Managed Care in Illinois

This profile reflects state managed care program information as of August 2014, and only includes information on active federal operating authorities, and as such, the program start date may not reflect the earliest date that a program enrolled beneficiaries and provided services. Some states report populations and services available to program participants under the federal authority (e.g. Section 1115 waiver), so these features cannot be easily distinguished for each program.

Overview of Current Managed Care Programs

In July 2011, over two thirds of Medicaid beneficiaries were enrolled in at least one of three managed care programs. The state of Illinois began providing managed care to Medicaid recipients in 1976 with the introduction of its **Voluntary Managed Care (VMC)** program, which covers primary, acute, and specialty care, and behavioral health services on a voluntary basis to low-income children and families, pregnant women, and American Indians who live in certain counties. The state has expanded managed care over time to include a number of other populations and services. Implemented in 2006, the state's primary care case management program - **Illinois Health Connect (IHC)** - covers acute, primary, and specialty care coordinated by a medical home. The program is available statewide and mandatory for most Medicaid beneficiaries with the exception of certain people with disabilities, dual-eligibles, those who choose to enroll in VMC, or those who are required to enroll in the Integrated Care Program. The **Integrated Care Program (ICP),** implemented in 2011, is a mandatory program for older adults and adults with disabilities in certain counties in the state who are eligible for Medicaid but not Medicare. Through ICP, beneficiaries can receive acute, primary, and specialty care; behavioral health; and long term supports and services coordinated using a team-based approach.

The state is currently in the process of adding services and supports to the Integrated Care Program. When it was originally implemented, the program only covered standard Medicaid acute, primary, and behavioral health services to beneficiaries. In 2013, the state integrated a range of long-term care services and home- and community-based services that were formerly available through various state waivers into its package of ICP-coordinated services. The state expects to incorporate developmental disability support services currently available through state waivers in the coming years.

In December 2013, the Center for Medicare and Medicaid Services approved the state's request to implement Care Coordination Entities (CCE). CCE's are a collaboration of providers and community agencies, governed by a lead entity to that receives a care coordination payment in order to provide services to enrollees under PCCM authority.

In May 2014, the Center for Medicare and Medicaid Services approved the state's request to implement a Managed Long Term Services and Support program (MLTSS) waiver to service the states dual-eligible beneficiaries who choose to opt out of the Medicare-Medicaid Alignment Initiative (MMAI). The program provides services on a mandatory bases for enrollees residing in the Greater Chicago or Central Illinois area to participants who are 21 and older, entitled to benefits under Medicare Part A and enrolled under Medicare Parts B and D. The program provides services to those receiving long term services based on the enrollee's need for nursing facility care. The MLTSS waiver will also provide benefits to enrollees who participate in one of the five 1915 (c) waivers.

Participating Plans, Plan Selection, and Rate Setting

In total, Illinois contracts with a mix of health plans. VMC is offered through Harmony Health Plan (**a national, for-profit plan)**, Meridian Health Plan (**a local, for-profit plan)**, and Family Health Network (a **national, non-profit plan)**. ICP is offered through several health plans servicing various counties throughout the state. **Cook County** IlliniCare Health Plan (**a local, for-profit** subsidiary of Centene Corporation), Blue Cross Blue Shield of Illinois, Cigna Health Spring of Illinois, Community Care Alliance if Illinois (CCAI), Humana Health Plan, Meridian, and Aetna Better Health (**a national, for-profit plan)**. **DuPage, Kane, Kankakee, Lake, and Will Counties:** Aetna Better Health and IlliniCare. **Boone, McHenery, and Winnebago Counties**: Aetna, Community Care Alliance of Illinois (CCAIO), **Knox, Peoria, Stark and Tazewell Counties**: Health Alliance, My Health Care Coordination (CCE), Meridan and Molina. **Rock Island and Mercer Counties**: IlliniCare and Precedence. **Madison, Clinton and St. Clair Counties:** Meridan and Molina. Illinois chooses plans through a competitive bidding process and sets rates through an administrative process using actuarial analyses that accounts for age, gender, and geographic factors.

