The Transition to Medicaid Managed Care in Illinois: An Opportunity for Long-Term Services and Supports Systems Change

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In Collaboration with: Illinois’ Older Adult Services Advisory Committee
The Transition to Medicaid Managed Care in Illinois

About the Older Adult Services Advisory Committee
The Older Adult Services Act was enacted in 2004 through Senate Bill 2880 (Public Act 093-1031) by the Illinois General Assembly in order:

“To promote a transformation of Illinois’ comprehensive system of older adult services from funding a primarily facility-based service delivery system to primarily a home-based and community-based system, taking into account the continuing need for 24-hour skilled nursing care and congregate housing with services. Such restructuring shall encompass the provision of housing, health, financial, and supportive older adult services. It is envisioned that this restructuring will promote the development, availability, and accessibility of a comprehensive, affordable, and sustainable service delivery system that places a high priority on home-based and community-based services. Such restructuring will encompass all aspects of the delivery system regardless of the setting in which the service is provided.” (PA 093-1031 Section 5)

The Older Adult Services Act and the creation of the Older Adult Services Advisory Committee (OASAC) resulted from advocacy at many levels to reform the Illinois system of long term care. The OASAC was established to lead this effort. The Act also established the OASAC to advise the Directors of Aging, Public Health, and Healthcare and Family Services on all matters related to the Act. The Illinois Department on Aging (IDoA) formed the OASAC in January 2005.

About Health & Medicine Policy Research Group
Health & Medicine Policy Research Group has a 32-year history of evaluating local health policy as an independent, voluntary policy center with a mission to promote social justice and challenge inequities in health and health care. Health & Medicine has long been familiar with the developments that have shaped the availability of health care in the region and state, and maintains its influence by developing groundbreaking standards for public programs.

In 2001 Health & Medicine created its Center for Long-Term Care Reform to promote the reform of Illinois’ long-term services and supports in favor of home- and community-based care. The Center supports the development of a predominately home- and community-based long-term care system for older people and persons with disabilities that is affordable, accessible, high-quality, and adequate to meet population health and caregiver needs.

Health & Medicine develops effective partnerships with community-based organizations, while at the same time, maintaining access to the corridors of power in the city, county and state. Health & Medicine is uniquely positioned to provide state and local linkages between the public and private sectors, and between policy leadership and community and grassroots opinion. Health & Medicine currently serves in two key capacities: to promote dialogue on health reform among diverse constituencies, and to interpret the needs of the state, city and county for reconfigured health programs. Not only does Health & Medicine contribute to local policy development, but also provides national thinkers with the rationale for our local agendas.
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Executive Summary

In January 2011, the 96th Illinois’ General Assembly passed legislation mandating 50% of the Medicaid population to be covered in a risk-based care coordination program, or managed care program. In Illinois, managed care is an approach to catalyze health systems that provide services to the Medicaid population to change their practices in alignment with the Institute for Healthcare Improvement’s triple aim\(^1\) of:

- Improving care on the consumer level (e.g. quality and satisfaction)
- Improving population health
- Reducing the cost of health care

Illinois’ State Medicaid Agency (SMA), the Department of Healthcare and Family Services (HFS), is providing leadership for the transition from a primarily fee-for-service (FFS) Medicaid system to a new managed care system. Under HFS’ leadership, Illinois’ Medicaid managed care (MMC) model is based on an ‘all-in’ approach where all Medicaid services will be integrated through managed care organizations (MCOs). The ‘all-in’ approach is a best practice within MMC and a good foundation for the development of Illinois’ MMC system.

Further, the ‘all-in’ approach includes long-term services and supports (LTSS) for older adults and persons with disabilities, both institutional (i.e., nursing facility) and home- and community-based care. HFS is working in partnership with the Department on Aging (DOA) and the Department of Human Service (DHS) to ensure quality and to provide oversight of LTSS for older adults and persons with disabilities in the new MMC system. The choice to include LTSS gives Illinois the opportunity to build on the mostly medical model of the triple aim and include important social services that address the social determinants of health.

This report was developed in partnership between Health & Medicine Policy Research Group and Illinois’ Older Adult Services Advisory Committee. The report provides an overview of what the transition from a Medicaid FFS to a managed care system will entail for stakeholders in Illinois, paying particular attention to LTSS stakeholders. Six stakeholder groups are identified to include:

1. Consumers
2. Advocates
3. Providers (including informal family caregivers)
4. Payers (including state government agencies)
5. Managed care organizations
6. Researchers/academics

The transition to an MMC system is an almost immeasurable challenge because it represents not only a significant change from how stakeholders have worked together for several decades in the FFS system but also how they will work together in the future. The inclusion of LTSS in

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the MMC system is particularly challenging because of the inexperience of states across the country in implementing ‘all-in’ managed care models. Best practices, standardization, and demonstrated outcomes of these models are only now beginning to emerge.

This report provides a synthesis of a literature review on the topic of MMC and LTSS, and findings from interviews with key informants from Illinois and from several experienced MMC experts. Opportunities for Illinois to take advantage of these findings in order to ensure a smooth transition to an MMC system are provided at the end of the report. The opportunities are summarized below and formatted in a way to address the 4 greatest challenges identified for Illinois as it transitions to an MMC system:

**Challenge: Effective Stakeholder Engagement**
Stakeholders working in silos will limit Illinois’ capacity to achieve an integrated MMC system that improves health care, improves population health, reduces costs and addresses social determinants of health. In regards to LTSS, without formal channels for LTSS non-governmental stakeholder engagement, LTSS consumers are at risk for poor health care and poor health outcomes.

In order to integrate care in the new MMC system Illinois should go beyond innovation within silos and look to creating accountable partnerships across silos. Although State departments
must certainly take on a central leadership role in the transition to MMC, meaningful stakeholder engagement is essential through all phases of the transition to the MMC system. The states interviewed for this project and the literature strongly support formal development of stakeholder engagement processes (page 34-36).

**Opportunities for OASAC Engagement in Illinois:**

1. Identify and implement strategies for Illinois’ governmental agencies to increase interoperability and transparency (pages 34-36).

2. The Older Adult Services Advisory Committee (OASAC) should create a workgroup charged with developing a model for ensuring meaningful stakeholder engagement in the MMC system. While the workgroup should focus on LTSS stakeholder engagement, the model development should have applicability and utility for other stakeholder groups, including informal caregivers (pages 35-36).

3. OASAC should assess its membership structure in context of the transition to a MMC system and an ADRC system. Additional members should be added representing managed care expertise and disability services.

4. OASAC should immediately submit to HFS research on specific MMC LTSS quality measures described in this report. In collaboration with OASAC, HFS should identify additional priority LTSS quality measures for Illinois’ MMC system. Adequate LTSS quality measures in the MMC system are critical to ensure appropriate outcomes for LTSS consumers (pages 43-44).

**Challenge: Adequate State Government MMC Expertise**

MMC is not a typical Medicaid program in that a large number of beneficiaries are enrolled into one integrated program, therefore requiring a significant amount of money to be paid to one entity: an MCO. This represents a dramatic shift in how the Medicaid program has been historically structured, where beneficiaries were spread among many providers through many separate programs and service line FFS reimbursements (page 18).

As a result, the State must be prepared to provide a level of oversight greater than in the FFS system (pages 18-19). Therefore, Illinois’ state agencies must be knowledgeable about managed care in order to provide appropriate oversight of MCOs. For LTSS, this requires multiple State agencies to have trained staff and appropriate organizational structures. These agencies include DOA, HFS, and DHS (pages 19-23).

**Opportunities to develop adequate state government MMC expertise in Illinois:**

1. Illinois’ governmental agencies should assess their current organizational structures to determine whether they allow for sufficient MMC oversight. There is great opportunity for the State agencies to implement innovative oversight models like other states have done: Texas utilizes health plan management teams and Tennessee restructured their
MMC organizational structure to be similar to an MCO’s organizational structure (pages 22-23).

2. Illinois’ Governor’s Office should evaluate the current LTSS oversight for MMC that is now the responsibility of three agencies: DOA, HFS, and DHS. Clearly articulated roles and responsibilities should be developed between agencies (pages 36-38). Findings from the Illinois Framework for Healthcare and Human Services, particularly from the Governance project which looks at enhancing agency interoperability, should help guide this process (page 37).

3. Illinois’ governmental agencies involved with MMC should do an assessment of their current staff to determine what MMC expertise they already have in place and where they need to train staff or recruit additional staff (pages 20-22).

4. Illinois should collaborate with local academic institution(s) and MCOs to develop a managed care training curriculum for State government employees. Specific continuing education programs can be offered in important MMC areas that include: LTSS quality and oversight, and LTSS contract compliance (page 23).

Challenge: Aging and Disability Resource Center (ADRC) Integration with MMC

Stakeholders working in silos risk losing the opportunity to better integrate medical and social care and to rebalance LTSS in favor of HCBS. HFS, as the State Medicaid Agency, is ultimately responsible for the MMC system and developing a broad coordination effort across systems to assure there is no wrong door for MMC consumers.

DOA is providing leadership in the development of an ADRC system in partnership with the aging and disability communities to ensure no wrong door for LTSS consumers (pages 40-42). As DOA, DHS, and HFS develop the work plan for the State Balancing Incentive Payment Program (page 41), the ADRC network will become an important entry portal for the MMC system.

ADRCs are a coordinated-point-of-entry or no-wrong-door system of access to LTSS and include aging and disability network stakeholders. ADRCs have expertise in community-based social services that include Medicaid funded services, but also include other funded services like those provided through the Older Americans Act.

Under DOA’s leadership, ADRCs have the expertise and experience to develop a strong community-based LTSS network. Through deliberate and formal partnerships between HFS and DOA and engagement of ADRC stakeholders, the MMC and ADRC systems can better integrate medical and social care for individuals who require LTSS, and promote the balancing of LTSS in favor of home- and community-based care (pages 41-42).
Opportunities for ADRC integration with MMC in Illinois:

1. Under the leadership of the Department on Aging, Illinois should develop a strategic vision for its ADRC network that clearly articulates the formal relationship between ADRCs and the MCOs and how they interface at every level: consumer, agency/organization, and stakeholder (pages 41-42).

2. Under the leadership of Illinois’ Governor’s Office, Illinois should evaluate the utility of integrating State Aging and Disability departments. Two of the three states interviewed for this report have integrated aging and disability departments: Kansas and Texas (page 39).

3. Providers and ADRC stakeholders have the opportunity to negotiate contracts with MCOs that go beyond the typical FFS model and allow for innovative new reimbursement methods. MCOs should be viewed as an ally of providers and ADRC stakeholders, a partner to work with in order to provide innovative services that meet the unmet needs of Illinois’ Medicaid population (pages 30-32).

Challenge: Adequate Legislative Oversight of MMC

Legislative governance is essential in order to ensure consumer protections and quality assurances in Illinois’ MMC system.

Opportunities for Adequate Legislative Oversight of MMC in Illinois:

Develop a Medicaid managed care legislative subcommittee under the auspices of the Human Services Committee.

Conclusion

Illinois has embarked on an ambitious plan to improve healthcare, improve population health, reduce healthcare costs, and integrate medical services with social services that address the social determinants of health. Recognizing the fluidity of state government and the political process, if Illinois takes advantage of the opportunities described in this report, the State will better position itself to achieve these goals.

While MMC is not the silver bullet that will single handedly achieve these goals, MMC—along with Illinois’ many other health care reform initiatives—has the potential to move use closer to realizing them. Integrating LTSS into managed care is an important piece of this puzzle as this allows the state to address the social determinants of health. Through leadership and collaboration across stakeholder groups, Illinois can position itself on a stable course of reform and has the potential to become a leader in MMC including serving LTSS consumers.
Introduction

In January 2011, the 96th Illinois General Assembly passed legislation mandating 50% of the Medicaid population to be covered in a risk-based care coordination program, or managed care program by 2015. The law defines care coordination as: “delivery systems where recipients will receive their care from providers who participate under contract in integrated delivery systems”. Payment for care is required to be capitated “in which a fixed monthly premium per recipient is paid and full financial risk is assumed for the delivery of services, or through other risk-based payment arrangements.”

Although the law outlines the general ideas behind managed care, the Illinois Department of Healthcare and Family Services (HFS) is designated as the lead for implementing this transition of Illinois’ primarily FFS Medicaid system to a capitated managed care system.

To begin the transition process, HFS issued a solicitation from stakeholders in June 2011 under the title of: “Coordinated Care Program Key Policy Issues” in order to receive feedback on how to implement this major Medicaid reform. Over 75 responses were received from stakeholders representing the diversity of populations served through Illinois’ Medicaid program.

