna and 18.3% for IlliniCare. The number of travel days per member went down in FY14 to 13.6% from 17.2% in FY13 indicating that while more members were utilizing NEMT, they were using NEMT for less days on average.

Although Table 110 indicates that only about 20% of enrollees used transportation services through an MCO, it remains the largest topic of grievances for consumers. One of the more common themes concerned transportation "no shows" and lateness.

4. Have the types of NEMT transportation used by members changed?

The quality of transportation services is also defined by whether members are placed in vehicles that meet their current level of function and need. Table 111 describes the type of vehicles being used to provide non-emergency transportation and the percentage of the total travel days where each vehicle type was used. From baseline to FY13, the use of a few categories increased (notably Taxis and Service

Cars) and others decreased (Non-emergency Ambulance and Medicars). This trend continued in FY14. The MCOs noted that they used taxi services only when other transportation providers were not available. Aetna did not separate out Taxi vs. Medicar in FY14 and so 84% of their travel days are in those 2 categories. A table that describes each vehicle type is provided in the Appendix in Table 141.

Table 111: Travel by Category of Service (Percent of Travel Days)					
	ICP eligible			ICP FY14 Detail	
	FY11-FFS	FY13-MCO	FY14-MCO	Aetna	IlliniCare
Total travel days	88,682	99,022	116,229	58,095	58,134
Percent of Travel Days Served by Category of Service					
Non-emergency Ambulance	4.1%	2.6%	4.1%	5.0%	3.1%
Medicar	19.5%	7.7%	3.2%	5.7%	0.6%
Taxi	2.5%	11.9%	84.7%	84.0%	18.6%
Service Car	69.1%	73.1%	80.7%		65.9%
Private Transportation	2.0%	2.5%	1.6%	3.1%	0.0%
Bus or Paratransit	2.9%	2.1%	2.2%	2.1%	2.3%
Other			4.7%		9.5%
Data Source: Special datasets provided by MCOs for FY14 and FY13; Claims data from FFS FY11					

5. How have the costs of NEMT transportation changed?

There were some substantial changes in transportation costs during the ICP. Table 112 shows the total cost spent on emergency and non-emergency transportation in FY13 compared to FY11 for the Chicago and ICP groups. The last columns show the percent change from FY11 to FY13 for the ICP group and the Chicago group. Total non-emergency costs and non-emergency costs per 1,000 member months more than doubled in the ICP. Emergency transportation is provided through the MCOs and not through their broker, MTM. The MCOs paid more per 1000 member months for emergency transportation compared to Chicago. MCO transportation brokers paid the transportation providers more than in Chicago for non-emergency transportation as well. The costs more than doubled for non-emergency transportation for ICP members.

Table 112: Cost of Transportation*						
Costs per 1000 MM	ICP		Chicago		Percent Change	
	FY11	FY13	FY11	FY13	ICP	Chicago
Emergency costs	$5,498	$6,290	$6,342	$5,584	14.4%	-12.0%
Non-emergency costs	$5,242	$11,058	$5,747	$6,226	111.0%	8.3%
Data Source: Claims paid to transport providers from FFS FY11 and Chicago FY11 and FY13; Managed Care claims paid in FY13						

An explanation of the methodology that the research team used to check the accuracy of this increase is included in the Appendix in "Transportation Analysis Methods for the Increase in Costs" on page 164. To better understand where the costs increased among non-emergency transportation, cost was stratified according to the type of vehicle used in Table 113.

Table 113: Cost per Travel Day by Type of Vehicle

ICP Population	ICP Eligible			ICP FY14 Detail	
	FY11-FFS	FY13-MCO*	FY14-MCO*	MTM (Aetna)	MTM (IlliniCare)
Non-emergency Ambulance	$122	$216	$217	$251	$162
Medicar	$21	$59	$93	$99	$38
Taxi	$17	$61	-	$56	$22
Service Car	$17	$39	-		$32
Private Transportation	$17	$18	$11	$11	-
Bus or Paratransit (other)	$25	$6	$6	$5	$8
Other			$20		$20

*ICP costs are payments made by the Transportation Brokers MTM and First Transit to transport providers
Data Source: Special datasets provided by MCOs for FY14 and FY13; Claims data from FFS FY11

The cost of transportation increased substantially for most vehicle types in FY13 compared to FY11. The increase was especially pronounced in non-emergency ambulances ($216, increased from $122 in FY11), taxis ($61, increased from $17 in FY11) and Medicars ($59, increased from one dollars in FY11). The cost of non-emergency ambulances was about the same in FY14, although Medicar increased again to $93 (with a large difference between Aetna ($99) and IlliniCare ($38)).

The impact of the ICP on costs was also examined through a matched difference-in-difference (DID) analysis using propensity score matching. See Section "Comparison Group Matching and Difference in Differences Design" on page 12 on the methods used for matching members in the Chicago sample to the ICP members. Table 114 shows the costs per member month between ICP and Chicago members from FY11 to FY13 for outpatient visits only. Additional sub-group analyses were conducted for each of the waiver groups.

Table 114: Cost of Transportation Services to Outpatient Visits by Special Group

ICP Population	ICP*		Chicago		Treatment Effect	Significance
	FY11	FY13	FY11	FY13		
Total members	$5.02	$16.92	$5.01	$6.50	$10.41	p<.001
Physical Disabilities	$8.83	$39.24	$12.82	$14.68	$28.54	p<.001
Developmental Disabilities	$2.94	$3.21	$5.01	$5.02	$0.25	p=.835

Long Term Care	$21.36	$31.86	$17.31	$24.07	$3.74	p=.292
Brain Injury	$10.58	$32.25	$9.93	$14.06	$17.54	p=.314
HIV/AIDS	$26.15	$40.18	$8.21	$12.25	$9.99	p=0.56
Elderly	$5.29	$31.49	$3.61	$7.09	$22.73	p<.05
Community Residents	$3.14	$14.01	$2.78	$3.71	$9.95	p<.001
Assisted Living SLF	**	**	**	**	**	**

*ICP costs are payments made by the Transportation Brokers MTM and First Transit to transport providers
**No members from this group
Note: Cost = Transit cost /member month
Data Source: Claims from MCOs and Chicago FFS

The matched DID showed that the effect of the ICP was a $10.41 per member per month increase in transportation costs. The waiver group analysis indicated that the effect was significantly higher for individuals with physical disabilities and those on the Elderly waiver. These groups are probably more likely to use specialized transportation services.

6. What proportion of doctor's appointments is NEMT provided? Did the proportion change as a result of the ICP?

One of the key questions for evaluating transportation, is whether consumers receive transportation when it was needed? Did they receive transportation when they had a doctor's appointment? To examine this question, the research team calculated the proportion of outpatient visits where transportation was provided.

The treatment effect of the ICP (p<0.001) per member was a 4.6% increase in the proportion of outpatient visits where transportation was provided (see Table 115). Additional subgroup analyses of this proportion showed that the effect of the ICP was greater for some groups, such as members with physical disabilities (7.5%) but less for other groups, such as individuals with developmental disabilities (-4.6%). These results indicate that members are getting transportation when it is needed at a slightly higher rate than those in the FFS Chicago comparison group. However, some groups are not being provided as much transportation as others when they have medical appointments.

Table 141 in the Appendix examines utilization only among people with 1 or more trips. On average, people enrolled in Medicaid who used transportation services only used them for 30-40% of their outpatient visits. For other visits, they obtained other forms of transportation, whether by choice or by problems experienced, such as a providers not showing up to provide a ride. Future research should examine how people get to doctor's appointments for more than half of their outpatient visits.

Table 115: Proportion of Outpatient Visits Where Transportation Was Provided

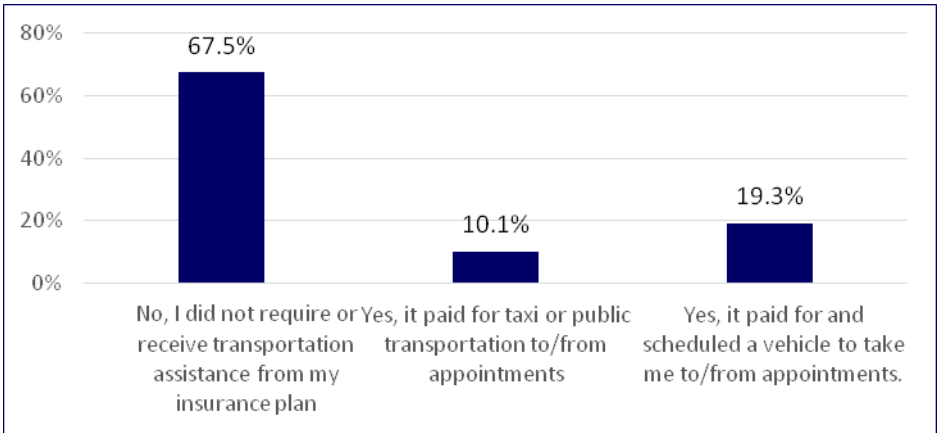
ICP Population	ICP		Chicago		Treatment Effect	Significance
	FY11	FY13	FY11	FY13		
Total Members	4.1%	8.8%	5.2%	5.3%	4.6%	p<.001
Physical Disabilities (n=3,686)	8.9%	15.3%	13.2%	12.1%	7.5%	p<.001
Developmental Disabilities	3.9%	2.7%	7.9%	11.4%	-4.6%	p<.001

(n=2,965)						
Long Term Care (n=6,666)	17.8%	13.4%	19.0%	17.8%	-3.2%	p<.01
Brain Injury (n=915)	10.8%	11.8%	16.3%	17.4%	-0.1%	p=0.97
HIV/AIDS (n=373)	15.1%	16.0%	8.3%	11.8%	-2.6%	p=0.60
Elderly (n=2,085)	5.2%	9.0%	4.9%	5.5%	3.2%	p<.01
Community Residents (n=73,903)	2.4%	8.3%	2.4%	2.8%	5.50%	p<.001
Data Source: Claims from MCOs and Chicago FFS						

7. Have member perceptions towards NEMT transportation changed?

In our consumer survey, members were asked about transportation services they received from MCOs. Figure 17 shows whether or not an enrollee received transportation assistance from their insurance plan and what type of assistance they received. Most enrollees (n=702, 67.5%) reported that they did not require or receive transportation assistance from their insurance plan (although it is likely that many of these enrollees did not need assistance). About 10% received transportation assistance via taxi or public transportation. About 19% received transportation assistance from their insurance plan via a scheduled vehicle (19.3%).

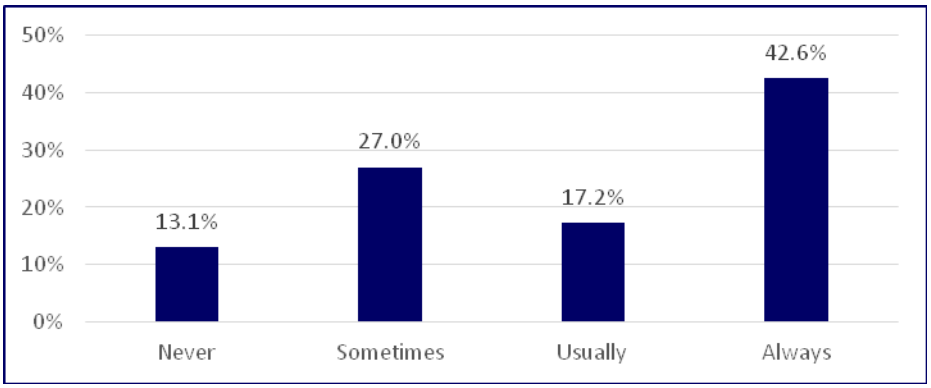
Figure 17: Did you receive transportation assistance from your insurance plan in the last year? If so, how did it help? (FY14)



Among people who reported needing transportation assistance from their insurance plan (n = 122), most reported that they always or usually received the assistance (59.8% combined). However, over 40% never or only sometimes received the transportation assistance they needed.

