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State/Territory Name: Illinois
State Plan Amendment (SPA)#: 13-010

This file contains the following documents in the order listed:

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

December 4, 2013

Julie Hamos, Director
Illinois Department of Healthcare and Family Services (HFS)
Prescott E. Bloom Building
201 South Grand Avenue East
Springfield, Illinois 62763-0001

ATTN: Theresa Eagleson

RE: TN 13-010

Dear Ms. Hamos:

Enclosed for your records is an approved copy of the following State Plan Amendment (SPA).

Transmittal #13-010 - Approves Illinois' request to regionally expand the Integrated Care Program.

--Effective Date: July 1, 2013

If you have any questions, please have a member of your staff contact Cathy Song at (312) 353-5184 or by email at Catherine.Song1@cms.hhs.gov.

Sincerely,

/s/
Verlon Johnson
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosure

cc: Mary Doran, HFS
Beth Green, HFS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTER FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTER FOR MEDICARE AND MEDICAID SERVICES

1. TRANSMITTAL NUMBER: **13-010**

2. STATE: **ILLINOIS**

3. PROGRAM IDENTIFICATION: **Title XIX of the *Social Security Act* (Medicaid)**

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: **July 1, 2013**

5. TYPE OF PLAN MATERIAL *(Check One)*

[ ] NEW STATE PLAN [ ] AMENDMENT TO BE CONSIDERED AS NEW PLAN [X] AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1902 of the *Social Security Act*

7. FEDERAL BUDGET IMPACT
a. FFY **2014** **($8.7 million)**
b. FFY **2015** **($56.3 million)**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-F, Pages 17, 19, ~~26 and 28~~ 25,26,28 and 29

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-F, Pages 17, 19, 26 and 28 25, 26, 28 and 29

10. SUBJECT OF AMENDMENT:
Integrated Care Program Expansion

11. GOVERNOR'S REVIEW *(Check One)*
[ ] GOVERNOR'S OFFICE REPORTED NO COMMENT
[ ] COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
[ ] NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
[X] OTHER, AS SPECIFIED: Not submitted for review by prior approval.

12. SIGNATURE OF AGENCY OFFICIAL:
[redacted]

13. TYPED NAME: **Julie Hamos**

14. TITLE: **Director of Healthcare and Family Services**

15. DATE SUBMITTED 9/12/13

16. RETURN TO:
Department of Healthcare and Family Services
Bureau of Program and Reimbursement Analysis
Attn: Theresa Eagleson
201 South Grand Avenue East
Springfield, IL 62763-0001

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: September 12, 2013

18. DATE APPROVED: December 4, 2013

PLAN APPROVED—ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2013

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPED NAME: Verlon Johnson

22. TITLE: Associate Regional Administrator

23. REMARKS:

STATE PLAN UNDER TITLE XIX OF THE *SOCIAL SECURITY ACT*

State: **Illinois**

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation	Condition or Requirement
07/13	Subsequent withheld amounts will be negotiated. The withheld amount will be combined with an additional bonus amount funded by the Department so that total funding of the incentive pool shall be equal to five percent (5%) of the Capitation rate. An equal portion of the incentive pool will be allocated to each P4P Metric. If Contractor reaches the target goal on a P4P Metric, Contractor will earn the percentage of the incentive pool assigned to that P4P Metric. Withholds of Contractor's Capitation payment will begin with the January 15, 2012. For purposes of measuring P4P Metrics for the initial implementation, calendar year 2010 will be considered the initial baseline year and calendar year 2012 will be considered the initial measurement year. All measurement years will be calendar years. In subsequent measurement years, the previous year's performance will be the baseline for that measurement year unless the previous year's performance was below the initial baseline, in which case the initial baseline remains the baseline. Similarly, for expansion of the Integrated Care Program (ICP), the baseline will be the latest complete calendar year preceding the implementation of the program. The first measurement year will be the first complete calendar year of the program. The P4P metrics for the first three years are specified in the contracts with the MCOs. They include metrics such as preventive visits, behavioral health supports, dental utilization, disease specific therapies, ambulatory care follow-up, medication management, and community retention. P4P metrics, baselines and goals for future years will be negotiated.
1905(t) 42 CFR 440.168 42 CFR 438.6(c)(5)(iii)(iv)	3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met. If applicable to this state plan, place a check mark to affirm the state has met ***all*** of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)). ____i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered. ____ii. Incentives will be based upon specific activities and targets. ____iii. Incentives will be based upon a fixed period of time. ____iv. Incentives will not be renewed automatically. ____v. Incentives will be made available to both public and private PCCMs.