Taking into account these responses, HFS recently began several managed care initiatives to better coordinate health care and services for Medicaid enrollees. The new programs include:

1. The Integrated Care Program (ICP)
2. The Innovations Project
3. The Medicare-Medicaid Alignment Initiative (MMAI)

The Transition to a Medicaid Managed Care System: What is Medicaid Managed Care and Why Now?

Historically, Illinois has operated its Medicaid program as a primarily FFS system, where HFS as the State Medicaid Agency (SMA) reimburses providers directly for services rendered. As the population of Medicaid beneficiaries and the services provided have grown, it has become

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2 All quotations and references in this paragraph are based upon or taken directly from Illinois public act 96-1501. Available online: [http://www.ilga.gov/legislation/publicacts/96/096-1501.htm](http://www.ilga.gov/legislation/publicacts/96/096-1501.htm)
4 77 responses were received and included the following types of stakeholders: primary health, aging and disability networks, health care worker unions, hospitals, managed care organizations, Medicaid beneficiaries, pharmaceutical companies, law and policy research centers, and service providers, including: HIV/AIDS, behavioral health, pediatric, aging, disability, home care, substance abuse, homeless, reproductive, optometry, hospice and palliative care. Responses available online: [http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/Comments.aspx](http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/Comments.aspx)
5 Information relevant to the care coordination programs can be found on HFS’ website: [http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/default.aspx](http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/default.aspx)
increasingly difficult for the State to integrate care across settings. Also, keeping pace with the latest health information system trends and client-management systems is a challenge for any state governmental agency, and contracting out to MCOs is seen as a way to better coordinate care by taking advantage of the business model around which MCOs are built.

Illinois’ goals, as articulated in contracts between HFS and the MCOs, for its MMC system are in alignment with the Institute for Healthcare Improvement’s triple aim of:

- Improving care on the consumer level (e.g. quality and satisfaction)
- Improving population health
- Reducing the cost of health care

In MMC practice, these goals are operationalized in the following manner. Within a managed care program, the Medicaid reimbursement or financing systems are changed to a pre-paid capitated payment system: HFS will contract with MCOs who will, in turn, reimburse providers. The payment from HFS to MCOs is based upon a reimbursement rate per individual enrolled in an MCO on a monthly basis: a “per-member per-month” capitated rate. However, the contracts between HFS and MCOs go beyond simple reimbursement rates; MCOs are challenged with the important task of integrating primary, acute and post-acute care.

Integration refers to bringing together components that were once separate. Although this report will not cover how MCOs integrate care in detail, a successful MCO will integrate the following five domains of healthcare:

1. Funding (source and structure of financing health care; e.g. Medicaid and Medicare)
2. Administration (regulatory, administrative functions, including eligibility and management of systems resources)
3. Organization (partnerships and relationships both within an MCO and with outside community and health entities)
4. Service Delivery (management and systems of delivery, including care coordination)
5. Clinical (consumer health needs, standards of care for certain conditions/diseases, provider-consumer communication)

Until recently, Illinois had a relatively low penetration of capitated managed care covering less than 10% of Illinois’ Medicaid beneficiaries. The main reason Illinois lags behind other states in implementing capitated managed care programs includes past negative experience with MMC

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in Illinois and across the country, coupled with Illinois’ strong advocacy community that recognized the many states that had bad experiences with managed care in the 1980s and 90s.\(^9\)

In the current transition to an MMC system, Illinois has chosen an “all-in” approach where all types of care are integrated:\(^10\)
- Primary care
- Diagnostic and treatment services
- Behavioral health services
- In-patient and out-patient hospital services
- Dental services
- Rehabilitation services
- Long-term services and supports (including both institutional, i.e. nursing facilities, and home- and community-based services)
- Prescription Drugs

Experienced MMC states, experts in MMC and research show that an “all-in” approach is the best approach to managed care.\(^11\) This approach holds the MCO accountable for all Medicaid services, prohibiting any Medicaid cost shifting to outside entities.

The choice to implement an all-in, integrated, MMC system that includes LTSS also gives Illinois the opportunity to integrate important social services that address the social determinants of health. Services provided through Medicaid—such as the 1915 (c) waiver programs and the Money follow the Person program—address social determinants of health including: access to health care services, availability of social supports in the community, and housing.

In addition to the role MMC will play in integrating care for Medicaid beneficiaries, it also allows HFS to have more consistent and predictable budget patterns based on its capitated payments to MCOs. Further, there is the added potential of cost savings to the system based on improved health outcomes and subsequent reduced utilization of hospitals, emergency room visits and nursing facilities. In fact, results from an independent evaluation of Year 1 of Illinois’ Integrated Care Program demonstrated decreased use in emergency room services, decreases in emergency room to hospital admission, decreases in hospital admissions and decreases in hospital lengths of stay.\(^12\)

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\(^9\) “Illinois stands in stark contrast to virtually all other large states in the modest degree to which its Medicaid program has adopted managed care techniques.” (p. ES 1). Further, in analysis of Illinois’ managed care program at the time, the financial outcomes were disappointing, and the MCOs used an ‘unusually small proportion of the State’s payments to pay for their enrollee’s health care and a disturbingly high proportion for administration and profit.” (p. 15). The Lewin Group. (2005). “Assessment of Medicaid Managed Care Expansion Options in Illinois”. Prepared for the Commission on Government Forecasting and Accountability. Available online: [http://www.lewin.com/publications/publication/213/](http://www.lewin.com/publications/publication/213/)


\(^11\) Please see below for discussion about experience managed care states and experts interviewed for this report. Research that supports an “all-in” approach includes: Sparer, M. (2012). “Medicaid managed care: Costs, access, and quality of care.” Robert Wood Johnson Foundation. See page 7 for discussion about the disadvantages of ‘carve-outs’ as opposed to having all services in, or ‘all-in’.

Long-Term Services and Supports: Balancing in Favor of Community-Based Care

The “balancing” of long-term services and supports (LTSS) is a national and state priority that refers to the shifting of state expenditures from institutional care to home- and community-based care. Balancing LTSS is strongly supported and driven by consumer preference to receive community-based LTSS.¹³

In Illinois, the Older Adult Services Advisory Committee (OASAC) is a legislatively mandated State committee¹⁴ focused on balancing LTSS for older adults. OASAC was established with members representing all of the stakeholders involved with LTSS for older adults in Illinois.

With DOA taking a leadership role in staffing the Committee, OASAC advises State departments involved with balancing LTSS for older adults: DOA, HFS, and Department of Public Health. In addition, OASAC is comprised of representation from the Governor’s Office, the Department of Veterans’ Affairs, the Department of Human Services, the Department of Insurance, the Department of Commerce and Economic Opportunity, the State Long Term Care Ombudsman, the Illinois Housing Finance Authority, and the Illinois Housing Development Authority.

In Illinois’ MMC system, LTSS are included as part of the integrated service package. Until recently, very few Medicaid beneficiaries across the country had their LTSS needs managed through MMC.¹⁵ The lack of experience across the country with implementing MMC LTSS poses both a challenge and opportunity for the State and its MCO contractors.

The balancing of Illinois LTSS system and the transition to an MMC system are strongly interrelated. It is recognized amongst policy experts that MMC has the capacity to not only support but to drive LTSS balancing.¹⁶

With best practices and lessons learned from existing MMC LTSS programs just now emerging from states and local programs across the country, there are no strict rules and regulations for implementation. This gives Illinois and its MCO contractors the opportunity to experiment with the best ways to integrate care and balance LTSS, with the equally important challenge of simultaneously ensuring consumer protections and quality assurances.

¹⁴ The Older Adult Services Act, enacted in 2004 (PA 093-1031), is the result of strong and persistent advocacy “to promote a transformation of Illinois’ comprehensive system of older adult services from funding a primarily facility-based service delivery system to primarily a home-based and community-based system...” Available online: http://www.ilga.gov/legislation/publicacts/93/PDF/093-1031.pdf
¹⁶ John Michael Hall, Senior Director of Medicaid Policy and Planning for the National Association of States United for Aging and Disabilities (NASUAD); Patti Killingsworth Assistant Commissioner, Chief, Long-Term Services and Supports, Tennessee Medicaid Managed Care Program: TennCare.
Methodology

This report was commissioned by the Illinois Department on Aging (DOA) at the request of OASAC to better understand the role of MMC in Illinois, with particular emphasis on older adults and balancing LTSS. Under contract and in partnership with DOA, Health & Medicine Policy Research Group:

- Performed a literature review that included both national and local research, and Illinois MMC documents
- Convened a time-limited OASAC workgroup: the MMC LTSS Workgroup
- Interviewed MMC experts in other states’ governmental agencies and from the National Association of States United for Aging and Disability (NASUAD)

OASAC Workgroup Meetings

Individuals representing a diversity of areas of expertise within the fields of aging and LTSS were chosen from the OASAC membership to participate in an MMC LTSS workgroup. The workgroup was initially developed in December of 2012 and met several times from January through April 2013.

Workgroup meetings were an opportunity to discuss findings in MMC LTSS literature and Illinois MMC documents. The meetings helped the authors in determining an approach to this report and in identifying states and individuals with MMC expertise to interview. Workgroup members also provided guidance in the editing process of finalizing the report.

Interviews with National MMC Experts

As part of the research for this project, the authors interviewed a national expert in MMC LTSS:

- National Association of States United for Aging and Disabilities (NASUAD): John Michael (Mike) Hall, Senior Director of Medicaid Policy and Planning

The authors also interviewed three state government employees from other states who hold MMC leadership positions:

- Tennessee State Medicaid Agency: Patti Killingsworth, Assistant Commissioner; Chief, Long-Term Services and Supports
- Kansas Department for Aging and Disability Services: Shawn Sullivan, Secretary
- Texas State Medicaid Agency: Gary Jessee, Deputy Director

Tennessee and Texas were selected because of their long-time experience in implementing MMC and in managing MCOs. Tennessee is often recognized nationally as the gold-star

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17 See appendix B for additional details about meetings
18 See appendix B for additional details about meetings and interviews
19 Mr. Hall has provided support in the research and scope of this project. He also joined Illinois’ OASAC and the OASAC MMC LTSS workgroup in-person on February 25th, 2013 in Chicago, Illinois. Mr. Hall is recognized as an expert in MMC and is extremely knowledgeable about other states’ MMC experiences, often working directly with state leaders.
20 The authors selected these three states based on a review of the current literature which cites established MMC states and through recommendations from John Michael (Mike) Hall.
standard for managed care contracting and management of MCOs. Our contact in Texas had extensive experience with the State Unit on Aging and Disability Services before more recently moving to the SMA; this perspective was invaluable. Kansas was selected because of their emphasis on communication with stakeholders about their recent transition to an MMC system.

This Report
Many of the existing reports on the transition to an MMC LTSS system focus on very specific components of what an ideal system would look like. These components include:

- Member Education: Transition to & Ongoing Implementation of a Managed Care System
- Monitoring & Oversight
- Consumer Input and Rights
- Network Adequacy/Access to Care
- Continuity of Care
- LTSS Provider Standards
- Evaluation/Quality Measurement

We have chosen not to focus on these categories for two main reasons. First, many other researchers have covered this territory. Second, in a state like Illinois, with a relatively low penetration of capitated managed care, the transition to a managed care system is itself a monumental task that requires intentional planning and attention. Illinois’ decision to include LTSS in its transition to an MMC system makes this transition phase even more complex. The diversity of LTSS—from institutional to home- and community-based and meeting both medical and functional needs—requires additional attention when integrating into a new MMC system.

Given these reasons, this report will focus specifically on Illinois’ transition to a managed care system that includes LTSS. The report is structured to present findings from a literature review on the topic of MMC and LTSS, and findings from interviews with key informants from Illinois as well as several experienced MMC states.

Following the presentation of research and interview findings, we will present the opportunities and challenges for innovation both within and across stakeholder entities, focusing on the leadership role that DOA can play in transitioning to the new MMC system. Lastly, we will highlight opportunities for DOA and other stakeholders that support a smooth transition to a new MMC system that includes LTSS.

Finally, MMC is not the silver bullet that will single handedly achieve Illinois’ goals of: improved health care, improved population health, reduced healthcare costs, and integrated social

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21 In an attempt to synthesize this research as it applies to Illinois, a working document has been developed by Health & Medicine Policy Research Group in partnership with SEIU Healthcare Illinois and Indiana: “Consumer Protections and Quality Assurances In Managed Long-Term Supports and Services Programs”. This unpublished working document is available upon request.
services that address social determinants of health. MMC, however, does offer the State a mechanism to contribute to the work in reaching these goals. Other related health reform initiatives are referenced throughout the report that relate to MMC and are part of the larger health systems reform in Illinois. Taken collectively, all of Illinois’ health reform initiatives share the same goals and present Illinois with an opportunity to be a leader in health reform.
Opportunities and Challenges for Innovation Within Silos

MCOs in Illinois are working to integrate previously separate entities involved in the current Medicaid health system, including: primary care providers, acute care providers, behavioral health providers, LTSS providers, case managers, payers (Medicaid and Medicare), and State government departments. As a result, each of these entities is challenged to change how they will interface with an evolving Medicaid system.