Figure 18: How often did you get the transportation help you needed from your insurance plan? (n=122)

How have provider networks and service utilization changed over time?



8. Summary and Findings

- MCOs have made some important improvements to the scheduling and implementation of NEMT. A useful addition has been the tracking of scheduled, denied, completed and cancelled trips. This information helps to put into context the consumer complaints related to transportation and was previously unavailable under FFS.
- The % of members using NEMT was slightly higher during the ICP period and the % is consistent with what is reported through our Consumer Survey. More noteworthy, was that the proportion of outpatient visits with transportation provided increased significantly more for ICP members than for Chicago members in FFS. Subgroup analyses showed differential impact for different waiver groups and that for some groups the proportion of outpatient visits that transportation was provided actually decreased. Future research could inquire into why certain groups aren't using NEMT as much through additional surveys or focus groups.
- The cost of NEMT paid per member increased during the ICP. Our analysis indicated that in part it was due to changes in the types of vehicles used, and to an increased capitation payment made to the MCOs transportation broker in charge of administering NEMT.
- Among NEMT users, transportation was provided for 30-40% of outpatient visits. It appears that for a majority of visits, members find other forms of transportation to their provider. It may be important to convene a meeting with transportation experts and stakeholders about transportation policy to develop guidelines for appropriate levels of service for NEMT in Illinois. Additional research is needed to understand how much of a burden transportation to most of the doctor's visits are on members and their families.

How has mortality changed as a result of the ICP?

The purpose of this section was to examine whether the ICP had any impact on mortality rates, a large concern in the transition to managed care.

A. Data and Methodology

UIC obtained data regarding member deaths for both the baseline period prior to the start of the program and during the first two years and 9 months of the program. Data was obtained through HFS and came from various sources within State government. Member information was cross-verified with other datasets by HFS staff. The end date for this study period was Feb 28, 2014 because after this time the Chicago group began to be enrolled in various managed care programs. The only information provided to the team about deaths was the death date, but nothing about the cause of death. Absent of this information, it is critical that the groups compared have similar characteristics, which can be accomplished through propensity score matching (described in the section entitled "Comparison Group Matching and Difference in Differences Design" on page 12).

B. Data Analysis

The UIC team attempted to conduct analysis that makes use of enrollment data as a measure of the time a person was at risk. The plan was to calculate the death per person years enrolled as well as the Relative Risk, which compares the incidence rate between groups. The team set out to conduct the analysis using a sample that was matched using propensity score weights. However, there were several limitations with both the both the mortality data and the enrollment data that precluded a valid analysis.

C. Limitations

The primary limitation was that the death dates did not always match up perfectly with the enrollment dates, and partially because the 2 datasets came from different data systems.

- HFS stated that deaths are only officially certified by the Illinois Department of Public Health (IDPH) up until 12/31/2012. There is currently a backlog in the process. While this data is still used by other Illinois State Agencies, changes may occur. Hence, there were inconsistencies in dates of enrollment and dates of death wherein people who had died were not yet taken off the enrollment data either at baseline or in FY14.
- Approximately 41% of members were missing baseline (FY11) demographic information when using the full sample of enrollees in the intervention period FY12-14. The death rates for those with demographic data (0.48) are lower than the death rates for those without the demographic data (0.079) The relative risk for those without demographic data compared with those with the data is 1.65 ($p<0.0001$), suggesting an increased risk for those without demographic data.

What are the recommendations for the Integrated Care Program?

After collecting data and evaluating the Integrated Care Program over the last four years, the research team has a number of recommendations for the State and the MCOs in order to improve the program and its implementation. The team recommends:

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

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

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

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

3. Continue to improve reporting standards for MCOs.

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

standardization of these reports so that consumers, legislators, and other stakeholders can make better comparisons between the plans.

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

- In meetings with stakeholders, including providers and community agencies, a frequent frustration expressed was not knowing who to contact regarding their complaints and suggestions. HFS should consider assigning a dedicated point person for stakeholder groups to contact with concerns.
- Coordination between HFS and senior agencies has improved, but there is still room for improvement. Many sister agencies do not have adequate information to work seamlessly within the managed care system.
- The team recommends that HFS begin holding regular stakeholder meetings at least twice each year to disseminate select information regarding the ICP. This would include updates on provider network, grievances and appeals, and other topics that the State deems as important. HFS has continued to improve the regular collection of data from the MCOs but very little of it has been released to the public. HFS should create a committee of HFS staff, MCO staff, and external stakeholders to decide which data could be shared with the external public and at what intervals.
- When the results of special reports regarding performance measures and other special areas of interest are published, a special meeting should be held with stakeholders to release these results and answer any questions/concerns related to the report. Stakeholders have informed the research team they are unaware of these special reports.
- The State should upgrade the current capitation payment system to focus on two problems:
  - Ideally recognize within 3 months when a member has moved to a new capitation cell and adjust the payment for that member.
  - Implement the 2 “plus” rates and the 90 day freeze rate related to movements into and out of the nursing facility capitation cell.

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

- It has been difficult to establish correct enrollment figures for the ICP program. Enrollment figures calculated from capitation payments made by HFS to the MCOs do not typically match MCO data. Ideally, all reporting entities should be using the same enrollment data for their reports.
- The existing State legacy system that tracks FFS enrollment and movement within the system is inadequate for tracking enrollment and member movement in the managed care environment and needs to be either upgraded or replaced.
- The current auto enrollment process emphasizes primary care physicians over specialists. For many people with disabilities, a specialist may be more important, because specialists are rarer and it can be difficult to find one with knowledge of specific conditions. Hence, in those cases a

specialist should be assigned to the person in the auto-enrollment process rather than a primary care physician. Before the State uses primary care as the second step in the auto enrollment process, the enrollment broker should reach out to the member by telephone to explain the options and encourage the eligible individual to make an active choice on MCOs rather than being auto enrolled.

- The State should convene a task force that includes representatives from HFS, the MCOs, DSCC, parents and other stakeholders to clarify policy about the transitioning of young adults into managed care programs when they age out of DSCC.

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

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

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

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

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

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

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

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

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

- Examine the definition of SNFist and be sure it is aligned with best practices in the SNFist field today. In particular, consider prioritizing and requiring the use of SNFists in an attending role, given the reported difficulties that SNFists often have with a consultative role.
- The State should review and seal contracting procedures for SNFists.
- State should have an independent party review the SNFist role in the ICP, the processes and methods used, the cost and health outcomes of members receiving SNFist services, and the impact the SNFist has had on member movement in and out of nursing facilities
- State should upgrade the current capitation payment system to permit the payment of the 2 "plus" rates and the 90 day delay in full nursing facility rate payment for new NF admissions as specified in the MCO contracts. This would strengthen the incentives for proper nursing facility placements.

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

- The State needs to continue evaluation work around mortality in ICP and other managed care initiatives.
- In order to adequately assess mortality, high quality data on deaths and enrollment is needed. Similarly, complete demographic data is needed to compare different groups of people and adjust for different demographic compositions.
- HFS should work to ensure that the enrollment data is accurate and that it gets updated when members die.

- Illinois Department of Public Health should work to keep official death records up to date so that any statistics developed on mortality are accurate.

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

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

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

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

Appendix: Extra Tables

A. Enrollment

- Table 116: Enrollment Process (Summary)

Table 116: Enrollment Process (Summary)	
Item	**Description**
How can a member enroll in the ICP (mail, online)?	A member may enroll in ICP by contacting the Illinois Client Enrollment Broker (ICEB) call center or by going online to enroll via the ICEB Program Web site.
What type of assistance is the member given regarding the various plans?	Members can: (1) read information about their Plan choices in the enrollment packet they receive in the mail, which includes a comparison chart, (2) received unbiased education from ICEB Customer Service Reps, (3) check the ICEB Program Website for information about each Plan, and (4) contact Aetna or IlliniCare directly to learn more about their plan.
How long does the member have to make a decision of which plan they will choose?	A member has 60 days to select a Plan and PCP. If a member does not make a voluntary choice, the ICEB will auto-assign the member to a Plan and PCP based on an auto-assignment algorithm that takes into consideration a members current PCP, claims data and location.
Is the member given information regarding providers in the area?	Members can: (1) use the ICEB Program Website to search for providers on their plan and in their area, (2) contact the ICEB call center for assistance, and (3) contact their Plan's service call center for assistance.
Can others (family, friends, and advocates) help the member during the enrollment process?	Yes, if a member has provided the necessary authorizations, a family member, friend, or other representative may assist the member with the enrollment process via the ICEB Call Center or ICEB Program Web Site.
When can a member switch plans under normal circumstances?	During the first 90 days of enrollment and during the members Open Enrollment Period.
Are there any other circumstances, other than the open enrollment period, under which a member can switch plans?	Yes, during the first 90 days of enrollment and during their lock-in period for cause.
How is the member aware of the open enrollment period and the choice he/she has?	The ICEB will mail the member an Open Enrollment Packet notifying them that they are in their Open Enrollment Period and may switch Plans. If the member does not switch, they will stay enrolled with their current Plan for another 12 month period.
Data Source: HFS	

B. Rebalancing

- Table 117: ICP Pilot Area Member Movement Year Beginning to Year End
- Table 118: Performance Measures: Member Movement