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation	Condition or Requirement
07/13	• The State's tribal consultation process included contacting the American Indian Health Services of Chicago (AIHSC) on April 6, 2011, to notify them of the State's intention to submit this SPA. A copy of the State's administrative rule was provided, and a meeting was set up on April 7, 2011, to discuss the consultation process, including this proposed amendment. On May 13, 2011, a draft copy of this SPA was provided to the AIHSC for review and comment. The AIHSC was notified on July 2013 of the State's intent to submit a SPA expanding the Integrated Care Program.
1932(a)(1)(A)	5. The state plan program will___/will not_X_ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory__X__/ voluntary_____ enrollment will be implemented in the following county/area(s): i. county/counties (mandatory) Du Page, Kane, Kankakee, Lake, Will and Suburban Cook (with the exception of the city of Chicago as defined as areas with zip codes that begin with "606") effective May 1, 2011.
07/13	During the State fiscal year that begins July 1, mandatory enrollment will begin on or after July 2013 for the following regions: Rockford Region (Boone, McHenry and Winnebago counties); Central Illinois Region (Champaign, Christian, DeWitt, Ford, Knox, Logan, Macon, McLean, Menard, Peoria, Piatt, Sangamon, Stark, Tazwell, and Vermilion counties); Metro East Region (Clinton, Madison and St. Clair counties) Quad Cities Region (Henry, Mercer and Rock Island counties); and City of Chicago as defined as areas with zip codes that begin with "606". ii. county/counties (voluntary)_____ iii. area/areas (mandatory)_____ iv. area/areas (voluntary)_____
	C. State Assurances and Compliance with the Statute and Regulations. If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.
1932(a)(1)(A)(i)(I) 1903(m) 42 CFR 438.50(c)(1)	1. **X** The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.
1932(a)(1)(A)(i)(I) 1905(t) 42 CFR 438.50(c)(2) 1902(a)(23)(A)	2. **N/A** The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.
1932(a)(1)(A)	3. **X** The state assures that all the applicable requirements of section

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation	Condition or Requirement
07/13	A Potential Enrollee who does not select an MCO will be auto-assigned to an MCO by the ICEB. During the first twelve (12) month period of an expansion in a geographical area ~~the contract~~, the auto-assignment will equalize enrollment in the participating MCOs so that each MCO has approximately the same number of enrollees. The ICEB will equalize the enrollment ~~auto-assignment~~ by distributing the auto-assignment ~~enrollment~~ of those that do not make an active choice between the available health ~~two~~ plans, taking into considerations existing provider patient relationships, provider capacity and geographical access. During the second year, auto-assignment will occur systematically and randomly by algorithm with the same considerations, but each MCO will receive an approximate equal percentage ~~approximately fifty percent (50%)~~ of all auto-assignments, as capacity allows. During the second year there will not be an effort to equalize enrollment between the plans. The Department will re-evaluate and modify, as necessary, the auto-assignment algorithm and may provide that auto-assignment will also be based on Contractor's performance on quality measures. The Department shall provide written notice of any modification of the auto-assignment algorithm at least sixty (60) days before the implementation of the modification.
1932(a)(4) 42 CFR 438.50	3. As part of the state's discussion on the default enrollment process, include the following information: i. The state will **_X_** / will not____ use a lock-in for managed care. ii. The time frame for recipients to choose a health plan before being auto-assigned will be 60 days. iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. *(Example: state generated correspondence.)* During the enrollment process, potential enrollees will be sent an initial enrollment packet, reminder letters and a second enrollment letter. The second enrollment letter will specify the provider to whom the potential enrollee will be assigned if no choice is made. If no choice is made and a client is enrolled through auto-assignment, within five days after enrollment the MCO will send a welcome packet to the enrollee that includes all basic information, including a summary of important topics, such as how to get needed care, a benefits summary, and information about the complaint, grievance and appeal processes
07/13	iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)*