The transition to a Medicaid Managed Care (MMC) system requires change for all of the entities involved in the Medicaid program; roles and responsibilities will not be the same for any stakeholder. This presents challenges and provides opportunities to re-evaluate roles, responsibilities, services and business models. Stakeholders have the opportunity to make strategic decisions about how they can best contribute to the evolution of an MMC system.

Despite the many challenges that the transition to an MMC system presents, the transition represents a growing trend across the country. In Illinois—through legislation and with several MMC initiatives in various stages of implementation and development—the transformation is underway, and rapidly evolving. In this section we will discuss the challenges and opportunities for innovation in a new MMC system paying particular attention to LTSS for the following stakeholders:

- State Government Departments
- The Aging Services Network
- The Centers for Independent Living Network (Disability Network)
- Medicaid Providers: both provider systems and individual providers

State Government Departments

Governmental oversight is especially important in an MMC system because MMC is not a typical Medicaid program. In MMC a large number of beneficiaries are enrolled into one integrated program, therefore requiring a significant amount of money to be paid to one entity: an MCO. This represents a dramatic shift in how the Medicaid program has been historically structured, where beneficiaries were spread among many providers through many separate programs and many service line reimbursements.

Thus, the transition from a FFS to an MMC system requires a new skill- and knowledge-set for Illinois’ governmental agencies:

- In a FFS system, the State is responsible for processing claims and reimbursing individual providers, providing oversight for potential fraud and billing errors, and ensuring quality and monitoring compliance with Medicaid requirements, rules and related policies.

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In an MMC system, the State’s roles and responsibilities shift to paying MCOs for subsequent provider reimbursement and providing oversight of MCOs to ensure MCO accountability in compliance with the specific MMC contract terms.

In our interviews with Tennessee and Texas, a theme emerged that the state—the SMA who holds the contract with the MCO, and other state agencies involved with MMC oversight—must be knowledgeable about managed care in order to provide appropriate oversight. In Tennessee and Texas’ experience, established MCOs often felt they were adequately prepared to implement managed LTSS programs without fully understanding that each state is different in their expectations and program design. Over time, these states learned to provide leadership and expertise in managing the MCOs and to clearly define what the state wants and expects through contracts with the MCOs.

The new MMC system requires specific, qualified staff with specialized skills, training and expertise. In large part this is due to the high level of scrutiny and accountability required in managing MCOs; when contracting out the integration of care to outside entities (MCOs) for hundreds of thousands of Medicaid beneficiaries for billions of dollars, simply put: the State’s level of oversight must be greater than in the FFS system and the skill set required to provide effective oversight must be in alignment with the MCOs.

Given the low penetration of managed care plans to date in Illinois, developing State government expertise and skills in the MMC field must be a priority for Illinois during the transition. MMC skill development is most critical for HFS staff because of their leadership role in the MMC system. However, other State agencies that interface with the Medicaid system should also acquire an MMC skill- and knowledge-set. These State agencies include:

- Illinois Department on Aging (DOA)
- Illinois Department of Human Services (DHS)

In the following section we will discuss several ways for Illinois’ governmental agencies to ensure they are successful as the State transitions to an MMC system.

**Developing the MMC Foundation: Staffing and Organizational Structure**

Continuity of care is a priority during the initial transition to an MMC system: ensuring that MCOs are ready to meet their consumers’ needs through adequate provider networks and reimbursement systems. Although both federal Centers for Medicare and Medicaid Services (CMS) and the State must assess each MCO’s readiness to begin enrolling consumers, it is ultimately the State’s job to ensure that this transition runs smoothly.

Prior to ensuring that MCOs are ready to enroll consumers, in order to ensure a smooth transition the State must also:

- Develop and negotiate the contracts that are the basis of the relationship between the HFS and MCOs; this includes the important task of negotiating reimbursement rates.
Educate consumers and providers about the changes to their Medicaid services that will be taking place.

Once the MCOs begin actively managing consumers’ care, HFS, DOA and DHS must be prepared to actively provide oversight and monitoring of the MCOs. This requires that organizational structures, processes and staff are in place when the MCO’s ‘go-live’.

HFS, DOA and DHS believe that they are prepared for the MMC transition as a result of regular interdepartmental meetings and correspondence about Illinois various MMC initiatives. In fact, during Illinois’ transition to the Integrated Care Program (ICP)—one of Illinois main MMC programs—State agencies assisted MCOs in building provider networks to ensure continuity of care and a smooth transition.  

The experience of ICP offers state agencies a blueprint for how to work together during the development and implementation of additional MMC initiatives that includes approximately 66% of its total Medicaid population, or about 2 million out of the 3 million beneficiaries, by 2015. This also includes 283,000 older adults and persons with disabilities that will be enrolled in the MMC system by 2015.

It is critical that Illinois’ governmental agencies are prepared for this transition, and that appropriate organizational structures, processes and staff are in place. There are a number of different approaches to meeting state agency structural, process and staffing needs within an MMC system, and the approaches will depend on the existing staff, structure and expertise already in place in Illinois’ governmental agencies.

**Innovative Approaches to Managed Care Oversight: Staffing Structure**

This section outlines the following activities the State can complete to meet the operating needs in a new MMC system: (1) re-training existing staff to work in an MMC environment; (2) recruiting additional staff with expertise in MMC; and (3) developing innovative processes and structures to appropriately monitor MCOs.

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23 In Illinois’ experience with the transition to the Integrated Care Program, a Medicaid-only managed care program in the far-suburbs of Cook County, a lot of attention was paid to the transition. There were sizable initial challenges with building provider networks and ensuring beneficiary understanding about the changes to their Medicaid providers and services, however Illinois governmental agencies were active in ensuring that consumers needs were met and providers were paid. Preliminary research from the University of Illinois at Chicago show that consumer’s needs have been met in the new MMC system: longitudinal data do not show a statistically significant difference in unmet need for consumers at baseline as compared to after year one of the Integrated Care Program. Heller, T., Mitchell, D., Owen, R., Keys, C., & Viola, J. (2013, February). “An Independent Evaluation of the Integrated Care Program: Results from the First Year.” University of Illinois at Chicago, Department of Disability and Human Development.

24 Illinois Care Coordination Roll Out Plan January 2013 to January 2015. Available online: [http://www2.illinois.gov/hfs/SiteCollectionDocuments/CareCoorPlan.pdf](http://www2.illinois.gov/hfs/SiteCollectionDocuments/CareCoorPlan.pdf)

25 Illinois Care Coordination Roll Out Plan January 2013 to January 2015. Available online: [http://www2.illinois.gov/hfs/SiteCollectionDocuments/CareCoorPlan.pdf](http://www2.illinois.gov/hfs/SiteCollectionDocuments/CareCoorPlan.pdf)
Re-Training Existing Staff
The Kansas Department on Aging and Disability Services (DADS) recognized the need for a change in the skill-set of their staff for the transition from FFS to MMC. KDADS did an assessment of their current staff to determine what MMC expertise existed and what expertise was missing. Given Kansas’ relatively new emergence into MMC, they contracted with Mercer, a consulting group, to assist the State with their readiness for and transition to an MMC system. Mercer assisted Kansas in making an assessment of their state employees’ skill-set within the Medicaid program, including contracting with a former Tennessee state government employee regarding the LTSS assessment component of the MMC system.

Through this staffing assessment, Kansas DADS noted that several of their staff were trained and qualified on the National Outcome Measure System.26 These individuals are experts in quality outcomes, specifically within the area of behavioral health, and were retained to continue their work and also to train other DADS and SMA staff on quality measurement within the MMC system.

Tennessee also completed an assessment of the expertise of existing staff in the SMA. In Tennessee’s experience, existing staff within areas of budgeting and quality assurance were able to transition into new MMC roles through retraining. More specifically, budget staff was trained on rate setting processes and quality assurance staff trained on thinking beyond process measures to broader health outcome measures.

Tennessee’s LTSS Division has also restructured since MMC transition, but was able to retain the majority of existing staff and place them into new MMC roles. As state employee positions naturally turned over, Tennessee’s LTSS Division took the opportunity to modify positions as needed to better meet the needs of their evolving MMC system.

A specific example of one area of Tennessee’s LTSS Division that changed more significantly was the Claims Department, which shrunk as a result of significantly fewer FFS claims. While a few claims staff moved to a new consolidated MMC claims unit, most of the staff that was originally responsible for claims transitioned to a new MMC enrollment unit.

Tennessee recognized that they did not want eligibility for LTSS to drive an LTSS capitation payment, but rather actual receipt of LTSS. This is particularly important since many nursing facility residents may qualify for LTSS long before other payer sources—primarily Medicare—are exhausted. Eligible members are actually enrolled into the managed LTSS program when Medicaid LTSS will commence, triggering the higher capitation payment.

LTSS claims staff with skills to oversee and monitor the FFS process of processing provider claims was easily transitioned to this new role. Further, in Tennessee, state LTSS staff within the SMA are now responsible for ensuring that LTSS eligible consumers actually receive LTSS

through analysis of MCO encounter data, thus confirming that MCOs are appropriately utilizing the enhanced LTSS reimbursement rate.\(^\text{27}\)

**Hiring Outside Expertise**

Tennessee also recommended that at a minimum, on day one, Illinois should have knowledgeable, experienced people to manage their MCO contracts. In Tennessee’s experience, contract management requires active, ongoing, day-to-day work. The only way for contract management to be successful in the MCO system is to have staff and processes in place starting from the very beginning.

All of the states interviewed expressed the importance of hiring from outside of state government to ensure that their state had the relevant expertise necessary to manage the MCOs. Interviewees talked about the continuum of skills and expertise required for adequate MCO oversight. In some cases, this expertise does not exist within state government agencies. It was reiterated that the state had to understand the business model of the MCOs in order to be successful.

While a list of potential outside areas of expertise to draw from is impossible, the State should look to MCOs directly, national organizations with expert resources in managed care such as the National Association of States United for Aging and Disabilities (NASUAD), other entities that work closely with MCOs within an MMC system, and to other experienced MMC states to recruit qualified staff.\(^\text{28}\) One concrete example Texas provided was that several State employees were hired with past experience working for Maximus, a managed care client enrollment broker company. These employees understand the importance of the ‘front door’ or entry into an MCO and their expertise has been useful for Texas.

**Innovative Approaches to Managed Care Oversight: Organizational Structure**

In the experience of Texas and Tennessee who have a long experience with MMC, the recruitment of outside expertise to their SMA has occurred over many years and has resulted in innovative approaches to the restructuring of the SMA.

Tennessee’s approach is to structure their SMA, and LTSS Division, more like an MCO’s structure. Tennessee notes that because it takes a very different skill set to manage MCOs than it does FFS providers their SMA looks much different than it did prior to their years of experience in developing an MMC system.

\(^{27}\) Like Tennessee, Illinois has ‘capitation cells’ where individuals who are deemed eligible by the State for LTSS are given a higher capitation reimbursement rate to the MCO. If an MCO is receiving an enhanced capitation rate, i.e. the individual is classified as fitting into the LTSS capitation cell, the State must ensure that the MCO is indeed providing this person with LTSS.

\(^{28}\) The authors note that Illinois’ HFS recently hired a former chief executive officer of a managed care organization to join HFS’ staff: Robert Mendonsa was hired as the Deputy Administrator for Care Coordination Rates and Finance within the Division of Medical Programs. Mr. Mendonsa has extensive experience in managed care and worked for Aetna (one of the Integrated Care Program MCOs) for 23 years; for 8 of these years Mr. Mendonsa served as a regional president of 16 states for Aetna where he oversaw strategic and financial decisions that include: pricing and provider reimbursement. Mr. Mendonsa has the responsibility for overseeing rate setting for MCOs and providers, the managed care risk adjustment process, shared savings base-lines, trend calculations and risk-based care coordination fee development. In his new role at HFS, Mr. Mendonsa will also oversee the Bureau of Rate Development and Analysis, and the Bureau of Program Reimbursement and Analysis.
Specific areas within Tennessee’s LTSS Division that have evolved with the transition to MMC include:

- **LTSS Quality and Administration.** The Quality and Administration unit is the programmatic lead and provides oversight and quality monitoring for all contracted LTSS entities: MCO and FFS. Many of the staff within the Quality and Administration unit are the primary contact points with the MCOs. Specifically: the LTSS Program Director of Quality and Administration, and the Director of Elderly and Physical Disability Services.