Quality and Performance Incentives

Like most states, Illinois requires plans participating in its risk-based, capitated managed care programs (VMC and ICP) to report data on HEDIS, CAHPS, and other performance and compliance measures. The state also rewards plans in both ICP, CCE and VMC programs for performance by withholding a portion of the capitation payment and allowing plans to earn back a portion based on selected HEDIS measures. In VMC, the state withholds and also allows plans to receive bonus/incentive payments of up to 0.5% of the paid capitation revenue based on performance on 3 or more of the 8 specified HEDIS measures that meet or exceed the 75th percentile. In ICP, the state withholds a portion of the monthly capitation rate that increases to 2% by the third contract year. This amount is combined with additional funds from the state so that plans can earn up to a total of 5% of the capitation back based on score for HEDIS or HEDIS-like measures above a minimum threshold. Additionally, Illinois Health Connect primary care providers are eligible to receive annual bonus payments of at least $20 per patient for each qualifying service, such as developmental screenings and diabetes management.

Table: Managed Care Program Features, as of August 2014

Program Name	Voluntary Managed Care (VMC)	IL Health Connect Primary Care Case Management	Integrated Care Program (ICP)	Care Coordination Entity
Program Type	MCO	PCCM	MCO	PCCM
Program Start Date	November 1974*	July 2006	May 2011	September 1, 2013
Statutory Authorities	1915(a)	1932(a)	1932(a)	1932(a)
Geographic Reach of Program	Select counties	Statewide	Select counties	Select Counties
	Populations Enrolled *(Exceptions may apply for certain individuals in each group)*			
Aged		X	X	X (age 19+)
Disabled Children & Adults		X	X (age 19+)	X (age 19 +)
Children	X	X		
Low-Income Adults	X	X		
Medicare-Medicaid Eligibles ("duals")				
Foster Care Children				X (voluntary enrollment)
American Indians/ Alaska Natives	X	X	X	X(voluntary enrollment)
Mandatory or Voluntary enrollment?	Voluntary	Mandatory (except for American Indians/ Alaska Natives)	Mandatory (except for American Indians/ Alaska Natives)	Mandatory (except for Duals and American Indians and Alaska Natives)
	Medicaid Services Covered in Capitation *(Specialized services other than those listed may be covered. Services not marked with an X are excluded or "carved out" of the benefit package.)*			
Inpatient hospital	X		X	
Primary Care and Outpatient Services	X	X	X	
Pharmacy			X	
Institutional LTC			X	

Program Name	Voluntary Managed Care (VMC)	IL Health Connect Primary Care Case Management	Integrated Care Program (ICP)	Care Coordination Entity
Personal care/HCBS	X		X	
Inpatient Behavioral Health Services	X		X	
Outpatient Behavioral Health Services	X		X	
Dental			X	
Transportation	X		X	
Participating Plans or Organizations	1. Family Health Network 2. Harmony Health Plan 3. Meridian Health Plan	1. Illinois Health Connect – participating providers	1. Aetna Better Health 2. IlliniCare Health Plan, Inc.	1. Be Well 2. EntireCare 3. Together4Health 4. My Health Care Coordination 5. Precedence
Uses HEDIS Measures or Similar	X		X	
Uses CAHPS Measures or Similar	X		X	
State requires MCOs to submit HEDIS or CAHPS data to NCQA		NA		
State Requires MCO Accreditation		NA		
External Quality Review Organization	Health Services Advisory Group			
State Publicly Releases Quality Reports	Yes			

Sources: Centers for Medicare and Medicaid Services (CMS), National Summary of State Medicaid Managed Care Programs as of July 1, 2011.

Kaiser Commission on Medicaid and the Uninsured. Profile of Medicaid Managed Care Programs in 2010. September 2011.

National Committee on Quality Assurance. NCQA Medicaid Managed Care Toolkit 2012 Health Plan Accreditation Standards. State Use of Accreditation as of February 2012.

Notes: Managed Care Organization (MCO); Prepaid Inpatient Health Plans (PIHP); Prepaid Ambulatory Health Plan (PAHP); Mental Health/Substance Use Disorder (MH/SUD); Healthcare Effectiveness Data and Information Set (HEDIS); Consumer Assessment of Healthcare Providers and Systems (CAHPS).

Primary Care and Outpatient Services include physician services, hospice, laboratory, imaging, FQHC, and other specialty services delivered in outpatient offices and clinics. Institutional Long Term Care (LTC) includes Skilled Nursing Facilities (SNF) and/or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IDD).

External Quality Review Organization activities are only required for MCOs, PIHPs, PAHPs, and other applicable entities with comprehensive risk contracts.

* According to numerous state documents, the Voluntary Managed Care program began in 1976. See http://www2.illinois.gov/hfs/agency/Documents/annualreport.pdf.