Table 117: ICP Pilot Area Member Movement Year Beginning to Year End			
Movement Type	**Aetna**	**IlliniCare**	**Total N (%)**
Began FY14 in Community ICF/MR	244	159	403
Stayed	211 (86.5%)	145 (91.2%)	356 (88.3%)
Moved to State ICF/MR	0 (0.0%)	0 (0.0%)	0 (0.0%)
Moved to Nursing Home	2 (0.8%)	0 (0.0%)	2 (0.5%)
Moved to DD Waiver	5 (2.0%)	1 (0.6%)	6 (1.5%)
Moved to Non DD Waiver	0 (0.0%)	0 (0.0%)	0 (0.0%)
Moved to Community Residents	1 (0.4%)	0 (0.0%)	1 (0.2%)
Left ICP	25 (10.2%)	13 (8.2%)	38 (9.4%)
Began FY14 in State ICF/MR	139	111	250
Stayed	118 (84.9%)	101 (91.0%)	219 (87.6%)
Moved to Community ICF/MR	1 (0.7%)	0 (0.0%)	1 (0.4%)
Moved to Nursing Home	0 (0.0%)	0 (0.0%)	0 (0.0%)
Moved to DD Waiver	4 (2.9%)	3 (2.7%)	7 (2.8%)
Moved to Non DD Waiver	0 (0.0%)	0 (0.0%)	0 (0.0%)
Moved to Community Residents	1 (0.7%)	0 (0.0%)	1 (0.4%)
Left ICP	15 (10.8%)	7 (6.3%)	22 (8.8%)
Began FY14 in Nursing Home	1378	1431	2809
Stayed	1055 (76.6%)	1019 (71.2%)	2074 (73.8%)
Moved to Community ICF/MR	0 (0.0%)	0 (0.0%)	0 (0.0%)
Moved to State ICF/MR	0 (0.0%)	0 (0.0%)	0 (0.0%)
Moved to DD Waiver	1 (0.1%)	1 (0.1%)	2 (0.1%)
Moved to Non DD Waiver	8 (0.6%)	11 (0.8%)	19 (0.7%)
Moved to Community Residents	83 (6.0%)	80 (5.6%)	163 (5.8%)
Left ICP	231 (16.8%)	320 (22.4%)	551 (19.6%)
Began FY14 in DD Waiver	1036	799	1835
Stayed	916 (88.4%)	697 (87.2%)	1613 (87.9%)
Moved to Community ICF/MR	2 (0.2%)	3 (0.4%)	5 (0.3%)
Moved to State ICF/MR	0 (0.0%)	1 (0.1%)	1 (0.1%)
Moved to Nursing Home	2 (0.2%)	1 (0.1%)	3 (0.2%)
Moved to Non DD Waiver	0 (0.0%)	0 (0.0%)	0 (0.0%)
Moved to Community Residents	3 (0.3%)	3 (0.4%)	6 (0.3%)
Left ICP	113 (10.9%)	94 (11.8%)	207 (11.3%)
Began FY14 in Non DD Waiver	1396	1790	3186
Stayed	1098 (78.7%)	1387 (77.5%)	2485 (78.0%)
Moved to Community ICF/MR	2 (0.1%)	0 (0.0%)	2 (0.1%)
Moved to State ICF/MR	0 (0.0%)	0 (0.0%)	0 (0.0%)
Moved to Nursing Home	9 (0.6%)	11 (0.6%)	20 (0.6%)
Moved to DD Waiver	17 (1.2%)	8 (0.4%)	25 (0.8%)
Moved to Community Residents	37 (2.7%)	36 (2.0%)	73 (2.3%)
Left ICP	233 (16.7%)	348 (19.4%)	581 (18.2%)
Began FY14 in Community Residents	13269	16152	29422
Stayed	10317 (77.8%)	12274 (76.0%)	22591 (76.8%)
Moved to Community ICF/MR	1 (0.0%)	0 (0.0%)	1 (0.0%)
Moved to State ICF/MR	1 (0.0%)	1 (0.0%)	2 (0.0%)
Moved to Nursing Home	67 (0.5%)	64 (0.4%)	131 (0.4%)
Moved to DD Waiver	48 (0.4%)	44 (0.3%)	92 (0.3%)
Moved to Non DD Waiver	152 (1.1%)	237 (1.5%)	389 (1.3%)
Left ICP	2683 (20.2%)	3532 (21.9%)	6216 (21.1%)
Data Source: HFS capitation payments to MCOs Note: Percentages displayed are based on row totals			

Table 118: Performance Measures: Member Movement						
Description		Baseline Rate	Aetna		IlliniCare	
			2012	2013	2012	2013
IMWS	Movement of Members - Started and Ended in Community	NA	NA	82.59%	NA	79.84%
IMWS	Movement of Members - Started and Ended in HCBS (LTSS)	NA	NA	78.91%	NA	74.45%
IMWS	Movement of Members - Started and Ended in LTC	NA	NA	80.95%	NA	73.41%
IMWS	Movement of Members - Total Medicaid Members with No Movement	NA	NA	82.12%	NA	78.93%
IMWS	Movement of Members - No Longer Enrolled	NA	NA	14.47%	NA	17.67%
Data Source: HSAG Reports						

C. Call Centers

- Table 119: IlliniCare: Reasons for Calling the Call Center
- Table 120: Call Center Statistics

Table 119: IlliniCare: Reasons for Calling the Call Center	
Description	IlliniCare % of Total Calls
Misc. (transfers to vendors, transportation, etc.)	10.8%
Eligibility inquiry	9.3%
PCP/PMP Change Request	4.8%
Specialist Search	4.2%
Vision Provider Search	3.7%
PCP Search	3.6%
Member Material Request/ID Card Request*	3.5%
Member Info Updates/Phone Number	2.9%
Dental Provider Search	2.9%
Authorization Status Inquiry	2.6%
Source: IlliniCare Annual Report, FY14	

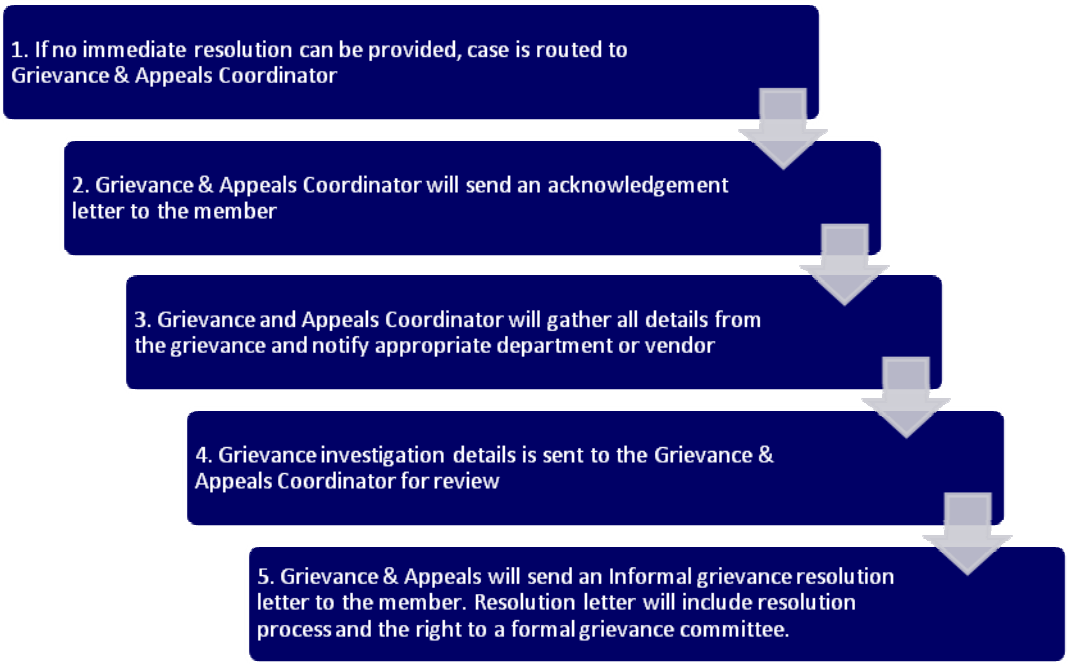
Table 120: Call Center Statistics

Month	Average Time to Answer (seconds)		Call Abandonment Rate (%)	
	Aetna	IlliniCare	Aetna (Goal <5%)	IlliniCare (Goal <4%)
July 2013	2	N/A	1 .6%	N/A
August 2013	10	9	4.3%	1.0%
September 2013	10	17	4.7%	2.2%
October 2013	2	13	1.5%	1.8%
November 2013	5	7	2.6%	0.8%
December 2013	4	8	2.2%	1.2%
January 2014	10	15	4.4%	2.0%
February 2014	4	19	1.8%	2.2%
March 2014	6	9	2.6%	0.9%
April 2014	13	18	3.8%	3.3%
May 2014	9	14	2.9%	2.0%
June 2014	6	7	3.1%	0.6%
Source: Aetna and IlliniCare Annual Reports, FY14				

D. Grievance and Appeals

- Figure 19: IlliniCare's Grievance Process

Figure 19: IlliniCare's Grievance Process



E. Complaints

- Table 121: Difference between "Complaint," "Grievance," and "Appeals"

- Table 122: Overview of Complaint Process (FY13)
- Table 123: Timelines for “Complaint,” “Grievance,” and “Appeals” (FY13)
- Table 124: Responsibilities of the Plans (FY13)
- Table 125: Critical Incidents Process Table

Table 121: Difference between “Complaint,” “Grievance,” and “Appeals”		
Contact Section	**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. IlliniCare: "A Grievance is an expression of dissatisfaction from a member (or authorized representative) while an appeal is a request to reconsider a decision to limit, terminate or deny a service or item such as a DME. Grievances not resolved to the member's satisfaction can be escalated to Grievance Committee for further review, then to the Department. Appeals can be escalated to external review, fair hearing process, or both."
Data Sources: MCO Contracts		

Table 122: Overview of Complaint Process (FY13)

Item	Aetna	IlliniCare	FSS Medicaid
How to Submit	Mail-Yes; Fax-Yes; Phone-	Mail-Yes; Fax-Yes; Phone-	Mail-Yes; Fax-No; Phone-Yes;

Grievance	Yes; Online-No	Yes; Online-No	Online-No
Initial Response Timeline	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.	Member/Provider files "complaint" with Illinois Health Connect--which has 30 days to respond.
2nd Level	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.	If member/provider not satisfied, he/she may file "appeal" with HFS thru the "Fair Hearing" process.
Data Sources: MCO and FFS Handbooks and Narratives			

Table 123: Timelines for "Complaint," "Grievance," and "Appeals" (FY13)

Code of Federal Regulations Section	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 appeal
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
Data Sources: MCO Contracts		

Table 124: Responsibilities of the Plans (FY13)

Contract Section	Question	Contract Language
Attachment XIII	What information does the plan	Contractor shall submit a detailed

	need to track for grievances and appeals?	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.
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.
Data Sources: MCO Contracts		

Table 125: Critical Incidents Process Table		
Measure	**Aetna**	**IlliniCare**
How does a	Information Not Yet Received	A critical incident can be reported to the MCO in a

critical incident get reported?		number of ways: by a provider; the care coordinator may observe an issue that requires reporting to law enforcement, OIG or Adult Protective Services. Examples of reportable incidents include, but are not limited to, a personal assistant padding hours, evidence of neglect or abuse; a member could report to the MCO that s/he is being abused. When a care coordinator receives such a report or observes a reportable issue such as neglect or abuse, that person is required to notify his/her IlliniCare manager within 4 hours; additional reporting to the appropriate agency is also required.
Who reports a critical incident?	Information Not Yet Received	For issues not involving potential fraud, the care coordinator is responsible for reporting the issue to the appropriate agency. For potential fraud, IlliniCare Compliance reports to the OIG and HFS for SFY 2014 and forward.
How does a MCO follow up on a critical incident?	Information Not Yet Received	Care coordinators continue to monitor members for whom a critical incident is reported. In some situations, changes need to be facilitated to protect the member such as removing a personal assistant. If the situation warrants, additional critical incidents will be reported. If reported to a law enforcement agency, the MCO may not receive official follow-ups from that agency. We will follow up with the member directly, but may not have any access to official follow-ups by other agencies.
Data Sources: Phone Interviews with Representatives from each MCO		

F. Care Coordinators

- Table 126: Overview of Care Coordination Activities by "Sister" State Agencies
- Table 127: Care Coordinators – Qualifications and Required Training (FY14)
- Table 128: Care Coordinator Caseload Monitoring Methodology
- Table 129: Care Coordinator Training Monitoring Methodology