- **Audit and Compliance.** The TN LTSS Division has its own Audit and Compliance unit that receives all deliverables pertaining to LTSS from both the MCOs and from FFS programs (e.g. 1915(c) waivers). This unit is responsible for on-site audits of LTSS contracts. It is anticipated that this unit will continue to grow as data analysis becomes increasingly important and contributes to the ongoing quality improvement of LTSS programs. The Audit and Compliance unit works closely with LTSS Quality and Administration unit to comprehensively manage MMC LTSS.

Texas’ SMA’s approach within the SMA to managing MCOs is grounded in the concept of team-based work. One of the types of teams is the Health Plan Management Team. Health Plan Management Teams were a new addition to the Texas MMC system. These Teams are in frequent contact with the MCOs and are responsible for the day-to-day support, oversight and monitoring of MCOs.

The Teams are responsible for the detailed communication necessary to track MCO performance and ensure the stability of the MMC system. There are four Teams, consisting of about seven staff each; as the MMC programs expand across the state, so do the Teams. One of the benefits of working in a team format is that the cross training across team members happens naturally and allows for skill and career growth within the teams and within the SMA.

Texas also shared their experience about the loss of state employee staff within the Department of Aging and Disability Services (DADS) during the transition to an MMC system. In some instances, it was not possible to transition all existing staff into the new MMC infrastructure and positions were cut. The largest driver of these staffing reductions was the termination of contracts between the states’ DADS and LTSS providers. In some areas of the states, there were no longer any FFS programs so all contracting went directly to the MCOs.

In Illinois the collective bargaining rights of unionized State employees will need to be considered when addressing issues such as retraining of staff, changes to organizational structures, and modification needed to existing positions to support MMC.
**Aging Services Network**

The Aging Services Network, or Aging Network, includes a robust partnership of AAAs, CCUs, providers and partners that work collaboratively to address the needs of older adults and their family caregivers. DOA administers a comprehensive service delivery system for the state's growing population of 2.3 million older adults and their caregivers.

Services are provided in coordination with the Aging Network which includes 13 Area Agencies on Aging and hundreds of contracted provider agencies at the local level. The Department’s major programs and services include the Medicaid 1915 waiver program: the Community Care Program (CCP), prevention of elder abuse and neglect, Long Term Care Ombudsman Program, and eligibility determination for various senior benefits. Approximately 90% of DOA’s funding comes from General Revenue Funds.

In addition to these services, the Aging Network also includes Older Americans Act funded services such as: information & assistance, outreach, nutritional services, employment services, and transportation, along with other community supportive services. Through this infrastructure, the Federal government funds Older Americans Act services in local communities based on the older adult population and older adults’ community-specific needs.²⁹

By definition, the Aging Network is older adult and caregiver centered. See figure below.³⁰

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²⁹ The federal government allocates funds to State Units on Aging (IDOA) based on a funding formula outlined in the Older Americans Act. This funding formula is based on each State’s population of older persons in the State. IDOA then allocates funds to the Area Agencies on Aging through an Intrastate Funding Formula based on the population characteristics among the Planning and Service Areas. The Area Agencies on Aging then allocate funds based on community-specific needs and needs assessment activities conducted by the Area Agencies on Aging.

Many aspects of the Aging Network will remain the same in the MMC system, and some roles and processes may be modified. For example, AoA will continue to fund Older Americans Act services through the SUA and down to the AAAs based on the population of older adults and an assessment of older adults’ needs.

Illinois’ Aging Network is unique in that it formally extends beyond the AAAs to Care Coordination Units (CCUs). Illinois’ AAAs are designated to plan and coordinate services and programs for older adults, while the CCUs are responsible in the FFS system for on the ground coordination of services, including Medicaid waiver services and Older Americans Act services. CCUs also contract with the DOA to perform the Determination of Need assessment for Medicaid waiver program functional eligibility.

The Aging Network represents the psychosocial, or social service, side of care, while Medicare and Medicaid covers the medical side. To date, ongoing efforts to better integrate these two systems have not proven successful on any large scale.
The following sections will discuss opportunities and challenges for AAAs and CCUs during the transition to an MMC system. The following section, *Opportunities for Innovation Across Silos: Building Accountable Partnerships* (page 33), will cover discussion of the integration of aging and disability networks by way of the Aging and Disability Resource Centers (ADRCs).

**Area Agencies on Aging**

Per Older Americans Act regulations, Illinois’ Aging Network is divided into 13 Planning and Service Areas (PSA); each PSA is managed by an AAA. Illinois AAA’s are responsible for the planning and coordinating of services and programs for older persons in their PSA, but generally are not direct service providers.  

AAAs directly provide older persons and their caregivers with a variety of resources including: information, assistance, referrals, benefit eligibility checks for public programs, health options counseling and health promotion training. In partnership with CCUs and providers, AAAs connect older adults to the home- and community-based services (HCBS) funded through Medicaid, Medicare, the Older Americans Act, and other Federal, State and local funded programs.

Unlike in most other states, in Illinois’ Aging Network, AAAs have not been responsible for any of the key Medicaid HCBS activities; AAAs do not determine functional eligibility for Medicaid HCBS, they do not develop Medicaid HCBS care plans, they do not provide Medicaid HCBS care coordination, nor do they directly provide Medicaid HCBS to older adults. Instead, Illinois’ Aging Network is designed to have CCUs perform many of these Medicaid HCBS activities.

As a result, AAAs traditional business model is expected to remain intact during the transition to an MMC system. However, given the resources that AAAs offer, there is great opportunity to partner with MCOs and potentially expand revenue streams for AAAs. There will be overlap between the consumers who benefit from AAA resources and the consumers enrolled in MCOs. The challenge for AAAs and the MCOs is to develop a way to efficiently and effectively partner in order to best meet the needs of their shared consumers.

Additional opportunities and challenges for AAAs through the ADRC system are discussed on pages 40-42.

**Care Coordination Units**

Unlike the AAAs, CCUs will see a modification in their current business model and day-to-day Medicaid HCBS responsibilities. In the FFS system, CCUs determine functional eligibility for Medicaid HCBS, they develop Medicaid HCBS care plans, and they provide Medicaid HCBS care coordination.

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In Illinois’ MMC system, it is the MCOs role to integrate care and the MCOs, not the CCUs, will have the responsibilities of developing a care plan and providing care coordination for MMC consumers. It is important to note that in both FFS and MMC, CCUs will continue to determine older adults’ functional eligibility for Medicaid HCBS. Illinois chose this bifurcation of functions between the CCUs and the MCOs to ensure conflict free case management; that is – the entity coordinating services is not the same as the entity determining eligibility for the service.

Although not all of Illinois’ Medicaid beneficiaries will be covered in the MMC system and some will remain in FFS, it is Illinois’ goal to enroll over 50% of the Medicaid population in the MMC system. While not all of these Medicaid beneficiaries are seniors and persons with disabilities, this represents a significant loss of responsibility and revenue for the CCUs, and as a result, the transition to MMC will be extremely challenging.

It makes the most sense from an efficiency and consumer-centered perspective to have the MCOs responsible for care coordination. In Illinois, MCOs are charged with fully integrating care by taking on financial risk for a Medicaid beneficiary’s acute, primary, behavioral and LTSS. As the CCUs well know, care plan development and care coordination is at the heart of ensuring quality of care and consumer well-being; in order for the MCOs to be successful it is logical that care coordination be their responsibility.

Kansas and Tennessee also experienced the same difficult transition in their Aging Networks and loss of some of the Medicaid HCBS responsibilities as these states also require the MCOs to provide care coordination instead of the Aging Network. These states justified the difficulty of the transition by reiterating the importance of MCOs managing a fully-integrated system that includes care coordination.

Kansas shared that this specific change to the Aging Network, the loss of responsibilities including care coordination, caused more “heartache” and dialogue than the overall MMC transition. In fact, Kansas developed a separate transition plan for the Aging Network transition to an MMC system to provide guidance for stakeholders during this challenging time.

Though some states require MCOs to contract with existing community-based care managers for at least the first year of MMC, Kansas’ perspective was that delegating care coordination to the MCOs on day one was in the best interest of the consumers. They felt that the quality of the MMC system would be compromised if they required MCOs to subcontract LTSS care coordination functions.

As a result of this dramatic departure from how the CCUs have operated in Illinois for the last 30-years, it is worth noting that this transition will take time and will affect all stakeholders (MCOs, State agencies, consumers, providers, etc.). The community-specific expertise of CCUs

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32 In the MMC system, MCOs are not limited to the 1915(c) waiver service packages, though the Determination of Need for eligibility into the 1915(c) waiver programs are how HFS determines if MCOs should be reimbursed an enhanced LTSS rate for a consumer.
and the additional resources CCUs offer to consumers are an important component of a successful MMC system.

There are opportunities for CCUs to contract with MCOs to ensure a smooth transition to the MMC system and to ensure continuity of care for consumers. An MLTSS expert said that the smart MCOs will contract with the Aging Network (CCUs) for at least a transition period of time in order to ensure continuity of care. 33 In fact, in Illinois several MCOs are or will be contracting with the CCUs for case management services during this transition phase for that exact reason.

The CCUs’ community-based and in-person structure and approach to care coordination for individuals who require LTSS is supported by research. 34 In Illinois’ ICP MMC initiative, MCO contracts include the requirement of in-person LTSS care coordination contact at least every 90 days. 35 Additional ways that MCOs can strengthen community-based care coordination approaches is through formal partnerships with the ADRC system (pages 41-42).

**Disability Networks and Centers for Independent Living**

In 1978 the Rehabilitation Act was amended to include consumer-controlled Centers for Independent Living (CILs). CILs are designed and operated by persons with disabilities based upon the independent living philosophy: people with disabilities are entitled to the same rights, options and control of choices in their lives as people without disabilities.

CILs are responsible for similar activities in the disability community as the AAAs and CCUs in the aging community: community planning, information and referral to services, and advocacy. CILs also provide peer counseling and independent living skills training. 36

Since 1999 Illinois’ Department of Human Services, Division of Rehabilitation Services (DHS/DRS) has contracted with CILs to provide a community reintegration service: assisting people with disabilities under the age of 60 with moving from skilled nursing facilities (SNFs) to their own homes in the community.

In 2007, Illinois was selected to participate in the federal Money Follows the Person (MFP) demonstration program, with the State’s Operational Protocol approved in June, 2008. MFP’s major goal is to incentivize states to reform their long-term care systems utilizing “enhanced” Medicaid matching funds earned on services provided to individuals who have transitioned

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33 John Michael Hall, Senior Director of Medicaid Policy and Planning for the National Association of States United for Aging and Disabilities (NASUAD)
34 Brown, R. (2009). The promise of care coordination: models that decrease hospitalizations and improve outcomes for Medicare beneficiaries with chronic illness; a report commissioned by the National Coalition on Care Coordination (N3C). Available online: [http://www.nyam.org/social-work-leadership-institute/docs/N3C-Promise-of-Care-Coordination.pdf](http://www.nyam.org/social-work-leadership-institute/docs/N3C-Promise-of-Care-Coordination.pdf); personal communication with Chris Duff, Executive Director of the Disability Practice Institute—an expert in managed care for individuals with disabilities.
from nursing facilities to qualified home and community-based settings. Illinois’ CILs have participated within MFP providing community reintegration services for persons 60 years and younger and incorporating additional MFP requirements.37

The CILs’ role with community reintegration work starts at the beginning of the transition process in the SNF and continues all the way through transition to the community. Like CCUs in the aging network, qualified CIL staff conducts the functional Medicaid HCBS assessment for people with disabilities participating in MFP, complete paper work, and assist in developing a care or service plan.

CILs also provide the following services as part of their community reintegration work:

- Conduct risk assessments and develop mitigation plans for community living
- Provide training to consumers to prepare them for living on their own in a community setting
- Help consumers identify housing that meets their needs
- Cover up-front costs associated with the initial transition to the community such as:
  - Security deposits
  - Utility deposits
  - Furniture and household goods
  - Food
- Assist consumers in identifying and hiring Personal Assistants who are able to support consumers in remaining independent in the community by providing various long-term services and supports (anywhere from helping to navigate public transportation to assistance with cooking and cleaning)
- Provide hands-on assistance on the day of the move from the SNF
- Conduct follow-up case management for a year post-transition.
- Provide peer support and other services as the consumers adjust to their new living situation

With the transition to an MMC system, it is not clear what role CILs will play and what role MCOs will play in providing community reintegration services. Much like the Aging Network, CILs have the community expertise and trusted relationships with consumers and other stakeholders within the disability network. CILs are currently in discussions with MCOs and HFS about the community reintegration services they provide and the formal role CILs can play in providing this service in the MMC system.