Citation	Condition or Requirement

During the enrollment process, potential enrollees will receive an information guide from the Illinois Client Enrollment Broker. This information guide will provide information regarding disenrollment rights, including without cause during the first 90 days of enrollment.

v. Describe the default assignment algorithm used for auto-assignment. *(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)*

- The default assignment algorithm will take into consideration:
- Current assignment to a PCP in the Primary Care Case Management Program
- Existing provider-client relationship based on claims data.
- The geographic location of the client and PCP.
- Special needs of the client, if known.
- Capacity limits set by HFS or the provider.
- Provider panel status.

07/13
- Performance on quality measures may be factored into the auto-assignment algorithm in the future.

vi. Describe how the state will monitor any changes in the rate of default assignment. *(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)*

07/13

On a monthly ~~weekly~~ basis, the Illinois Client Enrollment Broker will report to the Department Potential Enrollees who have voluntarily chosen a health care delivery system and PCP, Potential Enrollees who are enrolled by auto-assignment, and Enrollees who request to change from one HMO to another HMO during enrollment change periods. In addition, ~~Summary reports of such information will be provided by the Illinois Client Enrollment Broker to the Department on a monthly basis, and~~ the Department will produce ad-hoc reports as necessary.

1932(a)(4)
42 CFR 438.50

I. State assurances on the enrollment process

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

Citation	Condition or Requirement
	An Enrollee may request, orally or in writing, to disenroll from Contractor at any time for any of the following reasons: (i) the Enrollee moves out of the Contracting Area; (ii) Contractor, due to its exercise of Right of Conscience, does not provide the Covered Service that the Enrollee seeks; (iii) the Enrollee needs related Covered Services to be performed at the same time, not all of the related services are available through Contractor, and the Enrollee's PCP or other Provider determines that receiving the services separately would subject the Enrollee to unnecessary risk; or (iv) other reasons, including, but not limited to, poor quality of care, lack of access to Covered Services, lack of access to Providers experienced in dealing with the Enrollee's health care needs, or, if automatically re-enrolled and such loss of coverage causes the Enrollee to miss the Open Enrollment period.
	K. Information requirements for beneficiaries Place a check mark to affirm state compliance.
1932(a)(5) 42 CFR 438.50 42 CFR 438.10	**X** The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)
1932(a)(5)(D) 1905(t) 07/13	L. List all services that are excluded for each model (MCO & PCCM) The covered services in the initial implementation of the Integrated Care Program are being phased in through three service packages. Service package I will include all non-long term care services, including pharmacy, alcohol and substance abuse services and all medical services for nursing facility residents and all HCBS waiver participants. Service package II will include all nursing facility services and HCBS waiver services except those designed for individuals with developmental disabilities. Service package III will include the HCBS waiver services for individuals with developmental disabilities and ICF/DD services. The only excluded services in all three service packages are services provided in a State operated psychiatric hospital as a result of a forensic commitment and services provided through local education agencies.
07/13	The ICP expansion will include both Service package I and Service package II on the initial date of implementation in each region as follows: Rockford Region: Boon, McHenry, Winnebago effective July 2013 Central Illinois Region: Champaign, Christian, DeWitt, Ford, Knox, Logan, Macon, McLean, Menard, Peoria, Piatt, Sangamon, Stark, Tazwell, Vermilion effective August 2013. Metro East Region: Clinton, Madison, St. Clair effective September 2013 Quad Cities Region: Henry, Mercer, Rock Island effective October 2013 City of Chicago: as defined as areas with zip codes that begin with "606" effective February 2014.

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation	Condition or Requirement

1932 (a)(1)(A)(ii)

M. Selective contracting under a 1932 state plan option

07/13

To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

1. The state will **X** /will not_____ intentionally limit the number of entities it contracts under a 1932 state plan option.

2. **X** The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)*

   Through its research the State determined that the correct number of MCOs to make the program sustainable with the limited number of potential enrollees was two.

4. ____ The selective contracting provision is not applicable to this state plan.