Table 126: Overview of Care Coordination Activities by "Sister" State Agencies			
Department of Aging	**Division of Rehabilitation Services**	**Division of Mental Health**	**Division of Alcoholism and Substance Abuse**

How soon after the initial referral does this evaluation have to be completed?			
Staff have 30 calendar days (unless there is participant delay, which can create up to 60 calendar days) to complete assessment, determine eligibility and care plans for *IDoA* with feds	Agency did not respond to this question.	The provider shall complete a mental health assessment report within 30 days after the first face-to-face contact for services not initiated with an Admission Note or Healthy Kids mental health screen.	There is no mandated time frame from point of initial contact to the date of the first assessment
Does this evaluation have to done in person?			
Yes.	Agency did not respond to this question.	Mental health assessment (MHA) can be completed through face-to- face, video conference or telephone contact with the client and collaterals, resulting in the identification of the client's mental health service needs and recommendations for service delivery	Assessments must be in person unless the agency meets established protocol for video counseling.
Are there other assessments in addition to the initial intake evaluation that are used in the development of the care plan?			
The CCC assessment has addendums that CMs are required to use if a client "triggers" on these topics during the assessment	BI customers are about the only customers who have other assessments: neuropsychiatric exams. Most other customers do not.	DMH requires a LOCUS assessment when a client presents for service and is registered/enrolled in the DMH database. The LOCUS must be updated at a minimum of every 6 months while the client is receiving Rule 132 services	Each agency selects its own tools that need to fit the standards
Are there maximum caseloads for the care coordinators and if so, what are they?			
There is no maximum in the State rules now, although we do have max for proposed rules. Proposed rules are in flux so cannot be shared at this time	Agency did not respond to this question.	No.	No.
Are there any minimal requirements for contact between care coordinators and the members on their caseload (in person and otherwise), and if so, what are they?			
Care Coordinators are required to complete a redetermination at least annually & upon the request of the participants. Care Coordinators are also required to respond to	Agency did not respond to this question.	No.	No.

participant requests within 15 calendar days.			
Are satisfaction or quality of life surveys completed for consumers, and if so, how often?			
POSM surveys are completed upon initial assessment and then annually for all CCP clients (waiver and State funded). Annually, IDoA sends a satisfaction survey to randomly selected participants. Not all participants or provider agencies are selected.	No.	Generally, DMH conducts consumer perception of care surveys periodically for a random stratified sample of individuals receiving services. Although previously, these surveys were conducted annually, the last time the survey was conducted was approximately 2 and ½ years ago. We plan to conduct surveys again this year however. Quality of life and perception of care surveys are currently conducted every six months for a subset of individuals (Williams Class Members) for whom DMH purchases services.	We have no DASA generated satisfaction surveys; DASA's provider agencies may do surveys on their own or not.
Data Source: Conversations with State agencies			

Table 127: Care Coordinators – Qualifications and Required Training (FY14)	
FFS Waiver	**Requirement**
Qualifications	
Elderly Waiver	1. Registered Nurse licensed in Illinois 2. Bachelor's degree in nursing, social sciences, social work, or related field 3. LPN with one year experience in conducting comprehensive assessments and provision of formal service for the elderly

	4. One year satisfactory program experience may replace one year college education, at least four years' experience replacing baccalaureate degree
Disabilities	1. Registered Nurse licensed in Illinois 2. Licensed Clinical Social Worker 3. Licensed Marriage and Family Therapist 4. Licensed Clinical Professional Counselor 5. Licensed Professional Counselor 6. PhD 7. Doctorate in Psychology 8. Bachelor or Master's Degree prepared in human services-related field 9. Licensed Practical Nurse
Brain Injury	1. Registered Nurse licensed in Illinois 2. Certified or Licensed Social Worker 3. Unlicensed Social Worker: minimum of bachelor's degree or at least three years' experience working with people with disabilities 4. Vocational Specialist: certified rehabilitation counselor or at least three years' experience working with people with disabilities 5. Licensed Clinical Professional Counselor 6. Licensed Professional Counselor 7. Certified Case Manager
HIV/AIDS (must meet 1 of 3)	1. Registered Nurse licensed in Illinois and bachelor's degree in nursing, social work, social sciences or counseling or four years case management experience 2. Social worker with bachelor's degree in either social work, social sciences or counseling (bachelor's or masters of social work from a school accredited by nationally recognized organization for accreditation of social work schools preferred) 3. Individual with bachelor's degree in human services field; minimum five years case management experience
	Additionally – Care Coordinator for HIV/AIDS Waiver enrollees must have experience working with: • Addictive and dysfunctional family systems • Racial and ethnic minorities • Homosexuals and bisexuals • Substance abusers
Training Requirements: Minimum 20 hours in-service training initially and annually. For partial employment years: training prorated to equal 1.5 hours per full month of employment. Care coordinators must be trained on topics specific to HCBS Waiver type enrollee served. Training must include:	
Elderly Waiver	Aging-related subjects
Supported Living Waiver	Training on the following subjects: resident rights; prevention and notification of abuse, neglect, and exploitation; behavioral intervention; techniques for working with elderly and persons with disabilities; disability sensitivity training
TBI Waiver	Training relevant to provision of services to persons with brain injuries
HIV/AIDS Waiver	Training relevant to provision of services to persons with AIDS (e.g., infectious disease control procedures, sensitivity training, updates on information relating to treatment procedures)
Data Source: HSAG	

Table 128: Care Coordinator Caseload Monitoring Methodology

In May 2015, HSAG conducted an annual review of HCBS Waiver Care Coordination/Case Management Caseload requirements for Aetna and IlliniCare. In order to determine the total Full-Time Equivalent (FTE) allocation serving the waiver population for a health plan, HSAG requested that IlliniCare provide FTE equivalent of each staff member assigned to waiver enrollees. When a staff member served both waiver and non-waiver enrollees, then

the health plans provided the portion of that staff member's FTE that was allocated to serving the waiver population. In addition to staffing allocations, the HSAG review assessed caseload requirements to ensure each care coordinator responsible for enrollees with varying risk levels had an overall caseload that met requirements for case limits and case mix. Each plan was required to report on the caseload of each staff member serving the waiver population for each program.
Data Source: HSAG

Table 129: Care Coordinator Training Monitoring Methodology
In May 2015, HSAG conducted an annual review of the HCBS Waiver Care Coordination/Case Management Staffing, Qualifications, and Training requirements for Aetna and IlliniCare. In order to collect the staffing and training information, HSAG developed a standardized data collection tool. Related to the training of MCO coordinators, HSAG reviewed the educational qualifications, related experience, and annual training hours against the CMS HCBS program requirements. Immediately following this section is a copy of the “qualifications” and “training requirements” from the contract that HSAG used for their review. Care coordination staff assigned to HCBS Waiver enrollees are required to have a minimum 20 hours in-service training initially and annually. For partial employment years: training is prorated to equal 1.5 hours per full month of employment. Care coordinators must be trained on topics specific to the HCBS Waiver type they serve. To evaluate if the MCO met the HCBS training requirements, HSAG reviewed the number of annual training hours completed by HCBS waiver staff, the HCBS Waiver Training Curriculum, and the employee training sign-in sheets and or training attestations. HSAG developed a HCBS Training Requirements Review Tool to capture the waiver training requirements and a copy of this tool immediately follows this section. Training categories were scored as either "Pass" or "Fail." If gaps were identified for health plans, HFS requested a corrective action plan to be completed within a specified time period.
Data Source: HSAG

G. Role of DSCC

1. Overall Description

The Division of Specialized Care for Children (DSCC) based at the University of Illinois at Chicago is the Illinois Title V agency that provides care coordination for families and children with special healthcare needs. DSCC serves over 16,000 families with professional staff located in 13 regional offices throughout the State.

DSCC operates two main programs, the MF/TD waiver and the Core Program for non-waiver children with special health needs.

2. MFTD Waiver

The Medically Fragile and Technology Dependent (MF/TD) Waiver is a home and community based services waiver, also called a 1915(c) waiver. It is a Medicaid program that the federal government has granted to the State of Illinois to prevent costly institutionalization and permanent hospitalization of children who need medical technology. This waiver waives the family income eligibility requirement.

Most children on this waiver are ventilator-dependent, have tracheostomies, or have central IV lines, and require extensive care and services. Without this waiver, most of these children would require permanent hospitalization to receive their care. Children throughout the State are eligible for the waiver as long as they are under 21, meet medical eligibility, require ongoing home nursing, can safely be cared for at home, and the cost of care is less than it would be in a hospital or skilled nursing facility.

Waiver services include respite care, environmental modifications, vehicle modifications, extermination services, assistance with utilities, electrical modifications, family counseling, and nurse training.

Currently, the capacity of the waiver is 700 children, with 666 of these spots designated for children who require a hospital level of care. About 650 children are in the program at any given time. The average cost per child in fiscal year 2010 was $188,210 per year.

3. Core Program

Eligible health conditions-The list of eligible health conditions include: Cardiac Impairments, Cystic Fibrosis. Eye Impairments (Cataract, Glaucoma, Strabismus), External Body Impairments ((Cleft Lip and Palate, Craniofacial Anomalies), Hearing Impairments, Hemophilia, Inborn Errors of Metabolism (Phenylketonuria [PKU]), Nervous System Impairments (Seizures, Nerve, Brain, Spinal Cord), Orthopedic Impairments, Speech Impairments (Dysarthria, Vocal Cord Paralysis), and Urinary System Impairments.

Services include diagnostic tests are provided at no cost, specialized care providers, resources & information, care coordination plans, communication with the child's providers, school, and other care providers. The core program predates Medicaid; now that Medicaid is the primary payer for these services, DSCC acts as a "gap filler."