Additional opportunities for CILs are possible through some of their independent living model services that revolve around peer support. For example, CILs currently offer peer mentoring: pairing persons with disabilities—who are trained, knowledgeable and experienced in

37 The authors note that DOA also participates in MFP and contract with the CCUs to provide community reintegration for persons who are 60 years of age and older.
navigating health and social services systems—with persons with disabilities who are less familiar with navigating these complex systems. Peer mentoring is a useful service for many consumers during the transition to an MMC system and during ongoing implementation of the MMC system. Peer mentoring is also a way to ensure that consumers’ non-medical needs are met.

Like the AAAs and CCUs, figuring out new business models within the MMC system is an ongoing challenge for CILs. And also, like the Aging Network, another major change for Illinois’ CILs is the growing importance and reach of the ADRCs. Additional opportunities and challenges for CILs through the ADRC system are discussed on pages 40-42.

**Providers**

The transition to an MMC system will affect who providers contract with to be reimbursed for service provision. In an MMC system, instead of contracting with the State, providers contract directly with MCOs. In order to contract with an MCO, a provider must be a Medicaid certified provider.

The development of MCO provider networks is extremely important during the initial transition phases to MMC as there must be enough providers to care for the individuals enrolled in a MCO. CMS and HFS evaluate MCO provider networks through readiness checks before MCOs are allowed to enroll consumers. Illinois has learned through the Integrated Care Program (ICP) MMC initiative that provider networks must be in place prior to enrolling members.

A major difference between contracting with HFS and the MCOs is that each MCO has a different provider credentialing process. This has been recognized in Illinois and other states. In their current legislative session, Texas lawmakers introduced bills that would streamline MCO provider credentialing processes. In Illinois, for some of the larger provider groups who have experience with managed care in other states, the different credentialing processes are not problematic. However, for some of the smaller provider groups, having a number of different MCO credentialing processes may be burdensome.

In addition to these changes and potential challenges for providers during the transition to an MMC system, there is also great opportunity for providers to collaborate with MCOs. Providers and MCOs have the opportunity to negotiate contracts that go beyond the typical FFS model and allow for innovative new reimbursement methods. (See text box on the following page for an example in Illinois). MCOs should be viewed as an ally of providers, a partner to work with in order to provide innovative services that meet the unmet needs of Illinois Medicaid population. MMC gives providers an opportunity to step outside of the box.
Innovative Provider and MCO Collaboration in Illinois: An Example

An example of an innovative provider and MCO collaboration is through the Integrated Care Program (ICP) between Thresholds—a community-based mental health provider—and IlliniCare—an MCO. Taking HFS’ recommendation to initiate relationships with the MCOs, Thresholds spent a significant amount of time educating the two ICP MCOs—Aetna and IlliniCare—about the value of their services. This education included the value of community-based services generally and the opportunity to innovate and improve care delivery through community services, particularly by connecting consumers with the right care and services, thus enabling consumers to remain out of hospitals and other institutional settings.

Thresholds also spent time educating the MCOs about the value and details of services they provided. For example, Thresholds provided education for the MCOs on the value of the evidence based Assertive Community Treatment (ACT) model of care for persons with serious and persistent mental illness. The ACT model of care is built upon providers delivering care wherever an individual may be—home, homeless shelters, the streets—rather than in a clinic setting. This was a steep learning curve for the MCOs who had not traditionally served this population.

Through the development of relationships with the MCOs, Thresholds has been able to negotiate an innovative pilot project with IlliniCare. Thresholds and IlliniCare entered into a partnership to identify 50 individuals with severe mental illness whose current package of services are not working—they continue to cycle in and out of inpatient psychiatric units with alarming frequency and have not been able to use coordinated outpatient care as a result. Thresholds is now contracting with IlliniCare to provide enhanced services for these highest need individuals through a team based approach.

The Thresholds’ pilot team is taking responsibility for engaging this group of individuals in intense, targeted community-based care. A team—comprised of a psychiatrist, psychotherapist, nurse and community support specialists—becomes the single point of responsibility for coordinating the person’s primary and behavioral health care.

By instilling hope and creating a service package that lines up with individual goals, the team determines with the individual what services are needed to stabilize their lives and foster recovery, leading to a better, healthier life.

Continued on next page

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38 Thresholds assists and inspires people living with severe mental illnesses to reclaim their lives. Thresholds uses evidence-based practices and innovative models of care to help individuals move into and through long-term, sustainable recovery. For more information: http://www.thresholds.org/explore-thresholds

39 This was something other the state agencies interviewed shared as well: providers should work with the MCOs directly, not wait for the state to set the tone or lead the way.

Innovative Provider and MCO Collaboration in Illinois, continued

Thresholds will be paid by IlliniCare a flat, at-risk payment per person served rather than on a fee-for-service basis. The payment structure creates an incentive to provide better care with a focus on quality and outcome rather than a high volume of services. The pilot program will be evaluated through the specific outcomes associated with wellness and quality measures, timeliness of service provisions, hospital utilization and costs.

Thresholds leadership and initiative in working with IlliniCare is an example that illustrates the success of any system requires collaboration amongst entities. In the MMC system, providers have an opportunity that they did not have with the FFS system to leverage MCOs flexibility in reimbursement. In this specific example, an evidence-based model of care is now available to one of Illinois’ most vulnerable populations.
Opportunities for Integration Across Silos: Creating Accountable Partnerships

In order to integrate care in the new MLTSS system we must go beyond innovation within silos and look to creating accountable partnerships across silos. This includes all of the stakeholder systems: consumers, informal caregivers/family, State governmental departments, MCOs, providers, ADRCs, and advocates.

Although the State departments certainly must take on the central leadership role in the transition to MMC, they must also involve key stakeholders in both the development and implementation phases of any MMC initiative. The development of accountable partnerships through a collaborative atmosphere between and among all of the stakeholder systems is key to the success of Illinois’ new MMC system.

In Kansas, strategic planning for the transition to an MMC system included public forums, public input surveys and stakeholder workgroup sessions. Through a contract with Deloitte, Kansas developed a comprehensive summary and road map to reform their Medicaid system prior to the transition to MMC. This process allowed for stakeholders to buy-in to the transition to an MMC system.

In Texas’ many years of experience operating MMC programs, they have created a culture built on a partnership where MCOs inform the SMA about potential issues proactively. It is understood the SMA has high expectations that MCOs must meet.

In Tennessee, the MCOs work together and bring new ideas or challenges to the SMA; some topics are not discussed due to proprietary reasons, but the MCOs have actively collaborated with their competitors on many issues. For example, the Tennessee SMA invited one MCO to share their work around the management of an electronic visit verification process with the other MCOs in order to promote best practices.

In Illinois, MCOs and providers partner through innovative pilot projects, like the previously cited example with Thresholds providing a unique, evidence-based mental health service package through IlliniCare. Additionally, all of the MCOs in Illinois who are currently under contract with HFS, have come together as an association to talk about how to streamline their protocols and processes in order to work best with providers. In addition, a consulting group

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43 The Health Maintenance Organizations (HMOs) are a type of risk-bearing managed care organization that is licensed through the Illinois Department of Insurance. There are 11 HMOs currently under contract with Illinois through the various managed
is working with the State to help spur innovations for MCOs, providers and the State governmental departments.\textsuperscript{44}

Building off of the collaborative work already under way in Illinois and building from best practices identified in other states, in this section several critical areas have been identified where effective collaboration is essential during the transition to an MMC system and after the transition:

- Collaboration across stakeholder groups
- Integration of State government roles and responsibilities
- MMC quality
- Promoting home- and community-based LTSS

**Collaboration Across Stakeholder Groups**

A great challenge to health systems reform is the intentional development of a process for meaningful stakeholder input and collaboration. Collaboration amongst Illinois stakeholders in the transition to an MMC system should be built upon transparency, open communication and discussion.

Stakeholder engagement is a priority in developing accountable partnerships: deliberate collaborations across stakeholder groups. The more stakeholder engagement between the State and other entities the better—more can always be done and it will only improve the system. Illinois’ MMC system will never be stagnant and stakeholders—consumers, State agencies, community entities and providers—should continuously work together to figure out how to best meet the needs of the Medicaid population.

Stakeholder engagement is necessary through the planning, development, transition to and ongoing development of an MMC system. Illinois has a variety of options for enhancing their stakeholder engagement as the State implements multiple new managed care initiatives. For example:

- Develop, and implement, a stakeholder engagement model that outlines how Illinois will collaborate across stakeholders in the MMC system.
- Increase State government transparency by:
  - Developing a user friendly website that is easy to navigate and includes comprehensive information about the MMC system and all of Illinois’ various MMC initiatives
  - Sharing State governmental department organizational charts that are responsible for MMC activities

\textsuperscript{44} Health Management Associates has a contract with the Illinois Governor’s Office for a recently received Centers for Medicare and Medicaid Innovation (CMMI) planning grant (April 2013). Illinois CMMI grant will focus on 3 models: provider; provider and MCO; and provider, MCO and payer (i.e. HFS for Medicaid, CMS for Medicare, private payers, etc.).
It is important to recognize that stakeholder engagement does not equate with developing an MMC system based upon exactly what stakeholders want. There will be times when HFS must stand firm in order to maintain the integrity of the MMC system and not give in to stakeholder demands. When there are certain stakeholder demands that are not consistent with the State’s vision for the MMC system, it is important to have these discussions and for the State to explain why they are unable to accommodate certain stakeholder requests.

In interviews with Kansas, Tennessee and Texas, a theme emerged around stakeholder engagement: the State can always do more to engage stakeholders and advocates. These states stressed the critical importance of stakeholder engagement: if stakeholders do not feel comfortable with the transition to MMC and are not knowledgeable about the changes occurring, the transition and quality of the MMC system will not be trusted and will be compromised.

Community stakeholders also need to learn when to approach HFS and when to approach MCOs. Another change in this transition to MMC will be the move from advocating on behalf of and with consumers directly to HFS, to targeting the MCOs as the focus of advocacy efforts.

The remaining content in this section will focus on LTSS stakeholder engagement but the methods described are applicable to the entire Medicaid population.

**Optimizing Stakeholder Engagement in the MMC System**

As highlighted in the introduction, MMC LTSS programs are relatively new and have increased rapidly across the country in the last several years. Best practices for MMC LTSS are beginning to emerge, yet standardization of MLTSS has not yet occurred. Currently CMS and entities like the National Committee for Quality Assurance are developing standard guidance on ensuring quality in MLTSS programs.

Aging and disability stakeholders—consumers, providers, DOA, DHS/DRS, AAAs, CCUs, CILs—who have been involved with the administration, provision, and coordination of LTSS for decades should play a leadership role in standardizing Illinois’ MMC LTSS programs. In collaboration with HFS, aging and disability stakeholders have the expertise needed to help Illinois take emerging best practices and federal MLTSS guidance and shape this into something that works within the Illinois Medicaid system.

Illinois LTSS stakeholders should take a renewed interest in Illinois’ Medicaid Advisory Committee (MAC). The MAC has several subcommittees including care coordination (which covers managed care) and long-term care. The MAC is a federal mandated entity, is staffed by HFS, and provides an opportunity for stakeholders to engage directly with the current issues affecting the Medicaid program.  

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45 The Medicaid Advisory Committee pursuant to federal law 42 CFR 431.12 advises HFS on policy and planning related to health and medical services. Available online: [http://www2.illinois.gov/hfs/PublicInvolvement/BoardsandCommissions/MAC/Pages/default.aspx](http://www2.illinois.gov/hfs/PublicInvolvement/BoardsandCommissions/MAC/Pages/default.aspx)
In addition to the MAC there are several stakeholder committees that are involved with aging and disability programs and LTSS, including the balancing of LTSS in favor of home- and community-based care. Key among these committees are:

- The Older Adult Services Advisory Committee (a key partner in the development of this report, see page 14 for a more detailed description of OASAC)
- The Council on Aging
- The Illinois Long-Term Care Council
- The Illinois Health Facilities and Services Review Board, Long-Term Care Facility Advisory Subcommittee
- State of Illinois Human Services Commission
- Illinois’ Money Follows the Person Stakeholder Committee
- Illinois’ State Balancing Incentive Payment Program Stakeholder Committee
- Illinois Housing Development Authority – Illinois Affordable Housing Advisory Committee

Opportunities for collaboration and information sharing among these various LTSS stakeholder groups should be explored in order to ensure comprehensive LTSS stakeholder input in the MMC system. In addition to collaboration across State advisory bodies, an efficient, effective relationship between HFS and other State agencies is absolutely critical; all agencies should work together to balance out the myriad needs, desires and expectations in the MMC system. The roles and responsibilities of State agencies are discussed in the following subsection.

**Integration of State Government Roles and Responsibilities**

A first step in conceptualizing how Illinois’ MMC system will operate is to look at the roles and responsibilities across the current State departments who provide leadership in operating Illinois’ Medicaid program. Having recently begun its MMC transition, Kansas strongly recommended that Illinois complete an assessment of state agency structures in order to articulate clear lines of roles and responsibility.

The basic delineation of roles and responsibilities allows a state to work efficiently and collaboratively in order to transition to an MMC system. Kansas acknowledged that these types of conversations are difficult to have because sometimes changes are required that entail

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46 The Illinois Council on Aging is an advisory body to the Illinois Department on Aging pursuant to the Illinois Act on Aging (20 ILCS 105) that is mandated to review and comment on reports from DOA to the Governor’s Office or General Assembly, review and comment on DOA’s State plan and disbursement of public funds by DOA to private agencies. The Council is also required to submit an annual report evaluating all programs, services and facilities provided to the aging population by all State agencies. Available online: [http://www.state.il.us/aging/aboutidoa/coa.htm](http://www.state.il.us/aging/aboutidoa/coa.htm)

47 The Illinois Long-Term Care Council, pursuant to the Illinois Act on Aging (20 ILCS 105/4.04a), is mandated to ensure that consumers ages 60 years and older receive high quality long-term care if residing in facilities licensed or regulated by the Nursing Home Care Act, Skilled Nursing and Intermediate Care Facilities Code, Sheltered Care Facilities and Illinois’ Veterans Home Code. Available online: [http://www.state.il.us/aging/laboutidoa/LTC/LTC_council.htm](http://www.state.il.us/aging/laboutidoa/LTC/LTC_council.htm)

48 Illinois Human Services Commission. (2013). Available online: [http://www2.illinois.gov/hsc/Pages/default.aspx](http://www2.illinois.gov/hsc/Pages/default.aspx)

activities like: movement or re-training of staff and loss of existing roles and responsibilities that a state agency may have had for decades. Clearly articulated roles and responsibilities across State agencies are necessary for Illinois to ensure adequate oversight within the new MMC system.

Illinois governmental agencies involved with the Medicaid program are formally meeting regularly and communicating through email and telephone multiple times daily. These meetings are focused on the transition to an MMC system and relate specifically to Illinois’ three major managed care initiatives: the Integrated Care Program, the Medicare-Medicaid Alignment Initiative and the Innovations Project. This includes the following State governmental departments:

- Illinois Department on Aging
- Illinois Department of Healthcare and Family Services
- Illinois Department of Human Services
- Illinois’ Governor’s Office

While not an MMC specific initiative, Illinois is also one of seven states to receive a 12-month planning grant from the United States Department of Health and Human Services: the Illinois Framework for Healthcare and Human Services. One of the specific Framework projects is the Governance Project which is focused on developing recommendations to promote state agency and state program interoperability.

The Framework includes the same departments outlined above which are primarily responsible for MMC systems design and implementation. Thus, the Framework recommendations and findings should provide many useful tools and a methodology for enhancing Illinois interagency collaboration, a crucial component for the ultimate success of the MCC system. The following subsections present MMC best practices from others states that focus on interagency collaboration.

**State Medicaid Agency LTSS Oversight and Monitoring**

As Illinois develops its MMC system, a key decision will be how to efficiently provide LTSS oversight. There are three main models for MMC LTSS oversight: a fully integrated model, a partially integrated model, and a separate model:

- In a **fully integrated model**, the SMA has one unit that performs all oversight functions for all of its contracted MCOs, this includes MMC LTSS.

- In a **partially integrated model**, the SMA has a dedicated MMC unit, but within the MMC unit there is a distinct sub-unit that is dedicated to LTSS oversight that includes both FFS and managed care programs. In a partially integrated model, there will be two

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separate sets of staff performing MMC oversight: one for LTSS and one for everything outside of LTSS; these staff coordinate closely together to ensure coordination between LTSS and other services within the MMC system.

- In a separate model, the SMA has two separate units for its MMC programs: one unit is responsible for complete oversight of MCOs that includes LTSS; the other unit is responsible for complete oversight of MCOs that do not include LTSS.

In an MMC LTSS oversight study of eight states with MMC experience that were beginning to implement MMC LTSS programs, six of the eight chose to partially or fully integrate LTSS oversight within the SMA. Reasons for partially or fully integrating LTSS oversight within the SMA include: facilitation of information sharing across various MMC operations, reduced duplication of effort across agencies and divisions, and more efficient use of resources. Ultimately, the goal is to integrate LTSS with other MMC operations in order to promote the quality of MMC LTSS oversight.

It is not clear what model of LTSS oversight Illinois’ HFS will employ. Regardless of the model, the literature identifies five areas of LTSS oversight that states are responsible for:

1. Contract Monitoring and Performance Improvement
2. Provider Network Adequacy and Access to Services
3. Quality Assurance and Improvement
4. Member Education and Consumer Rights
5. Rate Setting

In the MMC LTSS oversight study, most of the eight states’ Medicaid agencies worked with other state agencies to enhance oversight capacity and add expertise to LTSS oversight. The roles and responsibilities of state agencies outside of the SMA varied depending on an assessment of the various agencies strengths, expertise and competencies of staff. Illinois’ current proposed structure for MMC LTSS oversight will be a shared responsibility between HFS, DOA, and DHS.

One way to clearly articulate the roles and responsibilities of Illinois’ governmental agencies involved with MMC LTSS is to develop Memorandums of Understanding (MOUs) between the agencies. Minnesota is a state that has developed an MOU between various state departments regarding specific MMC LTSS oversight roles and responsibilities.

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52 Ibid
53 Ibid
54 Ibid
Integrating Aging and Disability Services: State Departments and Local Networks

The integration of aging and disability services and networks is reflected through the Federal Government’s development of the Administration for Community Living (ACL). Within the Federal Department of Health and Human Services (HHS) the ACL integrates the Administration on Aging, the Administration on Intellectual and Developmental Disabilities, and the HHS Office on Disability. This Federal leadership on integrating aging and disability departments guides states in managing and planning for their own governmental agency system design.

With the integration of aging and disability networks, the cultural differences between the two fields must be acknowledged, embraced and taken into account in the practical world of designing programs and services. Integration of aging and disability requires the retention of expertise in the diversity of areas that encompass the two fields. Consideration must be made for the differences in the theoretical approaches to care, and the broad areas of care that include for both the aging and disability networks: intellectual or cognitive, mental health and physical health.

Although the fields of aging and disability are unique in their own right, they do intersect when it comes to LTSS. Alignment of aging and disability allows for:

- Alignment of policies and programs to ensure efficiency
- Strengthening the advocacy base for balancing LTSS in favor of HCBS and improving the quality of LTSS both in the institutional and HCBS settings.

Regardless of the challenges in integrating aging and disability services, at both a state government and local community stakeholder level, all three of the states interviewed integrated their aging and disability services.

Integrating State Departments

All three states interviewed integrate aging and disability activities and responsibilities, while only Kansas and Tennessee formally integrate their aging and disability departments. Depending on each state’s unique governmental agency infrastructure the integration of aging and disability services looks a little different.

In Texas, the Department of Aging and Disability Services (DADS) did not play a leadership role with any Medicaid programming; all Medicaid LTSS programming and oversight—both FFS and MMC—is integrated within the SMA. The Texas DADS is responsible for all other aging and disability related Federal and state programs and services.

In Kansas, all aging and disability programming and services—Medicaid, Federal and state-only—are integrated within DADS. Kansas chose to integrate their aging and disability departments into one agency prior to the transition to an MMC system. This decision was driven largely by the experience of New Mexico, an experienced MMC state, who shared that their transition to an MMC system was challenging as a result of having too many agencies involved.
Integrating Local Aging and Disability Networks
Local integration of disability and aging services is reflected through development of the Aging and Disability Resource Center (ADRC) network in Illinois and across the country. Illinois’ ADRC network represents collaborations between the Aging Network (including AAAs and CCUs) and the disability network, often represented by Centers for Independent Living (CILs). In Illinois, and in the 3 states interviewed, the AAAs have taken a leadership role in the transition to an ADRC system.

In Illinois, both the Aging Network and the CILs are already in alignment with the Federal guidance on and vision for the ADRC network. An important part of the Aging Network and the CILs is to streamline access to LTSS for older persons and persons with disabilities, and this the ADRC’s main purpose. In Illinois, ADRCs are designed as a Coordinated Entry Point, or no-wrong-door system for individuals seeking LTSS. This means that if a consumer contacts an AAA, CCU, CIL or other ADRC affiliated partner, the consumer will be assisted and connected with the resources they are seeking, either directly or through linkages and referrals.

The AoA and Centers for Medicare and Medicaid Services further describe their vision for ADRCs to:
- Operate as person-centered, community-based and promote independence and dignity
- Provide easy access to LTSS information and counseling on LTSS options
- Provide resources and services for consumers and their family caregivers

Under the DOA’s leadership, the Illinois ADRC network is designed as a no-wrong-door system that will help consumers access LTSS, navigate their health care options, and link consumers to services that include in-home care, nutrition, transportation and prescription assistance. ADRCs provide assistance to consumers regardless of payer-type and are a portal to Medicare, Medicaid, private pay, Older Americans Act, and other Federal and State funded LTSS.

In addition to providing oversight of the ADRC network, DOA is responsible for the oversight of the Senior Health Insurance Program (SHIP). SHIP provides individual counseling for Medicare beneficiaries to help consumers navigate health and LTSS systems. With 260 SHIP certified sites in Illinois, there is potential to align ADRC and SHIP efforts to strengthen the services and assistance offered to older persons and persons with disabilities navigate the health care system.

Illinois’ ADRC system is similar in design to the Kansas, Tennessee and Texas’ ADRCs as a Single Entry Point/no-wrong-door for LTSS. These three states talked about the ADRC system design giving the Aging Network an opportunity to return to their historic role of information and assistance, referrals and linkages—in partnership with the disability community.

Strategically, the three states interviewed determined that in the development of an MMC system, the best system design is for MCOs, not ADRCs, to provide leadership in care plan development, care coordination and service provision. Illinois’ ADRC system is designed this
way, too, and there are plans to further strengthen the role of ADRCs in Illinois as describe in a recently accepted proposal to CMS to participate in the Balancing Incentive Payment Program.\textsuperscript{55}

During the transition to an MMC system in Illinois, a major, and critical, undertaking for the ADRC network is learning to navigate and partner with MCOs. MCOs are new partners who operate under a different business model than ADRC entities are most familiar with. While ADRCs are familiar with the complexities of the systems and processes of AAAs, CCUs, and CILs, MCOs are a new system to learn about. Learning how to collaborate with MCOs will take time for the ADRCs and requires both learning about MCOs and educating MCOs about what the ADRC network does.

There is great potential for innovative partnerships in aligning the MMC system with the ADRC network. This alignment offers an opportunity to better integrate medical and social systems of care as discussed in the following sub-section.

\textit{Integration of MMC and the ADRC Network}

Through proactive and formalized collaboration between MCOs and the ADRCs, medical and social care can be better integrated than it was previously in the FFS system. Depending on the MMC initiative, MCOs will be responsible for management of health services—medical and social—paid for through Medicaid and in some cases Medicare. This includes the MCOs responsibility for Medicaid LTSS provided in the community setting. However, as discussed above, ADRCs are an important entry for all LTSS, regardless of payer, and goes beyond Medicaid LTSS.

As a result of going beyond Medicaid LTSS, ADRCs connect consumers to LTSS that address social determinants of health—for example economic counseling, housing assistance, access to transportation and nutrition counseling—and are advocates for consumers to promote their health, safety and happiness in the community setting. ADRC roles and responsibilities are distinctly different, and complimentary, to the MCOs.

However, finding the right role for the ADRC network to play in the integration of medical and social care is not without challenges. To date, the ADRC’s funding streams have not been sufficient to fund the programs that provide needed services to the older adults and persons with disabilities seeking care in the community setting. At the community-level in Illinois, AAAs, CCUs and CILs have always sought additional funds to ensure they are able to continuously provide the services in the community that older persons and persons with disabilities require. Finding adequate funding streams for the ADRC services that help consumers live in the community setting is essential and MCOs can play a new role in the ADRC business models.

\textsuperscript{55} The Balancing Incentive Payment Program is established by section 10202 of the Affordable Care Act and offers states an opportunity to strengthen their Medicaid HCBS infrastructure through an increased Medicaid federal matching rate for eligible Medicaid HCBS expenditures. In exchange for the increased match rate, states must make the following structural changes: (1) a no-wrong-door/single entry point system; (2) conflict-free case management; (3) unified assessment tool across LTSS populations. Available online: \url{http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/11-010.pdf}
Another major challenge is the lack of experience and expertise of operating in a business environment that requires negotiating contracts based upon rates for services and program outcomes. Historically, ADRC entities have largely relied on grant funding that did not require rate-setting for services nor were ADRCs required to collect the detailed program outcome data that MCOs are seeking. The current transition represents significant movement toward quality over quantity in the business model design for ADRCs.