4. Transition process

Transition begins at about age 18. Families typically work with their care coordinators to determine how the young adult's needs may best be met after leaving the MFTD Waiver. Young adults may transition to adult programs, typically the Persons with Disabilities Waiver (PWD) (operated by Division of Rehabilitation Services [DRS or DORS] and part of the Home Services Program) or the Adults with Developmental Disabilities (ADD) Waiver. Under the Hampe settlement, adults may also remain with UIC's Division of Specialized Care for Children to continue receiving services in the model of the MFTD Waiver. DSCC is exploring opportunities to begin this transition and explore options earlier (around age 16), by involving care coordinators, families, and children in transition planning. Children on MFTD Waiver who age out from the children's program have two options to continue receiving Medicaid service as adult:

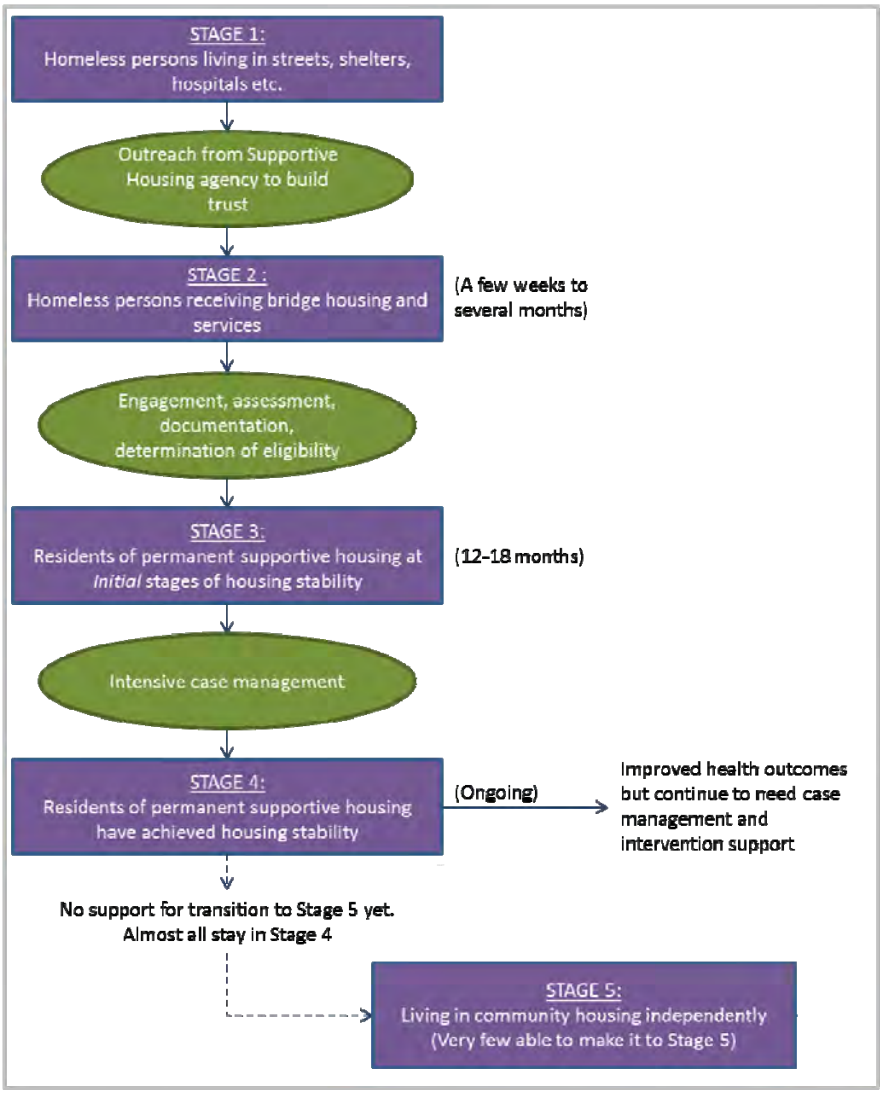
2) To transition to one of two pre-existing adult waiver programs (Adults with Developmental Disabilities Waiver or Persons with Disabilities Wavier). The waiver is managed by PAS agencies, and MCOs have frequent contact with these agencies to assist with care coordination and the acute care needs of those receiving the waiver.
9) To continue receiving case coordination services from DSCC. The latter cases are so-called "Hampe cases," referencing Hampe vs. Hamos. There are about 40 cases currently. Children who are enrolled in one of DRS Waiver programs could be transferred to this Hampe group.

Advocates note that the choice between continuing to be supported by DSCC and moving to be supported by one of the two adult waivers mentioned above-PWD or ADD- was not a meaningful choice for many families. The choice is not meaningful because under the adult waivers much less service is supported especially skilled nursing care even with the higher than usual exceptional care rate. Consequently, under these two adult waivers families could not obtain support for 18-24 hours of skilled

nursing care each day which many of their children need in order to live outside the hospital. Therefore, many young adults who are aging out of the MF/TD waiver program ("the Hampe cases") may not have an adequate adult waiver program to move into that will sustain their health.

H. Supportive Housing

Figure 20: Stages of Supportive Housing



I. Summary of Service Utilization Analysis Methodology

1. Questions of interest

3) Has there been a change in the locations ("place of service") that Medicaid members have received services from since the ICP began as compared to the traditional FFS Medicaid program?
10) Has there been changes in the types of providers and specialists who are delivering services to members since the ICP began as compared to the traditional FFS Medicaid program?

2. Members included in the analysis

UIC conducted separate analysis for two different member groups:

4) Members who were in the "community" cell and;
11) Members who were enrolled with one of four waivers: Elderly, Physical Disability, Brain Injury, and HIV/AIDS

Community Group-For the "community" group analysis, members had to be enrolled for all 4 years. For example, there were 15,555 "community" members who were in the FY11 FFS baseline group who were eligible for the ICP and were enrolled in the ICP for the first 4 years of the ICP (FY12, FY13, and FY14). Analysis was restricted to these 15,555 "common" community members.

Excluded from the "community" group study were members who were in the baseline group but dropped out before FY14 or members that joined the ICP after it began and therefore had not been in the FY11 baseline group.

Waiver Group-For the waiver group analysis, members had to be enrolled in both FY11 and in FY14. For example, there were 1,709 waiver members who were in the FY11 FFS baseline group who were eligible for the ICP and were still enrolled in the ICP as of FY14. Analysis was restricted to these 1,709 "common" waiver members.

3. Time period

UIC had FFS claims for the ICP eligible group for the 9 months of FY11 prior to start of the ICP and claims for from the MCOs for CY12 and CY13, from January 1, 2012 through December 31, 2013. As a result, FY11 covers 9 months of claims (July 2010 thru March 2011), FY12 covers 6 months of claims (January 2012 thru June 2012), FY13 covers 12 months of claims (July 2012 thru June 2013), and FY14 covers 6 months of claims (July 2013 thru December 2013).

4. Services included in the analysis

Community Group-Only outpatient services were included in the analysis-the following services were excluded from analysis:

5) Inpatient services–covered elsewhere in Hospital and Nursing Facilities sections;
12) All pharmacy claims which were medications or drugs that had NDC number; all other pharmacy services were included;
13) Monthly care coordination fee paid under the FFS system (CPT code=G9008)

Waiver Group-Only outpatient services were included in the analysis-the following services were excluded from analysis:

9) Inpatient services–covered elsewhere in Hospital and Nursing Facilities sections;
14) All pharmacy claims which were medications or drugs that had NDC number; all other pharmacy services were included;
15) Monthly care coordination fee paid under the FFS system (CPT code=G9008)
16) Claims made for Personal Attendant services (CPT code=S5125)-these services were still paid by HFS, even after ICP began, so they were excluded from the FY11 dataset

5. Types of claims covered in the analysis

UIC requested any claims that paid for services to MCO members during the specified time period, whether paid directly through the plan's own claims process or indirectly by another provider under contract with the plan. This included:

6) Claims marked as "Paid"
17) All pharmacy claims paid through the regular MCO claims process
18) All non-pharmacy claims paid through the regular MCO claims process; and
19) Any other claims submitted by providers to capitated providers for services delivered to ICP members for the defined time period.

6. Outcome measures

UIC established 2 primary outcome measures that it believed would be comparable among the 3 claims dataset (FY11 FFS, Aetna, and IlliniCare)

a. "Visits per 1,000 members"–Visits represented the number of distinct claims between a specific member and specific provider for unique dates of service.
b. "Dollars spent per 1,000 members"-this measure represented the cost of claims associated with visits for members.
c. POS counts calculated for Outpatient visits unique instances as follows:
    1. MemberID
    2. POS category
    3. Service Date
    4. NPI/ProviderID
d. Provider Type counts calculated for Outpatient visits unique instances as follows:
    1. MemberID
    2. Provider Type category
    3. Service Date
    4. NPI/ProviderID

Null NPIs were converted to zero ("0") value so at least one visit would be counted for unknown providers to minimize undercounting due to null values.

7. Steps taken to increase the probability of obtaining a "complete" claims dataset

The UIC team took the following steps to increase the probability that the claims dataset from each MCO would be "complete" and contain all requested claims:

a. Ran checks on claims using benchmarks from three main historical documents:
    1. MCO monthly "Adjudicated Claims" report submitted to HFS;
    2. MCO monthly Utilization Management" report submitted to HFS; and
    3. Final Medical Loss Ratio reconciliation spreadsheets for CY11 and CY12 submitted by MCOs to HFS

In using the historical reports to test for completeness of the claims dataset, UIC compared the outcome measures from these reports with the rates calculated by the team from the claims dataset. If there were substantial differences between the rates that the research team calculated from the claims and what the MCOs had reported in one of the three historical reports, the team did further analysis. If the difference could still not be resolved, the team contacted the MCO(s) in question.

b. Worked with MCOs to identify missing claims-UIC worked with both MCOs to identify and collect missing claims, most frequently from capitated providers (i.e. dental, vision, transportation, behavioral health) who paid for and processed claims from providers outside of the regular MCO claims process.

8. Steps taken to increase the probability that there would be comparability among the three sets of claims (fee-for-service claims for the regular Medicaid program and claims from the two MCOs)?

a. Worked to build crosswalks among the 3 datasets for "Place of Service" and "Provider Types" categories-The regular Medicaid FFS system and each MCO uses different methods to categorize the types of providers that deliver services. There are approximately 70 provider types in the regular Medicaid FFS program while each of the MCOs use over 100 categories to classify their providers. The UIC team built a crosswalk of provider types that linked the categories used by each of the MCOs to the standard categories used by HFS, permitting comparisons among the three claims datasets.

   The federal government uses approximately 40 different place of service (POS) types to classify Medicare claims. Both Aetna and IlliniCare basically use the Medicare POS types in their claims processing. However, HFS collapses many of the standard Medicare POS categories into 13 categories in processing the fee for service claims in the State's regular Medicaid system. To maintain comparability between the Medicaid FFS claims and the MCO claims, the UIC team built a crosswalk of POS types that linked the categories used by each of the MCOs to the standard POS categories used by HFS.

b. Worked with MCOs to reduce incompatibility of data between the plans-UIC worked with both plans to determine the algorithms and rules each plan used in processing claims in order to "clean" the datasets and increase comparability among all 3 claims datasets.

c. Rule sequence for converting POS and Provider Type categories to comparable values:
   1. Crosswalks
   2. Linking NPI with registered provider type in HFS State-wide provider registration table
   3. Other processes using Revenue Codes, Bill Type and other fields
   4. Any remaining "unknown" POS or Provider Type left in final "Outpatient Visits" total but not assigned to specific POS or Provider Type

J. Additional Detail on Physician Spending

Due to the size of the increase in spending for outpatient physician visits from FY11 to FY14, the research team did further analysis on claims to determine if there were any additional factors that could help explain this increased. Table 130 summarizes the FY11 and FY14 spending levels by Place of Service (POS). Generally all POS locations showed increased spending for both MCOs except for "Outpatient Hospital", where IlliniCare showed a decrease while Aetna reported an increase.

Table 130: Spending on Physician Outpatient Visits ($ per 1,000 Members)

Place of Service (POS)	FY11	Aetna	IlliniCare

		FY14	FY14
Clinics	$7,154	$53,901	$30,859
Emergency Room	$77,550	$136,368	$104,719
Outpatient Hospital	$181,244	$287,052	$156,938
Patient's Home	$431	$8,491	$16,936
Practitioner's Office	$283,890	$518,331	$352,711
Other Locations	$13,917	$26,121	$12,581
TOTAL	**$564,185**	**$1,030,265**	**$674,744**
Data Source: FFS claims (FY11) and MCO claims (FY14)			

Since spending for the "Practitioner's Office" location comprises the largest share of spending for outpatient physician visits for both the baseline and FY14, the research team drilled down for more detail on office visits. Since there are hundreds of CPT codes used for office visits, the team concentrated on claims for "established patient" office visits (CPT codes 99211-99215), which consistently generated about half of all outpatient claims for physicians. According to the CPT Professional Edition, "an established patient is one who has received professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the last 3 years." Table 131 summarizes the characteristics for these 5 visits types (for more detail, see Table 134).

Table 131: Established Patient Office Visits

Code	History & Exam	Medical Decision Making	Face to face (minutes)
99211	None Required	None	5
99212	Problem focused	Straightforward	10
99213	Expanded problem focused	Low	15
99214	Detailed	Moderate	25
99215	Comprehensive	High	40

Table 132 summarizes spending for the 5 CPT codes linked to "established patient" office visits. Overall for the 5 types of visits, Aetna increased spending about 90% over the baseline level ($139,000 to $264,000 per 1,000 members) while IlliniCare increased spending for these visits by 22% (to $170,000 per 1,000 members).

Table 132: Established Patient Office Visits ($ per 1,000 Members)

CPT Code	FY11	Aetna FY14	IlliniCare FY14
99211	$831	$1,339	$717
99212	$4,388	$4,785	$3,163
99213	$56,013	$99,563	$66,671

99214	$69,769	$144,208	$93,252
99215	$7,779	$14,371	$5,793
TOTAL	**$138,780**	**$264,266**	**$169,596**
Data Source: FFS claims (FY11) and MCO claims (FY14)			

A question that is not answered by the results in Table 132 is related to the factor(s) driving the increase in spending for these visits. For example, did total claims for these visits increase, or did the average payment for these visits increase, or was it a mixture of both factors? Table 133 shows data that focuses on these factors, summarizing number of claims per 1,000 members for each of the 5 visit types and the average payment made for each visit type. For the most part, both MCOs reported a substantial increase in the number of claims when compared to the baseline while the average payment for each claim either decreased or showed only modest increases. The results in Table 133 suggest that the increased spending by the MCOs for outpatient physician visits was driven more by an increase in the number of visits than by any increases in the average payment for these visits.

Table 133: Physician Office Visits for "Established Patient" (# of Claims)

CPT Code	Claims per 1,000 Members			Ave. $ per Claim		
	FY11	Aetna FY14	IlliniCare FY14	FY11	Aetna FY14	IlliniCare FY14
99211	78.3	132.8	132.8	$10.61	$10.08	$12.52
99212	189.7	235.0	235.0	$23.13	$20.36	$20.05
99213	1,392.0	3,026.2	3,026.2	$40.24	$32.90	$37.79
99214	1,147.1	2,715.3	2,715.3	$60.82	$53.11	$62.69
99215	166.8	225.1	225.1	$46.63	$63.83	$47.51
TOTAL	2,973.8	6,334.4	6,334.4	-	-	-
Data Source: FFS claims (FY11) and MCO claims (FY14)						

Table 134: Established Patient Office Visits CPT Codes

CPT/HCPCS CODE	CPT/HCPCS CODE DESCRIPTION
99211	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN

	ESTABLISHED PATIENT, THAT MAY NOT REQUIRE THE PRESENCE OF A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL. USUALLY, THE PRESENTING PROBLEM(S) ARE MINIMAL. TYPICALLY, 5 MINUTES ARE SPENT PERFORMING OR SUPERVISING THESE SERVICES.
99212	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: A PROBLEM FOCUSED HISTORY; A PROBLEM FOCUSED EXAMINATION; STRAIGHTFORWARD MEDICAL DECISION MAKING. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PHYSICIANS, OTHER QUALIFIED HEALTH CARE PROFESSIONALS, OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE SELF LIMITED OR MINOR. TYPICALLY, 10 MINUTES ARE SPENT FACETO FACE WITH THE PATIENT AND/OR FAMILY.
99213	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: AN EXPANDED PROBLEM FOCUSED HISTORY; AN EXPANDED PROBLEM FOCUSED EXAMINATION; MEDICAL DECISION MAKING OF LOW COMPLEXITY. COUNSELING AND COORDINATION OF CARE WITH OTHER PHYSICIANS, OTHER QUALIFIED HEALTH CARE PROFESSIONALS, OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF LOW TO MODERATE SEVERITY. TYPICALLY, 15 MINUTES ARE SPENT FACETOFACE WITH THE PATIENT AND/OR FAMILY.
99214	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: A DETAILED HISTORY; A DETAILED EXAMINATION; MEDICAL DECISION MAKING OF MODERATE COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PHYSICIANS, OTHER QUALIFIED HEALTH CARE PROFESSIONALS, OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF MODERATE TO HIGH SEVERITY. TYPICALLY, 25 MINUTES ARE SPENT FACETO-FACE WITH THE PATIENT AND/OR FAMILY.
99215	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; MEDICAL DECISION MAKING OF HIGH COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PHYSICIANS, OTHER QUALIFIED HEALTH CARE PROFESSIONALS, OR AGENCIES ARE PROVIDED
Data Source: http://www.cms.gov/medicare-coverage-database/staticpages/cpt-hcpcs-code-range.aspx?DocType=LCD&DocID=32007&Group=1&RangeStart=99211&RangeEnd=99215	

K. Provider Networks and Utilization

- Table 135: Estimated Payments to “Aging Waiver” Providers (SP2 Services)
- Table 136: Estimated Payments to “Disability Waiver” Providers (SP2 Services)
- Table 137: Estimated Payments to “HIV/AIDS Waiver” Providers (SP2 Services)
- Table 138: Estimated Payments to “Brain Injury Waiver” Providers (SP2 Services)
- Table 139: Transition of Waiver Providers from FFS to ICP (from Aetna)

Table 135: Estimated Payments to “Aging Waiver” Providers (SP2 Services)			
Provider Type	**# of Providers**	**$ Paid for SP2 Services**	**% SP2 $ Paid**
FFS (FY11)			

"Waiver Service" providers	29	$2,661,641	89.2%
All other Medicaid providers	39	$321,329	10.8%
Total	**68**	**$2,982,970**	**100.0%**
Aetna (FY14)			
"Waiver Service" providers (est.)[1]	15	$636,679	57.7%
All other Medicaid providers	22	$466,597	42.3%
Total	**37**	**$1,103,276**	**100.0%**
IlliniCare (FY14)			
"Waiver Service" providers (est.)[1]	14	$902,531	63.0%
All other Medicaid providers	27	$530,290	37.0%
Total	**41**	**$1,432,821**	**100.0%**

Data Source: FFS claims (FY11) and MCO claims (FY14)
[1]May be an undercount of claims due to missing Provider IDs for an unknown number of providers.

Table 136: Estimated Payments to "Disability Waiver" Providers (SP2 Services)

Provider Type	# of Providers	$ Paid for SP2 Services	% SP2 $ Paid
FFS (FY11)			
"Waiver Service" providers	88	$1,904,344	63.8%
All other Medicaid providers	78	$397,381	13.3%
Total	**166**	**$2,301,725**	**77.2%**
Aetna (FY14)			
"Waiver Service" providers (est.)[1]	29	$351,122	63.6%
All other Medicaid providers	25	$200,897	36.4%
Total	**54**	**$552,019**	**100.0%**
IlliniCare (FY14)			
"Waiver Service" providers (est.)[1]	26	$355,404	66.1%
All other Medicaid providers	38	$181,915	33.9%
Total	**64**	**$537,318**	**100.0%**

Data Source: FFS claims (FY11) and MCO claims (FY14)
[1]May be an undercount of claims due to missing Provider IDs for an unknown number of providers.

Table 137: Estimated Payments to "HIV/AIDS Waiver" Providers (SP2 Services)

Provider Type	# of Providers	$ Paid for SP2 Services	% SP2 $ Paid
FFS (FY11)			
"Waiver Service" providers	4	$39,759	73.6%

All other Medicaid providers	8	$14,256	26.4%
Total	**12**	**$54,015**	**100.0%**
Aetna (FY14)			
"Waiver Service" providers (est.)[1]	4	$27,462	100.0%
All other Medicaid providers	7	$0	0.0%
Total	**11**	**$27,462**	**100.0%**
IlliniCare (FY14)			
"Waiver Service" providers (est.)[1]	2	$9,580	71.7%
All other Medicaid providers	3	$3,775	28.3%
Total	**5**	**$13,355**	**100.0%**

Data Source: FFS claims (FY11) and MCO claims (FY14)
[1]May be an undercount of claims due to missing Provider IDs for an unknown number of providers.

Table 138: Estimated Payments to "Brain Injury Waiver" Providers (SP2 Services)

Provider Type	# of Providers	$ Paid for SP2 Services	Percent SP2 $ Paid
FFS (FY11)			
"Waiver Service" providers	29	$349,580	90.2%
All other Medicaid providers	24	$37,928	9.8%
Total	**53**	**$387,508**	**100.0%**
Aetna (FY14)			
"Waiver Service" providers (est.)[1]	10	$75,233	62.5%
All other Medicaid providers	11	$45,094	37.5%
Total	**21**	**$120,328**	**100.0%**
IlliniCare (FY14)			
"Waiver Service" providers (est.)[1]	5	$51,438	56.3%
All other Medicaid providers	17	$39,873	43.7%
Total	**22**	**$91,311**	**100.0%**

Data Source: FFS claims (FY11) and MCO claims (FY14)
[1]May be an undercount of claims due to missing Provider IDs for an unknown number of providers.

Table 139: Transition of Waiver Providers from FFS to ICP (from Aetna)

"Before the SPII program went live, Aetna Better Health offered contracts to all supportive living facilities and waiver providers in our service area, so long as such provider met all applicable Aetna Better Health, State, and federal requirements for participation in the Medicaid program as applicable and met the qualifications of the applicable HCBS waiver.
Because managed care was new to most of the waiver providers, Aetna Better Health held numerous Lunch and Learns for the providers. The agenda covered the basics of the program and managed care to how request an

authorization to how to bill on a CMS 1500 form. As a result, contracts were secured with 93% of the waiver providers contracted with the State. This success rate afforded members the continuity of care they desired and perhaps needed.
During the member's transition of care period, they were able to continue to utilize waiver providers that chose not to contract with Aetna Better Health. Once that period ended, and the provider still chose to remain nonpar, members had freedom of choice when selecting a new provider from the list of participating waiver providers.
Aetna Better Health follows the State's LTSS (waiver) Access Standards. In most cases, the access standards are exceeded.
At least two community LTSS Providers in each region for the following services: Enhanced Community Living, Homemaker, Waiver Transportation, Nutritional Consultation, Assisted Living, Social Work Counseling, Out of Home Respite, Home Medical Equipment and Supplemental Adaptive and Assistive Devices, Independent Living Assistance and Community Transition.

- At least one adult day health and one assisted living provider within 30 miles of each zip code within the region.
- At least two community LTSS Agency Providers in each region for the following services: Personal Care and Waiver Nursing.
- At least five community LTSS Independent Providers, in addition to self-directed care options in which and enrollee can choose his or her provider, in each region for the following services: Personal Care, Home Care Attendant, and Waiver Nursing.
- At least one community LTSS Provider in each Integrated Care Delivery System region for the following services: Pest Control, Home Delivered Meals, Emergency Response, Home Modifications Maintenance and Repairs and Chore Services."