Texas provides an excellent example for how ADRCs can serve as the MMC connection to the community and social supports beyond Medicaid. The contracts between Texas’ SMA and the MCOs require referral protocols to connect consumers with the ADRCs for LTSS not covered in the MMC system. Texas articulated that MCOs do not cover all of the services a consumer needs, but they are required to refer and ensure consumers are connected with the services they need beyond the MCO.

At the ADRC level, therefore, local partners—AAAs, CCUs, CILs, providers, advocacy groups—must be aware of each other and what services are offered. According to Texas, this local level is where the “magic” happens: communities coming together to coordinate and partner collectively with the MCOs. One indicator of this success is seeing MCOs include in their proposal language specific activities related to directly integrating with the ADRCs. Contracts for services between the ADRCs and MCOs are possible as well, giving the ADRCs new income streams to supplement their work.

At a larger systemic level, ensuring integration of the MMC system and the ADRC Network happens through interagency strategic planning; DOA and OASAC can provide leadership in this area.

**Promoting Home- and Community-based LTSS**

In partnership with ADRCS, MMC offers an opportunity to promote home- and community-based LTSS. As discussed above, there are a variety of best practice incentives that can be built into an MMC system to promote home- and community-based care that Illinois is already taking advantage of: require that all LTSS (both institutional and HCBS) are part of the MCO service package, offer quality measure pay-for-performance measures for home- and community-based LTSS, and offer individuals who require LTSS freedom of choice of setting by explaining all LTSS options.

There are additional requirements that Illinois can build into its MMC system to promote HCBS that other states identified, including:

- MCOs must have SNF diversion programs
- MCOs must have SNF transition programs, and must screen SNF residents for transition at least annually
There are additional SNF transition benchmarks and incentives that Illinois can build into its MMC system that align with Illinois’ Colbert consent decree implementation plan\(^{56}\) and Money Follows the Person (MFP) program. Tennessee offers extensive incentives for nursing facility-to-community transitions that serve as a good example for Illinois:

- An incentive payment is received for every consumer who transitions out of a nursing facility through the MFP program
- If an MCO exceeds the MFP transition benchmark established by the State, they receive double the incentive payment for all consumers transitioned above the benchmark
- Additional incentives are offered for consumers who have transitioned from a nursing facility and have their needs met a year later in the community
- Additional incentives are offered to MCOs who meet benchmarks in the MFP plan regarding participation in consumer-direction and network development of community-based residential alternative providers

Another important way to promote home and community-based LTSS is to clearly articulate within the MCO contracts which HCBS MCOs are required to offer. Although Illinois will allow MCOs to provide HCBS beyond the typical parameters of 1915(C) service packages, the State has not included specific language in its contracting that can be used to hold the MCOs accountable. For example, if Illinois would like to see greater usage of telehealth services within MMC and this is not explicitly written into MCO contracts there is no way easy way to track and require MCOs to provide telehealth services.

Finally, one of the most critical components of providing HCBS through MMC is the ability to track baseline data (either in FFS or in the beginning stages of MMC) and compare data over time. Simple outcomes data points over time about the percentage of total LTSS funding toward institutional (SNF) or HCBS allow stakeholders to assess if MMC is achieving the expected balancing of LTSS in favor of home- and community-based care.

**Quality: Broadly Defined**

Illinois’ governmental agencies have provided a good start in defining the quality measures to which MCOs will be held accountable.\(^{57}\) Stakeholders were invited to provide feedback to HFS on their draft Health and Outcome Measures in MMC. The OASAC workgroup involved in the development of this report were eager to provide feedback on LTSS specific health and quality of life measures. However, the workgroup quickly found the depth of research and information on managed LTSS quality to be staggering.

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\(^{56}\) Colbert v Quinn is a lawsuit filed on behalf of a class of Illinois nursing facility residents with disabilities who allege that they are unnecessarily institutionalized. The lawsuit is in alignment with the Americans with Disabilities Act and the Rehabilitation Act which is interpreted to mean that all Illinoisans have the choice to receive care in the most integrated setting appropriate to their care needs, including home- and community-based care. Illinois Pathways to Community Living. (2012). “Colbert V Quinn”. Available online: [http://mfp.illinois.gov/colbert.html](http://mfp.illinois.gov/colbert.html)

Illinois stakeholders should submit their preliminary LTSS quality measure research\(^{58}\) to HFS and work collaboratively with HFS to identify additional LTSS priority quality measures for the MMC system. The OASAC workgroup had several questions to guide the process in how to proceed with narrowing down which LTSS quality measures to add to the existing measures to strengthen LTSS in the MMC system:

1. Which measures are of greatest priority in the near future during the initial transition to MMC?
2. Which measures are next in line of priority after the initial transition to MMC?
3. Which measures should MCOs be responsible to oversee? Which measures require external research and evaluation?
4. Based upon the measures that are selected as a priority, how will the relevant data be collected and by whom (MCOs, outside researchers such as the University of Illinois at Chicago, or another entity)?

**Contracts as a the Driver Behind Quality Assurance**

Quality is a broad topic area, and is more than health and quality of life measures for consumers in an MMC system. Broadly defined, quality is a part of all of the components of an MMC system. These main components should be included in all MMC contracts and include the following:

- Member Education: Transition to & Ongoing Implementation of a Managed Care System
- Monitoring & Oversight
- Consumer Input and Rights
- Network Adequacy/Access to Care
- Continuity of Care
- LTSS Provider Standards
- Evaluation/Quality Measurement

Contracts are a vehicle to ensure accountability. Contract provisions that cover the components identified above should be defined clearly and explicitly to convey exactly how the State would like its MCOs to operate. Like many contracts, the final draft will be a negotiation—between HFS and the MCOs—and open for amendment by the HFS at any time. In this subsection, Tennessee and Texas’ experience in contract development, monitoring and updating will be covered.

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\(^{58}\) With the support of the OASAC workgroup, Health & Medicine Policy Research Group has completed preliminary research based on current literature about managed LTSS quality measures that is broken into two main sections: quality of life/consumer satisfaction, and quality of care. The research is further broken down into seven domains: consumer- and caregiver-centered experience and outcomes, safety, clinical care, care coordination, population or community health, staffing, and efficiency and cost reduction. This research is not published but available upon request of the authors.
Holding MCOs Accountable: Liquidated Damages

Financial penalties are a method to motivate MCO behavior change and an important way for HFS to provide feedback to the MCOs about their performance. One specific type of financial penalty that Texas and Tennessee use frequently is liquidated damages (LDs).

LDs require a fee to be paid in the case of a breach of a term in the contract between the MCO and HFS. This kind of financial penalty is not typical in the FFS system. Texas and Tennessee emphasized that if there is something important in the contract that HFS wants MCOs to pay attention to, an LD should be associated with that requirement.

LDs can be tied to any number of requirements, including the following examples given by Texas and Tennessee. Many of these examples represent LDs that the states have filed against MCOs because the requirements outlined in the contracts were not met by the MCOs:

- Performance standards for timely claims processing and claims payment accuracy
- Compliance with licensure and background check requirements
- Timely provision of an approved service
- Continuation of benefits pending appeal
- Timely development of a plan of care and initiation of LTSS upon a member’s enrollment
- Completion of care coordination contacts

LDs offer states a way to hold MCOs accountable to contract requirements. In Texas’ experience, LDs can be as small as $250 for not meeting a performance standard to process member appeals within 30-days, or as large as $100,000 for denying two LTSS eligible members access to a covered service. In Texas, LD fees are not allowed to be paid out from money given to the MCO from the state. Texas lists all of the LDs filed against the MCOs on their website so that the public can also monitor MCO performance.

Continuously Updating Contracts Through Amendments

MMC contracts between HFS and the MCOs may be continuously amended, and in practice these contracts should be amended on a regular basis. If HFS learns that a certain requirement should be updated or added to their contracts in order to improve the quality of the MMC system, they should amend their contracts in a timely manner.

In Tennessee, contracts are amended at least every 6-months; the Chief of the LTSS Division of the SMA keeps a running “Contract Amendment File” for all suggested LTSS amendments. Each business owner has responsibility for contract amendments pertaining to their respective

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program area and a central SMA contract compliance division integrates all of the amendments into one synthesized amendment.

The process in Tennessee requires the state to receive approval from a fiscal review committee prior to finalizing a contract amendment. Tennessee also affords MCOs the opportunity to review proposed amendments and provide input before they are finalized. In Tennessee’s experience, many changes are made based upon MCO feedback; the MCOs provide useful feedback to enhance the quality of the contracts. By the time an amendment is finalized, the state is already thinking about the next round of amendments.
Opportunities and Challenges for a Successful Transition to an MMC System in Illinois

Through the research and development of this report, the authors have identified a set of challenges and developed corresponding opportunities that if implemented will promote LTSS quality assurances and consumer protections in the MMC system. Further, if Illinois takes advantage of the opportunities described, the State will better position itself to achieve the goals of: better health care, improved population health, cost savings, and integration of medical services and social services that address the social determinants of health.

Taking advantage of the opportunities identified in this section will not be without challenge, change is never easy for complex institutions such as state government, and will require flexibility and new skills on everyone’s part as the system realigns to achieve the overarching goals. The areas of opportunity for Illinois’ MMC success are summarized in the image below:

**Challenge: Effective Stakeholder Engagement**
Stakeholders working in silos will limit Illinois’ capacity to achieve an MMC system that improves health care and population health, reduce costs, and address social determinants of health. In regards to LTSS, without formal channels for LTSS non-governmental stakeholder engagement, LTSS consumers are at risk for poor health care and poor health outcomes.

In order to integrate care in the new MMC system Illinois should go beyond innovation within silos and look to creating accountable partnerships across silos. Although State departments...
must certainly take on a central leadership role in the transition to a MMC system, meaningful stakeholder engagement is essential through all phases of the transition to the MMC system. The states interviewed for this project and the literature strongly support formal development of stakeholder engagement processes (pages 34-36).

**Opportunities for OASAC Stakeholder Engagement:**

1. Illinois’ governmental agencies should increase transparency by:
   - Developing a user friendly website that is easy to navigate and includes comprehensive information about the MMC system and all of Illinois’ various MMC initiatives (page 34).
   - Sharing State department organizational charts that are responsible for MMC activities (page 34).

2. Illinois’ Older Adult Services Advisory Committee (OASAC) should create a LTSS stakeholder engagement workgroup charged with recommending a model for ensuring meaningful stakeholder engagement in the MMC system. While the workgroup should focus on LTSS stakeholder engagement, the model development should have applicability and utility for all stakeholder groups. The workgroup should:
   - Develop recommendations for how LTSS stakeholders can become more involved in the development and review of MMC incentives for balancing LTSS in favor of home- and community-based services. Other states provide an example for additional LTSS balancing incentives that Illinois can consider (pages 42-43).
   - Take into account the various LTSS reform initiatives that are related to MMC, including: the Colbert Consent Decree, Money Follows the Person, the Balancing Incentive Payment Program, the Aging and Disability Resource Centers, new MMC waivers (1115(c)), the universal assessment tool, and the Illinois Framework for Healthcare and Human Services.
   - Develop recommendations for working in collaboration with and sharing information between the many other LTSS advisory groups in the State, including: the Medicaid Advisory Committee – Long-Term Care Subcommittee, the Illinois Council on Aging, the Council on Long-Term Care, and the Health Services and Facilities Review – Long-Term Care Subcommittee (pages 35-36).

3. OASAC should review its membership structure in response to the transition to an MMC system and an ADRC system. Additional members should be added representing managed care expertise and disability services.

4. OASAC should immediately submit to HFS the MMC LTSS quality measures research described in this report (page 43-44). In collaboration with LTSS stakeholders, HFS should identify additional priority LTSS quality measures for Illinois MMC system.
Challenge: Adequate State government MMC expertise

MMC is not a typical Medicaid program in that a large number of beneficiaries are enrolled into one integrated program, therefore requiring a significant amount of money to be paid to one entity: an MCO. This represents a dramatic shift in how the Medicaid program has been historically structured, where beneficiaries were spread among many providers through many separate programs and service line reimbursements (page 18).

As a result, the State’s level of oversight must be greater than in the FFS system (pages 18-19). Additionally, Illinois’ departmental leadership must be knowledgeable about managed care in order to provide appropriate oversight of MCOs. For LTSS this requires multiple State agencies to have trained staff and appropriate organizational structures. These agencies include DOA, HFS, and DHS (pages 19-23).