Data Source: Narrative from Aetna

L. Pharmacy

- Table 140: Medications Utilization (Percent of members utilizing)

Table 140: Medications Utilization (Percent of members utilizing)

Drug Class	FY13[1]		FY14[2]	
	Aetna	IlliniCare	Aetna	IlliniCare
Any medication	64.5%	58.5%	58.7%	62.6%
Any psychotropic medication	41.9%	28.4%	37.8%	32.1%
Any ADHD medication	0.6%	0.5%	0.5%	0.5%
Any antidepressant medication	22.9%	17.4%	20.0%	19.4%
Any bipolar disorder medication	10.4%	24.7%	9.2%	27.8%
Any SSRIs	14.0%	10.9%	12.0%	11.9%
Any antipsychotics	19.6%	12.8%	17.0%	14.7%
Any atypical antipsychotics	16.9%	12.8%	14.5%	12.6%
Any benzodiazepine or benzodiazepine hypnotics	12.6%	11.6%	10.8%	12.7%

Data Source: MCO Reports for HFS; [1]June 30, 2013; [2]June 30, 2014

M. Transportation

- Table 141: Proportion of Outpatient Visits Where Transportation Was Provided Among Member With At Least One Trip
- Table 142: Category of Service Descriptions
- Table 143: Procedures for Conducting On-site Assessments

Table 141: Proportion of Outpatient Visits Where Transportation Was Provided Among Member With At Least One Trip						
ICP Population	**ICP**		**Chicago**		**Treatment Effect**	**Significance**
	FY11	**FY13**	**FY11**	**FY13**		
Total members	27.6%	40.6%	30.3%	27.0%	16.3%	p<.001
Physical Disabilities	33.7%	47.6%	37.0%	31.1%	19.8%	p<.001
Developmental Disabilities	26.0%	25.8%	35.0%	35.6%	-0.7%	p=0.87
Long Term Care	27.6%	28.8%	28.3%	26.3%	3.1%	p<.05
Brain Injury	42.9%	46.9%	46.4%	50.9%	-0.4%	p=0.96
HIV/AIDS	44.6%	46.5%	42.3%	37.7%	6.6%	p=0.60
Elderly	31.3%	49.0%	36.8%	29.0%	25.5%	p<.001
Community Residents	26.0%	43.9%	28.2%	24.1%	21.9%	p<.001
Data Source: Claims from MCOs and Chicago FFS						

Table 142: Category of Service Descriptions	
Category of Service	**ICP FY14 Detail**
Non-emergency Ambulance	Ambulance for members whose medical condition of patient requires transfer by stretcher, medical supervision and possibly medical equipment or oxygen.
Medicar	Vehicles for members whose medical condition requires the use of a hydraulic or electric lift or ramp, wheelchair lockdowns, or transportation by stretcher but without medical supervision, equipment or oxygen
Taxi	Taxi for patient whose medical condition does not require a specialized mode
Service Car	Other cars operated by transportation vendors for patients whose medical condition does not require a specialized mode
Private Transportation	Member reimbursement by mileage for patients whose medical condition does not require a specialized mode
Bus or Paratransit (other)	Transportation by common carrier, e.g., bus, train
Data Source: Special datasets provided by MCOs for FY14 and FY13; Claims data from FFS FY11	

Table 143: Procedures for Conducting On-site Assessments		
Definition or Process Questions	**ICP-Aetna**	**ICP-IlliniCare**
How were offices chosen for on-site assessments?	Data requested-not supplied	Randomly chosen
How are on-site assessments conducted? And by whom?	Data requested-not supplied	On-Site assessments are conducted by IlliniCare Provider Relations Representatives using an ADA checklist, which requires measurement and visual inspection
When are onsite assessments conducted?	Data requested-not supplied	Completed at the end of a visit

What aspects of accessibility are evaluated during the on-site visit? (number of questions per category)	Parking spaces (1 question), restrooms (1 question), ASL (1 question), & lighting (1 question)	Parking (2 questions), routes (1 question), entry ways (6 questions), signage (1 question), elevators (1 question), restrooms (7 questions), exam rooms (1 question), equipment (2 questions), & accommodations (1 question).
How is the information gathered from on-site assessments used?	Data requested-not supplied	It is used to confirm the self-assessments. They do not comply the information because they report all sites were compliant
Data Source: Conversations with MCO, ADA forms sent by MCOs		

N. Transportation Analysis Methods for the Increase in Costs

Since the average cost per member doubled from the baseline to FY13, the team took extra steps to check the accuracy of this substantial increase. These steps included:

7) Looked at individual transportation claims for selected members with a large number of NEMT claims both during the baseline and in FY13 to study payments to providers both before and after the ICP began-This review of claims for a small sample of members confirmed that monthly payments for similar transportation services for the same clients was generally 2 to 3 times higher for FY13 claims than for FY11 claims. This was due to both higher payments to providers for similar services and for more services per month.

20) Reviewed capitation payments made by the MCOs to their Transportation broker-The team reviewed the average per member per month (PMPM) capitation rate that both MCOs had set for their transportation broker and found that in CY12 both MCOs had substantially increased the capitation rate they were paying their transportation broker, compared to the CY11 capitation rate. By the end of CY12, the transportation capitation rate both MCOs had set was slightly more than previous. The research team was told by one of the MCOs that the increase in the capitation rate came about due to higher than anticipated payments being made by the transportation broker for transportation services for plan members.

O. Payment of Providers

1. Individual Practitioners

Table 144 shows the number of days that it takes each provider to submit the claim to the MCO after providing service and the number of days that it takes the MCO to pay the claim after they have received it by year. In general, each plan improved both on how long it takes for a provider to submit a claim after service and to pay the claim after they receive it for each provider type. The data for occupational therapists shows more days on average than the other provider types to submit a claim, and for IlliniCare, the number of days that it takes to pay a claim for an occupational therapist has increased each year. However, this data is based on a relatively small number of claims (only 114 for Aetna over the three years and 66 for IlliniCare). With the exception of occupational therapists, the average time that it takes each provider to be paid after the MCO receives the claim is less than 18 days.

Table 144: Service to Submission to MCO and Submission to MCO to Paid: Individual Practitioners						
Provider Type	**Aetna**			**IlliniCare**		
	FY2012[1]	**FY2013[2]**	**FY2014[1]**	**FY2012[1]**	**FY2013[2]**	**FY2014[1]**
Days from Service to Submission to MCO						
Audiologists	57.8	34.2	32.4	50.3	29.3	27.4
Nurse Practitioners	44.3	21.1	21.7	46.5	38.3	27.2
Occupational Therapists	182.6	51.2	50.8	75.8	58.8	64.3
Optometrists	65.9	28.1	29.9	37.6	27.2	29.6
Physical Therapists	88.6	33.4	38.4	34.4	22.5	37.5
Days from Submission to MCO to Paid						
Audiologists	35.6	13.6	10.1	40.8	11.6	7.6
Nurse Practitioners	15.8	10.9	10.8	15.0	12.7	8.1
Occupational Therapists	24.6	10.4	10.1	14.8	22.6	33.8
Optometrists	52.4	13.7	9.1	13.9	11.1	11.3
Physical Therapists	35.5	13.9	17.8	14.1	10.2	13.0
Number of Claims / Number of Unique Providers						
Audiologists	72 / 13	230 / 19	124 / 16	52 / 13	230 / 27	126 / 24
Nurse Practitioners	4,385 / 228	14,989 / 402	4,790 / 361	1,787 / 244	7,802 / 376	7,254 / 370
Occupational Therapists	9 / 2	45 / 1	60 / 2	18 / 6	29 / 9	19 / 6
Optometrists	439 / 50	1,771 / 77	889 / 69	1,983 / 78	4,512 / 116	2,624 / 134
Physical Therapists	11 / 6	94 / 7	87 / 10	101 / 13	158 / 20	155 / 26
Data Source: MCO Special Datasets for Services Provided in CY12 & CY13 [1]6 months of data [2]12 months of data						

2. Hospitals

Tables 145 and 146 the show the average number of days that it takes a provider to submit a claim after providing a service and the average number of days that it takes the MCO to pay the claim after receiving the claim for both inpatient and outpatient services. For outpatient services, both NCOs pay the claim within 20 days of receiving the claim (with the exception of psychiatric hospitals for IlliniCare, which took 37.2 days and is only based on 50 claims). Initially it took general hospitals over 40 days to submit a claim after providing service, and that number improved for both MCO's in FY13. It continued improving for IlliniCare in FY14, although it rose again to 36.6 days for Aetna in FY14.

Table 145: Service to Submission to MCO and Submission to MCO to Paid: Inpatient Hospital						
Provider Type	**Aetna**			**IlliniCare**		
	FY2012[1]	**FY2013[2]**	**FY2014[1]**	**FY2012[1]**	**FY2013[2]**	**FY2014[1]**
Days from Service to Submission to MCO						
General Hospital	42.2	29.6	36.6	43.6	20.0	18.3
Psychiatric Hospitals	48.6	36.6	22.1	14.3	24.4	11.2
Rehabilitation Hospitals	92.3	22.0	22.6	19.2	33.5	18.4
Days from Submission to MCO to Paid						
General Hospital	28.7	26.4	20.2	22.3	17.1	15.1
Psychiatric Hospitals	25.7	17.5	12.1	28.3	35.7	37.2

Rehabilitation Hospitals	39.0	20.6	14.3	23.7	13.0	12.7
Number of Claims / Number of Unique Providers						
General Hospital	6,879 / 149	12,604 / 173	6,024 / 158	3,289 / 110	7,033 / 135	4,105 / 138
Psychiatric Hospitals	197 / 4	251 / 4	111 / 3	27 / 2	65/ 5	50 / 3
Rehabilitation Hospitals	4 / 2	14 / 2	15 / 3	17 / 3	63 / 3	34 / 3

Source: MCO Special Datasets for Services Provided in CY12 & CY13
[1]6 months of data
[2]12 months of data

Table 146: Service to Submission to MCO and Submission to MCO to Paid: Outpatient Hospital

Provider Type	Aetna			IlliniCare		
	FY2012[1]	FY2013[2]	FY2014[1]	FY2012[1]	FY2013[2]	FY2014[1]
Days from Service to Submission to MCO						
General Hospital	30.1	20.2	19.5	26.2	19.1	19.9
Psychiatric Hospitals	62.0	58.1	25.4	14.3	24.4	11.2
Rehabilitation Hospitals	52.3	58.5	29.7	19.2	33.5	28.7
Days from Submission to MCO to Paid						
General Hospital	16.4	17.6	18.6	23.0	12.7	8.8
Psychiatric Hospitals	20.7	16.6	8.2	124.0	41.7	-
Rehabilitation Hospitals	18.8	13.7	13.9	23.9	22.6	26.0
Number of Claims / Number of Unique Providers						
General Hospital	33,605 / 194	68,971 / 237	36,937 / 229	28,636 / 249	59,591 / 306	38,750 / 300
Psychiatric Hospitals	3 / 2	14 / 2	5 / 1	2 / 1	7 / 2	-
Rehabilitation Hospitals	45 / 3	17 / 3	78 / 1	251 / 3	744 / 3	436 / 4

Source: MCO Special Datasets for Services Provided in CY12 & CY13
[1]6 months of data
[2]12 months of data

3. Ancillary

Table 147 shows the average number of days that it takes each of the ancillary providers to submit a claim after providing the service and the average number of days that it takes the MCO to pay the claim after it has been received. In general, both MCO's improved the number of days that it takes the provider to submit the claim during the three years, however Aetna's home health agencies stands out as it takes a much longer time for a home health agency to submit the claim than it does for IlliniCare. Imaging services follow the same trend, but to a much smaller degree. When the claim is received by the MCO, each provider type is typically paid within 17 days. However, ambulatory surgical treatment centers stand out for IlliniCare, as it takes nearly 60 days for IlliniCare to pay this claim after has been received.