Opportunities for adequate state government MMC expertise in Illinois:

Illinois’ governmental agencies should train and recruit specific, qualified MMC staff with expertise to provide oversight and monitoring in the MMC system (pages 20-22). Several different activities are recommended to ensure appropriate State agency staff qualifications in the MMC system:

1. Illinois’ governmental agencies involved with MMC should do an assessment of their current staff to determine what MMC expertise they already have in place and where they need to train staff or recruit additional staff (pages 20-22). Other states emphasized the need for this assessment and acknowledged that some MMC expertise must be recruited from outside of state government (page 22). Illinois could engage more experienced MMC LTSS states, and/or national organizations with expert resources in managed care such as NASUAD as consultants to assist with this state government expertise assessment (page 21).

2. Illinois should collaborate with local academic institution(s) and MCOs to develop a managed care training curriculum for State government employees. Specific continuing education programs can be offered in important MMC areas that include: LTSS quality and oversight, and LTSS contract compliance (pages 22-23).

3. Illinois’ governmental agencies should assess their current organizational structures to determine if the current structures will allow for sufficient MMC oversight. There is great opportunity for the State agencies to implement innovative oversight models like other states have done: Texas utilizes health plan management teams and Tennessee restructured their MMC organizational structure to be significantly similar to an MCO’s organizational structure (pages 22-23).

4. Illinois’ Governor’s Office should evaluate the existing LTSS oversight for MMC that is currently the responsibility of three agencies: DOA, HFS, and DHS (pages 36-38). Clearly articulated roles and responsibilities should be developed between agencies. Findings from the Illinois Framework for Healthcare and Human Services, particularly from the Governance project which looks at enhancing agency interoperability, should help guide
this process (page 37). In other states two activities were described to ensure quality LTSS oversight; Illinois should evaluate these best practices for feasibility and applicability in Illinois:

- Integration of all MMC LTSS oversight within the State Medicaid Agency to allow for efficiency, reduction in duplication of efforts across departments, and to ensure quality of LTSS oversight (pages 37-38).

- Development of Memorandums of Understanding (MOUs) between State agencies that clearly define MMC LTSS oversight roles and responsibilities (page 38). MOUs also offer an easy way for the State to be more transparent.

**Challenge: Aging and Disability Resource Center (ADRC) integration with MMC**

Stakeholders working in silos risk losing the opportunity to better integrate medical and social care and to rebalance LTSS in favor of HCBS. HFS, as the State Medicaid Agency, is ultimately responsible for the MMC system and developing a broad coordination effort across systems to assure there is no wrong door for MMC consumers.

DOA is providing leadership in the development of an ADRC system in partnership with the aging and disability communities to ensure no wrong door for LTSS consumers (page 40-42). As HFS and DOA develop the work plan for the State Balancing Incentive Payment Program (page 41), the ADRC network will become an important entry portal for the MMC system.

ADRCs are a coordinated-point-of-entry or no-wrong-door system of access to LTSS and include aging and disability network stakeholders like: AAAs, CCUs, CILs and providers. ADRCs have expertise in community-based social services that include Medicaid funded services, but also include other funded services like those provided through the Older Americans Act.

Under DOA’s leadership, ADRCs have the expertise and experience to develop a strong community-based LTSS network. Through deliberate and formal partnerships between HFS and DOA and engagement of ADRC stakeholders, the MMC and ADRC systems can better integrate medical and social care for individuals who require LTSS, and promote the balancing of LTSS in favor of home- and community-based care.

**Opportunities for ADRC integration with MMC in Illinois:**

1. Under the leadership of the Department on Aging, Illinois should develop a strategic vision for its ADRC network that clearly articulates the formal relationship between ADRCs and the MCOs and how they interface at every level: consumer, agency/organization, and stakeholder. The strategic vision should:

   - Be developed in partnership with ADRC stakeholders, including: consumers, AAAs, CCUs, CILs, and providers. This will ensure stakeholder buy-in and will allow for community expertise to inform the ADRC vision
   - Be developed in partnership with HFS and DHS to ensure state government efficiency and to include state government expertise
• Include how ADRCs will collaborate with the following LTSS reform initiatives: the Colbert Consent Decree, Money Follows the Person, the Senior Health Insurance Program, the Balancing Incentive Payment Program (page 41), the development of new MMC waivers (1115 (c)), the universal assessment tool, and the Illinois Framework for Health and Human Services (page 37)

• Clearly state what services and supports ADRCs offer and how to navigate the system as a consumer, provider, and MCO

• Describe potential data collection methods that can be implemented to ensure ADRC and MMC integration is evidence-based

• Provide recommendations for MMC contract language that will formalize the collaboration between MCOs and ADRCs (pages 41-42)

• Provide recommendations for additional MMC contract language that will promote LTSS balancing in favor of community-based care (pages 42-43)

2. Under the leadership of Illinois’ Governor’s Office, Illinois should evaluate the utility and potential of integrating State Aging and Disability departments. Two of the three states interviewed for this report have integrated aging and disability departments: Kansas and Texas.

Although the fields of aging and disability are unique in their own right, they do intersect when it comes to LTSS (page 39). Integration of aging and disability enables:

• Alignment of policies and programs to ensure efficiency and quality of LTSS services

• Strengthening the advocacy base for balancing LTSS in favor of HCBS and improving the quality of LTSS both in institutional and HCBS settings

3. Providers and ADRC stakeholders have the opportunity to negotiate contracts with MCOs that go beyond the typical FFS model and allow for innovative new reimbursement methods. MCOs should be viewed as an ally of providers and ADRC stakeholders, a partner to work with in order to provide innovative services that meet the unmet needs of Illinois Medicaid population (pages 30-32).

In order to negotiate contracts with MCOs, Providers and ADRCs should:

• Collaborate at the local level to ensure there is an understanding of where services and programs overlap and to explore opportunities for community-level collaboration (page 42).

• Educate MCOs about their unique services and areas of expertise, clearly articulating how services offered will be useful to MMC beneficiaries (pages 30-32)
**Challenge: Adequate Legislative Oversight of MMC**

Legislative governance is essential to consumer protections in order to ensure consumer protections and quality assurances in Illinois MMC system.

**Opportunities for Adequate Legislative Oversight of MMC in Illinois:**

1. Develop a Medicaid managed care legislative subcommittee of the Human Services Committee.

2. Illinois MMC legislative committee should:
   - Hold hearings about Illinois’ transition to and implementation of an MMC system. These hearings should be broken down by population types to ensure that all stakeholder groups’ voices are heard
   - Publish hearings’ results in a clear and concise manner
   - Inform the development of legislation in Illinois that governs MMC including for example streamlining of MCO provider credentialing processes; currently each MCO has a unique provider credentialing process (page 30)
Conclusion

MMC, along with Illinois’ many other health reform initiatives including the Illinois Framework for Healthcare and Human Services, offers the State a mechanism that will contribute to reaching the goals of: better healthcare, improved population health, healthcare cost savings, and integration of medical services and social services that address social determinants of health.

As Illinois continues to transform its Medicaid program into an integrated MMC system that will better meet consumers’ needs, there is great need for leadership in developing how this new system will work. Recognizing the fluidity of state government and the political process, this is the time for leaders from government and non-government stakeholder groups to rise to the challenge of envisioning innovation in the MMC system that will best provide healthcare and promote health for Illinois’ low-income population.

The transition to an MMC system is already underway in Illinois and the success of the transition depends on collaboration across government and non-government stakeholder groups. With deliberate attention paid to developing processes for collaboration amongst all stakeholders, and promoting innovation and integration—within and across state government, providers, and other stakeholder entities—Illinois has the potential to become a national leader in MMC including serving LTSS consumers.
Appendix A: Acronyms and Abbreviations

- Administration for Community Living = ACL
- Aging and Disability Resource Center = ADRC
- Area Agency on Aging = AAA
- Care Coordination Unit = CCU
- Center for Independent Living = CIL
- Centers for Medicare and Medicaid Services = CMS
- Fee-For-Service = FFS
- Illinois Department of Healthcare and Family Services = HFS
- Illinois Department of Public Health = DPH
- Illinois Department on Aging = DOA
- KanCare Interagency Contract Monitoring Team = KICM
- Liquidated Damages = LD
- Long-Term Services and Supports = LTSS
- Managed Care Organization = MCO
- Managed Long-Term Services and Supports = MLTSS
- Medicaid Advisory Committee = MAC
- Medicaid Managed Care = MMC
- Money Follows the Person = MFP
- Older Adult Services Advisory Committee = OASAC
- Planning and Service Areas = PSA
- Single Entry Point = SEP
- Skilled Nursing Facility = SNF
- State Department on Aging and Disability Services = DADS
- State Medicaid Agency = SMA
- State Unit on Aging = SUA
- The Integrated Care Program = ICP
- The Medicare-Medicaid Alignment Initiative = MMAI
Appendix B: OASAC Medicaid Managed Care Workgroup Meetings and Interviews

Workgroup Members
- Phyllis Mitzen, Health & Medicine Policy Research Group – Co-Chair
- Kristen Pavle, Health & Medicine Policy Research Group– Co-Chair
- Sandra Alexander, Illinois Department on Aging
- Stephanie Altman, Health and Disability Advocates
- Darby Anderson, Addus HealthCare
- Carol Aronson, Shawnee Alliance for Seniors
- Ann Ford, Illinois Network of Centers for Independent Living
- Sue Hughes, University of Illinois at Chicago
- Jon Lavin, AgeOptions
- Chris Laxton, Life Services Network
- Dave Lowitzki, SEIU Healthcare Illinois and Indiana
- Eli Pick, Post Acute Innovations
- Dave Vinkler, AARP
- Cathy Weightman-Moore, Regional Ombudsman, Catholic Charities, Diocese of Rockford

Other Meeting Attendees
- Hillary Bray, University of Chicago Graduate Student Intern at Health & Medicine Policy Research Group
- John Michael Hall, National Association of States United for Aging and Disabilities
- Julie Hamos, Illinois Department of Healthcare and Family Services
- John K. Holton, Illinois Department on Aging
- Robert Kilbury, Illinois Department of Human Services
- Esther Macchione, Community Care Alliance of Illinois
- Patrick Maguire, University of Chicago Graduate Student Intern at Illinois Department on Aging
- Joseph Mason, Illinois Department on Aging
- James Parker, Illinois Department of Healthcare and Family Services
- Sally Petrone, Illinois Department on Aging, Office of the State Long-Term Care Ombudsman
- Sharon Post, SEIU Healthcare Illinois and Indiana
- Lyle VanDeventer, Illinois Department of Human Services
### Workgroup Meeting: January 7, 2013
- S. Alexander
- S. Altman
- D. Anderson
- C. Aronson
- H. Bray
- R. Kilbury
- J. Lavin
- P. Maguire
- P. Mitzen
- J. Parker
- K. Pavle
- E. Pick
- S. Post
- D. Vinkler
- C. Weightman
- Moore

### Workgroup Meeting: January 30, 2013
- S. Altman
- D. Anderson
- C. Aronson
- H. Bray
- A. Ford
- J. Holton
- J. Lavin
- P. Maguire
- P. Mitzen
- K. Pavle
- S. Post
- L. VanDeventer
- C. Weightman-Moore

### Workgroup Meeting: February 11, 2013
- S. Altman
- D. Anderson
- C. Aronson
- H. Bray
- A. Ford
- S. Hughes
- J. Lavin
- P. Maguire
- P. Mitzen
- K. Pavle
- E. Pick
- S. Post
- L. VanDeventer
- C. Weightman-Moore

### Full OASAC and Workgroup Meeting Featuring Mike Hall (NASUAD): February 25, 2013
- S. Alexander
- S. Altman
- D. Anderson
- C. Aronson
- H. Bray
- A. Ford
- M. Hall
- J. Hamos
- S. Hughes
- R. Kilbury
- J. Lavin
- E. Macchione
- P. Maguire
- J. Mason
- P. Mitzen
- K. Pavle
- S. Petrone
- E. Pick
- S. Post
- L. VanDeventer
- D. Vinkler
- C. Weightman-Moore

### Workgroup Meeting: March 4, 2013
- S. Alexander
- S. Altman
- D. Anderson
- C. Aronson
- H. Bray
- S. Hughes
- J. Lavin
- P. Maguire
- P. Mitzen
- K. Pavle
- S. Post
- L. VanDeventer
- D. Vinkler
- C. Weightman-Moore

### Interview with Patti Killingsworth, Assistant Commissioner for the Bureau of TennCare: March 20, 2013
- S. Alexander
- H. Bray
- P. Mitzen
- K. Pavle
Interview with Shawn Sullivan, Secretary of Aging and Disability Services in Kansas: March 22, 2013

- H. Bray
- P. Mitzen
- K. Pavle

Interview with Gary Jessee, Deputy Director of Program Operations in the Medicaid/CHIP Division in Texas: March 22, 2013

- P. Mitzen
- K. Pavle

Workgroup Meeting: April 17, 2013

- S. Alexander
- S. Altman
- D. Anderson
- H. Bray
- S. Hughes
- J. Lavin
- P. Maguire
- P. Mitzen
- K. Pavle