Table 147: Service to Submission to MCO and Submission to MCO to Paid: Ancillary Providers

Provider Type	Aetna			IlliniCare		
	FY2012[1]	FY2013[2]	FY2014[1]	FY2012[1]	FY2013[2]	FY2014[1]

Days from Service to Submission to MCO						
Ambulatory Surgical Treatment Centers	31.6	36.6	48.2	26.7	13.6	30.7
DME Providers	38.1	35.8	34.2	22.1	18.2	16.8
Home Health Agencies - In Home	105.5	87.6	60.8	49.9	41.4	31.5
Independent Laboratories	61.3	60.3	36.5	36.1	24.4	19.2
Days from Submission to MCO to Paid						
Ambulatory Surgical Treatment Centers	17.7	15.1	10.2	34.9	52.3	59.7
DME Providers	27.8	19.2	13.8	13.7	11.3	10.0
Home Health Agencies - In Home	22.5	20.8	17.1	37.9	28.1	13.6
Independent Laboratories	12.5	9.0	8.3	17.4	9.0	6.4
Number of Claims / Number of Unique Providers						
Ambulatory Surgical Treatment Centers	86 / 11	183 / 11	82 / 8	58 / 10	145 / 11	105 / 14
DME Providers	11,348/ 215	24,437 / 257	14,026 / 227	10,695 / 219	23,819 / 255	15,186 / 256
Home Health Agencies - In Home	657 / 38	3,213 / 67	2,525 / 68	787 / 38	2,438 / 72	1,761 / 75
Independent Laboratories	22,569 / 46	45,673 / 61	22,569 / 28	20,104 / 64	44,358 / 79	26,670 / 76

Data Source: MCO Special Datasets for Services Provided in CY12 & CY13
[1]6 months of data
[2]12 months of data

4. Behavioral Health

Table 148 shows that both Aetna and IlliniCare have improved the average number of days that it takes a provider to submit a claim after performing the service and paying the claim after it has been received. The rates for both MCO's are similar, except for the time it takes for DASA providers to submit a claim. Each year, it takes several times longer for those providers to submit a claim to Aetna than to IlliniCare.

Table 148: Service to Submission to MCO and Submission to MCO to Paid: Mental Health Providers

Provider Type	Aetna			IlliniCare		
	FY2012[1]	FY2013[2]	FY2014[1]	FY2012[1]	FY2013[2]	FY2014[1]
Days from Service to Submission to MCO						
Community mental health provider	47.9	36.6	31.2	47.9	29.1	24.2
Department of Alcohol and Substance Abuse Provider	97.6	75.7	60.8	19.3	20.2	21.9
Days from Submission to MCO to Paid						
Community mental health provider	63.3	28.2	8.1	25.0	10.2	10.2

Department of Alcohol and Substance Abuse Provider	49.2	16.2	11.8	29.4	27.5	14.4
Number of Claims / Number of Unique Providers						
Community mental health provider	10,437 / 69	60,128 / 83	38,681 / 83	14,075 / 73	39,661 / 91	26,423 / 82
Department of Alcohol and Substance Abuse Provider	303 / 11	421 / 13	209 / 10	837 / 16	1,712 / 19	896 / 18

Data Source: MCO Special Datasets for Services Provided in CY12 & CY13
[1]6 months of data
[2]12 months of data

5. Nursing Facilities

Table 149 shows the number of days that it takes a nursing facility or nursing/demonstration facility to submit a claim to the MCO after providing service and the average number of days that it takes the MCO to pay the claim. Aetna and IlliniCare both saw improvements in each measure for each type of provider from year to year. In each year, it takes a nursing facility providers in Aetna much longer to submit a bill to the MCO than providers in IlliniCare. In FY14, it takes nursing facilities over two months to submit a bill to Aetna, compared to about one month for IlliniCare providers. However, Aetna pays the claim much faster than IlliniCare in each of the years for both nursing facilities and nursing/demonstration facilities. IlliniCare struggled with paying providers initially (155 days for nursing facilities and 121.2 days for nursing/demonstration facilities) in FY12, although those numbers have improved to 24.6 and 33.4, respectively.

Table 149: Service to Submission to MCO and Submission to MCO to Paid: Nursing Facility

Provider Type	Aetna			IlliniCare		
	FY2012[1]	FY2013[2]	FY2014[1]	FY2012[1]	FY2013[2]	FY2014[1]
Days from Service to Submission to MCO						
Nursing Facilities	206.0	122.3	69.6	126.6	65.3	29.7
Nursing Facilities-Demonstration Facility	185.6	141.1	66.9	95.6	84.7	33.0
Days from Submission to MCO to Paid						
Nursing Facilities	38.3	27.2	20.7	155.0	50.2	24.6
Nursing Facilities-Demonstration Facility	72.6	22.3	20.4	121.2	46.2	33.4
Number of Claims / Number of Unique Providers						
Nursing Facilities	102 / 41	3,263 / 431	4,115 / 663	325 / 38	4,409 / 418	6,022 / 491
Nursing Facilities-Demonstration Facility	25 / 11	2,313 / 695	2,569 / 724	22 / 14	867 / 159	1,262 / 215

Source: MCO Special Datasets for Services Provided in CY12 & CY13
[1]6 months of data

[2]12 months of data

P. Overall Summary of Impact of ICP

1. Table 150: Overall Summary of Impact of ICP

Table 150: Overall Summary of Impact of ICP			
Outcome or Quality Indicator(s)	**Source**	**Overall Impact**	**Description**
NEGATIVE IMPACT - Areas that ICP showed a decline compared with FFS system			
Outpatient visits for behavioral health	Tables 78-79	Decline	Rate of visits is still below the baseline, especially among DASA providers
NEUTRAL IMPACT - Areas where there was little difference between ICP and FFS			
Consumer Appraisal of Health Services	Table 6		Although satisfaction went down in the 1st year, subsequent years have not shown a significant difference
Consumer Appraisal of Self-Direction	Table 10		There were no significant differences
Consumer Appraisal of Unmet Health Needs	Table 7		A few individual services and improved, but there was no significant difference in the number of unmet health care needs
Consumer Appraisal of Unmet LTSS Needs	Table 8-9		There were no significant differences in the number of unmet LTSS needs
POSITIVE IMPACT - Areas that ICP showed an overall improvement compared with FFS system			
Access to and Utilization of Care (HEDIS indicators)	Table 23	Improvement	Improvement on 14 of 15 measures
Completion of health risk screenings, assessments, and care plans for members	Table 37	Improvement	Health risk screenings, assessments, and care plans are not completed for most FFS members
Cost of medications	Tables 101 and 105	Improvement	Average costs of medication per script declined compared to the baseline and comparison groups. Total cost of medication per member declined from baseline (but not as steeply as the comparison group under the SMART Act)
General Health Promotion Activities offered to members	Table 18	Improvement	
Inpatient hospital utilization and outcomes	Table 71-73	Mixed	Improvement on 3 of 4 measures; mixed on the 4th measure
Outcome measures for NFs	Table 84	Improvement	Improved on 2 of 2 measures

Outpatient visits for dentists	Table 61	Improvement	Non-emergency dental services are significantly higher for ICP members than FFS members
Outpatient visits by other individual professionals	Table 64-66	Improvement	During first 2 years the rate lagged behind the FFS level but had exceeded the baseline rate by Year 3
Outpatient visits by physicians	Tables 58-60	Improvement	During first 2 years the rate lagged behind the FFS level but had exceeded the baseline rate by Year 3
Prevention Services (basic physician office visits)	Table 20	Improvement	Increase on 2 of 2 measures
SNFist care coordination services for members living in NFs	Tables 43-46	Improvement	Many questions to be answered; follow-up evaluation needed
Special behavior health pilot initiative for high cost members	Table 42	Improvement	Initial reported results by Thresholds are positive
Spending for waivers services	Table 95	Improvement	Generally, spending for waiver services (both SP1 and SP2) has increased
Supply of medications	Tables 100 and 105	Improvement	Average days supply of medications increased substantially under the ICP when compared to the FFS baseline while the comparison group reported substantial decline
Tracking calls from members	Tables 119-120	Improvement	Both MCOs have implemented a call center to handle member calls and report number of calls, time to respond, and other statistics. There is no similar function for FFS members.
Tracking caseloads of care coordinators	Tables 35-36	Improvement	No centralized tracking in FFS Medicaid
Tracking number of care coordinators	Table 22	Improvement	No centralized tracking in FFS Medicaid
Tracking of member appeals	Tables 24-27	Improvement	No centralized tracking in FFS Medicaid
Tracking of member critical incidents	Tables 31-32	Improvement	No centralized tracking in FFS Medicaid
Tracking of member grievances	Tables 28-30	Improvement	No centralized tracking in FFS Medicaid
Tracking of prior authorization requests	Tables 14-17	Improvement	No centralized tracking in FFS Medicaid

Tracking of provider accessibility	Tables 106-108	Improvement	The current provider self-assessment process is more comprehensive than the FFS process; HFS and MCOs are adding spot checks on provider self-assessment
Tracking of provider network by county	Table 57	Improvement	HSAG tracks a wide variety of MCO providers by county on a quarterly basis
Tracking of timely payment of claims to providers	Tables 50-53	Improvement	No centralized tracking in FFS Medicaid
Tracking turnover of care coordinators	Table 34	Improvement	No centralized tracking in FFS Medicaid
Transition of Colbert members out of NFs	Table 129	Improvement	Movement of 799 members out of NFs
Transportation	Tables 109-115	Improvement	Both MCOs appear to have increase the rate of trips and spending on transportation services along with a centralized scheduling and member assistance process
MIXED IMPACT - Areas that ICP showed both improvement and decline compared with FFS system			
Outcome measures for behavioral health	Tables 80-82	Mixed	Some measures have shown improvement and some have declined
Prevention Services (HEDIS indicators)	Table 22	Mixed	Improvement on 1 indicator; Mixed results on 1 indicator
UNKNOWN IMPACT - Areas for which the data was either unclear or unavailable to determine the overall impact of the ICP			
Face-to-face contact between care coordinators and waiver members	Table 97	Unknown	As of FY14, it appears that both MCOs were not meeting the contract requirements (average of about 70% of the required contacts) but there is no existing data for FFS care coordinators to compare this data to
Mortality	Page 131 of report	Unknown	Incomplete data on deaths of members precluded any definitive conclusion
Consumer Experience/Satisfaction with Care Coordination	Figures 10-14		Little is known about the experience under FFS
Training of care coordinators for specialized waiver topics	Table 129	Unknown	Data was fragmented among the MCOs and HFS on training of care coordinators but HSAG

			has now begun monitoring this area on a regular basis so
Use of special waiver providers	Table 96	Unknown	Due to the difference in claim bundling by the FFS and ICP systems, it is not possible to arrive at a definitive result for this measure. Available data indicates that use of special waiver providers by the MCOs may have declined slightly but they continue to make frequent use of these special providers